Spirituality & Health: A Select Bibliography Of *Medline*-Indexed Articles Published In 2003

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The following is a selection of 183 Medline-indexed journal articles pertaining to spirituality & health published during 2003. 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). For more information, e-mail: john.ehman@uphs.upenn.edu.

Abrahm, J. L. [Pain and Palliative Care Program, Dana-Farber Cancer Institute, Boston, MA; Jabrahm@partners.org]. "**Update in palliative medicine and end-of-life care**." *Annual Review of Medicine* 54 (2003): 53-72. [Review, 94 refs.]
This overview notes, among other things, that the domain of palliative care involves relief of spiritual aspects of suffering as well as physical, psychological, and social aspects of suffering. See especially the section on The Relief of Suffering, on pp. 57-8.

Acton, G. J. and Miller, E. W. [School of Nursing, University of Texas at Austin, TX]. "**Spirituality in caregivers of family members with dementia**." *Journal of Holistic Nursing* 21, no. 2 (Jun 2003): 117-30.
This descriptive, naturalistic field study used interviews of 9 family caregivers of adults with dementia to investigate spiritual meaning in their caregiving and how it informs their sense of the burden of caregiving. Spirituality is here construed broadly as "a connection between a higher power, others, and oneself that resulted from patterns of process, communication, and discovery."

Advani, A. S., Atkeson, B., Brown, C. L., Peterson, B. L., Fish, L., Johnson, J. L., Gockerman, J. P. and Gautier, M. [Department of Hematology/Oncology, Duke University Medical Center, Durham, NC; advania@ccf.org]. "**Barriers to the participation of African-American patients with cancer in clinical trials: a pilot study**." *Cancer* 97, no. 6 (Mar 15, 2003): 1499-506.
This study of 72 African-American and 146 Caucasian patients with malignant disease found, among other things, that belief that God would determine if they would be cured or die was (along with education and income) correlated with willingness to participate in clinical trials.

Al-Kassimi, M. [King Abdulaziz University Hospital, Jeddah, Saudi Arabia; makassimi@hotmail.com]. "**Cultural differences: practising medicine in an Islamic country**." *Clinical Medicine* 3, no. 1 (Jan-Feb 2003): 52-3. Comment in: *Clinical Medicine* 3, no. 2 (Mar-Apr 2003): 186.
The author offers practical insight and guidance for non-Muslim clinicians working with Muslim patients in an Islamic country, based upon his 25 years of practice at a university hospital in Saudi Arabia. The article may also be of general value to non-Muslim clinicians working across such lines of religious/cultural diversity with their patient populations.

Albaugh, J. A. [Northwestern Memorial Hospital, Chicago, IL; jaalbaug@nmh.org]. "**Spirituality and life-threatening illness: a phenomenologic study**." *Oncology Nursing Forum. Online* 30, no. 4 (Jul-Aug 2003): 593-8.
This study of 5 women and 2 men, aged 44-74, living in the Midwest, found [from the abstract]: Participants described how their spirituality provided comfort throughout their journey, strength in facing the life-threatening illness, many blessings despite the hardship of the illness, and trust in a higher power to see them through the journey. All participants described a sense of meaning in their lives throughout their experience. ...Spirituality greatly affected patients' journeys through a life-threatening illness and provided a sense of meaning despite the illness.

Ambuel, B. [Waukesha Family Practice Center, Waukesha, WI; bruce.ambuel@phci.org]. "**Taking a spiritual history**." *Journal of Palliative Medicine* 6, no. 6 (Dec 2003): 932-3.
The author reflects briefly on practice of taking a spiritual history, using Maugans' SPIRIT assessment. The article is an excerpt from the chapter, "Discussing Spiritual Issues and Maintaining Hope," in *Improving End-of-Life Care: A Resource Guide for Physician Education* (3rd. ed., Milwaukee: Medical College of Wisconsin, 1999, pp. 133-144), by the author and D. E. Weissman.

Armbruster, C. A., Chibnall, J. T. and Legett, S. [Department of Pediatrics, Saint Louis University School of Medicine, SSM Cardinal Glennon Children's Hospital, 1465 S. Grand Blvd., St. Louis, MO 63104; brooksca@slu.edu]. "**Pediatrician beliefs about spirituality and religion in medicine: associations with clinical practice**." *Pediatrics* 111, no. 3 (Mar 2003): e227-35. [The abstract (only) appears in the print edition on pp. 262-3, referring the reader to the journal's "electronic pages."]
[Abstract:] OBJECTIVES: Identify pediatrician (faculty and resident) beliefs about spirituality and religion (SR) in medicine and the relationship of those beliefs to SR behavior and experiences in clinical practice. METHODS: A self-report questionnaire was administered to full-time pediatric faculty (N = 65) and residents (N = 56) of an urban children's hospital affiliated with a school of medicine. The response rate was 70.8% among faculty (n = 46) and 78.6% among residents (n = 44). Respondents indicated the extent of their SR inquiry and the frequency of their SR experiences (requests by patients or families to discuss SR or pray), routinely and during health crisis, and rated 19 belief statements about SR in pediatrics. RESULTS: Few pediatricians routinely ask about SR issues. Faculty were more likely than residents to ask about religious affiliation, whereas residents were more likely to be asked to pray during health crises, to believe that SR has health relevance, and to perceive pediatrician-initiated prayer as appropriate. Composite scores indicated that physicians who did not expect negative patient reactions to SR inquiry and prayer, who believed more strongly that SR is relevant to pediatric outcomes, and who felt more capable with SR inquiry were more likely to engage in SR inquiry and to experience SR requests. CONCLUSIONS: Pediatrician beliefs with respect to health

relevance of SR, patient reactions to SR inquiry, and physician capabilities regarding SR in the clinic are strongly related to their clinical practice concerning SR inquiry and experiences. Correction of physician misperceptions about SR issues and incorporation of religious sensitivity into physician training may remove barriers to both patient and physician SR inquiry.

Arnstein, P. [School of Nursing, Boston College, Chestnut Hill, MA; arnstein@bc.edu]. "**Comprehensive analysis and management of chronic pain**." *Nursing Clinics of North America* 38, no. 3 (Sep 2003): 403-17. [Review, 92 refs.]
Among the assertions of this article is [from the abstract]: Eliciting self-reflective narratives about the context of pain in [chronic pain sufferers'] lives taps into the spiritual domain and initiates processes of grieving, forgiveness, and acceptance that are needed to transcend perceived limits and find new meaning in their lives.

Avants, S. K., Marcotte, D., Arnold, R. and Margolin, A. [Department of Psychiatry, Yale University School of Medicine, New Haven, CT]. "**Spiritual beliefs, world assumptions, and HIV risk behavior among heroin and cocaine users**." *Psychology of Addictive Behaviors* 17, no. 2 (Jun 2003): 159-62.
[Abstract:] The relationship between spirituality and HIV risk behavior in a sample of 34 inner-city cocaine-using methadone-maintained patients was examined. Spirituality was operationally defined in terms of "life meaningfulness" and included the Santa Clara Strength of Religious Faith (T. G. Plante & M. T. Boccaccini, 1997b) and the World Assumptions Scale (R. Janoff-Bulman, 1989; assessing benevolence, meaningfulness, and worthiness of the self). Hierarchical multiple regression analyses of self-reported drug- and sex-related risk behavior were conducted with sex and race entered as control variables. The full models accounted for 23% and 42% of the variance in drug- and sex-related risk behavior, respectively. Strength of spiritual/religious faith (B = .37) and belief in a benevolent (beta = .50) and meaningful (beta = .46) world were independent predictors of sex-related, but not drug-related, HIV preventive behavior.

Baker, D. C. [Chaplaincy Services, Passavant Retirement and Health Center, Zelienople, PA 16063; dbaker@lassenior.com]. "**Studies of the inner life: the impact of spirituality on quality of life**." *Quality of Life Research* 12, Suppl. 1 (2003): 51-7. [33 refs.]
[From the abstract:] This article defines spirituality and relates the importance of spirituality to understanding quality of life. Spirituality is examined through organizational religious activities, non-organizational activities and/or as an expression of faith.

Baldacchino, D. R. and Buhagiar, A. [Institute of Health Care, University of Malta, 16 St. John's Street, Siggiewi, Malta QRM 13; donia.baldacchino@um.edu.mt]. "**Psychometric evaluation of the Spiritual Coping Strategies scale in English, Maltese, back-translation and bilingual versions**." *Journal of Advanced Nursing* 42, no. 6 (Jun 2003): 558-70.
This study offers insights on spiritual coping that go beyond its focus on a Maltese patient population. [From the abstract:] The little research that has been done on the topic considers spiritual coping as consisting mainly of religious coping strategies. This limits spiritual coping solely to believers. However, it is argued that spiritual coping should address both believers and non-believers. The development of the new Spiritual Coping Strategies (SCS) scale, which consists of both religious and non-religious coping strategies attempts to fill this research gap.

Barham, D. [Oncology Day Centre, Prince of Wales Hospital, High Street, Randwick, NSW 2031, Australia]. "**The last 48 hours of life: a case study of symptom control for a patient taking a Buddhist approach to dying**." *International Journal of Palliative Nursing* 9, no. 6 (Jun 2003): 245-51.
The article describes the case of a 39-year-old woman and her family (husband and two young children) and how issues of spirituality, serenity, and peacefulness in dying played into her choices regarding end-of-life care and how they were accommodated by her health care providers.

Barilan, Y. M. [Department of Internal Medicine B, Meir Hospital, Kfar Saba, Israel; bentovia@shani.net]. "**Revisiting the problem of Jewish bioethics: the case of terminal care**." *Kennedy Institute of Ethics Journal* 13, no. 2 (Jun 2003): 141-68.
[Abstract:] This paper examines the main Jewish sources relevant to end-of-life ethics: two Talmudic stories, the early modern code of law (Shulhan Aruch), and contemporary Halakhaic (religious law) responsa. Some Orthodox rabbis object to the use of artificial life support that prolongs the life of a dying patient and permit its active discontinuation when the patient is suffering. Other rabbis believe that every medical measure must be taken in order to prolong life. The context of the discussion is the most recent release of the "Steinberg Report," which proposes a law regulating end-of-life issues in Israel. It is argued that the Orthodox rabbis base their views on a strongly positivist concept of religious law. The rabbis deliberate the law as a manifestation of the will of God and try to stretch the law as much as possible in order to benefit the patient, even when it is good for the patient to die. Direct and active actions that kill are prohibited; certain forms of passive euthanasia and contrivances that terminate life support without needing direct human action are accepted.

Bartlett, S. J., Piedmont, R., Bilderback, A., Matsumoto, A. K. and Bathon, J. M. [Johns Hopkins AAC, 5501 Hopkins Bayview Circle, Suite 1B.15, Baltimore, MD 21224; Bartlett@jhmi.edu]. "**Spirituality, well-being, and quality of life in people with rheumatoid arthritis**." *Arthritis & Rheumatism* 49, no. 6 (Dec 15, 2003): 778-83.
[Abstract:] OBJECTIVE: To evaluate spirituality, well-being, and quality of life (QOL) among people with rheumatoid arthritis (RA). METHODS: Questionnaires assessing positive and negative affect, depression, QOL and spirituality were completed. Disease activity was assessed by rheumatologic examination. RESULTS: Women (n = 62) had a mean (+/- SD) age of 53.0 (+/- 13.0) years with 12 (+/- 13) swollen and tender joints (STJ). Men (n = 15) were 61.9 (+/- 13.0) years with 7 (+/- 11) STJ. Disease activity was associated ($P < 0.05$) positively with depression (r = 0.23), pain (r = 0.26), poorer self-ratings of health (r = 0.29) and physical role limitations (r = 0.26). Spirituality was associated directly with positive affect (r = 0.26) and higher health perceptions (r = 0.29). In multiple regression, spirituality was an independent predictor of happiness and positive health perceptions, even after controlling disease activity and physical functioning, for age and mood. CONCLUSION: Spirituality may facilitate emotional adjustment and resilience in people with RA by experiencing more positive feelings and attending to positive elements of their lives.

Bartoli, E. [University of Pennsylvania, Pennsylavania; bartoli@pobox.upenn.edu]. "**Psychoanalytic practice and the religious patient: a current perspective**." *Bulletin of the Menninger Clinic* 67, no. 4 (Fall 2003): 347-66.
[Abstract:] Via a national survey and in-depth interviews, the author investigated training psychoanalysts' views on religion and spirituality and the impact of such views on their treatment practices. The training analysts surveyed described being appreciative of a patient's religious or spiritual worldview when it allowed for flexibility in its theological tenets or when it played a psychologically supportive role. In most

instances, empathy for a suffering human being together with the desire to enter a patient's subjective field of experience overrode analysts' personal and professional biases vis-a-vis religious involvement, when these were present.

Baumann, S. L. and Englert, R. [Hunter College, City University of New York, NY]. "**A comparison of three views of spirituality in oncology nursing**." *Nursing Science Quarterly* 16, no. 1 (Jan 2003): 52-9. [Review, 70 refs.]

[From the abstract:] This article compares three views of spirituality with specific consideration for persons who live with cancer. These views represent theological, psychological, and nursing perspectives. Three dimensions of theologically inspired spirituality are discussed: institutional religious approaches, intellectual questioning, and mystical experiences. The authors review numerous psychological perspectives on the topic of spirituality, particularly from the analytic, humanistic, and existential schools of thought. A human-becoming nursing theory perspective is also offered.

Benjamins, M. R., Musick, M. A., Gold, D. T. and George, L. K. [Population Research Center, Department of Sociology, The University of Texas at Austin, Austin, TX; reindl@prc.utexas.edu]. "**Age-related declines in activity level: the relationship between chronic illness and religious activities**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 58, no. 6 (Nov 2003): S377-85.

[From the abstract:] OBJECTIVES: When they are faced with major life transitions such as worsening health, older adults may selectively withdraw from activities. Because of the importance of religion to a large proportion of the elderly population, research is needed to determine whether levels of religious involvement are affected by serious health problems such as the onset of a chronic disease. METHODS: Multiple waves of data from the Duke Established Populations for Epidemiologic Studies of the Elderly were used to analyze the effects of five different chronic conditions on two religious activities: service attendance and religious media use. RESULTS: Findings show that broken hip, cancer, and stroke were significantly related to levels of religious attendance. Furthermore, the combined conditions also significantly predicted religious attendance, with more conditions being associated with lower attendance. Neither the individual or summed conditions were significantly related to religious media use.

Bookwalter, T. C., Rabow, M. W. and McPhee, S. J. [School of Pharmacy, University of California, 521 Parnassus Avenue, Room C-152, San Francisco, CA 94143-0622; thomasb@itsa.ucsf.edu]. "**Content on end-of-life care in major pharmacy textbooks**." *American Journal of Health-System Pharmacy* 60, no. 12 (Jun 15, 2003): 1246-50.

[From the abstract:] The overall quality of content [about end-of-life care] was low, especially in the domains of spiritual issues, ethics, and context of care. The results were consistent with findings for medicine and nursing textbooks. A review of eight commonly used pharmacy textbooks revealed inadequate coverage of EOLC.

Bosworth, H. B., Park, K. S., McQuoid, D. R., Hays, J. C. and Steffens, D. C. [Durham Veterans Affairs Medical Center, Center for Health Services Research in Primary Care, Durham, NC, USA. hayden.bosworth@duke.edu]. "**The impact of religious practice and religious coping on geriatric depression**." *International Journal of Geriatric Psychiatry* 18, no. 10 (Oct 2003): 905-14.

[Abstract:] OBJECTIVE: Both religiousness and social support have been shown to influence depression outcome, yet some researchers have theorized that religiousness largely reflects social support. We set out to determine the relationship of religiousness with depression outcome after considering clinical factors. METHODS: Elderly patients (n=114) in the MHCRC for the Study of Depression in Late Life while undergoing treatment using a standardized algorithm were examined. Patients completed measures of public and religious practice, a modified version of Pargament's RCOPE to measure religious coping, and subjective and instrument social support measures. A geriatric psychiatrist completed the Montgomery-Asberg Depression Rating Scale (MADRS) at baseline and six months. RESULTS: Both positive and negative religious coping were related to MADRS scores in treated individuals, and positive coping was related to MADRS six months later, independent of social support measures, demographic, and clinical measures (e.g. use of electro-convulsive therapy, number of depressed episodes). Public religious practice, but not private religious practice was independently related to MADRS scores at the time of completion of the religiousness measures. Religious coping was related to social support, but was independently related to depression outcome. CONCLUSIONS: Clinicians caring for older depressives should consider inquiring about spirituality and religious coping as a way of improving depressive outcomes.

Bowie, J., Sydnor, K. D. and Granot, M. [Department of Health Policy and Management, Johns Hopkins University, Bloomberg School of Public Health, 624 North Broadway, Baltimore, MD 21205; jbowie@jhsph.edu]. "**Spirituality and care of prostate cancer patients: a pilot study**." *Journal of the National Medical Association* 95, no. 10 (Oct 2003): 951-4.

[Abstract:] PURPOSE: To explore the integration of spirituality into medical care for African-American men coping with prostate cancer. PROCEDURES: A total of 14 African-American prostate cancer patients completed a self-administered quantitative survey examining the dimension of spirituality as a resource for coping. FINDINGS: A high proportion of survivors reported a general religious orientation as expressed through church affiliation and frequent church attendance. A majority (67%) had spoken with their doctors about their spiritual and religious beliefs and more than half the physicians had solicited their patients' spiritual beliefs as part of their handling of prostate cancer. While one-third of the men reported their doctors had been in contact with their clergy, two-thirds would like their doctor and clergy to be in contact with one another. CONCLUSIONS: This is a pilot study that incorporated both qualitative and quantitative data collection but with the small sample, has limited generalizability. However, this work does suggest that integrating spirituality and religion into medical care may be beneficial to prostate cancer patients. Physicians and physician organizations should engage in future research in this area.

Brett, A. S. and Jersild, P. [Department of Medicine, Center for Bioethics and Medical Humanities, University of South Carolina, Columbia, SC]. "**'Inappropriate' treatment near the end of life: conflict between religious convictions and clinical judgment**." *Archives of Internal Medicine* 163, no. 14 (Jul 28, 2003): 1645-9.

[Abstract:] Not infrequently, Christian patients and families provide religious justifications for an insistence on aggressive medical care near the end of life. Four commonly invoked reasons are (1) hope for a miracle, (2) refusal to give up on the God of faith, (3) a conviction that every moment of life is a gift from God and is worth preserving at any cost, and (4) a belief that suffering can have redemptive value. For each of these 4 reasons, however, there are alternative Christian interpretations that point in the direction of limiting medical intervention under certain circumstances. When clinicians believe that an intervention is medically inappropriate or inhumane, they are not necessarily obligated to provide it simply because it is demanded on religious grounds. Instead, clinicians--preferably assisted by chaplains or clergy--should discuss

alternative religious interpretations with the patient or family, and should attempt to reach a consensus on the appropriate limits to life-sustaining treatment.

Brudenell, I. [Department of Nursing, Boise State University, ID; ibruden@boisestate.edu]. "**Parish nursing: nurturing body, mind, spirit, and community**." *Public Health Nursing* 20, no. 2 (Mar-Apr 2003): 85-94.
[From the abstract:] A descriptive study was conducted in the intermountain West to determine how faith communities form parish nursing programs and what their effect is. Thirteen congregations representing eight denominations with parish nurse/health ministries participated. Parish nurses, parish nurse coordinators from two medical centers, pastors, and hospital chaplains (n = 24) were interviewed and provided documents from their programs. Over time, congregations formed parish nursing/health ministries using strategies in a developmental process. The process involved significant support from the pastor, congregation members, and the parish nurses. Collaboration between faith communities and health organizations were successful using a limited domain approach to attain specific health goals. ...Conclusions and recommendations are included for future research, practice, and education.

Buckwalter, G. L. [Episcopal Church Home, 2511 Cottonwood Drive, Louisville, KY 40242; stlukchpl@aol.com]. "**Addressing the spiritual & religious needs of persons with profound memory loss**." *Home Healthcare Nurse* 21, no. 1 (Jan 2003): 20-4.
Written by a chaplain in long-term health care, the article offers practical suggestions for nurses and some theological reflection on case illustrations. There is emphasis on the patient's meaning-making history and the need to grieve.

Cameron, M. E. [Center for Spirituality and Healing, Center for Bioethics, University of Minnesota, Minneapolis, MN]. "**Legal and ethical issues: our best ethical and spiritual values**." *Journal of Professional Nursing* 19, no. 3 (May-Jun 2003): 117-8.
The author offers a brief commentary in light of four phenomenologic studies with which she was involved. Those studies suggest that patients, as well as nurses, tend to desire to "live according to their best ethical and spiritual values, even when some patients appear to behave in contrary ways" (p. 118). Fourteen ethical and spiritual values are identified, indicating actions and states of being.

Cameron, M. E. [University of Minnesota, Center for Spirituality and Healing, Minneapolis NM; camer008@umn.edu]. "**A Tibetan perspective on ethics, spirituality, and healing**." *Journal of Professional Nursing* 19, no. 5 (Sep-Oct 2003): 245-6.
This brief commentary addresses Tibetan medicine as a complementary and alternative therapeutic approach that integrates ethics, spirituality, and healing: "ethical behavior is the foundation of spiritual growth, and spirituality is essential for healing mind, body and spirituality" (p. 245).

Carlson, L. E., Speca, M., Patel, K. D. and Goodey, E. [Dept. of Psychosocial Resources, Tom Baker Cancer Centre, Calgary, Canada; lcarlso@ucalgary.ca]. "**Mindfulness-based stress reduction in relation to quality of life, mood, symptoms of stress, and immune parameters in breast and prostate cancer outpatients**." *Psychosomatic Medicine* 65, no. 4 (Jul-Aug 2003): 571-81.
[Abstract:] OBJECTIVES: This study investigated the relationships between a mindfulness-based stress reduction meditation program for early stage breast and prostate cancer patients and quality of life, mood states, stress symptoms, lymphocyte counts, and cytokine production. METHODS: Forty-nine patients with breast cancer and 10 with prostate cancer participated in an 8-week MBSR program that incorporated relaxation, meditation, gentle yoga, and daily home practice. Demographic and health behavior variables, quality of life (EORTC QLQ C-30), mood (POMS), stress (SOSI), and counts of NK, NKT, B, T total, T helper, and T cytotoxic cells, as well as NK and T cell production of TNF, IFN-gamma, IL-4, and IL-10 were assessed pre- and postintervention. RESULTS: Fifty-nine and 42 patients were assessed pre- and postintervention, respectively. Significant improvements were seen in overall quality of life, symptoms of stress, and sleep quality. Although there were no significant changes in the overall number of lymphocytes or cell subsets, T cell production of IL-4 increased and IFN-gamma decreased, whereas NK cell production of IL-10 decreased. These results are consistent with a shift in immune profile from one associated with depressive symptoms to a more normal profile. CONCLUSIONS: MBSR participation was associated with enhanced quality of life and decreased stress symptoms in breast and prostate cancer patients. This study is also the first to show changes in cancer-related cytokine production associated with program participation.

Cavendish, R., Konecny, L., Mitzeliotis, C., Russo, D., Luise, B., Lanza, M., Medefindt, J. and Bajo, M. A. [College of Staten Island/City, University of New York, Brooklyn, NY; RCavendish@prodigy.net]. "**Spiritual care activities of nurses using Nursing Interventions Classification (NIC) labels**." *International Journal of Nursing Terminologies & Classifications* 14, no. 4 (Oct-Dec 2003): 113-24.
Questionnaires from 97 Sigma Theta Tau International members indicated 32 spiritual care activities by nurses, which could be mapped according to 10 Nursing Interventions Classification (NIC) labels. The authors conclude [from the abstract]: The use of NIC labels can facilitate documentation of spiritual care activities in diverse practice settings. PRACTICE IMPLICATIONS: This study supports greater specificity in describing spiritual care interventions to a level that allows replication and advancement of knowledge.

Chibnall, J. T., Jeral, J. M., Cerullo, M., Knorp, J. F. and Duckro, P. N. [Department of Psychiatry, Saint Louis University School of Medicine, St. Louis, MO; chibnajt@slu.edu]. "**Medical school exposure to spirituality and response to a hypothetical cancer patient**." *Journal of Cancer Education* 17, no. 4 (Winter 2002): 188-90.
[Abstract:] BACKGROUND: Spiritual and religious issues (SRI) in medical school curricula may promote psychosocial and spiritual sensitivity, but few data exist on this relationship. METHOD: A questionnaire was administered to third-year medical students (response rate = 69.2%). Students indicated exposure to SRI and read a vignette about a hypothetical cancer patient. RESULTS: SRI exposure through lectures, small-group discussions, and physician modeling predicted, respectively, likelihood of extra attention toward the patient, conversing with the patient about dying, and praying with the patient. CONCLUSIONS: Exposure to SRI in medical school may sensitize students to the psychosocial and spiritual needs of dying patients.

Clarfield, A. M., Gordon, M., Markwell, H. and Alibhai, S. M. [Soroka Hospital, Ben Gurion University of the Negev, Beersheva, Israel; markclar@hotmail.com]. "**Ethical issues in end-of-life geriatric care: the approach of three monotheistic religions--Judaism, Catholicism, and Islam**." *Journal of the American Geriatrics Society* 51, no. 8 (Aug 2003): 1149-54.
[From the abstract:] The authors present three clinical cases, each of which presents ethical dilemmas typical of geriatric care, especially at the end of life. On the basis of these scenarios, the normative ethical position of each religion is compared and contrasted. It is hoped that this approach will offer the geriatrician a useful approach to treating patients in an increasingly multicultural society.

Clarke, E. B., Curtis, J. R., Luce, J. M., Levy, M., Danis, M., Nelson, J., Solomon, M. Z., and the Robert Wood Johnson Foundation Critical Care End-Of-Life Peer Workgroup Members [Center for Applied Ethics and Professional Practice, University of Washington, Seattle WA]. "**Quality indicators for end-of-life care in the intensive care unit**." *Critical Care Medicine* 31, no. 9 (Sep 2003): 2255-62. Comment on pp. 2399-400.

[From the abstract:] Participants were the 36 members of the Robert Wood Johnson Foundation (RWJF) Critical Care End-of-Life Peer Workgroup and 15 nurse-physician teams from 15 intensive care units affiliated with the work group members. Fourteen adult medical, surgical, and mixed intensive care units from 13 states and the District of Columbia in the United States and one mixed intensive care unit in Canada were represented. ...MEASUREMENTS AND MAIN RESULTS: Seven EOLC domains were identified for use in the intensive care unit: a) patient- and family-centered decision making; b) communication; c) continuity of care; d) emotional and practical support; e) symptom management and comfort care; f) spiritual support; and g) emotional and organizational support for intensive care unit clinicians. Fifty-three EOLC quality indicators within the seven domains were proposed. More than 100 examples of clinician and organizational behaviors and interventions that could address the EOLC quality indicators in the intensive care unit setting were identified. CONCLUSIONS: These EOLC domains and the associated quality indicators, developed through a consensus process, provide clinicians and researchers with a framework for understanding quality of EOLC in the intensive care unit. Once validated, these indicators might be used to improve the quality of EOLC by serving as the components of an internal or external audit evaluating EOLC continuous quality improvement efforts in intensive care unit settings.

Clark, P. A., Drain, M. and Malone, M. P. [Department of Research Operations and Service, Press Ganey Associates, South Bend, IN; pclark@pressganey.com]. "**Addressing patients' emotional and spiritual needs**." *Joint Commission Journal on Quality & Safety* 29, no. 12 (Dec 2003): 659-70. [Review, 148 refs.]

[Abstract:] BACKGROUND: A comprehensive, systematic literature review and original research were conducted to ascertain whether patients' emotional and spiritual needs are important, whether hospitals are effective in addressing these needs, and what strategies should guide improvement. METHODS: The literature review was conducted in August 2002. Patient satisfaction data were derived from the Press Ganey Associates' 2001 National Inpatient Database; survey data were collected from 1,732,562 patients between January 2001 and December 2001. RESULTS: Data analysis revealed a strong relationship between the "degree to which staff addressed emotional/spiritual needs" and overall patient satisfaction. Three measures most highly correlated with this measure of emotional/spiritual care were (1) staff response to concerns/complaints, (2) staff effort to include patients in decisions about treatment, and (3) staff sensitivity to the inconvenience that health problems and hospitalization can cause. DISCUSSION: The emotional and spiritual experience of hospitalization remains a prime opportunity for QI. Suggestions for improvement include the immediate availability of resources, appropriate referrals to chaplains or leaders in the religious community, a team dedicated to evaluating and improving the emotional and spiritual care experience, and standardized elicitation and meeting of emotional and spiritual needs. Survey data suggested a focus on response to concerns/complaints, treatment decision making, and staff sensitivity.

Clements, P. T., Vigil, G. J., Manno, M. S., Henry, G. C., Wilks, J., Das, S., Kellywood, R. and Foster W. [College of Nursing, University of New Mexico, Albuquerque, NM; pclements@salud.unm.edu]. "**Cultural perspectives of death, grief, and bereavement**." *Journal of Psychosocial Nursing & Mental Health Services* 41, no. 7 (Jul 2003): 18-26. [Review, 19 refs.]

This article discusses a number of beliefs, customs, and rituals that may be characteristic of Latino, African American, Navajo, Jewish, and Hindu groups in order to raise awareness of the differences health care professionals may encounter among their clients amid grief.

Cohen, M. [Department of Religious Studies, Arizona State University, Tempe, AZ]. "**The affirmation of a religious (not merely spiritual!) orientation in clinical treatment**." *Journal of the American Academy of Psychoanalysis & Dynamic Psychiatry* 31, no. 2 (Summer 2003): 269-73.

The author comments on the prevalence of the term *spiritual* in present day mental health treatment in often positive ways, while *religion* has a bad connotation; and she suggests that the latter, especially as it relates to organized religious activity, should be not be dismissed.

Coleman, C. L. [Assistant Professor, Department of Integrative Systems, School of Nursing, Virginia Commonwealth University, Richmond, VA; clcoleman@vcu.edu]. "**Spirituality and sexual orientation: relationship to mental well-being and functional health status**." *Journal of Advanced Nursing* 43, no. 5 (Sep 2003): 457-64. [Review, 35 refs.]

This study of 117 African-American men and women employed the Spiritual Well-Being Scale to explore the influence of spirituality and sexuality on mental well-being and functional health status in people with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). The authors conclude that [from the abstract]: ...regression analysis showed that spirituality, sexual orientation, age and HIV symptoms contributed significantly to mental well-being and functional health status. ...The findings support the inclusion of spirituality as a variable when examining mental well-being and physical health.

Connor, K. M., Davidson, J. R. and Lee, L. C. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC; kathryn.connor@duke.edu]. "**Spirituality, resilience, and anger in survivors of violent trauma: a community survey**." *Journal of Traumatic Stress* 16, no. 5 (Oct 2003): 487-94.

[Abstract:] This study evaluates the relationship between spirituality, resilience, anger and health status, and posttraumatic symptom severity in trauma survivors. A community sample (N = 1,200) completed an online survey that included measures of resilience, spirituality (general beliefs and reincarnation), anger, forgiveness, and hatred. In survivors of violent trauma (n = 648), these measures were evaluated with respect to their relationship to physical and mental health, trauma-related distress, and posttraumatic symptom severity. Using multivariate regression models, general spiritual beliefs and anger emerged in association with each outcome, whereas resilience was associated with health status and posttraumatic symptom severity only. Forgiveness, hatred, and beliefs in reincarnation were not associated with outcome. The importance of these findings to treating trauma survivors is discussed.

Corrigan, P., McCorkle, B., Schell, B. and Kidder, K. [University of Chicago Center for Psychiatric Rehabilitation, Tinley Park, IL 60477; p-corrigan@uchicago.edu]. "**Religion and spirituality in the lives of people with serious mental illness**." *Community Mental Health Journal* 39, no. 6 (Dec 2003): 487-99.

[Abstract:] Although there is a fair sized literature documenting the relationship of religiousness and spirituality with health and well-being, far fewer studies have examined this phenomenon for people with serious mental illness. In this research, religiousness is defined as participation in an institutionalized doctrine while spirituality is framed as an individual pursuit of meaning outside the world of immediate experience. In this study, 1,824 people with serious mental illness completed self-report measures of religiousness and spirituality. They also completed measures of three health outcome domains: self-perceived well-being, psychiatric symptoms, and life goal achievement. Results showed that both religiousness and spirituality were significantly associated with proxies of well being and symptoms, but not of goal achievement. Implications of these findings for enhancing the lives of people with psychiatric disability are discussed.

Counsell, C., Adorno, G. and Guin, P. [Shands Hospital, University of Florida, Gainesville, FL]. "**Establishing an end-of-life program in an academic acute care hospital**." *SCI Nursing* 20, no. 4 (Winter 2003): 238-49.

[From the abstract:] This article discusses the components of a pilot project that focused on palliative EOL care at an academic acute care hospital. An interdisciplinary team of nurses, social workers, chaplains, patient care coordinators, and advanced practice nurses established a common vision for the care of patients who were "in the dying process," or were expected to die during their hospitalizations. A nurse-social worker "Care-Pair Team" completed a consistent interdisciplinary EOL care needs assessment when treatment goals became strictly palliative. Interventions were driven by a clinical pathway and a pre-printed physician's order set that continually clarified the goals of treatment.

Cox, T. "**Theory and exemplars of advanced practice spiritual intervention."** *Complementary Therapies in Nursing & Midwifery* 9, no, 1 (Feb 2003): 30-4. [Review, 25 refs.]

[Abstract:] Spirituality, defined consistently with the work of Martha E Rogers, is explored and application of spiritual interventions is described and discussed using two case studies that exemplify working with clients in a manner that blends environmental resources with personal needs. This paper illustrates how nurses can perform non-denominational spiritual interventions without compromising belief systems of client or nurse and without a great deal of material resources or time. Simple, time-limited interventions that respond to clients' minimal needs are well within the abilities of all nurses to perform, do not require excessive material or personnel resources and may reduce clients' anxieties, leading to reduced dissatisfactions with care and facilitating client recovery and rehabilitation.

Cummings, S. M., Neff, J. A. and Husaini, B. A. [College of Social Work, University of Tennessee, 193-E Polk Avenue, Nashville, TN 37210; scumming@utk.edu]. "**Functional impairment as a predictor of depressive symptomatology: the role of race, religiosity, and social support**." *Health & Social Work* 28, no. 1 (Feb 2003): 23-32.

[Abstract:] The study discussed in this article examined the relationship between depression symptomatology and functional impairment among white and African American elderly people and investigated the effect of race, religiosity, and social support on this relationship. Study results indicate that although African American elderly people were more impaired in the performance of activities of daily living (ADL) and instrumental activities of daily living (IADL) than white elderly people, they did not experience higher levels of depression. However, African Americans did report significantly higher levels of religiosity and social support.

Devinsky, O. [New York University, New York, NY 10016; od4@nyu.edu]. "**Religious experiences and epilepsy**." *Epilepsy & Behavior* 4, no. 1 (Feb 2003): 76-7.

The authors comment briefly and historically about associations between religiosity and epilepsy and about how latter day research has focused on religions conversion rather than interictal religious experience.

Dykes, C. M. "**Menetrier's disease: case study in the quality of life**." *Gastroenterology Nursing* 26, no. 1 (Jan-Feb 2003): 3-6. [Review, 34 refs.]

[Abstract:] Menetrier's disease is a type of hypertrophic gastropathy, a rare, acquired premalignant disorder of the stomach accompanied by debilitating symptoms such as nausea and vomiting, anorexia, edema, epigastric pain, and weight loss. The disease results in a marked negative effect on the patient's quality of life. This article will present information on Menetrier's disease, quality of life, and the effect this disease and subsequent treatment had on a patient's physical, emotional, and spiritual well-being.

Eeles, J., Lowe, T. and Wellman, N. [Oxford Mental Healthcare, NHS Trust, Warneford Hospital, Headington, OX3 7JX, Oxford, UK]. "**Spirituality or psychosis?—An exploration of the criteria that nurses use to evaluate spiritual-type experiences reported by patients**." *International Journal of Nursing Studies* 40, no. 2 (Feb 2003): 197-206.

[Abstract:] Spiritual experiences and psychotic symptoms have many aspects of form and content in common. Despite this, clinicians make judgements about the pathology of these experiences and base care-plans on these judgements. Semi-structured interviews incorporating vignettes of spiritual-type experiences were given to 14 UK mental health nurses. This revealed that the nurses employed a complex and inter-relating set of criteria when evaluating spiritual-type experiences. The nature of the experience was considered, but the outcome of the experience (positive or negative) was an important evaluative factor, together with the personal and cultural context in which the experience occurred. The nurses demonstrated a tolerance of ambiguity and the need for awareness of their own subjectivity. They emphasized the importance of close-engagement with patients to achieve a rounded and holistic view of the patient's experience. They also emphasized the importance of team working in reducing idiosyncratic decision making.

Egan, M. and Swedersky, J. [Ontario Ministry of Health and Long-Term Care, Occupational Therapy Program, School of Rehabilitation Sciences, University of Ottawa, Ontario, Canada; megan@uottawa.ca]. "**Spirituality as experienced by occupational therapists in practice**." *American Journal of Occupational Therapy* 57, no. 5 (Sep-Oct 2003): 525-33.

[Abstract:] Despite considerable literature describing the potential place of spirituality in occupational therapy, surveys repeatedly demonstrate that therapists are uncomfortable with this concept in practice. To gain a better understanding of how spirituality might inform practice, we interviewed eight occupational therapists who stated that they considered spirituality while working with patients. Participants defined spirituality as one's beliefs about the world and one's place in it and how one lives out these beliefs, through reflection and conscious actions. Four themes of consideration of spirituality in practice emerged. In the first, addressing religious concerns, therapists dealt with patients' religious questions and issues. In the second, addressing suffering, therapists assisted patients to deal with their feelings related to loss and pain, attempted to relieve patients' distress and helped patients move towards increased functioning. In the third, encouraging the self, therapists worked to assist patients to acknowledge their own worth and to use their unique gifts and interests. In the fourth, growing as a person, therapists themselves were transformed as a result of the therapeutic encounter. This study represents an early attempt to determine what

occupational therapists who consider spirituality actually do in practice. Future research should go deeper into the experience of such therapists, to gain a richer understanding of the phenomenon.

Emmons, R. A. and Paloutzian, R. F. [Department of Psychology, University of California, Davis, CA; raemmons@ucdavis.edu]. "**The psychology of religion**." *Annual Review of Psychology* 54 (2003): 377-402. [Review, 130 refs.]

[Abstract:] This chapter discusses progress in the psychology of religion by highlighting its rapid growth during the past 25 years. Recent conceptual and empirical developments are described, with an emphasis on the cognitive and affective basis of religious experience within personality and social psychology. Religion and spirituality as domains of study, as well as being common and important process variables that touch a large portion of human experience, are highlighted. Movement away from the previously dominant measurement paradigm is noted, and particularly promising directions suggestive of an emerging interdisciplinary paradigm are described.

Everly, G. S. Jr. "**Pastoral crisis intervention in response to terrorism**." *International Journal of Emergency Mental Health* 5, no. 1 (Winter 2003): 1-2.

[Abstract:] Pastoral crisis intervention may be thought of as the functional integration of crisis intervention and pastoral support. In effect, the practice of pastoral crisis intervention largely represents the use of faith-based interventions refined and augmented through the use of an emergency mental health delivery context. The value of pastoral crisis intervention seems apparent in situations involving death, serious injury, mass disasters, and cataclysmic events such as war. Nowhere, however, is pastoral crisis intervention potentially more useful than in response to real or threatened terrorism.

Falsetti, S. A., Resick, P. A. and Davis, J. L. [University Family Health Center, College of Medicine at Rockford, University of Illinois at Chicago]. "**Changes in religious beliefs following trauma**." *Journal of Traumatic Stress* 16, no. 4 (Aug 2003): 391-8.

[Abstract:] Information processing theorists propose that traumatic events can lead to disruptions in the processing of information and to changes in beliefs. This study examined the relationships among trauma, posttraumatic stress disorder (PTSD), and religious beliefs. Participants included 120 individuals from community and clinical samples who participated in the DSM-IV Field Trial Study on PTSD. Results indicated that the PTSD group was more likely to report changes in religious beliefs following the first/only traumatic event, generally becoming less religious. PTSD status was not related to change in religious beliefs following the most recent event. Intrinsic religiosity was related to multiple victimization, but not PTSD. Results are discussed in terms of understanding the function of religiosity in participants' lives and future directions for research.

Felix A. K., Levine, D. and Burstin, H. R. [Center of Primary Care Research, Agency of Healthcare Research and Quality, Rockville, MD; kfaaron@ahrq.gov] "**African American church participation and health care practices**." *Journal of General Internal Medicine* 18, no. 11 (Nov 2003): 908-13. Comment on pp. 962-3.

[Abstract:] BACKGROUND: While religious involvement is associated with improvements in health, little is known about the relationship between church participation and health care practices. OBJECTIVES: To determine 1) the prevalence of church participation; 2) whether church participation influences positive health care practices; and 3) whether gender, age, insurance status, and levels of comorbidity modified these relationships. DESIGN: A cross-sectional analysis using survey data from 2196 residents of a low-income, African-American neighborhood. MEASUREMENTS: Our independent variable measured the frequency of church attendance. Dependent variables were: 1) Pap smear; 2) mammogram; and 3) dental visit-all taking place within 2 years; 4) blood pressure measurement within 1 year, 5) having a regular source of care, and 6) no perceived delays in care in the previous year. We controlled for socioeconomic factors and the number of comorbid conditions and also tested for interactions. RESULTS: Thirty-seven percent of community members went to church at least monthly. Church attendance was associated with increased likelihood of positive health care practices by 20% to 80%. In multivariate analyses, church attendance was related to dental visits (odds ratio [OR], 1.5; 95% confidence interval [CI], 1.3 to 1.9) and blood pressure measurements (OR, 1.6; 95% CI, 1.2 to 2.1). Insurance status and number of comorbid conditions modified the relationship between church attendance and Pap smear, with increased practices noted for the uninsured (OR, 2.3; 95% CI, 1.2 to 4.1) and for women with 2 or more comorbid conditions (OR, 1.9; 95% CI, 1.1 to 3.5). CONCLUSION: Church attendance is an important correlate of positive health care practices, especially for the most vulnerable subgroups, the uninsured and chronically ill. Community- and faith-based organizations present additional opportunities to improve the health of low-income and minority populations.

Ferrell, B. R., Smith, S. L., Juarez, G. and Melancon, C. [Department of Nursing Research and Education, City of Hope National Medical Center, Duarte, CA; bferrell@coh.org]. "**Meaning of illness and spirituality in ovarian cancer survivors**." *Oncology Nursing Forum* 30, no. 2 (Mar-Apr 2003): 249-57.

[From the abstract:] PURPOSE/OBJECTIVES: To describe spirituality and meaning of illness in survivors of ovarian cancer. DESIGN: Ethnographic study based on seven years of natural correspondence among survivors of ovarian cancer and a support newsletter. SAMPLE: 21,806 letters, cards, and e-mails received from survivors of ovarian cancer from 1994-2000. ...FINDINGS: Spirituality was relied on heavily as a coping mechanism, as well as a method of deriving meaning from the cancer experience. Data from survivors of ovarian cancer validated previously established meaning in cancer themes and identified eight new themes specific to meaning in ovarian cancer survivorship. CONCLUSIONS: The nature of ovarian cancer implicates specific characteristics that alter the meaning of QOL and survivorship. Spirituality is an important component of QOL and contributes to the process of deriving meaning from the ovarian cancer experience....

Feudtner, C., Haney, J. and Dimmers, M. A. [Division of General Pediatrics, Children's Hospital of Philadelphia, Philadelphia, PA; feudtner@email.chop.edu]. "**Spiritual care needs of hospitalized children and their families: a national survey of pastoral care providers' perceptions**." *Pediatrics* 111, no. 1 (Jan 2003): e67-72. [The abstract (only) appears in the print edition on p. 192, referring the reader to the journal's "electronic pages."]

[Abstract:] OBJECTIVE: Although spirituality is viewed as a vital aspect of the illness experience by most Americans, little is known about this domain of pediatric health care. The objective of this study was to profile pastoral care providers' perceptions of the spiritual care needs of hospitalized children and their parents, barriers to better pastoral care, and quality of spiritual care in children's hospitals. METHODS: A cross-sectional mail survey was conducted of pastoral care providers at children's hospitals throughout the United States, with a 67% response rate from 115 institutions. RESULTS: Respondents estimated that, among patients they visited, 34% were chronically ill and 21% were clearly dying. Half or more of patients were thought to have spiritual care needs regarding feeling fearful or anxious, coping with pain or other physical symptoms, and regarding their relationship to their parents or the relationship between their parents. Among patients' parents, 60% to

80% were estimated to have felt fearful or anxious, had difficulty coping with their child's pain or other symptoms, sought more medical information about their child's illness, questioned why they and their child were going through this experience, asked about the meaning or purpose of suffering, and felt guilty. Respondents agreed on 3 barriers to providing spiritual care: inadequate staffing of the pastoral care office, inadequate training of health care providers to detect patients' spiritual needs, and being called to visit with patients and families too late to provide all the care that could have been provided. Overall, respondents judged that their hospitals were providing 60% of what they deemed as ideal spiritual care. CONCLUSIONS: Pastoral care providers believe that the spiritual care needs of hospitalized children and their parents are diverse and extensive. With system-level barriers cited as limiting the quality of spiritual care, considerable improvement may be possible.

Finch, N. and Sneed, N. [College of Nursing, Medical University of South Carolina, Charleston, SC; finchn@musc.edu]. "**Quality of life when living with heart failure**." *Critical Care Nursing Clinics of North America* 15, no. 4 (Dec 2003): 511-7. [35 refs.]
In this overview, the authors focus on four major domains of QOL as it manifests in chronic illness, with implications for heart failure patients: health & functioning, psychologic & spiritual issues, social & economic issues, and family issues. See p. 515 for discussion of spirituality.

Fisch, M., Zichi, Cohen, M., Rutledge, C. and Cripe, L. D. [Dept. of Palliative Care and Rehabilitation Medicine, M. D. Anderson Cancer Center, Houston, TX; mfisch@mdanderson.org]. "**Teaching patients how to improve communication with their health care providers: a unique workshop experience**." *Journal of Cancer Education* 18, no. 4 (Winter 2003): 188-93.
In their analysis of a survey completed by 28 of 70 participants in a one-day program aimed at helping cancer patients improve communication with their cancer care providers, 41% agreed with the statement: "Overall, my discussions with my physician about emotional or spiritual issues were very helpful." Explanatory comments by those surveyed indicated a wide range of experiences on this point.

Fisch, M. J., Titzer, M. L., Kristeller, J. L., Shen, J., Loehrer, P. J., Jung, S. H., Passik, S. D. and Einhorn, L. H. [M. D. Anderson Cancer Center, Unit 008, Room P12.2911, 1515 Holcombe Blvd., Houston, TX 77030-4009; mfisch@mdanderson.org]. "**Assessment of quality of life in outpatients with advanced cancer: the accuracy of clinician estimations and the relevance of spiritual well-being--a Hoosier Oncology Group Study**." *Journal of Clinical Oncology* 21, no. 14 (Jul 15, 2003): 2754-9.
[Abstract:] PURPOSE: To evaluate the association between quality-of-life (QOL) impairment as reported by patients and QOL impairment as judged by nurses or physicians, with and without consideration of spiritual well-being (SWB). PATIENTS AND METHODS: A total of 163 patients with advanced cancer were enrolled onto a therapeutic trial, and cross-sectional data were derived from clinical and demographic questionnaires obtained at baseline, including assessment of patient QOL and SWB. Clinicians rated the QOL impairment of their patients as mild, moderate, or severe. Clinician-estimated QOL impairment and patient-derived QOL categories were compared. Correlation coefficients were estimated to associate QOL scores using different instruments. The analysis of variance method was used to compare Functional Assessment of Cancer Therapy-General scores on categorical variables. RESULTS: There was no significant association between self-assessment scores and marital status, education level, performance status, or predicted life expectancy. However, a strong relationship between SWB and QOL was noted (P <.0001). Clinician-estimated QOL impairment matched the level of patient-derived QOL correctly in approximately 60% of cases, with only slight variation depending on the method of categorizing patient-derived QOL scores. The accuracy of clinician estimates was not associated with the level of SWB. Interestingly, a subset analysis of the inaccurate estimates revealed an association between lower SWB and clinician underestimation of QOL impairment (P =.0025). CONCLUSION: Clinician estimates of QOL impairment were accurate in more than 60% of patients. SWB is strongly associated with QOL, but it is not associated with the overall accuracy of clinicians' judgments about QOL impairment.

Flannelly, K. J., Liu, C., Oppenheimer, J. E., Weaver, A. J. and Larson, D. B. [HealthCare Chaplaincy, 307 E. 60th St., New York, NY 10022]. "**An evaluation of the quantity and quality of empirical research in three pastoral care and counseling journals, 1990-1999: has anything changed?**" *Journal of Pastoral Care & Counseling* 57, no. 2 (Summer 2003): 167-78.
[Abstract:] This article summarizes a review of all articles published in Pastoral Psychology, The Journal of Religion and Health, and The Journal of Pastoral Care between 1900 and 1999, identifying a total of 737 scholarly articles, of which 165 (22.4%) were research studies. The proportion of research studies, especially quantitative studies, increased significantly between the first and second half of the study period ($p < .05$). There was a significant positive correlation between compliance with three out of four criteria of internal validity. Three of five criteria of external validity were also positively related to one another. Compared to previous research using identical criteria to assess quantitative studies in the same journals in 1980-1989, the 1990-1999 sample showed improved compliance with respect to specifying the sampling method ($p < .001$), reporting the response rate ($p < .05$), and discussing the limitations of research studies ($p < .001$). However, the overall findings suggest that many researchers in the field do not have a sophisticated knowledge of statistical sampling, statistical analysis, or research design. Several recommendations for increasing the quality of quantitative research are offered.

Flannelly, K. J., Weaver, A. J. and Handzo, G. F. [The HealthCare Chaplaincy, 307 E. 60th St., New York, NY 10022; kflannelly@healthcarechaplaincy.org]. "**A three-year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York city**." *Psycho-Oncology* 12, no. 8 (Dec 2003): 760-8.
[Abstract:] The pastoral-care interventions of chaplains at Memorial Sloan-Kettering Cancer Center were documented during two-week periods in each of three years. The study describes the pattern of referrals to and from chaplains and the kinds of interventions performed during the chaplains' contacts with patients and their families and friends. Nearly a fifth of all chaplain interventions were the result of referrals. The vast majority of staff referrals to chaplains came from nurses, with the frequency and proportion of referrals from nurses significantly increasing over time. More than a third of all chaplain contacts were with friends and family without the patient present, and over 40% of referrals to chaplains were for the friends and family of patients. Pastoral visits were significantly shorter when patients were not present. In particular, pastoral-care interventions were found to differ according to the patient's religion and the circumstances of the chaplain's visit to the patient (i.e. patient status). Visit duration also varied by patient status, with pre-operative visits being significantly shorter than post-operative or treatment visits.

Flannelly, K. J., Weaver, A. J., Smith, W. J. and Oppenheimer, J. E. [The HealthCare Chaplaincy, New York, NY]. "**A systematic review on chaplains and community-based clergy in three palliative care journals: 1990-1999**." *American Journal of Hospice & Palliative Care* 20, no. 4 (Jul-Aug 2003): 263-8. [Review, 45 refs.]

[Abstract:] A systematic review of all articles appearing between 1990 and 1999 in the American Journal of Hospice and Palliative Care, the Hospice Journal, and the Journal of Palliative Care was conducted. Articles citing at least one reference were categorized as scholarly, included in the study, and divided into either research or nonresearch categories. Scholarly articles were classified as research if they contained clearly defined methods and results sections, even if these headings were not used. Research and nonresearch articles were subdivided into qualitative and quantitative research and general reviews or program descriptions, respectively. All scholarly articles were read to see if they mentioned clergy, including the terms rabbi, priest, minister, pastor, imam, chaplain, or other religious professionals. Of 838 scholarly articles published between 1990 and 1999 in the three journals, 348 (41.5 percent) were research articles, 417 (49.8 percent) were reviews, and 73 (8.7 percent) were program descriptions. Forty-seven (5.6 percent) of all 838 scholarly articles mentioned clergy or chaplains in some way. Clergy and chaplains were more likely to be an integral part of research articles, whereas mention of them in nonresearch articles tended to be incidental (chi-square = 16.8, $p < .001$). Moreover, quantitative articles were more likely to include clergy as an integral aspect of the article than were qualitative articles (Fischer's exact probability test, $p = .088$). The results are discussed with respect to the mutual roles hospice chaplains and community-based clergy play in providing spiritual care at the end of life.

Fry, P. S. [Graduate Program in Psychology, Trinity Western University, Langley, British Columbia, Canada; fry@twu.ca]. "**Perceived self-efficacy domains as predictors of fear of the unknown and fear of dying among older adults**." *Psychology & Aging* 18, no. 3 (Sep 2003): 474-86.

[Abstract:] Using a sample of 167 women and 121 men, aged 65-87, this study tested the hypothesis that self-efficacy beliefs of older persons are significantly stronger predictors of death fears than are demographics, social support, and physical health variables used in earlier predictor models. Standard self-report measures were used to assess all predictor variables, including perceived self-efficacy in 8 different domains. Findings from a series of hierarchical regression analyses that were conducted separately for men and women supported the hypothesis concerning the superiority of self-efficacy variables as predictors of fear of the unknown after death and fear of dying, with spiritual health efficacy and instrumental efficacy being the most potent predictors of death fears for women and men, respectively.

Gall, T. L. [Faculty of Human Sciences, Saint Paul University, Ottawa, Ontario, Canada]. "**The role of religious resources for older adults coping with illness**." *Journal of Pastoral Care & Counseling* 57, no. 2 (Summer 2003): 211-24.

[Abstract:] The present study investigated the role of religious/spiritual appraisal and coping among a community sample of older adults with illness. In particular this study explored the relationship between these religious resources and nonreligious cognitive appraisals (e.g., threat) and coping behavior in response to illness. These religious resources were related to more adaptive forms of general appraisal and coping. For example, meaning-making related to God (e.g., God's will) was linked to more positive appraisals of the illness and its potential to lead to growth. As well, various forms of religious coping behavior were associated with older adults' use of positive reframing and active forms of general coping. Such findings have implications for counselors and health care providers in their work with older adults adjusting to illness.

Garroutte, E. M., Goldberg, J., Beals, J., Herrell, R., Manson, S. M., and the AI-SUPERPFP Team [Department of Sociology, Boston College, 140 Commonwealth Avenue, Chestnut Hill, MA 02467; eva.garroutte@bc.edu]. "**Spirituality and attempted suicide among American Indians**." *Social Science & Medicine* 56, no. 7 (Apr 1003): 1571-9.

[Abstract:] American Indians exhibit suicide-related behaviors at rates much higher than the general population. This study examines the relation of spirituality to the lifetime prevalence of attempted suicide in a probability sample of American Indians. Data were derived from a cross-sectional sample of 1456 American Indian tribal members (age range 15-57yr) who were living on or near their Northern Plains reservations between 1997 and 1999. Data were collected by personal interviews. Commitment to Christianity was assessed using a measure of beliefs. Commitment to tribal cultural spirituality (or forms of spirituality deriving from traditions that predate European contact) was assessed using separate measures for beliefs and spiritual orientations. Results indicated that neither commitment to Christianity nor to cultural spirituality, as measured by beliefs, was significantly associated with suicide attempts (p(trend) for Christianity=0.22 and p(trend) for cultural spirituality=0.85). Conversely, commitment to cultural spirituality, as measured by an index of spiritual orientations, was significantly associated with a reduction in attempted suicide (p(trend)=0.01). Those with a high level of cultural spiritual orientation had a reduced prevalence of suicide compared with those with low level of cultural spiritual orientation. (OR=0.5, 95% CI=0.3, 0.9). This result persisted after simultaneous adjustment for age, gender, education, heavy alcohol use, substance abuse and psychological distress. These results are consistent with anecdotal reports suggesting the effectiveness of American Indian suicide-prevention programs emphasizing orientations related to cultural spirituality.

Gatrad, R., Panesar, S. S., Brown, E., Notta, H. and Sheikh, A. [steadman@walsallhospitals.nhs.uk]. "**Palliative care for Sikhs**." *International Journal of Palliative Nursing* 9, no. 11 (Nov 2003): 496-8.

[Abstract:] This article provides an overview of the palliative care needs of Sikh patients. It describes the basis of Sikh beliefs and practices and discusses practical aspects of caring for terminally ill Sikh patients and their families. Issues before and after death are considered and the importance of an individual approach is highlighted.

Gatrad, R. P., Brown, E. and Sheikh, A. [Manor Hospital, Moat Road, Walsall, WS2 2PS, UK]. "**Palliative care for Hindus**." *International Journal of Palliative Nursing* 9, no. 10 (Oct 2003): 442-8. [Review, 31 refs.]

[Abstract:] This article presents the chronology and significance of events that typically occur before and after death in the Hindu household. In the first section the authors concentrate on issues and consideration before death that are potentially of relevance to healthcare professionals providing terminal care. The section that follows aims to help healthcare professionals to understand the events that often occur in the immediate aftermath of death. It is hoped that this will help healthcare professionals provide holistic care for their patients.

Gibson, L. M. [Clemson University School of Nursing, College of Health, Education and Human Development, Clemson, SC 29634-0743]. "**Inter-relationships among sense of coherence, hope, and spiritual perspective (inner resources) of African-American and European-American breast cancer survivors**." *Applied Nursing Research* 16, no. 4 (Nov 2003): 236-44.

[Abstract:] This descriptive study compared sense of coherence (SOC), hope, and spiritual perspective in African-American and European-American breast cancer survivors. Five African-American and five European-American survivors completed multiple self-report instruments. Nonparametric statistical analyses included the Spearman rho and Mann-Whitney U tests. As hypothesized, there were significant positive relationships between SOC and spiritual perspective ($r(s) = .768$, $p = .005$) and hope and spiritual perspective ($r(s) = .561$, $p = .046$). There were

no significant differences in SOC, hope, or spiritual perspective scores in the African-American compared with the European-American survivors. Results justify a larger study to explore inner resources of African-American breast cancer survivors.

Good, P. D. [Department of Palliative Care, Newcastle Mater Misericordiae Hospital, Locked Bag 7, Regional Mail Centre, Newcastle, NSW 2310; Phillip.Good@mater.health.nsw.gov.au]. "**Advances in palliative care relevant to the wider delivery of healthcare**." *Medical Journal of Australia* 179, no. 6, Suppl. (Sep 15, 2003): S44-6.
Among other points, the author suggests [from the abstract:] In taking patient histories, recognizing the spiritual component of life experience enlarges the focus of care.

Grabovac, A. D. and Ganesan, S. [Department of Psychiatry, University of British Columbia, Vancouver, British Columbia; agrabovac@bccancer.bc.ca]. "**Spirituality and religion in Canadian psychiatric residency training**." *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie* 48, no. 3 (Apr 2003): 171-5.
[Abstract:] OBJECTIVE: Mental health professionals are increasingly aware of the need to incorporate a patient's religious and spiritual beliefs into mental health assessments and treatment plans. Recent changes in assessment and treatment guidelines in the US have resulted in corresponding curricular changes, with at least 16 US psychiatric residency programs now offering formal training in religious and spiritual issues. We present a survey of training currently available to Canadian residents in psychiatry and propose a lecture series to enhance existing training. METHODS: We surveyed all 16 psychiatry residency programs in Canada to determine the extent of currently available training in religion and spirituality as they pertain to psychiatry. RESULTS: We received responses from 14 programs. Of these, 4 had no formal training in this area. Another 4 had mandatory academic lectures dedicated to the interface of religion, spirituality, and psychiatry. Nine programs offered some degree of elective, case-based supervision. CONCLUSION: Currently, most Canadian programs offer minimal instruction on issues pertaining to the interface of religion, spirituality, and psychiatry. A lecture series focusing on religious and spiritual issues is needed to address this apparent gap in curricula across the country. Therefore, we propose a 10-session lecture series and outline its content. Including this lecture series in core curricula will introduce residents in psychiatry to religious and spiritual issues as they pertain to clinical practice.

Greenwald, D. F. and Harder, D. W. [Department of Counseling, Northeastern University, Boston, MA]. "**The dimensions of spirituality**." *Psychological Reports* 92, no. 3, pt. 1 (Jun 2003): 975-80.
[From the abstract:] The purpose of the study was to identify the major dimensions of spirituality by asking 147 participants to rate 122 adjectives for how spiritual each seemed. ...A principal components factor analysis was performed on the responses, and seven interpretable factors emerged. Four represented various dimensions of spirituality. One indicated what is not spiritual. One reflected the positive tone of many of the items. And the last represented adventurousness. The four spiritual factors were named Loving Connection to others, Self-effacing Altruism, Blissful Transcendence, and Religiosity/Sacredness. The one factor that garnered very low ratings for spirituality was named Lonely/Angry and consisted of items related to anger, pointlessness, selfishness, abandonment, and loneliness.

Gregory, S. R. [University of Texas Medical Branch at Galveston; scgregor@sas.upenn.edu]. "**Growth at the edges of medical education: spirituality in American medical education**." *Pharos of Alpha Omega Alpha Honor Medical Society* 66, no. 2 (Spring 2003): 14-9.
The author offers an account of the pioneering efforts of Richard C. Cabot, MD, (1886-1939) in promoting the idea that patients should receive spiritual care as part of their overall hospital care. Cabot worked to bring chaplains into the medical setting and hoped that physicians would become more attentive to patients' spirituality.

Griffin, J. P., Nelson, J. E., Koch, K. A., Niell, H. B., Ackerman, T. F., Thompson, M., and Cole, F. H. Jr., for the American College of Chest Physicians. [Division of Pulmonary and Critical Care Medicine, Department of Medicine, College of Medicine, The University of Tennessee Health Science Center, 956 Court Avenue, Room H 314, Memphis, TN 38163; jpgriffin@utmem.edu]. "**End-of-life care in patients with lung cancer**." *Chest* 123, Suppl. 1 (Jan 2003): 312S-331S. [Review, 152 refs.]
This comprehensive assessment of end-of-life care notes at various points the importance of spiritual concerns (see esp. pp. 316-7 and 326).

Hale, W. D. and Bennett, R. G. [Department of Psychology, Stetson University, DeLand, FL 32723; dhale@stetson.edu]. "**Addressing health needs of an aging society through medical-religious partnerships: what do clergy and laity think?**" *Gerontologist* 43, no. 6 (Dec 2003): 925-30.
[Abstract:] PURPOSE: This article reports on the interest within the religious community in a medical-religious partnership model designed to address some of the health challenges communities face as the population continues to age and become more diverse. DESIGN AND METHODS: A geographically and religiously diverse group of 183 clergy who were attending a continuing education program on theology and preaching were invited to complete a 16-item survey asking about their interest in working with hospitals to offer health-related programs and activities in their congregations. Another sample, this one consisting of 524 individuals from a religiously diverse group of congregations in Florida, was also asked about their interest in having health programs offered in their congregations. RESULTS: Of the 54% of clergy who completed the surveys, 72% said it was "very important" and 28% said it was "somewhat important" to actively address the health needs of their congregations. Support for specific programs was also strong, with at least 80% reporting it was very likely they would support screenings, preventive interventions, and health-related classes in their congregations. Strong support was also found among the laity surveyed, with 85% expressing interest in faith-based health programs and 45% reporting they would be interested in helping organize and promote such programs. IMPLICATIONS: Health care systems and other organizations interested in addressing health needs of older adults can look to religious institutions for assistance in providing the information and support patients and family members need to prevent or minimize the impact of chronic illnesses.

Hall, D. E., Curlin, F. and Koenig, H. G. [Center for Aging, Duke Univ. Medical Center, Durham, NC; revdocdan@aya.yale.edu]. "**When clinical medicine collides with religion**." *Lancet* 362 Suppl. (Dec 2003): s28-9.
In this brief commentary, the authors (the principal author being a surgeon and Episcopal priest) consider how religious perspectives may be in tension with standard medical practice and how clinicians may prepare to work with such circumstances.

Hammond, A. [Substance Misuse Service, Social Care Trust, Dartford, Kent; andrea.hammond@tgt.sthames.nhs.uk]. "**Substance misuse and serious mental illness: spiritual care**." *Nursing Standard* 18, no. 2 (Sep 24-31, 2003): 33-8. [Review, 22 refs.]

The author considers how spirituality can be integrated into community care plans for patients with a dual diagnosis of serious mental illness and substance misuse. The article is intended for a British nursing audience, but much of the content may be of wider interest.

Hart, A. Jr., Kohlwes, R. J., Deyo, R., Rhodes, L. A. and Bowen, D. J. [Department of Medicine, University of Washington, Seattle, WA]. "**Hospice patients' attitudes regarding spiritual discussions with their doctors**." *American Journal of Hospice & Palliative Care* 20, no. 2 (Mar-Apr 2003): 135-9. Comment on pp. 88-9 and 90-2.

[Abstract:] The purpose of this study was to assess hospice patients' attitudes regarding the discussion of spiritual issues with their physicians. We conducted in-depth interviews using open-ended questions on living with illness, spirituality and religion, and physician-patient relationships. The interviews were audiotaped, transcribed, and analyzed for dominant themes. The following dominant themes were identified: (1) treating the whole person, (2) treating with sensitivity, (3) favorable attitudes toward religious or spiritual discussions with doctors, and (4) no "preaching." Our findings suggest that patients do not expect physicians to be their primary spiritual advisors; however, physicians should be aware of and comfortable communicating with patients about religious or spiritual issues. More training in this topic may enhance the care physicians provide to patients near the end of life.

Hassouneh-Phillips, D. [Oregon Health Sciences University; phillide@ohsu.edu]. "**Strength and vulnerability: spirituality in abused American Muslim women's lives**." *Issues in Mental Health Nursing* 24, nos. 6-7 (Sep-Nov 2003): 681-94.

[Abstract:] The importance of spirituality for individuals coping with and recovering from trauma has been widely recognized. Despite this recognition, little information is available addressing the influence of spirituality on the abuse experiences of women surviving intimate partner violence (IPV). This paper begins to amend this gap in knowledge by examining the influence of spirituality on the abuse experiences of American Muslim women, a large and growing population. Findings from this qualitative study indicate that spirituality provided participants with an important means of coping with ongoing violence while in many instances also creating barriers to safety. These findings underscore the complex role spirituality may play as a source of both strength and vulnerability in American Muslim women's response to IPV.

Henderson, P. D. and Fogel, J. [Johns Hopkins University, School of Nursing; phender8@son.jhmi.edu]. "**Support networks used by African American breast cancer support group participants**." *ABNF Journal* 14, no. 5 (Sep-Oct 2003): 95-8.

[From the abstract:] This study explored the support networks used by 43 southeastern United States African American women who participated in African American breast cancer support groups. Both qualitative and quantitative approaches were used. African American women were found to rely more on God for support than either family or friends. Health care professionals and Internet use was reported less often as a source of support among these women.

Henery, N. [Social Work Department, Dundee City Council, 62 Dundee Street, Carnoustie, Angus DD7 7PF, Dundee, Scotland; ropane@blueyonder.co.uk]. "**Constructions of spirituality in contemporary nursing theory**." *Journal of Advanced Nursing* 42, no. 6 (Jun 2003): 550-7. [Review, 29 refs.]

[Abstract:] BACKGROUND: The nursing literature on spirituality tends to agree that modern science is relatively powerless to address the loss of personal meaning experienced by people facing death, suffering and loss. As a remedy, the literature recommends addressing patients' spirituality. The typical analytical move is to distinguish spirituality from religion and consider it a part, dimension or property of the patient. AIM AND METHOD: This paper uses discourse analysis to identify the formal properties of scientific and religious discourses and their social and political implications. The nursing literature is then investigated to detect the use of such discourses in constructing the object spirituality and to consider any implications for nursing as a social practice. FINDINGS: Far from escaping science and religion, the literature constructs spirituality by means of scientific and religious discourses. These discourses have characteristic strengths and weaknesses that the nursing literature seems to miss. Accordingly, its use of religious discourse lacks coherence and depth, and risks merging human with transcendent authority. Its use of scientific discourse lacks precision and clarity and risks intensifying those features of modernity which contribute to a loss of personal meaning in the face of death, suffering and loss. CONCLUSION: Nursing literature on spirituality raises important questions but is limited in its capacity to address them. This paper provides an alternative perspective. First, it draws on an analysis of the modern institutional environment and its existential dimension. Secondly, it applies discourse analysis to the task of helping people experiencing illness and injury. This approach respects the strengths and limitations of both scientific and religious discourses.

Highfield, M. E. and Osterhues, D. [Calif. State University, Northridge, CA,; martha.highfield@csun.edu]. "**Spiritual care rights and quality of care: perspectives of physical therapy students**." *Journal for Healthcare Quality* 25, no. 1 (Jan-Feb 2003): 12-6.

The authors report the perspective of physical therapists who participated in an online discussion (n=34) about the importance of incorporating spiritual values into health care and whether they did so in their practice. [From the abstract:] Most suggested that spiritual and religious considerations should be part of PT practice, noting their potential effect upon motivation, functional status, and outcomes.

Hill, P. C. and Pargament, K. I. [Rosemead School of Psychology, Biola University, 13800 Biola Avenue, La Mirada, CA 90639; peter.hill@biola.edu]. "**Advances in the conceptualization and measurement of religion and spirituality. Implications for physical and mental health research**." *American Psychologist* 58, no. 1 (Jan 2003): 64-74. [Review, 113 refs.] [This article is one of four state-of-the-science overview articles comprising a special section in this journal issue. See also articles by Miller, et al.; Powell, et al.; and Seeman, et al.; noted in this bibliography.]

[Abstract:] Empirical studies have identified significant links between religion and spirituality and health. The reasons for these associations, however, are unclear. Typically, religion and spirituality have been measured by global indices (e.g., frequency of church attendance, self-rated religiousness and spirituality) that do not specify how or why religion and spirituality affect health. The authors highlight recent advances in the delineation of religion and spirituality concepts and measures theoretically and functionally connected to health. They also point to areas for areas for growth in religion and spirituality conceptualization and measurement. Through measures of religion and spirituality more conceptually related to physical and mental health (e.g., closeness to God, religious orientation and motivation, religious support, religious struggle), psychologists are discovering more about the distinctive contributions of religiousness and spirituality to health and well-being.

Holt, C. L., Clark, E. M., Kreuter, M. W. and Rubio, D. M. [Health Communication Research Laboratory, School of Public Health, Saint Louis University, MO; holtcl@slu.edu]. "**Spiritual health locus of control and breast cancer beliefs among urban African American women**." *Health Psychology* 22, no. 3 (May 2003): 294-9.

[Abstract:] The present study examined the relationship between spiritual health locus of control, breast cancer beliefs, and mammography utilization among a sample of 1,227 African American women from urban public health centers. Spiritual health locus of control was conceptualized as having an active and passive dimension, empowering individuals in their health beliefs and behaviors or rendering them to rely on a higher power (e.g., God) to determine their health outcomes, respectively. The active dimension was negatively associated with perceived benefits of mammography and positively associated with perceived barriers to mammography. The active and passive spiritual dimensions are distinct from internal and external health locus of control. Further study of their associations with other health-related beliefs and behaviors is warranted.

Holt, C. L., Lukwago, S. N. and Kreuter, M. W. [Health Communication Research Laboratory, School of Public Health, Saint Louis University, MO; holtcl@slu.edu]. "**Spirituality, breast cancer beliefs and mammography utilization among urban African American women**." *Journal of Health Psychology* 8, no. 3 (May 2003): 383-96.
[From the abstract:] The present study proposes a two-dimensional model in which spirituality encompasses a belief and behavioral dimension. This hypothesis was examined, as were relationships between these dimensions and spiritual health locus of control, breast cancer beliefs and mammography utilization among African American women. The belief dimension played a more important role in adaptive breast cancer beliefs and mammography utilization that did the behavioral dimension. These findings suggest the importance of spiritual belief systems for health, and implications for spiritual cancer communication interventions are discussed.

Hunt, J., Cobb, M., Keeley, V. L. and Ahmedzai, S. H. [Sheffield Palliative Care Studies Group, University of Sheffield, Academic Palliative Medicine Unit, Royal Hallamshire Hospital, UK]. "**The quality of spiritual care--developing a standard**." *International Journal of Palliative Nursing* 9, no. 5 (May 2003): 208-15. [Review, 29 refs.]
[Abstract:] Spiritual care is an important aspect of holistic care. However, it is seldom the subject of audit, or included in quality standards. This article reports on the work of the Trent Hospice Audit Group (THAG) into the development of a quality standard for the assessment, delivery and evaluation of spiritual care. The standard was drafted by a multidisciplinary team and circulated among the THAG user group and other interested specialists, and subsequently revised. Three levels of assessment are defined and the different levels of expertise needed for these assessments identified. Education has been highlighted as a key issue in enabling effective use of the standard package. Although acknowledging possible limitations and the importance of professional judgement, the standard should help provide a consistent approach to assessment, care planning and outcome review of spiritual care.

James, A. and Wells, A. [Bolton, Salford and Trafford Mental Health Partnership, Bolton, UK]. "**Religion and mental health: towards a cognitive-behavioural framework**." *British Journal of Health Psychology* 8, pt. 3 (Sep 2003): 359-76.
[From the abstract:] The established associations between religious dimensions and mental health could be mediated by cognitive-behavioural mechanisms. This paper proposes a preliminary conceptual framework in which two types of cognitive and behavioural mechanisms are described, 1) generic mental models that provide a basis for guiding appraisals of life events and 2) self-regulation of thinking processes (metacognitive control). METHOD: A critical analysis of extant literature was employed to examine support for each of the mechanisms. DISCUSSION: Evidence supports the idea that a religious framework can serve as a generic mental model that influences appraisals and affects well-being. The benefits derived depend on the salience of the framework, level of certainty with which attributions can be accepted, and the content of the information. Evidence for the self-regulation mechanism is weaker. Although consistent with this supposition, it requires further empirical evaluation. CONCLUSION: The relationships between religious variables and mental health may depend on cognitive-behavioural mechanisms. Developments in this area might encourage clinicians to consider further the ways in which religious variables might be utilized and assessed in therapy. However, there is a need for further efforts to incorporate religious and spiritual factors in the clinical arena.

Kahn, M. J., Lazarus, C. J. and Owens, D. P. [Department of Medicine and Psychiatry, Tulane University School of Medicine, New Orleans, LA; mkahn@tulane.edu]. "**Allowing patients to die: practical, ethical, and religious concerns**." *Journal of Clinical Oncology* 21, no. 15 (Aug 1, 2003): 3000-2.
This is a case-based discussion that considers, among other things, the potential role of religious concerns in clinical treatment. It is part of a series: "The art of oncology: when the tumor is not the target."

Kemper, K. J. and Barnes, L. [Wake Forest University School of Medicine, Winston-Salem, NC]. "**Considering culture, complementary medicine, and spirituality in pediatrics**." *Clinical Pediatrics* 42, no. 3 (Apr 2003): 205-8.
This article offers cases for discussion (and possible role playing) about the [from the abstract:] ways cultural backgrounds, religious beliefs and complementary medicine affect physicians, colleagues and patients.

Kendler, K. S., Liu, X. Q., Gardner, C. O., McCullough, M. E., Larson, D. and Prescott, C. A. [Virginia Institute for Psychiatry and Behavioral Genetics and Department of Psychiatry and Human Genetics, Medical College of Virginia, Virginia Commonwealth University, Richmond VA 23298-0126; kendler@hsc.vcu.edu]. "**Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders**." *American Journal of Psychiatry* 160, no. 3 (Mar 2003): 496-503.
[Abstract:] OBJECTIVE: The role of religion in mental illness remains understudied. Most prior investigations of this relationship have used measures of religiosity that do not reflect its complexity and/or have examined a small number of psychiatric outcomes. This study used data from a general population sample to clarify the dimensions of religiosity and the relationships of these dimensions to risk for lifetime psychiatric and substance use disorders. METHOD: Responses to 78 items assessing various aspects of broadly defined religiosity were obtained from 2,616 male and female twins from a general population registry. The association between the resulting religiosity dimensions and the lifetime risk for nine disorders assessed at personal interview was evaluated by logistic regression. Of these disorders, five were "internalizing" (major depression, phobias, generalized anxiety disorder, panic disorder, and bulimia nervosa), and four were "externalizing" (nicotine dependence, alcohol dependence, drug abuse or dependence, and adult antisocial behavior). RESULTS: Seven factors were identified: general religiosity, social religiosity, involved God, forgiveness, God as judge, unvengefulness, and thankfulness. Two factors were associated with reduced risk for both internalizing and externalizing disorders (social religiosity and thankfulness), four factors with reduced risk for externalizing disorders only (general religiosity, involved God, forgiveness, and God as judge), and one factor with reduced risk for internalizing disorders only (unvengefulness). CONCLUSIONS: Religiosity is a complex, multidimensional construct with substantial associations with lifetime psychopathology. Some dimensions of religiosity are related to reduced risk specifically for internalizing disorders,

and others to reduced risk specifically for externalizing disorders, while still others are less specific in their associations. These results do not address the nature of the causal link between religiosity and risk for illness.

Kennedy, C. and Cheston, S. E. [Hospice of the Chesapeake, 8424 Veterans Hwy, Millersville, MD 21108]. "**Spiritual distress at life's end: finding meaning in the maelstrom**." *Journal of Pastoral Care & Counseling* 57, no. 2 (Summer 2003): 131-41.
[Abstract:] Recent trends in social research indicate a decline in church attendance and a corresponding increased interest in spirituality. With the aging of the population, attention to end of life care, with its corresponding spiritual concerns and distress, has become a prominent issue. Spiritual distress can be difficult to distinguish from psychological and physical distress and indicates the need for differential diagnostic markers to distinguish between genuine spiritual experience and psychosis related to the physical death process. Further, for hospice patients who are in genuine need of amelioration through pharmacologic suppression, the question of when and how to medicate becomes paramount as the distinction between spiritual process and physchosis becomes less evident. This article is an exploratory attempt to encourage dialogue across interdisciplinary lines and foster participation from alternative therapies representing the spiritual context of the patient. Anecdotal data from hospice professionals representing a variety of disciplines are presented to illustrate and emphasize the need for continued dialogue and research in this important area.

Khodabuku, R. "**Advising patients with diabetes about fasting during Ramadhan**." *Nursing Times* 99, no. 28 (Jul 15-21, 2003): 26-7. [Review, 11 refs.]
[Abstract:] Fasting for Ramadhan is one of the five Pillars of Islam and is very important to Muslims. Nurses can help patients with diabetes to fast successfully by means of a pre-fast assessment, careful medicine management and good patient education.

Kim, K. H., Sobal, J. and Wethington, E. [Division of Nutritional Sciences, Cornell University, Ithica, NY; khk4@cornell.edu]. "**Religion and body weight**." *International Journal of Obesity & Related Metabolic Disorders: Journal of the International Association for the Study of Obesity* 27, no. 4 (Apr 2003): 469-77.
[Abstract:] OBJECTIVES: Relationships between religion and body weight were examined in a US national sample. METHODS: Data from the National Survey of Midlife Development in the United States (MIDUS), collected through telephone and postal questionnaires, were analyzed for 3032 adults aged 25-74. RESULTS: Religious denomination was significantly related to higher body weight in men after accounting for sociodemographic controls. Conservative Protestant men had a 1.1 +/- 0.45 higher body mass index (BMI) than those reporting no religious affiliation. Other religion variables that initially had significant relationships with greater body weight before adjusting for control variables became nonsignificant after smoking was controlled. No significant relationships between religion and body weight were present in women. CONCLUSIONS: Religious denomination was related to body weight in men. Other dimensions of religiosity showing a relationship with higher BMI appeared to be because of the lower rates of smoking among more religious individuals.

Kimmel, P. L., Emont, S. L., Newmann, J. M., Danko, H. and Moss, A. H. [Department of Medicine, Division of Renal Diseases and Hypertension, George Washington University, Washington, DC]. "**ESRD patient quality of life: symptoms, spiritual beliefs, psychosocial factors, and ethnicity**." *American Journal of Kidney Diseases* 42, no. 4 (Oct 2003): 713-21.
[Abstract:] BACKGROUND: Recent research suggests that patients' perceptions may be more important than objective clinical assessments in determining quality of life (QOL) for patients with end-stage renal disease (ESRD). METHODS: We interviewed 165 hemodialysis patients from 3 sites using a QOL questionnaire that included the Satisfaction With Life Scale (SWLS) and the McGill QOL (MQOL) scale, which includes a single-item global measure of QOL (Single-Item QOL Scale [SIS]). The MQOL scale asks patients to report their most troublesome symptoms. We also initiated the use of a Support Network Scale and a Spiritual Beliefs Scale. RESULTS: Mean patient age was 60.9 years, 52% were men, 63% were white, and 33% were African American. Patients had a mean treatment time for ESRD of 44 months, mean hemoglobin level of 11.8 g/dL (118 g/L), mean albumin level of 3.7 g/dL (37 g/L), and mean Kt/V of 1.6. Forty-five percent of patients reported symptoms. Pain was the most common symptom (21% of patients). There was an inverse relationship between reported number of symptoms and SWLS ($P < 0.01$), MQOL scale score ($P < 0.001$), and SIS ($P < 0.001$). The Spiritual Beliefs Scale correlated with the MQOL scale score, SWLS (both $P < 0.01$), and SIS ($P < 0.05$). The Support Network Scale score correlated with the MQOL Existential ($P = 0.01$) and MQOL Support ($P < 0.01$) subscales. No clinical parameter correlated with any measure of QOL, spiritual beliefs, or social support. CONCLUSION: Symptoms, especially pain, along with psychosocial and spiritual factors, are important determinants of QOL of patients with ESRD. Additional studies, particularly a longitudinal trial, are needed to determine the reproducibility and utility of these QOL measures in assessing patient long-term outcome and their association with other QOL indices in larger and more diverse patient populations.

King, D. E. and Wells, B. J. [Dept. of Family Medicine, Medical University of South Carolina, Charleston, SC; kingde@musc.edu]. "**End-of-life issues and spiritual histories**." *Southern Medical Journal* 96, no. 4 (Apr 2003): 391-3.
[Abstract:] BACKGROUND: Patients facing end-of-life issues have spiritual concerns that may have an impact on their medical decision-making. METHODS: To determine whether physicians address spiritual concerns in this context, we reviewed the charts of 92 elderly hospitalized patients facing decisions regarding resuscitation status or feeding tube placement. RESULTS: The average age of the participants was 72.4 years and 51% of them were female. Only 6.5% of the patients had spiritual histories documented in their charts; 29% had either a spiritual history or some mention of chaplain or psychiatrist involvement. CONCLUSION: Spiritual concerns of many patients facing end-of-life decisions are not being addressed.

King, G., Cathers, T., Brown, E., Specht, J. A., Willoughby, C., Polgar, J. M., MacKinnon, E., Smith, L. K. and Havens, L. [Thames Valley Children's Centre, London, Ontario, Canada; gilliank@tvcc.on.ca]. "**Turning points and protective processes in the lives of people with chronic disabilities**." *Qualitative Health Research* 13, no. 2 (Feb 2003): 184-206.
[Abstract:] In this qualitative study, the authors examined the nature of resilience in people with chronic disabilities. Fifteen people with disabilities identified the factors that helped or hindered them at major turning points, and the triggers and resolutions to these turning points. Turning points were emotionally compelling experiences and realizations that involved meaning acquired through the routes of belonging, doing, or understanding the self or the world. The major protective factors were social support, traits such as perseverance and determination, and spiritual beliefs. Three new protective processes were identified: replacing a loss with a gain (transcending), recognizing new things about oneself (self-understanding), and making decisions about relinquishing something in life (accommodating). These protective factors, processes, and ways in which people with disabilities draw sense and meaning in life have important implications for service delivery.

Kneier, A. W. [Department of Dermatology, Comprehensive Cancer Center, University of California at San Francisco, 1600 Divisadero Street, Box 1706, San Francisco, CA 944115; awkneier@orca.ucsf.edu]. "**Coping with melanoma—ten strategies that promote psychological adjustment**." *Surgical Clinics of North America* 83, no. 2 (Apr 2003): 417-30. [Review, 61 refs.]
The author discusses patients' coping strategies, including how patients come to understand that [from the abstract:] survival is not the only important objective; the quality of their lives and relationships, the values they live by, and their spirituality also deserve attention and effort.

Krause, N. [School of Public Health and Institute of Gerontology, University of Michigan, Ann Arbor, MI; nkrause@umich.edu]. "**Religious meaning and subjective well-being in late life**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 58, no. 3 (May 2003): S160-70.
[Abstract:] OBJECTIVES: The purpose of this study is to examine the relationship between religious meaning and subjective well-being. A major emphasis is placed on assessing race differences in the relationship between these constructs. METHODS: Interviews were conducted with a nationwide sample of older White and older Black adults. Survey items were administered to assess a sense of meaning in life that is derived specifically from religion. Subjective well-being was measured with indices of life satisfaction, self-esteem, and optimism. RESULTS: The findings suggest that older adults who derive a sense of meaning in life from religion tend to have higher levels of life satisfaction, self-esteem, and optimism. The data further reveal that older Black adults are more likely to find meaning in religion than older White adults. In addition, the relationships among religious meaning, life satisfaction, self-esteem, and optimism tend to be stronger for older African Americans persons than older White persons. DISCUSSION: Researchers have argued for some time that religion may be an important source of resilience for older Black adults, but it is not clear how these beneficial effects arise. The data from this study suggest that religious meaning may be an important factor.

Kub, J. E., Nolan, M. T., Hughes, M. T., Terry, P. B., Sulmasy, D. P., Astrow, A. and Forman, J. H. [School of Nursing, Johns Hopkins University, Baltimore, MD]. "**Religious importance and practices of patients with a life-threatening illness: implications for screening protocols**." *Applied Nursing Research* 16, no. 3 (Aug 2003): 196-200.
[Abstract:] Although providing spiritual support to patients has received growing attention in the nursing and medical literature, little has been written about how to screen new patients to determine whether a more in-depth spiritual assessment is in order. In many hospitals, newly admitted patients are simply asked whether they are affiliated with a specific religious denomination. This question alone provides little insight into potential spiritual needs that may require attention. Questions that inquire about patients' religious practices and the importance of religion in their lives may be more useful as screening questions to identify the need for a more detailed spiritual assessment. As a part of a longitudinal study on decision control preferences in terminal illness, data were collected on enrollment about religious practices and the importance of religion in a group of subjects recently diagnosed with a life-threatening illness. This study examines cross-sectionally the relationship between religious practices, importance of religion, and demographic variables. Recommendations are presented on how health professionals can use the responses to these questions to determine the need for further spiritual assessment and intervention.

Kurup, R. K. and Kurup, P. A. [Department of Neurology, Medical College, Trivandrum, Kerala, India; kvgnair@satyam.net.in]. "**Hypothalamic digoxin, hemispheric chemical dominance, and spirituality**." *International Journal of Neuroscience* 113, no. 3 (Mar 2003): 383-93.
[Abstract:] The isoprenoid pathway was assessed in atheistic and spiritually inclined individuals. The pathway was also assessed in individuals with differing hemispheric dominance to assess whether hemispheric dominance has a correlation with spiritual and atheistic tendency. HMG CoA reductase activity, serum digoxin, RBC membrane Na(+)-K+ ATPase activity, serum magnesium, and tyrosine/tryptophan catabolic patterns were assessed in spiritual/atheistic individuals and in those differing hemispheric dominance. In spiritually-inclined individuals, there was increased digoxin synthesis, decreased membrane Na(+)-K+ ATPase activity, increased tryptophan catabolites (serotonin, quinolinic acid, and nicotine), and decreased tyrosine catabolites (dopamine, noradrenaline, and morphine). The pattern in spiritually-inclined individuals correlated with right hemispheric chemical dominance. In atheistic individuals there was decreased digoxin synthesis, increased membrane Na(+)-K+ ATPase activity, decreased tryptophan catabolities (serotonin, quinolinic acid, and nicotine), and increased tyrosine catabolites (dopamine, noradrenaline, and morphine). This pattern in atheistic individuals correlated with that obtained in left hemispheric chemical dominance. Hemispheric chemical dominance and hypothalamic digoxin could regulate the predisposition to spirituality or atheism.

Larson, K. [Division of Nephrology, Medical University of South Carolina, Charleston, SC]. "**The importance of spiritual assessment: one clinician's journey**." *Geriatric Nursing* 24, no. 6 (Nov-Dec 2003): 370-1. [Review, 8 refs.]
The author offers a personal reflection, discusses the SPIRIT and HOPE assessments, and gives an example of "spiritual care in action."

Levin, J. "**Spiritual determinants of health and healing: an epidemiologic perspective on salutogenic mechanisms**." *Alternative Therapies in Health & Medicine* 9, no. 6 (Nov-Dec 2003): 48-57. [Review, 64 refs.]
[Abstract:] This article provides an overview of both empirical research and conceptual and theoretical approaches bearing on the connection between spirituality and health. Special emphasis is placed on key epidemiologic concepts that are typically overlooked or misinterpreted in discussions of religious and spiritual factors in health and healing. These include the natural history of disease, the epidemiologic triangle, the levels of prevention, risk factors, protection, salutogenesis, and host resistance. After reviewing research evidence of both a protective factor for health and therapeutic factor in healing attributed to religiousness, faith, or spirituality, a typology is proposed which classifies potentially salutogenic mechanisms underlying such effects. This model differentiates among biological, psychosocial, bioenergy-based, nonlocal, and supernatural pathways. Finally, the clinical and scientific implications of this work is described.

Lin, H. R. and Bauer-Wu, S. M. [Research and Development Center, National Taipei College of Nursing, Taipei, Taiwan]. "**Psycho-spiritual well-being in patients with advanced cancer: an integrative review of the literature**." *Journal of Advanced Nursing* 44, no. 1 (Oct 2003): 69-80. [Review, 48 refs.]
[From the abstract:] An integrative literature review was undertaken to examine the research on psycho-spiritual well-being in terminally ill people, specifically patients with advanced cancer. METHOD: A comprehensive search of MEDLINE, CINAHL, CancerLit and PsycINFO using relevant keywords produced 43 primary research studies that investigated psycho-spiritual well-being in patients with advanced cancer.... Six major themes repeatedly emerged as essential components of psycho-spiritual well-being: self-awareness, coping and adjusting effectively with stress, relationships and connectedness with others, sense of faith, sense of empowerment and confidence, and living with meaning and

hope. CONCLUSION: Patients with an enhanced sense of psycho-spiritual well-being are able to cope more effectively with the process of terminal illness and find meaning in the experience. Prognostic awareness, family and social support, autonomy, hope and meaning in life all contribute to positive psycho-spiritual well-being. Emotional distress, anxiety, helplessness, hopelessness and fear of death all detract from psycho-spiritual well-being. The research indicated that health professionals can play an important role in enhancing psycho-spiritual well-being, but further research is needed to understand specific interventions that are effective and contribute to positive patient outcomes.

Lo, B., Kates, L. W., Ruston, D., Arnold, R. M., Cohen, C. B., Puchalski, C. M., Pantilat, S. Z., Rabow, M. W., Schreiber. R. S. and Tulsky, J. A. [Program in Medical Ethics, Division of General Internal Medicine, University of California, San Francisco, CA; bernie@medicine.ucsf.edu]. "**Responding to requests regarding prayer and religious ceremonies by patients near the end of life and their families**." *Journal of Palliative Medicine* 6, no. 3 (June 2003): 409-15. Comment on pp. 429-31.

[Abstract:] Prayer and religious ceremonies may help patients near the end of life and their relatives find comfort and discover meaning in their lives. In this paper, we analyze how physicians might respond in two situations regarding prayer and religious ceremonies. First, how should physicians respond when such patients or their families ask physicians to pray for them or with them? Physicians' responses to such requests will depend on their own religious and spiritual beliefs, the congruence of their beliefs with those of the patient and family, and their relationship with the patient. Many physicians may be willing to be present and stand silently while the patient prays. Second, how should physicians respond when such patients and families seek to carry out their religious and spiritual practices in the hospital? Religious ceremonies can provide meaning, hope, and solace to patients and families. Institutional guidelines regarding religious ceremonies should allow as much leeway as is compatible with good care both for the patient for whom the ritual is offered and also for other patients within the facility. Physicians should inquire whether there are religious and spiritual practices that patients and families would like to engage in. However, physicians should be cautious about recommending specific ceremonies or practices. Physicians can respond to requests and respect patients' spiritual needs in ways that may deepen the therapeutic doctor-patient relationship, without compromising their own religious and spiritual beliefs or professional roles. [Note: The article unfortunately contains several typographical errors.]

Loeb, S. J., Penrod, J., Falkenstern, S., Gueldner, S. H. and Poon, L. W. [Department of Nursing, University of Delaware]. "**Supporting older adults living with multiple chronic conditions**." *Western Journal of Nursing Research* 25, no. 1 (Feb 2003): 8-23. Discussion on pp. 23-9.

[From the abstract:] This qualitative study was conducted using focus groups to explore the strategies commonly employed by older adults (N=37) to manage multiple chronic conditions. Key strategies identified were relating with health care providers, medicating, exercising, changing dietary patterns, seeking information, relying on spirituality and/or religion, and engaging in life. Although social support was not mentioned as a discrete strategy, the participants' social networks were embedded in all of the categories....

MacDonald, D. A. and Holland, D. [Department of Psychology, University of Detroit Mercy, MI; macdona@udmercy.edu]. "**Spirituality and the MMPI-2**." *Journal of Clinical Psychology* 59, no. 4 (Apr 2003): 399-410.

[Abstract:] The present investigation was an exploratory examination of the relation of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) Clinical scales to spirituality operationalized in terms of self-reported religious involvement and scores on a multidimensional measure called the Expressions of Spirituality Inventory (ESI; MacDonald, 1997, 2000). MANOVA and correlational results indicate that the MMPI-2 Clinical scales generate patterns of findings consistent with available research on spirituality and health. In particular, persons reporting involvement in organized religion obtained significantly lower MMPI-2 Clinical scale scores and were found to be less likely to obtain a clinically significant score (i.e., t-scores >64) on any of the MMPI-2 scales. Further, with the exception of Masculine-Feminine and Hypomania, all MMPI-2 scales were found to associate appreciably with ESI dimension scores. The study concludes with a brief discussion of the meaning and implications of the findings for future research aimed at investigating the relation of spirituality to health.

MacLean, C. D., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., Klioze, A., Monroe, M., Garrett, J. and Cykert, S. [University of Vermont College of Medicine, Burlington, VT; charles.maclean@vtmednet.org]. "**Patient preference for physician discussion and practice of spirituality**." *Journal of General Internal Medicine* 18, no. 1 (Jan 2003): 38-43.

[From the abstract:] SETTING: Primary care clinics of 6 academic medical centers in 3 states (NC, Fla, Vt). PATIENTS/PARTICIPANTS: Patients 18 years of age and older who were systematically selected from the waiting rooms of their primary care physicians. MEASUREMENTS AND MAIN RESULTS: Four hundred fifty-six patients participated in the study. One third of patients wanted to be asked about their religious beliefs during a routine office visit. Two thirds felt that physicians should be aware of their religious or spiritual beliefs. Patient agreement with physician spiritual interaction increased strongly with the severity of the illness setting, with 19% patient agreement with physician prayer in a routine office visit, 29% agreement in a hospitalized setting, and 50% agreement in a near-death scenario (P <.001). Patient interest in religious or spiritual interaction decreased when the intensity of the interaction moved from a simple discussion of spiritual issues (33% agree) to physician silent prayer (28% agree) to physician prayer with a patient (19% agree; P <.001). Ten percent of patients were willing to give up time spent on medical issues in an office visit setting to discuss religious/spiritual issues with their physician. After controlling for age, gender, marital status, education, spirituality score, and health care utilization, African-American subjects were more likely to accept this time trade-off (odds ratio, 4.9; confidence interval, 2.1 to 11.7). CONCLUSION: Physicians should be aware that a substantial minority of patients desire spiritual interaction in routine office visits. When asked about specific prayer behaviors across a range of clinical scenarios, patient desire for spiritual interaction increased with increasing severity of illness setting and decreased when referring to more-intense spiritual interactions....

MacLeod, R. D., Parkin, C., Pullon, S. and Robertson, G. [Mary Potter Hospice, PO Box 7442, Wellington South, New Zealand; rod.macleod@marypotter.org.nz]. "**Early clinical exposure to people who are dying: learning to care at the end of life**." *Medical Education* 37, no. 1 (Jan 2003): 51-8.

This study of a program designed for medical students in their first clinical year in Wellington, NZ, found that students' reflections on their time with dying patients and those patients' families emphasized five key themes: 1) it represented a different experience from what the student expected, 2) the emotional element of the experience, 3) spiritual and religious elements, 4) personal reflections, and 5) future care approaches.

Marcotte, D., Margolin, A. and Avants, S. K. [Department of Psychiatry, Division of Substance Abuse, Yale University School of Medicine, New Haven, CT; david.marcotte@yale.edu]. "**Addressing the spiritual needs of a drug user living with human immunodeficiency virus: a case study**." *Journal of Alternative & Complementary Medicine* 9, no. 1 (Feb 2003): 169-75.

[Abstract:] OBJECTIVES: To describe an application of Spiritual Self-Schema Therapy (3-S) with a human immunodeficiency virus (HIV)-seropositive, injection drug-using individual. INTERVENTION: 3-S is a structured and readily administered therapy for integrating a spiritual dimension into addiction treatments for HIV-positive drug users. It posits the existence of many potential "selves," salient among which are the "addict" self and the "spiritual" self. The central strategy of 3-S is to "deactivate" the addict self and "activate" the spiritual self. Techniques to achieve this shift are discussed. RESULTS: Over the course of treatment, this patient was able to use 3-S therapy to shift her dominant sense of self from that of an addict to a spiritual person and reported that this increased feelings of hope and the sense of control. CONCLUSION: A spiritually based therapy appears to help injection drug users with HIV infection and warrants further investigation.

Marcuccio, E., Loving, N., Bennett, S. K. and Hayes, S. N. [WomenHeart: The National Coalition for Women with Heart Disease, Washington, DC]. "**A survey of attitudes and experiences of women with heart disease**." *Women's Health Issues* 13, no. 1 (Jan-Feb 2003): 23-31.

This study of 204 women with a self-reported diagnosis of heart disease used open-ended questions in a telephone survey. Among the findings: [from the abstract] Many women reported that they were unable or unwilling to make appropriate lifestyle changes after the diagnosis was made because of insufficient social, medical, or educational support. Educational opportunities may have been limited because less than 60% of women with CAD received cardiac rehabilitation services. Respondents reported significant changes in their interpersonal relationships, mental health, and financial and spiritual well-being as a result of having heart disease.

Margalith, I., Musgrave, C. F. and Goldschmidt, L. [Dina Academic School of Nursing, Tel Aviv University and Rabin Medical Center, Petah Tikva, Israel; ilanama@post.tau.ac.il]. "**Physician-assisted dying: are education and religious beliefs related to nursing students' attitudes?**" *Journal of Nursing Education* 42, no. 2 (Feb 2003): 91-6.

This study of 190 nursing students at three nursing schools in Israel found that "exposure to theoretical knowledge regarding euthanasia or having a clinical experience in oncology played a small role in shaping...attitudes toward [Physician Assisted Suicide]. A greater determinant of...attitudes were...religious beliefs" (p. 94).

Margolis, S. A., Carter, T., Dunn, E. V. and Reed, R. L. [Department of Family Medicine, United Arab Emirates University, Al Ain, United Arab Emirates; margolis@uaeu.ac.ae]. "**Validation of additional domains in activities of daily living, culturally appropriate for Muslims**." *Gerontology* 49, no. 1 (Jan-Feb 2003): 61-5.

[Abstract:] BACKGROUND: Measurement of activities of daily living (ADL) is an integral part of geriatric care. Prayer is a central part of the life of practicing Muslims. OBJECTIVES: To validate additional domains of ADL based on the functional capacity of Muslims to perform prayer, a culturally appropriate measure for those practicing the Islamic faith. METHODS: Functional capacity was measured using 2 scales: an 8-domain scale (ADL-8) and a 3-component domain scale assessing the key components of Islamic prayer: washing for prayer, physical motion during prayer and the words spoken. A randomly selected sample of 132 community-based practicing Muslim people from Arabic-speaking countries, aged 65+ years were assessed. RESULTS: The mean age +/- standard deviation was 72.6 +/- 7.0 with a female to male ratio of 0.97. The correlation between the summation scores for the prayer ADL and the ADL-8 was $r = 0.922$ ($p < 0.001$), while correlation with prayer ADL and each of the 8 components in the ADL-8 ranged from $r = 0.806$ ($p < 0.001$) to $r = 0.906$ ($p < 0.001$). There was a high level of construct validity with the reliability coefficient for the 3 components of the prayer ADL being 0.933 with a standardized item alpha of 0.935, with a range of 0.746-0.896 for the subscales. CONCLUSION: The prayer ADL domains provide an additional valid, short, simple and culturally orientated functional assessment for those of the Islamic faith.

Marshall, E. S., Olsen, S. F., Mandleco, B. L., Dyches, T. T., Allred, K. W. and Sansom, N. [College of Nursing, Brigham Young University, Provo, UT]. "'**This is a Spiritual Experience': perspectives of Latter-Day Saint families living with a child with disabilities**." *Qualitative Health Research* 13, no. 1 (Jan 2003): 57-76.

[Abstract:] The presence of a child with disabilities elicits a variety of stress demands on the family. Religion is recognized as a powerful personal, family, and cultural variable. However, little is known about the influence of religion in dealing with disability among families within particular religious groups. This descriptive study explored themes of spiritual belief and religious support among families of the Church of Jesus Christ of Latter-Day Saints (LDS, or Mormon) with a child with developmental disabilities. Parents shared perspectives of meaning that emerged from experiences with religion and family beliefs perceived to be unique. The core theme, "This is a Spiritual Experience," provides the foundation for a descriptive model that depicts aspects of finding meaning and perceived transcendence.

Mazanec, P. and Tyler, M. K. [Palliative Care Team, Hospice of the Western Reserve, Cleveland, OH; pmazanec@hospicewr.org]. "**Cultural considerations in end-of-life care: how ethnicity, age, and spirituality affect decisions when death is imminent**." *AJN: American Journal of Nursing* 103, no. 3 (Mar 2003): 50-8; quiz on p. 59. [Review, 25 refs.]

This is a broad consideration of diversity issues in patient care, with a case illustration. The FICA spiritual assessment is recommended.

McCarthy, M. K. and Peteet, J. R. [Department of Psychiatry, Brigham & Women's Hospital, Boston, MA 02115]. "**Teaching residents about religion and spirituality**." *Harvard Review of Psychiatry* 11, no. 4 (Jul-Aug 2003): 225-8.

McClain, C. S., Rosenfeld, B. and Breitbart, W. [Fordham University, Bronx, NY]. "**Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients**." *Lancet* 361, no. 9369 (May 10, 2003): 1603-7.

[Abstract:] BACKGROUND: The importance of spirituality in coping with a terminal illness is becoming increasingly recognized. We aimed to assess the relation between spiritual well-being, depression, and end-of-life despair in terminally-ill cancer patients. METHODS: 160 patients in a palliative care hospital with a life expectancy of less than 3 months were interviewed with a series of standardized instruments, including the functional assessment of chronic illness therapy-spiritual well-being scale, the Hamilton depression rating scale, the Beck hopelessness scale, and the schedule of attitudes toward hastened death. Suicidal ideation was based on responses to the Hamilton depression rating scale. FINDINGS: Significant correlations were seen between spiritual well-being and desire for hastened death ($r=-0.51$), hopelessness ($r=-0.68$), and suicidal ideation ($r=-0.41$). Results of multiple regression analyses showed that spiritual well-being was the strongest predictor

of each outcome variable and provided a unique significant contribution beyond that of depression and relevant covariates. Additionally, depression was highly correlated with desire for hastened death in participants low in spiritual well-being (r=0.40, p<0.0001) but not in those high in spiritual well-being (r=0.20, p=0.06). INTERPRETATION: Spiritual well-being offers some protection against end-of-life despair in those for whom death is imminent. Our findings have important implications for palliative care practice. Controlled research assessing the effect of spirituality-based interventions is needed to establish what methods can help engender a sense of peace and meaning.

McEvoy, M. [Department of Pediatrics and Family Life Program, Albert Einstein College of Medicine, Bronx, NY; mcevoy@aecom.yu.edu]. "**Culture & spirituality as an integrated concept in pediatric care**." *MCN, American Journal of Maternal Child Nursing* 28, no. 1 (Jan-Feb 2003): 39-43. Quiz on p. 44. [Review, 24 refs.]

[Abstract:] The purpose of this article is to propose an integrated approach to culture and spirituality in pediatric care. In the spirit of sensitive and respectful communication with patients, pediatric nurses have become increasingly concerned with the child's and family's culture, spirituality, and religion. As a result, various approaches and models have been created to help nurses initiate discussions surrounding these topics. These models have given rise to categorizations of culture, spirituality, and religion. It is important for pediatric nurses to understand that while delineations can be made, there are also many intersecting factors that make separation of these issues difficult and perhaps unnecessary for the purpose of culturally sensitive communication. Pediatric nurses should, perhaps, focus instead on understanding the individual child's or family's traditions, values, and beliefs and how these dimensions impact the health of the child. This article suggests three areas that can be used as an organizing framework for pediatric nurses to broach culturally sensitive issues within the context of pediatric primary healthcare: (1) Family beliefs/values, (2) Family daily practices, and (3) Community involvement.

McGrath, P. [School of History, Philosophy, Religion and Classics, University of Queensland, St Lucia, Australia]. "**Spiritual pain: a comparison of findings from survivors and hospice patients**." *American Journal of Hospice & Palliative Care* 20, no. 1 (Jan-Feb 2003): 23-33.

[Abstract:] The article presents comparative research findings on the notion of "spiritual pain." The findings from interviews with hospice patients affirm the previously published, preliminary conceptualization of spiritual pain from interviews with survivors. However, while the survivor findings highlight the potential for spiritual pain associated with life after high-tech curative treatment, the hospice patient data emphasize the protectiveness of the hospice experience for deflecting the possibility of spiritual pain. It is anticipated the discussion of comparative findings will affirm the importance of researching this "ignored dimension" and, in so doing, will enrich our understanding of the spiritual dimension of healthcare. The work is part of a program presently developing a language of spirituality through research.

McIllmurray, M. B., Francis, B., Harman, J. C., Morris, S. M., Soothill, K. and Thomas, C. [Royal Lancaster Infirmary, Lancaster, UK; Malcolm.McIllmurray@1.bay-tr.nwest.nhs.uk]. "**Psychosocial needs in cancer patients related to religious belief**." *Palliative Medicine* 17, no. 1 (Jan 2003): 49-54.

[Abstract:] In a study of psychosocial needs amongst cancer patients, the possession of a religious faith has been identified as a significant factor in determining a range of psychosocial needs. Of the 354 respondents to a questionnaire, which included a comprehensive psychosocial needs inventory, 83% said they had a religious faith, and in general these patients were less reliant on health professionals, had less need for information, attached less importance to the maintenance of independence and had less need for help with feelings of guilt, with their sexuality or with some practical matters than those who said they had no religious faith. In addition, they had fewer unmet needs overall (32% compared with 52%). The knowledge of a patient's spirituality should help service providers to predict aspects of psychosocial need and to respond sensitively and appropriately to a patient's experience of cancer.

McLane, S., Lox, C. L., Butki, B. and Stern, L. [Southern Illinois University, Edwardsville, IL]. "**An investigation of the relation between religion and exercise motivation**." *Perceptual & Motor Skills* 97, no. 3, pt. 2 (Dec 2003): 1043-8.

[Abstract:] The present study sought to investigate whether traditional secular or faith-based program factors were more responsible for motivating women (N = 220, M age = 44.6 yr.) to participate in Christian exercise programs. Based on the results of a pilot study, the Christian Exercise Program Questionnaire was developed and mailed to the study participants. The internal reliability of the questionnaire was excellent as indicated by Cronbach coefficient alpha. As expected, those aspects of the exercise program that were faith-based, e.g., modest clothing, noncompetitive, and worshipful atmosphere. were considered more important than traditional secular factors, e.g., personal trainers and childcare, in the decision to enroll in the program ($t219 = 9.23$, $p < .001$). The findings suggest exercise programs that incorporate faith-based practices may appeal to a segment of the population and provide an alternative strategy for improving participation rates in physical activity.

Medvene, L. J., Wescott, J. V., Huckstadt, A., Ludlum, J., Langel, S., Mick, K., Patrick, R. and Base, M. [Center for Congregational Health Ministry, Via Christi Health System, Wichita, KS; louis.medvene@wichita.edu]. "**Promoting signing of advance directives in faith communities**." *Journal of General Internal Medicine* 18, no. 11 (Nov 2003): 914-20. Comment on pp. 962-3.

[Abstract:] OBJECTIVE: To develop a participatory educational program implemented in faith communities that would increase discussion and signing of two types of advance directives-living will and durable power of attorney for health care decisions. DESIGN: Longitudinal study with four annual cycles of program implementation, evaluation, and revision incorporating a program that fostered the discussion, signing, and/or revision of advance directives. The program involved an educational workbook and ongoing support by parish nurses. SETTING: Seventeen faith communities in Wichita, Kansas. Faith communities included several predominantly white congregations, as well as several primarily African-American and Hispanic congregations. PARTICIPANTS: Seventeen faith communities, their pastors, and 25 parish nurses worked with 361 self-selected residents, living in community settings, to participate in the program as members of their faith communities. Congregations were recruited by the executive director of a local interfaith ministries organization and parish nurses. MAIN RESULTS: Two hundred forty-eight (69%) of the congregants who started the program completed it. Of the program completers, 83 (33%) had a directive prior to the program and 140 (56%) had a directive after completion. One hundred eighty-six of the completers discussed directives with family members. Overall, 89 (36%) of the 248 program completers revised an existing directive or signed one for the first time. Age was positively related to having signed/revised a directive prior to the program. Fear that advance directives would be used to deny medical care was negatively related to signing both prior to the program and after program completion, and contributed to participants' reluctance to sign directives. CONCLUSIONS: Educational programs implemented by parish nurses in faith communities can be effective in increasing rates of discussion, revision, and/or signing of advance directives.

Meisenhelde, J. B. [MGH Institute of Health Professions, Boston, MA]. "**Gender differences in religiosity and functional health in the elderly**." *Geriatric Nursing* 24, no. 6 (Nov-Dec 2003): 343-7.

[Abstract:] This secondary analysis of a random, community survey of 271 people over 65 years old examined gender differences in religious coping, importance of faith, and frequency of prayer for their relationship on eight categories of functional physical and mental health, as measured by the Medical Outcomes Study Health Survey Short-Form 36. Mental health was the only outcome related to the spiritual indices for both genders but used differently. Frequency of prayer, a behavioral indicator, was positively related to mental health for men. Reliance on religious coping and a high importance of one's faith were positively related to mental health for women. The results indicated that cognitive coping responses were associated with lower anxiety and depression for women, whereas behavioral spiritual responses were the relevant variables for male mental health in this sample of elders.

Meyer, C. L. [School of Nursing, Baker University, Topeka, KS; cleda.meyer@bakeru.edu]. "**How effectively are nurse educators preparing students to provide spiritual care?**" *Nurse Educator* 28, no. 4 (Jul-Aug 2003): 185-90.

This study analyzed questionnaires from a convenience sample of nursing students and faculty at 12 Midwestern nursing schools. Among the findings: most students said that spiritual care of patients was an essential component of holistic practice but most also said that they felt inadequately prepared to conduct a spiritual assessment and provide spiritual care; also, most students said that their views had been positively affected in terms of spirituality in patient care as a result of their programs.

Miller, B. E., Pittman, B. and Strong, C. [Department of Obstetrics and Gynecology, Wake Forest University School of Medicine, Winston-Salem, NC; bemiller@wfubmc.edu]. "**Gynecologic cancer patients' psychosocial needs and their views on the physician's role in meeting those needs**." *International Journal of Gynecological Cancer* 13, no. 2 (Mar-Apr 2003): 111-9.

This study analyzed questionnaires from 95 patients at least 6 months after completion of therapy for gynecological malignancies. Topics explored included: emotional needs, spiritual concerns, patient-family communication, patient participation in decision making, and advance directives. Results showed that most of these patients wanted physicians to take an active role in helping them with psychosocial needs. Among the findings [from the abstract:] Fifty-nine percent stated that physicians should ask whether help is needed in discussing spiritual matters.

Miller, W. R. and Thoresen, C. E. [Department of Psychology, University of New Mexico, Albuquerque, NM 87131-1161; wrmiller@unm.edu]. "**Spirituality, religion, and health. An emerging research field**." *American Psychologist* 58, no. 1 (Jan 2003): 24-35. [Review, 102 refs.] [This article, prepared in association with the NIH Working Group on Research on Spirituality, Religion, and Health, is one of four state-of-the-science articles comprising a special section in this journal issue. See also articles by Hill, et al.; Powell, et al.; and Seeman, et al.; noted in this bibliography.]

[Abstract:] The investigation of spiritual/religious factors in health is clearly warranted and clinically relevant. This special section explores the persistent predictive relationship between religious variables and health, and its implications for future research and practice. The section reviews epidemiological evidence linking religiousness to morbidity and mortality, possible biological pathways linking spirituality/religiousness to health, and advances in the assessment of spiritual/religious variables in research and practice. This introduction provides an overview of this field of research and addresses 3 related methodological issues: definitions of terms, approaches to statistical control, and criteria used to judge the level of supporting evidence for specific hypotheses. The study of spirituality and health is a true frontier for psychology and one with high public interest.

Milstein, G., Bruce, M. L., Gargon, N., Brown, E., Raue, P. J. and McAvay, G. [Department of Psychology, City College of the City University of New York, NY; gmilstein@ccny.cuny.edu]. "**Religious practice and depression among geriatric home care patients**." *International Journal of Psychiatry in Medicine* 33, no. 1 (2003): 71-83.

[Abstract:] OBJECTIVE: To examine the relationship between religious practice and depression in a sample of geriatric patients receiving homecare nursing services. METHODS: Patients were sampled weekly for six months from all those aged 65 to 102, and newly enrolled in a visiting nurse agency (N = 130). Depression was assessed by home interviews using the SCID and HRSD. Patients reported their religious service participation prior to receiving homecare and currently. Health status, disability, pain, social support and history of depression were also assessed. RESULTS: The current prevalence of DSM-IV Major Depressive Disorder (MDD) was significantly greater ($p < .05$), and depressive symptoms were more severe ($p < .02$), among those persons who had not attended religious services prior to receiving homecare. Logistic regression demonstrated that the effect of religious attendance remained significant when controlling for health status, disability, pain, social support and history of depression. A subsequent analysis compared three groups of patients. They were those who had: 1) Not attended religious services; 2) Stopped attending since homecare; 3) Continued attending. Data demonstrated significantly decreasing prevalence of MDD ($p < .03$) across the groups. CONCLUSIONS: Prevalence of DSM-IV Major Depressive Disorder and the severity of depressive symptoms were significantly lower among homecare patients who attend religious services. Because a large proportion of persons stop attending religious services after initiating homecare, it is suggested that visitation by clergy may improve depressive symptoms for these patients.

Milstein, J. M. [Division of Neonatalogy, Department of Pediatrics, University of California, Davis]. "**Detoxifying death in the neonate: in search of meaningfulness at the end of life**." *Journal of Perinatology* 23, no. 4 (Jun 2003): 333-6.

The author presents two cases to describe two different families approaches to their dying newborn infants. [From the abstract:] We shall consider the concepts of interference versus intervention as we examine subtle medical differences between the two cases. We will address medical, legal, and ethical issues in each case, but special attention will be given to the provision of compassionate care. People face physical, mental, emotional, and spiritual challenges as they go through life. The families' approaches with their infants at the end of their lives may support the premise that the latter two challenges, emotional and spiritual, confront us the most at the end. Encouraging families to engage with their dying infants helps detoxify the experience and make it more meaningful.

Mitchell, L. and Romans, S. [Department of Psychological Medicine, University of Otago, P.O. Box 913, Dunedin, New Zealand]. "**Spiritual beliefs in bipolar affective disorder: their relevance for illness management**." *Journal of Affective Disorders* 75, no. 3 (Aug 2003): 247-57.

[From the abstract:] ...A questionnaire covering religious, spiritual and philosophical beliefs and religious practice was given to a sample of patients with bipolar affective disorder in remission. RESULTS: Most patients often held strong religious or spiritual beliefs (78%) and

practised their religion frequently (81.5%). Most saw a direct link between their beliefs and the management of their illness. Many used religious coping, and often religio-spiritual beliefs and practice put them in conflict with illness models (24%) and advice (19%) used by their medical advisors. ...CONCLUSIONS: Religio-spiritual ideas are of great salience to many patients with bipolar disorder and shape the ways in which they think about their illness. Many reported experiencing significant paradigm conflict in understanding and managing their illness between medical and their spiritual advisors. These data suggest that the whole area of religion and spirituality is directly relevant to people living with a chronic psychiatric illness and should be firmly on the discussion agenda of clinicians working with patients with bipolar disorder.

Monroe, M. H., Bynum, D., Susi, B., Phifer, N., Schultz, L., Franco, M., MacLean, C. D., Cykert, S. and Garrett, J. [Department of Internal Medicine, Carolinas Medical Center, Charlotte, NC; mmonroe@carolinas.org]. "**Primary care physician preferences regarding spiritual behavior in medical practice**." *Archives of Internal Medicine* 163, no. 22 (Dec 8-22, 2003): 2751-6.

[Abstract:] BACKGROUND: Knowledge of physician attitudes and preferences regarding religion and spirituality in the medical encounter is limited by the nonspecific questions asked in previous studies and by the omission of specialties other than family practice. This study was designed to determine the willingness of internists and family physicians to be involved with varying degrees of spiritual behaviors in varied clinical settings. METHODS: The study was a multicenter, cross-sectional, nonrandomized design recruiting physicians from 6 teaching hospitals with sites in North Carolina, Vermont, and Florida. A self-administered survey was used to explore physicians' willingness to address religion and spirituality in the medical encounter. Data were gathered on the physicians' religiosity and spirituality and sociodemographic characteristics. RESULTS: Four hundred seventy-six physicians responded, for a response rate of 62.0%. While 84.5% of physicians thought they should be aware of patients' spirituality, most would not ask about spiritual issues unless a patient were dying. Fewer than one third of physicians would pray with patients even if they were dying. This number increased to 77.1% if a patient requested physician prayer. Family practitioners were more likely to take a spiritual history than general internists. CONCLUSIONS: Most primary care physicians surveyed would not initiate any involvement with patients' spirituality in the medical encounter except for the clinical setting of dying. If a patient requests involvement, however, most physicians express a willingness to comply, even if the request involves prayer.

Murphy, S. A. and Johnson, L. C. [University of Washington, Seattle, WA; samurphy@u.washington.edu]. "**Finding meaning in a child's violent death: a five-year prospective analysis of parents' personal narratives and empirical data**." *Death Studies* 27, no. 5 (Jun 2003): 381-404.

[Abstract:] Finding meaning in the death of a loved one is thought to be extremely traumatic when the circumstances surrounding the death is perceived to be due to negligence, is intentional, and when the deceased suffered extreme pain and bodily harm immediately prior to death. We addressed this assumption by obtaining personal narratives and empirical data from 138 parents 4, 12, 24, and 60 months after an adolescent's or young adult child's death by accident, suicide, or homicide. Using the Janoff-Bulman and Frantz's (1997) framework of meaning-as-comprehensibility and meaning-as-significance, the purposes were to identify the time course to find meaning, present parents' personal narratives describing finding meaning in their experiences, identify predictors of finding meaning, and compare parents who found meaning versus those who did not on five health and adjustment outcomes. The results showed that by 12 months post death, only 12% of the study sample had found meaning in a child's death. By 60 months post death, 57% of the parents had found meaning but 43% had not. Significant predictors of finding meaning 5 years post death were the use of religious coping and support group attendance. Parents who attended a bereavement support group were 4 times more likely to find meaning than parents who did not attend. Parents who found meaning in the deaths of their children reported significantly lower scores on mental distress, higher marital satisfaction, and better physical health than parents who were unable to find meaning. Recommendations for future research are made.

Murray, S. A., Kendall, M., Boyd, K., Worth, A. and Benton, T. F. [Division of Community Health Sciences, University of Edinburgh, Scotland; Scott.Murray@ed.ac.uk]. "**General practitioners and their possible role in providing spiritual care: a qualitative study**." *British Journal of General Practice* 53, no. 497 (Dec 2003): 957-9.

[Abstract:] We interviewed the general practitioners (GPs) of 40 patients with life-threatening illnesses over the course of the last year of life. We asked them to identify their patients' holistic needs, and to discuss whether they considered that they had a role in providing 'spiritual care'. The GPs varied greatly in their understanding of their patients' experiences and needs. Most said that they had a role in providing spiritual care, but hesitated to raise spiritual issues with patients, mentioning lack of time, a feeling that they should wait for a cue, or being unprepared or unskilled.

Musgrave, C. F. and McFarlane, E. A. [University of Pennsylvania, Philadelphia, PA; musgrave@hadassah.org.il]. "**Oncology and nononcology nurses' spiritual well-being and attitudes toward spiritual care: a literature review**." *Oncology Nursing Forum* 30, no. 3 (May-Jun 2003): 523-7. [Review, 35 refs.]

[From the abstract:] PURPOSE/OBJECTIVES: To review literature about oncology and nononcology nurses' attitudes toward spiritual care and the way that their spiritual well-being influences those attitudes. ...CONCLUSIONS: A significant association exists between attitudes toward spiritual care and spiritual well-being in nurses who care for nononcology populations. However, little research examines oncology nurses' attitudes toward spiritual care and the way that their spiritual well-being affects those attitudes.

Musick, D. W., Cheever, T. R., Quinlivan, S. and Nora, L. M. [Department of Rehabilitation Medicine, University of Pennsylvania School of Medicine, Philadelphia, PA; david.musick@uphs.upenn.edu]. "**Spirituality in medicine: a comparison of medical students' attitudes and clinical performance**." *Academic Psychiatry* 27, no. 2 (Summer 2003): 67-73.

[Abstract:] OBJECTIVE: The authors sought to examine attitudes about spirituality in medicine among medical students in psychiatric clerkships and determine whether instruction on concepts of spirituality in medicine had an effect on students' clinical performance in related tasks. METHODS: A total of 192 students entering psychiatric clerkships were randomly assigned to one of two groups; both groups received identical didactic instruction on spirituality in medicine. One group worked on a problem-based learning case that featured spirituality as a prominent theme, whereas the other group worked on problem-based learning cases that made no mention of it. Students completed pre- and posttest questionnaires, and their examination at the end of rotation included a standardized patient encounter requiring them to elicit a spiritual history. RESULTS: Among the 131 students who completed and returned both questionnaires, a significant difference ($p=0.001$) was noted between groups on students' self-reported knowledge of taking a spiritual history. However, students in the two groups received identical scores on the component of the examination requiring them to write a spiritual history. CONCLUSIONS: Although students who were exposed to material on spirituality in medicine reported greater understanding of the issue, no difference in clinical performance was observed.

Nairn, R. C. and Merluzzi, T. V. [Department of Psychology, Haggar Hall, University of Notre Dame, Notre Dame, IN 46556; narin.1@nd.edu]. "**The role of religious coping in adjustment to cancer**." *Psycho-Oncology* 12, no. 5 (Jul-Aug 2003): 428-41.
[Abstract:] This study tested a model of adjustment to cancer in which social support, disease impact, and religious coping were hypothesized to have an impact on adjustment to cancer that was mediated by self-efficacy. Two hundred and ninety-two people with cancer completed questionnaires. Three analyses were undertaken: first, the structure of the Religious Problem Solving Scale was assessed by a factor analysis in which two factors emerged, Deferring-Collaborative and Self-Directing; second, the resulting factors' relationships to outcome measures were assessed through correlational and regression analyses; third, a mediated model of coping was tested with self-efficacy as a mediating variable between religious coping and adjustment. The Deferring-Collaborative factor had positive relationships with most of the variables and was partially mediated by self-efficacy. The results indicate that religious coping has no relationship to quality of life, a positive relationship with adjustment, and was more important in this study than available social support.

Nelson, K. A. and Walsh, D. [Cancer Treatment Research Foundation, Arlington Heights, IL]. "**The business of palliative medicine--Part 3: The development of a palliative medicine program in an academic medical center**." *American Journal of Hospice & Palliative Care* 20, no. 5 (Sep-Oct 2003): 345-52.
The authors address generally the subject of comprehensive palliative care and look particularly at the Cleveland Clinic Foundation palliative medicine program (PMP). The article emphasizes [from the abstract:] pain and symptom relief, psychosocial and spiritual care, and support for the patient and family extending from the time of diagnosis through the bereavement period.

Nelson, N. D., Trail, M., Van, J. N., Appel, S. H. and Lai, E. C. [Department of Neurology, Baylor College of Medicine, Houston, TX]. "**Quality of life in patients with amyotrophic lateral sclerosis: perceptions, coping resources, and illness characteristics**." *Journal of Palliative Medicine* 6, no. 3 (Jun 2003): 417-24.
This study of 100 patients with amyotrophic lateral sclerosis suggests [from the abstract:] Illness characteristics do influence QOL for patients with ALS, but they are not the only concerns. When measuring QOL in patients with ALS, the unique features of the psychosocial factors, personality traits, and spiritual factors, in addition to disease symptoms, need to be identified and discussed with patients and families throughout the illness.

Neumann, J. K. and Olive, K. E. [Psychology Department, VA Medical Center, Johnson City, TN; joseph.neumann@state.tn.us]. "**Absolute versus relative values: effects on family practitioners and psychiatrists**." *Southern Medical Journal* 96, no. 5 (May 2003): 452-7.
[Abstract:] BACKGROUND: Research demonstrates that religious values clearly impact on the judgments made by physicians and their patients. One basic dichotomy--belief in ethical values that do not change (absolute values) versus belief in values that change depending on the situation (relative values)--has recently been experimentally associated with different ethical decision-making patterns. METHODS: An anonymous, randomized, national survey and 1-week response prompt with 1-month follow-up mailing as necessary were distributed to nationwide samples of board-certified American family practitioners and psychiatrists. Physicians answered descriptive questions and standardized personality assessments and responded to three vignettes describing ethically sensitive scenarios concerning birth control medication for sexually active single women, euthanasia, and abortion. RESULTS: Response rates were 34% for psychiatrists and 38% for family practitioners. Family practitioners and absolutists were significantly more supportive of religious activities and had more religious parents than psychiatrists and relativists. Furthermore, family practitioners and absolutists were less approving of the vignettes than other groups. CONCLUSION: Family practitioners were more supportive of religious activities than psychiatrists as reported in previous research. The absolute versus relative value dichotomy is a useful concept in examining physician attitudes as they affect health care and personal behavior. However, questions concerning place of worship attendance and giving in addition to specific religious value labels may be more efficient experimentally. Physicians should be aware of their own biases in discussions with patients, families, and other health care providers.

Newberg, A., Pourdehnad, M., Alavi, A. and d'Aquili, E. G. [Division of Nuclear Medicine, Hospital of the University of Pennsylvania, Philadelphia, PA; newberg@oasis.rad.upenn.edu]. "**Cerebral blood flow during meditative prayer: preliminary findings and methodological issues**." *Perceptual & Motor Skills* 97, no. 2 (Oct 2003): 625-30.
[Abstract:] Meditative practices typically require several coordinated cognitive activities. This study measured changes in cerebral blood flow during "verbal" based meditation by Franciscan nuns involving the internal repetition of a particular phrase. These results are compared with those we previously described in eight Buddhist meditators who use a type of "visualization" technique. Three experienced practitioners of verbal meditation were injected via i.v. at rest with 260 MBq of Tc-99m HMPAO and scanned 30 min. later on a triple head SPECT camera for 45 min. Following the baseline scan, subjects meditated for approximately 40 min. at which time they were injected with 925 MBq of HMPAO while they continued to meditate for 10 min. more (total of 50 min. of meditation). The injection during meditation was designed not to disturb practice. Subjects were scanned 20 min. later for 30 min. Counts were obtained for regions of interest for major brain structures and normalized to whole-brain blood flow. Compared to baseline, mean verbal meditation scans showed increased blood flow in the prefrontal cortex (7.1%), inferior parietal lobes (6.8%), and inferior frontal lobes (9.0%). There was a strong inverse correlation between the blood flow, change in the prefrontal cortex and in the ipsilateral superior parietal lobe ($p<.01$). This study on a limited number of subjects demonstrated the feasibility of studying different types of meditation with neuroimaging techniques, suggested that several coordinated cognitive processes occur during meditation, and also raised important methodological issues.

Newlin, K., Melkus, G. D., Chyun, D. and Jefferson, V. [Yale University School of Nursing, New Haven, CT; Kelley.newlin@yale.edu]. "**The relationship of spirituality and health outcomes in Black women with type 2 diabetes**." *Ethnicity & Disease* 13, no. 1 (Winter 2003): 61-8.
[Abstract:] The purpose of this pilot study was to explore the relationships between spiritual well-being emotional distress, HbA1c values, and blood pressure levels in a convenience sample of 22 Black women with type 2 diabetes. Results revealed significant inverse correlations between diastolic blood pressure (BP) and both total spiritual well-being ($r=-.51$, $P=.02$) and religious well-being (RWB) ($r=-.55$, $P=.01$). Women with higher RWB scores tended to have lower diastolic BP, as compared to their counterparts with lower RWB scores ($z=2.78$, $P=.005$). Emotional distress was positively related to systolic BP ($r=.48$, $P=.03$). These finding suggest that holistic care, addressing the spiritual and emotional dimensions, may foster improved BP levels among Black women with type 2 diabetes, thereby potentially reducing their high risk for secondary complications.

Nonnemaker, J. M., McNeely, C. A., and Blum, R. W., for the National Longitudinal Study of Adolescent Health [Research Triangle Institute International, 3040 Cornwallis Road, PO Box 12194, Research Triangle Park, NC 22709-2194; jnonnemaker@rti.org]. "**Public and private domains of religiosity and adolescent health risk behaviors: evidence from the National Longitudinal Study of Adolescent Health**." *Social Science & Medicine* 57, no. 11 (Dec 2003): 2049-54.

The study explores the complexity of religious factors in adolescent health, in terms of public and private religiosity. [From the abstract:] Our results support previous evidence that religiosity is protective for a number of adolescent health-related outcomes. In general, both public and private religiosity was protective against cigarettes, alcohol, and marijuana use. On closer examination it appeared that private religiosity was more protective against experimental substance use, while public religiosity had a larger association with regular use, and in particular with regular cigarette use. Both public and private religiosity was associated with a lower probability of having ever had sexual intercourse. Only public religiosity had a significant effect on effective birth control at first sexual intercourse and, for females, for having ever been pregnant. However, neither dimension of religiosity was associated with birth control use at first or most recent sex. Public religiosity was associated with lower emotional distress while private religiosity was not. Only private religiosity was significantly associated with a lower probability of having had suicidal thoughts or having attempted suicide. Both public and private religiosity was associated with a lower probability of having engaged in violence in the last year.

Nussbaum, G. B. [Allegheny General Hospital, Pittsburgh, PA; gnussbau@wpahs.org]. "**Spirituality in critical care: patient comfort and satisfaction**." *Critical Care Nursing Quarterly* 26, no. 3 (Jul-Sep 2003): 214-20. [Review, 20 refs.]

The author discusses the role of spirituality in the nursing care of patients, especially in critical care units, and asserts that nurses will experience less burnout as a result of the experience of their spiritual caring for others.

Ogle, K., Greene, D. D., Winn, B., Mishkin, D., Bricker, L. G. and Lambing, A. K. [Department of Family Practice, Michigan State University, East Lansing, Michigan; Karen.Ogle@ht.msu.edu]. "**Completing a life: development of an interactive multimedia CD-ROM for patient and family education in end-of-life care**." *Journal of Palliative Medicine* 6, no. 5 (Oct 2003): 841-50.

[From the abstract:] Completing a Life covers a wide range of information for the user to choose from, spanning physical, emotional, family, and spiritual issues. A calm and comforting tone and welcoming environment enhances the users' ability to take in the information and make proactive decisions about his/her own well-being and care. The CD contains video narratives of individuals who tell their own stories of living with terminal illness. In addition to being a highly relevant means of conveying sensitive, health-related information, this collection of personal interviews may offer a form of "virtual support group" for the user. Finally, the interactive format allows stories and informational content to be linked in topic-specific ways that complement one another.

Ohm, R. [University of Kansas, Baker University School of Nursing, Topeka, KS; rohm@stormontvail.org]. "**The African American experience in the Islamic faith**." *Public Health Nursing* 20, no. 6 (Nov-Dec 2003): 478-86.

[From the abstract:] A historical overview of the African American experience in the Islam faith, from the Nation of Islam to universal Islam, is presented. A systematic assessment of the Islamic faith, with emphasis on the African American Muslim, was conducted as an assessment for a Community Health Nursing class. Leininger's Sunrise Model of Culture Care Diversity and Universality, with the ethnonursing model of data collection, served as the framework for data collection and analysis. The Islamic faith was noted to offer holistic direction for a "way of life" that promotes health and harmony of the mind, body, and soul. Implications for research [are] discussed.

Olson, J. K., Paul, P., Douglass, L., Clark, M. B., Simington, J. and Goddard, N. [Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada; Joanne.olson@ualberta.ca]. "**Addressing the spiritual dimension in Canadian undergraduate nursing education**." *Canadian Journal of Nursing Research* 35, no. 3 (Sep 2003): 94-107.

[Abstract:] The purpose of this study was to identify the extent to which the spiritual dimension is addressed in Canadian university undergraduate nursing curricula. An exploratory descriptive design was used to gather data from faculty members at Canadian university schools of nursing. Eighteen (62%) of the 29 eligible schools participated. The findings indicate that conceptual confusion exists and that the spiritual dimension is rarely defined or included in curricular objectives. However, they also indicate that the spiritual dimension is more frequently evident in course objectives and that a number of creative methods are used to address it. Testing in this area is sporadic and limited. The results indicate that greater attention could be given to this dimension.

Ott, B. B., Al-Khadhuri, J. and Al-Junaibi, S. [College of Nursing, Villanova University, Villanova, PA]. "**Preventing ethical dilemmas: understanding Islamic health care practices**." *Pediatric Nursing* 29, no. 3 (May-Jun 2003): 227-30.

The authors offer very practical information for non-Muslim clinicians' care of Muslim patients, under such headings as Dress, Prayer, Diet, Family, Menstruation, Marriage, Childbearing, Visiting the Sick, Care Providers, The Dying Process, Death, Ritual Washing, and Burial. A case illustration is provided, along with web sources for additional information.

Papathanassoglou, E. D. and Patiraki, E. I. [University of Athens, School of Nursing (UoA-SoN), Intensive Care Unit UoA-SoN, Athens, Greece; elipapa@nurs.uoa.gr]. "**Transformations of self: a phenomenological investigation into the lived experience of survivors of critical illness**." *Nursing in Critical Care* 8, no. 1 (Jan-Feb 2003): 13-21.

This phenomenological study of 8 individuals who had experienced hospitalization in an intensive care unit analyzes semi-structured interviews with particular attention to patients' dreams. Among the findings [from the abstract]: Transformations in perception, in lived-body, and in lived time and space were some of the themes emerging as part of both conscious and dreaming experiences. Attitudes towards death were altered, and elements of heightened spirituality were evident in the aftermath of critical illness. Critical illness was conceptualized as a 'cocooning phase' leading to transformation of self, spiritual arousal and personal growth.

Parker, M., Lee Roff, L., Klemmack, D. L., Koenig, H. G., Baker, P. and Allman, R. M. [University of Alabama, School of Social Work, Tuscaloosa, AL]. "**Religiosity and mental health in southern, community-dwelling older adults**." *Aging & Mental Health* 7, no. 5 (Sep 2003): 390-7.

[Abstract:] This study considers potential interaction effects of three measures of religiosity: organized (OR), non-organized (NOR), and intrinsic religiosity (IR), on depression and general mental health, controlling for socio-demographic characteristics and mobility. In-home interviews were conducted among a stratified random sample of Medicare beneficiaries from five central Alabama counties (the University of

Alabama at Birmingham Study of Aging). Those who were high on all three dimensions of religiosity reported having fewer symptoms of depression and better mental health than did those who were low on all three dimensions of religiosity. Subjects who scored high on OR reported lower levels of depression ($F(1,981) = 3.97$, $p<0.05$). Neither IR nor NOR had salutary effects on the measure of depression nor on the general measure of mental health.The interpretation of the relationships of religiosity with the Geriatric Depression Scale (GDS) and the general mental health (Mental Component Score of the SF-12; MCS) measures was complicated by the presence of three way interactions ($F(1,981) = 9.02$, $p<0.01$ and $F(1, 981) = 5.46$, $p<0.05$, for GDS and MCS respectively). The presence of interaction effects between the different dimensions of religiosity and mental health affirms the importance of remaining sensitive to the multidimensional nature of religiousness and its relationships with measures of mental health.

Parker Oliver, D. [University of Missouri, School of Social Work, Columbia, MO; oliverdr@missouri.edu]. "**Social work and spiritual counseling: results of one state audit**." *Journal of Palliative Medicine* 6, no. 6 (Dec 2003): 919-25.
[From the abstract:] State regulatory reports were analyzed to identify compliance issues for social workers and spiritual counselors within hospice programs in a midwestern state. Problems with care planning, assessment, and bereavement services were identified in this process. Deficiencies point to the opportunities for social work educators to improve the training of future hospice social workers and the challenges involved in training spiritual counselors.

Pesut, B. [Trinity Western University, Langley, British Columbia, Canada; pesut@twu.ca]. "**Developing spirituality in the curriculum: worldviews, intrapersonal connectedness, interpersonal connectedness**." *Nursing Education Perspectives* 24, no. 6 (Nov 2003): 290-4. [Review, 22 refs.]
[Abstract:] Although many nursing education programs are searching for ways to incorporate spirituality into the curriculum, how this should be done remains a point of debate. A number of models and teaching strategies have been posed in the literature. This article explores how definitions of spirituality can inform the integration of this important concept into the curriculum. Three key themes from definitions of spirituality in the literature are discussed: worldviews, intrapersonal connectedness, and interpersonal connectedness. Strategies are presented for facilitating discussions around worldviews and for fostering a climate that promotes intra- and interpersonal connectedness for students and faculty.

Pincharoen, S. and Congdon, J. G. [Khon Kaen University, Faculty of Nursing, Khon Kaen, Thailand]. "**Spirituality and health in older Thai persons in the United States**." *Western Journal of Nursing Research* 25, no. 1 (Feb 2003): 93-108.
[From the abstract:] This study describes spirituality as perceived and experienced by older Thai persons. Specific aims were to describe how spirituality helped older Thai persons maintain their health and to describe what they valued most as they aged. ...The sample included 9 older Thai persons from an urban U.S. community. Data were generated using ethnographic interviews and participant observation. ...Five major themes emerged from the data: Connecting with spiritual resources provided comfort and peace, finding harmony through a healthy mind and body, living a valuable life, valuing tranquil relationships with family and friends, and experiencing meaning and confidence in death. For these Thai participants, health and spirituality coexisted and were linked to all of life.

Powe, B. D. and Finnie, R. [Behavioral Research Center, American Cancer Society, Atlanta, GA; bpowe@cancer.org]. "**Cancer fatalism: the state of the science**." *Cancer Nursing* 26, no. 6 (Dec 2003): 454-65; quiz 466-7. [Review, 35 refs.]
This review of the literature concludes, among other things, that [from the abstract:] Cancer fatalism may be modified through culturally relevant interventions that incorporate spirituality.

Powell, L. H., Shahabi, L. and Thoresen, C. E. [Department of Preventive Medicine, Rush-Presbyterian-St. Luke's Medical Center, Suite 470, 1700 West Van Buren Street, Chicago, IL 60612; lpowell@rush.edu]. "**Religion and spirituality. Linkages to physical health**." *American Psychologist* 58, no. 1 (Jan 2003): 36-52. [Review, 112 refs.] [This article is one of four state-of-the-science articles comprising a special section in this journal issue. See also articles by Hill, et al.; Miller, et al.; and Seeman, et al.; noted in this bibliography.]
[Abstract:] Evidence is presented that bears on 9 hypotheses about the link between religion or spirituality and mortality, morbidity, disability, or recovery from illness. In healthy participants, there is a strong, consistent, prospective, and often graded reduction in risk of mortality in church/service attenders. This reduction is approximately 25% after adjustment for confounders. Religion or spirituality protects against cardiovascular disease, largely mediated by the healthy lifestyle it encourages. Evidence fails to support a link between depth of religiousness and physical health. In patients, there are consistent failures to support the hypotheses that religion or spirituality slows the progression of cancer or improves recovery from acute illness but some evidence that religion or spirituality impedes recovery from acute illness. The authors conclude that church/service attendance protects healthy people against death. More methodologically sound studies are needed.

Prochnau, C., Liu, L. and Boman, J. [Department of Occupational Therapy, Faculty of Rehabilitation Medicine, University of Alberta, Edmonton, Alberta, Canada T5G 2G4; pcproc@telusplanet.net]. "**Personal-professional connections in palliative care occupational therapy**." *American Journal of Occupational Therapy* 57, no. 2 (Mar-Apr 2003): 196-204.
[From the abstract:] This qualitative study examined the experiences of occupational therapists working in palliative care. Multiple qualitative interviews were conducted with each of eight occupational therapists working with people who are terminally ill. ...Five themes emerged: satisfaction, hardship, coping, spirituality, and growth.

Rajaram, S. S. and Rashidi, A. [Deptartment of Sociology, University of Nebraska, Omaha NE; srajaram@mail.unomaha.edu]. "**African-American Muslim women and health care**." *Women & Health* 37, no. 3 (2003): 81-96.
[Abstract:] Muslims constitute a growing proportion of the African-American population. This paper explores the health practices, health behaviors, and code of ethics as informed by the Islamic religion within the context of African-American Muslim women's lives. An overview of the history of Islam in the world, and in the U.S., the main Islamic tenets, and the socio-cultural context of African-American Muslim women provides the broad framework for this paper. This information will be helpful in meeting the health needs of African-American Islamic women, within an outreach/community health promotion setting, within a clinical/hospital setting, or within a home care setting.

Ramondetta, L. M. and Sills, D. [Department of Gynecologic Oncology, M. D. Anderson Cancer Center, Houston, TX 77030-4009; lramonde@mdanderson.org]. "**Spirituality and religion in the 'art of dying**.'" *Journal of Clinical Oncology* 21, no. 23 (Dec 1, 2003): 4460-2. [Review, 14 refs.]

This report of a study of 328 gynecologic oncologists indicated that most felt that their training had inadequately prepared them to deal with dying patients. The authors discuss various particular findings and suggest that a helpful program should especially involve issues of religious meaning (rather than just a survey of various religious teachings/customs) and an understanding of the "art" by which patients cope with dying.

Reed, P. S., Foley, K. L., Hatch, J. and Mutran, E. J. [Center on Minority Aging, University of North Carolina at Chapel Hill, NC; preed@email.unc.edu]. "**Recruitment of older African Americans for survey research: a process evaluation of the community and church-based strategy in The Durham Elders Project**." *Gerontologist* 43, no. 1 (Feb 2003): 52-61.

The authors reflect on collaboration efforts between university and community institutions and conclude [from the abstract]: A strategy of coordinating a community research advisory board to incorporate the views of community members and to drive a church-based recruitment procedure provides a starting point for tapping into an immensely important segment of society historically ignored by the research community. [The article may be of value to researchers working with and through congregations.]

Roberts, K. S. [USN, Naval Medical Center Portsmouth, 620 John Paul Jones Circle, (Bldg 1), Surgical Services Dept, Portsmouth, VA 23708; kimberly_roberts@hotmail.com]. "**Providing culturally sensitive care to the childbearing Islamic family: Part II**." *Advances in Neonatal Care* 3, no. 5 (Oct 2003): 250-5. [For Part I, see the August 2002 issue (vol. 2, no. 4, pp. 222-8).]

[Abstract:] Culturally sensitive care requires a unique combination of empathy, curiosity, and a profound respect for others. This article provides insight into the Islamic family structure and the traditional male and female roles that health care providers may encounter. Best practice considerations focused on communication with and care of the family during hospitalization, and strategies to support breastfeeding, dietary, and medication requirements are provided. Neonatal end-of-life decision making and death rituals are also discussed in context with commonly held religious beliefs and practices of this population.

Rosenberg, E., Clarfield, A. M., Caine, Y. and Patterson, C. J. [National Geriatics Council, Israeli Ministry of Health, Tel-Aviv, Israel; reli@netmedia.net.il]. "**SCOPE: SCripture Oriented Preventive Education**." *American Journal of Preventive Medicine* 25, no. 4 (Nov 2003): 333-8.

This study pilots a strategy to encourage lasting change in health behaviors by using a developed SCripture Oriented Preventive Education (SCOPE) tool. [From the abstract:] Forty-eight SCOPE articles were written to complement the weekly Torah portion read throughout the year in Orthodox Jewish synagogues. These were disseminated via newsletter within a modern Orthodox Jewish community in Israel. Two articles are included. An age-stratified, 25% random sample (120/471) of community readership was surveyed to ascertain receptivity to SCOPE and to gauge support for future implementation. RESULTS: Response rate was 76% (92/120). Lifestyle behavior-related articles were most popular (77% found them interesting) and injury prevention the least (41%). Knowledge gained was the most common benefit reported (55% of respondents), followed by attitude change (24%). Those aged 30 to 49 years were significantly more likely than others to report behavior change (p=0.002) and health improvement (p=0.005) secondary to SCOPE. Clinical prevention (p=0.007) and environmental health (p=0.03) articles were significantly more popular in people aged > or =30 and 30 to 49, respectively. Between 69% and 84% supported the implementation of SCOPE in secondary schools, by physicians, and/or rabbis. CONCLUSIONS: SCOPE was designed to deliver prevention materials to faith communities via a Scripture-based vehicle. A postexposure readership survey in an Israeli Orthodox Jewish community demonstrated its effectiveness. SCOPE's ultimate utility as a counseling adjunct in Scripture-adherent communities awaits broader assessment.

Rumbold, B. D. [Palliative Care Unit, School of Public Health, La Trobe University, 215 Franklin Street, Melbourne, VIC 3000; b.rumbold@latrobe.edu.au]. "**Caring for the spirit: lessons from working with the dying**." *Medical Journal of Australia* 179, no. 6, Suppl. (Sep 15, 2003): S11-3.

[Abstract:] Spiritual care is integral to palliative care, and palliative care experience in offering spiritual care can be a resource for the emerging healthcare interest in spirituality. Spirituality is best understood in terms of the web of relationships that gives coherence to our lives, uniquely identifying each person. In palliative care, responsibility for spiritual care is shared by the whole team, with leadership given by specialist practitioners such as pastoral care workers. The palliative care approach to spiritual care may, however, be transferred to other contexts and to individual practice. Spiritual care encourages and supports people in a quest for meaning and personal autonomy. It is offered, not imposed.

Sakurai, M. le D. [Nat'l. Assoc. of Catholic Chaplains, Milwaukee, WI]. "**The challenge and heart of chaplaincy. Recent decades have brought a host of changes to the health care chaplain's role**." *Health Progress* 84, no. 1 (Jan-Feb 2003): 26-8, 56.

The author, a Catholic chaplain, discusses the role of chaplaincy in modern health care institutions.

Samson, A. and Zerter, B. [Faculty of Education, University of Ottawa, Ontario, Canada]. "**The experience of spirituality in the psycho-social adaptation of cancer survivors**." *Journal of Pastoral Care & Counseling* 57, no. 3 (Fall 2003): 329-43.

[Abstract:] This article presents the results of a retrospective, phenomenological study of the experience of spirituality in the psychosocial adaptation of cancer survivors. The experience of illness for the participants in the study is one which promotes greater personal and spiritual growth. The study demonstrates that illness provokes personal growth and transformation in the individual. While making use of pre-existing coping resources, the person with cancer reevaluates and restructures her or his life, integrating new values, priorities, and perspectives which lead the patient to invest her or his life in something meaningful and beneficial to others.

Scheurich, N. [Department of Psychiatry, University of Kentucky College of Medicine, Lexington KY; nesche2@uky.edu]. "**Reconsidering spirituality and medicine**." *Academic Medicine* 78, no. 4 (Apr 2003): 356-60.

[Abstract:] Increasing awareness of possible links between religion and health has led to greater attention to spirituality and medicine in medical education; both trends have culminated in vigorous debate about the place of spirituality and related values in medical care. The author argues that due to basic ambiguities of the term "spirituality" as well as prevailing biases of both patients and practitioners, this debate risks valorizing theistic religious views, a trend that would be to the detriment of physicians, residents, and students who happen to be non-believers or adherents of minority faiths. It is maintained that philosophical value theory, a broad inquiry into value and meaning that is carefully neutral as regards religious matters, provides the greatest possible protection of both secular and non-secular world views. A notion of "separation of church and medicine," similar in some ways to the well-known political model, is proposed. Because so many issues of meaning and value may

be relevant to health, vigilance is required to properly delineate the purview of medicine. The author concludes by proposing that a medicine that neither exalts nor demeans religious belief but rather situates the latter among the countless values persons may hold should be the goal.

Schwartz, C., Meisenhelder, J. B., Ma, Y. and Reed, G. [Division of Preventive and Behavioral Medicine, Department of Medicine, University of Massachusetts Medical School, Worcester, MA; carolyn.schwartz@deltaquest.org]. "**Altruistic social interest behaviors are associated with better mental health**." *Psychosomatic Medicine* 65, no. 5 (Sep-Oct 2003): 778-85.

[Abstract:] OBJECTIVE: This study investigated whether altruistic social interest behaviors such as engaging in helping others were associated with better physical and mental health in a stratified random sample of 2016 members of the Presbyterian Church throughout the United States. METHODS: Mailed questionnaires evaluated giving and receiving help, prayer activities, positive and negative religious coping, and self-reported physical and mental health. RESULTS: Multivariate regression analysis revealed no association between giving or receiving help and physical functioning, although the sample was highly skewed toward high physical functioning. Both helping others and receiving help were significant predictors of mental health, after adjusting for age, gender, stressful life events, income, general health, positive and negative religious coping, and asking God for healing (R2 =.27). Giving help was a more important predictor of better reported mental health than receiving help, and feeling overwhelmed by others' demands was an independent predictor of worse mental health in the adjusted model. Significant predictors of giving help included endorsing more prayer activities, higher satisfaction with prayer life, engaging in positive religious coping, age, female gender, and being a church elder. Frequency of prayer and negative religious coping were not related to giving help. CONCLUSIONS: Helping others is associated with higher levels of mental health, above and beyond the benefits of receiving help and other known psychospiritual, stress, and demographic factors. The links between these findings and response shift theory are discussed, and implications for clinical interventions and future research are described.

Schwartz, C. E., Mazor, K., Rogers, J., Ma, Y., and Reed G. [Division of Preventive and Behavioral Medicine, Department of Medicine, University of Massachusetts Medical School, Worcester, MA; carolyn.schwartz@deltaquest.org]. "**Validation of a new measure of concept of a good death**." *Journal of Palliative Medicine* 6, no. 4 (Aug 2003): 575-84.

[From the abstract:] BACKGROUND: ...The present work describes the development and testing of a set of items intended to measure the importance of several components posited to be critical to the concept of a good death. It is intended for use with health care providers and lay people in the context of end-of-life care research and education. POPULATION: Four cohorts (n = 596) were recruited to participate, representing two helping profession disciplines, nonhelping professionals, and a range of ages, specifically: (1) undergraduate medical students; (2) master's degree students in nursing; (3) graduate students from the life sciences; and (4) practicing hospice nurses. METHODS: Participants completed self-report questionnaires at baseline and retest. Psychometric analyses included item frequency distributions, factor analysis, alpha reliability, intraclass correlation, and measures of association. RESULTS: The new Concept of a Good Death measure demonstrated good item frequency distributions, acceptable internal consistency reliability, and test-retest stability. Its factor structure revealed that three distinct domains are measured, reflecting the psychosocial/spiritual, physical, and clinical aspects of a good death. An examination of patterns of correlations showed differential associations with death anxiety, spiritual beliefs and practices, anxious mood, and sociodemographic characteristics....

Seeman, T. E., Dubin, L. F. and Seeman, M. [Division of Geriatrics, University of California, Los Angeles, School of Medicine, 10945 Le Conte Ave, Suite 2339, Los Angeles, CA 90095-1687]. "**Religiosity/spirituality and health. A critical review of the evidence for biological pathways**." *American Psychologist* 58, no. 1 (Jan 2003): 53-63. [Review, 61 refs.] This article is one of four state-of-the-science overview articles comprising a special section in this journal issue. See also articles by Hill, et al.; Miller, et al.; and Powell, et al.; noted in this bibliography.]

[Abstract:] The authors review evidence regarding the biological processes that may link religiosity/spirituality to health. A growing body of observational evidence supports the hypothesis that links religiosity/spirituality to physiological processes. Although much of the earliest evidence came from cross-sectional studies with questionable generalizability and potential confounding, more recent research, with more representative samples and multivariate analysis, provides stronger evidence linking Judeo-Christian religious practices to blood pressure and immune function. The strongest evidence comes from randomized interventional trials reporting the beneficial physiological impact of meditation (primarily transcendental meditation). Overall, available evidence is generally consistent with the hypothesis that religiosity/spirituality is linked to health-related physiological processes—including cardiovascular, neuroendocrine, and immune function—although more solid evidence is needed.

Shannon-Dorcy, K. and Wolfe, V. [Clinical Research Department, Fred Hutchinson Cancer Research Center, 1100 Fairview Ave N, Seattle, WA 98115]. "**Decision-making in the diagnosis and treatment of leukemia**." *Seminars in Oncology Nursing* 19, no. 2 (May 2003): 142-9. [Review, 12 refs.]

The authors make extensive use of abstracts from a leukemia patient's reflections on her diagnosis, treatment, and follow-up; and they identify four "factors that influence decision making": Spirituality, Family, Temperament, and Control Issues (see p. 146).

Shuford, R. W. [Our Lady of the Resurrection Medical Center, 5645 W. Addison Street, Chicago, IL 60634]. "**The spiritual journey of an organ transplant patient**." *Journal of Pastoral Care & Counseling* 57, no. 2 (Summer 2003): 191-6.

[Abstract:] In this article, a hospital chaplain presents a detailed narrative of the psychological, emotional, and spiritual dynamics of an organ transplant patient. The chaplain explicates the many complex factors that may characterize an organ transplant patient's recovery and the many persons--family members and hospital personnel--who can be impacted by such a journey.

Silver, L. M. [Department of Molecular Biology, Woodrow Wilson School of Public and International Affairs, Princeton University]. "**Biotechnology and conceptualizations of the soul**." *Cambridge Quarterly of Healthcare Ethics* 12, no. 4 (Fall 2003): 335-41.

In this philosophical commentary, the author suggests that biotechnology impinges upon conceptualizations of the "soul," as seen in religious reservations about genetic engineering, and that forthright admission of this tension is necessary for clearer public debate on biotechnology.

Silvestri, G. A., Knittig, S., Zoller, J. S. and Nietert, P. J. [Department of Medicine and Center for Health Care Research, Medical University of South Carolina, Charleston, NC; Silvestri@musc.edu]. "**Importance of faith on medical decisions regarding cancer care**." *Journal of Clinical Oncology* 21, no. 7 (Apr 1, 2003): 1379-82.

[From the abstract:] One hundred patients with advanced lung cancer, their caregivers, and 257 medical oncologists were interviewed. Participants were asked to rank the importance of the following factors that might influence treatment decisions: cancer doctor's recommendation, faith in God, ability of treatment to cure disease, side effects, family doctor's recommendation, spouse's recommendation, and children's recommendation. RESULTS: All three groups ranked the oncologist's recommendation as most important. Patients and caregivers ranked faith in God second, whereas physicians placed it last (P <.0001). Patients who placed a high priority on faith in God had less formal education (P <.0001). CONCLUSION: Patients and caregivers agree on the factors that are important in deciding treatment for advanced lung cancer but differ substantially from doctors. All agree that the oncologist's recommendation is most important. This is the first study to demonstrate that, for some, faith is an important factor in medical decision making, more so than even the efficacy of treatment.

Simoni, J. M. and Ortiz, M. Z. [Department of Psychology, University of Washington, Box 351525, Seattle, Washington 98195-1525; jsimoni@u.washington.edu]. "**Mediational models of spirituality and depressive symptomatology among HIV-positive Puerto Rican women**." *Cultural Diversity & Ethnic Minority Psychology* 9, no. 1 (Feb 2003): 3-15.

[Abstract:] A survey of 142 Puerto Rican women living with HIV/AIDS in New York City revealed high Centers for Epidemiological Studies Depression (CES-D) scores, with 66% of the sample scoring above the conventional threshold of possible clinical depression. Most respondents (71%) were Catholic, 29% considered themselves members of a church or other place of worship, and 30% reported attending religious services 1-3 times a month. As predicted, spirituality was high and negatively associated with CES-D scores. A series of simultaneous multiple regression analyses controlling for all potentially confounding medical and sociodemographic variables demonstrated that both mastery and self-esteem scores mediated this relationship. Implications for future research and the provision of services to HIV-positive Puerto Rican women are discussed.

Smith, T. B., McCullough, M. E. and Poll, J. [Department of Counseling Psychology, Brigham Young University, Provo, Utah 84602-5093; timsmith@byu.edu]. "**Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events**." *Psychological Bulletin* 129, no. 4 (Jul 2003): 614-36.

[Abstract:] The association between religiousness and depressive symptoms was examined with meta-analytic methods across 147 independent investigations (N = 98,975). Across all studies, the correlation between religiousness and depressive symptoms was -.096, indicating that greater religiousness is mildly associated with fewer symptoms. The results were not moderated by gender, age, or ethnicity, but the religiousness-depression association was stronger in studies involving people who were undergoing stress due to recent life events. The results were also moderated by the type of measure of religiousness used in the study, with extrinsic religious orientation and negative religious coping (e.g., avoiding difficulties through religious activities, blaming God for difficulties) associated with higher levels of depressive symptoms, the opposite direction of the overall findings.

Smith-Toner, M. [California State University in Fullerton]. "**How Buddhism influences pain control choices**." *Nursing* 33, no. 4 (Apr 2003): 17.

This brief article illustrates how the teachings and practice of Buddhism may influence pain management decisions, especially in terms of patients' reluctance to take medication that may impair their alertness. Practical strategies are offered.

Tam Ashing, K., Padilla, G., Tejero, J. and Kagawa-Singer, M. [Department of Psychiatry and Biobehavioral Sciences, UCLA, Los Angeles, CA] "**Understanding the breast cancer experience of Asian American women**." *Psycho-Oncology* 12, no. 1 (Jan-Feb 2003): 38-58.

This study analyzed data from focus groups involving 34 Asian American breast cancer survivors. [From the abstract:] The common themes identified in this series of qualitative studies included: lack of knowledge about breast cancer; medical care issues such as cost and amount of time spent with physician; cultural factors related to beliefs about illness, gender role and family obligations (e.g. self-sacrifice) and language barriers; the importance of spirituality; and psychosocial concerns related to worry about children, burdening the family, body image and sexual health concerns. A primary source of support and coping for Asian American women with breast cancer was their spiritual beliefs.

Tanyi, R. A. and Werner, J. S. [Department of Family Practice, Allina Medical Clinic, Coon Rapids, MN]. "**Adjustment, spirituality, and health in women on hemodialysis**." *Clinical Nursing Research* 12, no. 3 (Aug 2003): 229-45.

[From the abstract:] This descriptive correlational study examined levels of and relationships between adjustment, spiritual well-being, and self-perceived health in women with ESRD. The sample included 65 women aged 24 to 82 receiving hemodialysis at five outpatient centers in a large metropolitan area. ...Overall, these women were fairly well adjusted as measured by the Psychosocial Adjustment to Illness Scale-Self-Report. They demonstrated fairly high levels of religious, existential, and overall spiritual well-being. Self-perceived health was good Spiritual well-being variables were all positively and significantly related to overall psychosocial adjustment and psychological distress adjustment. Self-perceived health variables were all positively and significantly related to overall psychosocial adjustment. Few significant relationships were found between spiritual well-being and other adjustment domains and between self-perceived health and other types of adjustment.

Tarumi, Y., Taube, A. and Watanabe, S. [Division of Palliative Medicine, Department of Oncology, University of Alberta, Edmonton, Alberta, Canada]. "**Clinical pastoral education: a physician's experience and reflection on the meaning of spiritual care in palliative care**." *Journal of Pastoral Care & Counseling* 57, no. 1 (Spring 2003): 27-31.

[Abstract:] In this article a physician reflects on her experience as a chaplain intern and how this Clinical Pastoral Education experience led to a deeper understanding of spiritual care in the palliative setting.

Taylor, E. J. [School of Nursing, Loma Linda University, CA; ejtaylor@sn.llu.edu]. "**Nurses caring for the spirit: patients with cancer and family caregiver expectations**." *Oncology Nursing Forum* 30, no. 4 (Jul-Aug 2003): 585-90.

[From the abstract:] PURPOSE/OBJECTIVES: To determine what patients with cancer and primary family caregivers expect from nurses with regard to having their spiritual needs addressed. ...SETTING: Outpatient and inpatient settings in a county hospital and a comprehensive cancer center, both located in a large, southwestern, metropolitan area. PARTICIPANTS: 28 African American and Euro-American adult patients with cancer and primary family caregivers were purposively selected to provide variation of experiences (e.g., religious backgrounds). METHODOLOGIC APPROACH: In-depth, semistructured, tape-recorded interviews conducted by the investigator. ...FINDINGS: Informants identified nursing approaches for spiritual needs, including kindness and respect; talking and listening; prayer; connecting with symmetry, authenticity, and physical presence; quality temporal nursing care; and mobilizing religious or spiritual resources. To provide spiritual care,

nurses must possess requisites of a personal, relational, or professional nature. CONCLUSIONS: Although some patients or caregivers do not want overt forms of spiritual care, others are eager for them. Many recognize nonreligious actions or attitudes that nurses can practice to care for spiritual needs.

Taylor, E. J. [School of Nursing, West Hall 1352, Loma Linda University, Loma Linda, CA 92350; ejtaylor@sn.llu.edu]. "**Prayer's clinical issues and implications**." *Holistic Nursing Practice* 17, no. 4 (Jul-Aug 2003): 179-88. [Review, 49 refs.]
[Abstract:] Because prayer frequently sustains coping and brings comfort, it is an important resource for nurses to support or offer. How shall nurses incorporate prayer in nursing practice? This article explores practical aspects of including prayer in bedside nursing care, including suggestions for assessment, supporting patients when beliefs about prayer challenge, discussing prayer with clients for whom prayer may be harmful, overcoming nursing barriers to prayer, and more.

Taylor, E. J. [School of Nursing, Loma Linda University, Loma Linda, CA; ejtaylor@sn.llu.edu]. "**Spiritual needs of patients with cancer and family caregivers**." *Cancer Nursing* 26, no. 4 (Aug 2003): 260-6.
[Abstract:] The purpose of this descriptive, cross-sectional, qualitative study was to describe the spiritual needs experienced in living with cancer from the perspective of patients with cancer and family caregivers. The sample included 28 African American and Euro-American patients with cancer and family caregivers receiving care from inpatient and outpatient units at two metropolitan hospitals in the southwestern United States. In-depth, tape-recorded, semistructured interviews were analyzed using the process of data reduction, data display, and verification. Seven categories of identified spiritual needs included needs associated with relating to an Ultimate Other; the need for positivity, hope, and gratitude; the need to give and receive love; the need to review beliefs, the need to have meaning; and needs related to religiosity and preparation for death. Informants responded with varying levels of awareness of personal spiritual needs. Caregivers were observed to have spiritual needs similar to those of patients. The findings of this study will inform nurses as they assess and document spiritual needs.

Theis, S. L., Biordi, D. L., Coeling, H., Nalepka, C. and Miller B. [School of Nursing, Oregon Health & Science University, Ashland, OR]. "**Spirituality in caregiving and care receiving**." *Holistic Nursing Practice* 17, no. 1 (Jan-Feb 2003): 48-55.
[From the abstract:] This qualitative, descriptive study examined spirituality in 60 caregivers and 60 care receivers, equally divided between Caucasians and African Americans. Themes were coping (subthemes of formal religion and social support) and meaning (subthemes of positive attitude, retribution or reward, and all encompassing). Needs of caregivers and care receivers include opportunities for formal religion (communion, prayer), social support (visiting, respite), and interactions to assist them find meaning in their caregiving and care receiving. Implications for nurses include collaborating with clergy to support the spiritual needs of caregivers and care receivers.

Thomas, J. R. and von Gunten, C. F. [Center for Palliative Studies, San Diego Hospice, San Diego School of Medicine, University of California, San Diego, CA; jthomas@sdhospice.org]. "**Pain in terminally ill patients: guidelines for pharmacological management**." *CNS Drugs* 17, no. 9 (2003): 621-31. [Review, 65 refs.]
[From the abstract:] Successful pharmacological treatment of pain in terminally ill patients is possible most of the time. It requires a determination of the type of pain syndrome (i.e. nociceptive, neuropathic or mixed). Complete pain assessment also requires an understanding of other dimensions of suffering that a patient may be experiencing on psychological, social and spiritual/existential levels.

van Olphen, J., Schulz, A., Israel, B., Chatters, L., Klem, L., Parker, E. and Williams, D. [San Francisco State University, Department of Health Education, San Francisco, CA; jvo@sfsu.edu]. "**Religious involvement, social support, and health among African-American women on the east side of Detroit**." *Journal of General Internal Medicine* 18, no. 7 (Jul 2003): 549-57.
[From the abstract:] The research presented here examines the direct effects of different forms of religious involvement on health, and the mediating effects of social support received in the church as a potential mechanism that may account for observed relationships between church attendance and health. DESIGN: This study involved a random sample household survey of 679 African-American women living on the east side of Detroit, conducted as part of the ESVHWP. MAIN RESULTS: Results of multivariate analyses show that respondents who pray less often report a greater number of depressive symptoms, and that faith, as an important source of strength in one's daily life, is positively associated with chronic conditions such as asthma or arthritis. Tests of the mediating effect of social support in the church indicated that social support received from church members mediates the positive relationship between church attendance and specific indicators of health. CONCLUSIONS: These findings are consistent with the hypothesis that one of the major ways religious involvement benefits health is through expanding an individual's social connections. The implications of these findings for research and practice are discussed.

Walsh, S. M., Bremer, B. A., Felgoise, S. H. and Simmons Z. [Greater Philadelphia Chapter ALS Association, Fort Washington, PA]. "**Religiousness is related to quality of life in patients with ALS**." *Neurology* 60, no. 9 (May 13, 2003): 1527-9.
[Abstract:] The authors studied quality of life (QOL) and religiousness in 49 patients with ALS over five consecutive visits spanning approximately 1 year. QOL was not significantly correlated with religiousness at entry. Over time, a significant relationship developed between QOL and total, public, and private religiousness.

Walter, T. [Department of Sociology, University of Reading, Reading, UK, RG6 6AA; j.a.walter@reading.ac.uk]. "**Historical and cultural variants on the good death**." *BMJ: British Medical Journal* 327, no. 7408 (Jul 26, 2003): 218-20.
The author considers religion in his brief overview of the diversity of perspectives on a "good death," especially in multicultural societies and in an age when the process of dying is often protracted due to the capabilities of modern medicine.

Weaver, A. J., Flannelly, K. J. and Oppenheimer, J. E. [The HealthCare Chaplaincy, New York, NY 10022-1505; aweaver@healthcarechaplaincy.org]. "**Religion, spirituality, and chaplains in the biomedical literature: 1965-2000**." *International Journal of Psychiatry in Medicine* 33, no. 2 (2003): 155-61. [Review, 19 refs.]
[From the abstract:] A correlational design was used, based on an electronic survey of all articles in MEDLINE for the years 1965 through 2000. ...Statistically significant upward trends across years were found for the rates of articles addressing religion ($r = .59$, $p < .001$) and spirituality ($r = .89$, $p < .001$) and a non-significant trend was found for chaplains ($r = .31$). The rising rates of articles on religion and spirituality in biomedical journals suggest a growing recognition of the need to address spiritual and religious issues in health-care.

Weaver, A. J., Flannelly, K. J., Stone, H. W. and Dossey, L. [HealthCare Chaplaincy, New York, NY]. "**Spirituality, health, and CAM: current controversies**." *Alternative Therapies in Health & Medicine* 9, no. 6 (Nov-Dec 2003): 42-6. [Review, 41 refs.]

This overview of the debate about the place of spirituality in health care and research is largely a response to the criticisms of R. P. Sloan.

Weinstein, L. B. [Marquette University School of Dentistry, Division of Public Health, Milwaukee, WI; lenorewein@aol.com]. "**Bereaved Orthodox Jewish families and their community: a cross-cultural perspective**." *Journal of Community Health Nursing* 20, no. 4 (Winter 2003): 233-43.

[Abstract:] This article examines the laws and customs of bereavement in Orthodox Jewish families and their community. It considers definitions of bereavement, the need for health care team members' cross-cultural understanding of bereavement, the community's role, and the role of the community health nurse and health care team with this particular group.

Wink, P. and Dillon, M. [Department of Psychology, Wellesley College, MA; pwink@wellesley.edu]. "**Religiousness, spirituality, and psychosocial functioning in late adulthood: findings from a longitudinal study**." *Psychology & Aging* 18, no. 4 (Dec 2003): 916-24.

[Abstract:] This study used longitudinal data to examine the relations among religiousness, spirituality, and 3 key domains of psychosocial functioning in late adulthood: (a) sources of well-being, (b) involvement in tasks of everyday life, and (c) generativity and wisdom. Religiousness and spirituality were operationalized as distinct but overlapping dimensions of individual difference. In late adulthood, religiousness was positively related to well-being from positive relations with others, involvement in social and community life tasks, and generativity. Spirituality was positively related to well-being from personal growth, involvement in creative and knowledge-building life tasks, and wisdom. Neither religiousness nor spirituality was associated with narcissism. The relations between religiousness, spirituality, and outcomes in late adulthood were also observed using religiousness scored in early and spirituality scored in late middle adulthood. All analyses were controlled for gender, cohort, social class, and the overlap between religiousness and spirituality.

Winslow, G. R. and Winslow, B. W. [Loma Linda University, CA; gwinslow@univ.llu.edu]. "**Examining the ethics of praying with patients**." *Holistic Nursing Practice* 17, no. 4 (Jul-Aug 2003): 170-7; quiz 177-8.

[Abstract:] Nurses should reflect carefully about the meaning and purpose of prayer in the clinical setting before engaging in prayer with patients. This article discusses the ethics of prayer with patients in regard to respectful care of the patient and integrity for the nurse. Five guidelines are offered to assist nurses in their ethical decisions about prayer with patients.

Wolinsky, F. D., Wyrwich, K. W., Kroenke, K., Babu, A. N. and Tierney, W. M. [School of Public Health, Saint Louis University, St. Louis, MO; wolinsky@slu.edu]. "**9-11, personal stress, mental health, and sense of control among older adults**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 58, no. 3 (May 2003): S146-50.

[Abstract:] OBJECTIVES: We assessed whether the events of 9-11 affected the personal stress, mental health, or sense of control of older adults participating in an ongoing longitudinal study, and whether baseline characteristics were associated with the magnitude of any such changes. METHODS: Personal stress, mental health, and sense of control were measured at baseline and at six bimonthly follow-up interviews among 1662 patients. Of these, 437 had the opportunity to complete three interviews before and after 9-11, with 291 (67%) completing all six. We performed graphic comparisons, paired t tests, classification based on standard errors of measurement (SEMs), and multiple linear regressions for patients who completed all six interviews. RESULTS: No noticeable changes in aggregate trends for personal stress or mental health were associated with 9-11. However, 9-11 was associated with an aggregate decline in sense of control. This decline in sense of control was greater among those who were working for pay, had more comfortable incomes, and reported greater religiosity. DISCUSSION: Older adults more closely resembling those who died during 9-11 and those with greater levels of religiosity were most likely to have their sense of control affected by this catastrophic event.

Wright, V. L. [NIH/NINDS, Stroke Neuroscience Unit, Bethesda, MD 20891-1294; wrightv@ninds.nih.gov]. "**A phenomenological exploration of spirituality among African American women recovering from substance abuse**." *Archives of Psychiatric Nursing* 17, no. 4 (Aug 2003): 173-85.

[Abstract:] Spirituality among African American women recovering from substance abuse is a recovery phenomena: little is known about the individual's experience in this process. The ameliorating effect of spirituality covering a broad range of positive outcomes has been consistent across populations, regardless of gender, race, study design, and religious affiliation. Giorgi's phenomenological method was used to explore and described the meaning of spirituality of 15 African American women recovering from substance abuse. The findings are described and discussed relative to the state of the science on spirituality. Implications for substance abuse and recovery practitioners are presented.

Young, J. L., Griffith, E. E. and Williams, D. R. [Connecticut Valley Hospital, Middletown, CT; john.young@po.state.ct.us]. "**The integral role of pastoral counseling by African-American clergy in community mental health**." *Psychiatric Services* 54, no. 5 (May 2003): 688-92. Comment in: *Psychiatric Services* 54, no. 7 (Jul 2003): 1041-2; author reply, p. 1042.

[Abstract:] OBJECTIVE: Little is currently known about the pastoral counseling work of pastors of African-American churches. The authors interviewed the pastors of nearly all African-American churches in a metropolitan area about their pastoral counseling work and related aspects of their ministry. METHODS: Of 121 African-American pastors identified, 99 completed a semistructured interview describing their backgrounds, attitudes, concerns, and work. The interview included detailed queries about how they understood and carried out any pastoral counseling work. RESULTS: The respondents averaged more than six hours of counseling work weekly and often addressed serious problems similar to those seen by secular mental health professionals, with whom they reported readily exchanging referrals. Many of the respondents reported having and maintaining specialized education for their counseling work, which they described as including both spiritual and psychological dimensions. Most of the pastors reported that they observe and address severe mental illness and substance abuse in their congregations and that they also counsel individuals outside their own denominations. CONCLUSIONS: African-American urban ministers functioning as pastoral counselors constitute an engaging and useful group with experiences and skills that can be tapped by interested secular professionals. Their work represents a significant mental health resource for persons who lack sufficient access to needed care.