Spirituality & Health: A Select Bibliography of *Medline*-Indexed Articles Published in 2005

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April 12, 2006; revised June 7, 2006

The following is a selection of 241 *Medline*-indexed journal articles pertaining to spirituality & health published during 2005, from among the more than 600 articles categorized under the subject headings of "Religion and Medicine," "Religion and Psychology," "Pastoral Care," and "Spirituality" (and includes a handful of articles from Medline's "In-Process" database). The sample here indicates the great scope of the literature, but note that since *Medline* is itself a selective index of journals, an even broader range of material may be found through other health science indices/databases—e.g., *CINAHL/Nursing* or *PsycINFO*.

Abrams, D., Albury, S., Crandall, L., Doka, K. J. and Harris, R. [The Hospice Foundation of America, Miami, FL]. "**The Florida Clergy End-of-Life Education Enhancement Project: a description and evaluation**." *American Journal of Hospice & Palliative Care* 22, no. 3 (May-Jun 2005): 181-187.

[Abstract:] The Florida Clergy End-of-Life Education Enhancement Project was a model program developed to provide an interdenominational and statewide model of clergy education on loss, grief dying, and death. The authors describe the project including materials and curriculum as well as present data from the project's evaluation. Clergy and their partners in ministry responded enthusiastically to the project. As a whole, they reported higher levels of knowledge on end-of-life (EOL) issues at the conclusion of the training. Clergy and their ministerial teams also reported that they were better informed about the technical, procedural, medical, and legal issues that arise at the end of life and expressed the desire for subsequent training. The project indicates that clergy both recognize the need for additional training and are anxious to improve their abilities to minister to the dying and bereaved. The model presented here could easily be applied to local organizations such as hospices or denominational training.

Ai, A. L., Cascio, T., Santangelo, L. K. and Evans-Campbell, T. [University of Washington-Seattle; amyai@u.washington.edu]. "**Hope, meaning, and growth following the September 11, 2001, terrorist attacks**." *Journal of Interpersonal Violence* 20, no. 5 (May 2005): 523-548.

[Abstract:] Positive psychologists found the increase of seven character strengths that encompass the so-called theological virtues, including hope and spirituality, in Americans after the September 11, 2001, attacks. Little is known about how they may affect post-September 11, 2001, mental health. Using multivariate analysis, this study investigated the relationship of hope and spiritual meaning with depression and anxiety in a sample of 457 students 3 months after September 11, 2001. Both characters contributed to lower levels of symptoms. In qualitative analysis, of 313 answers to an open-ended question regarding personal change, four categories emerged. The first three were consonant with other studies on posttraumatic growth (PTG), including changes in the self or behavior, relationships, and worldviews. The fourth category unique to September 11, 2001, was changes in political views. These findings offer further credence to the study of positive aspects resulting from violence-related trauma and highlight the needs for addressing the nature of traumatic events and PTG.

Ai, A. L. and Park, C. L. [University of Washington; amyai@u.washington.edu]. "**Possibilities of the positive following violence and trauma: informing the coming decade of research**." *Journal of Interpersonal Violence* 20, no. 2 (Feb 2005): 242-250.

[Abstract:] The effects of trauma and violence may be better understood by taking a broader perspective that includes resilience and recovery as well as damage and symptomatology. Based on this broader view, this article describes three interrelated, cutting-edge trends in mental health research: (a) the positive psychology movement, (b) the recognition of the role of spirituality and religion in health and well-being, and (c) stress-related growth. The integration of these trends into mainstream studies of trauma and violence will provide a counterbalance to the predominant orientation of victimization and pathology currently evidenced in the literature. All three have important implications for survivors of violence and trauma.

Ai, A. L., Peterson, C., Rodgers, W. L. and Tice, T. N. [University of Washington, Settle 98105-6299; amyai@u.washington.edu]. "**Faith factors and internal health locus of control in patients prior to open-heart surgery**." *Journal of Health Psychology* 10, no. 5 (Sep 2005): 669-676.

[Abstract:] This study explored the relationships between faith factors and internal health locus of control (IHLC) beliefs. Based on a review of different relationships of perceived control, spiritual surrender and faith factors in the liberation, we assumed a multivariate association among them. Using data from two sequential interviews and the Society of Thoracic Surgeons' Adult Cardiac Database, we tested these associations in a final sample of 202 middle-aged and older patients undergoing open-heart surgery. Primary findings from two-step multiple regression analyses supported hierarchical multi-faceted hypotheses. Greater internal control was positively associated with private prayer for coping, an event-specific, 'vicarious' control strategy, but negatively related to subjective religiosity, general faith measure controlling for other confounders, especially cardiac-significant ones.

Ai, A. L., Tice, T. N., Peterson, C. and Huang, B. [University of Washington, Seattle, WA 98105-6299; amyai@u.washington.edu]. "**Prayers, spiritual support, and positive attitudes in coping with the September 11 national crisis**." *Journal of Personality* 73, no. 3 (Jun 2005): 763-791.

[Abstract:] This study was designed to help fill gaps in faith-related and positive psychology research. Psychologists have called for precise assessment of effective faith factors inherent within spiritual experiences that may explain their beneficial effects. Positive psychologists suggest the need to examine social and faith-related origins of optimism. Based on previous research, we redefined spiritual support and developed a new assessment. The study is a survey of 453 graduate and undergraduate students 3 months after the September 11, 2001, terrorist attacks. The results showed that participants, who believed in diverse spiritual entities, used various types of prayer for coping. A structural equation model showed that a linkage of spiritual support and positive attitudes mediated the effect of faith-based and secular factors on post-September 11 distress. Higher levels of initial negative emotional response were associated with the use of prayer for coping, which was, in turn, related to less distress through the pathway of the above linkage.

Albert, S. M., Rabkin, J. G., Del Bene, M. L., Tider, T., O'Sullivan, I., Rowland, L. P. and Mitsumoto, H. [The Eleanor and Lou Gehrig MDA/ALS Research Center, Department of Neurology, Columbia University, New York, NY 10032; sma10@columbia.edu]. "**Wish to die in end-stage ALS**." *Neurology* 65, no. 1 (Jul 12, 2005): 68-74. Comment on pp. 9-10.

[From the abstract:] …RESULTS: Eighty patients with ALS were enrolled, 63% of eligible patients; 53 died over follow-up. Ten (18.9%) of the 53 expressed the wish to die, and 3 (5.7%) hastened dying. Patients expressing the wish to die did not differ in sociodemographic features, ALS severity, or perceived burden of family caregivers. They were more likely to meet criteria for depression, but differences were smaller when suicidality was excluded from the depression interview. Patients who expressed the wish to die reported less optimism, less comfort in religion, and greater hopelessness. Compared with patients unable to act on the wish to die, patients who hastened dying reported reduction in suffering and increased perception of control over the disease in the final weeks of life….

Ali, O. M., Milstein, G. and Marzuk, P. M. [Bellevue Hospital, New York University Medical Center, 462 First Avenue, 20 West 1, New York, NY 10016; oalimd@gmail.com]. "**The Imam's role in meeting the counseling needs of Muslim communities in the United States**." *Psychiatric Services* 56, no. 2 (Feb 2005): 202-205. Comment on p. 133.

[Abstract:] OBJECTIVE: Muslims are one of the most rapidly growing minority groups in the United States and have experienced increased stress since September 11, 2001. The purpose of this study was to elucidate the roles of imams, Islamic clergy, in meeting the counseling needs of their communities. METHODS: An anonymous self-report questionnaire was mailed to 730 mosques across the United States. RESULTS: Sixty-two responses were received from a diverse group of imams, few of whom had received formal counseling training. Imams reported that their congregants came to them most often for religious or spiritual guidance and relationship or marital concerns. Imams reported that since September 11, 2001, there has been an increased need to counsel persons for discrimination. An increased need to counsel persons who were discriminated against was reported by all imams with congregations in which a majority are Arab American, 60 percent of imams with congregations in which a majority are South Asian American, and 50 percent of imams with congregations in which a majority are African American. CONCLUSIONS: Although imams have little formal training in counseling, they are asked to help congregants who come to them with mental health and social service issues. Imams need more support from mental health professionals to fulfill a potentially vital role in improving access to services for minority Muslim communities in which there currently appear to be unmet psychosocial needs.

Amer, M. M. and Hovey, J. D. [University of Toledo, Toledo, OH]. "**Examination of the impact of acculturation, stress, and religiosity on mental health variables for second-generation Arab Americans**." *Ethnicity and Disease*. 15, no. 1, suppl. 1 (2005): S1-111-112.

This is a brief report of a study of 120 second-generation and early-immigrant Arab Americans who responded to an internet-based questionnaire three months after the "September 11, 2001 World Trade Center attacks." The population was 54% Muslim and 36% Christian. Among the findings: "For both Muslims and Christians, acculturative stress was related to family dysfunction, and family dysfunction was related to depression" (p. S111). However, the author does find differences between the two religious groups.

Anderson, M. J., Marwit, S. J., Vandenberg, B. and Chibnall, J. T. [Department of Psychology, University of Missouri--St. Louis, 8001 Natural Bridge Rd., St. Louis, MO 63121; mirjanderson@hotmail.com]. "**Psychological and religious coping strategies of mothers bereaved by the sudden death of a child**." *Death Studies* 29, no. 9 (Nov 2005): 811-826.

Among the findings of this study of 57 bereaved mothers [from the abstract:] The interaction of task coping and positive religious coping was also associated with lower self-reported grief.

Andrykowski, M. A., Bishop, M. M., Hahn, E. A., Cella, D. F., Beaumont, J. L., Brady, M. J., Horowitz, M. M., Sobocinski, K. A., Rizzo, J. D. and Wingard, J. R. [Department of Behavioral Science, University of Kentucky College of Medicine, Lexington, KY 40536-0086; mandry@uky.edu]. **"Long-term health-related quality of life, growth, and spiritual well-being after hematopoietic stem-cell transplantation**." *Journal of Clinical Oncology* 23, no. 3 (Jan 20, 2005): 599-608.

[Abstract:] PURPOSE: To examine health-related quality of life (HRQOL) and growth, and spiritual well-being in adult survivors of hematopoietic stem-cell transplantation (HSCT) for a malignant disease. METHODS: HSCT survivors (n = 662) were recruited through the International Bone Marrow Transplant Registry/Autologous Blood and Marrow Transplant Registry and were drawn from 40 transplantation centers. HSCT survivors completed a telephone interview and a set of questionnaires a mean of 7.0 years post-HSCT (range, 1.8 to 22.6 years). Study measures included a variety of standardized measures of HRQOL and growth and spiritual well-being. An age- and sex-matched healthy comparison (HC) group (n = 158) was recruited using a peer nomination method. The HC group completed a parallel telephone interview and set of questionnaires. RESULTS: Multivariate analysis of variance analyses found the HSCT survivor group reported poorer status relative to the HC group for all HRQOL outcome clusters including physical health, physical functioning, social functioning, psychological adjustment, and dyadic adjustment. In contrast, the HSCT survivor group reported more psychological and interpersonal growth. Mean effect size for the 24 outcome indices examined was 0.36 standard deviations, an effect size often considered clinically meaningful or important. The largest group differences were found for measures of general health, physical function and well-being, depression, cognitive function, and fatigue. CONCLUSION: The experience of HSCT for a malignant disease has a wide-ranging, longstanding, and profound impact on adult recipients. Relative to healthy controls, HSCT survivors reported poorer physical, psychological, and social functioning but, conversely, more psychological and interpersonal growth, differences that appeared to persist many years after HSCT. [See Table 3 (p. 604) for results for Spiritual Well-Being, as measured by the FACIT-sp: "The group effect for FACIT-sp scores narrowly missed statistical significance (P=.054), with the survivor group reporting poorer spiritual well-being" (p. 604, and discussed on p. 606).]

Ankeny, R. A., Clifford, R., Jordens, C. F., Kerridge, I. H. and Benson, R. [Unit for History and Philosophy of Science (HPS), University of Sydney, Carslaw Building (F07), Sydney, NSW 2006, Australia; rankeny@science.usyd.edu.au]. "**Religious perspectives on withdrawal of treatment from patients with multiple organ failure**." *Medical Journal of Australia* 183, nos. 11-12 (Dec 5-19, 2005): 616-621.

[Abstract:] Religious or spiritual values often influence health care decision-making by patients and their families, particularly in times of crisis. Though religious values might seem to be irrelevant where continuing treatment is judged to be "futile", such clinical assessments should instead serve to open a dialogue about values and beliefs. The six major religious traditions in Australia have some similar values and principles about death and provision of care for the dying, but differ in their processes of ethical reasoning, cosmologies, and key moral concepts. Engaging with religious traditions on the common ground of basic values (such as human dignity, care, the sacredness of human life, non-violence, compassion, and selflessness) promotes negotiation of the manner in which care is provided, even where conflicts exist.

Ano, G. G. and Vasconcelles, E. B. [Bowling Green State University, OH 43403; geneano@bgnet.bgsu.edu]. "**Religious coping and psychological adjustment to stress: a meta-analysis**." *Journal of Clinical Psychology* 61, no. 4 (Apr 2005): 461-480.

[Abstract:] A growing body of literature suggests that people often turn to religion when coping with stressful events. However, studies on the efficacy of religious coping for people dealing with stressful situations have yielded mixed results. No published studies to date have attempted to quantitatively synthesize the research on religious coping and psychological adjustment to stress. The purpose of the current study was to synthesize the research on situation-specific religious coping methods and quantitatively determine their efficacy for people dealing with stressful situations. A meta-analysis of 49 relevant studies with a total of 105 effect sizes was conducted in order to quantitatively examine the relationship between religious coping and psychological adjustment to stress. Four types of relationships were investigated: positive religious coping with positive psychological adjustment, positive religious coping with negative psychological adjustment, negative religious coping with positive psychological adjustment, and negative religious coping with negative psychological adjustment. The results of the study generally supported the hypotheses that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively. Implications of the findings and their limitations are discussed.

Ashing-Giwa, K. T. [Department of Psychiatry and Biobehavioral Sciences, UCLA, Los Angeles, CA 90095; kashing@ucla.edu]. "**The contextual model of HRQoL: a paradigm for expanding the HRQoL framework**." *Quality of Life Research* 14, no. 2 (Mar 2005): 297-307.

[Abstract:] Cancer is the second leading cause of death in most US populations. Unfortunately, ethnic minority status is associated with increased later stage at diagnosis, greater incidence for many cancer sites, differential treatments, greater mortality and morbidity. The government and public health focus on health disparities, evident in several documents including Healthy People 2010, Unequal Treatment and the Nation's Investment in Cancer Research, are spurring interest in research with ethnic minority populations. Research investigating the health-related quality of life (HRQoL) among ethnic minority cancer survivors is new and growing. However, there is a dearth of research that addresses theoretical frameworks in cross cultural research. In conducting research with diverse populations, appropriate theoretical grounding that is responsive to cultural and socioecological contexts must be considered. This paper will discuss the contextual model of HRQoL, a comprehensive framework developed to expand the traditional HRQoL framework to facilitate culturally and socioecologically responsive research. This model may provide a more comprehensive theoretical framework to investigate certain areas of health disparities and risk factors for poor outcomes in HRQoL research with cancer survivors. [See the section on spirituality on p. 301.]

Astrow, A. B., Mattson, I., Ponet, R. J. and White, M. [Department of Medicine and Comprehensive Cancer, St Vincent's Hospital-Manhattan, New York, NY; aastrow@maimonides.org]. "**Inter-religious perspectives on hope and limits in cancer treatment**." *Journal of Clinical Oncology* 23, no. 11 (Apr 10, 2005): 2569-2573.

Clergy from Islamic, Jewish, and Christian traditions each address religious perspectives on a case of a patient suffering from advanced metastatic cancer with two sons who resist the option for hospice care.

Aukst-Margetic, B. and Margetic, B. [Neuropsychiatric Hospital, Popovaca, Croatia; branka.aukst-margetic@zg.htnet.hr]. "**Religiosity and health outcomes: review of literature**." *Collegium Antropologicum* 29, no. 1 (Jun 2005): 365-371.

This article seems to indicate how subject of spirituality & health is appearing in the Eastern European health care literature. [Abstract:] Research into a connection between religiosity and health was neglected in scientific circles until recently. However, the interest in interactions between religiosity and mental and physical health has started to grow lately. A large proportion of published empirical data suggest that religious commitment shows positive associations with better mental and physical health outcomes. There are relatively few studies showing no effect or negative effect of religiosity on health outcomes. Despite somewhat inconclusive empirical evidence, because of the difficulties encountered in studying the topic, this area is worth of further investigation. The article reviews the literature on epidemiological and clinical studies regarding the relationship between religiosity and mental and physical health. The mentioned issues are discussed and directions for future research are proposed. [See also the articles by Jakovljevic and by Koic, elsewhere in this bibliography, for other examples from the Croatian literature.]

Baggini, J. and Pym, M. "**End-of-life: the humanist view**." *The Lancet* 366, no. 9492 (Oct 1-7, 2005): 1235-1237.

This is part of an article series on religious diversity in health care. [See also articles by Dorff, Engelhardt, Firth, Keown, Markwell, and Sachedina listed in this bibliography.]

Bauer-Wu, S. and Farran, C. J. [Phyllis F. Cantor Center for Research in Nursing and Patient Care, Dana-Farber Cancer Institute, Boston, Massachusetts 02115; susan_bauer_wu@dfci.harvard.edu]. "**Meaning in life and psycho-spiritual functioning: a comparison of breast cancer survivors and healthy women**." *Journal of Holistic Nursing* 23, no. 2 (Jun 2005): 172-190.

[Abstract:] PURPOSE: Incorporating holistic health perspectives, this study compared and examined relationships among meaning in life, spirituality, perceived stress, and psychological distress in breast cancer survivors (BCS) and healthy women. METHODS: Standardized self-report measures were completed once by all participants (N = 78). FINDINGS: Group comparison revealed statistically significant variances across the measures. Covariate analysis identified BCS without children had less meaningful lives and greater stress and distress than BCS with children and participants without cancer. Significant correlations ($p > .001$) between meaning in life and spirituality ($r = .43$), stress ($r = -.39$), and distress ($r = -.41$) were also identified. CONCLUSION: Personal factors (i.e., being a parent) may be especially important in BCS. Also,

psychological and spiritual variables are highly correlated, suggesting the use of an integrated term psycho-spiritual functioning. IMPLICATIONS: Holistic nursing interventions can facilitate self-awareness, interpersonal connection, and living a meaningful life, particularly in vulnerable patients such as BCS without children.

Bean, K. B. [University of Texas at Arlington, School of Nursing, Arlington, TX]. "**An exploratory investigation of quality of life in adult liver transplant recipients**." *Progress in Transplantation* 15, no. 4 (Dec 2005): 392-396.

[Abstract:] Quality of life is an important outcome indicator of experiences associated with liver transplantation. Unfortunately, quality of life has been defined in many different ways, causing confusion and misconceptions among practitioners, researchers, policy makers, and patients. This exploratory qualitative study was initiated to gain greater understanding regarding the adult transplant recipients' experiences with liver transplantation in order to direct future studies with this population and to assist in selection of a relevant quality of life survey tool for quantitative investigation. Twelve informants (7 women, 5 men) shared their experiences in face-to-face interviews conducted by the researcher. Analysis of these interviews reveals the importance of physiologic, psychological, social, spiritual, family, and socioeconomic aspects of quality of life for liver transplant recipients.

Beauregard, C. and Solomon, P. [McMaster University; chrissybeau@hotmail.com]. "**Understanding the experience of HIV/AIDS for women: implications for occupational therapists**." *Canadian Journal of Occupational Therapy* 72, no. 2 (Apr 2005): 113-120.

This article represents the ongoing consideration of spirituality among Canadian Occupational Therapists. [Abstract:] BACKGROUND: Within the past few years, HIV/AIDS has shifted from being an acute, palliative disease to one that is more chronic and episodic in nature. This shift has major implications for the role of occupational therapy in women's lives. Very few studies, however, have examined the perspective of women living with HIV/AIDS from an occupational therapy perspective. PURPOSE: This qualitative study was designed to examine the experiences of five women living with HIV/AIDS in Southern Ontario and to begin to explore the implications of these findings for occupational therapy. METHOD: Through the implementation of five in-depth interviews, a phenomenological approach was used to explore the lived experience of women with HIV/AIDS. RESULTS: Four main themes emerged: fearing disclosure, experiencing challenges (physical and psychological), having supportive networks, and coping positively with being HIV positive (spirituality and opportunity for living and learning). PRACTICE IMPLICATIONS: There are several potential roles for occupational therapy in working with women who are living with HIV/AIDS More studies need to be pursued in this area of rehabilitation.

Becker, G. and Newsom, E. [Institute for Health and Aging, School of Nursing, University of California, San Francisco, Box 0646, San Francisco, CA 94143-0646; becker@itsa.ucsf.edu]. "**Resilience in the face of serious illness among chronically ill African Americans in later life**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 60, no. 4 (Jul 2005): S214-223.

[From the abstract:] OBJECTIVES: The purpose of this work was to examine older African Americans' philosophies about their chronic illnesses and how those philosophies affected chronic illness management. METHODS: Three to five in-depth interviews were conducted over the course of several years with 38 respondents between the ages of 65 and 91. Both open-ended and semistructured questions were asked. RESULTS: Respondents demonstrated determination, perseverance, and tenacity no matter how serious their illnesses were. Racism was instrumental in shaping the responses of these African Americans to their illnesses through cultural values that emphasized independence, spirituality, and survival. Respondents demonstrated a resilient philosophy as they faced disabling illness….

Bell, R. A., Suerken, C., Quandt, S. A., Grzywacz, J. G., Lang, W. and Arcury, T. A. [Wake Forest University School of Medicine, Winston-Salem, NC]. "**Prayer for health among U.S. adults: the 2002 National Health Interview Survey**." *Complementary Health Practice Review* 10, no. 3 (Oct 2005): 175-188.

[Abstract:] Data for the United States is limited on prayer for health, including associations with other complementary and alternative medicine (CAM) modalities. The 2002 National Health Interview Survey and Alternative Health Supplement data were examined for associations between prayer for health and demographic, health, and CAM use characteristics. Forty-five percent of adults reported some form of prayer for health. Use of prayer for health was associated with increasing age, ethnic minority status, lower socioeconomic status, southern/midwestern U.S. region, poorer health, and use of most forms of CAM. These data provide information about prayer for health in the United States. Further research could examine associations between prayer for health and health-related decisions, behaviors, and outcomes.

Bernat, J. L. [Neurology Section, Dartmouth Medical School, Hanover, NH 03755; bernat@dartmouth.edu]. "**The concept and practice of brain death**." *Progress in Brain Research* 150 (2005): 369-379.

This is a broad overview, but see especially the consideration of religious beliefs on p. 376. [100 refs.]

Berry, D. [Department of Nursing, University of Cincinnati, OH]. "**Methodological pitfalls in the study of religiosity and spirituality**." *Western Journal of Nursing Research* 27, no. 5 (Aug 2005): 628-647.

[Abstract:] The number of studies demonstrating a relationship between religiosity and spirituality and physical and psychological health have increased rapidly during the past decade. There are significant disputes in the literature regarding the methodological quality of research in this area. Despite nursing scholars' interest in this area, no thorough review of the methodological critiques is available. The purpose of this study is to review areas of methodological difficulty in the study of religiosity and spirituality by identifying contemporary methodological critiques, critically evaluating the critiques and the underlying issues, and making suggestions for methodological advancement in the field. Three main areas of methodological critique exist: construct measurement, study design, and data analysis. Research in this area should aim for conceptual clarity, deliberate design, and appropriate analysis. Considerations of these critiques are instructive for nursing research done in the area of religiosity and spirituality.

Blanchette, H. [Morton Plant Hospital, Clearwater, FL]. "**Assessment and treatment of terminal restlessness in the hospitalized adult patient with cancer**." *MEDSURG Nursing* 14, no. 1 (Feb 2005): 17-22. Quiz on p. 23.

[Abstract:] Terminal restlessness affects a large proportion of patients with cancer at the end of life. It has many different risk factors, presentations, and causes. Management consists of keen assessment, identification and reversal of the causes, and treatment by a combination of pharmacological, environmental, and spiritual interventions.

Blinderman, C. D. and Cherny, N. I. [Department of Family Medicine, Beth Israel Medical Centre, New York, NY 10003; cblinderman@rcn.com]. "**Existential issues do not necessarily result in existential suffering: lessons from cancer patients in Israel**." *Palliative Medicine* 19, no. 5 (Jul 2005): 371-380. Comment on pp. 359-370.

[Abstract:] Existential distress has been recognized as a source of suffering for oncology patients. This study focusses on existential issues and coping mechanisms of a unique culturally diverse Jewish/Middle Eastern oncology population. A qualitative assessment of 40 patients with advanced cancer was undertaken through an interview process addressing the following themes: autonomy, dignity/body image, social isolation, coping mechanisms, guilt/past disappointments, spiritual health, meaning, hope and death/dying. The findings of this study indicate that existential concerns are endemic in this patient population, but that significant distress is relatively uncommon. Early palliative measures, family support, effective coping strategies, and religious belief systems may influence the way patients with advanced cancer deal with existential concerns.

Bormann, J. E., Smith, T. L., Becker, S., Gershwin, M., Pada, L., Grudzinski, A. H. and Nurmi, E. A. [VA San Diego Healthcare System, San Diego State University, CA]. "**Efficacy of frequent mantram repetition on stress, quality of life, and spiritual well-being in veterans: a pilot study**." *Journal of Holistic Nursing* 23, no. 4 (Dec 2005): 395-414.

[Abstract:] PURPOSE: Silent, frequent repetition of a mantram-a word or phrase with spiritual significance, sometimes called a Holy Name-is an ancient form of prayer that may reduce stress and related symptoms. The authors tested the feasibility and efficacy of a 5-week (90-min per week) intervention on mantram repetition in a sample of ambulatory veterans. METHOD: Aconvenience sample (N= 62) of outpatient veterans participated in the study by completing pre-and posttest self-report questionnaires on stress, anxiety, anger, quality of life, and spiritual well-being. Wrist-worn counters were provided to track mantram practice. FINDINGS: Mantram repetition significantly reduced symptoms of stress and anxiety and improved quality of life and spiritual well-being. CONCLUSION: Additional research using a larger sample size and control group is needed to further substantiate the benefits of this intervention. IMPLICATIONS: Frequent, silent mantram repetition is easily taught and could be used by nurses and patients for managing stress and increasing well-being.

Boscaglia, N., Clarke, D. M., Jobling, T. W. and Quinn, M. A. [Department of Psychological Medicine and General Practice, Monash University, Melbourne, Australia; nadia.boscaglia@med.monash.edu.au]. "**The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer**." *International Journal of Gynecological Cancer* 15, no. 5 (Sep-Oct 2005): 755-761.

[Abstract:] The objective of this study was to determine whether, after accounting for illness and demographic variables, spiritual involvement and beliefs and positive and negative spiritual coping could account for any of the variation in anxiety and depression among women within 1 year's diagnosis of gynecological cancer (GC). One hundred patients from outpatient GC clinics at two Melbourne-based hospitals completed a brief structured interview and self-report measures of anxiety, depression, spirituality, and spiritual coping. Using two sequential regression analyses, we found that younger women with more advanced disease, who used more negative spiritual coping, had a greater tendency towards depression and that the use of negative spiritual coping was associated with greater anxiety scores. Although not statistically significant, patients with lower levels of generalized spirituality also tended to be more depressed. The site of disease and phase of treatment were not predictive of either anxiety or depression. We conclude that spirituality and spiritual coping are important to women with GC and that health professionals in the area should consider these issues.

Boylan, L. N. [University of Southern Maine, Portland, ME; npteacher27@yahoo.com]. "**Caring for patients of diverse religious traditions: Judaism**." *Home Healthcare Nurse* 23, no. 12 (Dec 2005): 794-797.

This is the first of a new article series in the journal.

Bradley, R., Schwartz, A. C. and Kaslow, N. J. [Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA 30322; rebekah.bradley@emory.edu]. "**Posttraumatic stress disorder symptoms among low-income, African American women with a history of intimate partner violence and suicidal behaviors: self-esteem, social support, and religious coping**." *Journal of Traumatic Stress* 18, no. 6 (Dec 2005): 685-696.

[Abstract:] There is a dearth of research on risk/protective factors for posttraumatic stress disorder (PTSD) among low-income African American women with a history of intimate partner violence (IPV), presenting for suicidal behavior or routine medical care in a large, urban hospital. We examined self-esteem, social support, and religious coping as mediators between experiences of child maltreatment (CM) and IPV and symptoms of PTSD in a sample (N = 134) of low-income African American women. Instruments used included the Index of Spouse Abuse, the Childhood Trauma Questionnaire, the Taylor Self-Esteem Inventory, the Multidimensional Profile of Social Support, the Brief Religious Coping Activities Scale, and the Davidson Trauma Scale. Both CM and IPV related positively to PTSD symptoms. Risk and resilience individual difference factors accounted for 18% of the variance in PTSD symptoms over and above IPV and CM, with self-esteem and negative religious coping making unique contributions. Both variables mediated the abuse-PTSD symptom link. In addition, we tested an alternate model in which PTSD symptoms mediated the relationship between abuse and both self-esteem and negative religious coping.

Brillhart, B. [Arizona State University, College of Nursing, Tempe, AZ; barbara.brillhart@asu.edu]. "**A study of spirituality and life satisfaction among persons with spinal cord injury**." *Rehabilitation Nursing* 30, no. 1 (Jan-Feb 2005): 31-34.

[From the abstract:] The purpose of this study was to investigate the relationship of spirituality and life satisfaction among persons with spinal cord injury. A nationwide sample of 230 persons with long-term spinal cord injury completed the Satisfaction With Life Scale (SWLS), the Quality of Life Index (QLI), and a demographic data form. Data analysis also indicated that there was a significant positive correlation between life satisfaction and psychological/spiritual factors of the QLI instrument….

Brooks, D., Henry, J., LeBlanc, J., McKenzie, G., Nagy, T., Tallon, H., Wilhelm, T. and Flegel-Desautels, C. [Nursing Education Program of Saskatchewan, Regina, Canada]. "**Incorporating spirituality into practice**." *Canadian Nurse* 101, no. 6 (Jun 2005): 22-24.

This a brief account of the experience of students at the Nursing Education Program of Saskatchewan whose clinical placement was in parish nursing.

Bruce, A. and Davies, B. [University of Victoria, British Columbia, Canada]. "**Mindfulness in hospice care: practicing meditation-in-action**." *Qualitative Health Research* 15, no. 10 (Dec 2005): 1329-1344.

[Abstract:] In this interpretive study, the authors explore the experience of mindfulness among hospice caregivers who regularly practice mindfulness meditation at a Zen hospice. They explore meditative awareness constituted within themes of meditation-in-action, abiding in liminal spaces, seeing differently, and resting in groundlessness. By opening into nonconceptual, paradoxical, and uncertain dimensions of experience, hospice caregivers cultivate internal and external environments in which direct experience is increasingly held without judgment. This inquiry points to in-between spaces of human experience wherein mindfulness fosters openness and supports letting go, and creating spaces for whatever is happening in attending the living-and-dying process.

Burker, E. J., Evon, D. M., Sedway, J. A. and Egan, T. [Department of Allied Health Sciences, Medical School Wing E, University of North Carolina at Chapel Hill, 27599-7205; eburker@med.unc.edu]. "**Religious and non-religious coping in lung transplant candidates: does adding God to the picture tell us more?**" *Journal of Behavioral Medicine* 28, no. 6 (Dec 2005): 513-526. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] Individuals use many non-religious coping (NRC) and religious coping (RC) strategies to cope with stress. In previous studies with lung transplant candidates, we found that NRC and RC predicted depression, anxiety, and disability. The present study aimed to (a) assess whether RC and NRC contributed uniquely to the prediction of distress and disability, or whether they were redundant and offered no additional information, and (b) evaluate the unique contribution of each subscale to determine the strongest associations with outcomes. Participants were 81 patients with end-stage lung disease being evaluated for lung transplant. Our findings suggest that RC and NRC are not functionally redundant. The best RC predictor was reappraising the situation as a punishment from God, and the best NRC predictors were mental disengagement and denial. Our findings suggest that NRC and RC are independent components of psychological functioning, and measuring both coping styles provides more information than studying each alone.

Burnett, M., Genao, I. and Wong, W. F. [Interdenominational Theological Center, Atlanta, GA]. "**Race, culture, and trust: why should I take a shot if I'm not sick?**" *Ethnicity & Disease* 15, no. 2, suppl. 3 (2005): S3-13-16.

[Abstract:] This three-part panel discussion provides information on: 1) the role religious leaders can take in influencing health care, health access, and compliance; 2) barriers to equal health care and major gaps in immunizations among Hispanics; and 3) population management strategies for public health officials and private practice physicians. Citing barriers such as mistrust of government programs, socioeconomic conditions, lack of access to preventive healthcare services, cultural attitudes, and lack of education about immunizations, the speakers also offered solutions to overcome resistance to immunization. Panel members supported these strategies and provided techniques to implement the strategy: engaging faith-based organizations, improving patient-provider communication; and creating public health initiatives to be culturally competent.

Brun, W. L. [Samaritan Counseling Center of Southeastern Michigan, 29887 West Eleven Mile Road, Farmington Hills, MI 48336]. "**A proposed diagnostic schema for religious/spiritual concerns**." *The Journal of Pastoral Care & Counseling: JPCC* 59, no. 5, suppl. (2005): 425-440. Discussion on pp. 441-454.

[Abstract:] This article proposes the expansion of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) category on "Religious or Spiritual Problem" (V62.89), and the inclusion of an Axis 6 for the diagnosis of these issues. After defining and contrasting "religious" and "spiritual" as terms, and dealing with the potential difficulties of such a categorization for interfaith groups, the author proposes categories by which religious and/or spiritual issues presented by a client might be more pointedly and specifically assessed and understood. He also proposes criteria for each category, in keeping with the style of the DSM-IV-TR by which such assessments might be made. The author challenges his colleagues to both the beginning of a conversation regarding such a schema and research regarding the categories and/or criteria proposed. Several responses to the proposal are offered by colleagues in the pastoral arts and sciences.

Büssing, A., Ostermann, T. and Matthiessen, P. F. [Krebsforschung Herdecke, Department of Applied Immunology and Cancer Service, Herdecke Community Hospital, Gerhard-Kienle-Weg 4, 58313 Herdecke, Germany; arndt.buessing@uni-wh.de]. "**Role of religion and spirituality in medical patients: confirmatory results with the SpREUK questionnaire**." *Health & Quality of Life Outcomes* 3, no. 1 (Feb 10, 2005): 10.

[Abstract:] BACKGROUND: Spirituality has become a subject of interest in health care as it is was recognized to have the potential to prevent, heal or cope with illness. There is less doubt that values and goals are important contributors to life satisfaction, physical and psychological health, and that goals are what gives meaning and purpose to people's lives. However, there is as yet but limited understanding of how patients themselves view the impact of spirituality on their health and well-being, and whether they are convinced that their illness may have "meaning" to them. To raise these questions and to more precisely survey the basic attitudes of patients with severe diseases towards spirituality/religiosity (SpR) and their adjustment to their illness, we developed the SpREUK questionnaire. METHODS: In order to re-validate our previously described SpREUK instrument, reliability and factor analysis of the new inventory (Version 1.1) were performed according to the standard procedures. The test sample contained 257 German subjects (53.3 +/- 13.4 years) with cancer (51%), multiple sclerosis (24%), other chronic diseases (16%) and patients with acute diseases (7%). RESULTS: As some items of the SpREUK construct require a positive attitude towards SpR, these items (item pool 2) were separated from the others (item pool 1). The reliability of the 15-item the construct derived from the item pool 1 respectively the 14-item construct which refers to the item pool 2 both had a good quality (Cronbach's alpha = 0.9065 resp. 0.9525). Factor analysis of item pool 1 resulted in a 3-factor solution (i.e. the 6-item sub-scale 1: "Search for meaningful support"; the 6-item sub-scale 2: "Positive interpretation of disease"; and the 3-item sub-scale 3: "Trust in external guidance") which explains 53.8% of variance. Factor analysis of item pool 2 pointed to a 2-factor solution (i.e. the 10-item sub-scale 4: "Support in relations with the External life through SpR" and the 4-item sub-scale 5: "Support of the Internality through SpR") which explains 58.8% of variance. Generally, women had significantly higher SpREUK scores than male patients. Univariate variance analyses revealed significant associations between the sub-scales and SpR attitude and the educational level. CONCLUSIONS: The current re-evaluation of the SpREUK 1.1 questionnaire indicates that it is a reliable, valid measure of distinct topics of SpR that may be especially useful of assessing the role of SpR in health related research. The instrument appears to be a good choice for assessing a patients interest in spiritual concerns which is not biased for or against a particular religious commitment.

Moreover it addresses the topic of "positive reinterpretation of disease" which seems to be of outstanding importance for patients with life-changing diseases.

Byar, K. L., Eilers, J. E. and Nuss, S. L. [University of Nebraska Medical Center, Omaha, NE 68198; klbyar@unmc.edu]. "**Quality of life 5 or more years post-autologous hematopoietic stem cell transplant**." *Cancer Nursing* 28, no. 2 (Mar-Apr 2005): 148-157.

[Abstract:] This cross-sectional study used a mailed survey to evaluate the quality of life (QOL) of individuals at least 5 years post-autologous stem cell transplant and to determine instrument preference. Instruments selected were the Medical Outcomes Study-Short Form (MOS-SF-36) as the generic measure and the City of Hope-Quality of Life-Bone Marrow Transplant (COH-BMT) and the Functional Assessment of Cancer Therapy-Bone Marrow Transplant (FACT-BMT) as transplant-specific measures. Subjects received the MOS-SF-36 and were randomized to receive (1) COH-BMT, (2) FACT-BMT, or (3) COH-BMT and FACT-BMT. Ninety-two subjects returned completed forms, for a 56% response rate. A study-specific form indicated subjects preferred the BMT-specific instruments. The health of the majority of subjects (85%) was similar to or somewhat better than what it was the previous year. Their MOS-SF-36 scores for physical functioning, role-physical, bodily pain, and general health subscales were lower than the values for the general population, but those for the other subscales were not significantly different. When compared to the data reported by Hann and colleagues for posttransplant in breast cancer, study subjects scored significantly lower on all scales except General Health and Mental Health. COH-BMT scores compared with those reported by Whedon and Ferrel (Semin Oncol Nurs. 1994;10:42-57) were higher for Physical Well-Being, Spiritual Well-Being, and Global QOL. FACT-BMT results compared with those reported by McQuellen et al (Bone Marrow Transplant. 1997;19:357-368) showed that Physical, Social/Family, Emotional, and Functional Scores were similar; only BMT scores were significantly different. Research is needed to determine when QOL plateaus and whether instrument preference changes over time. Awareness of long-term effects that affect QOL can guide program revisions and facilitate decisions regarding the need for supportive rehabilitative services.

Callaghan, D. [Rutgers-The State University of New Jersey; drdonnarn@comcast.net]. "**Healthy behaviors, self-efficacy, self-care, and basic conditioning factors in older adults**." *Journal of Community Health Nursing* 22, no. 3 (2005): 169-178.

[Abstract:] A secondary statistical analysis of data from a study investigating the relations among health-promoting self-care behaviors, self-care self-efficacy, and self-care agency in an older adult population is reported (Callaghan, in press). Influences of selected basic conditioning factors on the practice of healthy behaviors, self-efficacy beliefs, and ability for self-care in 235 older adults is presented. The research instruments used to collect data for this study include the following: Health-Promoting Lifestyle Profile II scale, Self-Rated Abilities for Health Practices scale, Exercise of Self-Care Agency scale, and a demographic questionnaire assessing basic conditioning factors. Statistically significant relations were found between the following basic conditioning factors and the study variables: education, income, health insurance, race, support system, routine practice of religion, medical problems, marital status, gender, age, and number of children. Community health nurses can use these results in directing interventions that promote the self-care and health of older adults.

Campbell, A. and Campbell, D. [London South Bank University]. "**Emergency baptism by health professionals**." *Paediatric Nursing* 17, no. 2 (Mar 2005):39-42.

The authors address ethical, moral, and personal concerns regarding Christian baptism of seriously ill children as part of holistic nursing care.

Canada, A. L., Parker, P. A., Basen-Engquist, K., de Moor, J. S. and Ramondetta, L. M. [Department of Behavioral Science, The University of Texas M. D. Anderson Cancer Center, Houston, TX 77030; alcanada@mdanderson.org]. "**Active coping mediates the association between religion/spirituality and functional well-being in ovarian cancer**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S125.

This is a brief conference report of a study of 129 women. Among the findings: "…positive associations between R/S and functional well-being and R/S and overall QOL were mediated through the use of active coping [p. S125].

Carlson, B., Simopolous, N., Goy, E. R., Jackson, A. and Ganzini, L. [Portland Veterans Affairs Medical Center, Portland, OR 97239]. "**Oregon hospice chaplains' experiences with patients requesting physician-assisted suicide**." *Journal of Palliative Medicine* 8, no. 6 (Dec 2005): 1160-1166.

[Abstract:] BACKGROUND: Oregon's Death with Dignity Act (ODDA), which legalized physician-assisted suicide (PAS) for terminally ill individuals, was enacted in 1997. Eighty-six percent of the 171 patients who have died by PAS were enrolled in hospice. OBJECTIVE: To survey hospice chaplains regarding their views on the ODDA and experiences working with patients who request PAS. DESIGN: Single, anonymous, mailed survey. SUBJECTS: All chaplains affiliated with one of Oregon's 50 hospices. RESULTS: Fifty of 77 hospice chaplains whom we identified (65%) returned the survey. Forty-two percent of respondents opposed the ODDA and 40% supported it. Over half of respondents had, in the previous 3 years, worked with a patient who had made an explicit request for assisted suicide. Conversation with patients around PAS focused on the role of faith and spirituality in this decision, reasons for wanting hastened death, and family concerns or reactions to PAS. Chaplains did not feel that they had a strong influence on the patient's decisions about PAS (mean score of 4 on a 0-10 scale), though three chaplains reported a patient who withdrew their request for PAS because of the chaplain's involvement. Chaplains reported provision of a nonjudgmental presence helped the relationship with the patient. CONCLUSION: Oregon hospice chaplains are divided in their views on legalized PAS, but primarily see their role to deliver support to patients no matter what the patient's final decision regarding PAS.

Carothers, S. S., Borkowski, J. G., Lefever, J. B. and Whitman, T. L. [Department of Psychology, University of Notre Dame, Notre Dame, IN 46556; carothers.1@nd.edu]. "**Religiosity and the socioemotional adjustment of adolescent mothers and their children**." *Journal of Family Psychology* 19, no. 2 (Jun 2005): 263-275.

[Abstract:] This study assessed the impact of religiosity on the socioemotional and behavioral outcomes of 91 adolescent mothers and their offspring over 10 years. Religiosity was defined as involvement in church and contact with and dependence on church officials and members. Mothers classified as high in religious involvement had significantly higher self-esteem and lower depression scores, exhibited less child abuse potential, and had higher occupational and educational attainment than mothers classified as low in religious involvement; differences remained when multiple factors, such as stress and grandmother support, were held constant. Children with more religious mothers had fewer internalizing and externalizing problems at 10 years of age, with maternal adjustment mediating this relationship. Religiosity, through increased social support, served as a protective factor for teenaged mothers and their children.

Chang, B. H., Hendricks, A., Zhao, Y., Rothendler, J. A., LoCastro, J. S. and Slawsky, M. T. [Center for Health Quality, Outcomes, and Economic Research, Edith Nourse Rogers Memorial Veterans Hospital, Bedford VAMC, 200 Springs Road (152), Bedford, MA 01730; bhchang@bu.edu]. "**A relaxation response randomized trial on patients with chronic heart failure**." *Journal of Cardiopulmonary Rehabilitation* 25, no. 3 (May-Jun2005): 149-157.

[Abstract:] PURPOSE: Patients with various medical conditions benefit from eliciting the relaxation response (RR), using a variety of techniques, but few studies have focused on chronic heart failure (CHF). We evaluated the efficacy of an RR intervention program on the quality of life (QOL) and exercise capacity of CHF patients by conducting a single-blind, 3-arm, randomized, controlled trial. METHODS: Between April 2000 and June 2002, we enrolled 95 patients with moderate severity CHF from the Veterans Affairs Boston Healthcare System. Patients in the study intervention group attended a weekly RR group for 15 weeks and were requested to practice the techniques at home twice a day. A 15-week cardiac education (EDU) program was used as an alternative intervention, and usual care (UC) was the control group. The QOL questionnaires and a bicycle test were administered at baseline and after intervention or 15 to 19 weeks. RESULTS: Eighty-three (87%) of the 95 enrolled patients completed both baseline and post-intervention QOL measures (31 RR, 24 EDU, and 28 UC). No dropout bias was observed. The RR group had significantly better QOL change scores in peace-spiritual scales than did the UC group (P = .02), adjusting for baseline scores, time between assessments, age, education, diet, and medication, whereas no significant difference was observed between the EDU and UC groups. A similar trend was observed in emotional QOL (RR and UC group comparison, P = .07). No statistically significant intervention effect on physical QOL or exercise capacity was observed. CONCLUSIONS: A short RR intervention can improve some aspects of QOL in CHF patients.

Cheever, K. H., Jubilan, B., Dailey, T., Ehrhardt, K., Blumenstein, R., Morin, C. J. and Lewis, C. [Department of Nursing & Health, DeSales University, Center Valley, PA; kerry.cheever@desales.edu]. "**Surgeons and the spirit: a study on the relationship of religiosity to clinical practice**." *Journal of Religion & Health* 44, no. 1 (2005): 67-80.

[Abstract:] This study aimed to identify the religious practices and beliefs of surgeons and the relationship between surgeons' locus of control and religiosity. Thirty-five surgeons completed a survey that included items from the Duke University Religion Index, the Salesian Center Intrinsic Religiosity Scale for Clinicians, and Rotter's Locus of Control Scale. Over 68% of sampled surgeons affirmed that their religious beliefs play a part in their practice, 47% attend religious services at least weekly, and 44% pray daily. There was no correlation between locus of control and religiosity. These results challenge the myth of the egocentric, agnostic surgeon.

Cheraghi, M. A., Payne, S. and Salsali, M. [Doctoral Nursing Department, Tehran School of Nursing and Midwifery, Tehran, Iran]. "**Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran**." *International Journal of Palliative Nursing* 11, no. 9 (Sep 2005): 468-474.

[Abstract:] The aim of this article is to describe the spiritual aspects of palliative care of Muslim patients based on experiences of end-of-life care in Iran. The religions of the world play a major part in the life cycle of their adherents, and most have rituals and beliefs concerning the care of dying people. For Muslims, death is believed to be not only the cessation of a complex set of biochemical processes, but also a belief that the spirit continues to live and dying is a passage from this world to the resurrection. The spirit is believed to be eternal and does not perish with death. According to Muslims' beliefs, reading of the Quran (the main religious text) can produce peace of mind in those who are near death. Nursing research has shown that the spiritual dimension of care infiltrates all aspects of nursing care. Palliative care nurses need to be informed about religious aspects of people around the world as a part of palliative care. This article indicates the methods of attending to spiritual care for Muslim patients based upon our experiences in Iran. [32 refs.]

Chibnall, J. T., Cook, M. A. and Miller, D. K. "**Religious awareness training for medical students: effect on clinical interpersonal behavior**." *Southern Medical Journal* 98, no. 12 (Dec 2005): 1255.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Chochinov, H. M. and Cann, B. J. [University of Manitoba, Manitoba Palliative Care Research Unit, Cancer Care Manitoba, Winnipeg, Manitoba, Canada; harvey.chochinov@cancercare.mb.ca]. "**Interventions to enhance the spiritual aspects of dying**." *Journal of Palliative Medicine* 8, suppl. 1 (2005): S103-115. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] In recent years, medical and allied health publications have begun to address various topics on spirituality. Scholars have posited numerous definitions of spirituality and wrestled with the notion of spiritual pain and suffering. Researchers have examined the relationship between spirituality and health and explored, among other topics, patients' perceptions of their spiritual needs, particularly at the end of life. This paper summarizes salient evidence pertaining to spirituality, dying patients, their health care providers, and family or informal caregivers. We examine the challenging issue of how to define spirituality, and provide a brief overview of the state of evidence addressing interventions that may enhance or bolster spiritual aspects of dying. There are many pressing questions that need to be addressed within the context of spiritual issues and end-of-life care. Efforts to understand more fully the constructs of spiritual well-being, transcendence, hope, meaning, and dignity, and to correlate them with variables and outcomes such as quality of life, pain control, coping with loss, and acceptance are warranted. Researchers should also frame these issues from both faith-based and secular perspectives, differing professional viewpoints, and in diverse cultural settings. In addition, longitudinal studies will enable patients' changing experiences and needs to be assessed over time. Research addressing spiritual dimensions of personhood offers an opportunity to expand the horizons of contemporary palliative care, thereby decreasing suffering and enhancing the quality of time remaining to those who are nearing death.

Chow, R. K. [National Interfaith Coalition on Aging, National Council on the Aging, Washington, DC]. "**Life's quest for spiritual well-being: a holistic and gerontological nurse perspective**." *Imprint* 52, no. 4 (Sep-Oct 2005): 80-83.

The author addresses broadly the role of nurses in the support of patient spiritual well-being, seeing this as both a part of the nature of gerontological nursing and a practical challenge for the future.

Clark, A. P., Aldridge, M. D., Guzzetta, C. E., Nyquist-Heise, P., Norris, M., Loper, P., Meyers, T. A. and Voelmeck, W. [University of Texas at Austin School of Nursing, 1700 Red River, Austin, TX 78701; apclark@mail.utexas.edu]. "**Family presence during cardiopulmonary resuscitation**." *Critical Care Nursing Clinics of North America* 17, no. 1 (Mar 2005): 23-32, x.

[Abstract:] A recent phenomenon in emergency and critical care settings is the presence of family members during resuscitation events. It remains controversial in most institutions, but evidence is increasing that the experience has positive benefits for family members. In this article, the origin of family presence is described and research evidence about the experience is presented. Three case studies are presented to illustrate typical events, including the potential role of the hospital chaplain. Recommendations for implementation are included.

Cnaan, R. A., Boddie, S. C. and Kang, J. [University of Pennsylvania]. "**Religious congregations as social services providers for older adults**." *Journal of Gerontological Social Work* 45, nos. 1-2 (2005): 105-130. This special issue of the journal was simultaneously published as the book, *Religion, Spirituality, and Aging: A Social Work Perspective*, ed. Harry R. Moody (Haworth Press, 2005). [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] A large proportion of older adults are affiliated with congregations. The literature suggests that, in general, religious participation among the older adults enhances their quality of life and provides a network of social care. In this article, we explored the relevant literature on organized religion and social support for older adults. Based on a census study of congregations in Philadelphia (N = 1,393), we documented the following: (1) the number of congregations serving older adults, (2) the types of services provided, and (3) the number of beneficiaries. The study also identified the organizational factors that predict the provision of congregation-based services for older adults. The findings suggest that serving older adults is not a top priority for most congregations. Most senior programs are small and often informal. Approximately half (48%) of the congregations do not provide a formal social service. However, those congregations that are more likely to serve older adults have larger budgets, more members over 65 years old, and a moderate political orientation. We recommend that congregations, social service providers, and older adults explore ways to maximize this underutilized resource of congregational services to meet the needs of the increasing number of older adults.

Compton, M. T. and Furman, A. C. [Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA 30303]. "**Inverse correlations between symptom scores and spiritual well-being among African American patients with first-episode schizophrenia spectrum disorders**." *Journal of Nervous & Mental Disease* 193, no. 5 (May 2005): 346-349.

[Abstract:] Spirituality, religiosity, and spiritual/religious well-being are relatively understudied in the context of severe mental illnesses. Nonetheless, individuals dealing with such disorders, including schizophrenia, often make use of spirituality and religious affiliation as coping resources. In this preliminary study, we examined correlations between psychopathology severity and spiritual well-being among first-episode schizophrenia-spectrum disorder patients. The sample consisted of 18 African American patients hospitalized on an inpatient psychiatric unit in a large, urban, public hospital. After confirmation of diagnosis with the Structured Clinical Interview for DSM-IV Axis I Disorders, symptom severity was rated with the Positive and Negative Syndrome Scale, and self-reported spiritual well-being was evaluated with the Spiritual Well-Being Scale. Spearman correlations revealed that negative symptom scores were inversely correlated with religious well-being scores (rho = -.614; p = 0.007), and that general psychopathology symptom scores were inversely correlated with existential well-being scores (rho = -.539; p = 0.021). These preliminary findings indicate that negative symptoms and general psychopathology symptoms may have a detrimental effect on religious and existential well-being in patients with a first episode of a schizophrenia-spectrum disorder, or that religious and existential well-being may have an effect on symptomatology.

Cotton, S., Larkin, E., Hoopes, A., Cromer, B. A. and Rosenthal, S. L. [Health Services Research and Development, Department of Veterans Affairs, VA Medical Center, Cincinnati, OH; sian.cotton@uc.edu]. "**The impact of adolescent spirituality on depressive symptoms and health risk behaviors**." *Journal of Adolescent Health* 36, no. 6 (Jun 2005): 529.

[Abstract:] PURPOSE: The purpose of this study was to examine spirituality as a meaningful construct in adolescents' lives, and to examine the contribution of spirituality above and beyond that of religiosity to depressive symptoms and health-risk behaviors. METHOD: A total of 134 adolescents from a suburban high school completed a questionnaire assessing spirituality, religiosity, depressive symptoms, and health-risk behaviors. Spirituality was measured with 2 subscales: (1) religious well-being ("I believe that God loves/cares about me") and (2) existential well-being ("Life doesn't have much meaning"). Religiosity was assessed via belief in God/Higher Power and importance of religion. The Children's Depression Inventory-Short Form and the Youth Risk Behavior Survey (YRBS) were used to assess depressive symptoms and health-risk behaviors. RESULTS: The majority of the sample was Caucasian, with a mean age of 16.2 years. Eighty-nine percent reported a belief in God/Higher Power and 77% stated that religion was important in their lives. After controlling for demographics and religiosity, existential well-being and religious well-being accounted for an additional 29% of the variability in depressive symptoms and 17% of the variability in risk behaviors. Existential well-being was the only predictor significant in both final models ($p < .01$). CONCLUSIONS: Most of these adolescents reported some connection with religious and spiritual concepts, and those with higher levels of spiritual well-being, in particular, existential well-being, had fewer depressive symptoms and fewer risk-taking behaviors. This supports the inclusion of these concepts in our efforts to help promote resilience and healthy adolescent development, and in expanding our investigations beyond religious identification or attendance at religious services to broader concepts of spirituality.

Cunningham, A. J. [Ontario Cancer Institute/Princess Margaret Hospital, Toronto, Canada; acunningham@uhnres.utoronto.ca]. "**Integrating spirituality into a group psychological therapy program for cancer patients**." *Integrative Cancer Therapies* 4, no. 2 (Jun 2005): 178-186.

[Abstract:] PURPOSE: Although the importance of spiritual issues to people with cancer is by now widely acknowledged, there has been almost no research on the value of interventions specifically designed to enhance the spiritual experience of these patients. The present report describes an exploratory study on the effects of a brief psychoeducational course emphasizing spiritual aspects of coping and healing. METHODS: Ninety-seven patients with various types and stages of cancer took part in the 8-session course as the third stage in a progressive, stepwise program of support and psychological education. Standard psychometric tests were administered at entry, 8 weeks, and 6 months. Written home assignments, returned by participants, provided an insight into their experience. RESULTS: Significant improvements in scores were found immediately following the intervention; by 6 months, however, these improvements above entry level had declined to about half the 8-week value. In their written homework, patients grappled with such issues as doubts about the existence of a god, judgment and forgiveness, guilt, projection, self-importance, and the meaning of love. As the course progressed, many claimed to be better able to accept their condition and to experience an enhanced sense of meaning in their lives, coupled with a heightened appreciation for the events of everyday life and less tendency to conflict with others. CONCLUSIONS: These preliminary findings indicate that further, more rigorous

investigation would be worthwhile and support the growing view that addressing spiritual issues within the framework of group therapy can be of great benefit to people with cancer.

Curlin, F. A. and Hall, D. E. [Section of General Internal Medicine, Department of Medicine, University of Chicago, Chicago, IL; fcurlin@medicine.bsd.uchicago.edu]. "**Strangers or friends? A proposal for a new spirituality-in-medicine ethic**." *Journal of General Internal Medicine* 20, no. 4 (Apr 2005): 370-374. [Erratum appears in vol. 20, no. 5 (May 2005): 485.]

[Abstract:] We argue that debate regarding whether and how physicians should engage religious concerns has proceeded under inadequate terms. The prevailing paradigm approaches dialogue regarding religion as a form of therapeutic technique, engaged by one stranger, the physician, upon another stranger, the patient. This stranger-technique framework focuses the debate on questions of physicians' competence, threats to patients' autonomy, and neutrality regarding religion, and in so doing, it too greatly circumscribes the scope of physician-patient dialogue. In contrast, we argue that dialogue regarding religion is better approached as a form of philosophical discourse about ultimate human concerns. Such moral discourse is often essential to the patient-physician relationship, and rather than shrinking from such discourse, physicians might engage patients regarding religious concerns guided by an ethic of moral friendship that seeks the patient's good through wisdom, candor, and respect.

Curlin, F. A., Lantos, J. D., Roach, C. J., Sellergren, S. A. and Chin, M. H. [Section of General Internal Medicine, Department of Medicine, The University of Chicago, IL 60637; fcurlin@medicine.bsd.uchicago.edu]. "**Religious characteristics of U.S. physicians: a national survey**." *Journal of General Internal Medicine* 20, no. 7 (Jul 2005): 629-634. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] BACKGROUND: Patients' religious commitments and religious communities are known to influence their experiences of illness and their medical decisions. Physicians are also dynamic partners in the doctor-patient relationship, yet little is known about the religious characteristics of physicians or how physicians' religious commitments shape the clinical encounter. OBJECTIVE: To provide a baseline description of physicians' religious characteristics, and to compare physicians' characteristics with those of the general U.S. population. DESIGN/PARTICIPANTS: Mailed survey of a stratified random sample of 2,000 practicing U.S. physicians. Comparable U.S. population data are derived from the 1998 General Social Survey. MEASUREMENTS/RESULTS: The response rate was 63%. Fifty-five percent of physicians say their religious beliefs influence their practice of medicine. Compared with the general population, physicians are more likely to be affiliated with religions that are underrepresented in the United States, less likely to say they try to carry their religious beliefs over into all other dealings in life (58% vs 73%), twice as likely to consider themselves spiritual but not religious (20% vs 9%), and twice as likely to cope with major problems in life without relying on God (61% vs 29%). CONCLUSIONS: Physicians' religious characteristics are diverse and they differ in many ways from those of the general population. Researchers, medical educators, and policy makers should further examine the ways in which physicians' religious commitments shape their clinical engagements.

Curlin, F. A., Roach, C. J., Gorawara-Bhat, R., Lantos, J. D. and Chin, M. H. [Section of General Internal Medicine, Department of Medicine, Pritzker School of Medicine, The University of Chicago, Chicago, IL 60637; fcurlin@medicine.bsd.uchicago.edu]. "**How are religion and spirituality related to health? A study of physicians' perspectives**." *Southern Medical Journal* 98, no. 8 (Aug 2005): 761-766. Comment: Daly, C. C., "Religion and the attending physician's point-of-view," on p. 759.

[Abstract:] BACKGROUND: Despite expansive medical literature regarding spirituality and medicine, little is known about physician beliefs regarding the influence of religion on health. METHODS: Semistructured interviews with 21 physicians regarding the intersection of religion, spirituality, and medicine. Interviews were transcribed, coded, and analyzed for emergent themes through an iterative process of qualitative textual analysis. RESULTS: All participants believed religion influences health, but they did not emphasize the influence of religion on outcomes. Instead, they focused on ways that religion provides a paradigm for understanding and making decisions related to illness and a community in which illness is experienced. Religion was described as beneficial when it enables patients to cope with illness but harmful when it leads to psychological conflict or conflict with medical recommendations. CONCLUSIONS: Empirical evidence for a "faith-health connection" may have little influence on physicians' conceptions of and approaches to religion in the patient encounter.

Curlin, F. A., Roach, C. J., Gorawara-Bhat, R., Lantos, J. D. and Chin, M. H. [Sections of General Internal Medicine, The University of Chicago, IL 60637; fcurlin@medicine.bsd.uchicago.edu]. "**When patients choose faith over medicine: physician perspectives on religiously related conflict in the medical encounter**." *Archives of Internal Medicine* 165, no. 1 (Jan 10, 2005): 88-91.

[Abstract:] BACKGROUND: Patients at times disagree with medical recommendations for religious reasons. Despite a lively debate about how physicians should respond to patients' religious concerns, little is known about how physicians actually respond. We explored the ways in which physicians interpret and respond to conflict between medical recommendations and patients' religious commitments. METHODS: One-to-one, in-depth, semistructured interviews with 21 physicians from a range of religious affiliations, specialties, and practice settings. Interviews were transcribed, coded, and analyzed for emergent themes through an iterative process of textual analysis informed by the principle of constant comparison. RESULTS: Conflict introduced by religion is common and occurs in 3 types of settings: (1) those in which religious doctrines directly conflict with medical recommendations, (2) those that involve an area in which there is extensive controversy within the broader society, and (3) settings of relative medical uncertainty in which patients "choose faith over medicine." In response to such conflict, physicians first seek to accommodate patients' ideas by remaining open-minded and flexible in their approach. However, if they believe patients' religiously informed decisions will cause them to suffer harm, physicians make efforts to persuade patients to follow medical recommendations. CONCLUSIONS: When religiously related conflict arises, physicians appear to intuitively navigate a tension between respecting patients' autonomy by remaining open-minded and flexible and seeking patients' good by persuading them to follow medical recommendations. In such contexts, religion and medicine are intertwined, and moral counsel inheres in physicians' medical recommendations.

Daly, C. C. [East Tennessee State University, Johnson City; eutrapelia@gmail.com]. "**Definition of terms: spirituality versus religiousness**." *Southern Medical Journal* 98, no. 12 Dec 2005): 1238-1239.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Dann, N. J., Higby, D. J. and Mertens, W. C. [Baystate Regional Cancer Program, Springfield, MA 01107]. "**Can a cancer program-sponsored spiritual event meet with acceptance from patients and other attendees?**" *Integrative Cancer Therapies* 4, no. 3 (Sep 2005): 230-235.

[Abstract:] BACKGROUND: While many cancer patients derive strength from spiritual or religious faith, concern often remains regarding how different patient subgroups and other community members might react to faith-based services when sponsored by a secular health care organization. METHODS: "A Sacred Gathering for Those Touched by Cancer" was presented in 2 Catholic and 2 Protestant churches. The service included key themes (surrendering fear, peace, hope, community support, and God's love) reinforced by Scripture, music, ritual, and prayer. Patients, clergy, and staff participated. Questionnaires evaluating attendee characteristics, emotional response to the service, and satisfaction with service components were distributed. RESULTS: Attendees (women: 80%; Catholic: 71%; half older than 50 years) returned 450 questionnaires. Most found the service very (83%) or somewhat (14%) helpful. Multivariate regression of perceptions indicated (1) the opinion that the service was helpful was associated with the perception that the service made the respondent feel hopeful ($P < .0001$), that respondents found inspirational messages important ($P = .058$), and that the respondent was a current patient ($P = .018$) and (2) an angry response reported by respondents was associated with current patient status ($P = .0044$). Men tended to feel less loved by God ($P = .012$) and people ($P = .034$) and less hopeful ($P = .057$) than women did. Men liked music less ($P = .048$), liked Scripture and prayers concerning community less ($P = .040$), and found prayer ($P = .0035$) less important. However, men felt the gatherings were as helpful as women did. Past patients felt less sadness than did others ($P = .0084$). Increased perceived helpfulness of the service was associated in a multivariate analysis with current patient status, feeling hopeful as a result of the service, increased appreciation of the service's inspirational message, and the perception that the service was not too long. CONCLUSIONS: While almost all attendees found the service somewhat or very helpful, distinct preferences and reactions to the service were noted for gender, patient status, and religious affiliation. This evaluation will help tailor future events to better meet the spiritual needs of cancer patients and their loved ones.

Daugherty, C. K., Fitchett, G., Murphy, P. E., Peterman, A. H., Banik, D. M., Hlubocky, F. and Tartaro, J. [Section of Hematology/Oncology, University of Chicago Medical Center, Chicago, IL 60612-3833]. "**Trusting God and medicine: spirituality in advanced cancer patients volunteering for clinical trials of experimental agents**." *Psycho-Oncology* 14, no. 2 (Feb 2005): 135-146.

[Abstract:] The purpose of this study was to examine the role of spirituality in terminally ill cancer patients who volunteer for clinical trials of experimental agents. Information about spirituality (FACIT-Sp), quality of life (FACT-G), awareness of prognosis, and decision-making preferences was obtained from 162 advanced cancer patients who volunteered for phase I trials. In a multivariable model, phase I patients had slightly higher levels of spirituality ($p<0.001$) than a group of 156 advanced cancer patients who were not participants in phase I trials. For the phase I patients, spirituality was positively associated with quality of life (Spearman $rho=0.36$, $p<0.001$). There was little association between either spirituality or religious problem-solving style and phase I patients' awareness of their prognosis or decision-making preferences. One phase I patient who said, 'I put faith in doctors and God,' expressed these patients' willingness to trust both God and medicine.

Davidson, J. R., Connor, K. M. and Lee, L. C. [Dept. of Psychiatry & Behavioral Sciences, Duke University Medical Center, Durham NC 27710; jonathan.davidson@duke.edu]. "**Beliefs in karma and reincarnation among survivors of violent trauma--a community survey**." *Social Psychiatry & Psychiatric Epidemiology* 40, no. 2 (Feb 2005): 120-125.

[Abstract:] BACKGROUND: This survey was designed to examine beliefs in karma and reincarnation among survivors of violent trauma in the general US population. METHODS: Two community surveys were conducted in 2001. From a sample of 1,969 respondents, two groups were created based on level of agreement with karmic belief. This sample forms the basis of this report. Information was obtained as to mental and physical health, resilience, exposure to violent trauma, and posttraumatic stress disorder (PTSD) symptom severity, and the cohorts were compared on these variables. RESULTS: Five percent of the sample admitted strong agreement to a belief in karma and reincarnation ($n=99$), while 77% strongly disagreed with these beliefs ($n=1,511$). Characteristics associated with agreement included being non-white, unmarried, and in poor physical and mental health. Moreover, agreement was associated with more extensive traumatization, including abuse, rape, and loss of a family member through violent death, as well as more severe posttraumatic stress symptoms. CONCLUSIONS: Few people subscribe strongly to a belief in karma and reincarnation in the US population, but personal experience of trauma may be associated with greater acceptance, as well as certain demographic and health-associated variables. The importance of holding such beliefs, which may represent an important way of coping following violent trauma, deserves further study.

Davis, B. [University of New England, Biddeford, ME]. "**Mediators of the relationship between hope and well-being in older adults**." *Clinical Nursing Research* 14, no. 3 (Aug 2005): 253-272.

[Abstract:] This research examined well-being in relationship to the variables of hope, spirituality, and state anxiety using a cross-sectional correlation design to test two mediation models. The convenience sample of 130 older adults, mostly women, between the ages of 60 and 89, completed the Demographic Data Sheet and the Index of Well-Being, the Herth Hope Index, the Spiritual Perspective Scale, and the state anxiety portion of the State-Trait Anxiety Inventory. Statistically significant and positive correlations were found between hope and well-being, hope and spirituality, and spirituality and well-being. A statistically significant and negative correlation was found between hope and state anxiety and between state anxiety and well-being. Multiple regression analyses results indicated that neither spirituality nor state anxiety functioned as a mediator in the relationship between hope and well-being.

Davis, K., Holtzman, S., Durand, R., Decker, P. J., Zucha, B. and Atkins, L. [LifeGift Organ Donation Center, Houston, TX]. "**Leading the flock: organ donation feelings, beliefs, and intentions among African American clergy and community residents**." *Progress in Transplantation* 15, no. 3 (Sep 2005): 211-216.

[Abstract:] CONTEXT: Despite a considerable potential role in organ donation for African American clergy, there has been little investigation to date of the beliefs, attitudes, and personal intentions of such clergy regarding donation. OBJECTIVE: To compare the beliefs, attitudes, and behavioral intentions regarding organ donation among African American clergy to those of African American residents of the same large US city. DESIGN: Focus groups and 3 cross-sectional surveys. SETTING: Greater Houston, Tex, metropolitan area. PARTICIPANTS: A total of 761 randomly selected African American community residents and 311 African American clergy. MAIN OUTCOMES MEASURES: Beliefs about the importance of organ donation; how comfortable one is in thinking about donation; whether one believes that organ donation is against one's religion; trust in healthcare professionals regarding death declaration; concerns that donation leads to body mutilation; and the likelihood that one will donate one's own organs upon death. RESULTS: Compared to general African American residents, African American clergy in

the Houston area were found more often to believe in the importance of donation; to be more comfortable with thinking about donation; to feel more certain that donation was not against their religion; to believe that they could trust healthcare professionals regarding death declaration; to feel less often that donation leads to mutilation of the body; and to indicate a greater likelihood of donating their own organs upon death. The same was found to be true among clergy and congregants of the largest religious denomination in Houston, the Baptists.

Davis, K. E. and O'Neill, S. J. [Research Department of Thresholds Psychosocial Rehabilitation Centers in Chicago, 4101 North Ravenswood, Chicago, IL 60613; kdavis@thresholds.org]. "**A focus group analysis of relapse prevention strategies for persons with substance use and mental disorders**." *Psychiatric Services* 56, no. 10 (Oct 2005): 1288-1291.
[Abstract:] OBJECTIVE: The authors conducted a qualitative, thematic analysis of focus group data to determine the strategies and supports persons with dual diagnoses rely on in their relapse prevention efforts. METHODS: Data from four focus group sessions conducted at a large psychosocial rehabilitation center were analyzed for recurrent responses about what was most helpful in maintaining remission and grouped into major categories and subcategories. Each focus group comprised four to nine consumers who had been in remission from substance use for at least six months. A total of 27 consumers participated in the focus groups. RESULTS: The data indicate that maintaining stable housing, relying on "positive" social support, engaging in prayer or relying on a "higher power," participating in a meaningful activity, and thinking differently about life are important strategies for consumers in their attempts to stay clean. Just as frequently mentioned in the groups were conscious attempts to eat regularly, get sufficient sleep, and look presentable. CONCLUSION: Although this study was exploratory in nature, it identified areas for further qualitative study of strategies for relapse prevention among persons with dual diagnoses.

Davis, L. A. [Div. of Nursing, West Texas A&M University, Canyon, TX 76016; ldavis@mail.wtamu.edu]. "**A phenomenological study of patient expectations concerning nursing care**." *Holistic Nursing Practice* 19, no. 3 (May-Jun 2005): 126-133.
[Abstract:] This phenomenological study explored the expectations patients have of nursing care, specifically spiritual care, using the framework of humanistic nursing. Four themes emerged: (1) the definition of "good" and "bad" nursing, (2) surveillance and competence, (3) spiritual care expectations, and (4) the concept of time. [See pp. 129-130 for discussion of spiritual care expectations. Participants generally did not expect nurses to provide spiritual care.]

Delaney, C. [Western Connecticut State University, Danbury, CT]. "**The Spirituality Scale: development and psychometric testing of a holistic instrument to assess the human spiritual dimension**." *Journal of Holistic Nursing* 23, no. 2 (Jun 2005): 145-167. Discussion on pp. 168-171.
[Abstract:] PURPOSE: The purpose of this study was to develop, refine, and evaluate the psychometric characteristics of the Spirituality Scale (SS). The SS is a holistic instrument that attempts to measure the beliefs, intuitions, lifestyle choices, practices, and rituals representative of the human spiritual dimension and is designed to guide spiritual interventions. METHOD: A researcher-developed instrument was designed to assess spirituality from a holistic perspective. Items were generated to measure four conceptualized domains of spirituality. The SS was completed by 240 adults with chronic illness. FINDINGS: Psychometric analysis of the SS provided strong evidence of the reliability and validity of the instrument. Three factors of spirituality that supported the theoretical framework were identified: Self-Discovery, Relationships, and Eco-Awareness. IMPLICATIONS: These findings can assist in facilitating the inclusion of spirituality in health care and have the potential to provide a transforming vision for nursing care and a vehicle to evoking optimal patient outcomes.

Delgado, C. [School of Nursing, Cleveland State University, Cleveland, OH]. "**A discussion of the concept of spirituality**." *Nursing Science Quarterly* 18, no. 2 (Apr 2005): 157-162.
[Abstract:] The purpose of this article is to discuss the concept of spirituality. There is a recognized connection between spirituality and health, and nurse leaders have acknowledged the importance of the spiritual as well as the physical in providing optimal nursing care. Spirituality goes beyond religious or cultural boundaries. Spirituality is characterized by faith, a search for meaning and purpose in life, a sense of connection with others, and a transcendence of self, resulting in a sense of inner peace and well-being. A strong spiritual connection may improve one's sense of satisfaction with life or enable accommodation to disability. [38 refs.]

Dijoseph, J. and Cavendish, R. [St. Vincent's Hospital, Staten Island, NY 10314]. "**Expanding the dialogue on prayer relevant to holistic care**." *Holistic Nursing Practice* 19, no. 4 (Jul-Aug 2005): 147-154. Quiz 154-155.
[Abstract:] Because prayer is the most frequently used spiritual practice, it is beneficial to address the relationship between prayer and spiritual care needs. Raising awareness among nurses of the meaning of prayer practices in healthcare settings may strengthen holistic care. This article presents a synthesis of nursing theory on prayer and spirituality for holistic care and attempts to expand an understanding of prayer practices related to traditions of increasingly diverse patients and caregivers. In addition, a 4-point guide for spiritual caregiving is presented to help nurses address human responses in the spiritual domain. [60 refs.]

Dobratz, M. C. [University of Washington, Tacoma, WA; mdobratz@u.washington.edu]. "**A comparative study of life-closing spirituality in home hospice patients**." *Research & Theory for Nursing Practice* 19, no. 3 (2005): 243-256.
[Abstract:] This secondary analysis compared two groups of home hospice patients (expressed spirituality, N = 44, and nonexpressed spirituality, N = 53) on psychological well-being and adaptation, social support, physical function, pain, and demographic variables. Independent-samples t tests found no significant differences at $p < .05$ for age, psychological well-being and adaptation, social support, and physical function. Three components of the McGill-Melzack Pain Questionnaire were significantly higher for the nonexpressed spirituality group: Affective Dimension, Pain Rating Index, and Number of Words Chosen. A comparative analysis of two groups of home hospice patients supported higher pain reports as significant indicators of nonexpressed spirituality in a home hospice population.

Donnelly, J. P., Huff, S. M., Lindsey, M. L., McMahon, K. A. and Schumacher, J. D. [School and Educational Psychology, University at Buffalo/State University of New York, Buffalo, NY]. "**The needs of children with life-limiting conditions: a healthcare-provider-based model**." *American Journal of Hospice & Palliative Care* 22, no. 4 (Jul-Aug 2005): 259-267.
[Abstract:] Pediatric hospice and palliative care has progressed in recent years with the development of new programs and models of care. Missing from the empirical literature, however is a model of the needs of children. The purpose of the present study was to develop an empirically based conceptual model of the needs of children with life-limiting conditions. Recognizing the value of both qualitative and quantitative data, concept mapping methodology was selected as an effective way to obtain data that reflected both the "big picture" and subtleties of pediatric end-of-life needs. The seven-cluster concept map appeared best in terms of both interpretability and parsimony. This

model includes the following clusters of needs: 1) pain, 2) decision making, 3) medical system access and quality, 4) dignity and respect, 5) family-oriented care, 6) spirituality, and 7) psychosocial issues. We believe that the development of a comprehensive model of the needs of such children is a step toward concrete, measurable, and effective support for children and their families.

Dorff, E. N. "**End-of-life: Jewish perspectives**." *The Lancet* 366, no. 9488, (Sep 3-9, 2005): 862-865.
This is part of an article series on religious diversity in health care. [See also articles by Baggini, Engelhardt, Firth, Keown, Markwell, and Sachedina listed in this bibliography.]

Duggleby, W. and Berry, P. [wendy.duggleby@usask.ca]. "**Transitions and shifting goals of care for palliative patients and their families**." *Clinical Journal of Oncology Nursing* 9, no. 4 (Aug 2005): 425-428.
[Abstract:] Terminally ill patients and their families experience many confusing and, at times, traumatic transitions. Examples of such transitions include transitions from cure to comfort care, transitions related to loss, changes in care settings, and psychosocial and spiritual transitions. The purpose of this article is to discuss the experiences of palliative patients and their families as they journey through transitions and how oncology nurses can provide support. Using a composite case study from actual clinical cases as a framework for discussion, the authors present examples of evidence-based strategies that can be used by oncology nurses. Critical points from the case study are Adjustment to death is a process and cannot be rushed. The needs of a palliative patient and family should be heard, honored, and not questioned or challenged. A patient and family should remain in control of decision making, with the hospice and palliative care team acting as guides and facilitators. [See the Case Study: Psychosocial and Spiritual Transitions, on p. 427.]

Egnew, T. R. [Tacoma Family Medicine, WA 98405-4238; tom.egnew@multicare.org]. "**The meaning of healing: transcending suffering**." *Annals of Family Medicine* 3, no. 3 (May-Jun 2005): 255-262.
[Abstract:] PURPOSE: Medicine is traditionally considered a healing profession, but it has neither an operational definition of healing nor an explanation of its mechanisms beyond the physiological processes related to curing. The objective of this study was to determine a definition of healing that operationalizes its mechanisms and thereby identifies those repeatable actions that reliably assist physicians to promote holistic healing. METHODS: This study was a qualitative inquiry consisting of in-depth, open-ended, semistructured interviews with Drs. Eric J. Cassell, Carl A. Hammerschlag, Thomas S. Inui, Elisabeth Kubler-Ross, Cicely Saunders, Bernard S. Siegel, and G. Gayle Stephens. Their perceptions regarding the definition and mechanisms of healing were subjected to grounded theory content analysis. RESULTS: Healing was associated with themes of wholeness, narrative, and spirituality. Healing is an intensely personal, subjective experience involving a reconciliation of the meaning an individual ascribes to distressing events with his or her perception of wholeness as a person. CONCLUSIONS: Healing may be operationally defined as the personal experience of the transcendence of suffering. Physicians can enhance their abilities as healers by recognizing, diagnosing, minimizing, and relieving suffering, as well as helping patients transcend suffering.

Ellis, G. K. [Pastoral Care, Florida Hospital, Orlando, FL 32803; Greg.Ellis@flhosp.org]. "**Taking your patient's spiritual vital signs**." *Home Healthcare Nurse* 23, no. 10 (Oct 2005): 634-635.
In this brief article, a chaplain offers suggestions about how nurses may understand and support patients spiritually, including the patient's sense of journey, place of God, fear, hope, and purpose.

Ellis, M. R. and Campbell, J. D. [Cox Family Practice Residency, Springfield, MO]. "**Concordant spiritual orientations as a factor in physician-patient spiritual discussions: a qualitative study**." *Journal of Religion & Health* 44, no. 1 (2005): 39-53.
[Abstract:] Objectives: To understand the impact of physicians' and patients' religious/spiritual orientation on discussions of spiritual issues. Methods: We performed semi-structured interviews of 10 Missouri family physicians and 10 patients of these physicians, selecting subjects nonrandomly to represent a range of demographic factors, practice types, and chronic or terminal illness. We coded and evaluated transcribed interviews for themes. Results: Respondents expressed that similar belief systems facilitate patient-physician spiritual interactions and bring confidence to their relationships. Those holding dissimilar faiths noted limited ability to address spiritual questions directly. They cited significant barriers to spiritual interaction but considered that ecumenism, use of patient-centered care, and negotiation skills lessen these barriers. Conclusions: Our respondents view spirituality similarly to other aspects of the physician-patient relationship involving differing viewpoints. Where discordance exists, cross-cultural, patient-centered, diplomatic approaches facilitate spiritual discussions.

Elpern, E. H., Covert, B. and Kleinpell, R. [Rush University Medical Center, Chicago, IL]. "**Moral distress of staff nurses in a medical intensive care unit**." *American Journal of Critical Care* 14, no. 6 (Nov 2006): 523-530.
[From the abstract:] A total of 28 nurses working in a medical intensive care unit anonymously completed a 38-item moral distress scale and described implications of experiences of moral distress. RESULTS: Nurses reported a moderate level of moral distress overall. Highest levels of distress were associated with the provision of aggressive care to patients not expected to benefit from that care. Moral distress was significantly correlated with years of nursing experience. Nurses reported that moral distress adversely affected job satisfaction, retention, psychological and physical well-being, self-image, and spirituality. Experience of moral distress also influenced attitudes toward advance directives and participation in blood donation and organ donation.

Engelhardt, H. T., Jr. and Iltis, A. S. "**End-of-life: the traditional Christian view**." *The Lancet* 366, no. 9490 (Sep 17-23, 2005): 1045-1049.
This is part of an article series on religious diversity in health care. [See also articles by Baggini, Dorff, Firth, Keown, Markwell, and Sachedina listed in this bibliography.]

Ensberg, M., Gerstenlauer, C. [Geriatric Education Center of Michigan, Michigan State University, 4900 Zimmer Road, Williamston, MI 48895; ensberg@pilot.msu.edu]. "**Incremental geriatric assessment**." *Primary Care; Clinics in Office Practice* 32, no. 3 (Sep 2005): 619-643.
This article frequently refers to the importance of spirituality (--see pp. 619, 620, 622, 637-638, 641) in this outline of a [from the abstract:] method of incremental assessment…intended to provide the office-based clinician with sufficient information to make decisions regarding the preventive, therapeutic, rehabilitative, and supportive goals of care an incremental assessment process.

Ethier, A. M. [University of Texas Health Science Center at Houston, Houston, TX 77005; aethier@uth.tmc.edu]. "**Death-related sensory experiences**." *Journal of Pediatric Oncology Nursing* 22, no. 2 (Mar-Apr 2005): 104-111.

[Abstract:] A death-related sensory experience (DRSE) is a spiritually transforming experience occurring with the appearance of a messenger beyond the visible observable universe to guide a dying person through the dying process. DRSEs have been reported to occur among those who are dying, most commonly individuals with terminal illness. Known dead family members are most commonly seen, followed by religious beings. Communication takes place between the dying individual and the apparition. Feelings of peace and comfort are reported by the majority of individuals experiencing DRSEs. DRSEs can occur over a period of hours to months before death. They have been referred to as veridical hallucinations, visions of the dying, deathbed visions, and predeath visions. Reported throughout time, among people of all cultures, religions, races, ages, genders, socioeconomic status, and educational levels, DRSEs are intense spiritual experiences. Validating a child's DRSE provides a way to start a dialogue regarding death. Research is needed to more fully understand DRSEs from the perspective of the dying child.

Fallot, R. D. and Heckman, J. P. [Community Connections, Washington, DC 20003; rfallot@ccdc1.org]. "**Religious/spiritual coping among women trauma survivors with mental health and substance use disorders**." *Journal of Behavioral Health Services & Research* 32, no. 2 (Apr-Jun 2005): 215-226.

[Abstract:] This study examines the types of religious/spiritual coping used by women trauma survivors with co-occurring mental health and substance use disorders. Analyses based on data from 2 large racially diverse samples indicate that women from the study population rely considerably more on positive, than negative, religious coping, and that their reliance on religious coping, in general, is significantly higher than that of the general population. Numerous significant relationships were also found between the severity of trauma-related and mental health symptoms and more negative religious coping. This study further suggests that more frequent childhood abuse and childhood sexual violence are especially associated with negative religious coping in adulthood. Findings support the importance of spiritual coping for women trauma survivors with co-occurring disorders and suggest the value of increased attention to spirituality in behavioral health services, especially in assessment and therapeutic relationships.

Farvis, R. A. [Faculty of Health and Life Sciences, Canaan Lane Campus, Napier University, Canaan Lane, Edinburgh EH9 2TB, UK; r_farvis@yahoo.co.uk]. "**Ethical considerations in spiritual care**." *International Journal of Palliative Nursing* 11, no. 4 (Apr 2005): 189.

[Abstract:] Responding to the article on spirituality by Seymour and Ingleton (1999), reprinted in the special anniversary issue of IJPN, this author argues that it is imperative that ethical considerations are not overlooked in providing spiritual care. Ethical issues abound, including confidentiality, categorization of spiritual needs and the appropriateness of spiritual care for patients and staff. This brief comment piece raises a number of questions relating to these issues, which need to be addressed if best practice is to be ensured.

Feinberg, S. S. [Albert Einstein College of Medicine, Bronx, NY; shalomf@aol.com]. "**Issues in the psychopharmacologic assessment and treatment of the orthodox Jewish patient**." *CNS Spectrums* 10, no. 12 (Dec 2005): 954-965.

[Abstract:] As with members of other cultural and religious groups, patients within the Orthodox Jewish community present with their own distinct clinical psychiatric issues related to their unique beliefs and practices. This article reviews the existing literature and anecdotal experience on the psychopharmacologic assessment and treatment of Orthodox Jewish patients. Specific aspects examined include this group's perceived intense stigma in receiving treatment, the priority this community places on cognitive functioning, and how the influence of Jewish laws on marriage and sexual practices impacts one's treatment decisions. The relevance of Jewish dietary laws, the Sabbath, and the community's interest in alternative treatments are also discussed. The limited ethno-psychopharmacology research related to Orthodox Jewish psychiatric patients is reviewed. We conclude that understanding issues such as these is critical if one is going to work within this cultural system in order to successfully address their mental health issues. However, the dearth of controlled research in this community needs to be addressed to provide more effective treatment. [84 refs.]

Ferrell, B. "**Dignity Therapy: advancing the science of spiritual care in terminal illness**." *Journal of Clinical Oncology* 23, no. 24 (Aug 20, 2005): 5427-5428. Comment on pp. 5520-5525.

The author comments on the idea of Dignity Therapy as set out elsewhere in the journal issue (--see Chochinov, H. M., et al., "Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life" [also noted in this bibliography]).

Firth, S. "**End-of-life: a Hindu view**." *The Lance*t 366, no. 9486 (Aug 20-26 2005): 682-686.

This is part of an article series on religious diversity in health care. [See also articles by Baggini, Dorff, Engelhardt, Keown, Markwell, and Sachedina listed in this bibliography.]

Fitch, M. I. [Psychosocial and Behavioural Research Unit, Toronto Sunnybrook Regional Cancer Centre; marg.fitch@sw.ca]. "**Needs of patients living with advanced disease**." *Canadian Oncology Nursing Journal* 15, no. 4 (2005): 230-242.

[Abstract:] When a person has a life-threatening illness, many changes occur. These changes are more than just physical changes and include psychosocial, practical and spiritual consequences. If disease progresses, the impact of these changes intensifies. Nurses who are caring for patients with advancing disease must be able to provide appropriate interventions if they are to help individuals cope. This paper highlights information regarding the needs of patients with advanced disease and emphasizes approaches that could be taken by cancer nurses in their care of these patients. The material is drawn from over a decade of interviewing patients about their experiences with cancer, the literature about patient needs, and discussions with care providers. The over-arching perspective is one of seeing human beings as bio-psychosocial-spiritual entities. Holding this perspective has implications for assessment and interventions in caring for patients with advanced disease.

Fitzgibbon, M. L., Stolley, M. R., Ganschow, P., Schiffer, L., Wells, A., Simon, N. and Dyer, A. [Department of Medicine, School of Public Health, University of Illinois, Chicago; mlf@uic.edu]. "**Results of a faith-based weight loss intervention for black women**." *Journal of the National Medical Association* 97, no. 10 (Oct 2005): 1393-1402.

[Abstract:] Obesity is a risk factor for a variety of chronic diseases. Although weight loss may reduce these risks, weight loss programs designed for black women have yielded mixed results. Studies suggest that religion/spirituality is a prominent component of black culture. Given this, the inclusion of religion/spirituality as an active component of a weight loss program may enhance the benefits of the program. The role of religion/spirituality, however, has not been specifically tested as a mechanism that enhances the weight loss process. This paper presents the results of "Faith on the Move," a randomized pilot study of a faith-based weight loss program for black women. The goals of the study were to estimate the effects of a 12-week culturally tailored, faith-based weight loss intervention on weight loss, dietary fat consumption and physical activity. The culturally tailored, faith-based weight loss intervention was compared to a culturally tailored weight loss intervention

with no active faith component. Fifty-nine overweight/obese black women were randomized to one of the two interventions. Although the results were not statistically significant, the effect size suggests that the addition of the faith component improved results. These promising preliminary results will need to be tested in an adequately powered trial.

Flannelly, K. J., Galek, K. and Handzo, G. F. [HealthCare Chaplaincy, New York, NY; KFlannelly@HealthCareChaplaincy.org]. "**To what extent are the spiritual needs of hospital patients being met?**" *International Journal of Psychiatry in Medicine* 35, no. 3 (2005): 319-323. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] Although a substantial number of studies have documented the spiritual needs of hospitalized patients, few have examined the prevalence of these needs and even fewer have attempted to measure the extent to which they are being met. Since chaplains are the primary providers of spiritual care, chaplains' visits to patients would appear to provide a reasonable proxy for the latter. Based on the limited data available, we estimated the proportion of hospitalized patients who are visited by chaplains. Our analyses yielded a point estimate of 20% (+/- 10%), depending on a number of factors.

Flannelly, K. J., Galek, K., Bucchino, J., Handzo, G. F., Tannenbaum, H. P. [The HealthCare Chaplaincy, New York City]. "**Department directors' perceptions of the roles and functions of hospital chaplains: a national survey**." *Hospital Topics* 83, no. 4 (2005): 19-27.

[Abstract:] A national survey of hospital directors of medicine, nursing, social services, and pastoral care was conducted to obtain opinions about the importance of various chaplain roles. On average, directors in all four disciplines rated three of the seven chaplain roles (grief and death, prayer, and emotional support) to be "very" to "extremely" important. Most of the others roles were rated between "moderately" and "very" important (religious services-rituals consultation and advocacy, community liaison-outreach). Several significant differences were found among disciplines, as physicians rated the importance of most chaplains' roles lower than did other disciplines. Overall, there was a tendency for directors in smaller hospitals, especially those with fewer than 100 patients, to place less importance on most of the chaplain roles investigated here.

Flannelly, K. J., Weaver, A. J. and Tannenbaum, H. P. [The HealthCare Chaplaincy, New York, NY 10022; kflannelly@healthcarechaplaincy.org]. "**What do we know about the effectiveness of faith-based health programs?**" *Southern Medical Journal* 98, no. 12 (Dec 2005): 1243-1244.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

French, C. C. [Anomalistic Psychology Research Unit, Department of Psychology, Goldsmiths College, University of London, New Cross, London SE14 6NW, UK; c.french@gold.ac.uk]. "**Near-death experiences in cardiac arrest survivors**." *Progress in Brain Research* 150 (2005): 351-367.

[Abstract:] Near-death experiences (NDEs) have become the focus of much interest in the last 30 years or so. Such experiences can occur both when individuals are objectively near to death and also when they simply believe themselves to be. The experience typically involves a number of different components including a feeling of peace and well-being, out-of-body experiences (OBEs), entering a region of darkness, seeing a brilliant light, and entering another realm. NDEs are known to have long-lasting transformational effects upon those who experience them. An overview is presented of the various theoretical approaches that have been adopted in attempts to account for the NDE. Spiritual theories assume that consciousness can become detached from the neural substrate of the brain and that the NDE may provide a glimpse of an afterlife. Psychological theories include the proposal that the NDE is a dissociative defense mechanism that occurs in times of extreme danger or, less plausibly, that the NDE reflects memories of being born. Finally, a wide range of organic theories of the NDE has been put forward including those based upon cerebral hypoxia, anoxia, and hypercarbia; endorphins and other neurotransmitters; and abnormal activity in the temporal lobes. Finally, the results of studies of NDEs in cardiac arrest survivors are reviewed and the implications of these results for our understanding of mind-brain relationships are discussed. [60 refs.]

Galek, K., Flannelly, K. J., Vane, A. and Galek, R. M. [The HealthCare Chaplaincy, 307 E. 60th St, New York, NY 10022; kgalek@healthcarechaplaincy.org]. "**Assessing a patient's spiritual needs: a comprehensive instrument**." *Holistic Nursing Practice* 19, no. 2 (Mar-Apr 2005): 62-69.

[Abstract:] Seven major constructs-belonging, meaning, hope, the sacred, morality, beauty, and acceptance of dying-were revealed in an analysis of the literature pertaining to patient spiritual needs. The authors embedded these constructs within a 29-item survey designed to be inclusive of traditional religion, as well as non-institutional-based spirituality. This article describes the development of a multidimensional instrument designed to assess a patient's spiritual needs. This framework for understanding a patient's spiritual needs hopefully contributes to the growing body of literature, providing direction to healthcare professionals interested in a more holistic approach to patient well-being.

Gatrad, R., Jhutti-Johal, J., Gill, P. S. and Sheikh, A. [Manor Hospital, Walsall, UK]. "**Sikh birth customs**." *Archives of Disease in Childhood* 90, no. 6 (Jun 2005): 560-563.

This is a brief overview of Sikh religion/culture, with perinatal practice in mind.

Gee, L., Smucker, D. R., Chin, M. H. and Curlin, F. A. [University of Chicago Pritzker School of Medicine, IL]. "**Partnering together? Relationships between faith-based community health centers and neighborhood congregations**." *Southern Medical Journal* 98, no. 12 (Dec 2005): 1245-1250.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.
[Abstract:] OBJECTIVE: The US Bureau of Primary Health Care has promoted collaboration between federally funded community health centers and neighborhood religious congregations, yet little is known about how such organizations currently interact in underserved neighborhoods. METHODS: Semistructured interviews were conducted with leaders from five faith-based, urban community health centers and 23 neighborhood congregations. Transcripts were coded for prevalent concepts and themes regarding collaborations between the two types of organizations. RESULTS: Collaborations between health centers and congregations are generally limited to modest sharing of resources and personnel and intermittent health promotion programs. Leaders of both types of organizations desire greater collaboration, but such desires appear to be frustrated by inadequate resources and differing priorities, visions, and philosophies. CONCLUSIONS: Increased collaboration between community health centers and neighborhood congregations will require efforts to overcome organizational differences,

intercongregational tensions, and resource limitations. For the participants, comprehensive "faith partnerships" remain a desirable but elusive goal.

Gillum, R. F. [Centers for Disease Control and Prevention, National Center for Health Statistics, 3311 Toledo Road, Room 6424, Hyattsville, MD 20782; rfg2@cdc.gov]. "**Frequency of attendance at religious services and cigarette smoking in American women and men: the Third National Health and Nutrition Examination Survey**." *Preventive Medicine* 41, no. 2 (Aug 2005): 607-613.

[Abstract:] BACKGROUND: Data are lacking from representative samples of total populations and Hispanic Americans on the association of cigarette smoking and religiousness/spirituality, a protective factor for mortality, and on the validity of self-reported smoking data for religious research. METHODS: The Third National Health and Nutrition Examination Survey (NHANES III) included 18,774 persons aged 20 years and over with complete data on self-reported frequency of attendance at religious services, and cigarette smoking. RESULTS: After stratifying by age, gender, and ethnic group, and adjusting for age, education, region, and health status, infrequent attenders (<24 times/year) were much more likely to be smokers than frequent attenders; odds ratios (95% confidence limits) ranged from 1.74 (1.45-2.10) to 3.06 (1.86-5.03). Among current smokers, frequent attenders smoked an average of 1-5 fewer cigarettes per day. Using serum cotinine > or =14 ng/mL as the gold standard for current smoking, under-reporting of smoking did not vary appreciably with frequency of attendance: false negative percentage for never smokers 3.1% in frequent attenders, 4.2% in others. CONCLUSIONS: Greater frequency of attendance at religious services was associated with lower smoking prevalence by self-report or serum cotinine in a national, multi-ethnic sample.

Golmakani, M. M., Niknam, M. H. and Hedayat, K. M. [Center for Study and Research of Medical Ethics, Ministry of Health and Medical Education, I.R. Iran]. "**Transplantation ethics from the Islamic point of view**." *Medical Science Monitor* 11, no. 4 (Apr 2005): RA105-109.

[Abstract:] Organ transplantation has been transformed from an experimental procedure at Western academic centers to an increasingly common procedure in private and public hospitals throughout the world. Attendant with advancements in organ harvesting, preservation, and transplantation come moral issues. Islam is a holistic religion that takes into account social affairs of man as well as spiritual ones. Islam has a long history of ethics literature including the subgenre of medical ethics. Historical considerations are discussed as to why Muslim thinkers were late to consider contemporary medical issues such as organ donation. Islam respects life and values the needs of the living over the dead, thus allowing organ donation to be considered in certain circumstances. The sources of Islamic law are discussed in brief in order for non-Muslims to appreciate how the parameters of organ transplantation are derived. The Islamic viewpoint, both Shiite and Sunni, is examined in relation to organ donation and its various sources. The advantages and disadvantages of brain dead and cadaveric donation is reviewed with technical and ethical considerations. The Islamic concept of brain death, informed and proxy consent are also discussed. We discuss the concept of rewarded donation as a way to alleviate the current shortage of organs available for transplantation and consider secular and religious support for such a program. Suggestions are made for greater discussion and exchange of ideas between secular and religious thinkers in the Islamic world and between the Islamic world and secular Western countries.

Gordon, J. S. and Edwards, D. M. [Center for Mind-Body Medicine, Washington, DC 20015]. "**MindBodySpirit Medicine**." *Seminars in Oncology Nursing* 21, no. 3 (Aug 2005): 154-158.

[Abstract:] OBJECTIVES: To present an overview of MindBodySpirit medicine including discussions of the efficacy of select self-care approaches. DATA SOURCES: Research and clinical articles on select complementary interventions. The model developed by the Center for Mind Body Medicine. CONCLUSION: Good information, self-care skills, and a supportive environment can assist an individual to achieve a higher level of physical, emotional, and spiritual wellness while navigating the cancer experience. IMPLICATIONS FOR NURSING PRACTICE: Increasing numbers of patients with cancer are becoming active in their health care and are choosing complementary approaches. There is an increasing body of literature supporting these interventions in improving quality of life. Nurses can acquire information to help patients navigate the expanding arena of complementary practices. "What Else Can I Do?" "What Else Can I Do?"

Halliburton, M. [Department of Anthropology, Queens College, City University of New York, Flusing, NY, 11367; Murphy_Halliburton@qc.edu]. "**'Just some spirits': the erosion of spirit possession and the rise of 'tension' in South India**." *Medical Anthropology* 24, no. 2 (Apr-Jun 2005): 111-144.

[Abstract:] Based on research among possessed and mentally ill patients and an examination of depictions of mental health issues in the popular media in the state of Kerala, India, this article examines apparent changes in the incidence and form of spirit possession and the proliferation of psychological idioms such as "tension" and "depression." These changes involve a decline in the incidence of possession as well as the homogenization of the identities of spirits: spirits that were described as having names and personalities a few decades earlier are now presented as more anonymous. The homogenization of spirits and the use of psychological idioms are interpreted as signaling an erosion of context and the ascendance of universal categories, which, according to some theorists, is a characteristic of "modernity." It will also be shown that at the same time the "modern" can appear as simply another context, as when the idiom of possession permeates a psychological advice column in the print media. [41 refs.]

Harding, R., Karus, D., Easterbrook, P., Raveis, V. H., Higginson, I. J. and Marconi, K. [Department of Palliative Care and Policy, Guy's King's and St Thomas's School of Medicine, King's College, London, UK; Richard.Harding@kcl.ac.uk]. "**Does palliative care improve outcomes for patients with HIV/AIDS? A systematic review of the evidence**." *Sexually Transmitted Infections* 81, no. 1 (Feb 2005): 5-14.

[Abstract:] BACKGROUND: The need for palliative care in HIV management is underlined by the high prevalence of pain and symptoms, the toxicity, side effects, and virological failure associated with antiretroviral therapy, emergence of co-morbidities, continued high incidence of malignancies, late presentation of people with HIV disease, and the comparatively higher death rates among the infected individuals. METHODS: A systematic review was undertaken to appraise the effect of models of palliative care on patient outcomes. A detailed search strategy was devised and biomedical databases searched using specific terms relevant to models of palliative care. Data from papers that met the inclusion criteria were extracted into common tables, and evidence independently graded using well described hierarchy of evidence. RESULTS: 34 services met the inclusion criteria. Of these, 22 had been evaluated, and the evidence was graded as follows: grade 1 (n = 1); grade 2 (n = 2); grade 3 (n = 7); grade 4 (n = 1); qualitative (n = 6). Services were grouped as: home based care (n = 15); home palliative care/hospice at home (n = 7); hospice inpatient (n = 4); hospital inpatient palliative care (n = 4); specialist AIDS inpatient unit (n = 2); and

hospital inpatient and outpatient care (n = 2). The evidence largely demonstrated that home palliative care and inpatient hospice care significantly improved patient outcomes in the domains of pain and symptom control, anxiety, insight, and spiritual well-being. CONCLUSIONS: Although the appraisal of evidence found improvements across domains, the current body of evidence suffers from a lack of (quasi) experimental methods and standardized measures. The specialism of palliative care is responding to the clinical evidence that integration into earlier disease stages is necessary. Further studies are needed to both identify feasible methods and evaluate the apparent beneficial effect of palliative care on patient outcomes in the post-HAART era. [86 refs.]

Harrison, M. O., Edwards, C. L., Koenig, H. G., Bosworth, H. B., Decastro, L. and Wood, M. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC 27705; harril25@mc.duke.edu]. "**Religiosity/spirituality and pain in patients with sickle cell disease**." *Journal of Nervous & Mental Disease* 193, no. 4 (Apr 2005): 250-257.

[Abstract:] Religion/spirituality has been identified by individuals with sickle cell disease (SCD) as an important factor in coping with stress and in determining quality of life. Research has demonstrated positive associations between religiosity/spirituality and better physical and mental health outcomes. However, few studies have examined the influence religiosity/spirituality has on the experience of pain in chronically ill patients. Our aim was to examine three domains of religiosity/spirituality (church attendance, prayer/Bible study, intrinsic religiosity) and evaluate their association with measures of pain. We studied a consecutive sample of 50 SCD outpatients and found that church attendance was significantly associated with measures of pain. Attending church once or more per week was associated with the lowest scores on pain measures. These findings were maintained after controlling for age, gender, and disease severity. Prayer/Bible study and intrinsic religiosity were not significantly related to pain in our study. Positive associations are consistent with recent literature, but our results expose new aspects of the relationship for African American patients. We conclude that religious involvement likely plays a significant role in modulating the pain experience of African American patients with SCD and may be an important factor for future study in other populations of chronically ill pain sufferers.

Hasnain, M., Sinacore, J. M., Mensah, E. K. and Levy, J. A. [Department of Family Medicine, College of Medicine, University of Illinois at Chicago, IL 60612-7309; memoona@uic.edu]. "**Influence of religiosity on HIV risk behaviors in active injection drug users**." *AIDS Care* 17, no. 7 (Oct 2005): 892-901.

[Abstract:] Previous studies have shown a positive relationship between religiosity and the practice or adoption of protective health behaviors, including reduction of illicit drug use among hard-core injecting drug users (IDUs). The purpose of this study was to examine the role of religiosity in predicting HIV high-risk drug and sexual practices among a sample of IDUs in Chicago, USA. We hypothesized that high religiosity would be associated with a lower likelihood of IDUs engaging in risky behaviors for HIV transmission. Snowball sampling techniques were used to recruit 1,095 active IDUs for HIV testing, counseling and partner notification. Data were analyzed from 880 subjects who self-identified with one of three religions, Christianity, Islam or Judaism. Logistic regression was used to examine the relationship between religiosity (based on self-reports of personal strength of religious belief: very strong; somewhat strong; not at all), independent of specific religion, and HIV risk behaviors (defined as 12 unsafe sex- and drug-related practices) as well as HIV serostatus. Contrary to our hypothesis, subjects with stronger religiosity were more likely to engage in four risk behaviors related to sharing injection paraphernalia. Compared to those who self-reported having no religiosity, subjects who stated that their lives were strongly influenced by religious beliefs were significantly more likely to share injection outfits, cookers, cotton and water. The association of certain HIV risk behaviors with higher religiosity has implications for HIV prevention and warrants further research to explore IDUs' interpretation of religious teachings and the role of religious education in HIV prevention programs.

Head, B. and Faul, A. [University of Louisville, School of Medicine, Louisville, KY]. "**Terminal restlessness as perceived by hospice professionals**." *American Journal of Hospice & Palliative Care* 22, no. 4 (Jul-Aug 2005): 277-282.

[From the abstract:] …The purposes of this study were twofold: to compare the perceptions of practicing hospice clinicians with the literature related to terminal restlessness, and to determine if their experience with terminal restlessness agreed with the components of the one established scale for terminal restlessness found in the literature. In general, the study findings corresponded to the literature in regards to frequency, definition, causes, and behavioral manifestations of terminal restlessness. The clinicians in the study supported the impact of psychosocial and spiritual causes of terminal restlessness and defined the phenomenon in terms of time period; emotional, physical, and spiritual distress; changes in consciousness; and increased activity….

Hemming, L. and Maher, D. [Department of Nursing and Midwifery, University of Hertfordshire; l.hemming@herts.ac.uk]. "**Cancer pain in palliative care: why is management so difficult?**" *British Journal of Community Nursing* 10, no. 8 (Aug 2005): 362-367. Comment on p. 355.

[Abstract:] Pain is the major source of anxiety and distress at the end of life, particularly in cases of end-stage cancer. However, pain management is not always effective or effectively implemented. This article identifies several barriers to effective pain relief in terminal cancer--the complexity of pain; difficulties in physical, emotional and spiritual assessment; difficulties in the delivery of medication--that challenge the skills of all professionals involved in palliative care. There are no simple answers, but awareness of the breadth of the issues may help focus nurses' minds on the patient in every encounter.

Hills, J., Paice, J. A., Cameron, J. R. and Shott, S. [Palliative Care and Home Hospice Program, Northwestern Memorial Hospital, 676 N. St. Clair Street, Suite 720, Chicago, IL 60611; j-hills@northwestern.edu]. "**Spirituality and distress in palliative care consultation**." *Journal of Palliative Medicine* 8, no. 4 (Aug 2005): 782-788.

[Abstract:] BACKGROUND: One's spirituality or religious beliefs and practices may have a profound impact on how the individual copes with the suffering that so often accompanies advanced disease. Several previous studies suggest that negative religious coping can significantly affect health outcomes. OBJECTIVE: The primary aim of this study was to explore the relationship between spirituality, religious coping, and symptoms of distress among a group of inpatients referred to the palliative care consult service. DESIGN: Pilot study. SETTING: The study was conducted in a large academic medical center with a comprehensive Palliative Care and Home Hospice Program. MEASUREMENT: (1) National Comprehensive Cancer Network Distress Management Assessment Tool; (2) Pargament Brief Religious Coping Scale (Brief RCOPE); (3) Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp); (4) Puchalski's FICA; and (5) Profile of Mood States-Short Form (POMS-SF). RESULTS: The 31 subjects surveyed experienced moderate distress (5.8 +/- 2.7), major physical and psychosocial symptom burden, along with reduced function and significant caregiving needs. The majority (87.2%) perceived themselves to be

at least somewhat spiritual, with 77.4% admitting to being at least somewhat religious. Negative religious coping (i.e., statements regarding punishment or abandonment by God) was positively associated with distress, confusion, depression, and negatively associated with physical and emotional well-being, as well as quality of life. CONCLUSIONS: Palliative care clinicians should be alert to symptoms of spiritual distress and intervene accordingly. Future research is needed to identify optimal techniques to address negative religious coping.

Himelstein, B. P. [Palliative Care, Children's Hospital of Wisconsin, Milwaukee, WI 53201; bhimelstein@chw.org]. "**Palliative care in pediatrics**." *Anesthesiology Clinics of North America* 23, no. 4 (Dec 2005): 837-856, xi.
This is a broad overview of the subject. See especially the section on Psychological and Spiritual Concerns (p. 839ff) and specifically the sub-section on Spiritual Care (p. 842), and the assessment planning chart (figure 1, p. 843).

Hinshaw, D. B. [Palliative Care Program and Surgical Service, Ann Arbor VA Medical Center, 2215 Fuller Road (112), Ann Arbor, MI 48105; hinshaw@umich.edu]. "**Spiritual issues in surgical palliative care**." *Surgical Clinics of North America* 85, no. 2 (Apr 2005): 257-272.
[Abstract:] The key points of this article are: Spirituality gives meaning and purpose to life. Spiritual issues that may lie dormant for many years often surface at the end of life. Not all people are religious, but all are spiritual. Suffering affects the whole person and often is connected to the meaning that a patient associates with a symptom or symptoms. Spiritual history validates the importance of a patient's spirituality and gives permission to the patient for future discussion/questions. Spiritual care is the job of all members of the interdisciplinary team(including surgeons), not just chaplains. It is critical to be open to spiritual discussions/issues as they arise while seeking the assistance of professional pastoral care staff where appropriate. Redefining hope: hospice can help the dying patient to redefine hope in terms of realistic goals-from a hope for cure to a hope for good symptom relief. Reconciliation is the work of the dying. Empathy is the opportunity for those who care for the dying.

Hodge, D. R. [Arizona State University, Phoenix]. "**Developing a spiritual assessment toolbox: a discussion of the strengths and limitations of five different assessment methods**." *Health & Social Work* 30, no. 4 (Nov 2005): 314-323.
[Abstract:] Increasingly, social workers are being called on to conduct spiritual assessments, yet few assessment methods have appeared in academic literature. This article reviews five complementary assessment approaches that have recently been developed to highlight different facets of clients' spiritual lives. Specifically, one verbal model, spiritual histories, is discussed, along with four diagrammatic approaches: spiritual lifemaps, spiritual genograms, spiritual ecomaps, and spiritual ecograms. An overview of each approach is provided along with a discussion of its relative strengths and limitations. The aim here is to familiarize readers with a repertoire of spiritual assessment tools so that the most appropriate assessment method in a given client-practitioner setting can be selected.

Hodge, D. R. [Program for Research on Religion and Urban Civil Society, University of Pennsylvania, Philadelphia 19104]. "**Social work and the house of Islam: orienting practitioners to the beliefs and values of Muslims in the United States**." *Social Work* 50, no. 2 (Apr 2005): 162-173.
[Abstract:] Despite the media attention focused on the Islamic community after the terrorist attacks on the World Trade Center on September 11, 2001, Muslims remain one of the most misunderstood populations in the United States. Few articles have appeared in the social work literature orienting practitioners to the Islamic community, and much of the mainstream media coverage misrepresents the population. This article reviews the basic beliefs, practices, and values that commonly characterize, or inform, the House of Islam in the United States. The organizations that embody and sustain the Muslim communities that constitute the House of Islam are profiled, and areas of possible value conflicts are examined. The article concludes by offering suggestions for integrating the article's themes into practice settings. Particular attention is given to enhancing cultural competence and to suggestions for spiritual assessment and interventions. [References: 69]

Hodge, D. R. [University of Pennsylvania, Program for Research on Religion and Urban Civil Society, Philadelphia 19104]. "**Spiritual lifemaps: a client-centered pictorial instrument for spiritual assessment, planning, and intervention**." *Social Work* 50, no. 1 (Jan 2005): 77-87.
[Abstract:] Although some consumers desire to integrate spirituality into the clinical dialogue, few resources have appeared in the literature to help practitioners operationalize spiritual strengths. This article introduces and orients practitioners to a new pictorial instrument-the spiritual lifemap-that can be used for spiritual assessment. The instrument facilitates a smooth transition from assessment to exploring and planning interventions. The author provides a case study and suggestions on how to use the instrument in clinical settings. A number of common spiritual interventions, drawn from a wide variety of theoretical approaches, are highlighted. The author discusses several applications and possible value conflicts that may arise when assessing spirituality.

Holland, J. C. and Reznik, I. [Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 641 Lexington Avenue, New York, NY 10022; hollandj@mskcc.org]. "**Pathways for psychosocial care of cancer survivors**." *Cancer* 104, no. 11, suppl. (Dec 1, 2005): 2624-2637.
The authors present an assessment model, with includes attention to spiritual issues (see esp. figure 1 on p. 2626), [from the abstract:] that can assist oncologists and multidisciplinary teams in busy ambulatory settings to more readily identify those survivors who are distressed, whose quality of life is impaired, and who may benefit from further psychological evaluation and treatment.

Holland, J. M. and Neimeyer, R. A. [Deptartment of Psychology, University of Memphis, TN]. "**Reducing the risk of burnout in end-of-life care settings: the role of daily spiritual experiences and training**." *Palliative & Supportive Care* 3, no. 3 (Sep 2005): 173-181.
[Abstract:] OBJECTIVE: Individuals in the helping professions are subject to unique stressors that may lead to burnout, and research has shown that those who work with dying or bereaved individuals might be particularly at-risk. This study explores how factors such as spirituality and level of training might buffer the stress of working with terminally ill clients and their families. METHOD: A total of 80 medical and mental health practitioners attending palliative care seminars were surveyed, with each completing validated measures of daily spiritual experiences and caregiver burnout, as well as assessments of demographic factors, their general education and training experiences specific to working in end-of-life care and bereavement settings. RESULTS: Findings indicate that daily spiritual experiences might mitigate physical, cognitive, and emotional forms of burnout in the workplace. In addition, a negative correlation was found between the amount of end-of-life training received and burnout in the physical and cognitive domains. However, training was not related to professionals' level of

emotional exhaustion. SIGNIFICANCE OF THE RESEARCH: Results reinforce a growing literature on the salutary effects of spirituality, and underscore its relevance as one possible form of constructive coping for professionals attending to the needs of the dying and bereaved. The study carries further implications for how the stresses of such work might be ameliorated by enhanced training efforts, as well as creative facilitation of diverse spiritual expressions (e.g., inclusive forms of ritual recognition of loss) in the workplace.

Holley, J. L. [Department of Medicine, Nephrology Division, University of Virginia Health System, Charlottesville, VA 22908; jlh4qs@virginia.edu]. "**Palliative care in end-stage renal disease: focus on advance care planning, hospice referral, and bereavement**." *Seminars in Dialysis* 18, no. 2 (Mar-Apr 2005): 154-156.

[Abstract:] The components of palliative care in end-stage renal disease (ESRD) include pain and symptom management, advance care planning, psychosocial and spiritual support, and ethical issues in dialysis. End-of-life care is not synonymous with, but rather a subset of palliative care. Advance care planning occurs within the patient-family relationship and is a dynamic process that prepares for death, strengthens interpersonal relationships, and allows a patient to achieve control over his or her life. It is incumbent upon dialysis care providers to include advance care planning in overall care plans for their patients. Factors contributing to the failure of advance care planning in ESRD patients will be discussed, as will hospice and ESRD, and opportunities for bereavement programs.

Hollins, S. [Spiritual Healthcare Modernisation Agenda, South Yorkshire Strategic Health Authority]. "**Spirituality and religion: exploring the relationship**." *Nursing Management (Harrow)* 12, no. 6 (Oct 2005): 22-26.

The author, a chaplain, raises basic issues in spirituality & health, including the conception of spirituality, spiritual assessment, and cultural diversity.

Holt, C. L. and Klem, P. R. [University of Alabama at Birmingham, School of Medicine, Division of Preventive Medicine, MT 641, 1530 3rd Avenue South, Birmingham, AL 35294-4410; cholt@uab.edu]. "**As you go, spread the word: spiritually based breast cancer education for African American women**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S141-142.

[Abstract:] INTRODUCTION: In partnership with an African American church, we developed an educational booklet on breast cancer early detection from within a spiritual framework. This booklet included religious themes and biblical scripture supporting the early detection message, for women ages 40 and over to have regular mammograms. METHODS: The spiritually based booklet was compared against a demographically targeted booklet (for African American women, but with no spiritual or religious content) for communication effectiveness. One hundred and eight African American women were randomly assigned to read one of the booklets and complete a series of questionnaires about the booklet. RESULTS: Both those in the spiritually based and the secular groups reported significant increases in knowledge about breast cancer treatment and decrease in perceived barriers to mammography. Those in the spiritually based group additionally increased knowledge about mammograms. CONCLUSIONS: This small study suggests that spiritually based approaches may be more effective than secular based. Our future studies will explore these and other spiritually based interventions in larger sample sizes of patients.

Holtslander, L. F., Duggleby, W., Williams, A. M. and Wright, K. E. [College of Nursing, University of Saskatchewan, Saskatoon, Canada]. "**The experience of hope for informal caregivers of palliative patients**." *Journal of Palliative Care* 21, no. 4 (2005): 285-291.

[Abstract:] This study explored the experience of hope for informal caregivers of palliative patients. Interviews were conducted with 10 caregivers living with and providing care to a palliative patient. The interview data were analyzed using grounded theory qualitative methods. "Eroding hope" was their main concern--a result of bad days, negative messages, and experiences with the health care system. The participants dealt with eroding hope by "hanging on to hope." Hanging on to hope had four subprocesses: a) doing what you have to do, b) living in the moment, c) staying positive, and d) writing your own story. The support of friends, family, and health care professionals, and spiritually connecting with something bigger and stronger were subprocesses. These findings have application for informal caregivers providing palliative care at home, as a basis for assessment and interventions. Health care professionals need to recognize and value the experience of hope for the informal caregivers of palliative patients.

Hufford, D. J. [Penn State College of Medicine, Hershey, PA 17033; djh5@psu.edu]. "**Sleep paralysis as spiritual experience**." *Transcultural Psychiatry* 42, no. 1 (Mar 2005): 11-45.

[Abstract:] This article presents an overview of the sleep paralysis experience from both a cultural and a historical perspective. The robust, complex phenomenological pattern that represents the subjective experience of sleep paralysis is documented and illustrated. Examples are given showing that, for a majority of subjects, sleep paralysis is taken to be a kind of spiritual experience. This is, in part, because of the very common perception of a non-physical 'threatening presence' that is part of the event. Examples from various cultures, including mainstream contemporary America which has no widely known tradition about sleep paralysis, are used to show that the complex pattern and spiritual interpretation are not dependent on cultural models or prior learning. This is dramatically contrary to conventional explanations of apparently 'direct' spiritual experiences, explanations that are summed up as the 'Cultural Source Hypothesis.' This aspect of sleep paralysis was not recognized through most of the twentieth century. The article examines the way that conventional modern views of spiritual experience, combined with medical ideas that labeled 'direct' spiritual experiences as psychopathological, and mainstream religious views of such experiences as heretical if not pathological, suppressed the report and discussion of these experiences in modern society. These views have resulted in confusion in the scientific literature on sleep paralysis with regard to its prevalence and core features. The article also places sleep paralysis in the context of other 'direct' spiritual experiences and offers an 'Experiential Theory' of cross-culturally distributed spiritual experiences.

Husaini, B. A., Emerson, J. S., Hull, P. C., Sherkat, D. E., Levine, R. S. and Cain, V. A. [Center for Health Research, Tennessee State University in Nashville, TN; bahusaini@earthlink.net]. "**Rural-urban differences in breast cancer screening among African American women**." *Journal of Health Care for the Poor & Underserved* 16, no. 4, suppl. A (Nov 2005): 1-10.

[Abstract:] This study reports on rural-urban differences in the effectiveness of a church-based educational program aimed at increasing breast cancer screening among African American women ages 40 and over. The data were drawn from an intervention study in urban Nashville, and a pilot extension of the study in five rural counties of West Tennessee. The partial program was equally effective in rural Tennessee (17.6% increase in mammography attainment from baseline to Time 3) and in urban Nashville (22.3% increase). The rural women reported more barriers to mammography screening than the urban women. The rural women were more likely not to get a mammogram because they did not perceive a need, because they thought mammography was embarrassing, and because of their religious beliefs. The results of this study

demonstrate that an inexpensive church-based educational program was equally effective in both rural and urban Tennessee for increasing mammography rates among African American women.

Jacoby, L. H., Breitkopf, C. R. and Pease, E .A. [Center for Medical Ethics, Albany Medical College, 43 New Scotland Avenue, Albany, NY 12208; jacobyl@mail.amc.edu]. "**A qualitative examination of the needs of families faced with the option of organ donation**." *DCCN - Dimensions of Critical Care Nursing* 24, no. 4 (Jul-Aug 2005): 183-189.
Among the findings of this qualitative study (n=16): "Faith and spiritual support were important to nearly all donor family members but less so to non-donor group participants" (p. 187).

Jakovljevic, M. "**Current status of religion and spirituality in psychiatry**." *Psychiatria Danubina* 17, nos. 3-4 (Dec 2005): 138-140.
This article is interesting as a Croatian perspective on the subject, concluding: "A growing body of scientific evidence suggests a significant relationship between religion or spirituality and mental health. Psychiatrists should be aware of this connection and take it into account in clinical practice. Spirituality should be part of the clinical assessment and it is recommended that an appropriate spiritual anamnesis be taken from the patient. An increasing number of psychiatrists recognize the importance of spiritual or religious beliefs as a potential source of strength to many patients coping with the stress of mental disorders. Whenever needed, cooperation and referral to chaplains or other spiritual care experts is recommended." (p. 139) [See also the articles by Aukst-Margetic and by Koic, elsewhere in this bibliography, for other examples from the Croatian literature.]

Jang, Y., Borenstein, A. R., Chiriboga, D. A. and Mortimer, J. A. [Department of Aging and Mental Health, Florida Mental Health Institute, University of South Florida, MHC 1439, Tampa, FL 33612; yjang@fmhi.usf.edu]. "**Depressive symptoms among African American and white older adults**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 60, no. 6 (Nov 2005): P313-P319.
[Abstract:] Guided by a stress and coping model, we explored determinants of depressive symptoms among community samples of older African Americans (n=255) and older Whites (n=452). We gave focus to the effects of demographic variables, physical health constraints (chronic conditions and functional disability), and psychosocial attributes (sense of mastery, religiosity, social support, and satisfaction with support), along with their interactive roles. We identified lower education, greater functional disability, lower sense of mastery, and poorer satisfaction with support as common risk factors for depressive symptoms in both groups; in contrast, the effects of age, gender, and religiosity were race specific. In addition, we obtained significant interactions among predictor variables in each group, identifying risk-reducing and risk-enhancing factors within each group.

Jenkins, C., Lapelle, N., Zapka, J. G. and Kurent, J. E. [Medical University of South Carolina, College of Nursing College of Medicine, Charleston, SC 29425; jenkins@musc.edu]. "**End-of-life care and African Americans: voices from the community**." *Journal of Palliative Medicine* 8, no. 3 (Jun 2005): 585-592.
[Abstract:] BACKGROUND: In 1997, the Institute of Medicine called for reform, improved quality and expanded research in end-of-life care. Yet little empirical information about preferences of African Americans has been documented. A community-campus partnership was formed to guide a needs assessment related to end-of-life care in a Southern, urban, African American community. This paper presents focus group findings related to end-of-life and palliative care. METHODS: A qualitative design of multiple-meeting focus groups was used to explore experiences, preferences, needs, and feelings expressed by family members with at least one relative who had died in a hospital (group 1) or at home (group 2). Sessions were taped and transcribed; themes were identified using systematic analytic procedures. RESULTS: Thematic analysis revealed key concerns related to health care provider communications about end-of-life care and dying. Positive communications empowered and showed respect for patients and family members and recognized the importance of their spiritual beliefs; informed them about resources available to assist dying at home; and, for patients dying in the hospital, treated them with nurturing, compassion, and diligent monitoring of the patient's medical status and needs. Other themes related to end-of-life care issues include preparation, planning, and access. A table of quotes from participants is available from the corresponding author. CONCLUSIONS: Findings suggest important clinical implications for clinicians and other health professionals. These voices from the community remind us of the heterogeneity in needs and preferences and challenge us to listen and tailor communication to each patient and their families.

Johnson, K. S., Elbert-Avila, K. I. and Tulsky, J. A. [Department of Medicine, Division of Geriatrics, Duke University Medical Center, DUMC Box 3003, Durham, NC 27710; johns196@mc.duke.edu]. "**The influence of spiritual beliefs and practices on the treatment preferences of African Americans: a review of the literature**." *Journal of the American Geriatrics Society* 53, no. 4 (Apr 2005): 711-719.
[Abstract:] Spirituality is an important part of African-American culture and is often cited as an explanation for the more-aggressive treatment preferences of some African Americans at the end of life. This paper reviews the literature on spiritual beliefs that may influence the treatment decisions of African Americans. Medline 1966 to February 2003, Psych Info 1872 to February 2003, and CINAHL 1982 to February 2003 were searched for studies exploring spiritual beliefs that may influence the treatment preferences of African Americans. All candidate papers were examined for quality, and data were extracted on study population, design, analysis, and results to identify recurrent themes. Forty studies met inclusion criteria. Recurrent themes describing spiritual beliefs that may influence the treatment preferences of African Americans throughout the course of illness include the following: spiritual beliefs and practices are a source of comfort, coping, and support and are the most effective way to influence healing; God is responsible for physical and spiritual health; and the doctor is God's instrument. Spiritual beliefs specifically addressing treatment preferences at the end of life include: only God has power to decide life and death, there are religious prohibitions against physician-assisted death or advance directives limiting life-sustaining treatments, and divine intervention and miracles occur. For some African Americans, spiritual beliefs are important in understanding and coping with illness and may provide a framework within which treatment decisions are made. Given the growing ethnic diversity of the United States, some understanding of the complexities of culture and spirituality is essential for healthcare providers.

Johnson, T. D. [Lupine Creative Consulting, Inc., Rochester, NY]. "**Intensive spiritual care: a case study**." *Critical Care Nurse* 25, no. 6 (Dec 2005): 20-26. Quiz on p. 27.

The case of a Laotian patient is used to illustrate religious and cultural aspects of patient care, including Fitchett's model for spiritual assessment.

Jones, J. B. [University of Nevada, Reno]. "**Liver transplant recipients' first year of posttransplant recovery: a longitudinal study**." *Progress in Transplantation* 15, no. 4 (Dec 2005): 345-352.

[Abstract:] A longitudinal study of 20 liver transplant recipients was conducted to investigate their posttransplant recovery experience. Data were collected using semistructured interviews at 6 weeks, 6 months, and 1 year after transplantation. Qualitative analysis of data revealed physical, psychological, social, economic, and spiritual dimensions of recovery. Findings reflect ongoing improvement of physical health and functionality for most recipients. Those with continuing health problems often suffered from preexisting health conditions. Psychological adjustment was uneven, with intermittent periods of fear, anxiety, and depression. Some recipients reported short-lived split identities and personality changes. Social support of family was critical in the hospital and at home. Economic issues became primary by the 1-year interview, with all recipients questioning whether they could afford ongoing healthcare and medicines. Spiritual needs were met in secular and nonsecular activities. Findings suggest that healthcare personnel should attend to the lived experience of liver transplant recipients.

Jones-Cannon, S. and Davis, B. L. [Hampton University, College of Virginia Beach, VA 23462; sheila.cannon@hamptonu.edu]. "**Coping among African-American daughters caring for aging parents**." *ABNF Journal* 16, no. 6 (Nov-Dec 2005): 118-123.

[Abstract:] BACKGROUND: A higher proportion of African-American caregivers reported having suffered physical and mental problems because of caregiving (U. S. Department of Health & Human Services, 2005). PURPOSE: The purpose of this study was to examine the coping strategies of African-American daughters who have functioned as caregivers. The Neuman Systems model was utilized as the framework for this study. METHOD: An exploratory design utilizing qualitative and quantitative methodologies was conducted in two phases. Phase I (N = 44) consisted of a series of focus groups sessions and Phase II (N = 106) participants completed the Basic Interview Schedule Survey. DISCUSSION: Findings revealed than other groups to report dementia and stroke in their care recipients that daughters who attended support groups had increased family involvement, were religious and coped better with caregiving. CONCLUSION: This study concluded that religion gave most participants a strong tolerance for the caregiving situation and served to mediate the caregiving strain.

Jotkowitz, A. B. and Glick, S. [Department of Medicine, Soroka University Medical Center and the Faculty of Medicine, Ben-Gurion University of the Negev, Beer-Sheva, Israel]. "**Confession at the end of life: a Jewish perspective**." *Journal of Palliative Care* 21, no. 1 (2005): 57-58.

The authors address briefly but well the place of confession at the end of life within Judaism.

Kang, T., Hoehn, K. S., Licht, D. J., Mayer, O. H., Santucci, G., Carroll, J. M., Long, C. M., Hill, M. A., Lemisch, J., Rourke, M. T. and Feudtner, C. [Department of Pediatrics, The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard North, Philadelphia, PA 19104]. "**Pediatric palliative, end-of-life, and bereavement care**." *Pediatric Clinics of North America* 52, no. 4 (Aug 2005): 1029-1046, viii.

[Abstract:] The pediatric hospitalist plays an integral role in providing palliative, end-of-life, and bereavement care for children and families. This article focuses on a multifaceted approach to this domain of care in which the physician is a key member of an interdisciplinary team. We believe that we can improve quality of life and relieve suffering only by paying attention to the medical, emotional, spiritual, and practical needs and goals of dying children and their loved ones.

Keown, D. "**End-of-life: the Buddhist view**." *The Lancet* 366, no. 9489 (Sep 10-16, 2005): 952-955.

This is part of an article series on religious diversity in health care. [See also articles by Baggini, Dorff, Engelhardt, Firth, Markwell, and Sachedina listed in this bibliography.]

Kilpatrick, S. D., Weaver, A. J., McCullough, M. E., Puchalski, C., Larson, D. B., Hays, J. C., Farran, C. J. and Flannelly, K. J. [UCLA/RAND Center for Adolescent Health Promotion]. "**A review of spiritual and religious measures in nursing research journals: 1995-1999**." *Journal of Religion & Health* 44, no. 1 (2005): 55-66.

[Abstract:] Background: A series of systematic reviews has revealed relatively high levels of interest in religion and spirituality in different nursing specialties, but not in general nursing research journals. Purpose: To identify the extent to which spirituality and religiousness were measured in all quantitative and qualitative research articles published in Research in Nursing and Health, Nursing Research, Advances in Nursing Science (ANS), and Image: The Journal of Nursing Scholarship from 1995 to 1999. Methods: A full-text search was conducted of ANS and Image using the Ovid search system. Nursing Research and Research in Nursing and Health were hand searched for spiritual/religious measures. Characteristics of selected studies, the measures taken, and their uses were coded for data analysis. Results: A total of 564 research studies were identified, of which 67 (11.9%) included at least one measure of spirituality or religiousness. A significant difference was found between the percentage of qualitative and quantitative studies that contained measures of these concepts. Of the 119 qualitative studies, 23 (19.3%) contained a measure of religion or spirituality, compared to 44 of the 445 (9.9%) quantitative studies. Nominal indicators of religious affiliation were the most commonly used measures in the quantitative studies and measures of religion and spirituality were rarely used in the analyses. Although only a few quantitative or qualitative studies intended to focus on religion or spirituality, these themes often emerged spontaneously in the qualitative research. Conclusions: Research in Nursing and Health, Advances in Nursing Science, Nursing Research, and Image: The Journal of Nursing Scholarship all published research measuring spirituality and religiousness during the time-period studies. The rate at which spirituality and religion appeared in these nursing research articles is substantially higher than that found in most fields outside of nursing. Even more frequent inclusion of spiritual and religious variables and richer measures of spirituality and religiousness would help to increase the available scientific information on the role of spirituality and religion in nursing care.

King, D. E., Cummings, D., Whetstone, L. [Department of Family Medicine, Medical University of South Carolina, Charleston 29464; kingde@musc.edu]. "**Attendance at religious services and subsequent mental health in midlife women**." *International Journal of Psychiatry in Medicine* 35, no. 3 (2005): 287-297. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] OBJECTIVE: Spiritual and religious factors may influence mental health in midlife women. The purpose of this study was to explore whether strength of religious beliefs or attendance at religious services helps to mitigate the stresses of life in mid-life women. METHODS: Data are from a sub-sample of 265 women, ages 40-70, who were participants in the REACH study, a longitudinal study

investigating health parameters in a representative sample of households from rural communities in eastern North Carolina. Using t-tests and linear regression analyses, we analyzed the relationship between frequency of attendance at religious services and strength of religious beliefs in 1997 and subsequent mental health in 2003 as measured by the mental health component score (MCS) of the SF-12. RESULTS: The mean MCS in 2003 was significantly higher (better mental health) in women who reported attending religious services > or =1/week compared to those who reported attending <1/week (53.9 vs. 51.7; $p < 0.05$). In the linear regression model controlling for self-reported health status, baseline attendance at organized religious services remained a significant predictor of the MCS at six-year follow-up (standardized beta = -0.123, $p < 0.05$). CONCLUSIONS: Attendance at religious services is positively related to subsequent mental health in middle-aged women. The findings support the notion that religious commitment may help mitigate the stress of the midlife period. More research is needed to translate these findings into clinical interventions that can decrease the burden of anxiety and depression on midlife women.

Kinsel, B. [Greene County Council on Aging, Xenia, OH]. "**Resilience as adaptation in older women**." *Journal of Women & Aging* 17, no. 3 (2005): 23-39.

The study involved face-to-face open-ended interviews with 17 women. [From the abstract: Among seven factors that emerged as salient to resilience in the sample are the external resource of social connectedness and internal resources, including a head-on approach to challenge and spiritual grounding….

Klitzman, R. L. and Daya, S. [Center for Bioethics, College of Physicians and Surgeons, Joseph Mailman School of Public Health, Columbia University, 1051 Riverside Drive, Unit 29, New York, NY 10032; rlk2@columbia.edu]. "**Challenges and changes in spirituality among doctors who become patients**." *Social Science & Medicine* 61, no. 11 (Dec 2005): 2396-2406.

[Abstract:] Though spirituality can help patients cope with illness, several studies have suggested that physicians view spirituality differently than do patients. These issues have not been systematically investigated among doctors who become patients, and who may be able to shed critical light on this area. We interviewed fifty doctors from major urban US centers who had become patients due to serious illnesses about their experiences and views relating to religion and spirituality before and after diagnosis, and we explore the range of issues that emerged. These physician-patients revealed continua of forms and contents of spirituality. The forms ranged from being spiritual to start with; to being spiritual, but not thinking of themselves as such; to wanting but being unable to believe. Some continued to doubt and, perhaps relatedly, appeared depressed. The contents of beliefs ranged from established religious traditions, to mixing beliefs, or having non-specific beliefs (e.g., concerning the power of nature). One group of doctors felt wary of organized religion, which could prove an obstacle to belief. Others felt that symptoms could be reduced through prayer. At times, self-assessments of spirituality were difficult to make or inaccurate. Questions surfaced concerning whether and how medical education could best address these issues, and how spirituality may affect clinical work. This study is the first that we know of to examine spirituality among physicians when they become patients. Obstacles to physicians' attentiveness to the potential role of spirituality arose that need to be further explored in medical education and future research. Increased awareness of these areas could potentially have clinical relevance, strengthening doctor-patient relationships and communication, and patient satisfaction.

Koenig, H. G. [Duke University Medical Center, Durham, NC 27710; Koenig@geri.duke.edu]. "**Religion, spirituality and medicine: the beginning of a new era**." *Southern Medical Journal* 98, no. 12 (Dec 2005): 1235-1236.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Koenig, L. B., McGue, M., Krueger, R. F. and Bouchard, T. J., Jr. [Department of Psychology, University of Minnesota-Twin Cities, Minneapolis, MN 55455; koen00999@umn.edu]. "**Genetic and environmental influences on religiousness: findings for retrospective and current religiousness ratings**." *Journal of Personality* 73, no. 2 (Apr 2005): 471-488.

[Abstract:] Estimates of the degree of genetic and environmental influences on religiousness have varied widely. This variation may, in part, be due to age differences in the samples under study. To investigate the heritability of religiousness and possible age changes in this estimate, both current and retrospective religiousness were assessed by self-report in a sample of adult male twins (169 MZ pairs and 104 DZ pairs, mean age of 33 years). Retrospective reports of religiousness showed little correlation difference between MZ (r=.69) and DZ (r=.59) twins. Reports of current religiousness, however, did show larger MZ (r=.62) than DZ (r=.42) similarity. Biometric analysis of the two religiousness ratings revealed that genetic factors were significantly weaker (12% vs. 44%) and shared environmental factors were significantly stronger (56% vs. 18%) in adolescence compared to adulthood. Analysis of internal and external religiousness subscales of the total score revealed similar results. These findings support the hypothesis that the heritability of religiousness increases from adolescence to adulthood.

Koenig, T. L. "**Caregivers' use of spirituality in ethical decision-making**." *Journal of Gerontological Social Work* 45, nos. 1-2 (2005): 155-172. This special issue of the journal was simultaneously published as the book, *Religion, Spirituality, and Aging: A Social Work Perspective*, ed. Harry R. Moody (Haworth Press, 2005). [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] This qualitative study examined ethical dilemmas faced by female caregivers of frail elders as well as the dominant role of caregivers' spirituality in addressing these dilemmas. Dilemmas are difficult decisions that involve conflicting values, e.g., freedom versus safety. In-depth interviews were conducted with thirteen ethnically diverse caregivers recruited from a home health agency and its parent hospital. Purposive sampling was used to obtain variation among research participants. Focus group interviews of home health staff, key informant caregivers, and interviewees provided guidance for the research design, reflection on findings and development of implications. In order to deal with ethical dilemmas, all caregivers used spirituality as (1) a philosophy of life, e.g., This is what you do when you're family, (2) an aid to decision-making, e.g., through the use of prayer; and/or, (3) a way to transcend dilemmas, e.g., no choice is hard. Implications include the importance of caregiver-driven assessment, professional self-reflection, and sustained formal services for caregivers.

Koic, E., Filakovic, P., Nad, S. and Celic, I. [Department of Psychiatry, General Hospital, Virovitica, Virovitica, Croatia; elvira.koic1@vt.htnet.hr]. "**Glossolalia**." *Collegium Antropologicum* 29, no. 1 (Jun 2005): 373-379.

[Abstract:] In this article the authors present through theory and case reports on the phenomenon of glossolalia, the unusual vocal utterances that sound language-like. Sense, meaning and function of glossolalia are closely connected with social and cultural context, and therefore glossolalia is experienced as a normal and expected behavior in religious prayer groups, while in mental disorders it is considered a psychopathological symptom. Historic theological debates explain the pure spiritual etiology of glossolalia, while the current studies present the phenomenon of glossolalia as a result of learned behavior and training. Glossolalia occurs as an individual or a group phenomenon after which the speaker and the persons around him feel good, what is explained psychodynamically as a regression upon early developmental

levels. In this temporary regression there is an explanation of positive, almost psychotherapeutic effect of glossolalia. [See also the articles by Aukst-Margetic and by Jakovljevic, elsewhere in this bibliography, for other examples from the Croatian literature.]

Konstam, V., Moser, D. K. and De Jong, M. J. [Department of Counseling and School Psychology, University of Massachusetts Boston, MA 02125]. "**Depression and anxiety in heart failure**." *Journal of Cardiac Failure* 11, no. 6 (Aug 2005): 455-463.
The article contains a section on Religiosity/Spirituality on pp. 459-460, drawing various connections between spirituality and health.

Kristeller, J. L., Rhodes, M., Cripe, L. D. and Sheets, V. [Department of Psychology, Indiana State University, Terre Haute, IN 47809; j-kristeller@indstate.edu]. "**Oncologist Assisted Spiritual Intervention Study (OASIS): patient acceptability and initial evidence of effects**." *International Journal of Psychiatry in Medicine* 35, no. 4 (2005): 329-347.
[Abstract:] PURPOSE: Individuals with serious illness often desire to discuss spiritual concerns with their physician, yet substantial barriers exist to doing so, including limited evidence of value. This study evaluated acceptability, impact on satisfaction with care and on quality of life (QOL) of a brief (5-7 minute) semi-structured exploration of spiritual/religious concerns. PATIENTS AND METHODS: 118 consecutive patients of four oncologist-hematologists (95% recruitment; 55.1% female, 91.5% Caucasian, 81.3% Christian) with mixed diagnoses, duration (51.7% diagnosed within 2 years) and prognosis (54.2% in active treatment) were alternately assigned to receive the intervention or usual care during an office visit. Assessment occurred just prior to the visit, immediately after, and after 3 weeks. Measures included the FACT-G QOL and FACIT-Sp (Spiritual Well-Being) Scales; BSI Depression Scale; the PCAS Interpersonal and Communication scales; and ratings of acceptability. RESULTS: Oncologists rated themselves as comfortable during the inquiry with 85% of patients. Of patients, 76% felt the inquiry was "somewhat" to "very" useful. At 3 weeks, the intervention group had greater reductions in depressive symptoms ($F= 7.57, p < .01$), more improvement in QOL ($F = 4.04$, $p < .05$), and an improved sense of interpersonal caring from their physician ($F = 4.79$, $p < .05$) relative to control patients. Effects on QOL remained after adjusting for other variables, including relationship to physician. Improvement on Functional Well-being was accounted for primarily by patients lower on baseline spiritual well-being ($beta = .293$, $p < .001$). CONCLUSIONS: This study supports the acceptability of a semi-structured inquiry into spiritual concerns related to coping with cancer; furthermore, the inquiry appears to have a positive impact on perception of care and well-being.

Krupski, T. L., Sonn, G., Kwan, L., Maliski, S., Fink, A. and Litwin, M. S. [Department of Urology, David Geffen School of Medicine and School of Public Health, Jonsson Comprehensive Cancer Center, University of California, Los Angeles, CA; tkrupski@mednet.ucla.edu]. "**Ethnic variation in health-related quality of life among low-income men with prostate cancer**." *Ethnicity & Disease* 15, no. 3 (2005): 461-468.
[From the abstract:] …DESIGN: Observational study of low-income, ethnically diverse men with non-metastatic prostate cancer. SETTING: Statewide public assistance program in California. PARTICIPANTS: 208 men (51 Caucasian, 115 Hispanic, and 42 African-American men) with non-metastatic disease. …RESULTS: …In univariate analyses, Caucasian men reported better physical function but less spirituality, while Hispanic men reported worse sexual function. Multivariate analysis revealed that Hispanic men had significantly worse physical function, bowel function, and bowel bother. African-American men experienced greater anxiety over recurrence. African-American and Hispanic men were more spiritual than Caucasian men….

Lagman, R. and Walsh, D. [The Harry R. Horvitz Center for Palliative Medicine, Cleveland Clinic Taussig Cancer Center, OH 44195]. "**Integration of palliative medicine into comprehensive cancer care**." *Seminars in Oncology* 32, no. 2 (Apr 2005): 134-138.
[Abstract:] Because of the advent of disease-modifying agents for patients with malignancies, cancer is now a chronic illness. However, most cancer patients will experience significant symptoms and complications during the course of their illness or its treatment. In addition to their physical symptoms, patient and families are burdened with psychological, social, and spiritual difficulties. Palliative medicine addresses all these issues and complements attempts to cure the disease; it is an essential part of modern comprehensive cancer care.

Lane, M. R. [Center for Art and Healing, Education, and Research and the Center of Spirituality and Healthcare, University of Florida, Gainesville, 32610; mlane@nursing.ufl.edu]. "**Creativity and spirituality in nursing: implementing art in healing**." *Holistic Nursing Practice* 19, no. 3 (May-Jun 2005): 122-125.
The author's perspective on spirituality is broad and historical, noting how dance, storytelling, painting, etc., have ancient roots to sacred activity. [From the abstract:] Creative modalities offer nurses a new perspective on how to care for patients. The link between creativity and healing is well documented. In response to this, many hospitals have instituted programs that include arts and creativity. Because of their unique bonds with patients, nurses play a crucial role in bringing creative arts into patient care. Several recommendations are given for implementing specific art media (eg, music, drawing, dance, writing) in the clinical setting.

Lawler, K. A., Younger, J. W., Piferi, R. L., Jobe, R. L., Edmondson, K. A. and Jones, W. H. [Department of Psychology, University of Tennessee, Knoxville, TN]. "**The unique effects of forgiveness on health: an exploration of pathways**." *Journal of Behavioral Medicine* 28, no. 2 (Apr 2005): 157-167.
[Abstract:] The relationship of forgiveness, both state and trait, to health was assessed. Eighty-one community adults completed a packet of questionnaires and participated in a laboratory interview about a time of hurt or betrayal. Heart rate and blood pressure were recorded during a 10 min baseline, the interview and during a recovery period; interviews were structured around a framework of questions and videotaped. Four measures of forgiveness were all statistically associated with five measures of health (physical symptoms, medications used, sleep quality, fatigue, and somatic complaints). Trait forgiveness was associated with decreased reactivity (rate-pressure product) to the interview, but sympathetic reactivity did not account for the trait forgiveness-health association. Four mechanisms or pathways by which forgiveness could lead to fewer physical symptoms were examined: spirituality, social skills, reduction in negative affect, and reduction in stress. All factors either partially or fully mediated the effect of forgiveness on health; however, the strongest mediator for both state and trait forgiveness was reduction in negative affect. For state forgiveness, the second strongest mediator was reduction in stress; for trait forgiveness, both conflict management and reduction in stress were strong contributors.

Lecomte, T., Wallace, C. J., Perreault, M. and Caron, J. [University of British Columbia in Vancouver, Canada; lecomte@interchange.ubc.ca]. "**Consumers' goals in psychiatric rehabilitation and their concordance with existing services**." *Psychiatric Services* 56, no. 2 (Feb 2005): 209-211.

[Abstract:] The objective of this study was to describe the rehabilitation goals of 165 consumers with serious mental illness who were living in the community and to assess the level of concordance between the consumers' perceived importance of their goals and the services they received to help them meet those goals. A structured interview was used to facilitate the expression of rehabilitation goals by consumers in the psychiatric rehabilitation program of a hospital in Montreal, Canada. The most frequently mentioned rehabilitation goals pertained to improving consumers' financial situation, physical health, cognitive capacities, and symptoms. Among these goals, the level of concordance was highest for services addressing symptoms and lowest for religious or spiritual goals.

Ledger, S. D. [St. Bartholomew School of Nursing and Midwifery, City University, London, UK]. "**The duty of nurses to meet patients' spiritual and/or religious needs**." *British Journal of Nursing* 14, no. 4 (Feb 24-Mar 9, 2005): 220-225.

[Abstract:] As part of giving holistic care, nurses have a duty to meet the spiritual, religious and cultural needs of patients. These aspects of care are clearly identified in the Nursing and Midwifery Council's standards for nurses. According to the latest Census, 76.8% of people claim to have a religion. It is recognized that while people may not have a religious affiliation, they may have spiritual needs. The article considers the concepts of spirituality and religions and the significance of meeting these needs from the patient's perspective. Research-based evidence demonstrates that patients' spiritual and/or religious needs are not always addressed by nurses. Barriers to giving spiritual/religious care are identified and spiritual assessment tools are considered.

Leigh, J., Bowen, S. and Marlatt, G. A. [Department of Psychology, University of Washington, Box 351525, Seattle WA 98195-1525; janis2@u.washington.edu]. "**Spirituality, mindfulness and substance abuse**." *Addictive Behaviors* 30, no. 7 (Aug 2005): 1335-1341.

[Abstract:] A growing body of research suggests that mindfulness-based therapies may be effective in treating a variety of disorders including stress, chronic pain, depression and anxiety. However, there are few valid and reliable measures of mindfulness. Furthermore, mindfulness is often thought to be related to spirituality, given its roots in Buddhist tradition, but empirical studies on this relationship are difficult to find. The present study: (1) tested the reliability and validity of a new mindfulness measure, the Freiburg Mindfulness Inventory (FMI), (2) explored the relationship between mindfulness and spirituality, and (3) investigated the relationship between mindfulness and/or spirituality and alcohol and tobacco use in an undergraduate college population (N=196). Results support the reliability of the FMI and suggest that spirituality and mindfulness may be separate constructs. In addition, smoking and frequent binge-drinking were negatively correlated with spirituality scores; as spirituality scores increased the use of alcohol and tobacco decreased. Thus, spirituality may be related to decreased substance use. In contrast, a positive relationship between mindfulness and smoking/frequent binge-drinking behavior was uncovered, and warrants further investigation.

Levenson, M. R., Jennings, P. A., Aldwin, C. M. and Shiraishi, R. W. [University of California-Davis; rick.levenson@oregonstate.edu]. "**Self-transcendence: conceptualization and measurement**." *International Journal of Aging & Human Development* 60, no. 2 (2005): 127-143.

[Abstract:] Self-transcendence has been hypothesized to be a critical component of wisdom (Curnow, 1999) and adaptation in later life (Tornstam, 1994). It reflects a decreasing reliance on externals for definition of the self, increasing interiority and spirituality, and a greater sense of connectedness with past and future generations. The Adult Self-Transcendence Inventory was administered to 351 individuals along with the NEO-FFI Personality Scale (McCrae & Costa, 1989). A principal axis factor analysis identified two factors: self-transcendence and alienation. The relationships between self-transcendence and neuroticism, openness to experience, extraversion, and agreeableness were significant, although modest, suggesting that self-transcendence cannot be accounted for in terms of positive personality traits alone. As expected, a multiple regression analysis indicated that self-transcendence was negatively related to neuroticism and positively related to meditation practice. The present study appears to lend support to the construct of self-transcendence.

Levin, J., Chatters, L. M. and Taylor, R. J. [University of Michigan School of Social Work; levin@religionandhealth.com]. "**Religion, health and medicine in African Americans: implications for physicians**." *Journal of the National Medical Association* 97, no. 2 (Feb 2005): 237-249.

[Abstract:] Recent years have seen a burgeoning of research and writing on the connections between religion and health. The very best of this work comes from epidemiologic studies of African Americans. This paper summarizes results of these investigations, including findings identifying effects of religious participation on both physical and mental health outcomes. Evidence mostly supports a protective religious effect on morbidity and mortality and on depressive symptoms and overall psychological distress among African Americans. This paper also carefully discusses what the results of these studies mean and do not mean, an important consideration due to frequent misinterpretations of findings on this topic. Because important distinctions between epidemiologic and clinical studies tend to get glossed over, reports of religion-health associations oftentimes draw erroneous conclusions that foster unrealistic expectations about the role of faith and spirituality in health and healing. Finally, implications are discussed for clinical practice, medical education and public health. [130 refs.]

Levine, E. G. [California Pacific Medical Center, Psychosocial Oncology, 2300 California Street, Suite 207, San Francisco, CA 94115; LevineE@cpmcri.org]. "**The relationship between physical factors, coping, and spirituality in cancer patients**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S133-134.

This is a conference report of two studies that show the importance of spirituality to cancer patients. Among the findings: "Spirituality is highly correlated with quality of life, adjustment, and coping style. Faith and assurance is more related to quality of life than meaning and peace and spiritual practice and spiritual growth. Faith and assurance are independent significant predictors of physical, functional, and social well-being." [pp. S133-134]

Lindberg, D. A. "**Integrative review of research related to meditation, spirituality, and the elderly**." *Geriatric Nursing* 26, no. 6 (Nov-Dec 2005): 372-377.

[Abstract:] Recently, increased attention has been given to meditation-relaxation strategies to improve physical health, reduce pain, enhance immune response, improve emotional well-being, and foster spiritual growth. This article reviews research conducted in the last 25 years about

meditation and spirituality, in particular as it relates to the health of the elderly. This review supports the hypothesis that meditation can be taught to the elderly, even those with dementia. The results also support the hypothesis that meditation and spiritual practices could promote significant social and emotional benefits for those in social isolation. Specific treatment plan interventions for nursing homes are discussed. Future research should investigate the effectiveness of various types of meditative and spiritual practices to nursing home residents.

Linnard-Palmer, L. and Kools, S. [Dominican University of California, 382 Irwin St., San Rafael, CA 94901; linnard@dominican.edu]. "**Parents' refusal of medical treatment for cultural or religious beliefs: an ethnographic study of health care professionals' experiences**." *Journal of Pediatric Oncology Nursing* 22, no. 1 (Jan-Feb 2005): 48-57.

[Abstract:] Pediatric nurses working in acute care settings serving religious and culturally diverse families may encounter parents whose beliefs influence treatment decisions. Previous literature describes how these complex situations lead to emotional distress and strained relationships between health care provider and family members. An ethnographic study was conducted to investigate the impact of parental treatment refusal on the bedside interactions between pediatric nurses and parents. Twenty in-depth interviews with nurses were conducted, and extensive field notes were taken during data collection. Emotional feelings associated with possible loss of guardianship and subsequent mandated treatment, the impact of the situation on the nurses' health and stress levels, and functional status were all explored. Three themes were identified following interpretive narrative analysis of transcriptions and field notes: weathering the storm of moral conflict, closeness and involvement versus distance and retreat, and battles between the supportive and oppositional groups. The findings of the study lead to a deeper understanding of the complexities of the ethical dilemma surrounding treatment refusal in pediatrics.

Luhrs, C. A., Meghani, S., Homel, P., Drayton, M., O'Toole, E., Paccione, M., Daratsos, L., Wollner, D. and Bookbinder, M. [VA-New York Harbor Healthcare System, Brooklyn, NY 11209]. "**Pilot of a pathway to improve the care of imminently dying oncology inpatients in a Veterans Affairs Medical Center**." *Journal of Pain & Symptom Management* 29, no. 6 (Jun 2005): 544-551.

[Abstract:] We report on the implementation of a previously developed clinical pathway for terminally ill patients, Palliative Care for Advanced Disease (PCAD), on a Veterans Administration (VA) acute care oncology unit, comparing processes of care and outcomes for patients on and off the pathway. The PCAD pathway is designed to identify imminently dying patients, review care goals, respect patients' wishes, assess and manage symptoms, address spirituality, and support family members. Retrospective chart reviews from 15 patients who died on PCAD, 14 patients who died on general wards during the same time, and 10 oncology unit patients who died prior to PCAD revealed that PCAD patients were more likely to have documentation of care goals and plans of comfort care (P=0.0001), fewer interventions, and more symptoms assessed (P=0.004), and more symptoms managed according to PCAD guidelines (P=0.02). Implementation of PCAD improved care of dying inpatients by increasing documentation of goals and plans of care, improving symptom assessment and management, and decreasing interventions at the end of life.

Luckhaupt, S. E., Yi, M. S., Mueller, C. V., Mrus, J. M., Peterman, A. H., Puchalski, C. M. and Tsevat, J. [Department of Internal Medicine, University of Cincinnati Medical Center, Veterans Healthcare System of Ohio; sluckhaupt@yahoo.com]. "**Beliefs of primary care residents regarding spirituality and religion in clinical encounters with patients: a study at a midwestern U.S. teaching institution**." *Academic Medicine* 80, no. 6 (Jun 2005): 560-570.

[Abstract:] PURPOSE: To assess primary care residents' beliefs regarding the role of spirituality and religion in the clinical encounter with patients. METHOD: In 2003, at a major midwestern U.S. teaching institution, 247 primary care residents were administered a questionnaire adapted from that used in the Religion and Spirituality in the Medical Encounter Study to assess whether primary care house officers feel they should discuss religious and spiritual issues with patients, pray with patients, or both, and whether personal characteristics of residents, including their own spiritual well-being, religiosity, and tendency to use spiritual and religious coping mechanisms, are related to their sentiments regarding spirituality and religion in health care. Simple descriptive, univariate, and two types of multivariable analyses were performed. RESULTS: Data were collected from 227 residents (92%) in internal medicine, pediatrics, internal medicine/pediatrics, and family medicine. One hundred four (46%) respondents felt that they should play a role in patients' spiritual or religious lives. In multivariable analysis, this sentiment was associated with greater frequency of participating in organized religious activity (odds ratio [OR] 1.55, 95% confidence interval [CI] 1.20-1.99), a higher level of personal spirituality (OR 1.05, 95% CI 1.02-1.08), and older resident age (OR 1.11, 95% CI 1.02-1.21; C-statistic 0.76). In general, advocating spiritual and religious involvement was most often associated with high personal levels of spiritual and religious coping and with the family medicine training program. Residents were more likely to agree with incorporating spirituality and religion into patient encounters as the gravity of the patient's condition increased ($p < .0001$). CONCLUSIONS: Approximately half of primary care residents felt that they should play a role in their patients' spiritual or religious lives. Residents' agreement with specific spiritual and religious activities depended on both the patient's condition and the resident's personal characteristics.

Luster, L. and Hines, B. "**Debate question: should physicians incorporate spirituality into the care of patients?**" *Southern Medical Journal* 98, no. 12 (Dec 2005): 1242.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Lutgendorf, S. K. [The University of Iowa, Department of Psychology and OB/GYN, E11 Seashore Hall, Iowa City, IA 52242-1407. susan-lutgendorf@uiowa.edu]. "**Stress, spirituality, and cytokines in aging and cancer**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S139-140.

In this conference report, the author writes: "We have recently reported that higher levels of religious attendance in a non-disabled population of older adults was prospectively related to lower mortality up to 12 years later and that these effects appear to be mediated by IL-6. These effects were independent of other risk factors including co-morbid disease, body mass index, social support, depression and age" [p. 139].

Mann, J. R., McKay, S., Daniels, D., Lamar, C. S., Witherspoon, P. W., Stanek, M. K. and Larimore, W. L. [Department of Family and Preventive Medicine, University of South Carolina School of Medicine, Columbia, SC 29208; joshua.mann@palmettohealth.org]. "**Physician offered prayer and patient satisfaction**." *International Journal of Psychiatry in Medicine* 35, no. 2 (2005): 161-170.

[Abstract:] OBJECTIVE: While there is ongoing debate about the role of physician-offered prayer during the physician-patient encounter, many physicians feel inclined to include prayer in their practices. This randomized-controlled trial evaluated patients' acceptance of physician-

offered prayer in a family practice setting, and the impact of physician-offered prayer on patient satisfaction with the physician-patient encounter. METHOD: Subjects were 137 patients in an urban, largely African American, Southeastern family medicine practice who were randomized to receive usual care plus an offer of physician-led prayer or usual care alone. Satisfaction surveys were administered following the clinical encounter. The outcomes of interest were the rate of acceptance of physician-offered prayer and the impact of the prayer offer on patient satisfaction. Personal characteristics and satisfaction scores for patients accepting prayer were compared to those for patients declining prayer. RESULTS: Over 90% of patients accepted the offer of prayer. The offer of prayer had no significant impact on patient satisfaction scores. The number of patients declining prayer was too low to permit comparison of prayer decliners with acceptors. CONCLUSIONS: This small pilot trial demonstrated that patient responses to spiritual interventions by physicians can be evaluated using randomized study designs. A large majority of patients accepted an offer of physician-led prayer, but no significant short-term impact on patient satisfaction was detected. Future research with larger sample sizes and more diverse patient populations should evaluate the effects of physician-offered prayer on the physician-patient relationship. Difficulties in conducting such research are discussed.

Manning-Walsh, J. [Bronson School of Nursing, Western Michigan University, Kalamazoo, MI]. "**Spiritual struggle: effect on quality of life and life satisfaction in women with breast cancer**." *Journal of Holistic Nursing* 23, no. 2 (Jun 2005): 120-140. Discussion on pp. 141-144.

[Abstract:] BACKGROUND: Women with breast cancer experience stressors affecting quality of life (QOL) and life satisfaction. Little is known about effects of spiritual struggle as a coping strategy on QOL and life satisfaction. PURPOSE: Examine relationships between spiritual struggle, QOL, and life satisfaction. METHOD: Nonprobablility sample of 100 participants recruited from an Internet Web site with mailed questionnaires. Three instruments were used: breast cancer-specific version of Functional Assessment of Cancer Therapy Scale (FACT-B), Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp-12) combined for QOL, Negative Coping subscale of Religious Coping (RCOPE) for spiritual struggle, and a single-item measuring life satisfaction. FINDINGS: Small inverse relationships between spiritual struggle, QOL ($r = -.36$, $p < .001$), and life satisfaction ($r = -.31$, $p < .001$) existed. CONCLUSIONS: Spiritual struggle gives voice to women's questionings implying lower QOL and life satisfaction. Implications: Assessment of and assistance with managing spiritual struggle are necessary to promote QOL and life satisfaction among those facing difficult health problems.

Marco, C. A., Buderer, N. and Thum, S. D. [Department of Emergency Medicine, St. Vincent Mercy Medical Center, Toledo, OH]. "**End-of-life care: perspectives of family members of deceased patients**." *American Journal of Hospice & Palliative Care* 22, no. 1 (Jan-Feb 2005): 26-31.

[Abstract:] This study was undertaken to determine the opinions of family members of deceased patients regarding end-of-life care. This multi-site cross-sectional survey was administered to 969 volunteer participants during 1997 to 2000. Eligible participants included immediate family members of deceased patients at five local institutions in a regional health system. Among 969 respondents, most (84.4 percent) indicated that the care for their family member was excellent. Reasons cited for satisfaction included overall care (40.2 percent), staff effort (23.2 percent), and communication (16.4 percent). Reasons cited for dissatisfaction included perceived incompetence (9.7 percent), perceived uncaring attitude (8.4 percent), and perceived understaffing (3.7 percent). Respondents were more satisfied with communication from nursing staff (88 percent) than physicians' communication (78 percent, $p < 0.001$, Bowker's test). Respondents indicated higher overall satisfaction with nursing (90 percent) and pastoral care (87 percent), than with physician care (81 percent, $p < 0.001$ and $p = 0.006$, Bowker's test). A unique survey instrument can be used to measure family perceptions and opinions regarding end-of-life care.

Markwell, H. "**End-of-life: a Catholic view**." *The Lancet* 366, no. 9491 (Sep 24-30, 2005): 1132-1135.

This is part of an article series on religious diversity in health care. [See also articles by Baggini, Dorff, Engelhardt, Firth, Keown, and Sachedina listed in this bibliography.]

Marthaler, M. T. [Purdue University Calumet, Hammond, IN 46323-2094; Maureen@calumet.purdue.edu]. "**End-of-life care: practical tips**." *DCCN - Dimensions of Critical Care Nursing* 24, no. 5 (Sep-Oct 2005): 215-218.

As the title indicates, this brief article notes a number of practical points in end-of-life care, including the consideration of "religious death rituals" (see Table 1 on p. 216).

McCain, N. L. [School of Nursing and Massey Cancer Center, Virginia Commonwealth University, 1220 E. Broad St., Richmond, VA 23298-0567; nlmccain@vcu.edu]. "**Psychoneuroimmunology, spirituality, and cancer**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S121.

This is a brief conference report of the author's ongoing work on psychoneuroimmunology and spirituality in cancer patients.

McCauley, J., Jenckes, M. W., Tarpley, M. J., Koenig, H. G., Yanek, L. R. and Becker, D. M. [Department of Medicine, Johns Hopkins University, Baltimore, MD]. "**Spiritual beliefs and barriers among managed care practitioners**." *Journal of Religion & Health* 44, no. 2 (2005): 137-146.

[Abstract:] Purpose: Ninety percent of American adults believe in God and 82% pray weekly. A majority wants their physicians to address spirituality during their health care visit. However, clinicians incorporate spiritual discussion in less than 20% of visits. Our objectives were to measure clinician beliefs and identify perceived barriers to integrating spirituality into patient care in a statewide, primary care, managed care group. Methods: Practitioners completed a 30-item survey including demographics and religious involvement (DUREL), spirituality in patient care (SPC), and barriers (BAR). We analyzed data using frequencies, means, standard deviations, and ANOVA. Findings: Clinicians had a range of religious denominations (67% Christian, 14% Jewish, 11% Muslim, Hindu or Buddhist, 8% agnostic), were 57% female and 24% had training in spirituality. Sixty-six percent reported experiencing the divine. Ninety-five percent felt that a patient's spiritual outlook was important to handling health difficulties and 68% percent agreed that addressing spirituality was part of the physician's role. Ninety-five percent of our managed care group noted 'lack of time' as an important barrier, 'lack of training' was indicated by 69%, and 21% cited 'fear of response from administration'. Conclusions: Managed care practitioners in a time constrained setting were spiritual themselves and believed this to be important to patients. Respondents indicated barriers of time and training to implementing these beliefs. Comparing responses from our group to those in other published surveys on clinician spirituality, we find similar concerns. Clinician education may overcome these barriers and improve ability to more fully meet their patients' expressed needs regarding spirituality and beliefs.

McCullough, M. E., Enders, C. K., Brion, S. L. and Jain, A. R. [Department of Psychology, University of Miami, Coral Gables, FL 33124; mikem@miami.edu]. "**The varieties of religious development in adulthood: a longitudinal investigation of religion and rational choice**." *Journal of Personality & Social Psychology* 89, no. 1 (Jul 2005): 78-89.

[Abstract:] The authors used growth mixture models to study religious development during adulthood (ages 27-80) in a sample of individuals who were identified during childhood as intellectually gifted. The authors identified 3 discrete trajectories of religious development: (a) 40% of participants belonged to a trajectory class characterized by increases in religiousness until midlife and declines in later adulthood; (b) 41% of participants belonged to a trajectory class characterized by very low religiousness in early adulthood and age-related decline; and (c) 19% of participants belonged to a trajectory class characterized by high religiousness in early adulthood and age-related increases. Gender, strength of religious upbringing, number of children, marrying, and agreeableness predicted membership in the trajectory classes. Results were largely consistent with the rational choice theory of religious involvement.

McCullough, M. E. and Laurenceau, J. P. [Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124; mikem@miami.edu]. "**Religiousness and the trajectory of self-rated health across adulthood**." *Personality & Social Psychology Bulletin* 31, no. 4 (Apr 2005): 560-573.

[Abstract:] This study evaluates the association of religiousness with the growth parameters characterizing changes in self-rated health during adulthood (ages 20-94 years). Even after controlling for health behaviors, social support/social activity, and four of the Big Five [personality traits], women who were highly religious in 1940 had higher mean self-rated health throughout their lifespan, slower rates of linear decline, and less pronounced cascades than did less religious women. For men, the associations of religiousness with the growth parameters underlying self-rated health were negligible. Results indicate that the association of religiousness with women's self-rated health may persist after controlling for mundane mediators and that the association of religiousness and self-rated health is not an artifact of the association between religiousness and the Big Five.

McEwen, M. [School of Nursing, University of Texas Health Science Center at Houston, TX 77030; Melanie.M.McEwen@uth.tmc.edu]. "**Spiritual nursing care: state of the ar**t." *Holistic Nursing Practice* 19, no. 4 (Jul-Aug 2005): 161-168.

[Abstract:] Until recently, little attention has been given to spiritual dimensions in the nursing literature. This article reviews spiritual nursing care in the nursing literature, including basic concepts and current thoughts on spirituality-related research. In addition, it describes mechanisms that may be used to promote spiritual care and outlines the need to enhance research efforts in this vital area. [75 refs.]

McGrath, P. [Centre for Social Science Research, School of Nursing and Health, Central Queensland University, Rockhampton Qld 4702, Australia; pam_mcgrath@bigpond.com]. "**Developing a language for nonreligious spirituality in relation to serious illness through research: preliminary findings**." *Health Communication* 18, no. 3 (2005): 217-235.

[Abstract:] The preliminary findings presented in this article are part of a research program that is concerned with exploring the notion of spirituality for those dealing with serious illness. The aim of the program is not only to deepen our understanding of how individuals construct their spirituality in the face of life-threatening illness, but also to respond to such insights by beginning to develop a language reflective of the commonalities of experience. The development of such a language involves a three-phase process including the thematic development of qualitative data, comparative analysis of findings from disparate sample groups, and expert reflection of conceptual notions within the context of the richness of traditional philosophical/theological literature. This discussion focuses on the preliminary process of qualitative data development based on in-depth interviews with survivors of a hematological malignancy. The findings indicate that, for those who have a nonreligious framework, there is no shared language readily available to communicate their insights and experience with serious illness. However, the qualitative analysis also indicates that such survivors share a number of identifiable conceptual notions. These notions are articulated as a preliminary step in language development.

McKay, D. J., Bentley, J. R. and Grimshaw, R. N. [Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada]. "**Complementary and alternative medicine in gynaecologic oncology**." *Journal of Obstetrics & Gynaecology Canada: JOGC* 27, no. 6 (Jun 2005): 562-568.

[From the abstract:] OBJECTIVES: To explore complementary and alternative medicine (CAM) use among gynaecologic oncology patients in Nova Scotia. METHODS: Over a 3-month period, 163 patients were asked to fill out a questionnaire concerning CAM. Those entering the study provided demographic information such as age, address, and employment status, as well as medical information and details of their use of alternative therapies. RESULTS: A total of 152 patients were entered into the study, giving a response rate of 93.3%. Of these, 116 had used at least one type of CAM, classifying them as users (76.3%). Women who considered themselves "more religious" were more likely to be CAM users ($P = 0.001$). There were no significant differences found between users and nonusers with respect to other patient characteristics reported. Patients with cervical cancer were less likely to use CAM than participants with another primary gynaecological malignancy ($P = 0.040$). The most frequent CAM therapy practiced was spirituality/prayer (52.6%). Most women used CAM to improve their physical well-being, and 53.3% of the women were interested in receiving more information on CAM….

McNelly, D. V. "**Spiritual mirroring: a concept and an experience**." *Creative Nursing* 11, no. 1 (2005): 11-15.

[From the text:] Spiritual mirroring, a new term, is an enhancement of the concept of empathy, which is quite familiar to health professionals. Although mirroring has long been used in psychoanalysis and in theater, this article explores a new definition. In addition, the technique will be explored for clarity of understanding. It is the author's contention that spiritual mirroring is a client/health professional connection that is practiced intuitively. The purpose of this article is to spark awareness among health professionals and those who have not experienced or identified spiritual mirroring, thus giving permission and encouragement to those who wish to practice the connection with their clients. (p. 11)

Meert, K. L., Thurston, C. S. and Briller, S. H. [Department of Pediatrics, Wayne State University, Detroit, MI 48201; kmeert@med.wayne.edu]. "**The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: a qualitative study**." *Pediatric Critical Care Medicine* 6, no. 4 (Jul 2005): 420-427. Comment on pp. 492-493.

[Abstract:] OBJECTIVE: Death is common in pediatric intensive care units. A child's death can shatter parents' personal identities, disrupt their relationships, and challenge their worldviews. Spirituality is a human characteristic that engenders transcendence; seeks meaning, purpose, and

connection to others; and helps to construct a coherent worldview. Greater attention to spiritual needs may help parents cope with their loss. Our objective is to gain a deeper understanding of parents' spiritual needs during their child's death and bereavement. DESIGN: Prospective, qualitative study. SETTING: University-affiliated children's hospital. Participants: Thirty-three parents of 26 children who died in the pediatric intensive care unit between January 1, 1999, and August 31, 2000. INTERVENTIONS: Semistructured, in-depth, videotaped interviews with parents 2 yrs after their child's death. MEASUREMENTS AND MAIN RESULTS: The main spiritual need described by parents was that of maintaining connection with their child. Parents maintained connection at the time of death by physical presence. Parents maintained connection after the death through memories, mementos, memorials, and altruistic acts such as organ donation, volunteer work, charitable fund raising, support group development, and adoption. Other spiritual needs included the need for truth; compassion; prayer, ritual, and sacred texts; connection with others; bereavement support; gratitude; meaning and purpose; trust; anger and blame; and dignity. CONCLUSIONS: Bereaved parents have intense spiritual needs. Health care providers can help to support parents' spiritual needs through words and actions that demonstrate a caring presence, impart truth, and foster trust; by providing opportunity to stay connected with the child at the time of death; and by creating memories that will bring comfort in the future.

Miller, B. [Wake Forest University, Department of Obstetrics and Gynecology, Medical Center Boulevard, 4th Floor, Comprehensive Cancer Center, Winston-Salem, NC 27157; bemiller@wfubmc.edu]. "**Spiritual journey during and after cancer treatment**." *Gynecologic Oncology* 99, no. 3, suppl. 1 (Dec 2005): S129-130.

This is a conference report of a study of 95 women with gynecologic cancers. Among the findings: "We learned that spirituality has many dimensions and that some aspects of spirituality can be measured. Most patients want to discuss spiritual needs and questions. From this work, it seemed a culturally appropriate discussion would be most comforting to patients. We learned that patients want physicians to show an interest and help take care of the patients' spiritual and religious needs." [p. S 130]

Miller, D. K., Chibnall, J. T., Videen, S. D. and Duckro, P. N. [Center for Aging Research, Indiana University School of medicine, 1050 Wishard Boulevard RG-6, Indianapolis, IN 46202; dokmille@iupui.edu]. "**Supportive-affective group experience for persons with life-threatening illness: reducing spiritual, psychological, and death-related distress in dying patients**." *Journal of Palliative Medicine* 8, no. 2 (Apr 2005): 333-343.

[Abstract:] BACKGROUND: Attention to psycho-socio-spiritual needs is considered critical by patients with life-threatening illnesses and their caregivers. Palliative care interventions that address these needs--particularly spirituality--are lacking. OBJECTIVE: To evaluate the effects of an innovative program to address psycho-socio-spiritual needs in patients with life-threatening illnesses. DESIGN: A group intervention entitled Life-Threatening Illness Supportive-Affective Group Experience (LTI-SAGE) was developed for reducing patient spiritual, emotional, and death-related distress. SETTING/SUBJECTS: African American and Caucasian patients (n = 69) from two hospitals in St. Louis, Missouri, with life-threatening medical conditions (cancer; human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDS]; geriatric frailty; liver, kidney, pulmonary, or cardiovascular disease) were randomly assigned to intervention or control groups. Intervention patients participated in a maximum of 12 LTI-SAGE groups over a 12-month period. Control patients received standard care. MEASUREMENTS: Outcome measures were depression symptoms, anxiety, spiritual well-being, and death-related emotional distress. RESULTS: After attrition, 51 (73.9%) patients completed the trial. At the end of the trial, after factoring in compliance, intervention patients had significantly fewer depression symptoms and death-related feelings of meaninglessness and significantly better spiritual well-being than did control patients. CONCLUSIONS: The use of the LTI-SAGE model for enhancing the end-of-life illness experience is promising.

Millspaugh, C. D. [VA San Diego Healthcare System, Box 008, 3350 La Jolla Village Drive, San Diego, CA 92161; dick.millspaugh@med.va.gov]. "**Assessment and response to spiritual pain: part I**." *Journal of Palliative Medicine* 8, no. 5 (Oct 2005): 919-923.

[Abstract:] Spiritual pain or suffering is common. Cicely Saunders described persons with "total pain" including the physical, psychological, social, and spiritual dimensions. Yet, a construct for what it is, and how to respond, is not so common. In this paper, I hypothesize that the components of spiritual pain can be summarized in the following manner:

$$\text{Spiritual Pain or Suffering} = \frac{\text{(Awareness of Death + Loss of Relationships + Loss of Self) (Loss of Purpose + Loss of Control)}}{\text{Life Affirming and Transcending Purpose + Internal Sense of Control}}$$

Thus, an assessment of spiritual pain or suffering should examine the degree to which the individual is experiencing each of these components and their relationship to each other. Further, each of these components is dynamic, always in process, both within and between the components. A second paper will examine the sufferer's religious responses and suggested pastoral responses.

Millspaugh, C. D. VA San Diego Healthcare System, San Diego, CA 92161; dick.millspaugh@med.va.gov]. "**Assessment and response to spiritual pain: part II**." *Journal of Palliative Medicine* 8, no. 6 (Dec 2005): 1110-1117.

[Abstract:] In the second of this two-part piece, the author looks at [from the abstract:] the Christian sufferer's religious responses and suggest[s] pastoral interventions.

Mitsumoto, H., Bromberg, M., Johnston, W., Tandan, R., Byock, I., Lyon, M., Miller, R. G., Appel, S. H., Benditt, J., Bernat, J. L., Borasio, G. D., Carver, A. C., Clawson, L., Del Bene, M. L., Kasarskis, E. J., LeGrand, S. B., Mandler, R., McCarthy, J., Munsat, T., Newman, D., Sufit, R. L. and Versenyi, A. [The Elenor & Lou Gehrig MDA/ALS Research Center, Columbia University Neurological Institute, New York, NY 10032;. hm264@columbia.edu]. "**Promoting excellence in end-of-life care in ALS**." *Amyotrophic Lateral Sclerosis & Other Motor Neuron Disorders* 6, no. 3 (Sep 2005): 145-154.

This literature review found that [from the abstract:] areas of investigation are needed on the incorporation of an interdisciplinary approach to care in ALS that includes: psychosocial evaluation and spiritual care; the use of validated instruments to assess patient and caregiver quality of life; and the establishment of proactive caregiver programs. Several public policy changes that will improve coverage for medical care, hospice, and caregiver costs are also reviewed. More clinical evidence is needed on how to provide optimal end-of-life care specifically in ALS.

Moberg, D. O. "**Research in spirituality, religion and aging**." *Journal of Gerontological Social Work* 45, nos. 1-2 (2005): 11-40. This special issue of the journal was simultaneously published as the book, *Religion, Spirituality, and Aging: A Social Work Perspective*, ed. Harry R. Moody (Haworth Press, 2005). [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] Research on the concept of spirituality demonstrates its overlap with religion, so for many purposes they need to be considered together as spirituality/religion. Investigations of age differences point to the likelihood that spirituality tends to increase during later adulthood. It has important positive relationships with various measures of life satisfaction, psychosocial well-being, and both physical and mental health. It benefits therapy for recovery from illness and is a source of meaning and purpose in life. Spiritual interventions help to relieve psychological distress and death anxiety, as well as the stresses of caregiving. Because of its therapeutic value, prayer is an important resource for coping with problems experienced during the life course. The Spiritual Well-Being Scale and many other instruments have been developed to measure spirituality and related concepts. As in all other domains of research on people, they all have limits and must be applied with caution for both technical and ethical reasons. Nevertheless, applications of the research findings, which overwhelmingly demonstrate the importance of spirituality to human well-being, already are improving the effectiveness of clinical work and social services in all of the health and human service professions. As scientific knowledge of spirituality expands, so does awareness of the need for further research, including the refinement of methodological procedures, expansion to new topics, and extension to international cultures and diverse religions. The outlook for research on spirituality and the consequent practical applications to benefit humanity is very promising.

Murdock, V. "**Guided by ethics: religion and spirituality in gerontological social work practice**." *Journal of Gerontological Social Work* 45, nos. 1-2 (2005): 131-154. This special issue of the journal was simultaneously published as the book, *Religion, Spirituality, and Aging: A Social Work Perspective*, ed. Harry R. Moody (Haworth Press, 2005). [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] This random national survey anonymously explored 299 gerontological social workers' attitudes about spirituality and the use of spiritual interventions in practice. Respondents support the inclusion of religion and spirituality in education and practice as a diversity component, as part of holistic assessment, and as a fundamental aspect of human life. Nearly 70% of respondents report little or no preparation on spiritual issues during their schooling and only 24.5% report satisfaction with their educational preparation on this topic. While respondents' personal spirituality correlates positively and weakly with the use of spiritual interventions, it is ethical attitudes toward spiritual interventions that predict the use of spiritual interventions by gerontological social workers.

Nandan, M. [Department of Government, Social Work & Sociology, Gerontology Program, Missouri Western State College, 4525 Downs Drive, St. Joseph, MO 64507; nandanmo@mwsc.edu]. "**Cross-cultural perspectives in thanatology: through a prism of religious faiths**." *Gerontology & Geriatrics Education* 26, no. 1 (2005): 43-56.

[Abstract:] Recent decades have witnessed an increase in thanatology education in colleges and universities. However, the infusion into thanatology curricula of religious faiths as they affect behaviors, experiences and emotions of dying individuals and survivors is still in its infancy. In this article I describe an effective approach I have used to integrate various religious beliefs and practices into an undergraduate course on death and dying. Before presenting my approach, I provide a brief description of the state of death education in professional and undergraduate institutions in America and a rationale for infusing cross-cultural components into thanatology curricula.

Narayanasamy, A. [University of Nottingham]. "**Conference report: towards transcultural spirituality**." *British Journal of Nursing* 14, no. 15 (Aug 11-Sep 7, 2005): 800.

This brief report of a conference in England not long after recent "London suicide bombings" hints at the tension between a felt need for a practical conceptualization of "transcultural spirituality" for health care and resistance to the idea from various sectors. (Dr. Narayanasamy is also the author of the popular HOPE spiritual assessment.)

Nasser, E. H. and Overholser, J. C. [Department of Psychology, Case Western Reserve University, Cleveland, OH 44106-7123]. "**Recovery from major depression: the role of support from family, friends, and spiritual beliefs**." *Acta Psychiatrica Scandinavica* 111, no. 2 (Feb 2005): 125-132.

[Abstract:] OBJECTIVE: Many of the risk factors for major depression are not amenable to change. The present study was designed to identify factors associated with recovery from depression that could be targets for clinical intervention. METHOD: Sixty-two psychiatric in-patients who met diagnostic criteria for major depression were interviewed while hospitalized and re-interviewed 3 months after discharge. Analyses examined the relationship between depression and three sources of emotional support: family, friends, and spiritual beliefs. RESULTS: Depression severity at baseline was the most consistent predictor of depression severity and diagnosis at follow-up. Patients who had recovered from depression by the time of the follow-up assessment reported higher perceived emotional support from family and friends at baseline. Support from friends, support from family and a composite of emotional support were significant predictors of depression beyond the effects of initial depression severity. CONCLUSION: Aspects of emotional support were significantly associated with depression outcome. ["Although a significant association was found between spiritual support and depression at baseline, this relationship was not maintained at follow-up" (p. 130).]

Nelson, R. M. [Anesthesiology and Critical Care, University of Pennsylvania School of Medicine] "**The compassionate clinician: attending to the spiritual needs of self and others**." *Critical Care Medicine* 33, no. 12 (Dec 2005): 2841-2842. Comment on pp. 2733-2736.

The author (MD, MDiv, PhD) comments on clinicians addressing patients' spiritual issues, largely in light of the article by Todres, et al., "The intensivist in a spiritual care training program adapted for clinicians," published in the same issue of the journal (and cited elsewhere in this bibliography).

Neff, J. A. and MacMaster, S. A. [College of Health Sciences, Old Dominion University, Norfolk, VA 23529; janeff@odu.edu]. "**Applying behavior change models to understand spiritual mechanisms underlying change in substance abuse treatment**." *American Journal of Drug & Alcohol Abuse* 31, no. 4 (2005): 669-684.

[Abstract:] Despite increasing attention directed to conceptual and methodological issues surrounding spirituality and despite the centrality of "spiritual transformation" in the recovery literature, there is little systematic evidence to support the role of spiritual change as a necessary condition for substance abuse behavior change. As an explicit conceptualization of mechanisms underlying behavior change is fundamental to effective interventions, this article: 1) briefly reviews relevant behavior change theories to identify key variables underlying change; 2) presents an integrative conceptual framework articulating linkages between program components, behavior change processes, spiritual change

mechanisms and substance abuse outcomes; and 3) presents a discussion of how the mechanisms identified in our model can be seen in commonly used substance abuse interventions. Overall, we argue that spiritual transformation at an individual level takes place in a social context involving peer influence, role modeling, and social reinforcement.

Ng, S. M., Yau, J. K., Chan, C. L., Chan, C. H. and Ho, D. Y. [Centre on Behavioral Health, the University of Hong Kong, G/F Pauline Chan Building, 10 Sassoon Road, Pokfulam, Hong Kong, China]. "**The measurement of body-mind-spirit well-being toward multidimensionality and transcultural applicability**." *Social Work in Health Care* 41, no. 1 (2005): 33-52.

[Abstract:] The Body-Mind-Spirit model of health promotion (Chan, Ho & Chow, 2002) guided the construction of a multidimensional inventory for assessing holistic health. Named Body-Mind-Spirit Well-Being Inventory (BMSWBI), it comprises four scales: Physical Distress, Daily Functioning, Affect, and Spirituality (differentiated from religiosity and conceived as ecumenical). Respondents (674 Chinese adults from Hong Kong) completed the BMSWBI via the Internet. Results indicate that all four scales have high reliability, with alpha coefficients ranging from .87 to .92, and concurrent validity. Factor analysis indicates that (a) positive and negative affect form two distinct factors; and (b) spirituality comprises three distinct aspects, tranquility, resistance to disorientation, and resilience. Spirituality is positively associated with mental well-being, positive affect, satisfaction with life, and hope; but negatively associated with negative affect and perceived stress. These results suggest that the inventory may be used to assess different dimensions of health satisfactorily.

Nottage, S. L. [Oregon Health and Science University, Child Development and Rehabilitation Center, Portland, OR; nottages@ohsu.edu]. "**Parents' use of nonmedical support services in the neonatal intensive care unit**." *Issues in Comprehensive Pediatric Nursing* 28, no. 4 (Oct-Dec 2005): 257-273.

[Abstract:] Parents frequently identify the need for support while their infant is in the Neonatal Intensive Care Unit (NICU), however, they may simultaneously distance themselves from traditional family and friend support. Recognizing this, many NICUs provide additional nonmedical support services such as social workers, chaplains/religious counselors, and support groups. This article, part of a larger research study, suggests an inverse relationship between social support and the use of supportive services. In addition, parents in this study appear to use support services less often than would be anticipated based on their reports of utility. Suggestions are provided to potentially improve desirability/accessibility of these services.

O'Connell, K. A. and Skevington, S. M. [WHO Centre for the Study of Quality of Life, University of Bath, UK]. "**The relevance of spirituality, religion and personal beliefs to health-related quality of life: themes from focus groups in Britain**." *British Journal of Health Psychology* 10, pt. 3 (Sep 2005): 379-398.

[Abstract:] BACKGROUND: Generic health-related quality of life (QoL) instruments have not routinely assessed spirituality, religion, and personal beliefs (SRPB) in their measurement. This research addresses the perceived importance of 18 facets (dimensions) of SRPB, for example, inner peace, to QoL that are not specific to a religion, but address the experience of having this belief, in relation to health. METHOD: Adult focus groups were structured according to beliefs from UK surveys. Quotas targeted gender and health status. Nine focus groups (N = 55, age 51, 47% male) contained sick and well people who were religious, Christians, Buddhists, Quakers (50.1%), agnostic (27.4%), or atheist (21.8%) participants. RESULTS: Qualitative and quantitative analysis showed considerable variability in the importance attributed to some concepts, although spiritual strength, meaning in life and inner peace were relevant to all groups. Spiritual strength (4.42), the meaning of life (4.09), wholeness/integration (4.06), and inner peace (4.02) were most important. Divine love, freedom to practice beliefs, and attachment/detachment were less relevant, conceptually confusing or had religious bias; atheists rated them as unimportant and as less important ($p < .04$) than agnostics or religious people. CONCLUSIONS: SRPB is relevant to health-related QoL and consensually important facets should be included in generic health care assessments. Their inclusion permits a more holistic assessment and improves the case for a biopsychosociospiritual model of health.

O'Connor, T. S., O'Neill, K., Van Staalduinen, G., Meakes, E., Penner, C. and Davis, K. [Waterloo Lutheran Seminary, Waterloo, Ontario, Canada N2L 3C5]. "**Not well known, used little and needed: Canadian chaplains' experiences of published spiritual assessment tools**." *The Journal of Pastoral Care & Counseling: JPCC* 59, nos. 1-2 (Spring-Summer 2005): 97-107.

This study, consisting of a survey of Canadian chaplains and focus groups found [from the abstract:] that published spiritual assessment tools are not well know, used little, criticized for being reductionistic and not fitting the clinical situation. Participants noted, however, that spiritual assessment is needed for spiritual care. Thirty percent reported the development of their own tools (not published) and three published tools were mentioned by 50% and more….

Ok, J. H., Meyers, F. J. and Evans, C. P. [Department of Urology, University of California-Davis, Sacramento, CA 95817]. "**Medical and surgical palliative care of patients with urological malignancies**." *Journal of Urology* 174, no. 4, pt. 1 (Oct 2005): 1177-1182.

The article makes references *passim* to spirituality as a component focus in palliative care.

Okon, T. R. [Department of Palliative Medicine, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449; okon.tomasz@marshfieldclinic.org]. "**Spiritual, religious, and existential aspects of palliative care**." *Journal of Palliative Medicine* 8, no. 2 (Apr 2005): 392-414.

This is a fairly thorough overview of the subject of spirituality & health in palliative care, with numerous tables and charts and an extensive bibliography. [173 refs.]

O'Mahony, S., Goulet, J., Kornblith, A., Abbatiello, G., Clarke, B., Kless-Siegel, S., Breitbart, W. and Payne, R. [Montefiore Medical Center, Bronx, NY 10467]. "**Desire for hastened death, cancer pain and depression: report of a longitudinal observational study**." *Journal of Pain & Symptom Management* 29, no. 5 (May 2005): 446-457.

[Abstract:] Desire for hastened death (DHD) is reported in the literature as being common in patients with cancer pain. However, there is currently little evidence to suggest that improvement in pain results in improvement in DHD. Our objectives were to assess 1) the impact of improvements in cancer pain severity and pain's interference with daily functioning and depression on DHD, and 2) the role of factors such as social and spiritual well-being, educational level, and patient age in moderating the impact of pain and depression on DHD. This observational study included patient-rated and clinician-rated scales administered twice at 4-week intervals. We enrolled 131 newly-referred patients to the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center or newly-admitted patients to Calvary Hospital in New York. One

hundred and sixteen patients completed the baseline measures and 64 patients completed both baseline and follow-up measures. The main outcome measures included the Brief Pain Inventory (BPI), Beck Depression Inventory (BDI), and the Desire for Hastened Death Scale (DHD). Sixty-six percent of patients had no DHD at baseline and 45% of patients had BDI scores of 14 or greater ('mild' depression). Only 40% of patients with moderate/severe depression were receiving antidepressants. BPI scores improved significantly from baseline to follow-up (6.36 vs. 4.86, P < 0.01). DHD scores increased significantly from baseline to follow-up (0.84 to 1.38, P = 0.03). All other measures including depression were stable. DHD scores were moderately correlated with depression (r = 0.43), low social support (r = 0.38), poor spiritual well-being (r = -0.38), religious well being (r = -0.25), pain interference (r = 0.27), higher educational level (F = 4.50, P = 0.02) and lower physical functioning (KPRS, r = -0.40), but were unrelated to sex, age, race, or marital status. In multivariate regression analyses, baseline DHD (beta = 0.30, P = 0.05) and change in depression (beta=0.36, P = 0.02) were predictive of follow-up DHD. Improvement in pain interference was not predictive of follow-up DHD. The results suggest that improvement in depression moderated the severity of desire for hastened death in a population of patients with cancer pain. Depression was common in this population and was often untreated. Improvements in functional impairment due to pain did not moderate the severity of DHD in a setting of aggressive pain management. Strategies to preemptively screen for depression in the routine assessment of patients with cancer pain may be important to address DHD.

Penson, R. T., Partridge, R. A., Shah, M. A., Giansiracusa, D., Chabner, B. A. and Lynch, T. J., Jr. [Department of Medicine, Division of Hematology-Oncology, Palliative Care Service, Massachusetts General Hospital, Boston, MA; rpenson@partners.org]. "**Fear of death**." *Oncologist* 10, no. 2 (Feb 2005): 160-169.

This article is the product of the Kenneth B. Schwartz Center Rounds at Massachusetts General Hospital. See pp. 164 and 166 regarding spiritual issues.

Polzer, R. and Miles, M. S. [University of North Carolina, Chapel Hill]. "**Spirituality and self-management of diabetes in African Americans**." *Journal of Holistic Nursing* 23 no. 2 (Jun 2005): 230-250. Discussion on pp. 251-254; quiz on pp. 226-227.

[Abstract:] Attention to spirituality is especially important for nurses when providing care to African Americans. Spirituality is deeply embedded in their rich cultural heritage. For many African Americans, spirituality is intertwined into all aspects of life, including beliefs about health and illness. Therefore, it is imperative that nurses understand the relationship between African American spirituality, health, and self-management of illness to provide culturally competent care to African Americans. The purpose of this article is to summarize the research literature on African American spirituality, health, and self-management as it relates to Type 2 diabetes, an illness that involves complex self-care management. Recommendations for holistic nursing practice and research related to this literature are also identified.

Popkess-Vawter, S., Yoder, E. and Gajewski, B. [University of Kansas Medical Center, School of Nursing, Kansas City]. "**The role of spirituality in holistic weight management**." *Clinical Nursing Research* 14, no. 2 (May 2005): 158-174.

[Abstract:] This descriptive, feasibility study was designed to determine how weight management patients defined spirituality and its connection with weight management. Relationships among spirituality assessment, spiritual well-being, self-esteem, and quality of life were explored. This study arose from clinical observations of possible relationships among patients' weight management failures, negative beliefs about self, and spiritual distress. Participants were 34 of 104 adult potential participants from a holistic weight management clinical practice. Survey data were analyzed using qualitative content analysis and quantitative linear regression analyses. Participants readily defined spirituality; significant linear relationships were found: Total spiritual well-being explained approximately 47% of the variance for self-esteem and existential spiritual well-being accounted for approximately 68% of the variance for self-esteem. Similarly, existential spiritual well-being explained approximately 35% of the variance of quality of life. For this convenience sample, spiritual well-being was significantly related to self-esteem and quality of life.

Pronk, K. [Redcliffe Hospital, Queensland, Australia]. "**Role of the doctor in relieving spiritual distress at the end of life**." *American Journal of Hospice & Palliative Care* 22, no. 6 (Nov-Dec 2005): 419-425.

[Abstract:] Relief of spiritual distress is a part of good palliative care. This literature review examines journal articles and texts dealing with patient spiritual issues at the end of life to see what constitutes spiritual care, why such issues are felt to be part of healthcare, and how, when, and by whom they should be explored. It also looks at the anticipated outcomes of addressing spiritual distress. This review also notes recommendations in the literature regarding prerequisite skills and attributes of those providing spiritual care and some tools for spiritual assessment and guidance.

Raab, M. [Center for Spiritual Care, Saint John's Health System, Anderson, IN 46016]. "**Training spiritual care volunteers**." *Health Progress* 86, no. 6 (Nov-Dec 2005): 60-61.

The author briefly outlines a 10-week (35 hour) training program for Spiritual Care Volunteers at Saint John's Health System in Anderson IN.

Rippentrop, E. A., Altmaier, E. M., Chen, J. J., Found, E. M. and Keffala, V. J. [Department of Orthopaedics and Rehabilitation, University of Iowa Health Care, 200 Hawkins Drive, Iowa City, IA 52242-1088; anne-rippentrop@uiowa.edu]. "**The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population**." *Pain* 116, no. 3 (Aug 2005): 311-321.

[Abstract:] This study sought to better understand the relationship between religion/spirituality and physical health and mental health in 122 patients with chronic musculoskeletal pain. The current study conceptualized religion/spirituality as a multidimensional factor, and measured it with a new measure of religion/spirituality for research on health outcomes (Brief Multidimensional Measure of Religion/Spirituality). Pain patients' religious and spiritual beliefs appear different than the general population (e.g. pain patients feel less desire to reduce pain in the world and feel more abandoned by God). Hierarchical multiple regression analyses revealed significant associations between components of religion/spirituality and physical and mental health. Private religious practice (e.g. prayer, meditation, consumption of religious media) was inversely related to physical health outcomes, indicating that those who were experiencing worse physical health were more likely to engage in private religious activities, perhaps as a way to cope with their poor health. Forgiveness, negative religious coping, daily spiritual experiences, religious support, and self-rankings of religious/spiritual intensity significantly predicted mental health status. Religion/spirituality was unrelated to pain intensity and life interference due to pain. This study establishes relationships between religion/spirituality and health in a chronic pain population, and emphasizes that religion/spirituality may have both costs and benefits for the health of those with chronic pain.

Rosner, F. [Elmhurst Medical Center, Elmhurst, NY; frosner@att.net]. "**An observant Jewish physician working in a secular ethical society: ethical dilemmas**." *Israel Medical Association Journal: IMAJ* 7, no. 1 (Jan 2005): 53-57.

The author offers personal and general thoughts on medical practice by an observant Jewish physician. He looks at "Jewish and secular approaches to medical ethics," and specific issues of informing patients of fatal illnesses, confidentiality and patients rights, and he presents a "case study of an observant Jewish physician's personal experience in the era of autonomy and patient self-determination and decision making" (pp. 54-55).

Rushing, D. A. [Division of Hematology/Oncology, Indiana University, Department of Medicine, Indianapolis 46202; drushing@iupui.edu]. "**Physical, psychological, and spiritual transformation at life's end: toward a theory of convergence**." *The Journal of Supportive Oncology* 3, no. 6 (Nov-Dec 2005): 439-443.

In this commentary, a physician reflects on his 25 years of practicing medicine and caring for dying patients and proposes a sixth stage to Kubler-Ross' model of the dying process: embracing He writes, "The experience of embracing death is both psychological and spiritual. It goes beyond acceptance and allows one to look forward to death. Embracing is marked by a deep sense of peace and joy stemming from complete acceptance. …[E]mbracing is a very positive sense of spiritual well-being. (p. 439).

Ryan, P. Y. [Behavioral Sciences Department, Colege of Medicine, University of Kentucky, Lexington KY]. "**Approaching Death: A Phenomenologic Study of Five Older Adults With Advanced Cancer**." *Oncology Nursing Forum*, 32, no. 6 (Nov 2005): 1101-1108

This study presents the cases of five patients, for whom four note aith as an important element. The authors comment that in patients with advanced cancer, "Faith often gets stronger" (p. 1108). The article is striking in its preference for the language of *faith* over the more common language of *spirituality* found on the health care literature.

Sachedina, A. "**End-of-life: the Islamic view**." *The Lancet* 366, no. 9487 (Aug 27-Sep 2, 2005): 774-779.

This is part of an article series on religious diversity in health care. [See also articles by Baggini, Dorff, Engelhardt, Firth, Keown, and Markwell listed in this bibliography.]

Salsman, J. M., Brown, T. L., Brechting, E. H. and Carlson, C. R. [Department of Behavioral Science, University of Kentucky, KY 40536; jmsals1@uky.edu]. "**The link between religion and spirituality and psychological adjustment: the mediating role of optimism and social support**." *Personality & Social Psychology Bulletin* 31, no. 4 (Apr 2005): 522-535.

[Abstract:] Although optimism, social support, religiousness, and spirituality are important predictors of adjustment, rarely have studies examined these variables simultaneously. This study investigated whether optimism and social support mediated the relationship between religiousness and adjustment (distress and life satisfaction) and between spirituality and adjustment. Findings indicate that the relationship between intrinsic religiousness and life satisfaction and between prayer fulfillment and life satisfaction was mediated by optimism and social support. Furthermore, the relationship between religiousness and adjustment varied depending on how religiousness was operationalized and whether positive versus negative adjustment indicators were used. That is, intrinsic religiousness and prayer fulfillment were associated with greater life satisfaction, but extrinsic religiousness was not associated with life satisfaction. These findings were significant even after accounting for covariates (age, gender, ethnicity, social desirability). Results suggest religiousness and spirituality are related but distinct constructs and are associated with adjustment through factors such as social support and optimism.

Sawatzky, R. and Pesut, B. [Department of Nursing, Trinity Western University]. "**Attributes of spiritual care in nursing practice**." *Journal of Holistic Nursing* 23, no. 1 (Mar 2005): 19-33.

[Abstract:] Nurses are increasingly being called on to engage in spiritual care with their patients. A diverse body of theoretical and empirical literature addresses spirituality as it relates to nursing practice, yet there is little consensus about what spiritual nursing care entails. The purpose of this article is to conceptualize spiritual care in relation to nursing practice. A brief historical review indicates that our current understandings of spiritual nursing care have been shaped by three eras characterized by particular approaches: the religious approach, the scientific approach, and the existential approach. We draw elements from each of these approaches to propose attributes of spiritual care in the context of nursing practice. We propose that spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the patient's reality.

Schaefer, K. M. [Department of Nursing, College of Health Professions, Temple University, 3307 N Broad St, Philadelphia, PA 19140; karen.schaefer@temple.edu]. "**The lived experience of fibromyalgia in African American women**." *Holistic Nursing Practice* 19, no. 1 (Jan-Feb 2005): 17-25.

[Abstract:] This study aimed to learn what it is like for African American women to live with fibromyalgia. Van Manen's phenomenological method of writing and rewriting guided the inquiry. The sample included 10 women, who were interviewed for 30 to 60 minutes each. Two agreed to second interviews, for a total of 12 interviews for data analysis. Data analysis revealed the following themes: (a) managing the symptoms, (b) becoming a self-advocate, (c) medications camouflage the pain, (d) coming to grips with the illness means making changes, (e) being accused of "taking a free ride" angers them, (f) support comes from self and spiritual connections, and (g) a certain amount of secrecy makes it easier to live with the illness. Recommendations focus on using a holistic approach to help African American women achieve or maintain their integrity.

Schulz, E. K. [The University of Alabama, Birmingham, Alabama 35294; Schulze@uab.edu]. "**The meaning of spirituality for individuals with disabilities**." *Disability & Rehabilitation* 27, no. 21 (Nov 15, 2005): 1283-1295.

[Abstract:] PURPOSE: To examine the experiences of people with disabilities regarding their spirituality and its meaning for them. This study asked: What are the differences in the meaning of spirituality in the lives of individuals with childhood onset disabilities when compared to those with adult onset disabilities? METHOD: This qualitative study involved semi-structured individual interviews of 12 adults, six with childhood onset and six with adult onset disabilities. Member checking of both transcribed data and open coding was done to ensure trustworthiness. Data was analyzed using open, axial, and selective coding. RESULTS: Findings suggested that the two groups held different perceptions about the meaning of spirituality. For childhood onset participants, two categories of 'connecting and expressing for purpose and

meaning in life', and 'disability as a vehicle to discover god's purpose' were generated. For adult onset participants, two categories of 'connecting and expressing through feelings and actions', and 'disability as a catalyst for spiritual awakening' were derived from the data. CONCLUSIONS: Individuals with childhood and adult onset disabilities perceive and experience spirituality differently. Therefore, different approaches to using spirituality in practice need to be employed for the two groups. Suggestions are provided for incorporating spirituality into occupational therapy practice.

Schwartz, C. E., Merriman, M. P., Reed, G. and Byock, I. [QualityMetric Incorporated, Waltham, MA; xschwartz@qualitymetric.com]. "**Evaluation of the Missoula-VITAS Quality of Life Index--revised: research tool or clinical tool?**" *Journal of Palliative Medicine* 8, no. 1 (Feb 2005): 121-135.

[Abstract:] BACKGROUND: Quality of life (QOL) is a central outcome measure in caring for seriously ill patients. The Missoula-VITAS Quality of Life Index (MVQOLI) is a 25-item patient-centered index that weights each of five QOL dimensions (symptoms, function, interpersonal, wellbeing, transcendence) by its importance to the respondent. The measure has been used to assess QOL for hospice patients, and has been found to be somewhat complex to use and analyze. OBJECTIVE: This study aimed to simplify the measure, and evaluate the reliability and validity of a revised version as either a research or clinical tool (i.e., "psychometric" versus "clinimetric"). DESIGN: Two data collection efforts are described. The psychometric study collected QOL data from 175 patients at baseline, 3-5 days, and 21 days later. The implementation study evaluated the feasibility and utility of the MVQOLI-R during over six weeks of use. SETTING/SUBJECTS: End-stage renal patients on dialysis, hospice, or long-term care patients participated in the psychometric study. The implementation study was done in hospice, home health, and palliative care settings. MEASUREMENTS: The MVQOLI-R and the Memorial Symptom Assessment Scale. RESULTS: The psychometric and implementation studies suggest that the MVQOLI-R performs well as a clinical tool but is not powerful as an outcome research instrument. The MVQOLI-R has the heterogeneous structure of clinimetric tools, and demonstrated both relevance and responsiveness. Additionally, in a clinical setting the MVQOLI-R was useful therapeutically for stimulating communication about the psychosocial and spiritual issues important to the tasks of life completion and life closure. CONCLUSIONS: The MVQOLI-R has clinical utility as a patient QOL assessment tool and may have therapeutic utility as a tool for fostering discussion among patients and their clinicians, as well as for helping patients identify sources of suffering and opportunities during this time in their lives.

Searight, H. R. and Gafford, J. [Forest Park Hospital Family Medicine Residency Program, St. Louis, MO 63139; russellsearight@msn.com]. "**Cultural diversity at the end of life: issues and guidelines for family physicians**." *American Family Physician* 71, no. 3 (Feb 1, 2005): 515-522. Comment on pp, 429-430.

[Abstract:] Ethnic minorities currently compose approximately one third of the population of the United States. The U.S. model of health care, which values autonomy in medical decision making, is not easily applied to members of some racial or ethnic groups. Cultural factors strongly influence patients' reactions to serious illness and decisions about end-of-life care. Research has identified three basic dimensions in end-of-life treatment that vary culturally: communication of "bad news"; locus of decision making; and attitudes toward advance directives and end-of-life care. In contrast to the emphasis on "truth telling" in the United States, it is not uncommon for health care professionals outside the United States to conceal serious diagnoses from patients, because disclosure of serious illness may be viewed as disrespectful, impolite, or even harmful to the patient. Similarly, with regard to decision making, the U.S. emphasis on patient autonomy may contrast with preferences for more family-based, physician-based, or shared physician- and family-based decision making among some cultures. Finally, survey data suggest lower rates of advance directive completion among patients of specific ethnic backgrounds, which may reflect distrust of the U.S. health care system, current health care disparities, cultural perspectives on death and suffering, and family dynamics. By paying attention to the patient's values, spirituality, and relationship dynamics, the family physician can elicit and follow cultural preferences.

Sethness, R., Rauschhuber, M., Etnyre, A., Gilliland, I., Lowry, J. and Jones, M. E. [School of Nursing & Health Professions, University of the Incarnate Word, San Antonio, TX 78209; sethness@universe.uiwtx.edu]. "**Cardiac health: relationships among hostility, spirituality, and health risk**." *Journal of Nursing Care Quality* 20, no. 1 (Jan-Mar 2005): 81-89.

[Abstract:] This study examined hostility, spirituality, and indices of health risk among 100 young, primarily males of Hispanic background. Over half of the subjects were prehypertensive or hypertensive; one third had at least 2 objective risk factors for cardiac disease; and younger participants had lower spirituality scores and higher cynical distrust scores. Body mass index, spirituality, and glucose accounted for 29% of variance in systolic blood pressure; body mass index and age accounted for 39% of variance in diastolic blood pressure. The tools to assess cardiac risk (blood pressure, history, capillary blood screening, body mass index) are all "low tech" and low cost but used together are powerful in identifying risk populations.

Shanafelt, T. D., Novotny, P., Johnson, M. E., Zhao, X., Steensma, D. P., Lacy, M. Q., Rubin. J. and Sloan, J. [Department of Oncology, Mayo Clinic, Rochester, MN; shanafelt.tait@mayo.edu]. "**The well-being and personal wellness promotion strategies of medical oncologists in the North Central Cancer Treatment Group**." *Oncology* 68, no. 1 (2005): 23-32.

This study of 241 oncologists considers spirituality throughout, particularly as a component of Quality of Life as measured by the LASA QOL Survey and special questions on strategies for dealing with stress.

Sherman, A. C., Simonton, S., Latif, U., Spohn, R. and Tricot, G. [Behavioral Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas 72205; ShermanAllenC@uams.edu]. "**Religious struggle and religious comfort in response to illness: health outcomes among stem cell transplant patients**." *Journal of Behavioral Medicine* 28, no. 4 (Aug 2005): 359-367.

[Abstract:] Growing interest has focused on relationships between health and religious coping among cancer patients. However, little is known about the health correlates of negative or conflicted religious responses. The current study examined general religiousness and two modes of cancer-specific religious coping, drawing closer to faith (positive) and struggling with faith (negative), among 213 multiple myeloma patients evaluated at the same point in treatment, during their initial work-up for autologous stem cell transplantation. The outcomes assessed included standardized measures and clinician ratings of depression, general distress, physical functioning, mental health functioning, pain, and fatigue. Results indicated that, after adjusting for relevant control variables, negative religious coping was associated with significantly poorer functioning on all outcomes but one: depression, distress, mental health, pain, and fatigue. Neither general religiousness nor positive religious coping was significantly related to any of the outcomes measured. Results highlight the role of negative or ambivalent religious responses to illness.

Sherman, D. W., Ye, X. Y., McSherry, C., Calabrese, M., Parkas, V. and Gatto, M. [College of Nursing, New York University, New York, NY]. "**Spiritual well-being as a dimension of quality of life for patients with advanced cancer and AIDS and their family caregivers: results of a longitudinal study**." *American Journal of Hospice & Palliative Care* 22, no. 5 (Sep-Oct 2005): 349-362.

[Abstract:] Based on a longitudinal, quality-of-life study, this article presents pilot data regarding the spiritual well-being of patients with advanced cancer or AIDS and their family caregivers. Data include similarities and differences between the patient and caregiver populations and patient/family caregiver dyads as well as trends with regard to changes in spiritual well-being during the illness and dying process. The reliability of the Spiritual Well-Being Scale was examined for patient and caregiver groups, as was the relationship between selected demographic variables and spiritual well-being. Implications for practice are discussed.

Simmons, H. C. [Union Theological Seminary, Richmond VA]. "**Religion, spirituality and aging for the aging themselves**." *Journal of Gerontological Social Work* 45, nos. 1-2 (2005): 41-49. This special issue of the journal was simultaneously published as the book, *Religion, Spirituality, and Aging: A Social Work Perspective*, ed. Harry R. Moody (Haworth Press, 2005). [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

[Abstract:] This article explores some likely characteristics of the particular and specific experiences of the relationship between religion and spirituality for cohorts born before 1935 by attending to three main points: (1) the word spirituality came into common usage in the 1960s, well after people born before [1935]; (2) for some in cohorts born before 1935 spirituality had negative connotations; (3) a definition of spirituality is possible that can express the experience of older adults and, at the same time, sharpen our current understanding of the term to include cognitive, experiential, and volitional elements.

Simmons, Z. [Department of Neurology, Penn State College of Medicine, Hershey, 17033; zsimmons@psu.edu]. "**Management strategies for patients with amyotrophic lateral sclerosis from diagnosis through death**." *Neurologist* 11, no. 5 (Sep 2005): 257-270.

[Abstract:] BACKGROUND: Amyotrophic lateral sclerosis (ALS) is a progressive neuromuscular disorder that is inevitably fatal. There are no effective treatments to stop or reverse the natural course of the disease. The role of the physician is to provide comfort and optimize quality of life. REVIEW SUMMARY: Management of patients with ALS is a process extending over months to years. It begins with breaking the news of the diagnosis and extends through the terminal phase. Medication may extend lifespan by a small amount. However, most efforts are centered around symptom management. Areas of importance include respiration, nutrition, secretions, communication, pseudobulbar affect, therapy and exercise, spasticity and cramps, pain, depression and suicide, spirituality and religion, cognitive changes, the development of advance directives, and care at the end of life. Multidisciplinary ALS clinics provide much-needed support for patients with ALS and their caregivers. CONCLUSION: Although physicians cannot cure ALS or even halt progression, there is much that can be done to manage the physical and emotional symptoms, thereby maintaining or enhancing quality of life. [195 refs.]

Smalligan, R. D. [Quillen College of Medicine, East Tennessee State University, Johnson City 37614; smalliga@etsu.edu]. "**Physician's perspective combining spirituality and medicine: one physician's approach**." *Southern Medical Journal* 98, no. 12 (Dec 2005): 1240-1241.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Speck, P. [Faculty of Medicine and Health Science, University of Southampton]. "**The evidence base for spiritual care**." *Nursing Management (Harrow)* 12, no. 6 (Oct 2005): 28-31.

The author offers a brief review of research supporting the need for spiritual care in health care and pointing up the need for further research.

Spurlock, W. R. [Graduate Nursing Program at Southern University, Baton Rouge, LA]. "**Spiritual well-being and caregiver burden in Alzheimer's caregivers**." *Geriatric Nursing* 26, no. 3 (May-Jun 2005): 154-161.

[Abstract:] The purpose of this study was to examine the relationship between spiritual well-being and caregiver burden in family caregivers of persons with Alzheimer's disease. A descriptive, correlational research design was used, and a convenience sample of 150 caregivers was surveyed (71 African Americans, 77 Caucasians, and 2 other caregivers). Descriptive statistics were used to examine selected caregiver demographics. Statistical analysis included bivariate correlations using the Pearson product-moment coefficient correlation. The study's research question was as follows: What is the relationship between spiritual well-being and caregiver burden? It was hypothesized that there would be an inverse relationship between the 2 variables. A statistically significance inverse relationship ($R = -.493$, $P < \text{or} = .01$) was found to exist between the variables, thereby supporting the study's hypothesis. Additional findings revealed significant differences in African American and Caucasian caregiver's perception of spiritual well-being and caregiver burden. Caregivers also reported frequent use of spiritual behaviors or practices such as prayer. Findings implicate the need for further investigation and development of culturally relevant caregiver intervention strategies and programs that incorporate spirituality as a core component.

Stefanek, M., McDonald, P. G. and Hess, S. A. [Behavioral Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, National Institutes of Health, Department of Health and Human Services, Bethesda, MD 20852; stefanem@mail.nih.gov]. "**Religion, spirituality and cancer: current status and methodological challenges**." *Psycho-Oncology* 14, no. 6 (Jun 2005): 450-463.

[Abstract:] The role of religion and spirituality in health has received increasing attention in the scientific and lay literature. While the scientific attention to this issue has expanded, there continue to be methodological and measurement concerns that often prevent firm conclusions about health and adjustment benefits. Limited attention has been provided to the role of spirituality and religion in cancer. This is true when both disease outcome and adjustment are considered. A recent 'levels of evidence' review examining the link between physical health and religion or spirituality found little overall support for the hypotheses that religion or spirituality impact cancer progression or mortality. Studies examining their impact on quality of life and adjustment are decidedly mixed. In sum, research specifically focusing on the role of religion or spirituality on cancer outcomes has been surprisingly sparse. Such research presents a number of methodological and measurement challenges. Due to these unmet challenges in the literature to date, it is premature to determine what role religion and spirituality play in disease, adjustment, or quality of life outcomes in cancer. A number of suggestions are made for continued research in this area. [114 refs.]

Steffen, P. R. and Masters, K. S. [Department of Psychology, Brigham Young University, Provo, UT 84602; steffen@byu.edu]. "**Does compassion mediate the intrinsic religion-health relationship?**" *Annals of Behavioral Medicine* 30, no. 3 (Dec 2005): 217-224.

[Abstract:] BACKGROUND: Religiosity has been related to positive health outcomes. Although this relationship is primarily based on studies of church attendance and health, more recent work has focused on the potential mechanisms that may mediate the religion-health findings. One principle that is taught by all of the world's major religions is compassion. PURPOSE: It was hypothesized that one pathway through which religiosity may exert its positive influence on health is through encouraging compassionate attitudes and behaviors toward others. METHODS: Two separate studies were conducted examining the relationships among intrinsic religiosity (IR), compassionate attitudes and behaviors, and measures of psychosocial health. Measures of psychosocial health included depressive symptoms, perceived stress, and social support. RESULTS: IR was related to positive psychosocial outcomes in both studies, and compassionate attitudes and behaviors mediated these relationships. Compassionate attitudes showed significant relationships with psychosocial outcome measures (depressive symptoms, $r = -.46$, $p < .0001$; perceived stress, $r = -.45$, $p < .0001$; satisfaction with social support, $r = .54$, $p < .0001$; marital adjustment, $r = .44$) and accounted for most of the mediating effect. Although social support was also related to the variables of interest, its effect was smaller than that of compassionate attitude, and controlling for social support did not significantly add to the mediating effect of compassionate attitude. CONCLUSIONS: This study found compassionate attitude to be an important factor in the religion-health relationship and related to positive psychosocial outcomes, including reduced depressive symptoms and reduced perceived stress. Future research on religiosity and health may benefit from exploring the concept of a "compassionate personality" (i.e., a way of being in the world where others are treated with love and respect).

Tan, H. M., Braunack-Mayer, A. and Beilby, J. [Dept. of General Practice, U. of Adelaide, Australia; heather.tan@adelaide.edu.au]. "**The impact of the hospice environment on patient spiritual expression**." *Oncology Nursing Forum* 32, no. 5 (Sep 2005): 1049-1055. [NOTE: This article was still in the Medline "In-Process" database (but expected to be included in the main Medline database) at the time that this bibliography was published.]

This qualitative study of 12 hospice inpatients found [from the abstract:] …Participants were comfortable discussing their spiritual expression within the context of four main themes: Relationships, That Which Uplifts, Spiritual Practice, and Having Hope. Finding meaning was a common link among these themes. The impact of the hospice environment was variable. Most believed that it facilitated their spiritual expression to some degree. CONCLUSIONS: Spiritual expression is important but is facilitated by individualized spiritual care. Nurses play an important role in the provision of spiritual care within a hospice setting. INTERPRETATION: Nurses are significant in assisting in patients' spiritual expression. Nurses' needs for training in listening skills, confidence in discussing spiritual issues, and time to provide individualized spiritual care should be assessed to ensure optimal patient expression.

Tartaro, J., Luecken, L. J. and Gunn, H. E. [Department of Psychology, Arizona State University, Tempe 85287]. **"Exploring heart and soul: effects of religiosity/spirituality and gender on blood pressure and cortisol stress responses**." *Journal of Health Psychology* 10, no. 6 (Nov 2005): 753-766.

[Abstract:] The current study investigated gender effects on the influence of self-reported religiosity and spirituality on cardiovascular and cortisol responses to a laboratory stressor among young adults. Participants with higher composite religiosity/spirituality scores, religiosity, levels of forgiveness and frequency of prayer showed lower cortisol responses. Greater composite religiosity/spirituality, religiosity, frequency of prayer and attendance at services were associated with lower blood pressure in males and elevated blood pressure in females. Findings suggest that spiritual and/or religious individuals may experience a protective effect against the neuroendocrine consequences of stress, though cardiovascular benefits may vary by gender. This work represents an important step in the convergence of multiple realms of research by linking physiological measures with indicators of individual belief systems.

Tarzian, A. J., Neal, M. T. and O'Neil, J. A. [University of Maryland, Baltimore, MD 21201-1786; atarzian@law.umaryland.edu]. "**Attitudes, experiences, and beliefs affecting end-of-life decision-making among homeless individuals**." *Journal of Palliative Medicine* 8, no. 1 (Feb 2005): 36-48. Comment on pp. 17-19.

[Abstract:] BACKGROUND: Individuals who are homeless may encounter various barriers to obtaining quality end-of-life (EOL) care, including access barriers, multiple sources of discrimination, and lack of knowledge among health care providers (HCPs) of their preferences and decision-making practices. Planning for death with individuals who have spent so much energy surviving requires an understanding of their experiences and preferences. OBJECTIVE: This study sought to increase HCPs' awareness and understanding of homeless or similarly marginalized individuals' EOL experiences and treatment preferences. DESIGN: Focus groups were conducted with homeless individuals using a semi-structured interview guide to elicit participants' EOL experiences, decision-making practices, and personal treatment preferences. SETTING/SUBJECTS: Five focus groups were conducted with 20 inner-city homeless individuals (4 per group) at a free urban health care clinic for homeless individuals in the United States. Sixteen of the 20 participants were African American; 4 were Caucasian. None were actively psychotic. All had experienced multiple losses and drug addiction. FINDINGS: Five main themes emerged: valuing an individual's wishes; acknowledging emotions; the primacy of religious beliefs and spiritual experience; seeking relationship-centered care; and reframing advance care planning. CONCLUSIONS: The narrative process of this qualitative study uncovered an approach to EOL decision-making in which participants' reasoning was influenced by emotions, religious beliefs, and spiritual experience. Relationship-centered care, characterized by compassion and respectful, two-way communication, was obvious by its described absence--reasons for this are discussed. Recommendations for reframing advance care planning include ways for HCPs to transform advance care planning from that of a legal document to a process of goal-setting that is grounded in human connection, respect, and understanding.

Taylor, E. J. [School of Nursing, Loma Linda University, Loma Linda, CA; ejtaylor@sn.llu.edu]. "**Spiritual complementary therapies in cancer care**." *Seminars in Oncology Nursing* 21, no. 3 (Aug 2005): 159-163.

[Abstract:] OBJECTIVES: To review literature documenting the frequency of use and efficacy of spiritual complementary therapies. Implications for clinical practice and research that reflect this literature are offered. DATA SOURCES: Data based research on complementary therapy usage and clinical articles about selected mind/body therapies. CONCLUSION: Spiritual complementary therapies are among the most frequently used. Prayer, spiritual healing, and meditation are the most frequently used spiritual therapies. Equivocal evidence supports their

efficacy. IMPLICATIONS FOR NURSING PRACTICE: Although spiritual practices may not be considered a "therapy," clinicians should assess and support these practices. Clinicians should only pray with patients when observing ethical guidelines.

Taylor, E. J. and Mamier, I. [School of Nursing, Loma Linda University, 11626 Campus Street, Loma Linda, CA 92350; ejtaylor@sn.llu.edu]. "**Spiritual care nursing: what cancer patients and family caregivers want**." *Journal of Advanced Nursing* 49, no. 3 (Feb 2005): 260-267.

[Abstract:] AIM: This paper presents findings from a study that was designed to understand, from the perspective of cancer patients and their family caregivers, what spiritual care is wanted from nurses. BACKGROUND: Distressing and transformative spiritual responses to living with cancer have been documented. Although there is momentum for providing spiritual care, previous research provides scanty and conflicting evidence about what are the clients' wishes or preferences with regard to receiving spiritual care from nurses. METHODS: A convenience sample of 156 adult cancer patients and 68 primary family caregivers, most of whom were Christians, independently completed the Spiritual Interests Related to Illness Scale and a demographic form, both of which were self-completed questionnaires. RESULTS: A variation in responses to items about nurses providing spiritual care therapeutics was observed; means and medians for these items mostly fell between 2 (disagree) and 3 (agree) on a scale of 1-4. Generally, therapeutics that were less intimate, commonly used, and not overtly religious were most welcomed. No significant differences were found between patient and caregiver preferences. A modest, direct correlation was observed between frequency of attendance at religious services and increased preference for nurse spiritual care. CONCLUSION: For both patients and caregivers, nurses must be sensitive to providing spiritual nurture in ways that are welcomed.

Tix, A. P. and Frazier, P. A. [Department of Psychology, Normandale Community College, Bloomington, MN 55431; andrew.tix@normandale.edu]. "**Mediation and moderation of the relationship between intrinsic religiousness and mental health**." *Personality & Social Psychology Bulletin* 31, no. 3 (Mar 2006): 295-306.

[Abstract:] The present study examined specific aspects of individuals' personal strivings as mediators, and religious tradition as a moderator, of the relationship between intrinsic religiousness and mental health. In a sample of 268 university students, the negative relationship between intrinsic religiousness and hostility was mediated by the degree of sanctification within individuals' strivings. The relationships between intrinsic religiousness and both anxiety and depression were moderated by religious tradition, with Catholics' intrinsic religiousness significantly associated with greater anxiety and depression but Protestants' intrinsic religiousness not significantly associated with either of these mental health variables. Implications of these results for future research on religiousness are discussed.

Todres, I. D., Catlin, E. A. and Thiel, M. M. [Pediatric Critical Care Unit, MassGeneral Hospital for Children, Boston, MA]. "**The intensivist in a spiritual care training program adapted for clinicians**." *Critical Care Medicine* 33, no. 12 (Dec 2005): 2733-2736. Comment on pp. 2841-2842.

[Abstract:] BACKGROUND: Critical illness is a crisis for the total person, not just for the physical body. Patients and their loved ones often reflect on spiritual, religious, and existential questions when seriously ill. Surveys have demonstrated that most patients wish physicians would concern themselves with their patients' spiritual and religious needs, thus indicating that this part of their care has been neglected or avoided. With the well-documented desire of patients to have their caregivers include the patient's spiritual values in their health care, and the well-documented reality that caregivers are often hesitant to do so because of lack of training and comfort in this realm, clinical pastoral education for health care providers fills a significant gap in continuing education for caregivers. OBJECTIVES: To report on the first 6 yrs of a unique training program in clinical pastoral education adapted for clinicians and its effect on the experience of the health care worker in the intensive care unit. We describe the didactic and reflective process whereby skills of relating to the ultimate concerns of patients and families are acquired and refined. DESIGN AND SETTING: Clinical pastoral education designed for clergy was adapted for the health care worker committed to developing skills in the diagnosis and management of spiritual distress. Clinician participants (approximately 10-12) meet weekly for 5 months (400 hrs of supervised clinical pastoral care training). The program is designed to incorporate essential elements of pastoral care training, namely experience, reflection, insight, action, and integration. RESULTS: This accredited program has been in continuous operation training clinicians for the past 6 yrs. Fifty-three clinicians have since graduated from the program. Graduates have incorporated clinical pastoral education training into clinical medical practice, research, and/or further training in clinical pastoral education. Outcomes reported by graduates include the following: Clinical practice became infused with new awareness, sensitivity, and language; graduates learned to relate more meaningfully to patients/families of patients and discover a richer relationship with them; spiritual distress was (newly) recognizable in patients, caregivers, and self. CONCLUSIONS: This unique clinical pastoral education program provides the clinician with knowledge, language, and understanding to explore and support spiritual and religious issues confronting critically ill patients and their families. We propose that incorporating spiritual care of the patient and family into clinical practice is an important step in addressing the goal of caring for the whole person.

Torke, A. M., Garas, N. S., Sexson, W. and Branch, W. T. [Division of General Medicine, Emory University School of Medicine, Atlanta, GA 30303]. "**Medical care at the end of life: views of African American patients in an urban hospital**." *Journal of Palliative Medicine* 8, no. 3 (Jun 2005): 593-602.

[Abstract:] BACKGROUND: Although one goal of end-of-life care is to honor the wishes and needs of patients, little research has been done to characterize what is important to seriously ill African American patients at the end of life. OBJECTIVE: To characterize the views of seriously ill African American patients toward end-of- life care. DESIGN: A qualitative study using semistructured, in-depth interviews. SETTING AND PARTICIPANTS: Patients in a large, urban, public hospital who are facing a serious illness. RESULTS: Twenty-three African American patients were interviewed. Although most acknowledged a point at which they would want to cease aggressive care, some equated this with giving up. Most subjects expressed that the end of life was in God's hands. Many expressed a concern to be free of pain and suffering. Few saw a significant role for the physician at the end of life. Some had expressed their wishes for care to a family member. Others thought such discussions were unnecessary because a family member would make decisions or because death was not imminent. Subjects raised concerns about trust in the physician and the burden of end-of-life discussions. CONCLUSIONS: African Americans in an urban, public hospital who are facing a severe illness have clear desires for care at the end of life and are willing to discuss their views at length. Such discussions should explore patients' desire for aggressive care, consider spiritual views and the importance of family in end-of-life decisions, and consider that some patients will not believe such discussions are necessary.

Torosian, M. H. and Biddle, V. R. [Department of Surgical Oncology, Fox Chase Cancer Center, Philadelphia, PA 19111; mh_torosian@fccc.edu]. "**Spirituality and healing**." *Seminars in Oncology* 32, no. 2 (Apr 2005): 232-236.
[Abstract:] Spirituality can exert a tremendous impact on ones health and promote recovery from trauma and illness, including cancer. Throughout the history of mankind, spirituality and religion have played a major role in healing a variety of physical and mental illnesses. Cancer is one of the most devastating illnesses, as it affects ones physical, emotional, psychological, and spiritual well-being. An increasing body of scientific literature supports the concept that spirituality can significantly improve healing from cancer and promote the coping response of caregivers and healthcare professionals. We believe that spirituality is an important component of the healing process and should be integrated with conventional medicine to treat this complex disease.

Touhy, T. A., Brown, C. and Smith, C. J. [Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL 33431]. "**Spiritual caring: end of life in a nursing home**." *Journal of Gerontological Nursing* 31, no. 9 (Sep 2005): 27-35.
[Abstract:] The purpose of this qualitative study was to explore spiritual care for dying nursing home residents from the perspectives of registered nurses, practical nurses, certified nursing assistants, advanced practice nurses, and physicians. Five major themes emerged: honoring the person's dignity, intimate knowing in the nursing home environment, wishing we could do more, personal knowing of self as caregiver, and struggling with end-of-life treatment decisions. Spiritual caring was described within the context of deep personal relationships, holistic care, and support for residents. Spiritual care responses and similarities and differences in the experiences of participants are presented. Education and research about how to assist residents and families as they struggle with difficult end-of-life decisions, adequate time and staff to provide the kind of care they "wished they could," and development of models that honor the close connection and attachment of staff to residents could enhance end-of-life care in this setting.

True, G., Phipps, E. J., Braitman, L. E., Harralson, T., Harris, D. and Tester, W. [Albert Einstein Healthcare Network, Philadelphia, PA 19144]. "**Treatment preferences and advance care planning at end of life: the role of ethnicity and spiritual coping in cancer patients**." *Annals of Behavioral Medicine* 30, no. 2 (Oct 2005): 174-179, 2005.
[Abstract:] BACKGROUND: Although studies have reported ethnic differences in approaches to end of life, the role of spiritual beliefs is less well understood. PURPOSE: This study investigated differences between African American and White patients with cancer in their use of spirituality to cope with their cancer and examined the role of spiritual coping in preferences at end-of-life. METHODS: The authors analyzed data from interviews with 68 African American and White patients with an advanced stage of lung or colon cancer between December 1999 and June 2001. RESULTS: Similar high percentages of African American and White patients reported being "moderately to very spiritual" and "moderately to very religious." African American patients were more likely to report using spirituality to cope with their cancer as compared to their White counterparts ($p = .002$). Patients who reported belief in divine intervention were less likely to have a living will ($p = .007$). Belief in divine intervention, turning to higher power for strength, support and guidance, and using spirituality to cope with cancer were associated with preference for cardiopulmonary resuscitation, mechanical ventilation, and hospitalization in a near-death scenario. CONCLUSIONS: It was found that patients with cancer who used spiritual coping to a greater extent were less likely to have a living will and more likely to desire life-sustaining measures. If efforts aimed at improving end-of-life care are to be successful, they must take into account the complex interplay of ethnicity and spirituality as they shape patients' views and preferences around end of life.

Upchurch, S. and Mueller, W. H. [School of Nursing, University of Texas Health Science Center at Houston, 77030; Sandra.L.Upchurch@uth.tmc.edu]. "**Spiritual influences on ability to engage in self-care activities among older African Americans**." *International Journal of Aging & Human Development* 60, no. 1 (2005): 77-94.
[Abstract:] The influence of spiritual factors on the ability of African-American elders to carry out instrumental activities of daily living (IADL) independent of age, gender, education, and self-rated health is explored using the religion-health explanatory model in a cross-sectional sample of 96 African-American community dwelling adults 62 to 93 years of age. The Reed spiritual perspective (SPS) and self-transcendence (STS) scales are used to study spiritual factors (Reed, 1991). The typical respondent was 75 years of age, female, widowed with 10.4 years of education. Self-rated health and age are strongly related to IADL in models that include the other variables ($R2 = 0.41$, $p < 0.01$). Those who are younger and those who self-report better health have higher IADL scores than those without these characteristics. Spiritual factors are significantly related to IADL in a model that includes an interaction of STS with education ($R2= 0.50$). Among the least educated, STS is associated with higher scores of IADL. Addition of the interaction to the model resulted in a significant positive association of both STS and education with IADL. SPS was unrelated to IADL. Caregivers concerned with functional ability may want to consider interventions based on increasing a sense of self-transcendence, and to consider educational level as a potential moderator of this relationship. Criticism of the religion-health literature has suggested that putative health effects of religion may be exaggerated, because of failure to take confounding variables into account (Sloan, Bagiella, & Powell, 1999). However, this study and a recent survey by Musick, House, and Williams (2004) are evidence that it is just as likely that health benefits of religion would be hidden by confounders as that they would be exaggerated by them.

Vance, D. E. and Woodley, R. A. [University of Alabama at Birmingham]. "**Strengths and distress in adults who are aging with HIV: a pilot study**." *Psychological Reports* 96, no. 2 (Apr 2005): 383-386.
[Abstract:] In this qualitative pilot study, distress and strengths associated with aging with Human Immunodeficiency Virus (HIV) were identified for 12 participants. Potential sources of distress were fear of death, financial worries, fear of disclosure, stigma, and long-term coping. Strengths were hardiness, renewed spirituality, social support, community service, and openness to aging. Ways of mitigating these barriers and accentuating these strengths can be explored by mental health professionals if extended with a representative larger sample.

Verna, E. C., Hunt, K. H., Renz, J. F., Rudow, D. L., Hafliger, S., Dove, L. M., Kinkhabwala, M., Emond, J. C. and Brown, R. S., Jr. [Center for Liver Disease and Transplantation, New York Presbyterian Hospital, New York, NY]. "**Predictors of candidate maturation among potential living donors**." *American Journal of Transplantation* 5, no. 10 (Oct 2005): 2549-2554.
Among the predictors for donation found in this study of a consecutive sample of 237 donors was [from the abstract:] self-description as religious but not regularly practicing.

Villagomeza, L. R. [University of South Florida, Tampa; lvillago@hsc.usf.edu]. "**Spiritual distress in adult cancer patients: toward conceptual clarity**." *Holistic Nursing Practice* 19, no. 6 (Nov-Dec 2005): 285-294.

[Abstract:] Spiritual distress is conceptualized as impairments in 7 constructs of a person's sense of spirituality: (1) connectedness, (2) faith and religious belief system, (3) value system, (4) meaning and purpose in life, (5) self-transcendence, (6) inner peace and harmony, and (7) inner strength and energy. This article clarifies spiritual distress through concept analysis and provides nurses with cues for its recognition in adult patients with cancer.

Wachholtz, A. B. and Pargament, K. I. [Bowling Green State University, Bowling Green, OH 43403; amywach@bgnet.bgsu.edu]. "**Is spirituality a critical ingredient of meditation? Comparing the effects of spiritual meditation, secular meditation, and relaxation on spiritual, psychological, cardiac, and pain outcomes**." *Journal of Behavioral Medicine* 28, no. 4 (Aug 2005): 369-384.

[Abstract:] This study compared secular and spiritual forms of meditation to assess the benefits of a spiritual intervention. Participants were taught a meditation or relaxation technique to practice for 20 min a day for two weeks. After two weeks, participants returned to the lab, practiced their technique for 20 min, and placed their hand in a cold-water bath of 2 degrees C for as long as they could endure it. The length of time that individuals kept their hand in the water bath was measured. Pain, anxiety, mood, and the spiritual health were assessed following the two-week intervention. Significant interactions occurred (time x group); the Spiritual Meditation group had greater decreases in anxiety and more positive mood, spiritual health, and spiritual experiences than the other two groups. They also tolerated pain almost twice as long as the other two groups.

Watters, C. L., Harvey, C. V., Meehan, A. J. and Schoenly, L. [Wake Forest University Baptist Medical Center, Winston-Salem, NC]. "**Palliative care: a challenge for orthopaedic nursing care**." *Orthopaedic Nursing* 24, no. 1 (Jan-Feb 2005): 4-7.

[Abstract:] Patients who face chronic, incurable, or life-ending musculoskeletal conditions often receive inadequate care either due to a lack of caregiver awareness or inattention to maintaining the highest quality at the end of life. Palliative care focuses on the comprehensive physical, psychological, social, spiritual, and existential needs of patients with life-threatening or debilitating illness. Orthopaedic nurses and all nurses in general are challenged to incorporate palliative care principles into care planned with patients and families facing end-of-life issues. This article addresses the leadership role the National Association of Orthopaedic Nurses (NAON) has taken to develop a consensus document which endorses the Last Acts Precepts of Palliative Care and affirms the need for palliative care with patients who experience life-threatening illness. A case study is used to illustrate the opportunity a multidisciplinary team has to center care on the individual, while remaining sensitive to the holistic needs of the patient for self-determination at the end of life.

Weaver, A. J. "**Clergy as health care provider**s." *Southern Medical Journal* 98, no. 12 (Dec 2005): 1237.

This brief piece is part of the journal's new Spirituality/Medicine Interface Project. See the section from pp. 1233-1255 for other articles.

Weisman, A., Rosales, G., Kymalainen, J. and Armesto, J. [Department of Psychology, University of Miami, Coral Gables, FL 33146-0751]. "**Ethnicity, family cohesion, religiosity and general emotional distress in patients with schizophrenia and their relatives**." *Journal of Nervous and Mental Disease* 193, no. 6 (Jun 2005): 359-368.

[Abstract:] This study included a sample of 57 Anglo-American, Latino American, and African American patients with schizophrenia and their family members. Findings indicate that for patients, as hypothesized, increasing perceptions of family cohesion was associated with less general emotional distress and fewer psychiatric symptoms. For family members of Latino and African American descent, greater self-reported family cohesion also appeared to have a protective effect against emotional distress, as hypothesized. However, no association was found between family cohesion and general emotional distress for Anglo-American family members. Interestingly, no relationship was found between patients' and their relatives' views of their family environment. Thus, researchers and clinicians working with families are encouraged to attain separate assessments of the family environment from each individual member. Contrary to expectations, religiosity was not associated with patient or family member emotional distress or with patient psychiatric symptoms. Study implications are discussed.

Wenzel, L., DeAlba, I., Habbal, R., Kluhsman, B. C., Fairclough, D., Krebs, L. U., Anton-Culver, H., Berkowitz, R. and Aziz, N. [Department of Medicine and Center for Health Policy Research, University of California-Irvine, 111 Academy Way, Suite 220, Irvine, CA 92697-5800; LWenzel@uci.edu]. "**Quality of life in long-term cervical cancer survivors**." *Gynecologic Oncology* 97, no. 2 (May 2005): 310-317. Comment on pp. 307-309.

[Abstract:] OBJECTIVES: To describe the quality of life (QOL) and long-term psychosocial sequelae of women of childbearing age diagnosed with cervical cancer 5-10 years earlier. METHODS: Utilizing a cross-sectional descriptive design, 51 cervical cancer survivors and 50 age-matched controls completed a comprehensive QOL interview. RESULTS: Participants were predominantly married, non-Hispanic White, with a mean age at diagnosis of 37 years and a mean age at interview of 45 years. This disease-free sample enjoys a good QOL, with physical, social, and emotional functioning comparable to or better than comparative norms. However, certain psychological survivorship sequelae and reproductive concerns persist. Participants reporting good QOL were less likely to report ongoing coping efforts related to having had this illness and were more likely to report greater social support, greater sexual pleasure, and less cervical cancer-specific distress. In a multiple-regression model, cancer-specific distress, spiritual well-being, maladaptive coping, and reproductive concerns accounted for 72% of the variance in QOL scores. Fifty-nine percent of respondents expressed that they would likely participate in a counseling program today to discuss psychosocial issues raised by having had cervical cancer, and 69% stated that they would have attended a support group program during the initial treatment if it had been offered. CONCLUSIONS: This information provides insight into the complex survivorship relationships between QOL and sequelae of cervical cancer for women diagnosed during childbearing years. Therefore, it is important for health care professionals to recognize that aspects of cancer survivorship continue to require attention and possible follow-up care.

Williams, A. L., Selwyn, P. A., Liberti, L., Molde, S., Njike, V. Y., McCorkle, R., Zelterman, D. and Katz, D. L. [Yale Prevention Research Center, New Haven, Connecticut 06418]. "**A randomized controlled trial of meditation and massage effects on quality of life in people with late-stage disease: a pilot study**." *Journal of Palliative Medicine* 8, no. 5 (Oct 2005): 939-952.

[Abstract:] CONTEXT: Certain meditation practices may effectively address spiritual needs near end-of-life, an often overlooked aspect of quality of life (QOL). Among people subject to physical isolation, meditation benefits may be blunted unless physical contact is also addressed. OBJECTIVE: To evaluate independent and interactive effects of Metta meditation and massage on QOL in people with acquired immunodeficiency syndrome (AIDS). DESIGN: Randomized controlled blinded factorial pilot trial conducted from November 2001 to September 2003. SETTING: An AIDS-dedicated skilled nursing facility in New Haven, Connecticut. PARTICIPANTS: Fifty-eight residents

(43% women) with late stage disease (AIDS or comorbidity). INTERVENTIONS: Residents were randomized to 1 month of meditation, massage, combined meditation and massage, or standard care. The meditation group received instruction, then self-administered a meditation audiocassette daily. A certified massage therapist provided the massage intervention 30 minutes per day 5 days per week. OUTCOME MEASURE: Changes on Missoula-Vitas QOL Index overall and transcendent (spiritual) scores at 8 weeks. Results: The combined group showed improvement in overall ($p = 0.005$) and transcendent ($p = 0.01$) scores from baseline to 8 weeks, a change significantly greater ($p < 0.05$) than the meditation, massage, and control groups. CONCLUSIONS: The combination of meditation and massage has a significantly favorable influence on overall and spiritual QOL in late-stage disease relative to standard care, or either intervention component alone.

Williams, C. M., Wilson, C. C. and Olsen, C. H. [Department of Family Medicine, Biostatistics Counsulting Center, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814; cwilliams@usuhs.mil]. "**Dying, death, and medical education: student voices**." *Journal of Palliative Medicine* 8, no. 2 (Apr 2005): 372-381.

[Abstract:] BACKGROUND: Medical schools require time for end-of-life topic. However, there is very little medical literature that directly addresses how medical students and residents are to behave, manage emotion, and confront their own grieving process when patients die. OBJECTIVE: The purpose of this study was to understand how preclinical medical students describe feelings toward the death of a hypothetical patient in order to affect curricular change at our institution. DESIGN: Qualitative methods using narrative analysis of student papers to identify patterns, core constructs, and themes related to student's projected feelings on patient death. SETTING/SUBJECTS: Federal medical school with volunteer medical students from the class of 2005. RESULTS: Two thirds of the students (108/162) volunteered to participate. Five significant themes emerged including: (1) affective responses (guilt, fear, blame, impotence), (2) personal experience with death, (3) survivorship and professionalism, (4) the meaning of death, and (5) the affects of religion and spirituality. Many feared facing families and responding to grief. An active belief in an afterlife was mentioned as a coping strategy by 40% of the students. CONCLUSIONS: End-of-life curriculum is more than teaching about the clinical care of the patient and support of family. These medical students overwhelmingly identified the need for coping strategies when confronting the dying patient. Teaching students these coping strategies should be an integral part of an end-of-life curriculum. Writing exercises cannot only help students recognize and reflect upon their emotions and feelings, but also allow educators a window into curricular elements that need to be added to death and dying education.

Williams, J. R., Jr. [VITAS Healthcare Corporation, Miami, FL; mountaindoctor@earthlink.net]. "**Depression as a mediator between spousal bereavement and mortality from cardiovascular disease: appreciating and managing the adverse health consequences of depression in an elderly surviving spouse**." *Southern Medical Journal* 98, no. 1 (Jan 2005): 90-95. Comment on pp. 3-4.

[Abstract:] Bereavement in the elderly is becoming a more frequent phenomenon as a result of the aging of the population. The death of an elderly spouse increases psychologic morbidity, particularly depressive symptoms, as well as mortality. Depression increases the risk of death independent of age or bereavement, and can thus exacerbate the health effects of losing a spouse. This magnifier effect is especially pernicious because bereavement and depression both tend to increase cardiovascular mortality rates. Primary care physicians should be alert for signs of mood disorders in elderly persons who have recently lost a spouse. Potential therapies for depression in an elderly bereaved individual include pharmacologic agents, psychotherapy, and psychosocial support. Data also support the value of encouraging religious patients to continue with spiritual observances. Although these approaches decrease mood disorders, it is not yet clear whether they also reduce the risk of death or cardiovascular disease.

Wink, P. and Scott, J. [Department of Psychology, Wellesley College, Wellesley, MA 02482; pwink@wellesley.edu]. "**Does religiousness buffer against the fear of death and dying in late adulthood? Findings from a longitudinal study**." *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 60, no. 4 (Jul 2005): P207-214.

[Abstract:] We used longitudinal data ($N = 155$) to investigate the relation between religiousness and fear of death and dying in late adulthood. We found no linear relations between religiousness and fear of death and dying. Individuals who were moderately religious feared death more than individuals who scored high or low on religiousness. Fear of death also characterized participants who lacked congruence between belief in an afterlife and religious practices. We replicated the curvilinear relation between fear of death and religiousness in late adulthood with religiousness in middle adulthood, controlling for sociodemographic variables, life satisfaction, social support, and stressors. Older participants (in their mid-70s) who experienced more bereavement and illness feared the dying process less than younger participants (in their late 60s). The findings support the hypothesis that firmness and consistency of beliefs and practices, rather than religiousness per se, buffers against death anxiety in old age.

Winn, P. A. and Dentino, A. N. [Geriatrics Program, Residency Division, Department of Family Medicine, University of Oklahoma Health Science Center, Oklahoma City, OK 73104; peter-winn@ouhsc.edu]. "**Quality palliative care in long-term care settings**." *Journal of the American Medical Directors Association* 6, no. 3, suppl. (May-Jun 2005): S89-98.

[Abstract:] It is paramount that physicians and midlevel practitioners who care for residents in long-term care facilities be able to provide high-quality comfort care to their patients, the majority of whom are frail and suffering from chronic and progressive diseases. Physicians must be knowledgeable in the assessment, prevention, and relief of patients' physical, emotional, and spiritual distress, as well as develop appropriate attitudes, knowledge, and skills to care for patients who are in the last years of life. The provision of high-quality palliative care is the essence of long-term care medicine.

Woodman, C. E. [Stillwater United Church, 135 North Hudson Avenue, Stillwater, NY 12170]. "**Seeking meaning in late stage dementia**." *The Journal of Pastoral Care & Counseling: JPCC* 59, no. 4 (2005): 335-343.

[Abstract:] The author uses case studies to illustrate the effectiveness of two techniques which pastoral caregivers may teach to family carers of dementia patients. In the last stages of dementia, it is important to seek meaning and keep in significant contact as long as possible, both for family members as well as for the dementia patients. After a brief literature review, implications for care theory, practice, and policy are reviewed, and a scientific bias is illustrated. These techniques build on the work of C. G. Jung and James Hillman, utilizing metaphor in non-rational uses of language. It is suggested that pastoral caregivers could teach these techniques to families of this population, in the hope of prolonging meaningful connection with their loved one.

Zachariae, R., Hojgaard, L., Zachariae, C., Vaeth, M., Bang, B. and Skov, L. [Psychooncology Research Unit, Department of Oncology, Aarhus University Hospital, 8000 Arhus C, Denmark; bzach@as.aaa.dk]. "**The effect of spiritual healing on in vitro tumour cell proliferation and viability--an experimental study**." *British Journal of Cancer* 93, no. 5 (Sep 5, 2005): 538-543.

[Abstract:] Alternative treatments such as spiritual healing and prayer are increasingly popular, especially among patients with life-threatening diseases such as cancer. According to theories of spiritual healing, this intervention is thought to influence living cells and organisms independently of the recipient's conscious awareness of the healer's intention. The aim of this study was to test the hypothesis that spiritual healing will reduce proliferation and viability of two cancer cell lines in vitro. Three controlled experiments were conducted with three different healers and randomized allocation of cells to five different doses of healing or control. Researchers conducting the assays and statistical analyses were blinded to the experimental conditions. Main outcome measures were MTT viability, 3H-thymidine incorporation and counts of an adherent human breast cancer cell line (MCF-7), and a nonadherent mouse B-lymphoid cell line (HB-94). Analyses of variance (ANOVAs) revealed no significant main or dose-related effects of spiritual healing compared to controls for either of the two cell lines or any of the assays (P-values between 0.09 and 0.96). When comparing healing and control across all three experimental days, doses, assays, and cells, 34 (51.6%) of 66 independent comparisons showed differences in the hypothesized direction (P = 0.90). The average effect size across cell lines, days, assays, and doses approached zero (Cohen's d = -0.01). The results do not support previous reports of beneficial effects of spiritual healing on malignant cell growth in vitro. Reported beneficial effects of spiritual healing on the well-being of cancer patients seem more likely to be mediated by psychosocial and psychophysiological effects of the healer-patient relationship.

Zaza, C., Sellick, S. M. and Hillier, L. M. [Centre for Behavioural Research and Program, University of Waterloo, Canada]. "**Coping with cancer: what do patients do**." *Journal of Psychosocial Oncology* 23, no. 1 (2005): 55-73.

This study of 296 Canadian outpatients (98% response rate from a sample taken from a master patient list) at the Northwestern Ontario Regional Cancer Centre, used in-person interviews about 7 individual coping strategies (music, breathing exercises, meditation, prayer, muscle relaxation, visualization/imagery, and hypnosis/self-hypnosis) and four coping strategies offered through the institution (individual counseling, family counseling, support groups, and religious support by a chaplain or other religious professional). Among the findings: "The three most commonly used strategies were prayer, used by 64% of participants, music, used by 43% of participants, and religious support, used by 27% of participants….[and]…Fifty-six percent of participants reported using prayer for over five years (80% of these reported that they had been praying their entire life)" [p. 59]. In terms of perceived effectiveness of coping strategies, prayer was perceived as "quite a bit or very much effective" by the most participants (146 patients), followed by music (89 patients), religious support (65 patients), and visualization/imagery (56 patients)--while 37, 43, 15, and 9 patients, respectively, found these particular coping strategies "not at all or little effective" [--see Figure 4 on p. 68].

Earlier bibliographies are available on line through the web site of the Department of Pastoral Care at the Hospital of the University of Pennsylvania at www.uphs.upenn.edu/pastoral.