

Spirituality & Health: A Select Bibliography of *Medline*-Indexed Articles Published in 2008

Chaplain John W. Ehman (john.ehman@uphs.upenn.edu)
University of Pennsylvania Health System - Philadelphia, PA
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The following is a selection of 387 *Medline*-indexed journal articles pertaining to spirituality & health published during 2008, from among the more than 1,700 articles categorized under the subject headings of “Religion and Medicine,” “Religion and Psychology,” “Religion,” “Spirituality,” and “Pastoral Care” (and includes some articles from *Medline*’s *In-Process* database not yet listed on the general *Medline* database at the time of this bibliography’s completion). 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*.

Abraham, J. L. [Dana-Farber Cancer Institute, Boston, MA; jabrahm@partners.org]. “**Patient and family requests for hastened death.**” *Hematology* (2008): 475-480. [This article was still listed on *Medline*’s *In-Process* database at the time of this bibliography’s completion.]

The author addresses at several points the role of spiritual or existential issues in requests for hastened death (--see pp. 476 and 478) and recommends that a chaplain be consulted in some cases.

Ahern, M. M. and Hendryx, M. [Dept. of Pharmacotherapy, Washington State University, Spokane]. “**Community participation and the emergence of late-life depressive symptoms: differences between women and men.**” *Journal of Women's Health* 17, no. 9 (Nov 2009): 1463-1470.

This analysis of a subset of data from a Wisconsin longitudinal survey (n = 2546) found [from the abstract:] Community participation, in the form of volunteering, religious attendance, and engagement in community organizations, is related to reduced risk of first-time depressive symptoms among older women.

Ai, A. L., Park, C. L. and Shearer, M. [University of Washington Health Sciences, Seattle; amyai@u.washington.edu]. “**Spiritual and religious involvement relate to end-of-life decision-making in patients undergoing coronary bypass graft surgery.**” *International Journal of Psychiatry in Medicine* 38, no. 1 (2008): 113-132.

[Abstract:] Settling one’s end-of-life affairs in the face of coronary artery bypass graft surgery (CABG) can be both distressing and beneficial for individuals who are facing imminent threat of death. Religious thoughts, common in this context, may offer some comfort and support for facing this process. However, few empirical studies have addressed the role of religious or spiritual involvement in the settling of one’s end-of-life affairs in cardiac patients. This prospective study investigated the effect of religious and spiritual factors on whether decisions regarding end-of-life had been made in a sample of middle-aged and older patients undergoing CABG. In particular, we expected faith factors of an intrinsic nature would promote this decision. Two weeks pre-operatively, patients (mean age = 65 years) were recruited for interviews. One hundred seventy-seven CABG patients completed the pre-operative and post-operative follow-up one month after surgery, while 96 offered information regarding their engagement in settling end-of-life affairs. Cardiac indicators were obtained from the computerized Society of Thoracic Surgeons’ Adult Cardiac Database (STS). Multiple regression analyses revealed that private religiousness increased the likelihood of having engaged in end-of-life decision planning by nearly half again (OR = .147, 95% CI = 1.10, 1.96, p < .05) and that experiencing reverence in secular contexts nearly doubled the likelihood (OR = .199, 95% CI = 1.16, 3.44, p < .05). The reduced likelihood of having made plans was observed among those who scored higher on experiencing reverence in religious contexts (OR = .44, 95% CI = .23, .87, p < .05) and among patients using petitionary prayer (OR = .21, 95% CI = .04, .98, p < .05). These effects manifested after controlling for age, impacted functioning, and number of diseased arteries. Therefore, faith factors appear to have independent but complex effects on end-of-life decision making in middle-aged and older cardiac patients.

Allen, R. S., Hilgeman, M. M., Ege, M. A., Shuster, J. L. Jr. and Burgio, L. D. [Department of Psychology, University of Alabama, Tuscaloosa; rsallen@bama.ua.edu]. “**Legacy activities as interventions approaching the end of life.**” *Journal of Palliative Medicine* 11, no. 7 (Sep 2008): 1029-1038.

[Abstract:] We examined the efficacy of an innovative family-based intervention designed to decrease caregiving stress and increase family communication among individuals with chronic, life-limiting illnesses and their family caregivers in a randomized, contact control group design. The intervention group received three home visits in which the interventionist actively worked with the family to construct a personal Legacy, usually a scrapbook with photographs or audiotaped stories. Control group families received three supportive telephone calls. Of the 42 families that entered the project, 31 families completed follow-up assessments within 9 to 10 weeks (14 control; 17 intervention; 72% African American) for a retention rate of 74%. Intervention caregivers showed reduced caregiving stress in comparison with control group caregivers, who showed increases in stress. Intervention patients reported decreased breathing difficulty and increased religious meaning. Caregivers and patients reported greater social interaction on the part of the patient. All participants in the intervention group initiated a Legacy activity and reported that Legacy improved family communication. Legacy interventions hold promise and are simple to implement.

Amstadter, A. B., McCauley, J. L., Ruggiero, K. J., Resnick, H. S. and Kilpatrick, D. G. [Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, National Crime Victims Center, Charleston, SC; amstadt@musc.edu]. “**Service**

utilization and help seeking in a national sample of female rape victims.” *Psychiatric Services* 59, no. 12 (Dec 2008): 1450-1457.

Among the findings of this study using telephone interviews with a representative sample of 3,001 women (aged 18 to 76 years), conducted in 2006: “In regard to specific types of help sought, 38% went to a medical professional, 15% sought religious counsel, and 54% sought help from a mental health specialist. (Percentages are weighted.)” [p. 1454]

Anastasi, M. W. and Newberg, A. B. [University of Pennsylvania, Philadelphia, PA]. “**A preliminary study of the acute effects of religious ritual on anxiety.**” *Journal of Alternative & Complementary Medicine* 14, no. 2 (Mar 2008): 163-165. Comment by Oman, D. in vol. 14, no. 6 (Jul 2008): 620.

[Abstract:] BACKGROUND: Various rituals have been shown to have both psychologic as well as physical effects. However, many rituals have multiple components that can account for such effects. Few studies have distinguished between the effects of ritual and those related specifically to religious content and teachings. OBJECTIVES: The present study investigated the acute effects of the ritual of reciting the Rosary, which contains relatively little specific religious content compared to receiving specific teaching of religious concepts, on the level of anxiety. METHODS: We studied 30 students in a Catholic college divided into two intervention groups. Twelve (12) students participated in recitation of the Rosary, whereas 18 students viewed a religiously oriented video. Both groups were measured for anxiety pre- and postintervention through the use of the State-Trait Anxiety Inventory. RESULTS: A significant reduction in anxiety was observed in subjects reciting the Rosary compared to the group of subjects watching the video. CONCLUSIONS: These preliminary results suggest that ritual itself may be a significant contributor to the effects of religious practices on psychologic well-being.

Anderson, C. J., Vogel, L. C., Chlan, K. M. and Betz, R. R. [Shriners Hospitals for Children, Chicago, IL; cjanderso@comcast.net]. “**Coping with spinal cord injury: strategies used by adults who sustained their injuries as children or adolescents.**” *Journal of Spinal Cord Medicine* 31, no. 3 (2008): 290-296.

[From the abstract:] OBJECTIVE: To identify the coping strategies used by adults with pediatric-onset spinal cord injuries (SCI) and to determine how these coping strategies were related to demographics, injury-related factors, and adult outcomes. METHODS: Study Participants were adults who sustained SCI at age 18 years or younger and were interviewed at age 24 years or older. This is part of a large longitudinal study for which there were 864 eligible participants....RESULTS: Of 259 participants, 62% were male and 58% had tetraplegia. The average age at injury was 14 years (0-18 years) and average age at interview was 30 years (24-42 years). Of 8 coping strategies assessed, 99% of participants used acceptance, 94% used positive reframing, 93% used active coping, 89% used emotional support, 89% used humor, and 74% used religion. The negative coping skills of behavioral disengagement and substance use were used by 28% and 15%, respectively. A hierarchical regression analysis was used to predict higher adult life satisfaction by using the positive coping strategies of seeking emotional support, acceptance, and religion; it was negatively associated with substance use....

Ando, M., Morita, T., Lee, V. and Okamoto, T. [St. Mary's College, Kurame City, Fukuoka, Japan; andou@st-mary.ac.jp]. “**A pilot study of transformation, attributed meanings to the illness, and spiritual well-being for terminally ill cancer patients.**” *Palliative & Supportive Care* 6, no. 4 (Dec 2008): 335-340.

[Abstract:] OBJECTIVE: The present study investigated what types of transformation terminally ill cancer patients experienced from diagnosis until the terminal stage, what meanings terminally ill cancer patients attributed to their illness, and whether or not those who attributed positive meaning to their illness achieved high levels of spiritual well-being as a preliminary study. METHOD: Ten terminally ill cancer patients in the hospice wards of two general hospitals participated. A clinical psychologist conducted a semistructured interview with the patients individually for about 60 min. Patients completed the FACIT-Sp and HADS before the interview and talked about the meanings of cancer experience. The contents of the interviews were analyzed qualitatively. Patients were separated into high and low levels of spiritual-well being by the median of FACIT-Sp scores. RESULTS: Three types of transformation were extracted: "group with peaceful mind," "group with both positive attitude and uneasy feeling," and "groups with uneasy feeling." As attributed meanings to the illness, five categories were extracted: "positive meaning," "natural acceptance," "negative acceptance," "search for meaning," and "regret and sorrow." Patients in the high level spiritual well-being group attributed the meaning of illness to "positive meaning" and "natural acceptance," and those in the low level spiritual well-being group attributed it to "regret and sorrow" and "search for meaning." SIGNIFICANCE OF RESULTS: Some Japanese terminally ill cancer patients experienced positive transformation, and patients who attributed "positive meaning" and "natural acceptance" to their illness experience achieved high levels of spiritual well-being.

Aranda, M. P. [School of Social Work, University of Southern California, Los Angeles; aranda@usc.edu]. “**Relationship between religious involvement and psychological well-being: a social justice perspective.**” *Health & Social Work* 33, no. 1 (Feb 2008): 9-21.

[Abstract:] Although religion has not been a mainline topic of empirical inquiry in the gerontological social work literature, there has been growing recognition in the past two decades of the health protective effects of religious involvement on both physical and psychological well-being. Depression interferes with both individual and social functioning that can lead to persistent problems in healthy human development, social relationships, and empowerment in the service of social justice. Attention to the salubrious effects of religious involvement on the psychological well-being among older U.S. racial and ethnic groups is still in its nascent stage. This article examines the relationship among religious involvement, private prayer, and depression in a low-income clinical sample of 230 older U.S.-born and immigrant Latinos. Higher levels of religious attendance were associated with lower risk of depressive illness after adjusting for selective factors such as physical functioning, stress exposure, and social support. Private prayer was not associated with depression. Although immigrants were more likely to attend worship services, they reported the same rates of depression as their U.S.-born counterparts. The study is an initial step toward disentangling the mental health protective effects of religious involvement on the health and well-being of older Latinos in the United States.

Arendt, K., Zhou, J., Segal, S. and Camann, W. [Brigham and Women's Hospital, Boston, MA; wcamann@partners.org]. “**Childbirth time selection based on religious belief.**” *Anesthesia & Analgesia* 107, no. 6 (Dec 2008): 2096-2097.

This is a brief account of “a case of deliberate manipulation of surgical start time by a parturient scheduled for elective cesarean delivery, based on traditional Chinese religious and cultural philosophy” [p. 2096].

- Arevalo, S., Prado, G. and Amaro, H. [Institute on Urban Health Research, Bouve College of Health Sciences, Northeastern University, Boston, MA; s.arevalo@neu.edu]. **“Spirituality, sense of coherence, and coping responses in women receiving treatment for alcohol and drug addiction.”** *Evaluation & Program Planning* 31, no. 1 (Feb 2008): 113-123.
 [Abstract:] PURPOSE: To examine the role of spirituality, sense of coherence, and coping responses in relation to stress and trauma symptoms among women in substance abuse treatment. DATA SOURCES/STUDY SETTING: Data for the present analyses were obtained from baseline interviews of 393 women in an urban area of Massachusetts. Interviews were conducted from April 2003 to September 2006. Participants came from four substance abuse treatment programs (three residential and one outpatient) participating in the Mother’s Hope, Mind and Spirit Study, an evaluation of an intervention funded by the Substance Abuse and Mental Health Services Administration (SAMSHA). PRINCIPAL FINDINGS: Stress was significantly associated with drug addiction severity and trauma symptoms were significantly related to alcohol addiction severity. Spirituality, sense of coherence, and coping responses did not mediate the relationship between perceived stress, and posttraumatic stress, and alcohol and drug addiction severity. However, negative and significant associations were found between perceived stress and spirituality, sense of coherence and coping responses, and between posttraumatic stress symptomatology and sense of coherence. CONCLUSION: Enhanced substance abuse treatments that increase spirituality, sense of coherence, and coping responses may be beneficial in helping women in substance abuse treatment to manage stress and posttraumatic stress symptoms. However, further research is needed to identify the pathways through which spirituality, sense of coherence and coping responses may mediate the effects of stress and posttraumatic stress symptoms on alcohol and drug addiction severity.
- Arockiasamy, V., Holsti, L. and Albersheim, S. [Department of Pediatrics, University of British Columbia, Vancouver, Canada]. **“Fathers’ experiences in the neonatal intensive care unit: a search for control.”** *Pediatrics* 121, no. 2 (Feb 2008): e215-222.
 Among the findings of this study of 16 fathers of very ill and/or very preterm infants who had been in the NICU for more than 30 days was that “a single overarching theme was identified: lack of control” [p. e217]. “Religious belief was also cited as an important influence on their sense of control” [p. e-218], as was the activity of “attending religious community gatherings” [p. e219].
- Athar, S. [Past President and Chair of Medical Ethics of the Islamic Medical Association of North America]. **“Enhancement technologies and the person: an Islamic view.”** *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 59-64.
 The availability of newer choices in contemporary bioethics, especially enhancement technologies, poses a challenge for Muslim patients and their care providers in making appropriate decisions. How should they reconcile personal autonomy with ethical guidelines of Islamic Shariah (jurisprudence)? This article discusses such concerns. [This article is part of a special “symposium” on religions and cultures of East and West. For other articles in the issue, see those by Kirkland, R., by LaFleur, W. R., by Lustig, A., by Matthew, D. B., by Sade, R. M., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]
- Atiyeh, B. S., Kadry, M., Hayek, S. N. and Musharafieh, R. S. [Division of Plastic and Reconstructive Surgery, American University of Beirut Medical Center, Beirut, Lebanon; aata@terra.net.lb]. **“Aesthetic surgery and religion: Islamic law perspective.”** *Aesthetic Plastic Surgery* 32, no. 1 (Jan 2008): 1-10.
 [Abstract:] BACKGROUND: Plastic surgeons are called upon to perform aesthetic surgery on patients of every gender, race, lifestyle, and religion. Currently, it may seem natural that cosmetic surgery should be perceived as permissible, and in our modern liberal age, it seems strange to attempt justifying certain surgical acts in the light of a particular cultural or religious tradition. Yet every day, cruel realities demonstrate that although the foremost intention of any scripture or tradition has been mainly to promote religious and moral values, most religions, including Christianity, Islam, and Judaism, invariably affect human behavior and attitude deeply, dictating some rigid positions regarding critical health issues. METHODS: A Web search was conducted, and the literature was reviewed using the Medline search tool. RESULTS: Islamic law closely regulates and governs the life of every Muslim. Bioethical deliberation is inseparable from the religion itself, which emphasizes continuities between body and mind, between material and spiritual realms, and between ethics and jurisprudence. CONCLUSIONS: The rule in Islam is that individuals should be satisfied with the way Allah has created them. Islam welcomes, however, the practice of plastic surgery as long as it is done for the benefit of patients. Even if it clearly considers “changing the creation of Allah” as unlawful, Islamic law is ambiguous regarding cosmetic surgery. Its objection to cosmetic surgery is not absolute. It is rather an objection to exaggeration and extremism. It has been mentioned that “Allah is beautiful and loves beauty.” [71 refs.]
- Aylor, A. L. and Grimes, G. C. [Dept. of Family Medicine, Scott & White Memorial Hospital, Amarillo, TX aylor@swmail.sw.org]. **“End-of-Life Review.”** *American Journal of Hospice & Palliative Medicine* 25, no. 3 (Jun-Jul 2008): 233-236.
 [Abstract:] CONTEXT: The term “End-of-Life Review” is often used by hospice workers in the context of spiritual apparitions or visitations prior to a patient’s death. A review of the literature reveals no clear definition or categorization of this expression. OBJECTIVE: The aim of this study is to define the term “End-of-Life Review”. DESIGN: The study was performed using the Delphi method. SETTING/PARTICIPANTS: A panel of interested parties was recruited from October 2006 to January 2007. INTERVENTION: Respondents were first asked to list their most common experiences associated with the term “End-of-Life Review,” and then to rate each item as to how well it represented their understanding of this term. This process continued until subsequent rounds produce little change in the ranking of each item, suggesting a consensus. CONCLUSIONS: The term “End-of-Life Review” is a constellation of behaviors ranging from visitations from the departed to spiritual apparitions prior to death.
- Badsha, H. and Tak, P. P. [Dubai Bone and Joint Center LLC, Dubai, United Arab Emirates; humeira.badsha@dbaj.ae]. **“Can Islamic prayers benefit spondyloarthritides? Case report of a patient with ankylosing spondylitis and increased spinal mobility after an intensive regimen of Islamic prayer.”** *Rheumatology International* 28, no. 10 (Aug 2008): 1057-1059.
 [Abstract:] A 35-year-old Arab male had severe Ankylosing Spondylitis for 10 years with syndesmophyte formation in the lumbar spine, decreased spinal mobility (modified Schoeber’s test of 0.5 cm), BASDAI of 4, and BASFI score of 6. He was initially started on non-steroidal anti-inflammatory medications (NSAID) and a regular swimming program as well as physiotherapy. Due to lack of response he was started on Etanercept monotherapy. After 1 month his modified Schoeber’s had improved to 1 cm, BASDAI to 2, and BASFI to 1. At 5 months after starting treatment, there was no further improvement. Patient embarked on an intensive regimen of Islamic prayers during the month of Ramadan, lasting approximately 2 h daily, for 1 month. At the end of 1 month he had improved spinal mobility with a modified schoeber’s test of 2.5 cm and stable BASFI scores. Islamic prayers consist of several postures, including stretching, bending and kneeling. Further study is

needed, but Muslim patients can be easily motivated to perform long hours of Islamic prayers, and this can offer benefits, when used in conjunction with conventional treatments, for spondyloarthritis.

Baetz, M. and Bowen, R. [University of Saskatchewan, Saskatoon, Canada]. **“Chronic pain and fatigue: associations with religion and spirituality.”** *Pain Research & Management* 13, no. 5 (Sep-Oct 2008): 383-388.

[Abstract:] BACKGROUND: Conditions with chronic, non-life-threatening pain and fatigue remain a challenge to treat, and are associated with high health care use. Understanding psychological and psychosocial contributing and coping factors, and working with patients to modify them, is one goal of management. An individual's spirituality and/or religion may be one such factor that can influence the experience of chronic pain or fatigue. METHODS: The Canadian Community Health Survey (2002) obtained data from 37,000 individuals 15 years of age or older. From these data, four conditions with chronic pain and fatigue were analyzed together -- fibromyalgia, back pain, migraine headaches and chronic fatigue syndrome. Additional data from the survey were used to determine how religion and spirituality affect psychological well-being, as well as the use of various coping methods. RESULTS: Religious persons were less likely to have chronic pain and fatigue, while those who were spiritual but not affiliated with regular worship attendance were more likely to have those conditions. Individuals with chronic pain and fatigue were more likely to use prayer and seek spiritual support as a coping method than the general population. Furthermore, chronic pain and fatigue sufferers who were both religious and spiritual were more likely to have better psychological well-being and use positive coping strategies. INTERPRETATION: Consideration of an individual's spirituality and/or religion, and how it may be used in coping may be an additional component to the overall management of chronic pain and fatigue.

Barber, J. A., Rosenheck, R. A., Armstrong, M. and Resnick, S. G. [New England MIRECC, VA Connecticut Healthcare System, West Haven, CT]. **“Monitoring the dissemination of peer support in the VA Healthcare System.”** *Community Mental Health Journal* 44, no. 6 (Dec 2008): 433-441.

[From the abstract:] This study illustrates a monitoring system for peer support programs, focusing on Vet-to-Vet, a program for veterans with chronic psychiatric disorders. The sample consisted of 1,847 anonymous surveys from 38 veteran peer support programs. ...Payment for peer facilitators was positively associated with recovery orientation, spirituality, and engagement in meaningful activity....

Barish, R. and Snyder, A. E. [Georgetown University Hospital, Washington, DC; rbarish@gmail.com]. **“Use of complementary and alternative healthcare practices among persons served by a remote area medical clinic.”** *Family & Community Health* 31, no. 3 (Jul-Sep 2008): 221-227.

Among the findings of this study (n=133): “The majority of the respondents expressed the importance that their religious beliefs have in healthcare practices. One woman indicated that prayer guides her decisions regarding medical care. She stated, ‘I pray, first of all, about everything, and I try to decide where I should go, and then seek medical attention.’ Other comments on the role of faith and prayer in healthcare included, ‘I know the Lord can heal, but he gives the knowledge to the doctors, that they can heal through him.’ ‘I believe in prayer, and I trust God. So many times, I’m hurting, and I trust God will heal me.’” [p. 225]

Barton-Burke, M., Barreto, R. C. Jr. and Archibald, L. I. [University of Missouri, St Louis; bartonburkem@umsl.edu]. **“Suffering as a multicultural cancer experience.”** *Seminars in Oncology Nursing* 24, no. 4 (Nov 2008): 229-236.

[Abstract:] OBJECTIVE: To highlight some of the explicit and implicit assumptions that contribute to suffering focusing on the socio-political and economic dimensions of the problem and the spiritual/religious dimension as one solution. DATA SOURCES: Journal articles, web sites and qualitative research data, and personal experience. CONCLUSION: The nature of suffering is such that sometimes we are not able to rationalize it, or find any meaning in it. But, one can still find resources in faith and community, and by other means that may not make sense to an outside observer. IMPLICATIONS FOR NURSING PRACTICE: For many people, suffering goes beyond the diagnosis of cancer. Faith and community can function as resources that help individuals to cope with this diagnosis despite the circumstances of their lives.

Baruth, M., Wilcox, S., Laken, M., Bopp, M. and Saunders, R. [Department of Exercise Science, Arnold School of Public Health, University of South Carolina, Columbia]. **“Implementation of a faith-based physical activity intervention: insights from church health directors.”** *Journal of Community Health* 33, no. 5 (Oct 2008): 304-312.

[Abstract:] Churches are becoming increasingly popular settings for conducting health promotion programs. Retrospective interviews were conducted with 19 health directors from churches taking part in the evaluation of a large-scale faith-based physical activity initiative. This paper first describes program implementation, church leadership support, and changes in church leadership, and then relates these variables to program outcomes (percentage of participants meeting physical activity recommendations). Finally, barriers and successes to program implementation are reported. The most commonly reported intervention activities implemented by churches were bulletin boards related to healthy eating and physical activity (79%) followed by bulletin inserts (69%), walking programs (58%), chair exercises (48%), praise aerobics (27%), a 10-min exercise CD (26%), and an 8 week behavior change class (26%). Significant increases in physical activity were associated with churches which had ever implemented the behavior change class at the 1-year follow-up. According to health directors, pastors sometimes to often spoke about physical activity and diet from the pulpit but rarely to sometimes took part in program activities. They also reported that pastors spouses' never to rarely spoke about physical activity and diet from the pulpit, and rarely to sometimes took part in program activities. About 68% of the churches had at least one change in pastor over the 3-year study. A majority of these variables, however, were not related to changes in physical activity. Potential reasons for these lack of associations are discussed.

Bay, P. S., Beckman, D., Trippi, J., Gunderman, R. and Terry, C. [Chaplaincy and Pastoral Education, Clarian Health Partners, Indianapolis, IN; pbay@clarian.org]. **“The effect of pastoral care services on anxiety, depression, hope, religious coping, and religious problem solving styles: a randomized controlled study.”** *Journal of Religion & Health* 47, no. 1 (Mar 2008): 57-69.

[Abstract:] This randomized controlled study measured the effect of chaplain interventions on coronary artery bypass graft (CABG) patients over time. One hundred sixty-six CABG patients, received pre- and post-surgery testing at 1 month and 6 months with four instruments. Five chaplain visits were made to the intervention group, the control group received none. Comparison scores for anxiety, depression, hope, positive and negative religious coping, and religious coping styles were analyzed. Significant difference was found between groups in positive religious coping (PRC) ($p = .023$) and negative religious coping (NRC) ($p = .046$) scores over time. PRC increased in intervention group, decreased in the control group while NRC decreased in intervention group and increased in the control group. Demographics were comparable between

groups. Moderate chaplain visits (average total visits time, 44 min) may be effective in helping CABG patients increase positive religious coping and decrease negative religious coping. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/mar09.html].

Belanti, J., Perera, M. and Jagadheesan, K. [Broadmeadows Adult Community Mental Health, Broadmeadows, Australia; belantijf@yahoo.com.au]. **“Phenomenology of near-death experiences: a cross-cultural perspective.”** *Transcultural Psychiatry* 45, no. 1 (Mar 2008): 121-133.

[Abstract:] Near-death experiences (NDEs) include a set of subjective experiences encountered by people who were close to death or were faced with life-threatening situations. Reports have suggested that the phenomenology of NDE might differ across cultures. This article is aimed at providing an updated phenomenological perspective by comparing NDEs in a cross-cultural context. We compared the various descriptions of NDEs from a phenomenological perspective. There were similarities between particular cultures, which differed from typical western European experiences. This article concludes that although there are common themes, there are also reported differences in NDEs. The variability across cultures is most likely to be due to our interpretation and verbalizing of such esoteric events through the filters of language, cultural experiences, religion, education and their influence on our belief systems either shedding influence as an individual variable or more often perhaps by their rich interplay between these factors.

Berkowitz, B. [bayla717@yahoo.com]. **“Cultural aspects in the care of the orthodox Jewish woman.”** *Journal of Midwifery & Women's Health* 53, no. 1 (Jan-Feb 2008): 62-67.

[Abstract:] This article offers an overview and explanation of some of the main customs and laws in the Jewish religion surrounding the reproductive health care of the Torah-observant woman. By understanding the religious and spiritual needs and preferences of a patient, the midwife is better able to provide optimal, culturally-competent care. Some of the aspects discussed include procreation, menstruation, modesty, contraception, abortion, genetic testing, induction, the Sabbath, Kosher diet, circumcision, and naming of the child.

Berlinger, N. [Hastings Center]. **“The nature of chaplaincy and the goals of QI: patient-centered care as professional responsibility.”** *Hastings Center Report* 38, no. 6 (Nov-Dec 2008): 30-33

This is one of five special essays in a set under the heading of, “Can We Measure Good Chaplaincy? A New Professional Identity Is Tied to Quality Improvement” and available also as a separate publication. The essays “examine the ‘professionalizing’ profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery” [--from the introductory statement by Gregory E. Kaebnick (no page number, in the separately available publication of the essays)]. Other essays in this set are by de Vries, R, by Jacobs, M. R., by Mohrmann, M. E., and by Smith, M. L. (--noted elsewhere in this bibliography).

Berntson, G. G., Norman, G. J., Hawkley, L. C. and Cacioppo, J. T. [Ohio State University, Columbus; berntson@osu.edu]. **“Spirituality and autonomic cardiac control.”** *Annals of Behavioral Medicine* 35, no. 2 (Apr 2008): 198-208.

[Abstract:] BACKGROUND: Spirituality has been suggested to be associated with positive health, but potential biological mediators have not been well characterized. PURPOSE AND METHODS: The present study examined, in a population-based sample of middle-aged and older adults, the potential relationship between spirituality and patterns of cardiac autonomic control, which may have health significance. Measures of parasympathetic (high-frequency heart rate variability) and sympathetic (pre-ejection period) cardiac control were obtained from a representative sample of 229 participants. Participants completed questionnaires to assess spirituality (closeness to and satisfactory relationship with God). Personality, demographic, anthropometric, health behavior, and health status information was also obtained. A series of hierarchical regression models was used to examine the relations between spirituality, the autonomic measures, and two derived indexes--cardiac autonomic balance (CAB, reflecting parasympathetic to sympathetic balance) and cardiac autonomic regulation (CAR, reflecting total autonomic control). RESULTS: Spirituality, net of demographics, or other variables were found to be associated with enhanced parasympathetic as well as sympathetic cardiac control (yielding a higher CAR) but was not associated with CAB. Although the number of cases was small (N = 11), both spirituality and CAR were significant negative predictors of the prior occurrence of a myocardial infarction. CONCLUSIONS: In a population-based sample, spirituality appears to be associated with a specific pattern of CAR, characterized by a high level of cardiac autonomic control, irrespective of the relative contribution of the two autonomic branches. This pattern of autonomic control may have health significance.

Beuscher, L. and Beck, C. [School of Nursing, Vanderbilt University, Nashville, TN; linda.m.beuscher@vanderbilt.edu]. **“A literature review of spirituality in coping with early-stage Alzheimer's disease.”** *Journal of Clinical Nursing* 17, no. 5A (Mar 2008): 88-97. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] AIMS: This paper presents a literature review focusing on the use of spirituality in coping by older persons with early-stage Alzheimer's disease from their perspectives. The purpose of this literature review is to examine the existing body of knowledge about spirituality in coping with Alzheimer's disease and to apply a spiritual framework of coping in organizing the literature to identify themes and gaps in knowledge. BACKGROUND: Despite the abundance of Alzheimer's disease research, little is known about how older persons with this devastating disease cope with the consequential losses. Maintaining a sense of normalcy and preserving self-worth are coping strategies reported by older persons with early-stage Alzheimer's disease. As spirituality is an effective coping resource for older persons with numerous psychological and personal losses in their lives, it may be an important coping resource for person with Alzheimer's disease. METHOD: A literature search was conducted to find research published between 1990-2006 aimed at understanding spirituality in coping with early-stage Alzheimer's disease. CONCLUSIONS: Six research studies were reviewed. Findings suggest that persons with early-stage Alzheimer's disease draw from their spirituality and faith to find meaning and courage in facing the challenges of cognitive losses. Furthermore, they are able to provide rich information about their spirituality and the psychosocial aspects of living with Alzheimer's disease. Limited empirical knowledge compels the need for future research to explore how spirituality is utilized in coping with early-stage Alzheimer's disease. RELEVANCE TO CLINICAL PRACTICE: Enhancing persons' abilities to cope effectively with their diseases is an important goal of nursing care. Understanding how older persons with Alzheimer's disease cope with their memory loss is critical to the development of evidence-based interventions to minimize the stress of living with this disease.

Binkewicz, M. P. **“Seven hours in a ditch.”** *American Journal of Hospice & Palliative Medicine* 25, no. 6 (Dec 2008 - Jan 2009): 512-513.

This is a hospice chaplain's account of an encounter with a patient who talks of his end-of-life situation in light of his experiences as a soldier in World War II.

Black, K. and Lobo, M. [University of New Mexico College of Nursing; Kblack@salud.unm.edu]. "**A conceptual review of family resilience factors.**" *Journal of Family Nursing* 14, no. 1 (Feb 2008): 33-55.

Among the factors considered in this review is spirituality, seen as a "shared belief system of hope and triumph" [p. 38]. The authors note, "Spirituality has been found to be an essential factor of resilience, as it provides families with the ability to unite, understand, and overcome stressful situations" [p. 39]. They cite a number of studies. [73 refs.]

Bland, E. D. [Department of Psychology, MidAmerica Nazarene University, Olathe, KS; ebland@mnu.edu]. "**An appraisal of psychological and religious perspectives of self-control.**" *Journal of Religion & Health* 47, no. 1 (Mar 2008): 4-16.

[Abstract:] The boundary between psychology and religion is at its murkiest around topics of interest to both forms of discourse. An attempt to clarify some of the boundary issues specifically present in discussions of self-control or self-regulation, this paper begins by examining self-control in healthy psychological functioning. Research on feedback loops, information processing and ego depletion have highlighted key psychological mechanisms involved in self-control. Next this paper explores common themes in religious perspectives regarding the virtue of self-control and self-restraint. A clear preoccupation of major religious traditions is the management of human passion and desire. In conclusion, three boundary concerns relevant to both psychology and religion are discussed: the meaning of virtue, differences in defining the self in self-control, and relational concerns important to understanding self-control.

Bock, G. L. [Philosophy Department, University of Tennessee, Knoxville; gbock@utk.edu]. "**Medically valid religious beliefs.**" *Journal of Medical Ethics* 34, no. 6 (Jun 2008): 437-440, 2008 Jun.

[Abstract:] Patient requests for "inappropriate" medical treatment (violations of the standard of care) based on religious beliefs should have special standing. Nevertheless, not all such requests should be honored, because some are morally disturbing. The trouble lies in deciding which ones count. This paper proposes criteria that would qualify a religious belief as medically valid to help physicians decide which requests to respect. The four conditions suggested are that the belief (1) is shared by a community, (2) is deeply held, (3) would pass the test of a religious interpreter and (4) does not harm others.

Bormann, J. E., Thorp, S., Wetherell, J. L. and Golshan, S. [VA San Diego Healthcare System and San Diego State University, CA; jill.bormann@va.gov]. "**A spiritually based group intervention for combat veterans with posttraumatic stress disorder: feasibility study.**" *Journal of Holistic Nursing* 26, no. 2 (Jun 2008): 109-116. Comments on pp. 117-118. [This is one of several spirituality-themed research articles in this issue of the journal. See the articles by Witte, et al. and Vance, et al. (noted elsewhere in this bibliography). See also the introduction to the issue: Cowling, W. R., 3rd., "On spirituality and holism," p. 83.]

[Abstract:] PURPOSE: To assess the feasibility, effect sizes, and satisfaction of mantram repetition -- the spiritual practice of repeating a sacred word/phrase throughout the day -- for managing symptoms of posttraumatic stress disorder (PTSD) in veterans. DESIGN: A two group (intervention vs. control) by two time (pre- and postintervention) experimental design was used. METHODS: Veterans were randomly assigned to intervention (n = 14) or delayed-treatment control (n = 15). Measures were PTSD symptoms, psychological distress, quality of life, and patient satisfaction. Effect sizes were calculated using Cohen's d. FINDINGS: Thirty-three male veterans were enrolled, and 29 (88%) completed the study. Large effect sizes were found for reducing PTSD symptom severity (d = -.72), psychological distress (d = -.73) and increasing quality of life (d = -.70). CONCLUSIONS: A spiritual program was found to be feasible for veterans with PTSD. They reported moderate to high satisfaction. Effect sizes show promise for symptom improvement but more research is needed.

Bosek, M. S. [Fletcher Allen Health Care and University of Vermont, Burlington; Marcia.Bosek@vtmednet.org]. "**Respecting a patient's religious values: what does this require?**" *JONA's Healthcare Law, Ethics, & Regulation* 10, no. 4 (Oct-Dec 2008): 100-105.

[Abstract:] An Orthodox Jewish father is approached by a physician to discuss potential treatment options for his critically injured infant son. The possibility that he might progress to a determination of brain death was raised. The father stated and a rabbi concurred that his religion only acknowledges cardiopulmonary death. This article will address the following ethical question: "what does it mean to respect another person's values?" An overview of brain death and culture will be presented. A concept analysis for respect will be presented and used to analyze the case. Recommendations for actions that nurse managers, nurses, and other healthcare professionals could take to promote their ability to respect a patient's values and beliefs will be made.

Boss, R. D., Hutton, N., Sulpar, L. J., West, A. M. and Donohue, P. K. [Department of Pediatrics, Division of Neonatology, Johns Hopkins University School of Medicine, Baltimore, MD; rboss1@jhmi.edu]. "**Values parents apply to decision-making regarding delivery room resuscitation for high-risk newborns.**" *Pediatrics* 122, no. 3 (Sep 2008): 583-589. [See also the article by Linton & Feudtner from this same issue (noted elsewhere in this bibliography).]

[From the abstract:] ...This was a qualitative multicenter study. We identified English-speaking parents at 3 hospitals whose infants had died as a result of extreme prematurity or lethal congenital anomalies in 1999-2005. Parents were interviewed about their prenatal decision-making. Maternal medical charts were reviewed for documented discussions regarding delivery room resuscitation. Subject enrollment was stopped when saturation of themes was achieved. RESULTS: Twenty-six mothers of infants were interviewed. All parents wanted to participate to some degree in decisions regarding delivery room resuscitation. Few parents recalled discussing options for delivery room resuscitation with physicians, and even fewer recalled being offered the option of comfort care, even when these discussions were documented in the medical chart. Parents did not report physicians' predictions of morbidity and death to be central to their decision-making. Religion, spirituality, and hope guided decision-making for most parents. Some parents felt that they had not made any decisions regarding resuscitation and instead "left things in God's hands." These parents typically were documented by staff members to "want everything done."...

Braun, U. K., Beyth, R. J., Ford, M. E. and McCullough, L. B. [Michael E. DeBakey VA Medical Center, Section of Health Services Research, Houston Center for Quality of Care and Utilization Studies, Houston, TX; ubraun@bcm.edu]. "**Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making.**" *Journal of General Internal Medicine* 23, no. 3 (Mar 2008): 267-274.

[Abstract:] **BACKGROUND:** End-of-life decisions are frequently made by patients' surrogates. Race and ethnicity may affect such decision making. Few studies have described how different racial/ethnic groups experience end-of-life surrogate decision making. **OBJECTIVES:** To describe the self-reported experience the self-reported experience of African-American, Caucasian, and Hispanic surrogate decision makers of seriously ill patients and to examine the relationship of race, ethnicity, and culture to that experience. **DESIGN:** Purposive sample to include racial/ethnic minorities in a qualitative study using focus group interviews. **PARTICIPANTS:** The participants of the study were 44 experienced, mostly female, surrogate decision makers for older veterans. **APPROACH:** Transcripts were qualitatively analyzed to identify major themes, with particular attention to themes that might be unique to each of the three groups. **RESULTS:** The experience of burden of end-of-life decision making was similar in all three groups. This burden in its medical, personal, and familial dimensions is compounded by uncertainty about prognosis and the patient's preferences. Racial/ethnic variations of responses to this burden concerned the physician-family relationship, religion and faith, and past experiences with race/ethnicity concordant versus non-concordant physicians. **CONCLUSIONS:** Regardless of race/ethnicity, surrogates for seriously ill patients appeared to experience increased significant, multidimensional burdens of decision making under conditions of uncertainty about a patient's preferences. This aspect of the burden of surrogate decision making may not be fully appreciated by physicians. Physicians should identify and be especially attentive to strategies used by surrogates, which may vary by race/ethnicity, to reduce the uncertainty about a patient's preferences and thus the burden of surrogate decision making to assist them in this difficult process.

Bressan, P., Kramer, P. and Germani, M. [Universita di Padova, Italy; paola.bressan@unipd.it]. "**Visual attentional capture predicts belief in a meaningful world.**" *Cortex* 44, no. 10 (Nov-Dec 2008): 1299-1306.

[Abstract:] Here we show that the automatic, involuntary process of attentional capture is predictive of beliefs that are typically considered as much more complex and higher-level. Whereas some beliefs are well supported by evidence, others, such as the belief that coincidences occur for a reason, are not. We argue that the tendency to assign meaning to coincidences is a byproduct of an adaptive system that creates and maintains cognitive schemata, and automatically directs attention to violations of a currently active schema. Earlier studies have shown that, within subjects, attentional capture increases with schema strength. Yet, between-subjects effects could exist too: whereas each of us has schemata of various strengths, most likely different individuals are differently inclined to maintain strong or weak ones. Since schemata can be interpreted as beliefs, we predict more attentional capture for subjects with stronger beliefs than for subjects with weaker ones. We measured visual attentional capture in a reaction time experiment, and correlated it with scores on questionnaires about religious and other beliefs and about meaningfulness and surprisingness of coincidences. We found that visual attentional capture predicts a belief in meaningfulness of coincidences, and that this belief mediates a relationship between visual attentional capture and religiosity. Remarkably, strong believers were more disturbed by schema violations than weak believers, and yet appeared less aware of the disrupting events. We conclude that (a) religious people have a stronger belief in meaningfulness of coincidences, indicative of a more general tendency to maintain strong schemata, and that (b) this belief leads them to suppress, ignore, or forget information that has demonstrably captured their attention, but happens to be inconsistent with their schemata.

Broderick, D. J., Biribilis, J. M. and Steger, M. F. [University of St. Thomas, St. Paul, MN; djbroderick@stthomas.edu]. "**Lesbians grieving the death of a partner: recommendations for practice.**" *Journal of Lesbian Studies* 12, nos. 2-3 (2008): 225-235. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

Among the guidance of this article, regarding spirituality: "Some clients may rely on religious or spiritual beliefs to cope with the death, because religion may provide an overarching meaning system that can unify a great range of pleasant and unpleasant events.... The clinician may want to become familiar with the many welcoming and inclusive faith communities available to the religiously committed or spiritual lesbian client. Other organizations may also provide meaning systems into which the grieving partner might integrate her loss. Importantly, clinicians should be aware that failure on the part of a given faith community to recognize the loss of a lesbian member's partner may arouse in that client profound feelings of anger, guilt, and shame that should be addressed in the therapeutic process." [p. 231]

Bruzzo, P. [Divisione Trapianti d'Organo, Dipartimento Paride Stefanini, Universita di Roma La Sapienza, Rome, Italy; paolo.bruzzo@fastwebnet.it]. "**Religious aspects of organ transplantation.**" *Transplantation Proceedings* 40, no. 4 (May 2008): 1064-1067.

In this brief overview, the author claims that "no religion formally forbid donation or receipt of organs or is against transplantation from living or deceased donors," though he does note instances of objections and reservations by religious authorities and laity. The article views the issue from a European perspective, though there is no apparent intention to limit the scope of the article to that context. He gives special attention to Roman Catholic tradition.

Bulow, H. H., Sprung, C. L., Reinhart, K., Prayag, S., Du, B., Armaganidis, A., Abroug, F. and Levy, M. M. [Department of Anaesthesiology and Intensive Care, Holbak Hospital, Holbak, Denmark; hbbulow@dadlnet.dk]. "**The world's major religions' points of view on end-of-life decisions in the intensive care unit.**" *Intensive Care Medicine* 34, no. 3 (Mar 2008): 423-430.

This is a brief overview regarding Christian, Jewish, Islamic, Hindu, Sikh, Confucian, Taoist, and Buddhist perspectives. While much of this information may be applied to an American context, it is worth noting that the authors appear to be working with information about religious traditions out of European, Asian, and Middle Eastern contexts. [61 references]

Burkhart, L. and Hogan, N. [Loyola University Chicago, Chicago, IL]. "**An experiential theory of spiritual care in nursing practice.**" *Qualitative Health Research* 18, no. 7 (Jul 2008): 928-938.

[Abstract:] Spiritual care has been recognized as integral to nursing care for centuries, as described by Florence Nightingale, and has been studied in both medicine and sociology. Health care institutions, particularly faith-based health systems, also have recognized the importance of spiritual care. Both qualitative and quantitative research support the importance of spirituality in patient health. Although the profession, health care institutions, and research support spiritual care, there is no empirically derived theoretical framework to guide research in spiritual assessment and spiritual care. We used focus group data from registered nurses who care for the chronically ill (n = 25) in a large Midwestern academic health center to generate a grounded theory of spiritual care in nursing practice. What emerged from this study was a beginning theoretical framework to guide future spiritual care research.

- Bush, T. and Bruni, N. [Royal Melbourne Institute of Technology University, Australia; tony.bush@rmit.edu.au]. **“Spiritual care as a dimension of holistic care: a relational interpretation.”** *International Journal of Palliative Nursing* 14, no. 11 (Nov 2008): 539-545.
 This qualitative study of eight palliative care professionals (nurses, complementary therapists and pastoral carers) identified two themes regarding the meaning of spiritual care: “a living nexus between spiritual care, spirituality, and holism” and “a world of relationships.”
- Byrne, M. [Prince & Princess of Wales Hospice, Glasgow, UK; marjory.byrne@ppwh.org.uk]. **“Spirituality in palliative care: what language do we need?”** *International Journal of Palliative Nursing* 14, no. 6 (Jun 2008): 274-280.
 [From the abstract:] This article considers the language of spirituality in palliative care...., and focuses on the concepts of metaphor and story, demonstrated in practice by the art project and publication at The Prince & Princess of Wales Hospice (PPWH), Glasgow, UK. ...In palliative care the metaphor of the journey is often used to describe the experience of illness. Cicely Saunders...described it as a spiritual journey, demonstrating opportunities for growth and development, hope and discovery. As professionals we share that journey. Stories often include metaphoric images and give an understanding of the uniqueness of individual fear and inner need....
- Cadge, W., Freese, J. and Christakis, N. A. [Department of Sociology, Brandeis University, Waltham, MA; wcadge@brandeis.edu]. **“The provision of hospital chaplaincy in the United States: a national overview.”** *Southern Medical Journal* 101, no. 6 (Jun 2008): 626-630.
 [Abstract:] Over the past 25 years, the Joint Commission for the Accreditation of Healthcare Organizations has changed its guidelines regarding religious/spiritual care of hospitalized patients to increase attention concerning this aspect of hospital-based care. Little empirical evidence assesses the extent to which hospitals relied on hospital chaplains as care providers during these years. This study investigates (1) the extent of chaplaincy service availability in US hospitals between 1980 and 2003; (2) the predictors of having chaplaincy services in 1993 and 2003; and (3) the change in the magnitude of these predictors between years. This study examines the presence or absence of chaplaincy or pastoral care services in hospitals using the American Hospital Association Annual Survey of Hospitals (ranging from 4,946-6,353 hospitals) in 1980-1985, 1992-1993, and 2002-2003. Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over this period. In 1993 and 2003, hospital size, location, and church affiliation were central factors influencing the presence of chaplaincy services. Smaller hospitals and those in rural areas were less likely to have chaplaincy services. Church-operated hospitals were much more likely to have chaplaincy services; but between 1993 and 2003, church-operated hospitals were more likely to drop chaplaincy services than to add them. Not-for-profit hospitals were more likely than investor-owned hospitals to add chaplaincy services. Changes to Joint Commission for the Accreditation of Healthcare Organizations policies about the religious/spiritual care of hospitalized patients between 1980 and 2003 seem to have had no discernible effect on the fraction of US hospitals that had chaplaincy services. Rather, characteristics of hospitals, their surroundings, and their religious affiliations influenced whether they provided chaplaincy services to patients. [This article is part of the journal’s series on spirituality in conjunction with the Southern Medical Association’s Spirituality & Medicine Interface Project.] [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/jul08.html].
- Campbell, J., Blank, K. and Britton, M. L. **“Experiences with an elective in spirituality.”** *American Journal of Pharmaceutical Education* 72, no. 1 (Feb 15, 2008): 16.
 This is a report of an elective course concerning spirituality in medicine, offered for the first time by the Oklahoma Health Center Clinical Pastoral Education Institute, Inc., designed primarily for students in the University of Oklahoma College of Medicine. The authors focus here on the pharmacy aspects of the course.
- Canada, A. L., Murphy, P. E., Fitchett, G., Peterman, A. H. and Schover, L. R. [Department of Behavioral Sciences, Rush University Medical Center, Chicago, IL; Andrea_L_Canada@rush.edu]. **“A 3-factor model for the FACIT-Sp.”** *Psycho-Oncology* 17, no. 9 (Sep 2008): 908-916.
 [Abstract:] OBJECTIVE: The 12-item Functional Assessment of Chronic Illness Therapy-Spiritual Well-being Scale (FACIT-Sp) is a popular measure of the religious/spiritual (R/S) components of quality of life (QoL) in patients with cancer. The original factor analyses of the FACIT-Sp supported two factors: Meaning/Peace and Faith. Because Meaning suggests a cognitive aspect of R/S and Peace an affective component, we hypothesized a 3-factor solution: Meaning, Peace, and Faith. METHODS: Participants were 240 long-term female survivors of cancer who completed the FACIT-Sp, the SF-12, and the BSI 18. We used confirmatory factor analysis to compare the 2- and 3-factor models of the FACIT-Sp and subsequently assessed associations between the resulting solutions and QoL domains. RESULTS: Survivors averaged 44 years of age and 10 years post-diagnosis. A 3-factor solution of the FACIT-Sp significantly improved the fit of the model to the data over the original 2-factor structure (Delta $\chi^2(2)=72.36$, $df=2$, $p<0.001$). Further adjustments to the 3-factor model resulted in a final solution with even better goodness-of-fit indices ($\chi^2(2)=59.11$, $df=1$, $p=0.13$, CFI=1.00, SMRM=0.05). The original Meaning/Peace factor controlling for Faith was associated with mental ($r=0.63$, $p<0.000$) and physical ($r=0.22$, $p<0.01$) health on the SF-12, and the original Faith factor controlling for Meaning/Peace was negatively associated with mental health ($r=-0.15$, $p<0.05$). The 3-factor model was more informative. Specifically, using partial correlations, the Peace factor was only related to mental health ($r=0.53$, $p<0.001$); Meaning was related to both physical ($r=0.18$, $p<0.01$) and mental ($r=0.17$, $p<0.01$) health; and Faith was negatively associated with mental health ($r=-0.17$, $p<0.05$). CONCLUSION: The results of this study support a 3-factor solution of the FACIT-Sp. The new solution not only represents a psychometric improvement over the original, but also enables a more detailed examination of the contribution of different dimensions of R/S to QoL.
- Carey, L. B. and Cohen, J. [La Trobe University, Melbourne, Australia]. **“Religion, spirituality and health care treatment decisions: the role of chaplains in the Australian clinical context.”** *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 25-39. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]
 [Abstract:] This paper summarizes the views of Australian health care chaplains concerning their role and involvement in patient/family health care treatment decisions. In general terms the findings indicated that the majority of chaplains surveyed believed that it was part of their pastoral role to help patients and their families make decisions about their health care treatment. Differences in involvement of volunteer and staff chaplains, Catholic and Protestant, male and female chaplains are noted, as are the perspectives of chaplaincy informants regarding their role in relation to health care treatment decisions. Some implications of this study with respect to quality patient centered care, chaplaincy utility, and training are noted.

- Carmody, J., Reed, G., Kristeller, J. and Merriam, P. [Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, Worcester; james.carmody@umassmed.edu]. **“Mindfulness, spirituality, and health-related symptoms.”** *Journal of Psychosomatic Research* 64, no. 4 (Apr 2008): 393-403.
 [Abstract:] OBJECTIVE: Although the relationship between religious practice and health is well established, the relationship between spirituality and health is not as well studied. The objective of this study was to ascertain whether participation in the mindfulness-based stress reduction (MBSR) program was associated with increases in mindfulness and spirituality, and to examine the associations between mindfulness, spirituality, and medical and psychological symptoms. METHODS: Forty-four participants in the University of Massachusetts Medical School's MBSR program were assessed preprogram and postprogram on trait (Mindful Attention and Awareness Scale) and state (Toronto Mindfulness Scale) mindfulness, spirituality (Functional Assessment of Chronic Illness Therapy--Spiritual Well-Being Scale), psychological distress, and reported medical symptoms. Participants also kept a log of daily home mindfulness practice. Mean changes in scores were computed, and relationships between changes in variables were examined using mixed-model linear regression. RESULTS: There were significant improvements in spirituality, state and trait mindfulness, psychological distress, and reported medical symptoms. Increases in both state and trait mindfulness were associated with increases in spirituality. Increases in trait mindfulness and spirituality were associated with decreases in psychological distress and reported medical symptoms. Changes in both trait and state mindfulness were independently associated with changes in spirituality, but only changes in trait mindfulness and spirituality were associated with reductions in psychological distress and reported medical symptoms. No association was found between outcomes and home mindfulness practice. CONCLUSIONS: Participation in the MBSR program appears to be associated with improvements in trait and state mindfulness, psychological distress, and medical symptoms. Improvements in trait mindfulness and spirituality appear, in turn, to be associated with improvements in psychological and medical symptoms.
- Carr, T. [University of New Brunswick, Saint John, New Brunswick, Canada; tcarr@unbsj.ca]. **“Mapping the processes and qualities of spiritual nursing care.”** *Qualitative Health Research* 18, no. 5 (May 2008): 686-700.
 [Abstract:] Although the importance of spiritual care is widely recognized in nursing theory, recent research suggests that it is rarely attended to in nursing practice. One explanation for this contradiction is the conceptual confusion that exists regarding the meaning of spiritual nursing care. To help unravel this confusion, in-depth open-ended interviews were conducted in an oncology care setting with 29 individuals representing the multiple perspectives of nurses, patients, family, and others. Phenomenological analysis of these interviews reveals that spiritual nursing care involves a complexity of social processes, of which developing caring relationships is core. For these social processes to work and for spiritual nursing care to be realized, the nurse must embody four essential human qualities: receptivity, humanity, competency, and positivity. Participants' descriptions of these processes and qualities not only offer clarity and understanding but also capture the diffuse and amorphous nature of spiritual nursing care.
- Carpenter, K., Girvin, L., Kitner, W. and Ruth-Sahd, L. A. [York College of Pennsylvania, PA]. **“Spirituality: a dimension of holistic critical care nursing.”** *DCCN - Dimensions of Critical Care Nursing* 27, no. 1 (Jan-Feb 2008): 16-20.
 [Abstract:] Although many patients face significant physical needs, their mind and spirit may be ill as well. Three facets make up an individual: physical, mental, and spiritual. To provide optimal holistic care, the critical care nurse must take into consideration each of these three aspects. But most importantly, the critical care nurse must recognize that spiritual care begins with oneself. Spirituality is one such area of patient care that, when addressed, can reap positive benefits for both the client and the healthcare provider. This article explores all aspects of spirituality for the critical care nurse. [23 refs.]
- Carr, M. F. [Loma Linda University, Loma Linda, CA; mcarr@llu.edu]. **“The spectrum of religion and science in clinical encounters.”** *Journal of Clinical Ethics* 19, no. 4 (Winter 2008): 360-370.
 “Some clinical practitioners may hold biases toward religious beliefs and practices, and some patients may hold biases toward secular medical science and its practitioners. When this happens, the resulting misunderstandings and poor communication can exacerbate biases and contribute to adverse clinical interactions. In this article, I posit a faith-science continuum as an analytical tool to help remedy these problems.” [--from the Introduction, p. 360]
- Casarett, D., Pickard, A., Bailey, F. A., Ritchie, C., Furman, C., Rosenfeld, K., Shreve, S., Chen, Z. and Shea, J. A. [Center for Health Equity Research and Promotion, Dept. of Veterans Affairs, Philadelphia, PA; Casarett@mail.med.upenn.edu]. **“Do palliative consultations improve patient outcomes?”** *Journal of the American Geriatrics Society* 56, no. 4 (Apr 2008): 593-599.
 Among the findings of this telephone survey of 524 respondents from five VA Medical Centers or their affiliated nursing homes and outpatient clinics was: “Patients who received a palliative consultation had significantly higher scores for...[the] domains [of] information and communication (P<.001), access to home care services (P=.007), emotional and spiritual support (P<.001), well-being and dignity (P=.001), and care around the time of death (P<.001)” [p. 596].
- Casarett, D., Pickard, A., Bailey, F. A., Ritchie, C. S., Furman, C. D., Rosenfeld, K., Shreve, S. and Shea, J. [Center for Health Equity Research and Promotion, Philadelphia VAMC, Philadelphia, PA; Casarett@mail.upenn.edu]. **“A nationwide VA palliative care quality measure: the family assessment of treatment at the end of life.”** *Journal of Palliative Medicine* 11, no. 1 (Jan-Feb 2008): 68-75.
 This is an evaluation of the FATE (Family Assessment of Treatment at End of Life) Survey, which includes 3 items for Emotional & Spiritual Support: “Providers were kind, caring, and respectful,” “Providers gave adequate spiritual support to patient/family prior to death,” and “Providers gave adequate emotional support to patient/family prior to death.” The measure, which consists of 32 items for 9 domains, is said to evidence excellent psychometric characteristics. [The FATE Survey was also used in Casarett, D., et al., “Do palliative consultations improve patient outcomes?” *Journal of the American Geriatrics Society* 56, no. 4 (Apr 2008): 593-599 --cited also in this bibliography.]
- Catlin, E. A., Cadge, W., Ecklund, E. H., Gage, E. A. and Zollfrank, A. A. [Massachusetts General Hospital for Children, Boston; ecatlin@partners.org]. **“The spiritual and religious identities, beliefs, and practices of academic pediatricians in the United States.”** *Academic Medicine* 83, no. 12 (December 2008): 1146-1152. Comment by Curlin, F. A., on pp. 1118-1120.
 [Abstract:] PURPOSE: Physicians' spiritual and religious identities, beliefs, and practices are beginning to be explored. The objective of this study was to gather descriptive information about personal religion and spirituality from a random sample of academic American pediatricians

and to compare this information with similar data from the public. **METHOD:** In 2005, a Web-based survey of a random sample of 208 pediatrician faculty from 13 academic centers ranked by the US News & World Report as "honor roll" hospitals was conducted. Surveys elicited information about personal beliefs and practices as well as their influence on decisions about patient care and clinical practice. Multiple questions were replicated from the General Social Survey to enable comparisons with the public. Descriptive statistics were generated, and logistic regression analyses were conducted on relevant variables. **RESULTS:** Nearly 88% of respondents were raised in a religious tradition, but just 67.2% claimed current religious identification. More than half (52.6%) reported praying privately; additional spiritual practices reported included relaxation techniques (38.8%), meditation (29.3%), sacred readings (26.7%), and yoga (19%). The majority of academic pediatricians (58.6%) believed that personal spiritual or religious beliefs influenced their interactions with patients/colleagues. These odds increased 5.1-fold when academic pediatricians attended religious services monthly or more ($P < .05$). **CONCLUSIONS:** Compared with the American public, a notably smaller proportion of academic pediatricians reported a personal religious identity. The majority believed spiritual and religious beliefs influenced their practice of pediatrics. Whether secular or faith-based belief systems measurably modify academic pediatric practice is unknown.

Charlton, B. G. [editorMeHy@yahoo.com]. "**Genospirituality: genetic engineering for spiritual and religious enhancement.**" *Medical Hypotheses* 71, no. 6 (Dec 2008): 825-828.

This is an editorial by the journal's Editor-in-Chief. [Abstract:] The most frequently discussed role for genetic engineering is in relation to medicine, and a second area which provokes discussion is the use of genetic engineering as an enhancement technology. But one neglected area is the potential use of genetic engineering to increase human spiritual and religious experience - or genospirituality. If technologies are devised which can conveniently and safely engineer genes causal of spiritual and religious behaviors, then people may become able to choose their degree of religiosity or spiritual sensitivity. For instance, it may become possible to increase the likelihood of direct religious experience - i.e. 'revelation': the subjective experience of communication from the deity. Or, people may be able to engineer 'animistic' thinking, a mode of cognition in which the significant features of the world - such as large animals, trees, distinctive landscape features - are regarded as sentient and intentional beings; so that the individual experiences a personal relationship with the world. Another potentially popular spiritual ability would probably be shamanism; in which states of altered consciousness (e.g. trances, delirium or dreams) are induced and the shaman may undergo the experience of transformations, 'soul journeys' and contact with a spirit realm. Ideally, shamanistic consciousness could be modulated such that trances were self-induced only when wanted and when it was safe and convenient; and then switched-off again completely when full alertness and concentration are necessary. It seems likely that there will be trade-offs for increased spirituality; such as people becoming less 'driven' to seek status and monetary rewards - as a result of being more spiritually fulfilled people might work less hard and take more leisure. On the other hand, it is also possible that highly moral, altruistic, peaceable and principled behaviors might become more prevalent; and the energy and joyousness of the best churches might spread and be strengthened. Overall, genospirituality would probably be used by people who were unable to have the kind of spiritual or religious experiences which they wanted (or perhaps even needed) in order to lead the kind of life to which they aspired.

Chatters, L. M., Bullard, K. M., Taylor, R. J., Woodward, A. T., Neighbors, H. W. and Jackson, J. S. [School of Social Work, Institute for Social Research, University of Michigan, Ann Arbor; chatters@umich.edu]. "**Religious participation and DSM-IV disorders among older African Americans: findings from the National Survey of American Life.**" *American Journal of Geriatric Psychiatry* 16, no. 12 (Dec 2008): 957-965.

[Abstract:] **OBJECTIVES:** This study examined the religious correlates of psychiatric disorders. **DESIGN:** The analysis is based on the National Survey of American Life (NSAL). The African American sample of the NSAL is a national representative sample of households with at least one African American adult 18 years or over. This study uses the older African American subsample ($N = 837$). **METHODS:** Religious correlates of selected measures of lifetime Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) psychiatric disorders (i.e., panic disorder, agoraphobia, social phobia, generalized anxiety disorder, obsessive compulsive disorder, posttraumatic stress, major depressive disorder, dysthymia, bipolar I & II disorders, alcohol abuse/dependence, and drug abuse/dependence) were examined. **PARTICIPANTS:** Data from 837 African Americans aged 55 years or older are used in this analysis. **MEASUREMENT:** The DSM-IV World Mental Health Composite International Diagnostic Interview was used to assess mental disorders. Measures of functional status (i.e., mobility and self-care) were assessed using the World Health Organization Disability Assessment Schedule-Second Version. Measures of organizational, nonorganizational and subjective religious involvement, number of doctor diagnosed physical health conditions, and demographic factors were assessed. **RESULTS:** Multivariate analysis found that religious service attendance was significantly and inversely associated with the odds of having a lifetime mood disorder. **CONCLUSIONS:** This is the first study to investigate the relationship between religious participation and serious mental disorders among a national sample of older African Americans. The inverse relationship between religious service attendance and mood disorders is discussed. Implications for mental health treatment underscore the importance of assessing religious orientations to render more culturally sensitive care.

Chen, L. M., Miaskowski, C., Dodd, M. and Pantilat, S. [School of Nursing, Kaohsiung Medical University, Kaohsiung City, Taiwan; Lih-Mih.Chen@ucsf.edu]. "**Concepts within the Chinese culture that influence the cancer pain experience.**" *Cancer Nursing* 31, no. 2 (Mar-Apr 2008): 103-108.

[Abstract:] The purpose of this article is to describe some of the concepts within the Chinese culture that influence the sociocultural dimension of the cancer pain experience. The major concepts that influence Chinese patients' perspectives on cancer pain and its management include Taoism/energy, Buddhism, and Confucianism. Within the beliefs of Taoism/energy, pain occurs if Qi, or blood circulation, is blocked. To relieve pain, the blockage of Qi/blood must be removed and the person needs to maintain harmony with the universe. Within the beliefs of Buddhism, pain/suffering is a power, unwanted but existent, that comes from a barrier in the last life; from the objective world; from a person's own sensation; or from other people, animals, and materials. Only by following the 8 right ways (ie, right view, right intention, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration) can an individual end the path of pain/suffering. A Confucian believes that pain is an essential element of life, a "trial" or a "sacrifice." Therefore, when a person suffers with pain, he or she would rather endure the pain and not report it to a clinician until the pain becomes unbearable. Oncology nurses who care for Chinese patients need to understand the fundamental beliefs that influence the sociocultural dimension of the pain experience for these patients. This information will assist the oncology nurse in developing a more effective pain management plan. [33 refs.]

- Chio, C. C., Shih, F. J., Chiou, J. F., Lin, H. W., Hsiao, F. H. and Chen, Y. T. [Department of Neurosurgery, Chi-Mei Medical Center, Yung Kang City, Tainan, Taiwan]. **“The lived experiences of spiritual suffering and the healing process among Taiwanese patients with terminal cancer.”** *Journal of Clinical Nursing* 17, no. 6 (Mar 2008): 735-743.
 [Abstract:] AIMS AND OBJECTIVES: The purposes of this study were to explore the lived experiences of spiritual suffering and the change mechanism in healing processes among Taiwanese patients with terminal cancer. METHODS: The approach to this study was phenomenological-hermeneutic. Twenty-one patients with terminal cancer were invited to participate in a semi-structured interview that dealt with their experiences of spiritual suffering and the healing process. This study was conducted in the inpatient unit of the oncology department in two general hospitals. The interviews were recorded, transcribed and later analysed using the approach of narrative analysis. RESULTS: According to the results of case narration, the causes of spiritual suffering included cancer, known as a life-threatening illness, physical pain, treatment complications, uncertain illness progression, disability problems and lack of support. Patients turned to internal resources (including regarding the suffering as a life challenge, volunteering to help other cancer patients and searching for life wisdoms) and external resources (including peer support groups and family support) as they endured spiritual suffering. Taiwanese patients turned to Eastern and Western philosophies of Taoism, Confucianism, Buddhism and Christianity as methods to interpret their spiritual suffering. CONCLUSION: Patients’ positive views of misfortune because of cancer and sufficient social supports were the key elements of the healing process to alleviate spiritual suffering. RELEVANCE TO CLINICAL PRACTICE: Nurses who learn to participate in suffering assessment are better able to understand spiritual needs of cancer patients. Cancer patients’ views on the change mechanism in healing processes could provide essential information for nurses in developing an effective intervention programme. If nurses consider cultural factors that shape patients’ experiences of spiritual suffering and the healing process, they could learn how to meet the needs of patients better from different cultural backgrounds.
- Chochinov, H. M., Hassard, T., McClement, S., Hack, T., Kristjanson, L. J., Harlos, M., Sinclair, S. and Murray, A. [CancerCare Manitoba, Canada; harvey.chochinov@cancercare.mb.ca]. **“The patient dignity inventory: a novel way of measuring dignity-related distress in palliative care.”** *Journal of Pain & Symptom Management* 36, no. 6 (Dec 2008): 559-571.
 This article presents validity and reliability testing for the Patient Dignity Inventory (PDI), which focuses on factors of psychosocial, existential and spiritual distress that the authors assert are often overlooked in assessments. Specific factors for the instrument: Symptom Distress, Existential Distress, Dependency, Peace of Mind, and Social Support. Spirituality is addressed throughout.
- Choi, G., Tirrito, T. and Mills, F. [College of Social Work, University of South Carolina, Columbia]. **“Caregiver's spirituality and its influence on maintaining the elderly and disabled in a home environment.”** *Journal of Gerontological Social Work* 51, nos. 3-4 (2008): 247-259.
 [Abstract:] This study examined the role that faith-based organizations play for caregivers in maintaining the elderly and disabled in their homes. The study explored if persons who use religious beliefs and practices cope with caregiver stress better than those who do not use religious beliefs and practices. The study also explored the role of religious coping as a factor affecting decisions to institutionalize, and the role that faith-based practices and organizations play in helping caregivers maintain the elderly and disabled in their homes. [See also, from the same issue of this journal, Cohen, H. L., et al., “Religion and spirituality as defined by older adults” (pp. 284-299), noted elsewhere in this bibliography.]
- Choi, N. G., Ransom, S. and Wyllie, R. J. [University of Texas at Austin; nchoi@mail.utexas.edu]. **“Depression in older nursing home residents: the influence of nursing home environmental stressors, coping, and acceptance of group and individual therapy.”** *Aging & Mental Health* 12, no. 5 (Sep 2008): 536-547. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]
 Among the findings from in-depth interviews with 65 older nursing home residents [from the abstract:] ...Self-reported coping mechanisms included religion and stoicism, a sense of reality, positive attitude and family support....
- Clark, M. M., Novotny, P. J., Patten, C. A., Rausch, S. M., Garces, Y. I., Jatoi, A., Sloan, J. A. and Yang, P. [Department of Psychiatry and Psychology, Mayo Clinic College of Medicine, Rochester, MN; clark.matthew@mayo.edu]. **“Motivational readiness for physical activity and quality of life in long-term lung cancer survivors.”** *Lung Cancer* 61, no. 1 (Jul 2008): 117-122.
 Among the findings of this study of a sample of 272 long-term lung cancer survivors was that those who reported engaging in regular physical activity indicated better overall Quality of Life on all five domains of mental, physical, social, emotional, and spiritual.
- Cohen, C. I., Colemon, Y., Yaffee, R. and Casimir, G. J. [Division of Geriatric Psychiatry, SUNY Downstate Medical Center, Brooklyn, NY; carl.cohen@downstate.edu]. **“Racial differences in suicidality in an older urban population.”** *Gerontologist* 48, no. 1 (Feb 2008): 71-78.
 Among the findings of this study of 214 Whites and 860 Blacks in Brooklyn, NY, was that while religiosity was generally associated with lower suicidality, the use of “spiritualists” (or “neighborhood healers”) was associated with greater suicidality among Whites, but not Blacks. See p. 77 for discussion. [From the abstract:] Among both racial groups, suicidality is likely to be impacted by addressing depressive and anxiety symptoms and, when appropriate, by encouraging various coping strategies, especially religiosity.
- Cohen, H. L., Thomas, C. L. and Williamson, C. [Department of Social Work, Texas Christian University, Fort Worth, TX; h.cohen@tcu.edu]. **“Religion and spirituality as defined by older adults.”** *Journal of Gerontological Social Work* 51, nos. 3-4 (2008): 284-299.
 [Abstract:] This exploratory qualitative study examined the intrinsic definitions of spirituality and religion across three different religious or ethnic groups of older adults--Jewish, African American Protestants and Caucasian Protestants. The study explores how older adults from these various backgrounds self-identify with the terms religion and spirituality. Because both African-Americans and Jewish older adults are underrepresented in the research on spirituality and religion, their inclusion lends insights to this topic and helps to anchor the findings in a cross-cultural context. Focus groups were employed to understand how these groups characterize their relationship to spirituality and religion. Social work professionals can utilize these findings to work more effectively with the diverse and complex issues of older adults. [See also, from the same issue of this journal, Choi, G., et al., “Caregiver's spirituality and its influence on maintaining the elderly and disabled in a home environment” (pp. 247-259), noted elsewhere in this bibliography.]

Cohen, J., van Delden, J., Mortier, F., Lofmark, R., Norup, M., Cartwright, C., Faisst, K., Canova, C., Onwuteaka-Philipsen, B., Bilsen, J. and the Eureld Consortium. [Vrije Universiteit Brussel, End-of-Life Care Research Group, Department of Medical Sociology and Health Sciences, Laarbeeklaan 103, B-1090 Brussels, Belgium; Joachim.Cohen@vub.ac.be]. **"Influence of physicians' life stances on attitudes to end-of-life decisions and actual end-of-life decision-making in six countries."** *Journal of Medical Ethics* 34, no. 4 (Apr 2008): 247-253.

[Abstract:] AIM: To examine how physicians' life stances affect their attitudes to end-of-life decisions and their actual end-of-life decision-making. METHODS: Practising physicians from various specialties involved in the care of dying patients in Belgium, Denmark, The Netherlands, Sweden, Switzerland and Australia received structured questionnaires on end-of-life care, which included questions about their life stance. Response rates ranged from 53% in Australia to 68% in Denmark. General attitudes, intended behaviour with respect to two hypothetical patients, and actual behaviour were compared between all large life-stance groups in each country. RESULTS: Only small differences in life stance were found in all countries in general attitudes and intended and actual behaviour with regard to various end-of-life decisions. However, with regard to the administration of drugs explicitly intended to hasten the patient's death (PAD), physicians with specific religious affiliations had significantly less accepting attitudes, and less willingness to perform it, than non-religious physicians. They had also actually performed PAD less often. However, in most countries, both Catholics (up to 15.7% in The Netherlands) and Protestants (up to 20.4% in The Netherlands) reported ever having made such a decision. DISCUSSION: The results suggest that religious teachings influence to some extent end-of-life decision-making, but are certainly not blankly accepted by physicians, especially when dealing with real patients and circumstances. Physicians seem to embrace religious belief in a non-imperative way, allowing adaptation to particular situations.

Cole, B. S., Hopkins, C. M., Tisak, J., Steel, J. L. and Carr, B. I. [Department of Behavioral Medicine, University of Pittsburgh Cancer Institute, PA]. **"Assessing spiritual growth and spiritual decline following a diagnosis of cancer: reliability and validity of the Spiritual Transformation Scale."** *Psycho-Oncology* 17, no. 2 (Feb 2008): 112-121.

[Abstract:] This study assessed the factor structure, reliability, and validity of an instrument designed to assess spiritual transformations following a diagnosis of cancer—the Spiritual Transformation Scale (STS). The instrument was administered to 253 people diagnosed with cancer within the previous 2 years. Two underlying factors emerged (spiritual growth (SG) and spiritual decline (SD)) with adequate internal reliability ($\alpha = 0.98$ and 0.86 , respectively) and test-retest reliability ($r = 0.85$ and 0.73 , respectively). Validity was supported by correlations between SG and the Positive and Negative Affect Scale (PANAS) Positive Affect Subscale ($r = 0.23$, $p < 0.001$), the Daily Spiritual Experiences Scale ($r = 0.57$, $p < 0.001$), and the Post-traumatic Growth Inventory ($r = 0.68$, $p < 0.001$). SD was associated with higher scores on the Center for Epidemiological Studies Depression scale ($r = 0.38$, $p < 0.001$) and PANAS-Negative Affect Subscale ($r = 0.40$, $p < 0.001$), and lower scores on the PANAS-Positive Affect Subscale ($r = -0.23$, $p < 0.001$), and the Daily Spiritual Experiences Scale ($r = -0.30$, $p < 0.001$). Hierarchical regression analyses indicated that the subscales uniquely predicted adjustment beyond related constructs (intrinsic religiousness, spiritual coping, and general post-traumatic growth). The results indicate that the STS is psychometrically sound, with SG predicting better, and SD predicting poorer, mental and spiritual well-being following a diagnosis of cancer. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/may08.html].

Colucci, E. and Martin, G. [Centre for International Mental Health, School of Population Health, University of Melbourne, Australia; ecolucci@unimelb.edu.au]. **"Religion and spirituality along the suicidal path."** *Suicide & Life-Threatening Behavior* 38, no. 2 (Apr 2008): 229-244.

[From the abstract:] The inner experience of spiritual and religious feelings is an integral part of the everyday lives of many individuals. For over 100 years the role of religion as a deterrent to suicidal behavior has been studied in various disciplines. We attempt to systematize the existing literature investigating the relationship between religion/spirituality and suicide in this paper. After an overview of the attitudes of the dominant religions (e.g., Catholicism, Islam, and Buddhism) toward suicide, the three main theories that have speculated regarding the link between religion and suicide are presented: "integration theory"..., "religious commitment theory"..., and "network theory".... Subsequent to this theoretical introduction, we report on studies on religion/spirituality keeping the suicidal path as a reference: from suicidal ideation to nonlethal suicidal behavior to lethal suicidal behavior. Studies presenting indications of religious beliefs as a possible risk factor for suicidal behavior are also presented. The last section reviews possible intervention strategies for suicidal patients and suicide survivors. Indications for future research, such as more studies on nonreligious forms of spirituality and the use of qualitative methodology to achieve a better and deeper understanding of the spiritual dimension of suicidal behavior and treatment, are offered. [132 refs.]

Copel, L. C. [Villanova University, College of Nursing, Villanova, PA; linda.copel@villanova.edu]. **"The lived experience of women in abusive relationships who sought spiritual guidance."** *Issues in Mental Health Nursing* 29, no. 2 (2008): 115-130.

[Abstract:] Women in abusive relationships have recognized the silence of religious institutions and clergy in addressing intimate partner violence. The old message, that women are to blame when family dysfunction occurs, remains evident in society. The objective of this qualitative study was to describe the experience of abused women attempting to decrease their spiritual distress and obtain spiritual guidance from their religious leaders. The findings revealed that clergy were not helpful in alleviating the women's spiritual distress or intervening in the violence. Four themes that epitomized the negative outcomes of the help-seeking behavior were spiritual suffering, devaluation, loss, and powerlessness.

Cottle, E. M. and James, J. E. [Treatment Centre, Royal United Hospital, Bath, UK]. **"Role of the family support person during resuscitation."** *Nursing Standard* 23, no. 9 (Nov 5-11, 2008): 43-47.

[Abstract:] This article discusses family witnessed resuscitation and describes the need for a healthcare professional to be available to support the family before and during this experience. Careful explanation and emotional support are required during the event and if cardiopulmonary resuscitation is unsuccessful, further explanation and support will be required. A family support person is usually a nurse but could also be a hospital chaplain or social worker. The chaplain's background and ability to interpret medical information, combined with the emotional and spiritual support he or she can offer, make the chaplain suitable for this role. However, for some patients and families a chaplain's involvement might not be appropriate. The authors suggest that further research and evidence-based guidance should be developed to maximize the benefits of a family support person's presence during witnessed resuscitation.

Coughlin, S. S. [Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA]. **“Surviving cancer or other serious illness: a review of individual and community resources.”** *CA: A Cancer Journal for Clinicians* 58, no. 1 (Jan-Feb 2008): 60-64.

This review notes: “Studies of cancer patients have shown that religion and spirituality are positively associated with better physical and mental health outcomes (for example, lower levels of depression, anxiety, and pain) and that coping strategies may mediate the relationship between spirituality and greater wellbeing.... People who have survived a potentially life threatening illness may reflect on the meaning of their life experiences and draw strength from spirituality and enhanced relationships with others.” [p. 62] [32 refs.]

Creel, E. and Tillman, K. [School of Nursing, Southeastern Louisiana University, Hammond; ecreel@selu.edu]. **“The meaning of spirituality among nonreligious persons with chronic illness.”** *Holistic Nursing Practice* 22, no. 6 (Nov-Dec 2008): 303-309, with quiz on pp. 310-301.

[Abstract:] A phenomenological approach was used to uncover the meaning of spirituality for 11 nonreligious participants with a chronic illness. Spirituality for these participants was revealed through the themes of beliefs, spiritual awakening, and spiritual enhancement. This study supports each person as uniquely spiritual with spiritual needs that could be enhanced.

Cunningham, A. J. [Ontario Cancer Institute/Princess Margaret Hospital, Toronto, Canada; cunningh@uhnres.utoronto.ca]. **“The healing journey: incorporating psychological and spiritual dimensions into the care of cancer patients.”** *Current Oncology* 15, suppl 2 (Aug 2008): s37-41. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]

[Abstract:] Research on the factors that promote healing of the body through mind and spirit is at a very early stage. Reliance on experimental designs seems premature; we need much more exploratory research to identify relevant variables and useful therapeutic approaches before applying to them the same methods used to evaluate drugs. The Healing Journey is a program that has been in operation since 1982 at the Princess Margaret Hospital, Toronto, Ontario. Observational data collection, followed by qualitative analysis has demonstrated benefits for many cancer patients.

Curlin, F. A., Nwodin, C., Vance, J. L., Chin, M. H. and Lantos, J. D. [Pritzker School of Medicine, University of Chicago, IL; fcurlin@uchicago.edu]. **“To die, to sleep: US physicians’ religious and other objections to physician-assisted suicide, terminal sedation, and withdrawal of life support.”** *American Journal of Hospice & Palliative Care* 25, no. 2 (Apr-May 2008): 112-120.

[Abstract:] This study analyzes data from a national survey to estimate the proportion of physicians who currently object to physician-assisted suicide (PAS), terminal sedation (TS), and withdrawal of artificial life support (WLS), and to examine associations between such objections and physician ethnicity, religious characteristics, and experience caring for dying patients. Overall, 69% of the US physicians object to PAS, 18% to TS, and 5% to WLS. Highly religious physicians are more likely than those with low religiosity to object to both PAS (84% vs 55%, $P < .001$) and TS (25% vs 12%, $P < .001$). Objection to PAS or TS is also associated with being of Asian ethnicity, of Hindu religious affiliation, and having more experience caring for dying patients. These findings suggest that, with respect to morally contested interventions at the end of life, the medical care patients receive will vary based on their physicians’ religious characteristics, ethnicity, and experience caring for dying patients.

Curtis, J. R. and White, D. B. [Division of Pulmonary and Critical Care Medicine, Harborview Medical Center, University of Washington, Seattle; jrc@u.washington.edu]. **“Practical guidance for evidence-based ICU family conferences.”** *Chest* 134, no. 4 (Oct 2008): 835-843. Comments on pp. 676-678.

[From the abstract:] ...The purpose of this narrative review is to provide a context and rationale for improving the quality of communication with family members and to provide practical, evidence-based guidance on how to conduct this communication in the ICU setting. We emphasize the importance of discussing prognosis effectively, the key role of the integrated interdisciplinary team in this communication, and the importance of assessing spiritual needs and addressing barriers that can be raised by cross-cultural communication.... [84 refs.]

Daaleman, T. P., Williams, C. S., Hamilton, V. L. and Zimmerman, S. [Department of Family Medicine, University of North Carolina at Chapel Hill; tim_daaleman@med.unc.edu]. **“Spiritual care at the end of life in long-term care.”** *Medical Care* 46, no. 1 (Jan 2008): 85-91.

[Abstract:] BACKGROUND: There is growing attention given to the spiritual needs of dying patients and long-term care (LTC) facilities are common settings in which patients receive care as they approach death. OBJECTIVES: To describe the sources of support, the structure and processes of spiritual care in LTC, and examine the relationship between these components and family ratings of overall care. RESEARCH DESIGN: After-death interviews of family members of decedents. SUBJECTS: Family members of 284 decedent residents from a stratified sample of 100 residential care/assisted living facilities and nursing homes in Florida, Maryland, New Jersey, and North Carolina. MEASURES: Interview items included sources of spiritual support, processes of spiritual care, and the impression of overall care (4 = very good, 3 = good, 2 = fair, 1 = poor) for decedents. Facility-level data included demographics, counseling by clergy, on-site religious services, hospice services, and hospice unit. RESULTS: Most decedents (87%) received assistance with their spiritual needs and those who received spiritual care were perceived by family members to have had better overall care (3.59 vs. 3.25, $P = 0.002$). Family ratings of care ratings were higher for those who received spiritual support or care from facility staff when compared with those who did not (3.76 vs. 3.49, $P < 0.001$) and better care was associated with the facilitation of individual devotional activities (3.87 vs. 3.53, $P = 0.001$). CONCLUSIONS: Spiritual support and care are associated with better overall care at the end of life for LTC residents, and interventions to improve this type of care may best target interactions between residents and facility staff.

Dale, H. and Hunt, N. [University of Nottingham, UK]. **“Perceived need for spiritual and religious treatment options in chronically ill individuals.”** *Journal of Health Psychology* 13, no. 5 (Jul 2008): 712-718.

[Abstract:] The objective of the study was to examine the desire for spiritual and religious treatment options in chronically ill adults. Email interview data ($N = 12$) generated themes for religion, spirituality, and desired treatments. The resultant questionnaire data ($N = 83$) analyzed the popularity of treatments. Thirty-five wide-ranging spiritual and religious treatment options were identified for use in the questionnaire; 47

per cent of the sample was interested in spiritual or religious treatments. There is a need for spiritual and religious treatment options, and translation of treatments into practice would assist coping for many people.

Davidson, J. E., Boyer, M. L., Casey, D., Matzel, S. C. and Walden, C. D. [Scripps Mercy Hospital, San Diego, CA; Davidson.judy@scrippshealth.org]. **“Gap analysis of cultural and religious needs of hospitalized patients.”** *Critical Care Nursing Quarterly* 31, no. 2 (Apr-Jun 2008): 119-126.

[Abstract:] PURPOSE: Identify patient and family needs specifically related to an in-hospital birth or death. This study aimed to perform a gap analysis between identified needs and current hospital practice, services, and resources. METHODS: With the IRB approval, and purposive sampling using the demographics of a community hospital plus subgroups from problematic cases. Twenty-two semistructured interviews were audiotaped, and 6 lectures and 2 panel discussions were videotaped. Transcriptions were distributed to the research team and manually coded for gaps between current practices versus stated needs. Group process was used to form consensus regarding findings. PARTICIPANTS: The following subgroups were targeted: Muslim, Baha'i, Catholic, Protestant, Jewish, Buddhist, Mormon, Jehovah's Witness, Latino, Filipino, Chinese, African American. RESULTS: Gaps in available resources, such as prayer books, rugs, and compasses, were identified. Knowledge gaps included many issues such as the Muslim preference for decreasing sedatives at end of life to be able to recite the sacred prayer while dying. Practice issues such as respecting plain-clothed clergy, the impact of "rule-orientation" on family needs, and the universal need to call clergy early were identified. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/apr08.html].

Degenholtz, H. B., Rosen, J., Castle, N., Mittal, V. and Liu, D. [Department of Health Policy & Management, Center for Bioethics and Health Law, Graduate School of Public Health, University of Pittsburgh, PA]. **“The association between changes in health status and nursing home resident quality of life.”** *Gerontologist* 48, no. 5 (Oct 2008): 584-592.

Among the findings of this qualitative, longitudinal study of quality of life (QOL) for residents in two nursing homes [from the abstract:] Residents with one or more Stage II or higher pressure ulcers for two consecutive 6-month periods reported declines in autonomy, security, and spiritual well-being QOL domains....

Delaney, C. and Barrere, C. [School of Nursing, University of Connecticut, Storrs; Colleen.Delaney@uconn.edu]. **“Blessings: the influence of a spirituality-based intervention on psychospiritual outcomes in a cardiac population.”** *Holistic Nursing Practice* 22, no. 4 (Jul-Aug 2008): 210-219.

Forty-six patients with cardiovascular disease received a spirituality intervention consisting of music and imagery on a CD created for the study. They were instructed to repeat the intervention on their own at least 3 times a week for the next 4 weeks. Spirituality and anxiety measures were completed at baseline, after the initial intervention and after four weeks. Halfway through the four-week period, researchers telephoned the participants to check on progress, answer questions, and hear of the experiences of the intervention. Participants also were invited to write of their experiences in a small journal to be returned with the third round of measures (self-administered) at the end of the study. Quantitative analysis showed a significant increase in the spirituality score and a significant decrease in the anxiety score between the baseline and the first post-intervention assessments. However, only 24% of the participants continued to the end of the 4-week study period and returned the third set of measures. Analysis of the final data set from the remaining 13 participants did not show a significant further change in spirituality or anxiety outcomes. Qualitative findings (from the telephone and journal data) indicated that most participants' had a highly positive experience of the music and imagery intervention, especially in terms of the relaxation response it engendered. As they repeated the intervention, some also found in it "a deeper meaning behind the words in the imagery script" and an increasing capacity to utilize the exercise to "take their experience to a new level" [p. 217]. Only 5 participants reported that they found no benefits in the intervention, though others indicated that the time that it took became problematic. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/aug08.html].

Delgado-Guay, M. O. and Bruera, E. [University of Texas M. D. Anderson Cancer Center, Houston, TX]. **“Management of pain in the older person with cancer. Part 2: treatment options.”** *Oncology (Williston Park)* 22, no. 2 (Feb 2008): 148-152.

This overview considers, among other things, the role of spiritual distress in patients experiencing pain. The author emphasizes multidimensional assessment and a multidisciplinary team approach. [24 refs.]

Devinsky, O. and Lai, G. [Department of Neurology, NYU School of Medicine, New York University, NYU Epilepsy Center, NY; od4@nyu.edu]. **“Spirituality and religion in epilepsy.”** *Epilepsy & Behavior* 12, no. 4 (May 2008): 636-643.

[Abstract:] Revered in some cultures but persecuted by most others, epilepsy patients have, throughout history, been linked with the divine, demonic, and supernatural. Clinical observations during the past 150 years support an association between religious experiences during (ictal), after (postictal), and in between (interictal) seizures. In addition, epileptic seizures may increase, alter, or decrease religious experience especially in a small group of patients with temporal lobe epilepsy (TLE). Literature surveys have revealed that between .4% and 3.1% of partial epilepsy patients had ictal religious experiences; higher frequencies are found in systematic questionnaires versus spontaneous patient reports. Religious premonitory symptoms or auras were reported by 3.9% of epilepsy patients. Among patients with ictal religious experiences, there is a predominance of patients with right TLE. Postictal and interictal religious experiences occur most often in TLE patients with bilateral seizure foci. Postictal religious experiences occurred in 1.3% of all epilepsy patients and 2.2% of TLE patients. Many of the epilepsy-related religious conversion experiences occurred postictally. Interictal religiosity is more controversial with less consensus among studies. Patients with postictal psychosis may also experience interictal hyper-religiosity, supporting a "pathological" increase in interictal religiosity in some patients. Although psychologic and social factors such as stigma may contribute to religious experiences with epilepsy, a neurologic mechanism most likely plays a large role. The limbic system is also often suggested as the critical site of religious experience due to the association with temporal lobe epilepsy and the emotional nature of the experiences. Neocortical areas also may be involved, suggested by the presence of visual and auditory hallucinations, complex ideation during many religious experiences, and the large expanse of temporal neocortex. In contrast to the role of the temporal lobe in evoking religious experiences, alterations in frontal functions may contribute to increased religious interests as a personality trait. The two main forms of religious experience, the ongoing belief pattern and set of convictions (the religion of the everyday man) versus the ecstatic religious experience, may be predominantly localized to the frontal and temporal regions, respectively, of the right hemisphere. [68 refs.]

- de Vries, R., Berlinger, N. and Cadge, W. [Department of Medical Education, Medical School, University of Michigan, Ann Arbor]. **"Lost in translation: the chaplain's role in health care."** *Hastings Center Report* 38, no. 6 (Nov-Dec 2008): 23-27.
- This is one of five special essays in a set under the heading of, "Can We Measure Good Chaplaincy? A New Professional Identity Is Tied to Quality Improvement" and available also as a separate publication. The essays "examine the 'professionalizing' profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery" [--from the introductory statement by Gregory E. Kaebnick (no page number, in the separately available publication of the essays)]. Other essays in this set are by Berlinger, N., by Jacobs, M. R., by Mohrmann, M. E., and by Smith, M. L. (--noted elsewhere in this bibliography).
- Dew, R. E., Daniel, S. S., Armstrong, T. D., Goldston, D. B., Triplett, M. F. and Koenig, H. G. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC; red@geri.duke.edu]. **"Religion/Spirituality and adolescent psychiatric symptoms: a review."** *Child Psychiatry & Human Development* 39, no. 4 (Dec 2008): 381-398.
- [Abstract:] The aim of the current article is to review the literature on religion and spirituality as it pertains to adolescent psychiatric symptoms. One hundred and fifteen articles were reviewed that examined relationships between religion/spirituality and adolescent substance use, delinquency, depression, suicidality, and anxiety. Ninety-two percent of articles reviewed found at least one significant ($p < .05$) relationship between religiousness and better mental health. Evidence for relationships between greater religiousness and less psychopathology was strongest in the area of teenage substance use. Methods of measuring religion/spirituality were highly heterogeneous. Further research on the relationship of religion/spirituality to delinquency, depression, suicidality, and anxiety is warranted. Measurement recommendations, research priorities, and clinical implications are discussed.
- Dew, R. E., Daniel, S. S., Goldston, D. B. and Koenig, H. G. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC; red@geri.duke.edu]. **"Religion, spirituality, and depression in adolescent psychiatric outpatients."** *Journal of Nervous & Mental Disease* 196, no. 3 (Mar 2008): 247-251.
- [Abstract:] This study examines in a preliminary manner the relationship between multiple facets of religion/spirituality and depression in treatment-seeking adolescents. One hundred seventeen psychiatric outpatients aged 12 to 18 completed the brief multidimensional measure of religiousness/spirituality, the Beck Depression Inventory (BDI), a substance abuse inventory. Controlling for substance abuse and demographic variables, depression was related to feeling abandoned or punished by God ($p < 0.0001$), feeling unsupported by one's religious community ($p = 0.0158$), and lack of forgiveness ($p < 0.001$). These preliminary results suggest that clinicians should assess religious beliefs and perceptions of support from the religious community as factors intertwined with the experience of depression, and consider the most appropriate ways of addressing these factors that are sensitive to adolescents' and families' religious values and beliefs.
- DiLorenzo, T. A., Becker-Feigeles, J., Halper, J. and Picone, M. A. [Yeshiva University, New York, NY; tcdil@optonline.net]. **"A qualitative investigation of adaptation in older individuals with multiple sclerosis."** *Disability & Rehabilitation* 30, no. 15 (2008): 1088-1097.
- [From the abstract:] ...METHOD: Thirteen individuals (age 60 and above) with MS were recruited from an MS Comprehensive Care Centre and local chapters of the National Multiple Sclerosis Society. Participants completed The Perceptions of Aging Interview by telephone. This open-ended interview was developed to explore two lines of inquiry: MS: Perceptions of Aging, which was based on the literature on adaptation in MS, and Life Strengths, which was adapted from Kivnick's Life Strengths Inventory. RESULTS: The majority of participants reported having adapted to MS and aging. They described several themes and subthemes that seemed to influence their levels of adaptation: social comparisons, mobility/independence, integration of MS into self-identity, acceptance, pacing and planning, finding meaning/cognitive reframing, social support, religion/spirituality and generativity....
- Douglas, A. N., Jimenez, S., Lin, H. J. and Frisman, L. K. [Department of Psychology, Mount Holyoke College, South Hadley, MA; adouglas@mtholyoke.edu]. **"Ethnic differences in the effects of spiritual well-being on long-term psychological and behavioral outcomes within a sample of homeless women."** *Cultural Diversity & Ethnic Minority Psychology* 14, no. 4 (Oct 2008): 344-352.
- [Abstract:] The present study examines ethnicity as a moderator variable between spiritual well-being (SWB) and psychological and behavioral outcomes. Participants included in this analysis were 88 African American (46.6%) and 101 non-African American (total $N = 189$) homeless mothers. Through structured interviews conducted at 3-month intervals over a period of 15 months, data were collected on spiritual well-being, mental health, trauma symptoms, substance use, parenting, and child behavior. Hierarchical linear model and general estimating equation results indicated that ethnicity moderates the relationship between SWB and anxiety, trauma symptoms, child behavior, and parenting outcomes. On average, African Americans reported significantly higher SWB than non-African Americans, indicating the relative importance of spirituality in their lives. These findings support previous research indicating a difference in the role that SWB plays in the lives of African Americans compared to non-African Americans.
- Easterbrook, C. and Maddern, G. [Department of Surgery, University of Adelaide and the Queen Elizabeth Hospital, Woodville, South Australia]. **"Porcine and bovine surgical products: Jewish, Muslim, and Hindu perspectives."** *Archives of Surgery* 143, no. 4 (Apr 2008): 366-370; discussion on p. 370.
- [Abstract:] OBJECTIVE: To determine the acceptability of porcine and bovine surgical implants among persons of Jewish, Muslim, and Hindu faiths whose beliefs prohibit them from consuming porcine and bovine products. DATA SOURCES: An evaluation of current literature concerning religious beliefs among persons of Jewish, Muslim, and Hindu faiths was undertaken to determine if animal-derived surgical implants are permitted for use in these religions. STUDY SELECTION: Because of the limited published literature about this topic, the opinions of religious leaders in Australia were sought. DATA EXTRACTION: Religious and cultural beliefs can conflict with and limit treatment options, especially in surgery. Approximately 81 porcine and bovine surgical implants are regularly used in Australia. DATA SYNTHESIS: It is deemed acceptable for members of the Jewish faith to undergo surgery using porcine products. In dire situations and only after all other options have been exhausted, followers of the Muslim faith are permitted to use porcine surgical products. Hindu religious leaders did not accept the use of bovine surgical implants. CONCLUSIONS: Australia comprises a multicultural society; therefore, it is necessary to consider religious beliefs of all patients. As part of a surgeon's duty of care, the informed consent process should include a

discussion about animal-derived surgical implants to avoid religious distress and possible litigation. A greater understanding of religious views would enhance the medical care of persons of Jewish, Muslim, and Hindu faiths.

Edmondson, D., Park, C. L., Blank, T. O., Fenster, J. R. and Mills, M. A. [University of Connecticut, Storrs; donald.edmondson@uconn.edu]. **“Deconstructing spiritual well-being: existential well-being and HRQOL in cancer survivors.”** *Psycho-Oncology* 17, no. 2 (Feb 2008): 161-169.

[Abstract:] We demonstrate the utility of partitioning the spiritual well-being (SpWB) construct into spiritual and religious components using results from a study of the relationship of existential well-being to health-related quality of life (HRQOL) in a sample of 237 cancer survivors. Existential and religious well-being were measured using the FACIT-Sp-12 and HRQOL was measured using the mental and physical component scores of the SF-12. In hierarchical linear regression analyses, existential well-being fully mediated religious well-being's effect on HRQOL and explained unique variance in both the mental and physical HRQOL domains, controlling for demographic, disease, and psychosocial variables previously shown to impact HRQOL. Religious well-being was not predictive of HRQOL.

Edmondson, D., Park, C. L., Chaudoir, S. R. and Wortmann, J. H. [University of Connecticut, Storrs; donald.edmondson@uconn.edu]. **“Death without God: religious struggle, death concerns, and depression in the terminally ill.”** *Psychological Science* 19, no. 8 (Aug 2008): 754-758.

[Abstract:] Religious worldviews often provide comfort near the end of life, but they can cause distress if life circumstances are perceived as evidence of God's disfavor. This study, the first to test terror management theory (TMT) with terminally ill participants, examined the hypothesis that concerns about death mediate the relationship between religious struggle (and religious comfort) and depression in the terminally ill. Ninety-eight patients with end-stage congestive heart failure (CHF) completed measures of religious comfort, religious struggle, belief in an afterlife, concerns about death, and depression. In separate hierarchical linear regression models that controlled for degree of belief in an afterlife, death concerns fully mediated the relationships between religious struggle and depression and between religious comfort and depression. These findings suggest that religious struggle is a breakdown in the terror management system that leaves the individual vulnerable to the terror of death, and that properly functioning religious worldviews offer comfort by buffering the individual against death concerns. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/jan09.html].

Elia, G. and Thomas, J. [San Diego Hospice and Palliative Medicine, 4311 Third Avenue, San Diego, CA 92103]. **“The symptomatic relief of dyspnea.”** *Current Oncology Reports* 10, no. 4 (Jul 2008): 319-325.

[From the abstract:] ...In addition to opioids, there are other important pharmacologic and nonpharmacologic tools with varying degrees of support that can be considered for symptomatic relief. Importantly, because dyspnea is a subjective symptom that occurs in a unique individual, the optimal treatment of dyspnea will always entail an understanding of, and support for, a patient's other sources of psychosocial, spiritual, and/or existential suffering. [68 refs.]

Emery, E. S. [International Center for Equal Health Care Access; EJEmeny@aol.com]. **“In the light of mourning: spiritual transformations between trauma and presence.”** *Psychoanalytic Review* 95, no. 4 (Aug 2008): 625-654.

This is a version of a paper presented at the meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry, December 2007, in which the author discusses the importance of spirituality in psychiatric care.

Ergott, K. M. [School of Nursing, University of North Carolina at Greensboro]. **“Hold my hand . . . don't let go: moments of caring from a patient's perspective.”** *Journal of Holistic Nursing* 26, no. 4 (Dec 2008): 308-310.

[Abstract:] The author provides her perspective, as a patient, on the holistic nursing she received during the birth of her second child. The moments of caring and compassion she encountered are described. Four years later, the author reflects on the spiritual and emotional journey she has had as a result of this experience.

Fanos, J. H., Gelinias, D. F., Foster, R. S., Postone, N. and Miller, R. G. [Dartmouth Medical School, Dartmouth-Hitchcock Medical Center, Lebanon, NH; Joanna.Fanos@Dartmouth.edu]. **“Hope in palliative care: from narcissism to self-transcendence in amyotrophic lateral sclerosis.”** *Journal of Palliative Medicine* 11, no. 3 (Apr 2008): 470-475.

Among the findings of this qualitative study of 16 ALS patients was the following regarding the theme of Spiritual Beliefs: “Ten individuals called upon an existing belief in a higher power. One man hoped for ‘faith in God, faith in medicine, faith in something’.... Several hoped that God would intervene, grant a miracle, and cure them. Others felt less lonely and less afraid when they invoked God. Some hoped for a better afterlife, taking comfort in looking forward to going ‘home to heaven’ and seeing lost loved ones. Several searched for ways to find meaning in their suffering. They hoped to move to a position of acceptance, in which all things would be taken care of and would unfold as predestined. One man stated: ‘I believe in God as a greater power; I am a little pawn. I don't know the big picture’....” [pp. 472-473]

Farah, J. and McColl, M. A. [Queen's University, Kingston, Canada; jenn.farah@hotmail.com]. **“Exploring prayer as a spiritual modality.”** *Canadian Journal of Occupational Therapy - Revue Canadienne d'Ergotherapie* 75, no. 1 (Feb 2008): 5-13. Comments on pp. 14-17.

[Abstract:] BACKGROUND: What does it mean to focus on the spiritual in occupational therapy? What interventions would qualify as spiritual modalities? This paper attempts to define the boundaries of what may be considered legitimate uses of spirituality in occupational therapy by using the example of prayer. PURPOSE: The purpose of this paper was to provide an in-depth analysis of the use of prayer in practice. METHOD: Medical and allied health journals were searched using the terms spirituality, spirit, religion, and prayer. Identified articles were synthesized to identify potential advantages and disadvantages of using prayer in therapy. FINDINGS: Prayer can be considered an appropriate occupational therapy intervention so long as four questions can be answered positively. IMPLICATIONS: To answer these questions, guidelines are provided that will lead the therapist through a decision making process to determine the appropriateness of incorporating prayer into any clinical situation.

Farrell, J. L. and Goebert, D. A. [Department of Psychiatry, University of Hawaii, Honolulu]. **“Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness.”** *Psychiatric Services* 59, no. 4 (Apr 2008): 437-440.

[Abstract:] OBJECTIVE: A surprisingly high number of Americans seek clergy support for treatment of mental illness. However, little is known about how the clergy prepare for fulfilling this need or their beliefs regarding mental illness. This study examined the ability to

recognize and treat mental illness among Hawaii's Protestant clergy. METHODS: Ninety-eight clergy members responded to the survey. RESULTS: Most (71%) reported feeling inadequately trained to recognize mental illness. The most common cause of mental illness that clergy members cited was medical (37%), yet when asked to comment on two case vignettes, many reported that they would provide counseling instead of referral. When referrals were made, 41% considered shared religious beliefs between parishioner and provider important, and 15% considered shared beliefs essential. CONCLUSIONS: These findings highlight the need for collaboration between mental health professionals and the clergy. Knowledge of a patient's belief system may help improve crisis interventions and treatment planning for religious patients. [See also the related editorial: Mattox, R. and Sullivan, G., "Treatment: 'just what the preacher ordered,'" on p. 349.]

Fegg, M. J., Kramer, M., L'hoste, S. and Borasio, G. D. [Interdisciplinary Center for Palliative Medicine, University Hospital, Munich, Germany; martin@fegg.de]. "**The Schedule for Meaning in Life Evaluation (SMiLE): validation of a new instrument for meaning-in-life research.**" *Journal of Pain & Symptom Management* 35, no. 4 (Apr 2008): 356-364.

This research indicates good feasibility and acceptability of the SMiLE measure in palliative care patients. Among the points of the article regarding spirituality: the concept of Meaning in Life (MiL) showed a correlation with self-transcendence and/or spirituality. MiL, as assessed by SMiLE, was not found to be correlated with religiousness, though the authors note other research that showed a correlation with religious commitment; and they comment: "These different findings may depend on the proportion of how much the individual considers religiosity as an important area for his or her idiographic MiL" [p. 363]. The researchers further note: "Cognitive interviews revealed overlaps between the constructs of MiL and self-transcendence/spirituality. Therefore, the relations between MiL, religiosity, self-transcendence, and spirituality should be investigated in further detail." [p. 363]

Feldbush, M. W. "**Healthcare chaplaincy: taking a look at the new model.**" *Southern Medical Journal* 101, no. 6 (Jun 2008): 580.

This is a brief piece, as part of the journal's series on spirituality in conjunction with the Southern Medical Association's Spirituality & Medicine Interface Project.

Ferrell, B., Levy, M. H. and Paice, J. [City of Hope National Medical Center, Duarte, CA; bferrell@coh.org]. "**Managing pain from advanced cancer in the palliative care setting.**" *Clinical Journal of Oncology Nursing* 12, no. 4 (Aug 2008): 575-581.

The authors consider *passim* the importance of spirituality in end-of-life care and pain management, and they include the FICA spiritual assessment (--see p. 580).

Ferrell, B., Paice, J. and Koczywas, M. [Department of Nursing Research and Education, and Division of Medical Oncology and Therapeutics Research, City of Hope National Medical Center, Duarte, CA; bferrell@coh.org]. "**New standards and implications for improving the quality of supportive oncology practice.**" *Journal of Clinical Oncology* 26, no. 23 (Aug 10, 2008): 3824-3831.

The authors review current guidelines and national initiatives to improve the quality of supportive oncology care, focusing on the National Consensus Project for Quality Palliative Care and the National Quality Forum. See Domain 5: Spiritual, Religious, and Existential Aspects of Care in tables on pp. 3826 and 3829. The latter table lists four Preferred Practices: "Develop and document a plan based on assessment of religious, spiritual, and existential concerns using a structured instrument and integrate the information obtained from the assessment into the palliative care plan"; "Provide information about the availability of spiritual care services and make spiritual care available either through organizational spiritual counseling or through the patient's own clergy relationships"; "Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care"; and "Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care" [p. 3829].

Ferrell, B. and Virani, R. [Department of Nursing Research and Education, City of Hope, Duarte, CA]. "**National guidelines for palliative care: A roadmap for oncology nurses.**" *Oncology (Williston Park)* 22, no. 2, Suppl Nurse Ed (Feb 2008): 28-34; discussion on pp. 34-35. [Available online at www.cancernetwork.com/cme/article/10165/1148935.]

This article reviews guidelines developed by the National Consensus Project for Quality Palliative Care and preferred practices defined by the National Quality Forum, including those for Spiritual, Religious, and Existential Aspects of Care: "Oncology nurses have long advocated for attention to spiritual care needs. Many of the advances in spiritual assessment and in addressing diverse religious preferences have been pioneered in oncology. The key recommendations within Domain 5 include the following: Assess and address spiritual concerns; Recognize and respect religious beliefs—provide religious support; [and] Make connections with community and spiritual/ religious groups or individuals as desired by patient/family. ...In much the same way that structured assessment of pain or symptoms facilitates consistent care, this domain and its referred practices emphasizes the importance of routine practice related to spirituality. Many clinical settings have adopted standard spiritual assessments such as use of the FICA tool. Oncology nurses can be instrumental in promoting collaboration between chaplaincy and community clergy." Examples are given for NQF Preferred Practices for this domain. [Text available freely online at www.cancernetwork.com/display-cme/article/10165/1148935#]

Ferrell, B. R. and Coyle, N. [Dept. of Nursing Research & Education at City of Hope National Medical Center in Duarte, CA; bferrell@coh.org]. "**The nature of suffering and the goals of nursing.**" *Oncology Nursing Forum* 35, no. 2 (Mar 2008): 241-247.

The authors of this review address the role of spirituality *passim*, and offer 10 tenets regarding suffering, including: "Suffering often is accompanied by spiritual distress. Regardless of religious affiliation, individuals experiencing illness may feel a sense of hopelessness. When life is threatened, people may conduct self-evaluation of what has been lived and what remains undone. Becoming weak and vulnerable and facing mortality may cause a person to reevaluate his or her relationship with a higher being." Also: "Suffering is not synonymous with pain but is closely associated with it. Physical pain is closely related to psychological, social, and spiritual distress. Pain that persists without meaning becomes suffering." [p. 246] [36 refs.]

Finkelstein, D. [Wilmer Eye Institute, Johns Hopkins Hospital]. "**Medical ethics: the role of religion and spirituality in building the patient-physician relationship.**" *Maryland Medicine* 9, no. 1 (2008): 28, 32.

- Fitzpatrick, K. M., Piko, B. F. and Miller, E. [University of Arkansas, Fayetteville; kfitzpa@uark.edu]. **“Suicide ideation and attempts among low-income African American adolescents.”** *Suicide & Life-Threatening Behavior* 38, no. 5 (Oct 2008): 552-563.
 [From the abstract:] We examined the impact of risk and protective factors on the odds that African American adolescents seriously think about or attempt suicide. Data from students in grades 5-12 in a mostly urban, southeastern U.S. school district were analyzed. ...Protective factors were not consistent predictors; the lowering role of religious protective factors was limited, though student's belonging to or their perception of belonging to a spiritual community was a significant factor in lowering the odds of suicide ideation.
- Fosarelli P. [Ecumenical Institute of Theology, 5400 Roland Ave, Baltimore, MD 21210; pfosarelli@stmarys.edu]. **“Medicine, spirituality, and patient care.”** *JAMA* 300, no. 7 (Aug 20, 2008): 836-838.
 This commentary by an MD who also holds an MDiv degree encourages attention to patients' spiritual issues by careful physician inquiry. He also notes caution regarding spirituality research.
- Franklin, M. D., Schlundt, D. G. and Wallston, K. A. [Vanderbilt University; monica.d.franklin@vanderbilt.edu]. **“Development and validation of a religious health fatalism measure for the African-American faith community.”** *Journal of Health Psychology* 13, no. 3 (Apr 2008): 323-335.
 [Abstract:] Health researchers struggle to understand barriers to improving health in the African-American community. The African-American church is one of the most promising venues for health promotion, disease prevention, and disparities reduction. Religious fatalism, the belief that health outcomes are inevitable and/or determined by God, may inhibit healthy behaviors for a subset of religious persons. This study reports the development and validation of the Religious Health Fatalism Questionnaire, a measurement tool for studying faith-related health beliefs in African-Americans. Participants included 276 members of seven predominantly African-American churches. Factor analysis indicated three dimensions: (1) Divine Provision; (2) Destined Plan; and (3) Helpless Inevitability. Evidence is presented for the reliability, convergent and predictive validity of the Religious Health Fatalism Questionnaire.
- Fyffe, D. C., Brown, E. L., Sirey, J. A., Hill, E. G. and Bruce, M. L. [Institute for the Elimination of Health Disparities, School of Public Health, University of Medicine & Dentistry of New Jersey, Newark; fyffedc@umdnj.edu]. **“Older home-care patients' preferred approaches to depression care: a pilot study.”** *Journal of Gerontological Nursing* 34, no. 8 (Aug 2008): 17-22.
 [From the abstract:] ...Twenty-eight long-term home-care patients, ages 62 to 95, were interviewed. Patients ranked their depression care preferences and provided rationale for their responses. Results indicated prayer was preferred by the highest percentage of patients (50%). Comparing patients with and without depression experience, prayer was preferred by the latter group....
- Galanter, M. [NYU School of Medicine, New York; marcgalanter@nyu.edu]. **“The concept of spirituality in relation to addiction recovery and general psychiatry.”** *Recent Developments in Alcoholism* 18 (2008): 125-140.
 [Abstract:] This chapter is directed at defining the nature of spirituality and its relationship to empirical research and clinical practice. A preliminary understanding of the spiritual experience can be achieved on the basis of diverse theoretical and empirically grounded sources, which will be delineated: namely, physiology, psychology, and cross-cultural sources. Furthermore, the impact of spirituality on mental health and addiction in different cultural and clinical settings is explicated regarding both beneficial and compromising outcomes. Illustrations of its application in addiction and general psychiatry are given: in meditative practices, Alcoholics Anonymous, and treatment programs for addiction singly and comorbid with major mental illness. Given its prominence in Alcoholics Anonymous and related Twelve-Step groups, spirituality plays an important role in the rehabilitation of many substance-dependent people. The issue of spirituality, however, is prominent within contemporary culture as well in the form of theistic orientation, as evidenced in a probability sampling of American adults, among whom 95% of respondents reply positively when asked if they believe in "God or a universal spirit." Responses to a follow-up on this question suggest that this belief affects the daily lives of the majority (51%) of those sampled, as they indicated that they had talked to someone about God or some aspect of their faith or spirituality within the previous 24 h (Gallup, 2002). [85 refs.] [This article is part of an issue highlighting spiritual issues. See also the article by Pearce, M. J., Rivojoja, C. M. and Koenig, H. G., noted elsewhere in this bibliography. Other articles in the issue are: Hsu, S. H., et al., "Mindfulness and addiction"; Connors, G. J, et al., "Spiritual change in recovery"; Johnson, T., et al., "Issues in measuring spirituality and religiousness in alcohol research"; and Zemore, S. E., "An overview of spirituality in AA (and recovery)."]
- Galanter, M. [Division of Alcoholism and Drug Abuse, New York University School of Medicine, New York, NY]. **“Spirituality, evidence-based medicine, and Alcoholics Anonymous.”** *American Journal of Psychiatry* 165, no. 12 (Dec 2008): 1514-1517.
 This physician's commentary supports research into the role of spirituality in Alcoholics Anonymous. The author's general perspective is summed up in his conclusion: Although a spiritual orientation may have a positive impact on patient care, it can also be deleterious when it generates conflict within individuals or deters them from seeking empirically grounded treatment from qualified professionals. Nonetheless, a spiritual commitment that is well integrated into ongoing medical care may help many patients fulfill their treatment goals." [p. 1516]
- Gaventa, W. C. [Community and Congregational Supports, The Elizabeth M. Boggs Center on Developmental Disabilities, Robert Wood Johnson Medical School, UMDNJ, New Brunswick, NJ; bill.gaventa@umdnj.edu]. **“Rekindling commitment: reflections from a pastoral educator enmeshed in direct support professional workforce development and person centered supports.”** *Journal of Intellectual Disability Research* 52, no. 7 (Jul 2008): 598-607.
 [Abstract:] BACKGROUND: Services with people with intellectual disabilities (ID) are increasingly structured by regulations, policies and licensing standards by public funding entities. The key responsibility for direct care staff often becomes that of compliance with all the rules and regulations. METHOD: The impact of an increasing focus on compliance with regulations in the systems of services and supports for people with ID is explored along with the absence of focus on professional commitment and relationships. This exploration is done through a review of literature and also anecdotes and observations from 30 years of professional experience in working with direct care staff. RESULTS: Whether the source for enhanced regulation is concern about health and safety, honouring rights, meeting laws and/or an underlying fear that we cannot rely on the caregivers because of the turnover or lack of skill; we end up building a system based more and more on compliance, on regulations, programme and behavioural plans and competencies, without the same kind of concern or attention for people who are doing the caring, their motivation and what they need. One of the hypotheses and conclusions of this article is that the focus on compliance diminishes professional competence and commitment, and contributes both to staff disillusionment and to the rapid turnover. CONCLUSIONS: As

recruitment and turnover in the direct support professional workforce become ever more difficult problems, the newer focus on person-centred planning, self-directed supports and workforce development have both possibilities and problems in enhancing staff commitment in relationships with people they support. The importance of enhancing and supporting commitment also calls for new forms of professional identity and education that recapture the language and habits of commitment while also providing opportunities for staff to reflect on the values, visions and commitments that support their work.

Gentry, J. “**Don't tell her she's on hospice': ethics and pastoral care for families who withhold medical information.**” *Journal of Pastoral Care & Counseling* 62, no. 5, Suppl. (2008): 421-426. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] When family members enroll a patient in hospice, they sometimes request that the patient not be told of the diagnosis and their enrollment in hospice--usually so the patient won't be sad. In these situations, hospice staff face an ethical dilemma involving a patient's right to full disclosure. A discussion of this issue at an ethics committee session, chaired by the author of this article, brought to light many personal dynamics associated with these situations, and the discussion is used by the author to draw conclusions about pastoral care for these patients and families. Several responses from colleagues follow.

Gettman, M. T., Karnes, R. J., Arnold, J. J., Klipfel, J. M., Vierstraete, H. T., Johnson, M. E., Johnson, D. R. and Leibovich, B. C. [Department of Chaplain Services, Mayo Clinic, Rochester, MN]. “**Urology resident training with an unexpected patient death scenario: experiential learning with high fidelity simulation.**” *Journal of Urology* 180, no. 1 (Jul 2008): 283-288, with discussion on p. 288.

“The study is...the first to use nurses, hospital chaplains and critical care medicine fellows in conjunction with a sophisticated interactive mannequin for training purposes in urology” [p. 286]. Among the results: “Unexpectedly, we found that including actual urology nurses, chaplains and critical care fellows in the scenario fostered camaraderie and increased awareness among our residents of the contribution by other health care disciplines and delivery systems” [p. 286].

Gillum, R. F., King, D. E., Obisesan, T. O. and Koenig, H. G. [Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention, Hyattsville, MD; rfg2@cdc.gov]. “**Frequency of attendance at religious services and mortality in a U.S. national cohort.**” *Annals of Epidemiology* 18, no. 2 (Feb 2008): 124-129.

[Abstract:] OBJECTIVE: Few nationally representative cohort studies have appeared on frequency of attendance at religious services and mortality. We test the hypothesis that > weekly attendance compared with nonattendance at religious services is associated with lower probability of future mortality in such a study. METHODS: Data were analyzed from a longitudinal follow-up study of 8450 American men and women age 40 years and older who were examined from 1988 to 1994 and followed an average of 8.5 years. Measurements at baseline included self-reported frequency of attendance at religious services, sociodemographics, and health, physical and biochemical measurements. RESULTS: Death during follow-up occurred in 2058. After adjusting for confounding by baseline sociodemographics and health status, the hazards ratios (95% confidence limits) were never 1.00 (reference); < weekly 0.89 (0.75-1.04), $p = 0.15$; weekly 0.82 (0.71-0.94) $p = 0.005$; and > weekly attenders 0.70 (0.59-0.83), $p < 0.001$. Mediators, including health behaviors and inflammation, explained part of the association. CONCLUSIONS: In a nationwide cohort of Americans, predominantly Christians, analyses demonstrated a lower risk of death independent of confounders among those reporting religious attendance at least weekly compared to never. The association was substantially mediated by health behaviors and other risk factors.

Gillum, R. F. and Sullins, D. P. [Centers for Disease Control and Prevention, Hyattsville, MD; rfg2@cdc.gov]. “**Cigarette smoking during pregnancy: independent associations with religious participation.**” *Southern Medical Journal* 101, no. 7 (Jul 2008): 686-692. Comment on pp. 673-674.

[Abstract:] OBJECTIVE: Data from a national health survey were used to test the hypothesis of a negative association of smoking in pregnancy and three measures of religious participation and importance. METHODS: The 2002 National Survey of Family Growth included 2395 women aged 15 to 44 years with a history of at least one pregnancy in the five years before interview. An association between religious participation and cigarette smoking during the last pregnancy was assessed in bivariate and multivariate analyses. RESULTS: The rate of smoking during the last pregnancy was 4% (95% confidence limit [CL] 2-7%) among those who attended service more than once weekly and 24% (95% CL 20-30%) among those who never attended (chi-square 68, $P < 0.0001$). In logistic regression models compared with those who never attended, those attending once a week or more were only one-fifth as likely to smoke during pregnancy among European Americans (adjusted odds ratio with 95% confidence limits of 0.22, 0.12-0.39) and Hispanics (0.28 95% CL, 0.11-0.73), and one-half as likely to smoke among African Americans (0.53 95% CL, 0.16-1.69). Significant associations were also observed for affiliation and importance of religion. CONCLUSION: The frequency of attendance at religious services, affiliation, and importance were independently inversely associated with smoking during pregnancy in American women. The strength of these associations varied among ethnic groups.

Glass, A. P. and Nahapetyan, L. [Institute of Gerontology, College of Public Health, University of Georgia Institute of Gerontology, Athens, GA; aglass@geron.uga.edu]. “**Discussions by elders and adult children about end-of-life preparation and preferences.**” *Preventing Chronic Disease* 5, no. 1 (Jan 2008): A08.

[From the abstract:] This project focused on informal family communication about end-of-life preparation and preferences, about which little is known. METHODS: In May 2006, we conducted in-depth exploratory interviews with 15 older adults about their end-of-life preparation and preferences and with 15 younger adults about their parents' end-of-life preparation and preferences. The interview included an item rating the depth of discussion. RESULTS: ...Barriers to discussions about end-of-life preparation and preferences were fear of death, trust in others to make decisions, family dynamics, and uncertainty about preferences. Facilitators for discussion were acceptance of the reality of death, prior experience with death, religion or spirituality, and a desire to help the family. Successful strategies included casually approaching the topic and writing down end-of-life preparation and preferences....

Gonnerman, M. E. Jr., Lutz, G. M., Yehieli, M. and Meisinger, B. K. [Department of Psychology, University of Northern Iowa, Center for Social and Behavioral Research, Cedar Falls; Mel.Gonnerman@uni.edu]. “**Religion and health connection: a study of African American, Protestant Christians.**” *Journal of Health Care for the Poor & Underserved* 19, no. 1 (Feb 2008): 193-199. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] The roles religious and health promoting behaviors may play in bolstering positive physical and emotional health were assessed using structured, face-to-face interviews conducted using a non-random community sample of 105 adult African American, Protestant Christians in a small city in a rural state in the Midwest. The interview measured health promotion, health locus of control beliefs, emotional health, physical health, religious practices, and demographics. Health promotion, church attendance, or both were related to decreased prevalence of loneliness, depression, trouble sleeping, and family problems. More than 80% of those interviewed ascribed healing power to God and prayer. There was an apparent lack of connection between respondents' attitudes about faith and healing and their actual experiences.

Goodman, G. and Manierre, A. [Long Island University, Brookville, NY; ggoodman@liu.edu]. **“Representations of God uncovered in a spirituality group of borderline inpatients.”** *International Journal of Group Psychotherapy* 58, no. 1 (Jan 2008): 1-15.

[Abstract:] We present aspects of a psychoanalytically-oriented, exploratory spirituality group for nine female psychiatric inpatients diagnosed with borderline personality disorder. Through drawings and group process, the patients uncovered and elaborated on their representations of God. Two patterns of representations were identified: (1) representations of a punitive, judgmental, rigid God that seemed directly to reflect and correspond with parental representations and (2) representations of a depersonified, inanimate, abstract God entailing aspects of idealization that seemed to compensate for parental representations. Interestingly, the second pattern was associated with comorbid narcissistic features in the patients. Those patients who presented punitive God representations were able to begin the process of re-creating these representations toward more benign or benevolent images in the context of this group, while those participants who presented depersonified God representations seemed unable to do so.

Gould, J., Wilson, S. and Grassau, P. [Women's College Hospital, Toronto, Canada; judy.gould@wchospital.ca]. **“Reflecting on spirituality in the context of breast cancer diagnosis and treatment.”** *Canadian Oncology Nursing Journal* 18, no. 1 (2008): 34-46.

[Abstract:] In this first part of a longitudinal study, women were asked to reflect on the meaning of spirituality in the first year following diagnosis of breast cancer. Twenty-two women were interviewed at approximately one year post-diagnosis. This paper reports on a thematic analysis of these interviews. Participants' responses reflected three higher-order themes: relationship with a higher power, a deepening sense of self, and spiritual connection with others. The findings provide an enhanced understanding of how spirituality frames and impacts (both positively and negatively) the experience of breast cancer immediately following diagnosis and treatment. Most participants in this study found strength and support in their experiences of spirituality. They also spoke at times of feeling disconnected from or abandoned by God. The paper concludes with a discussion of how cancer health professionals might respond to the spiritual needs expressed by women living with cancer.

Grabovac, A., Clark, N. and McKenna, M. [Department of Psychiatry, University of British Columbia, Vancouver, Canada; agrabovac@bccancer.bc.ca]. **“Pilot study and evaluation of postgraduate course on ‘the interface between spirituality, religion and psychiatry.’”** *Academic Psychiatry* 32, no. 4 (Jul-Aug 2008): 332-337.

[Abstract:] OBJECTIVES: Understanding the role of religion and spirituality is significant for psychiatric practice. Implementation of formal education and training on religious and spiritual issues, however, is lacking. Few psychiatric residencies offer mandatory courses or evaluation of course utility. The authors present findings from a pilot study of a course on the interface between spirituality, religion, and psychiatry. Course objectives were to increase both residents' understanding of clinically relevant spiritual/religious issues and their comfort in addressing these issues in their clinical work. METHODS: A 6-hour mandatory course was implemented for third- and fourth-year psychiatry residents at the University of British Columbia. Teaching sessions consisted of didactic and case-based modules delivered by multidisciplinary faculty. The Course Impact Questionnaire, a 20-item Likert scale, was used to assess six areas: personal spiritual attitudes, professional practice attitudes, transpersonal psychiatry, competency, attitude change toward religion and spirituality, and change in practice patterns. A pre/post study design was used with the questionnaire being administered at week 0, week 6, and 6 months follow-up to two groups of residents (N=30). Qualitative feedback was elicited through written comments. RESULTS: The results from this pilot study showed that there was increased knowledge and skill base for residents who participated in the sessions. Paired t test analysis indicated a statistically significant difference between the pre- and postsession scale for competency. No other statistically significant differences were found for the other components. CONCLUSION: The findings suggest improvement in the competency scores for residents and overall usefulness of this course; however, limited conclusions can be made due to a small sample size and lack of adequate comparison groups. Establishing educational significance will require gathering larger usable control data as well as validation of the Course Impact Questionnaire tool to distinguish between different skill levels.

Grange, C. M., Matsuyama, R. K., Ingram, K. M., Lyckholm, L. J. and Smith, T. J. [Dept. of Psychology, Virginia Commonwealth University, Richmond, VA; grangec@vcu.edu]. **“Identifying supportive and unsupportive responses of others: perspectives of African American and Caucasian cancer patients.”** *Journal of Psychosocial Oncology* 26, no. 1 (2008): 81-99.

[Abstract:] This study uses focus group methodology to examine supportive and unsupportive responses experienced by African American and Caucasian cancer patients. Supportive responses included practical assistance, as well as people's willingness to listen, maintain a positive attitude, and pray. Unsupportive responses included others' withdrawal behaviors, patients having to support friends/family as they coped, and family/friends limiting patients' independence. Results reflect ways in which mental health providers, social workers, and health care providers can help patients express support needs, as well as how social networks can be better educated about the types of support valued by patients.

Gries, C. J., Curtis, J. R., Wall, R. J. and Engelberg, R. A. [Division of Pulmonary and Critical Care, Department of Medicine, University of Washington, Seattle; cderuit1@u.washington.edu]. **“Family member satisfaction with end-of-life decision making in the ICU.”** *Chest* 133, no. 3 (Mar 2008): 704-712.

[Abstract:] RATIONALE: Families of ICU patients may be at risk for increased psychological morbidity due to end-of-life decision making. The identification of chart-based quality indicators of palliative care that predict family satisfaction with decision making may help to guide interventions to improve decision making and family outcomes. OBJECTIVE: To determine patient and family characteristics and chart the documentation of processes of care that are associated with increased family satisfaction with end-of-life decision making for ICU patients. METHODS: We conducted a cohort study of ICU patients dying in 10 medical centers in the Seattle-Tacoma area. Measurement: Outcomes from family surveys included summary scores for family satisfaction with decision making and a single-item score that indicated feeling supported during decision making. Predictor variables were obtained from surveys and chart abstraction. Main results: The survey response rate was 41% (442 of 1,074 families responded). Analyses were conducted of 356 families with questionnaire and chart abstraction data. Family satisfaction with decision making was associated with the withdrawal of life support, and chart documentation of physician recommendations

to withdraw life support, discussions of patients' wishes, and discussions of families' spiritual needs. Feeling supported during decision making was associated with the withdrawal of life support, spiritual care involvement, and chart documentation of physician recommendations to withdraw life support, expressions of families' wishes to withdraw life support, and discussions of families' spiritual needs. **CONCLUSIONS:** Increased family satisfaction with decision making is associated with withdrawing life support and the documentation of palliative care indicators including the following: physician recommendations to withdraw life support; expressions of patients' wishes; and discussions of families' spiritual needs. These findings provide direction for future studies to investigate approaches to improving family satisfaction in end-of-life decision making. In addition, because there were few nonwhites in this study, these results may not be generalizable to more diverse populations. Future studies should target diverse populations in order to test whether similar factors are similarly important for end-of-life decision making.

Griffiths, R., Richards, W., Johnson, M., McCann, U. and Jesse, R. [Department of Psychiatry and Behavioral Sciences and Department of Neuroscience, Johns Hopkins University, School of Medicine, Baltimore, MD; rgriff@jhmi.edu]. **"Mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance 14 months later."** *Journal of Psychopharmacology* 22, no. 6 (Aug 2008): 621-632.

[Abstract:] Psilocybin has been used for centuries for religious purposes; however, little is known scientifically about its long-term effects. We previously reported the effects of a double-blind study evaluating the psychological effects of a high psilocybin dose. This report presents the 14-month follow-up and examines the relationship of the follow-up results to data obtained at screening and on drug session days. Participants were 36 hallucinogen-naïve adults reporting regular participation in religious/ spiritual activities. Oral psilocybin (30 mg/70 kg) was administered on one of two or three sessions, with methylphenidate (40 mg/70 kg) administered on the other session(s). During sessions, volunteers were encouraged to close their eyes and direct their attention inward. At the 14-month follow-up, 58% and 67%, respectively, of volunteers rated the psilocybin-occasioned experience as being among the five most personally meaningful and among the five most spiritually significant experiences of their lives; 64% indicated that the experience increased well-being or life satisfaction; 58% met criteria for having had a 'complete' mystical experience. Correlation and regression analyses indicated a central role of the mystical experience assessed on the session day in the high ratings of personal meaning and spiritual significance at follow-up. Of the measures of personality, affect, quality of life and spirituality assessed across the study, only a scale measuring mystical experience showed a difference from screening. When administered under supportive conditions, psilocybin occasioned experiences similar to spontaneously occurring mystical experiences that, at 14-month follow-up, were considered by volunteers to be among the most personally meaningful and spiritually significant of their lives.

Grossoehme, D. H. [Cincinnati Children's Hospital Medical Center, Department of Pastoral Care; Daniel.grossoehme@cchmc.org]. **"Development of a spiritual screening tool for children and adolescents."** *Journal of Pastoral Care & Counseling* 62, nos. 1-2 (Spring-Summer 2008): 71-85.

[Abstract:] A chaplain's ability to provide care where it is most needed depends upon some method of pastoral triage. Screening for spiritual needs of children and adolescents has been a largely neglected area. A Delphi panel developed elements to be included in a tool to screen 10-18 year olds' spiritual needs and resources. The Delphi panelists were informed of survey results of school-aged children and adolescents' opinions on spiritual issues important to them if they were hospitalized. A case study of the tool's use was conducted with a convenient sample of children and adolescents. Subsequent pilot use of the tool by five pediatric chaplains demonstrated the tool's utility in identifying patients' spiritual issues, ability to serve as a springboard to deeper discussion, and as a basis for initiating discussion of spiritual concerns with other disciplines on the healthcare team. Feedback indicates the potential clinical usefulness of this tool for hospitalized children and adolescents.

Gunderman, R. B. and Wilson, P. K. [Department of Radiology, Indiana University School of Medicine, Indianapolis; rbgunder@iupui.edu]. **"Spirituality in medicine."** *Journal of the American College of Radiology* 5, no. 9 (Sep 2008): 946-950. The authors offer a historical perspective on spirituality in medicine.

Gusick, G. M. [St. Luke's Episcopal Health System, Houston, TX; ggusick@sleh.com]. **"The contribution of depression and spirituality to symptom burden in chronic heart failure."** *Archives of Psychiatric Nursing* 22, no. 1 (Feb 2008): 53-55.

This report of original research suggests that spirituality may function as a moderator rather than a predictor of symptom burden in heart failure patients. "According to the findings, in the case of depression, spirituality, and HF symptom burden, the relationship between depression and symptom burden varied depending on spirituality" [p. 54].

Hales, S., Zimmermann, C., Rodin, G. [Department of Psychosocial Oncology & Palliative Care, Princess Margaret Hospital, University Health Network, Toronto, Canada; sarah.hales@uhn.on.ca]. **"The quality of dying and death."** *Archives of Internal Medicine* 168, no. 9 (May 12, 2008): 912-918.

[From the abstract:] During the past decade, research has examined definitions and conceptualizations of quality of dying and death in different populations. At the same time, there has been a call to clarify the distinctions between quality of dying and death and other end-of-life constructs. The purposes of this article are to (1) review research that examined definitions and conceptualizations of the quality of dying and death, (2) clarify the quality of dying and death construct and its distinction from quality of life and quality of care at the end of life, and (3) outline challenges that remain for health care professionals, researchers, and policy makers. Review of the literature revealed that the quality of dying and death construct is multidimensional, with 7 broad domains: physical experience, psychological experience, social experience, spiritual or existential experience, the nature of health care, life closure and death preparation, and the circumstances of death.... [20 refs.]

Hall, D. E. [Dept. of General Surgery, University of Pittsburgh, Presbyterian Hospital, Pittsburgh, PA; hallde@upmc.edu]. **"Altar and table: a phenomenology of the surgeon-priest."** *Yale Journal of Biology & Medicine* 81, no. 4 (Dec 2008): 193-198.

This is a personal and historical reflection, in light of the author's own experience as both a surgeon and an Episcopal priest.

Hall, D. E., Koenig, H. G. and Meador, K. G. [Center for Health Equities Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA; hallde@upmc.edu]. **"Hitting the target: why existing measures of 'religiousness' are really reverse-scored measures of 'secularism.'"** *Explore: The Journal of Science & Healing* 4, no. 6 (Nov-Dec 2008): 368-373.

[Abstract:] Over 100 measures of religiousness and spirituality are used in research investigating the associations between religion and health. These measures are often used to assess "religiousness in general," but this approach lumps together widely divergent worldviews in ways that can distort religion beyond recognition. The authors suggest that the existing measures of religiousness are perhaps better understood as

reverse-coded measures of "secularism." This argument suggests that the existing data regarding religiousness and health might be best interpreted as demonstrating a small, robust health liability associated with a deliberately secular worldview. If true, this conclusion might change the direction of future research, and it would imply that meaningful inferences about the health associations of religious practice will depend on developing tools that measure specific religions in their particularity.

Hall, D. E., Meador, K. G. and Koenig, H. G. [Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA; hallde@upmc.edu]. **"Measuring religiousness in health research: review and critique."** *Journal of Religion & Health* 47, no. 2 (Jun 2008): 134-163.

[Abstract:] Although existing measures of religiousness are sophisticated, no single approach has yet emerged as a standard. We review the measures of religiousness most commonly used in the religion and health literature with particular attention to their limitations, suggesting that vigilance is required to avoid over-generalization. After placing the development of these scales in historical context, we discuss measures of religious attendance, private religious practice, and intrinsic/extrinsic religious motivation. We also discuss measures of religious coping, wellbeing, belief, affiliation, maturity, history, and experience. We also address the current trend in favor of multi-dimensional and functional measures of religiousness. We conclude with a critique of the standard, "context-free" approach aimed at measuring "religiousness-in-general", suggesting that future work might more fruitfully focus on developing ways to measure religiousness in specific, theologically relevant contexts.

Hamilton, J. G. and Lobel, M. [Department of Psychology, Stony Brook University, NY]. **"Types, patterns, and predictors of coping with stress during pregnancy: examination of the Revised Prenatal Coping Inventory in a diverse sample."** *Journal of Psychosomatic Obstetrics & Gynecology* 29, no. 2 (Jun 2008): 97-104.

[From the abstract:] The present study investigated coping in early, mid-, and late pregnancy in 321 ethnically and socioeconomically diverse women of varying medical risk. The goal was to determine how women cope with stress across pregnancy and to explore the association of coping with maternal characteristics, stress perceptions, disposition, and social support. Factor analysis of the Revised Prenatal Coping Inventory revealed three distinct types of coping: Planning-Preparation, Avoidance, and Spiritual-Positive Coping. Spiritual coping was used most frequently during pregnancy; avoidant coping was used least often. As hypothesized, use of spiritual coping and avoidance differed across pregnancy. Planning was used more consistently across time. Multivariate regression analyses revealed that the strongest predictors of planning were high optimism and pregnancy-specific distress. Avoidance was most strongly predicted by high state anxiety and pregnancy-specific distress. Greater religiosity and optimism were the strongest predictors of spiritual coping....

Handzo, G. F., Flannelly, K. J., Kudler, T., Fogg, S. L., Harding, S. R., Hasan, Y. H., Ross, A. M. and Taylor, B. E. [The HealthCare Chaplaincy, New York, NY; ghandzo@healthcarechaplaincy.org]. **"What do chaplains really do? II. Interventions in the New York Chaplaincy Study."** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 39-56. [See other articles from the special journal issue on chaplaincy research by Handzo, et al.; Weaver, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography. Two articles, by Handzo, et al. and Vanderwerker, et al., are companion analyses of the New York Chaplaincy Study.]

[Abstract:] The current study analyzes data from 30,995 chaplain visits with patients and families that were part of the New York Chaplaincy Study. The data were collected at 13 healthcare institutions in the Greater New York City area from 1994-1996. Seventeen chaplain interventions were recorded: nine that were religious or spiritual in nature, and eight that were more general or not specifically religious. Chaplains used religious/spiritual interventions, alone or in conjunction with general interventions, in the vast majority of their visits with patients and families. The types of interventions used varied by the patient's medical status to some degree, but the pattern of interventions used was similar across faith group and medical status. The results document the unique role of the chaplain as a member of the healthcare care team and suggest there is desire among a broad range of patients, including those who claim no religion, to receive the kind of care chaplains provide.

Handzo, G. F., Flannelly, K. J., Murphy, K. M., Bauman, J. P., Oettinger, M., Goodell, E., Hasan, Y. H., Barrie, D. P. and Jacobs, M. R. [The HealthCare Chaplaincy, New York, NY; ghandzo@healthcarechaplaincy.org]. **"What do chaplains really do? I. Visitation in the New York Chaplaincy Study."** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 20-38. [See other articles from the special journal issue on chaplaincy research by Handzo, et al.; Weaver, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography. Two articles, by Handzo, et al. and Vanderwerker, et al., are companion analyses of the New York Chaplaincy Study.]

[Abstract:] The current study presents findings from the New York Chaplaincy Study about chaplain visits with patients and their families in 13 healthcare institutions in the Greater New York City area during 1994-1996. It documents the distribution of 34,279 clinical visits by religious affiliation, population served (patients, family and friends), and type of healthcare setting (acute care and non-acute care), and analyzes the number and duration of visits with patients by their medical status. Chaplains in acute settings tended to make less frequent but longer visits with patients than chaplains in non-acute settings. On average, chaplains spent less time with patients who were alone than they did during visits with patients whose family was present during the visit or visits with only family members. Average visit duration was positively related to the percentage of visits in each of the 13 facilities that were made in response to referrals ($r = .65$, $p < .05$), and the average duration of referred visits was significantly longer ($p < .001$) than that of non-referred visits ($p < .001$). The findings are intended to provide a general picture of what these particular chaplains did in these particular institutions over this particular time-period and are not intended to represent a standard of what chaplains should be doing.

Hansen, M., Ganley, B. and Carlucci, C. [Dominican University of California, San Rafael; farnat115@comcast.net]. **"Journeys from addiction to recovery."** *Research & Theory for Nursing Practice* 22, no. 4 (2008): 256-272.

This qualitative study of nine participants who described their experience with long-term recovery from addiction notes spirituality as part of a number of themes: e.g., "A Spiritual Intervention Further Encourages Change" (pp. 265-266), "Confess to Another and Choose to Be Honest" (p. 267), and "An Awareness that Things Lost in Addiction Are Being Recovered" (pp. 269-270); and, regarding maintenance, that "group meetings of one kind or another, nurtured spirituality, and continued growth toward becoming a better human being" (p. 270).

- Hanson, L. C., Dobbs, D., Usher, B. M., Williams, S., Rawlings, J. and Daaleman, T. P. [Division of Geriatric Medicine, University of North Carolina, Chapel Hill; lhanson@med.unc.edu]. **“Providers and types of spiritual care during serious illness.”** *Journal of Palliative Medicine* 11, no. 6 (Jul 2008): 907-914.
 [Abstract:] OBJECTIVE: Patients and palliative care experts endorse the importance of spiritual care for seriously ill patients and their families. However, little is known about spiritual care during serious illness, and whether it satisfies patients' and families' needs. The objective of this study was to describe spiritual care received by patients and families during serious illness, and test whether the provider and the type of care is associated with satisfaction with care. METHODS: Cross-sectional interview with 38 seriously ill patients and 65 family caregivers about spiritual care experiences. RESULTS: The 103 spiritual care recipients identified 237 spiritual care providers; 95 (41%) were family or friends, 38 (17%) were clergy, and 66 (29%) were health care providers. Two-thirds of spiritual care providers shared the recipient's faith tradition. Recipients identified 21 different types of spiritual care activities. The most common activity was help coping with illness (87%) and the least common intercessory prayer (4%). Half of recipients were very or somewhat satisfied with spiritual care, and half found it very helpful for facilitating inner peace and meaning making. Satisfaction with spiritual care did not differ by provider age, race, gender, role, or frequency of visits. Types of care that helped with understanding or illness coping were associated with greater satisfaction with care. CONCLUSION: Seriously ill patients and family caregivers experience spiritual care from multiple sources, including health care providers. Satisfaction with this care domain is modest, but approaches that help with understanding and with coping are associated with greater satisfaction.
- Harding, S. R., Flannelly, K. J., Galek, K. and Tannenbaum, H. P. [NYU Medical Center, NY; stephen.harding@nyumc.org]. **“Spiritual care, pastoral care, and chaplains: trends in the health care literature.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008) 99-117. [See other articles from the special journal issue on chaplaincy research by Handzo, et al.; Weaver, et al.; Vanderwerker, et al.; and Koenig --all noted elsewhere in this bibliography.]
 [Abstract:] This study analyzes trends in the health care literature based on electronic searches of MEDLINE between the years 1980 and 2006. The search terms used were "spiritual care," "pastoral care," and "chaplain.*" The results document an expected surge in the rate of English-language journal articles about spiritual care beginning in the mid 1990s. Although the rate of articles about pastoral care was several times higher than that for spiritual care over much of the study period, there was a steady decline in articles about pastoral care during the past 10 years. These two trends produced a convergence in the rates, so by 2006 the rate of published articles on pastoral care (21.1 per 100,000) was less than twice as high as that on spiritual care (13.3 per 100,000). The rate of articles about chaplains rose moderately but significantly from 9.6 per 100,000 in the years 1980-1982 to 12.2 per 100,000 in the years 2004-2006. Increasing interest in spiritual care was evident in nursing, mental health, and general health care journals, being most pronounced in nursing. Declining interest in pastoral care was also most pronounced in nursing. This article discusses some implications of and responses to these trends.
- Harris, J. I., Erbes, C. R., Engdahl, B. E., Olson, R. H., Winkowski, A. M. and McMahill, J. [VA Medical Center, Minneapolis, MN; jeanette.harris2@med.va.gov]. **“Christian religious functioning and trauma outcomes.”** *Journal of Clinical Psychology* 64, no. 1 (Jan 2008): 17-29.
 [Abstract:] While some trauma survivors find their faith helpful in recovery, others find it a source of distress, and still others abandon their faith. More complex conceptualizations of religious functioning are needed to explore its relationship with trauma. This study explores such relationships using measures of religious action and behaviors in a community sample of 327 church-going, self-identified trauma survivors. A principal components analysis of positive and negative religious coping, religious comforts and strains, and prayer functions identified two dimensions: Seeking Spiritual Support, which was positively related to posttraumatic growth, and Religious Strain, which was positively related to posttraumatic symptoms.
- Harris, S. K., Sherritt, L. R., Holder, D. W., Kulig, J., Shrier, L. A. and Knight, J. R. [Department of Pediatrics, Harvard Medical School, Boston, MA; sion.harris@childrens.harvard.edu]. **“Reliability and validity of the brief multidimensional measure of religiousness/spirituality among adolescents.”** *Journal of Religion & Health* 47, no. 4 (Dec 2008): 438-457.
 [Abstract:] BACKGROUND: Developed for use in health research, the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) consists of brief measures of a broad range of religiousness and spirituality (R/S) dimensions. It has established psychometric properties among adults, but little is known about its appropriateness for use with adolescents. PURPOSE: We assessed the psychometric properties of the BMMRS among adolescents. METHOD: We recruited a racially diverse (85% non-White) sample of 305 adolescents aged 12-18 years (median 16 yrs, IQR 14-17) from 3 urban medical clinics; 93 completed a retest 1 week later. We assessed internal consistency and test-retest reliability. We assessed construct validity by examining how well the measures discriminated groups expected to differ based on self-reported religious preference, and how they related to a hypothesized correlate, depressive symptoms. Religious preference was categorized into "No religion/Atheist" (11%), "Don't know/Confused" (9%), or "Named a religion" (80%). RESULTS: Responses to multi-item measures were generally internally consistent ($\alpha > \text{or} = 0.70$ for 12/16 measures) and stable over 1 week (intraclass correlation coefficients $> \text{or} = 0.70$ for 14/16). Forgiveness, Negative R/S Coping, and Commitment items showed lower internal cohesiveness. Scores on most measures were higher ($p < 0.05$) among those who "Named a religion" compared to the "No religion/Atheist" group. Forgiveness, Commitment, and Anticipated Support from members of one's congregation were inversely correlated with depressive symptoms, while BMMRS measures assessing negative R/S experiences (Negative R/S Coping, Negative Interactions with others in congregation, Loss in Faith) were positively correlated with depressive symptoms. CONCLUSIONS: These findings suggest that most BMMRS measures are reliable and valid for use among adolescents. [See also the introduction to the issue: Ferrell, D. R., "Religion and health," on pp. 435-437.]
- Harvey, I. S. [University of Illinois, College of Applied Health Sciences, Champaign, IL; shevon@uiuc.edu]. **“Assessing self-management and spirituality practices among older women.”** *American Journal of Health Behavior* 32, no. 2 (Mar-Apr 2008): 157-168.
 [Abstract:] OBJECTIVE: To understand the role of spirituality in the self-management of cardiovascular disease and arthritis. METHOD: Self-management practices were selected from older women enrolled in a longitudinal study (N=492) whereas 24 of the enrolled participants were selected for an in-depth interview regarding the role of spirituality in their self-management practices. RESULTS: Significant differences were found in the level of spirituality in self-management behaviors based on ethnicity. The qualitative analyses reaffirmed the importance of spirituality in the self-management of chronic illness. CONCLUSION: Using multiple methodologies, this study elucidated the role of spirituality in the self-management of chronic illness among older women.

- Harvey, K., Brown, B., Crawford, P. and Candlin, S. [University of Nottingham, Nottingham, UK]. **“Elicitation hooks’: a discourse analysis of chaplain-patient interaction in pastoral and spiritual care.”** *Journal of Pastoral Care & Counseling* 62, nos. 1-2 (Spring-Summer 2008): 43-61.
[Abstract:] The article considers the communicative role of the hospital chaplain and maps some of the language strategies deployed to facilitate disclosure of the patients’ concerns and achieve enhanced spiritual care. These include: i) involvement, ii) politeness and iii) encouraging disclosure or exploring emotion.
- Hassed, C [Department of General Practice, Monash University, Victoria, Australia; craig.hassed@med.monash.edu.au]. **“The role of spirituality in medicine.”** *Australian Family Physician* 37, no. 11 (Nov 2008):955-957.
This brief overview covers connections between spirituality and health, relevance for clinical medicine, and how to take a spiritual history. [26 refs.]
- Haward, M. F., Murphy, R. O. and Lorenz, J. M. [Department of Pediatrics, Division of Neonatology, Columbia University, New York, NY; mhaward@aol.com]. **“Message framing and perinatal decisions.”** *Pediatrics* 122, no. 1 (Jul 2008): 109-118.
[Abstract:] OBJECTIVES: The purpose of this study was to explore the effect of information framing on parental decisions about resuscitation of extremely premature infants. Secondary outcomes focused on elucidating the impact of other variables on treatment choices and determining whether those effects would take precedence over any framing effects. METHODS: This confidential survey study was administered to adult volunteers via the Internet. The surveys depicted a hypothetical vignette of a threatened delivery at gestational age of 23 weeks, with prognostic outcome information framed as either survival with lack of disability (positive frame) or chance of dying and likelihood of disability among survivors (negative frame). Participants were randomly assigned to receive either the positively or negatively framed vignette. They were then asked to choose whether they would prefer resuscitation or comfort care. After completing the survey vignette, participants were directed to a questionnaire designed to test the secondary hypothesis and to explore possible factors associated with treatment decisions. RESULTS: A total of 146 subjects received prognostic information framed as survival data and 146 subjects received prognostic information framed as mortality data. Overall, 24% of the sample population chose comfort care and 76% chose resuscitation. A strong trend was detected toward a framing effect on treatment preference; respondents for whom prognosis was framed as survival data were more likely to elect resuscitation. This framing effect was significant in a multivariate analysis controlling for religiousness, parental status, and beliefs regarding the sanctity of life. Of these covariates, only religiousness modified susceptibility to framing; participants who were not highly religious were significantly more likely to be influenced to opt for resuscitation by the positive frame than were participants who were highly religious. CONCLUSIONS: Framing bias may compromise efforts to approach prenatal counseling in a nondirective manner. This is especially true for subsets of participants who are not highly religious.
- Haynes, D. F. and J Watt, P. [Joseph F. Sullivan Center, Clemson University, SC; Haynes@clemson.edu]. **“The lived experience of healthy behaviors in people with debilitating illness.”** *Holistic Nursing Practice* 22, no. 1 (Jan-Feb 2008): 44-53.
[Abstract:] The purpose of this study was to gain an understanding of healthy behaviors in individuals living with debilitating illness. Two key concepts developed: spirituality and focus/adaptation. Professionals empowering an individual’s innate spirituality can markedly improve adaptation, successful living with chronic illness, and quality of life.
- Hebert, R. S., Schulz, R., Copeland, V. and Arnold, R. M. [General Internal Medicine, Section of Palliative Care and Medical Ethics, University of Pittsburgh, PA; rhebert@wpahs.org]. **“What questions do family caregivers want to discuss with health care providers in order to prepare for the death of a loved one? An ethnographic study of caregivers of patients at end of life.”** *Journal of Palliative Medicine* 11, no. 3 (Apr 2008): 476-483.
This focus group study of 33 current and bereaved caregivers found [from the abstract:] Caregivers had a wide spectrum of questions that were categorized as medical, practical, psychosocial, or religious/spiritual in nature. Although caregivers felt comfortable asking most questions, many were not discussed with HCPs, particularly questions about what dying “looked like,” medical errors, funeral arrangements, family disagreements, the meaning of illness, and the afterlife. ...The primary barriers to asking questions were feeling overwhelmed, “not knowing what to ask,” the perception that HCPs were untrustworthy, and worries about being perceived as “ignorant.”
- Hegge, M. and Larson, V. [Accelerated Nursing Program, Sioux Falls, SD; Margaret.Hegge@sdstate.edu]. **“Stressors and coping strategies of students in accelerated baccalaureate nursing programs.”** *Nurse Educator* 33, no. 1 (Jan-Feb 2008): 26-30.
Among the findings of this survey of nursing students was: “The most helpful coping strategy category was ‘seeking social support for emotional reasons....’ The second most helpful coping strategy was ‘turning to religion....’ The third most helpful was ‘positive reinterpretation and growth’ ...“The top 5 most helpful individual coping strategies were as follows: sought God’s help..., put my trust in God..., discussed my feelings with someone..., did what had to be done one step at a time..., and tried to get emotional support from friends or relatives....” [p. 28] “The coping strategy category of turning to religion was the only category in which there was a significant difference between students with high stress and those with low-to-moderate stress.... Those with low stress...reported higher levels of helpfulness of turning to religion than those with high stress....” [p. 29]
- Helsel, P. B. **“In memoriam: the disenfranchised grief of chaplains and the recovery of memory.”** *Journal of Pastoral Care & Counseling* 62, no. 4 (2008): 337-342.
This article, by a hospice chaplain, explores the grief work of chaplains and “how personal remembrances connect the chaplain with his or her own repressed grief in a way that communal events can not accomplish because of the chaplain’s responsibility for the grief of the community in these settings” [p. 337, abstract]. The author poses particular implications within Christian traditions.
- Hendricks-Ferguson, V. [Barnes-Jewish College of Nursing, St. Louis, MO; vlf7549@bjc.org]. **“Hope and spiritual well-being in adolescents with cancer.”** *Western Journal of Nursing Research* 30, no. 3 (Apr 2008): 385-401. Discussion on pp. 402-407.
[Abstract:] This study examines the relationships of hope and spiritual well-being (SWB)--and its dimensions, religious well-being (RWB) and existential well-being (EWB)--to time since diagnosis among adolescents with cancer. A descriptive cross-sectional design was used. The sample of 78 adolescents diagnosed with cancer was recruited from two pediatric oncology clinics. Adolescents in the first two time periods reported significantly higher levels of SWB, RWB, and EWB than those in subsequent time periods. Hope did not significantly vary over time.

Hence, time since diagnosis may influence adolescents' levels of SWB and its dimensions during the cancer experience. Adolescents' use of SWB, RWB, and EWB as coping resources should be examined in longitudinal studies from diagnosis through survivorship.

Hickey, D., Doyle, C., Quinn, S., O'Driscoll, P., Patience, D., Chittick, K. and Cliverd, A. [St. Luke's Hospices, Basildon, UK]. **"Catching' the concept of spiritual care: implementation of an education programme."** *International Journal of Palliative Nursing* 14, no. 8 (Aug 2008): 396-400.

[Abstract:] This article will outline the achievements of a project group as they translate the recommendations set out in the UK National Institute for Health and Clinical Excellence (NICE) guidance on spiritual care provision in clinical practice (NICE, 2004). It was evident that there was an opportunity to offer a comprehensive, competency-based course that developed recognition of the spiritual care needs of patients with cancer and their carers. A two-day experiential programme was devised that included role play, the evidence base, theory and fun, resulting in the acquisition of tacit and explicit knowledge. The course was based around the following tenets: Spiritual issues are broader than religious ones and include a quest for meaning in the illness, resolution of old conflicts and integration of past life experiences (Barraclough, 1994). We cannot know others except by knowing ourselves (Carrither, 1992). It is hoped that by providing holistic training that stimulates the growth of an individual's spirituality and allows them to identify their spiritual needs, we can increase understanding, awareness, confidence and knowledge in ways that can have a real application within the workplace, enabling spiritual care provision to become realistically integral to care.

Hill, T. D. [Department of Sociology, University of Miami, Coral Gables, FL; tdh@miami.edu]. **"Religious involvement and healthy cognitive aging: patterns, explanations, and future directions."** *Journals of Gerontology Series A-Biological Sciences & Medical Sciences* 63, no. 5 (May 2008): 478-479.

This guest editorial reviews recent research published in the Journals of Gerontology that suggests that religious involvement favor healthy cognitive aging, and the author outlines promising avenues for future research. The author includes comments about research by Reyes-Ortiz, C. A., et al. on pp. 480-486 of the same issue of the journal (--noted elsewhere in this bibliography). [19 refs.]

Hillbrand, M. and Young, J. L. [Dept. of Psychiatry, Connecticut Valley Hospital, Middletown, CT; marc.hillbrand@po.state.ct.us]. **"Instilling hope into forensic treatment: the antidote to despair and desperation."** *Journal of the American Academy of Psychiatry & the Law* 36, no. 1 (2008): 90-94.

Among the findings of this study, in which 33 maximum-security forensic patients completed (anonymously) the Religious Coping Scale (R-COPE), in addition to other measures. "In our sample, agency was strongly related to spirituality.... In other words, patients' initiative and persistence about the pursuit of a goal go hand in hand with how spiritual they are...." [p. 91]

Hilsman, G. and Iregui, J. [St. Joseph Medical Center, Tacoma, WA]. **"When physicians open their souls. Regular group sessions help doctors improve holistic quality of their work and spiritual wellness of their lives."** *Health Progress* 89, no. 6 (Nov-Dec 2008): 34-38.

The authors describe the development of a program for physicians at the Franciscan Health System (Tacoma, WA), and they also note results from a survey used to guide some of the program development which indicated "that physicians see themselves as exceptionally good at eye contact and at behaviors that involve protecting people, and most in need of improvement in regard to their ability to rest when advisable, to ask for what they want, to tune in to others' emotions, to affirm themselves, and to maintain a hobby" [p. 37].

Hodge, D. R. and Nadir, A. [Arizona State University]. **"Moving toward culturally competent practice with Muslims: modifying cognitive therapy with Islamic tenets."** *Social Work* 53, no. 1 (Jan 2008): 31-41.

[Abstract:] Relatively little information exists on the provision of culturally competent services to Muslims, in spite of the growing presence of this population in the United States. Consequently, the authors discuss a number of therapeutic approaches in light of their level of congruence with common Islamic values. Psychodynamic approaches, for example, may not be as congruent as cognitive approaches. Although cognitive therapy may be relatively consistent with Islamic values, the self-statements that are central to this modality are often packaged in secular terminology that is inconsistent with Islamic norms. To provide culturally relevant services, practitioners must unwrap the secular terminology used to express the underlying therapeutic precepts and then repackage the precepts in terminology that reflects Islamic teaching. The authors conclude by offering a number of examples to illustrate the construction of statements that reflect Islamic values.

Hok, J., Tishelman, C., Ploner, A., Forss, A. and Falkenberg, T. [Karolinska Institutet, Dept. of Neurobiology, Care Sciences and Society, Division of Nursing, Unit for Studies of Integrative Care, Huddinge, Sweden; johanna.hok@ki.se]. **"Mapping patterns of complementary and alternative medicine use in cancer: an explorative cross-sectional study of individuals with reported positive 'exceptional' experiences."** *BMC Complementary & Alternative Medicine* 8 (2008): 48 [online journal].

In this analysis of 38 unstructured interviews with persons who reported exceptional experiences associated with CAM use after cancer diagnosis, the researchers added two categories to the NCCAM taxonomy of CAM practices: "Spiritual/health literature" and "Treatment centers." Regarding the former: "The empirically-derived category Spiritual/health literature consisted predominantly of inspirational literature about CAM and cancer in a broad context, with the book 'Love, Medicine and Miracles' by Bernie Siegel referred to by the largest number of participants (n = 7). In total, 15 participants provided reports categorized under this heading."

Holt, C. L., Lee, C. and Wright, K. [School of Medicine, Division of Preventive Medicine, University of Alabama at Birmingham; cholt@uab.edu]. **"A spiritually based approach to breast cancer awareness: cognitive response analysis of communication effectiveness."** *Health Communication* 23, no. 1 (Jan-Feb 2008): 13-22.

[Abstract:] The purpose of this study was to compare the communication effectiveness of a spiritually based approach to breast cancer early detection education with a secular approach, among African American women, by conducting a cognitive response analysis. A total of 108 women from 6 Alabama churches were randomly assigned by church to receive a spiritually based or secular educational booklet discussing breast cancer early detection. Based on the elaboration likelihood model (Petty & Cacioppo, 1981), after reading the booklets participants were asked to complete a thought-listing task, writing down any thoughts they experienced and rating them as positive, negative, or neutral. Two independent coders then used 5 dimensions to code participants' thoughts. Compared with the secular booklet, the spiritually based booklet resulted in significantly more thoughts involving personal connection, self-assessment, and spiritually based responses. These results suggest that a spiritually based approach to breast cancer awareness may be more effective than the secular approach because it caused women to more

actively process the message, stimulating central route processing. The incorporation of spiritually based content into church-based breast cancer education could be a promising health communication approach for African American women.

Hong, B. A., Olatunde, L., McGill, K. L., Ridenour, T. A., Lucas, A. and North, C. S. [Barnes-Jewish Hospital, St. Louis, MO; hongb@psychiatry.wustl.edu]. **“Violently injured patients seen in the emergency department of Barnes-Jewish Hospital: a descriptive study of context, future views and spirituality.”** *Missouri Medicine* 105, no. 1 (Jan-Feb 2008): 86-89.

[Abstract:] To explore the characteristics of individuals who were evaluated and treated at an urban university medical center emergency room due to violence-related injuries. The study also explored issues of religion and/or spirituality. METHODS: Seventy-three violently injured patients (VIPs) who required hospitalization were systematically interviewed for this study while seeking treatment through the emergency department at Barnes-Jewish Hospital in St. Louis, Missouri. The interviews were conducted by the emergency room (ER) chaplain. More than one-third (38%) of these VIPs had previously been arrested for assault. For more than half (52%), this was their first experience with emergency care for a violent injury, while nearly half (48%) reported previous experience with violence. Sixty-two percent of the patients said they vowed to get revenge. Gunshot wounds accounted for almost half (45%) of the injuries. This report provides descriptive data about the characteristics of VIPs who required hospital care after a violence-related attack, the context of the event and provides data about how spirituality/religion issues were used to cope with the aftermath of these attacks. The cycle of violence clearly calls for interventions and solutions involving hospitals and the community. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/jun08.html].

Hossain, M. S. and Siddique, M. Z. [Medical College for Women and Hospital, Bangladesh; hmanjur@bttb.net.bd]. **“Does religiosity help Muslims adjust to death? A research note.”** *Omega - Journal of Death & Dying* 57, no. 1 (2008): 113-119.

[From the abstract:] ...To explore the impact of religious perception, thus religiosity, a cross-sectional, descriptive, analytic and correlational study was conducted on 150 Muslims. Self-declared healthy Muslims equally from both sexes (N = 150, Age range--20 to 50 years, Minimum education--Bachelor) were selected by stratified sampling and randomly under each stratum. Subjects, divided in five levels of religiosity, were assessed and scored for the presence of maladjustment symptoms and stage of adjustment with death. ANOVA and correlation coefficient was applied on the sets of data collected. All statistical tests were done at the level of 95% confidence (P < 0.05). Final results were higher than the table values used for ANOVA and correlation coefficient yielded P values of < 0.05, < 0.01, and < 0.001. Religiosity as a criterion of Muslims influenced the quality of adjustment with death positively....

Howard, M. D. and Cox, R. P. [Naval Hospital Camp Lejeune, Pastoral Care Department, Camp Lejeune, NC]. **“Collaborative intervention: a model for coordinated treatment of mental health issues within a ground combat unit.”** *Military Medicine* 173, no. 4 (Apr 2008): 339-348.

[From the abstract:] ...Traditionally, the medical officer focuses on the treatment of physical symptoms, diseases, and physical injuries, whereas the chaplain treats spiritual and adjustment issues that may affect how well an individual service member functions personally and/or professionally. Located between these two points is a void, the treatment of psychological or emotional issues. By using the collaborative intervention model presented here, unit medical officers and chaplains can work together to treat these issues, thus reducing the number of service members needing referral to mental health agencies, decreasing the number of mental health-related medical separations, and increasing overall mission readiness....

Hsiao, A. F., Wong, M. D., Miller, M. F., Ambs, A. H., Goldstein, M. S., Smith, A., Ballard-Barbash, R., Becerra, L. S., Cheng, E. M. and Wenger, N. S. [VA Long Beach Healthcare System, Long Beach, CA; anfu.hsiao@va.gov]. **“Role of religiosity and spirituality in complementary and alternative medicine use among cancer survivors in California.”** *Integrative Cancer Therapies* 7, no. 3 (Sep 2008): 139-146. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

Among the findings of this study using data from subsample of 1844 people with cancer or a history of cancer from the 2003 California Health Interview Survey of CAM [from the abstract:] The majority of cancer survivors reported that they were very/moderately religious or spiritual. Both religiosity and spirituality were strongly related to non-R/S CAM use, but in opposite directions. Very or moderately religious cancer survivors were less likely (odds ratio=0.30; 95% confidence interval, 0.12-0.40) than nonreligious cancer survivors to use non-R/S CAM. In contrast, very or moderately spiritual cancer survivors were more likely (odds ratio=2.42; 95% confidence interval, 1.16-6.02) than nonspiritual cancer survivors to use non-R/S CAM.

Hsu, C., Phillips, W. R., Sherman, K. J., Hawkes, R. and Cherkin, D. C. [Group Health Center for Community Health and Evaluation, Seattle, WA; hsu.c@ghc.org]. **“Healing in primary care: a vision shared by patients, physicians, nurses, and clinical staff.”** *Annals of Family Medicine* 6, no. 4 (Jul-Aug 2008): 307-314.

The authors discuss spirituality *passim*, and especially in terms of its “contribution to wholeness” [p. 312]. [From the abstract:] ...Participants were drawn from primary care clinics of a large, integrated, health care system in Washington State in 2005. Nine focus groups included 84 participants: 28 patients, 23 primary care physicians (19 family physicians), 20 registered nurses, 11 licensed practical nurses, and 2 medical assistants. Randomly sampled established patients were aged from 21 to 65 years; 71% were female. RESULTS: We found remarkable concordance across focus groups and among types of participants in the definition of healing: Healing is a dynamic process of recovering from a trauma or illness by working toward realistic goals, restoring function, and regaining a personal sense of balance and peace. Healing is a multidimensional process with physical, emotional, and spiritual dimensions. The key themes are as follows: (1) healing is multidimensional and holistic; (2) healing is a process, a journey; (3) the goal of healing is recovery or restoration; (4) healing requires the person to reach a place of personal balance and acceptance; and (5) relationships are essential to healing. Factors that facilitate healing help build relationships, improve communication, and share responsibility between the patient and clinician. Major barriers are logistical factors that limit high-quality time with healing professionals. CONCLUSIONS: Patients and health care team members share a vision of healing and agree on ways to enhance the process in primary care.

Hu, J. C., Kwan, L., Krupski, T. L., Anger, J. T., Maliski, S. L., Connor, S. and Litwin, M. S. [Brigham and Women's Hospital, Lank Center for Genitourinary Oncology, Dana Farber Cancer Institute, Harvard Medical School; jhu2@partners.org]. **“Determinants of treatment regret in low-income, uninsured men with prostate cancer.”** *Urology* 72, no. 6 (Dec 2008): 1274-1279.

Among the findings of this study 195 men in California was that [from the abstract:] ...men confident of cancer cure (OR 0.19, 95% confidence interval 0.04 to 0.86), men with greater spirituality (OR 0.91, 95% confidence interval 0.87 to 0.96), and men with acute treatment effects (OR 0.34, 95% confidence interval 0.12 to 0.93) were less likely to regret their treatment decisions. CONCLUSIONS: In our study, a fear of cancer recurrence, less spirituality, a longer interval since treatment, and nonwhite race were associated with treatment regret in low-income, underserved men with prostate cancer. Attempts to decrease anxiety and enhance spirituality in men treated for prostate cancer might diminish treatment regret....

Hudacek, S. S. [Department of Nursing, University of Scranton, PA; Hudaceks1@scranton.edu]. **"Dimensions of caring: a qualitative analysis of nurses' stories."** *Journal of Nursing Education* 47, no. 3 (Mar 2008): 124-129.

This analysis of 200 stories by nurses identified seven dimensions of caring that define professional nursing practice: caring, compassion, spirituality, community outreach, providing comfort, crisis intervention, and going the extra distance. Among the observations regarding spirituality in nursing: "Nurses appreciate the need for scripture reading, prayer, and other expressions of faith. Nurses understand that spiritual distress can occur when individuals are disconnected from their religious or cultural ties. Patients will express these concerns to nurses. If solutions are possible, they are implemented early. Nurses write goals and specific plans of care to manage the spiritual needs of patients. These may include assessing beliefs and preferences, informing patients of spiritual resources, and creating an environment conducive to free expression. Spirituality was a dimension consistently reported in many of the stories. Nurses wrote about guidance in their work by a higher power. They emphasized the power of prayer when all other resources were no longer effective. Nurses told stories of praying with patients for strength and peace and asking patients whether this would facilitate their passing on from this life to perhaps another." [p. 127]

Hudak, P. L., Armstrong, K., Braddock, C. 3rd., Frankel, R. M. and Levinson, W. [St. Michael's Hospital, Toronto, Canada; hudakp@smh.toronto.on.ca]. **"Older patients' unexpressed concerns about orthopaedic surgery."** *Journal of Bone & Joint Surgery - American Volume* 90, no. 7 (Jul 2008): 1427-1435.

[From the abstract:] ...CONCLUSIONS: Patients raised only half their concerns regarding surgery with orthopaedic surgeons. Orthopaedic surgeons are encouraged to fully address how patients' capacity to meet the demands of the surgery, defined by their resources (such as social support, transportation, and finances) and obligations (to family members, employers, and religion), may impinge on their willingness to accept recommended surgery.

Hummel, L., Galek, K., Murphy, K. M., Tannenbaum, H. P. and Flannelly, L. T. [Luthern Theological Seminary at Gettysburg, PA]. **"Defining spiritual care: an exploratory study."** *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 40-51. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] An electronic search was conducted on Medline for the years 1980-2005 identified 101 journal articles with the words "spiritual care" in their title, the majority of which were from nursing journals. Content analysis performed on 28 articles judged to be most relevant yielded 250 unique descriptions of interventions, which were subsequently consolidated to form 66 discrete interventions. Twenty five professional chaplains rated each item on the degree to which they considered it to be part of providing spiritual care to patients. The patterns of correlations among the interventions suggested that most of the items fell into ten major categories and a few minor categories, with only two of the major categories being explicitly religious in nature. The article discusses these categories within the context of pastoral care.

Hurst, G. A., Williams, M. G., King, J. E. and Viken, R. [Department of Family Practice, University of Texas Health Center at Tyler; george.hurst@uthct.edu]. **"Faith-based intervention in depression, anxiety, and other mental disturbances."** *Southern Medical Journal* 101, no. 4 (Apr 2008): 388-392.

[Abstract:] OBJECTIVE: To determine if the effects of using the Steps to Freedom would be beneficial for a group of individuals who attended a Christian Conference. METHODS: A user-friendly 12-item questionnaire was used to monitor the outcomes of Steps to Freedom addressing six symptom/behavioral problems and six function areas. In addition, the Symptom Checklist-90 R (SCL-90-R) questionnaire was employed to document the validity of the shorter questionnaire. The questionnaires were completed before and after the administration of the Steps to Freedom. The Wilcoxon matched pairs test was used to measure the significance of the findings for the 12-item questionnaire. RESULTS: Thirty-three clients who went through the Steps to Freedom showed statistically significant improvement ($P < \text{or} = 0.005$) at 3 to 4 months in all symptom/behavior categories (items 1-6). All function areas (items 7-12) also demonstrated statistically significant improvement ($P < \text{or} = 0.05$). A comparison group who did not attend the conference or receive counseling showed no significant changes during the same period. CONCLUSIONS: These significant preliminary findings need to be confirmed by additional studies. Steps to Freedom model prayers, used by individual patients personally and/or with a counselor, could expand the care and hopefully lower the cost of mental illness. [This article is part of a series in the journal, in conjunction with the Southern Medical Association's Spirituality in Medicine project.]

Im, E. O., Lim, H. J., Clark, M. and Chee, W. [School of Nursing, The University of Texas at Austin; eim@mail.nur.utexas.edu]. **"African American cancer patients' pain experience."** *Cancer Nursing* 31, no. 1 (Jan-Feb 2008): 38-46. Quiz on pp. 47-48.

Among the findings of this qualitative study of 11 African American cancer patients: "Most participants mentioned that, after the cancer diagnosis, their views on life have changed in a positive way.... In the process of changing their perspectives, spirituality was the most influential factor. Many participants mentioned that, through faith in God, they learned how to appreciate life and cope with cancer. Participants also frequently mentioned that they got emotional comfort and managed fear by praying and reading the Bible." [p. 43] "Spirituality may also play an important role in diverting or tolerating cancer pain during this process." [p. 44] [This issue of the journal contained two other studies relating to spirituality & health: see the articles by Juarez, G., et al. and by Leak, A., et al, also noted in this bibliography.]

Ironson, G. and Hayward, H. [Department of Psychology, University of Miami, Coral Gables, FL; gironson@aol.com]. **"Do positive psychosocial factors predict disease progression in HIV-1? A review of the evidence."** *Psychosomatic Medicine* 70, no. 5 (Jun 2008): 546-554.

The authors discuss spirituality *passim*, as a coping mechanism. See especially the section on Spirituality [p. 547]. Also: "In our review, we found that the most promising positive psychosocial predictors of HIV disease progression were optimism, active coping, and spirituality [p. 549]. Among their observations regarding mechanisms: "Spirituality and religiosity may also facilitate positive reappraisals of stressful situations, and these reappraisals may in turn support positive psychological states" [p. 550]. [122 refs.]

Jacobs, M. R. "What are we doing here? Chaplains in contemporary health care." *Hastings Center Report* 38, no. 6 (Nov-Dec 2008): 15-18.

This is one of five special essays in a set under the heading of, "Can We Measure Good Chaplaincy? A New Professional Identity Is Tied to Quality Improvement" and available also as a separate publication. The essays "examine the 'professionalizing' profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery" [--from the introductory statement by Gregory E. Kaebnick (no page number, in the separately available publication of the essays)]. Other essays in this set are by Berlinger, N., by de Vries, R., by Mohrmann, M. E., and by Smith, M. L. (--noted elsewhere in this bibliography).

Jamieson, P. E. and Romer, D. [Adolescent Risk Communication Institute (ARCI), Annenberg Public Policy Center (APPC), University of Pennsylvania, Philadelphia, PA; patrick@asc.upenn.edu]. "Unrealistic fatalism in U.S. youth ages 14 to 22: prevalence and characteristics." *Journal of Adolescent Health* 42, no. 2 (Feb 2008): 154-160.

This study analyzed four waves of a nationally representative telephone survey from 2002 to 2005 with youth ages 14 to 22 (N = 4201) to investigate unrealistic fatalism about one's future (i.e., not expecting to live past age 30). Among the findings: "Youth who were more religious, both in identifying with a religion and attending services, were significantly less likely to be fatalistic, an effect that remained in the model despite controlling for suicide acceptance. In addition to not accepting suicide, religion may also act as a buffer against fatalism because it provides reasons for living that may help to counteract stressors that trigger feelings of hopelessness about the future.... Religious practice that relies on one's coping with adversity rather than depending on a deity for help has also been found to be related to resilience, a factor our study did not control for." [p. 159]

Johnson, T. J., Sheets, V. L. and Kristeller, J. L. [Department of Psychology, Indiana State University, Terre Haute; tjohnsonl@isugw.indstate.edu]. "Identifying mediators of the relationship between religiousness/spirituality and alcohol use." *Journal of Studies on Alcohol* 69, no. 1 (Jan 2008): 160-170.

[Abstract:] OBJECTIVE: Religiousness is known to be inversely related to alcohol use and problems, but few studies have attempted to identify mediators of this relationship. We examined beliefs about alcohol, social influences, well-being, and motives for drinking as potential mediators of the relationship between religiousness/spirituality and alcohol use and problems. METHOD: Participants were 315 female and 197 male college students who responded to a survey sent to a stratified (by gender and year in school) random sample. We used path analysis to test models specifying hypothesized mediators of the relationship between several religious/spiritual constructs (identified via factor analysis in previous studies) and alcohol use and problems. Models were tested in the full sample and a subsample consisting of alcohol users only. RESULTS: The effect of religious/spiritual involvement on alcohol use was mediated by negative beliefs about alcohol, social influences, and spiritual well-being. The effect of religious struggle on alcohol problems was mediated by spiritual well-being. Search for meaning had both direct and indirect (via negative beliefs about alcohol) effects on use and problems. Negative beliefs about alcohol and social influences were related to alcohol use via enhancement motives and, in some models, social motives for drinking. Spiritual well-being was related to alcohol problems via coping motives. Social influences also had direct effects on alcohol use. CONCLUSIONS: Although future studies using longitudinal designs are needed, the study identified several plausible mechanisms by which religiousness/spirituality could causally impact alcohol use and problems. Results also provide further support for the motivational model of alcohol use.

Johnstone, B., Franklin, K. L., Yoon, D. P., Burriss, J. and Shigaki, C. [Department of Health Psychology, University of Missouri-Columbia; johnstoneg@health.missouri.edu]. "Relationships among religiousness, spirituality, and health for individuals with stroke." *Journal of Clinical Psychology in Medical Settings* 15, no. 4 (Dec 2008): 308-313.

[Abstract:] The current study evaluated the relationships among spiritual beliefs, religious practices, physical health, and mental health for individuals with stroke. A cross-sectional analysis of 63 individuals evaluated in outpatient settings, including 32 individuals with stroke and 31 healthy controls was conducted through administration of the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) and the Medical Outcomes Scale-Short Form 36 (SF-36). For individuals with stroke, the SF-36 General Mental Health scale was significantly correlated with only the BMMRS Religious and Spiritual Coping scale ($r = .43$; $p < .05$). No other BMMRS factors were significantly correlated with SF-36 mental or physical health scales. Non-significant trends indicated spiritual factors were primarily related to mental versus physical health. This study suggests spiritual belief that a higher power will assist in coping with illness/disability is associated with better mental health following stroke, but neither religious nor spiritual factors are associated with physical health outcomes. The results are consistent with research that suggests that spiritual beliefs may protect individuals with stroke from experiencing emotional distress.

Juarez, G., Ferrell, B., Uman, G., Podnos, Y. and Wagman, L. D. [Department of Nursing Research and Education, City of Hope National Medical Center, Duarte, CA; gjuarez@coh.org]. "Distress and quality of life concerns of family caregivers of patients undergoing palliative surgery." *Cancer Nursing* 31, no. 1 (Jan-Feb 2008): 2-10.

Among the findings of this study of family caregivers (n=30) of patients with advanced disease at a National Cancer Institute-designated Comprehensive Cancer Center undergoing palliative surgery was: "The most negative factor across time in the domain of spiritual wellbeing well-being was the caregiver's uncertainty about the patient's future, which improved slightly at 3 weeks but declined at 2 and 3 months postoperatively" [p. 6] The Quality of Life-Family Caregiver measure employed is a 37-item instrument, with 7 items devoted to Spiritual Well-being. [This issue of the journal contained two other studies relating to spirituality & health: see the articles by Im, E. O., et al. and by Leak, A., et al. also noted in this bibliography.]

Katz, M. L., Kauffman, R. M., Tatum, C. M. and Paskett, E. D. [College of Public Health, Ohio State University, Columbus; mira.katz@osumc.edu]. "Influence of church attendance and spirituality in a randomized controlled trial to increase mammography use among a low-income, tri-racial, rural community." *Journal of Religion & Health* 47, no. 2 (Jun 2008): 227-236.

[Abstract:] BACKGROUND The influence of church attendance and spirituality on mammography use was studied among Native American, White, and African American women living in a rural county. METHODS A randomized trial was conducted to increase mammography use. Women (n = 851) were randomly assigned to receive either an educational program delivered by a lay health advisor or a physician letter and brochure about cervical cancer screening (control group). Church attendance and spirituality were measured at baseline and mammography use was evaluated 12 months after enrollment using medical record review. RESULTS Almost two-thirds of the women reported that they attended

church at least once a week, and less than 4% were classified as having low spirituality. Church attendance ($P = 0.299$) or spirituality ($P = 0.401$) did not have a significant impact on mammography use. Conclusions Church attendance and spirituality did not impact mammography use.

Khouzam, H. R. [Veterans Affairs Central California Health Care System, Fresno, CA; hani.khouzam2@va.gov]. **“Posttraumatic stress disorder and aging.”** *Postgraduate Medicine* 120, no. 3 (Sep 2008): 122-129.

[From the abstract:] ...This article will review the epidemiology, the morbidity, the mortality, the biological perspective, the prognosis, and the psychosocial and pharmacological treatment options, in addition to the spiritual dimensions of PTSD and aging. [57 refs.]

Kim, J. [Department of Psychology, Virginia Polytechnic Institute and State University, Blacksburg]. **“The protective effects of religiosity on maladjustment among maltreated and nonmaltreated children.”** *Child Abuse & Neglect* 32, no. 7 (Jul 2008): 711-720.

[Abstract:] OBJECTIVE: The aim of this study was to investigate the role of child religiosity in the development of maladaptation among maltreated children. METHODS: Data were collected on 188 maltreated and 196 nonmaltreated children from low-income families (ages 6-12 years). Children were assessed on religiosity and depressive symptoms, and were evaluated by camp counselors on internalizing symptomatology and externalizing symptomatology. RESULTS: Significant interactions indicated protective effects of religiosity. Child reports of the importance of faith were related to lower levels of internalizing symptomatology among maltreated girls ($t=-2.81, p<.05$). Child reports of attendance at religious services were associated with lower levels of externalizing symptomatology among nonmaltreated boys ($t=1.94, p=.05$). CONCLUSION: These results suggest that child religiosity may largely contribute to stress coping process among maltreated and nonmaltreated children from low-income families. The results also indicate that the protective roles of religiosity varied by risk status and gender. PRACTICAL IMPLICATIONS: The results indicate that a range of child religiosity behaviors and practices can be assessed in translational prevention research. It is recommended that healthcare professionals, psychologists, and social workers working with maltreated children and their families assess for salience of religiosity and may encourage them to consider the role religiosity plays in the development of prevention and intervention programs to alleviate distress and enhance stress coping.

Kim, K. H., Linnan, L., Campbell, M. K., Brooks, C., Koenig, H. G. and Wiesen, C. [University of Arkansas for Medical Sciences, Little Rock, AR; khk@uams.edu]. **“The WORD (wholeness, oneness, righteousness, deliverance): a faith-based weight-loss program utilizing a community-based participatory research approach.”** *Health Education & Behavior* 35, no. 5 (Oct 2008): 634-650.

[Abstract:] Despite multidisciplinary efforts to control the nation's obesity epidemic, obesity has persisted as one of the U.S.'s top public health problems, particularly among African Americans. Innovative approaches to address obesity that are sensitive to the unique issues of African Americans are needed. Thus, a faith-based weight-loss intervention using a community-based participatory research approach was developed, implemented, and evaluated with a rural African American faith community. A two-group, quasi-experimental, delayed intervention design was used, with church as the unit of assignment (treatment $n=2$, control $n=2$) and individual as the unit of observation (treatment $n=36$, control $n=37$). Weekly small groups led by trained community members met for 8 weeks and emphasized healthy nutrition, physical activity, and faith's connection with health. The mean weight loss of the treatment group was 3.60 ± 0.64 lbs. compared to the 0.59 ± 0.59 -lb loss of the control group.

Kim, Y. and Given, B. A. [Behavioral Research Center, American Cancer Society, Atlanta, GA; youngmee.kim@cancer.org]. **“Quality of life of family caregivers of cancer survivors: across the trajectory of the illness.”** *Cancer* 112, no. 11 Suppl. (Jun 1, 2008): 2556-2568.

This review notes research on spirituality *passim*. The authors comment: “The spiritual aspect of QOL among caregivers...has been studied inadequately” [p. 2558]. [195 refs.]

Kirkland, R. **““Enhancing life?” Perspectives from traditional Chinese value-systems.”** *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 26-40.

The author looks at enhancing technologies in light of Confucianism and Taoism. [This article is part of a special “symposium” on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by LaFleur, W. R., by Lustig, A., by Matthew, D. B., by Sade, R. M., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]

Kitzes, J. A., Kalishman, S., Kingsley, D. D., Mines, J. and Lawrence, E. [Palliative Care Section, School of Medicine, University of New Mexico, Albuquerque; Jkitzes@salud.unm.edu]. **“Palliative medicine Death Rounds: small group learning on a vital subject.”** *American Journal of Hospice & Palliative Medicine* 25, no. 6 (Dec 2008 - Jan 2009): 483-491.

The authors report on the effectiveness of Death Rounds at the University of New Mexico School of Medicine for medical students in a third year clerkship. Evidence from student feedback indicated the rounds were effective in increasing students knowledge and skills in core competency areas of palliative care/symptom management, end-of-life ethics, end-of-life legal issues, end-of-life cultural/spiritual issues, and discussing a patient's death with team members.

Klager, J., Duckett, A., Sandler, S. and Moskowitz, C. **“Huntington's disease: a caring approach to the end of life.”** *Care Management Journals* 9, no. 2 (2008): 75-81.

The article addresses end-of-life care for patients with Huntington's Disease, in light of guidelines by the Huntington's Disease Peer Workgroup (sponsored by the Robert Wood Johnson Foundation) and practice at the Terence Cardinal Cooke Health Care Center (New York). Regarding spirituality: “Pastoral care is represented in virtually every case conference, where the chaplain meets with the interdisciplinary team as well as invited family members. Patients are invited and transported to religious service and receive one-on-one visits in their rooms as well. Residents at all stages respond to the stimulation of fellowship and familiar rituals and songs. Many patients find their faith a great source of sustenance and peace of mind in the face of this debilitating illness.” [p. 80]

Klein, H., Elifson, K. W. and Sterk, C. E. [Emory University, Atlanta, GA; hughk@aol.com]. **“Depression and HIV risk behavior practices among at risk women.”** *Women & Health* 48, no. 2 (2008): 167-188.

Among the findings of this study of 250 at risk, predominantly African American women living in the Atlanta, Georgia metropolitan area was: "The more religious women were, the less depression they experienced ($p < .05$)" [p. 176]. And, for these authors, among the implications of their results for prevention and intervention efforts: "heightening faith community involvement and religious participation to decrease depression" [p. 167, abstract].

Knapik, G. P., Martsof, D. S. and Draucker, C. B. [College of Nursing, Kent State University, Kent, OH]. "**Being delivered: spirituality in survivors of sexual violence.**" *Issues in Mental Health Nursing* 29, no. 4 (Apr 2008): 335-350.

[Abstract:] A theoretical framework explaining how survivors of sexual violence use spirituality to respond to or recover from sexual violence is presented. Data were drawn from open-ended interviews of 27 women and 23 men who participated in a larger, ongoing study of women's and men's responses to sexual violence. Grounded theory methodology was used to develop the core category of Being Delivered, reflecting the participants' experiences of being rescued, saved, or set free from the effects of sexual violence by a spiritual being or power. The theoretical framework describing Being Delivered is composed of three dimensions: Spiritual Connection, Spiritual Journey, and Spiritual Transformation. The framework can be used by clinicians to guide discussions of spirituality and healing with survivors of sexual violence.

Koenig, H. G. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Geriatric Research, Education and Clinical Center, VA Medical Center, Durham, NC; koenig@geri.duke.edu]. "**Concerns about measuring 'spirituality' in research.**" *Journal of Nervous & Mental Disease* 196, no. 5 (May 2008): 349-355. [See comments: Franch, M. S., "Spirituality, religion, and meaning," *Journal of Nervous & Mental Disease* 196, no. 8 (Aug 2008): 643-646; Tsuang, M. T. & Simpson, J. C., "Commentary on Koenig (2008): 'Concerns about measuring 'spirituality' in research,'" *Journal of Nervous & Mental Disease* 196, no. 8 (Aug 2008): 647-649; and Underwood, L., "Measuring 'spirituality,'" *Journal of Nervous & Mental Disease* 196, no. 9 (Sep 2008): 715-716.]

Abstract: Spirituality is increasingly being examined as a construct related to mental and physical health. The definition of spirituality, however, has been changing. Traditionally, spirituality was used to describe the deeply religious person, but it has now expanded to include the superficially religious person, the religious seeker, the seeker of well-being and happiness, and the completely secular person. Instruments used to measure spirituality reflect this trend. These measures are heavily contaminated with questions assessing positive character traits or mental health: optimism, forgiveness, gratitude, meaning and purpose in life, peacefulness, harmony, and general well-being. Spirituality, measured by indicators of good mental health, is found to be correlated with good mental health. This research has been reported in some of the world's top medical journals. Such associations are meaningless and tautological. Either spirituality should be defined and measured in traditional terms as a unique, uncontaminated construct, or it should be eliminated from use in academic research. [38 refs.]

Koenig, H. G. [Duke University Medical Center, Durham, NC; koenig@geri.duke.edu]. "**Why research is important for chaplains.**" *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 83-90. [See other articles from the special journal issue on chaplaincy research by Handzo, et al.; Weaver, et al.; Vanderwerker, et al.; and Harding, et al. --all noted elsewhere in this bibliography.]

[Abstract:] Research forms the basis for all health care disciplines, including nursing, medicine, and psychology. This research is necessary to document both the benefits and the costs of health care services, and applies equally to the services and interventions that chaplains provide. It is important that chaplains do this research, rather than others without sensitivity to the main issues at stake. Unfortunately, training in how to conduct research is not usually part of the education that chaplains receive. There are specific skills that need to be acquired in order to identify a research question, design a study to answer that question, obtain funding, manage the project, and publish the results. Learning these research skills will at some point become non-optional if chaplaincy is to continue to grow and flourish as a profession and receive the recognition and respect that it deserves.

Koenig, L. B., McGue, M. and Iacono, W. G. [Department of Psychology, University of Minnesota; koen0099@umn.edu]. "**Stability and change in religiousness during emerging adulthood.**" *Developmental Psychology* 44, no. 2 (Mar 2008): 532-543.

[Abstract:] Understanding the development of religiousness is an important endeavor because religiousness has been shown to be related to positive outcomes. The current study examined mean-level, rank-order, and individual-level change in females' religiousness during emerging adulthood. Genetic and environmental influences on religiousness and its change and stability were also investigated. Analyses were completed with an epidemiological study of 2 cohorts of twins: 1 assessed at ages 14 and 18 and a 2nd at 20 and 25. Mean levels of religiousness decreased significantly with age, while rank-order stability was high. Individual-level change was also evident. Analyses also supported the hypotheses that more change would occur in the younger cohort compared with the older cohort and that more change would occur in religious service attendance than the general index of religiousness. Twin analyses suggested that the heritability of religiousness increased with age, while the shared environmental influences decreased. For the younger cohort, change was genetic in origin, while stability was environmental. In the older cohort, change was influenced by nonshared environment and stability by both genes and family environment.

Koffman, J., Morgan, M., Edmonds, P., Speck, P. and Higginson, I. J. [King's College London, Department of Palliative Care, London, UK; jonathan.s.koffman@kcl.ac.uk]. "**Cultural meanings of pain: a qualitative study of Black Caribbean and White British patients with advanced cancer.**" *Palliative Medicine* 22, no. 4 (Jun 2008): 350-359.

Among the findings of this qualitative study involving 26 Black Caribbean patients was that the interviews with the Black Caribbean participants indicated the themes of [from the abstract:] pain as a 'test of faith' that referred to confirmation and strengthening of religious belief, and pain as a 'punishment' that was associated with wrongdoing. These meanings influenced the extent patients were able to accommodate their distress.

Koffman, J., Morgan, M., Edmonds, P., Speck, P. and Higginson, I. J. [Department of Palliative Care, Policy and Rehabilitation, King's College London, UK; jonathan.koffman@kcl.ac.uk]. "**'I know he controls cancer': the meanings of religion among Black Caribbean and White British patients with advanced cancer.**" *Social Science & Medicine* 67, no. 5 (Sep 2008): 780-789.

[Abstract:] There is evidence that religion and spirituality affect psychosocial adjustment to cancer. However, little is known about the perceptions and meanings of religion and spirituality among Black and minority ethnic groups living with cancer in the UK. We conducted semi-structured interviews with 26 Black Caribbean and 19 White British patients living in South London boroughs with advanced cancer to explore how religion and spirituality influenced their self-reported cancer experience. Twenty-five Black Caribbean patients and 13/19 White

British patients volunteered views on the place of religion or God in their life. Spirituality was rarely mentioned. Christianity was the only religion referred to. Strength of religious belief appeared to be more pronounced among Black Caribbean patients. Three main themes emerged from patients' accounts: the ways in which patients believed religion and belief in God helped them comprehend cancer; how they felt their faith and the emotional and practical support provided by church communities assisted them to live with the physical and psychological effects of their illness and its progression; and Black Caribbean patients identified the ways in which the experience of cancer promoted religious identity. We identified that patients from both ethnic groups appeared to derive benefit from their religious faith and belief in God. However, the manner in which these were understood and expressed in relation to their cancer was culturally shaped. We recommend that when health and social care professionals perform an assessment interview with patients from different cultural backgrounds to their own, opportunities are made for them to express information about their illness that may include religious and spiritual beliefs since these may alter perceptions of their illness and symptoms and thereby influence treatment decisions.

Konkle-Parker, D. J., Erlen, J. A. and Dubbert, P. M. [Division of Infectious Diseases, University of Mississippi Medical Center, Jackson]. **"Barriers and facilitators to medication adherence in a southern minority population with HIV disease."** *Journal of the Association of Nurses in AIDS Care* 19, no. 2 (Mar-Apr 2008): 98-104.

This study of 20 HIV-infected clients of a large public infectious diseases clinic in the Deep South identified prayer and spirituality as facilitators of medication adherence. See pp. 100, 101, and 103.

Kramer, A., Hubner, N., Below, H., Heidecke, C. D. and Assadian, O. [Institute of Hygiene and Environmental Medicine, Ernst Moritz Arndt University, Greifswald, Germany]. **"Improving adherence to surgical hand preparation."** *Journal of Hospital Infection* 70, suppl. 1 (Oct 2008): 35-43.

The authors address the concern that some Muslims may believe that the use of alcohol-based hand sanitizers may conflict with the religion's prohibition on alcohol. "For Muslims, any substance leading to a disconnection from a state of awareness or consciousness is 'haram'. Some Muslims believe that if something taken in a large quantity acts as an intoxicant, then it is 'haram' to even take in a small quantity of that. However, a small amount which does not cause intoxication is not 'haram'. The only condition is that it must not be drunk for amusement and pastime. If it is used to gain strength, to digest the food, or for medical reasons then it is permissible as long as it does not intoxicate." [p. 39]

Kraus, J. K. [Spiritual Care Department, St. Michael's Hospital, Toronto, Canada]. **"From reel time to real time: patient simulation for chaplain interns."** *Journal of Pastoral Care & Counseling* 62, no. 4 (2008): 331-336.

[Abstract:] The simulation center provides the chaplain interns with a safe environment to practice and participate in different scenarios. It gives them the time to familiarize themselves with intensive care conditions such as the equipment, alarms and noise as well as the levels of activity and the very real limitations of space. It is an important opportunity to try new skills, to address their fears of being present in intense medical interventions, to see where improvement in their conduct is needed, to confirm the value of the communication skills they are being taught, and to develop empathy with patients, family members, and hospital staff. The students receive immediate feedback from peers and supervisors as well as immediate reaction from live actors portraying staff, patients, and family. For the teaching supervisor it is a valuable way to observe clinical conduct. It also provides evidence-based observations of the development and maintenance of professional standards. All participants, including the chaplain interns, the teaching supervisors, and the simulation coordinators observe that the CPE goals involving patient simulation are being met. An immediate result of addressing these goals demonstrates that the patients, families, and staff of St. Michael's Hospital receive high-quality spiritual and religious care from chaplain interns who are studying and working to improve their proficiency.

LaFleur, W. R. [Saunders Professor in Japanese Studies and Senior Fellow in Bioethics at the University of Pennsylvania]. **"Enhancement and desire: Japanese qualms about where biotechnology is taking us."** *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 65-72.

[Abstract:] Japan's Buddhists view bodily enhancement neither negatively in terms of sin nor positively as repairing the world. They prefer prudence, however, due to the fact that human desires will be enflamed by proffered new biotechnologies and ironically increase psychosocial dissatisfaction. In spite of great pressures for bodily enhancements within in East Asian societies, bioethicists issue strong cautions. [This article is part of a special "symposium" on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by Kirkland, R., by Lustig, A., by Matthew, D. B., by Sade, R. M., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]

Lamond, A. J., Depp, C. A., Allison, M., Langer, R., Reichstadt, J., Moore, D. J., Golshan, S., Ganiats, T. G. and Jeste, D. V. [School of Medicine, University of California, San Diego]. **"Measurement and predictors of resilience among community-dwelling older women."** *Journal of Psychiatric Research* 43, no. 2 (Dec 2008): 148-154.

[From the abstract:] BACKGROUND: Resilience, the ability to adapt positively to adversity, may be an important factor in successful aging. However, the assessment and correlates of resilience in elderly individuals have not received adequate attention. METHOD: A total of 1395 community-dwelling women over age 60 who were participants at the San Diego Clinical Center of the Women's Health Initiative completed the Connor-Davidson Resilience Scale (CD-RISC), along with other scales pertinent to successful cognitive aging. Internal consistency and predictors of the CD-RISC were examined, as well as the consistency of its factor structure with published reports. RESULTS: The mean age of the cohort was 73 (7.2) years and 14% were Hispanic, 76% were non-Hispanic white, and nearly all had completed a high school education (98%). ...Exploratory factor analysis yielded four factors (somewhat different from those previously reported among younger adults) that reflected items involving: (1) personal control and goal orientation, (2) adaptation and tolerance for negative affect, (3) leadership and trust in instincts, and (4) spiritual coping. The strongest predictors of CD-RISC scores in this study were higher emotional well-being, optimism, self-rated successful aging, social engagement, and fewer cognitive complaints...

Lane, M. R. [Center of Spirituality and Healthcare, College of Nursing, University of Florida, Gainesville]. **"Spirit-body healing II: a nursing intervention model for spiritual/creative healing."** *Cancer Nursing* 31, no. 3 (May-Jun 2008): E24-31.

[Abstract:] This article describes an advanced intervention for spiritual healing that evolved from spirit-body healing, a hermeneutic phenomenological research study. The research study examined the lived experience of art and healing with cancer patients in the Arts in Medicine program at Shands Hospital, University of Florida. Max Van Manen's method of researching the lived experience was used in 63 patients over a 4-year period. Healing themes that emerged from the research were (1) go into darkness, (2) go elsewhere, (3) art becomes the

turning point, (4) slip through the veil, (5) know the truth and trust the process, (6) embody your spirit, (7) feel the healing energy of love and compassion, and (8) experience transcendence. The intervention we offer allows nurses to apply creativity and guided imagery as advanced therapeutics and to continue to provide the leadership needed for integrating spiritual healing into patient care. It is one that personifies the nursing mission formalized by many hospitals: a commitment to treat the bodies, minds, and spirits of patients to the best of our ability as part of our routine care.

Lantos, J. D. and Curlin, F. A. [Center for Practical Bioethics, Kansas City, MO; j-lantos@uchicago.edu]. **“Religion, conscience and clinical decisions.”** *Acta Paediatrica* 97, no. 3 (Mar 2008): 265-266.

The authors consider the topic in light of three cases, looking at reasons why conscientious decisions become controversial.

Larocca-Pitts, M. A. [Athens Regional Medical Center, Athens, GA]. **“FACT: Taking a Spiritual History in a Clinical Setting.”** *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 1-12. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] Healthcare clinicians need a good tool for taking spiritual histories in a clinical setting. A spiritual history provides important clinical information and any properly trained clinician can take one. Professionally trained chaplains follow-up with more in-depth spiritual assessments if indicated. A spiritual history tool's effectiveness depends on five criteria: brevity, memorability, appropriateness, patient-centeredness, and credibility (Koenig, 2007). The chaplain-developed FACT stands for: F-Faith (and/or Belief); A-Active (and/or Available, Accessible, Applicable); C-Coping (and/or Comfort)/Conflict (and/or Concern); and T-Treatment. FACT compares favorably, if not better in some categories, with three physician-developed spiritual history tools: Koenig's (2007) CSI-MEMO, American College of Physicians' tool (Lo, Quill, & Tulskey, 1999), and Puchalski's and Romer's (2000) FICA.

Lavric, M. and Flere, S. [Department of Sociology, University of Maribor, Maribor, 2000, Slovenia; miran.lavric@uni-mb.si]. **“The role of culture in the relationship between religiosity and psychological well-being.”** *Journal of Religion & Health* 47, no. 2 (Jun 2008): 164-175.

[Abstract:] Several measures of religious practice and religious orientation (intrinsic/extrinsic/quest) and two measures of psychological well-being (positive affect and negative affect) have been employed in a cross-cultural survey of undergraduate university students from five different cultural/religious environments: Slovenia, Bosnia and Herzegovina, Serbia, the United States of America, and Japan. Results suggest that measures of extrinsic, intrinsic, and quest religiosity are not entirely applicable in most of the cultures observed. Nevertheless, it was possible to discern abbreviated cross-culturally valid scales for each dimension. The strength and direction of the correlation between psychological well-being and a particular type of religious orientation proved to depend substantially upon culture. More importantly, the cultural environment plays a crucial role in shaping the relationship between general measures of religiosity and psychological well-being. According to the data, higher general levels of religiosity at the societal level are linked to more positive correlations between religiosity and psychological well-being. The overall picture leads to the conclusion that there is no culturally universal pattern in the relationship between measures of religiosity and psychological well-being and that the particular cultural and religious context should always be considered in studies dealing with this issue.

Leak, A., Hu, J. and King, C. R. [School of Nursing, Duke University, Durham, NC; ashley_leak@hotmail.com]. **“Symptom distress, spirituality, and quality of life in African American breast cancer survivors.”** *Cancer Nursing* 31, no. 1 (Jan-Feb 2008): E15-21.

[Abstract:] This study examined the relationships among the demographic characteristics, symptom distress, spirituality, and quality of life (QOL) of African American breast cancer survivors. A convenience sample of 30 survivors with a mean age of 56 years and a mean survival of 6 years was recruited from African American breast cancer support groups and churches in the Southeastern United States. Data were collected through face-to-face interviews using a demographic questionnaire, the Quality of Life Index-Cancer Version, the Symptom Distress Scale, and the Spiritual Perspective Scale. Statistically significant relationships were found between symptoms and QOL ($r = -0.62, P < .05$) and between spirituality and QOL ($r = 0.70, P < .05$). No statistically significant relationships were found between age at diagnosis, income, or education and QOL. This research suggests that symptoms and spirituality are associated with QOL. Culturally appropriate care should be provided to these women to reduce health disparities and to improve their QOL. [This issue of the journal contained two other studies relating to spirituality & health: see the articles by Juarez, G., et al. and by Im, E. O., et al, also noted in this bibliography.]

Ledbetter, T. J. [Tri-Cities Chaplaincy, Kennewick, WA]. **“Screening for pastoral visitations using the Clinical+Coping Score.”** *Journal of Pastoral Care & Counseling* 62, no. 4 (2008): 367-374.

[Abstract:] Hospital chaplains struggle to know which patients most likely need pastoral care and why. The author presents a computerized model to screen and document indicated patients. A new screening tool is introduced, the Clinical+Coping Score, which can check with greater precision for patients who show evidence of insufficient coping. This screening model informs the subsequent assessment and intervention opportunities, though they are not discussed. The model's format enables chaplains to efficiently and effectively document pastoral screening using the hospital's electronic charting program. Two levels of visitation priority are suggested. In so doing, the chaplains are able to identify the indicators for pastoral care contacts and interventions, as well as the number of patients whose recognized needs have yet to be addressed.

Lee, V. [Cancer Care Mission, McGill University Health Centre, Montreal, Canada; virginia.lee@muhc.mcgill.ca]. **“The existential plight of cancer: meaning making as a concrete approach to the intangible search for meaning.”** *Supportive Care in Cancer* 16, no. 7 (Jul 2008): 779-785.

[Abstract:] INTRODUCTION: Despite modern advances that have led to improved prognoses and symptom management, a cancer diagnosis continues to evoke images of pain, suffering, and death. DISCUSSION: The current literature suggests that the "existential plight of cancer" refers to what is now commonly known as the "search for meaning" following a cancer experience. Mounting evidence suggests that global meaning--defined as the general sense that one's life has order and purpose--is a key determinant of overall quality of life. It provides the motivation for people with cancer to re-engage in life amongst a bewildering array of physical, psychosocial, social, spiritual, and existential changes imposed by the disease. Health care providers are inherently involved in their patients' search for global meaning. Yet, few empirical studies have operationalized how this search can be achieved. CONCLUSION: The meaning-making intervention is presented as one concrete approach to address the normative distress associated with the search for meaning within the context of cancer. [64 references]

- Leighton, S. [South Staffordshire Healthcare NHS Trust, UK; sharonleighton@btinternet.com]. **“Bereavement therapy with adolescents: facilitating a process of spiritual growth.”** *Journal of Child & Adolescent Psychiatric Nursing* 21, no. 1 (Feb 2008): 24-34.
 [Abstract:] TOPIC: Bereavement therapy as a catalyst for spiritual growth. PURPOSE: This study aims to review the literature and reflect on the bereavement therapy undertaken with two adolescents who had been bereaved during childhood. SOURCES: Research articles and books identified through a combination of electronic and manual searches. CONCLUSIONS: It would appear that grief therapy could facilitate spiritual growth in such circumstances. Further in-depth studies are required to identify how typical or atypical this experience is, and to contribute to the evidence base for working with bereaved children and adolescents. [31 refs.]
- LePage, J. P. and Garcia-Rea, E. A. [University of Texas Southwestern Medical School, VA North Texas Health Care System, Dallas; james.lepage@va.gov]. **“The association between healthy lifestyle behaviors and relapse rates in a homeless veteran population.”** *American Journal of Drug & Alcohol Abuse* 34, no. 2 (2008): 171-176.
 [Abstract:] This study evaluates the association between Healthy Lifestyle Behaviors (HLBs) and relapse rates in a homeless residential rehabilitation program. Ninety-seven homeless veterans with Substance Dependence in Early Remission were evaluated. Veterans recorded recreational, social, coping/spiritual, and substance recovery activities. Those who relapsed during residential treatment were compared to those who did not. Higher numbers of HLBs were associated with lower relapse rates during treatment. No differences were found between the two groups in the number of recovery activities performed. HLBs proved better predictors of success than recovery behaviors. Implications and limitations are discussed.
- Levav, I., Kohn, R. and Billig, M. [Mental Health Services, Ministry of Health, Jerusalem, Israel; Itzhak.Levav@moh.health.gov.il]. **“The protective effect of religiosity under terrorism.”** *Psychiatry* 71, no. 1 (2008): 46-58.
 [Abstract:] Abstract Religious observance has a protective effect on the mental health of individuals facing adverse events. Its role under terrorism has been less investigated. Gaza and West Bank settlers, both secular and those keeping different degrees of observance, have faced terrorism in recent years. We investigated their PERI-Demoralization mean scores following terrorist attacks controlling for confounding variables. The results showed that the higher the religiosity the lower the demoralization mean score. This protective effect lessened when there was dissonance between the degree of religiosity of the respondent and the religious observance of the settlement of residence.
- Levin, J. [Duke University Medical Center, Durham, NC]. **“Esoteric healing traditions: a conceptual overview.”** *Explore: The Journal of Science & Healing* 4, no. 2 (Mar-Apr 2008): 101-112.
 [Abstract:] This paper presents, for the first time, a comprehensive scholarly examination of the history and principles of major traditions of esoteric healing. After a brief conceptual overview of esoteric religion and healing, summaries are provided of eight major esoteric traditions, including descriptions of beliefs and practices related to health, healing, and medicine. These include what are termed the kabbalistic tradition, the mystery school tradition, the gnostic tradition, the brotherhoods tradition, the Eastern mystical tradition, the Western mystical tradition, the shamanic tradition, and the new age tradition. Next, commonalities across these traditions are summarized with respect to beliefs and practices related to anatomy and physiology; nosology and etiology; pathophysiology; and therapeutic modalities. Finally, the implications of this survey of esoteric healing are discussed for clinicians, biomedical researchers, and medical educators. [121 refs.]
- Lewis, L. M. [Family and Community Health Department, School of Nursing, University of Pennsylvania, Philadelphia; lisaml@nursing.upenn.edu]. **“Spiritual assessment in African-Americans: a review of measures of spirituality used in health research.”** *Journal of Religion & Health* 47, no. 4 (Dec 2008): 458-475.
 [Abstract:] BACKGROUND: A number of instruments have been developed for investigating relationships between spirituality and health, and have been used to assess spirituality in African-Americans. Yet, the cultural appropriateness for African-Americans of these instruments has not been investigated to date. OBJECTIVES: To evaluate the construct validity and reliability of spirituality measures used in health research from 1982 to 2005. METHOD: Systematic review of the literature. RESULTS: Thirty five studies and five measures of spirituality met the inclusion criteria. Most of the spirituality measures were developed in primarily Caucasian-American samples. African-Americans were represented in 71% of the studies (n = 25) using spirituality measures in health research. Distinct cultural attributes of African-American spirituality were omitted in most of the spirituality measures. Two studies were retrieved in which psychometric evaluation was conducted in entirely African-American samples. DISCUSSION: Spirituality is a significant cultural experience and belief that influences the health behaviors of African-Americans. The lack of a culturally appropriate measure of African-American spirituality is a major limitation of studies investigating spirituality and health in this population. Development of a culturally appropriate and sensitive measure of spirituality in African-Americans is suggested to strengthen the quality of research in this area. [91 refs.] [See also the introduction to the issue: Ferrell, D. R., “Religion and health,” on pp. 435-437.]
- Lewis, L. M. and Ogedegbe, G. [University of Pennsylvania School of Nursing, Philadelphia; lisaml@nursing.upenn.edu]. **“Understanding the nature and role of spirituality in relation to medication adherence: a proposed conceptual model.”** *Holistic Nursing Practice* 22, no. 5 (Sep-Oct 2008): 261-267.
 [Abstract:] Racial disparities in hypertension prevalence and its attendant complications are well documented. Spirituality is an important component of African American beliefs and a small body of literature suggests that spirituality influences hypertension management in African Americans. This article describes a conceptual model of spirituality that may be useful for developing interventions for increasing medication adherence and decreasing blood pressure in African Americans diagnosed with hypertension. [62 refs.]
- Likes, W. M., Russell, C. and Tillmanns, T. [College of Nursing, University of Tennessee Health Science Center, Memphis, TN; wlikes@utm.edu]. **“Women's experiences with vulvar intraepithelial neoplasia.”** *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing* 37, no. 6 (Nov-Dec 2008): 640-646.
 In this small focus group study, participants were asked open-ended questions about their experiences, quality of life, sexual functioning, body image, and well-being. Among the findings: “Spirituality appeared as a positive influence. Participants discussed the importance of God and prayer, and others in the group looked up to and admired the strong faith and testimony of one participant who spoke strongly of her faith. This participant’s experience not only demonstrates the influence of faith but also age; she was older and did not experience much effect from VIN.” [p. 664]

- Lillis, J., Gifford, E., Humphreys, K. and Moos, R. [VA Palo Alto Health Care System, Stanford University Medical School, Menlo Park, CA; jasonlillis22@gmail.com]. **“Assessing spirituality/religiosity in the treatment environment: the Treatment Spirituality/Religiosity Scale.”** *Journal of Substance Abuse Treatment* 35, no. 4 (Dec 2008): 427-433. [Abstract:] There has been much interest in measuring and evaluating the role of spirituality/religiosity (S/R) in substance use disorder (SUD) treatment. This study presents the initial evaluation of a new measure of S/R in the treatment environment: the Treatment Spirituality/Religiosity Scale (TSRS). The TSRS has 10 items and can be completed by both patient and staff to measure the emphasis on S/R in a given treatment program, which may have important implications for patient-program fit. Data on the TSRS were gathered from 3,018 patients and 329 staff members from 15 residential SUD treatment programs within the Department of Veterans Affairs Health Care System. The TSRS showed good internal consistency ($\alpha = .77$), a single-factor structure, close agreement between patients and staff members ($r = .93$), and good discriminant validity. The TSRS appears to be a brief, easily administered, and potentially useful measure of the emphasis on S/R in residential SUD treatment programs.
- Linton, J. M. and Feudtner, C. [Division of General Pediatrics, Children's Hospital of Philadelphia, PA]. **“What accounts for differences or disparities in pediatric palliative and end-of-life care? A systematic review focusing on possible multilevel mechanisms.”** *Pediatrics* 122, no. 3 (Sep 2008): 574-582. [See also the article by Boss, et al. from this same issue (noted elsewhere in this bibliography.)] Among the findings of this review examining 19 studies was that: “Religion and spirituality are cited by many people (especially members of minority communities) as primary resources they use to cope with symptoms and to make decisions at the end of life. Black patients are more likely to rely on religion and spirituality to cope with cancer, and patients with cancer with greater reliance on spiritual coping are less likely to have a living will and more likely to desire life-sustaining measures. Similarly, disagreement with hospice philosophy is associated with church attendance and black race. At the individual and community levels, religious leaders and spiritual support staff members may influence perceptions. Investigators are beginning to consider the role of black religious leaders in shaping community perceptions regarding health care.” [p. 578]
- Lissoni, P., Messina, G., Parolini, D., Balestra, A., Brivio, F., Fumagalli, L., Vigore, L. and Rovelli, F. [Division of Radiation Oncology, San Gerardo Hospital, Monza, Milan, Italy; p.lissoni@hsgerardo.org]. **“A spiritual approach in the treatment of cancer: relation between faith score and response to chemotherapy in advanced non-small cell lung cancer patients.”** *In Vivo* [Athens, Greece] 22, no. 5 (Sep-Oct 2008): 577-581. [Abstract:] BACKGROUND: The recent advances in the psychooncological and psychoneuroimmunological investigations of cancer patients has allowed the rediscovery of the importance of spiritual faith in influencing the clinical course of neoplastic disease, not only in terms of supportive care but also as a potential prognostic variable. MATERIALS AND METHODS: Clinical criteria were worked out to explore the existence of a real status of faith, in an attempt to correlate the degree of faith with the clinical response to chemotherapy, consisting of cisplatin plus gemcitabine, and the overall survival time in a group of 50 metastatic nonsmall cell lung cancer patients. RESULTS: The tumor response rate achieved in patients with a high degree of faith was significantly higher than in the other group of patients. Moreover, the mean postchemotherapeutic lymphocyte number was significantly higher in the patients with evident spiritual faith than in the other patients. Finally, the percent age of 3-year survival observed in the patients with a high degree of faith was significantly higher than that in the patients with a low faith score. CONCLUSION: This preliminary study suggests that spiritual faith may positively influence the efficacy of chemotherapy and the clinical course of neoplastic disease, at least in lung cancer, by improving the lymphocyte-mediated anticancer immune response.
- Locher, J. L., Ritchie, C. S., Robinson, C. O., Roth, D. L., Smith West, D. and Burgio, K. L. [Department of Medicine, University of Alabama at Birmingham; jlocher@uab.edu]. **“A multidimensional approach to understanding under-eating in homebound older adults: the importance of social factors.”** *Gerontologist* 48, no. 2 (Apr 2008): 223-234. Among the findings of this study involving 230 homebound older adults currently receiving home health services is an indication that a lack of participation in religious organizations may increase the risk of under-eating. See esp. pp. 227 and 232 and information in tables.
- Long, W. J. and Scuderi, G. R. [Insaall Scott Kelly Institute for Orthopaedics and Sports Medicine, New York, NY]. **“High-flexion total knee arthroplasty.”** *Journal of Arthroplasty* 23, no. 7 Suppl. (Oct 2008): 6-10. While the article does not directly address religious issues, it is prefaced by the statement [from the abstract:] “Some cultures and religions place more emphasis on deep knee flexion” [p. 6].
- Loustalot F. [National Centre for Chronic Disease Health Promotion and Prevention, Atlanta, GA]. **“Assessing patients' spiritual needs.”** *Nursing New Zealand (Wellington)* 14, no. 8 (Aug 2008): 21-22. The article addresses the importance of spirituality for patients in New Zealand, where data show that 60% find spirituality to be “rather” or “very important” in their lives. The author promotes spiritual assessment, especially by nurses, who are “more likely than other health care providers to find themselves in a situation where spiritual needs are presented” [p. 21]. Internet resources are offered, in addition to the bibliography.
- Lustig, A. [Department of Religion, Davidson College, Davidson, NC.]. **“Enhancement technologies and the person: Christian perspectives.”** *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 41-50. [Abstract:] Distinctions between therapy and enhancement are difficult to draw with precision, especially in marginal cases. Nevertheless, most recent Christian discussions of enhancement technologies accept the general plausibility of distinctions drawn between therapeutic interventions and enhancement technologies by appealing to general understandings of nature and human nature as available benchmarks. On that basis, a range of religious assessments of enhancement technologies can be identified. Those judgments incorporate different interpretations of nature as a source of moral insight, different understandings of human responsibility in light of God's purposes, and different assessments of the effects of sin and finitude on human freedom. [This article is part of a special “symposium” on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by Kirkland, R., by LaFleur, W. R., by Matthew, D. B., by Sade, R. M., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]

Mallin, R. and Hull, S. K. [Family Medicine, Psychiatry and Behavioral Medicine, Medical University of South Carolina, Charleston; mallin@musc.edu]. **“Role of the social milieu in health and wellness.”** *Primary Care: Clinics in Office Practice* 35, no. 4 (Dec 2008): 857-866.

[From the abstract:] ...The impact of the social milieu on health and wellness is not a new concept. Before the invention of an effective pharmacopoeia, manipulation of the social environment was one of the few tools available to physicians. Modern medicine continues to focus on individual rather than community efforts at risk reduction. To understand health and wellness, we must look not only at bodies and illnesses but also at communities and social structure. This article discusses the impact of spirituality and religion, education, economics, and politics on health and wellness....

Manii, D. and Ammerman, D. [Social Work, Ottawa Hospital, Ottawa, Ontario, Canada; dmanii@ottawahospital.on.ca]. **“Men and cancer: a study of the needs of male cancer patients in treatment.”** *Journal of Psychosocial Oncology* 26, no. 2 (2008): 87-102.

Among the findings of this study of 128 male patients diagnosed with 138 primary cancers: “When asked if they were doing anything above and beyond their medical treatment that contributes to their own healing, 58.6% ($n = 75$) responded affirmatively. Of these participants, 21.8% exercised regularly, 16.7% learned about their disease and new treatments, 14.9% talked to other men with cancer, 11.5% spent more time with their family, and 10.3% tried to be more spiritual.” [p. 94]

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R. and Bush, F. [Department of Family and Preventive Medicine, University of South Carolina School of Medicine, Columbia; joshua.mann@sc.edu]. **“Do antenatal religious and spiritual factors impact the risk of postpartum depressive symptoms?”** *Journal of Women's Health* 17, no. 5 (Jun 2008): 745-755. [See also the article by Wade, et al., in this journal issue (noted elsewhere in this bibliography).]

[Abstract:] OBJECTIVES: Previous research has identified an inverse relationship between religiosity/spirituality and depressive symptoms. However, prospective studies are needed. This study investigates the association between antenatal religiosity/spirituality and postpartum depression, controlling for antenatal depressive symptoms, social support, and other potential confounders. METHODS: This is a prospective cohort study. Women receiving prenatal care were enrolled from three obstetrics practices. Follow-up assessment was conducted at the 6-week postpartum clinic visit. Four measures of religiosity and two measures of spirituality were assessed at baseline. A measure of overall religiosity/spirituality was also created using principal component factor analysis. Depressive symptoms were measured at baseline and again at follow-up using the Edinburgh Postnatal Depression Scale (EPDS). A cutoff score of ≥ 13 was used to identify women with significant depressive symptoms. RESULTS: Four hundred four women were enrolled, and 374 completed follow-up. Thirty women experienced pregnancy loss, leaving 344 with postpartum assessment; 307 women had complete data and were used for analyses. Thirty-six women (11.7%) scored above the EPDS screening cutoff. Controlling for significant covariates (baseline EPDS score and social support), women who participated in organized religious activities at least a few times a month were markedly less likely (OR = 0.18, 95% CI) to exhibit high depressive symptom scores. No other religiosity/spirituality measure was statistically significant. CONCLUSIONS: Organized religious participation appears to be protective from postpartum depressive symptoms. Because this association is independent of antenatal depressive symptoms, we hypothesize that religious participation assists in coping with the stress of early motherhood.

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R. and Bush, F. [University of South Carolina School of Medicine, Columbia; joshua.mann@sc.edu]. **“Predicting depressive symptoms and grief after pregnancy loss.”** *Journal of Psychosomatic Obstetrics & Gynecology* 29, no. 4 (Dec 2008): 274-279.

Among the findings of this prospective cohort study was that participation in organized religious activities was protective against post-pregnancy loss grief.

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R. and Bush, F. [Department of Family and Preventive Medicine, University of South Carolina School of Medicine, Columbia; joshua.mann@sc.edu]. **“Religiosity, spirituality and antenatal anxiety in Southern U.S. women.”** *Archives of Women's Mental Health* 11, no. 1 (2008): 19-26.

[Abstract:] INTRODUCTION: We investigated the association between religiosity, spirituality, and anxiety in pregnant women, taking into account potential confounders. MATERIALS AND METHODS: From September 2005 through March 2006, pregnant women in three obstetrics practices in the American South were included in a cross-sectional study. The anxiety subscale of the Hospital Anxiety and Depression Scale (HADS) was used to measure anxiety. RESULTS: Of the 344 participating women, 23 screened positive for moderate to severe anxiety (HADS [anxiety] score greater than 10). Overall religiosity or spirituality (odds ratio [OR], 0.53; $p=0.006$) and social support (OR, 0.42; $p<0.0001$) were significantly associated with significantly lower odds of a positive anxiety screen. Among the specific measures of religiosity or spirituality, self-rated religiosity, self-rated spirituality, and participation in nonorganizational religious activities were significantly associated with lower odds of moderate to severe anxiety symptoms. DISCUSSION AND CONCLUSIONS: Religiosity and spirituality are associated with reduced anxiety in pregnant women. Additional study is needed to evaluate whether the association is causal.

Mao, J. J., Palmer, S. C., Straton, J. B., Cronholm, P. F., Keddem, S., Knott, K., Bowman, M. A. and Barg, F. K. [Department of Family Medicine and Community Health, University of Pennsylvania, Philadelphia; maoj@uphs.upenn.edu]. **“Cancer survivors with unmet needs were more likely to use complementary and alternative medicine.”** *Journal of Cancer Survivorship* 2, no. 2 (Jun 2008): 116-124.

[Abstract:] PURPOSE: Despite advancements in cancer care, cancer survivors continue to experience a substantial level of physical and emotional unmet needs (UMN). This study aims to determine the relationship between patients' perceived UMN and their use of complementary and alternative medicine (CAM) to help with cancer problems during and after treatment. METHODS: A mailed, cross-sectional survey was completed by 614 cancer survivors identified through the Pennsylvania Cancer Registry 3.5 to 4 years from initial diagnosis. Relationships among UMN and CAM use along with clinical and socio-demographic factors were examined. RESULTS: Respondents who identified any UMN were 63% more likely to report CAM use than those without UMN (58% vs. 36%), $p < 0.001$. UMN remained the only independent predictor (adjusted odds ratio = 2.30, 95% confidence interval = 1.57-3.36, $p < 0.001$) of CAM use in a multivariate logistic regression model that included age, sex, marital status, education, previous chemotherapy and radiotherapy. Adjusted for covariates, UMN in domains of emotional, physical, nutritional, financial, informational, treatment-related, employment-related, and daily living activities were all related to CAM use, whereas UMN in transportation, home care, medical staff, family and spirituality were not related

to CAM use. Patients who experienced multiple types of unmet needs were also more likely to use multiple types of CAM ($p < 0.001$ for model). CONCLUSIONS: Cancer survivors who experienced unmet needs within the existing cancer treatment and support system were more likely to use CAM to help with cancer problems. Research is needed to determine if appropriate CAM use decreases unmet needs among cancer survivors. [See also Schulz, E., et al., "Role of spirituality in cancer coping..." on pp. 104-115 of the same issue of the journal.]

Marco, C. A. and Larkin, G. L. [St. Vincent Mercy Medical Center, Toledo, OH]. "**Cardiopulmonary resuscitation: knowledge and opinions among the U.S. general public. State of the science-fiction.**" *Resuscitation* 79, no. 3 (Dec 2008): 490-408.

Among the findings of this study involving 1831 participants representing 38 states was the following rating of six factors that they considered important or very important in the event of their own cardiac arrest: most advanced technology (90%), physician communication with family (85%), family presence in the hospital (72%), prayer/other religious acts (57%), clergy communication with family (53%), and family presence in resuscitation room (31%) [--see Table 3, p. 492].

Maselko, J. and Buka, S. [Department of Public Health, College of Health Professions, Temple University, Philadelphia, PA; maselko@temple.edu.] "**Religious activity and lifetime prevalence of psychiatric disorder.**" *Social Psychiatry & Psychiatric Epidemiology* 43, no. 1 (Jan 2008): 18-24.

[Abstract:] BACKGROUND: There is growing evidence that current religious activity is associated with less psychological distress, yet research on clinical levels of psychopathology along with lifetime patterns of religious activity remains limited. METHOD: In this study, we used data on 718 participants from the Providence, RI, cohort of the National Collaborative Perinatal Project, to test for the association between lifetime patterns of religious service attendance frequency, subjective religiosity, and lifetime psychiatric diagnosis. RESULTS: For women, but not men, a changing pattern of service attendance (having stopped or started attending services since childhood) was associated with increased lifetime rates of generalized anxiety, and marginally increased rates of alcohol abuse/dependence (OR for generalized anxiety: 2.71, 95% CI: 1.11-6.62; OR for alcohol abuse/dependence=1.97, 95% CI: 0.92-4.20) compared to a stable pattern of continuous religious service attendance. Conversely, men who changed their frequency of religious service attendance were less likely to have ever met diagnostic criteria for major depression (OR=0.50, 95% CI: 0.31-0.83) as compared to those who had always been religiously active. The rates of psychiatric illness among those who reported never attending religious services were not statistically different from those who either had always been religiously active or those who reported changing patterns of attendance. CONCLUSION: These findings suggest that lifetime religious activity patterns are associated with psychiatric illnesses, with different patterns observed for men and women.

Matthew, D. B. [University of Colorado Law School]. "**Race, religion, and informed consent--lessons from social science.**" *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 150-173.

[Abstract:] That minority patients have not figured at all in the literature about informed consent is an egregious omission which this article begins to repair. Moreover, the article demonstrates that by addressing identifiable harms which informed consent law now causes to racial, religious, and ethnic minority patients, the law may also better address many of the concerns legal commentators have been discussing for years with only majority patients in mind. Ironically, the solution to the discrimination felt by the excluded members of society may turn out to provide the remedy for the informed consent doctrine as a whole. [This article is part of a special "symposium" on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by Kirkland, R., by LaFleur, W. R., by Lustig, A., by Sade, R. M., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]

McBrien, B. [Mater Misericordiae University Hospital, Dublin]. "**Emergency nurses should be careful not to neglect their patients' spiritual needs.**" *Emergency Nurse* 16, no. 4 (Jul 2008): 39.

This brief "Board's Eye View" piece promotes attention to patients' spiritual needs.

McCarthy, M. P. [College of Nursing, University of Akron, OH; mccarthy@uakron.edu]. "**Women's lived experience of infertility after unsuccessful medical intervention.**" *Journal of Midwifery & Women's Health* 53, no. 4 (Jul-Aug 2008): 319-324.

[Abstract:] The purpose of this qualitative descriptive study was to explore the phenomenon of women's experience with infertility in the aftermath of unsuccessful medical treatment. A purposive sample of 22 women between the ages of 33 and 48 years participated in a hermeneutic-phenomenological research process and were interviewed an average of 3.9 years after unsuccessful medical treatment. Women described the existential challenges to their sense of self, their identity, and the meaning and purpose of life. The paradoxical dimensions of loss and opportunity in their experience contributed to an altered view of themselves and their world. Infertility and its role as a life-defining experience pervaded their stories of living with infertility after unsuccessful treatment. Health care professionals are advised to assess women's overall well-being, mental health status with particular attention to spiritual well-being, and their social support network as a basis for determining supportive services that may be required in the wake of unsuccessful treatment for infertility.

McCauley, J., Tarpley, M. J., Haaz, S. and Bartlett, S. J. [Johns Hopkins School of Medicine, Baltimore, MD]. "**Daily spiritual experiences of older adults with and without arthritis and the relationship to health outcomes.**" *Arthritis & Rheumatism* 59, no. 1 (Jan 15, 2008): 122-128.

[Abstract:] OBJECTIVE: Strategies to improve coping with chronic disease are increasingly important, especially with the aging US population. For many, spirituality serves as a source of strength and comfort. However, little is known about the prevalence of daily spiritual experiences (DSE) and how they may relate to physical and mental health. METHODS: We surveyed older adults age >50 years with chronic health conditions seen in a primary care setting about their DSE, health perceptions, pain, energy, and depression. RESULTS: Of 99 patients, 80% reported DSE most days and many times per day. Women had significantly lower DSE scores than men (reflecting more frequent DSE, mean+/-SD 37.3+/-15.0 versus 45.8+/-17.5; $P=0.012$). African American women reported the most frequent DSE and white men reported the least frequent DSE (mean+/-SD 35.9+/-13.6 versus 52.2+/-19.1). Frequent DSE were significantly associated with a higher number of comorbid conditions ($P=0.003$), although not with age, education, or employment status. Persons with arthritis reported significantly more DSE than those without arthritis (mean+/-SD 35.2+/-12.1 versus 47.1+/-18.6; $P<0.001$). After adjustment for age, race, sex, pain, and comorbid conditions, more frequent DSE were associated with increased energy ($P<0.009$) and less depression ($P<0.007$) in patients with arthritis. CONCLUSION: DSE are common among older adults, especially those with arthritis. Increased DSE may be associated with more energy and less depression. DSE may represent one pathway through which spirituality influences mental health in older adults.

McClain, E. K., McClain, R. L., Desai, G. J. and Pyle, S. A. [Department of Family Medicine, Kansas City University of Medicine and Biosciences College of Osteopathic Medicine, Kansas City, MO]. “**Spirituality and medicine: prevalence of spirituality-in-medicine instruction at osteopathic medical schools.**” *Journal of the American Osteopathic Association* 108, no. 4 (Apr 2008): 197-202. [Comment: Reeves, R. R. and Beazley, A. R., “Spirituality is fundamental to osteopathic medicine.” *Journal of the American Osteopathic Association* 108, no. 8 (Aug 2008): 468-469.]

[Abstract:] CONTEXT: Since the 1990s, there has been a heightened awareness of the value of teaching medical students about how aspects of spirituality and religion may affect patient care. OBJECTIVE: To determine the prevalence of spirituality-in-medicine instruction at colleges of osteopathic medicine (COMs) in the United States. METHODS: Prescreened subjects at 20 COMs were contacted by electronic mail and asked to complete a 25-item Web-based survey. The survey instrument consisted of questions about spirituality-in-medicine instruction at their institutions. If an institution was not represented in our survey results through subject response, we reviewed that institution's Web site to locate material suggestive of an extant spirituality-in-medicine curricula (eg, prospective student information). Results: Surveys were submitted to investigators by representatives of 12 COMs for a response rate of 60%. Subjects from 8 COMs reported a structured spirituality-in-medicine curriculum currently in place at their institutions. Osteopathic medical students generally receive a total of 2 to 20 hours of instruction on spirituality and religion. Of the 10 unrepresented institutions, 4 COMs had material available on their Web sites that suggested spirituality-in-medicine topics were embedded in their curricula. Therefore, approximately 55% of all COMs have some form of spirituality-in-medicine program in place. CONCLUSION: Some form of spirituality-in-medicine instruction is available at slightly more than half the COMs in the United States. As the need for spirituality-in-medicine curricula is increasingly recognized, improved methods of documenting ongoing curricular development and student competency will be required.

McGinnis, S. L. and Zoske, F. M. [Center for Health Workforce Studies, University at Albany, Rensselaer, NY]. “**The emerging role of faith community nurses in prevention and management of chronic disease.**” *Policy, Politics, & Nursing Practice* 9, no. 3 (Aug 2008): 173-180.

[Abstract:] Faith community nursing, formerly known as parish nursing, is one model of care that relies heavily on older registered nurses (RNs) to provide population-based and other nonclinical services in community settings. Faith community nursing provides services not commonly available in the traditional health care system (e.g., community case management, community advocacy, community health education). With appropriate support, this model of nursing could be expanded into other settings within the community and has the potential to draw on the skills of experienced RNs to provide communities with services that address unmet health care needs.

McLeish, A. C. and Del Ben, K. S. [Department of Psychiatry and Human Behavior, University of Mississippi Medical Center, Jackson; amcleish@psychiatry.umsmed.edu]. “**Symptoms of depression and posttraumatic stress disorder in an outpatient population before and after Hurricane Katrina.**” *Depression & Anxiety* 25, no. 5 (2008): 416-421.

[Abstract:] The aim of the present investigation was to evaluate symptoms of depression and posttraumatic stress disorder (PTSD) in an outpatient psychiatric population before and after Hurricane Katrina. The sample consisted of 156 patients (110 females; M(age)=41.2 years, SD=10.9) at an outpatient psychiatric clinic who completed measures of psychological symptoms as part of their regular clinical care in the month before (n=76; 49%) and the 1 month after (n=80; 51%) Hurricane Katrina made landfall. Partially consistent with prediction, depression scores were significantly higher in the month following the hurricane, but PTSD scores were not significantly different. Depressive symptoms after the hurricane were predicted by watching television coverage of the looting that occurred in New Orleans and by the amount of time the participant was without electricity. Symptoms of PTSD after the hurricane were predicted by the participants' use of general television viewing as a coping strategy, the amount of time they spent watching television coverage of the looting in New Orleans, and the use of prayer as a coping behavior. Of these variables, only prayer was associated with a decrease in PTSD symptoms. Findings are discussed in relation to the need for collaborative efforts between clinically oriented and research-oriented institutions to study the impact of large-scale disasters on a variety of populations.

McLeod, D. L. and Wright, L. M. [Capital Health / QE Cancer Care Program, Halifax, Nova Scotia, Canada; deborahl.mcleod@cdha.nshealth.ca]. “**Living the as-yet unanswered: spiritual care practices in family systems nursing.**” *Journal of Family Nursing* 14, no. 1 (Feb 2008): 118-141.

[Abstract:] A serious illness often creates suffering and precipitates a search for spiritual meaning. The purpose of this hermeneutic inquiry was to explore the meaning of spirituality and spiritual care practices in family systems nursing. The videotapes of 12 therapeutic conversations with three families living with serious illness were the primary data for the inquiry. Findings suggest that suffering embodies an invitation to respond to the spiritual. Identified spiritual care practices included gathering stories of illness and faith, opening space to reinterpret experiences from a spiritual perspective, drawing on imagination and metaphor, and listening with an opening silence. The therapeutic work with one family is highlighted. This inquiry revealed that spiritual care requires literacy in reading the spiritual, a willingness to respond to the particular and the unpredictable, and a belief that good care demands a wise and thoughtful response to the suffering other.

McSherry, W., Gretton, M., Draper, P. and Watson, R. [University of Hull, UK; W.McSherry@hull.ac.uk]. “**The ethical basis of teaching spirituality and spiritual care: a survey of student nurses perceptions.**” *Nurse Education Today* 28, no. 8 (Nov 2008): 1002-1008.

[Abstract:] BACKGROUND: There is a professional requirement for student nurses to achieve competence in the delivery of spiritual care. However, there is no research exploring student nurses' perceptions of being educated in these matters. AIM: This paper explores the ethical basis of teaching student nurses about the concepts of spirituality and spiritual care by reporting the findings from the first year of a 3 year investigation. DESIGN: An exploratory longitudinal design was used to obtain student nurses perceptions of spirituality and spiritual care as they progressed through a 3 year program. METHOD: A questionnaire incorporating the Spirituality and Spiritual Care Rating Scale was distributed to 176 pre-registration nursing students undertaking either the Advanced Diploma or Bachelor of Science degree programs. RESULTS: A response rate of 76.7% was obtained. Findings reveal that the majority of student nurses perceived spirituality to be a universal phenomenon of a type that can be associated with existentialism. Some students were very uncertain and apprehensive about being instructed in spiritual matters. CONCLUSION: A cohort of student nurses held similar understandings of spirituality to those presented in the nursing literature. However the results also suggest an overwhelming majority felt it was wrong for spirituality to imply that some people are better than others and most were uncertain whether spirituality was related to good and evil. RELEVANCE TO NURSE EDUCATION: The

investigation reveals that there are a number of ethical concerns surrounding the teaching of spirituality to student nurses that need to be resolved.

Menagi, F. S., Harrell, Z. A. and June, L. N. [Department of Psychology, Michigan State University, Lansing]. **“Religiousness and college student alcohol use: examining the role of social support.”** *Journal of Religion & Health* 47, no. 2 (Jun 2008): 217-226.

[Abstract:] The purpose of this study was to examine the mediating role of social support in the relationship between religiousness and alcohol use in a sample of college students. Two dimensions of religiousness: religious commitment and religious coping were examined as predictors of alcohol use. Participants were male and female college students (N = 221); the majority of the sample was Christian (73.8%). Emotional social support was tested as a mediator. Both religiousness dimensions and emotional social support were related to less frequent alcohol use; however, mediation was not supported. These findings indicate that religious commitment and dispositional religious coping are protective against alcohol use, yet social support does not account for this relationship.

Miller, C. H. and Hedges, D. W. [Department of Psychology, Brigham Young University, Provo, UT; CHMiller1984@gmail.com]. **“Scrupulosity disorder: an overview and introductory analysis.”** *Journal of Anxiety Disorders* 22, no. 6 (Aug 2008): 1042-1058.

[Abstract:] Scrupulosity is a psychological disorder primarily characterized by pathological guilt or obsession associated with moral or religious issues that is often accompanied by compulsive moral or religious observance and is highly distressing and maladaptive. This paper provides a comprehensive overview of scrupulosity and an original conceptualization of the disorder based on an exhaustive literature review to increase awareness of the disorder among practicing clinicians and stimulate further research. It explores the clinical features of scrupulosity, classified as cognitive, behavioral, affective, and social features, as well as the epidemiology, etiology, and treatment of the disorder. Additionally, it is suggested that scrupulosity, despite its similarity to OCD, may merit a distinctive diagnosis, particularly considering its unique constellation and severity of symptoms and its treatment refractoriness, as supported by statistical analysis. [59 refs.]

Milstein, J. M. [Division of Neonatology, Department of Pediatrics, University of California, Davis;. jmmilstein@ucdavis.edu]. **“Introducing spirituality in medical care: transition from hopelessness to wholeness.”** *JAMA* 299, no. 20 (May 28, 2008): 2440-2441.

This brief *JAMA* commentary by a physician considers the clinical and research aspects of spirituality in patient care.

Mobeireek, A. F., Al-Kassimi, F., Al-Zahrani, K., Al-Shimemeri, A., al-Damegh, S., Al-Amoudi, O., Al-Eithan, S., Al-Ghamdi, B. and Gamal-Eldin, M. [Department of Medicine, King Faisal Specialist Hospital and Research Center, King Saud University, Riyadh, Saudi Arabia; mobeireek@yahoo.com]. **“Information disclosure and decision-making: the Middle East versus the Far East and the West.”** *Journal of Medical Ethics* 34, no. 4 (Apr 2008): 225-229.

[From the abstract:] OBJECTIVES: to assess physicians' and patients' views in Saudi Arabia (KSA) towards involving the patient versus the family in the process of diagnosis disclosure and decision-making, and to compare them with views from the USA and Japan. DESIGN: A self-completion questionnaire (used previously to study these issues in Japan and the USA) was translated to Arabic and validated. PARTICIPANTS: Physicians (n = 321) from different specialties and ranks and patients (n = 264) in a hospital or attending outpatient clinics from 6 different regions in KSA. RESULTS: In the case of a patient with incurable cancer, 67% of doctors and 51% of patients indicated that they would inform the patient in preference to the family of the diagnosis (p = 0.001). Assuming the family already knew, 56% of doctors and 49% of patients would tell the patient even if family objected (p NS). However, in the case of HIV infection, 59% of physicians and 81% of patients would inform the family about HIV status without the patient's consent (p = 0.001). With regards to withholding ventilatory support, about 50% of doctors and over 60% of patients supported the use of mechanical ventilation in a patient with advanced cancer, regardless of the wishes of the patient or the family. Finally, the majority of doctors and patients (>85%) were against assisted suicide. CONCLUSIONS: Although there was more recognition for a patient's autonomy amongst physicians, most patients preferred a family centred model of care. Views towards information disclosure were midway between those of the USA and Japan. Distinctively, however, decisions regarding life prolonging therapy and assisted suicide were not influenced to a great extent by wishes of the patient or family, but more likely by religious beliefs.

Mohrmann, M. E. [University of Virginia]. **“Ethical grounding for a profession of hospital chaplaincy.”** *Hastings Center Report* 38, no. 6 (Nov-Dec 2008): 18-23.

This is one of five special essays in a set under the heading of, “Can We Measure Good Chaplaincy? A New Professional Identity Is Tied to Quality Improvement” and available also as a separate publication. The essays “examine the ‘professionalizing’ profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery” [--from the introductory statement by Gregory E. Kaebnick (no page number, in the separately available publication of the essays)]. Other essays in this set are by Berlinger, N., by de Vries, R., by Jacobs, M. R., and by Smith, M. L. (--noted elsewhere in this bibliography).

Molock, S. D., Matlin, S., Barksdale, C., Puri, R. and Lyles, J. [George Washington University, Washington, DC; smolock@gwu.edu]. **“Developing suicide prevention programs for African American youth in African American churches.”** *Suicide & Life-Threatening Behavior* 38, no. 3 (Jun 2008): 323-333.

[Abstract:] Suicide prevention programs for African American youth in African American churches may have broad appeal because: (1) the Black Church has a strong history of helping community members, regardless of church membership; (2) African Americans have the highest level of public and private religiousness; and (3) the church can help shape religious and cultural norms about mental health and help-seeking. The proposed gatekeeper model trains lay helpers and clergy to recognize the risk and protective factors for depression and suicide, to make referrals to the appropriate community mental health resources, and to deliver a community education curriculum. Potential barriers and suggestions for how to overcome these barriers are discussed.

Molzahn, A. E. and Shields, L. [School of Nursing, University of Victoria, British Columbia]. **“Why is it so hard to talk about spirituality?”** *Canadian Nurse* 104, no. 1 (Jan 2008): 25-29. Comment in vol. 104, no. 4, p. 4.

[Abstract:] Although there is recognition of the importance of spirituality in the nursing literature and in nursing theory, many nurses find it difficult to talk about this sensitive area with people for whom they provide care. In this article, the authors discuss why spirituality is integral

to nursing care and explore why nurses don't talk about spiritual concerns with their clients. The authors examine the meaning of spirituality and the factors that contribute to the reluctance of nurses to discuss spirituality with others: not having the right words, lack of education, a view that spiritual care is someone else's responsibility, influences of secularism and diversity in society, and the current health-care context. Openness to learning about the spiritual beliefs of individuals and attending to their nursing needs in a holistic way will enhance nursing care. [28 refs.]

Moreira-Almeida, A. and Koenig, H. G. [Federal University of Juiz de Fora School of Medicine, Brazil; alex.ma@ufjf.edu.br]. **"Religiousness and spirituality in fibromyalgia and chronic pain patients."** *Current Pain & Headache Reports* 12, no. 5 (Oct 2008): 327-332.

[Abstract:] The influence of psychosocial factors on pain experience and patient response has received increasing interest and recognition. Patients with chronic pain from several sources (eg, musculoskeletal, cancer, or sickle cell) usually report that religiousness and spirituality are important in their lives. Prayer is the most used complementary therapy; religious coping is among the most common strategies used to deal with pain. Religious variables are not usually associated with pain measures, except in some studies indicating that petitionary prayer is related to higher pain levels, possibly suggesting a turning to religion due to increasing pain. The best available evidence supports a positive association between religiousness and spirituality, with higher well-being and positive affect, and a negative association with depressive and anxiety symptoms. We discuss the importance of addressing spiritual issues in clinical practice, and increasing and improving research on religiousness/spirituality in chronic pain patients.

Moremen, R. D. [Department of Sociology, Northern Illinois University, DeKalb; rmoremen@niu.edu]. **"Best friends: the role of confidantes in older women's health."** *Journal of Women & Aging* 20, nos. 1-2 (2008): 149-167.

This study of 26 older women in San Francisco found a "lack of connection on spiritual matters" with their "best friends": "...many of the women saw no need to involve their confidantes in such issues or they eschewed religiosity altogether. They would take care of spiritual matters themselves or they would call upon family members or priests if necessary. Nevertheless, a small group of women (n = 6) found spiritual solace in their relationships with their best friends." [p. 158] "Confidantes kept older women healthy by offering advice and encouragement about diet and exercise; by providing meals and transportation; by laughing, talking, and joking with them; by keeping them happy and feeling good about themselves; and, on rare occasions, by offering spiritual guidance. Practical and policy considerations of their choices were discussed." [p. 149, abstract]

Morgan, P. D., Tyler, I. D. and Fogel, J. [Fayetteville State University, Fayetteville, NC; pmorgan@uncfsu.edu]. **"Fatalism revisited."** *Seminars in Oncology Nursing* 24, no. 4 (Nov 2008): 237-245.

[Abstract:] OBJECTIVES: To review the concept of fatalism among African Americans by discussing how religiosity/spirituality may guide them in seeking cancer care in a positive rather than a fatalistic way. DATA SOURCES: Nursing, social science, and medical journals. CONCLUSION: Using culturally targeted faith-based interventions to educate African Americans about cancer can serve as a strategy to increase cancer knowledge, decrease cancer fatalism, and ultimately increase cancer screening and treatment resulting in cancer activism. IMPLICATIONS FOR NURSING PRACTICE: Nurses should advocate for faith-based initiatives to help address fatalism in the African American community, and to assist them in developing a more proactive role in cancer screening, treatment, and survivorship.

Morgan, S. E., Harrison, T. R., Afifi, W. A., Long, S. D. and Stephenson, M. T. [Department of Communication, Purdue University, West Lafayette, IN; semorgan@purdue.edu]. **"In their own words: the reasons why people will (not) sign an organ donor card."** *Health Communication* 23, no. 1 (Jan-Feb 2008): 23-33.

The authors of this multisite, qualitative study of 78 family-pair dyads note: "One of the most surprising findings is that religion is offered far more often as a rationale for wanting to help sick people through organ donation than it was for not wanting to donate organs." [p. 23, abstract]

Muller, E., Schuler, A. and Yates, G. B. [National Association of State Directors of Special Education, Alexandria, VA; eve.muller@nasdse.org]. **"Social challenges and supports from the perspective of individuals with Asperger syndrome and other autism spectrum disabilities."** *Autism* 12, no. 2 (Mar 2008): 173-190.

In light of this qualitative study of 18 individuals with Asperger syndrome and other autism spectrum disabilities (ASDs), the authors identify a number of recommended social supports [from the abstract]: external supports (e.g. activities based on shared interests, highly structured or scripted social activities, and small groups or dyads); communication supports (e.g. alternative modes of communication, explicit communication, and instruction in interpreting and using social cues); and self-initiated strategies for handling social anxiety (e.g. creative/improvisational outlets, physical activity, spiritual practice/organized religion, and time spent alone).

Mystakidou, K., Tsilika, E., Parpa, E., Hatzipli, I., Smyrnioti, M., Galanos, A. and Vlahos, L. [Pain Relief and Palliative Care Unit, Department of Radiology, Areteion Hospital, School of Medicine, University of Athens, Greece; mistakidou@yahoo.com]. **"Demographic and clinical predictors of spirituality in advanced cancer patients: a randomized control study."** *Journal of Clinical Nursing* 17, no. 13 (Jul 2008): 1779-1785.

[Abstract:] AIM: To study the influence of cancer patients' sociodemographic and clinical characteristics in their spiritual beliefs and attitudes. BACKGROUND: Patients' sociodemographic and clinical characteristics may have an important role in their spirituality. Failure to control these factors can lead to a false estimation on patients' spiritual beliefs. Previous studies have found that age, gender and health status associate with spiritual attitudes and beliefs. Design. Survey. METHODS: The Spiritual Involvement and Beliefs Scale was administered to 82 cancer patients. Demographic characteristics, disease status and treatment regimen were recorded. RESULTS: Among the most significant correlations were those between gender and all the subscales, cancer diagnosis, existential/meditative subscale, radiotherapy treatment and external/ritual, internal/fluid and existential meditative. In the prediction of spirituality, the contribution of gender, age, years of education, performance status and radiotherapy is high. CONCLUSION: Acknowledging the specific patients' demographic and medical characteristics, such as female gender, old age, years of education, performance status and radiotherapy treatment, contributes to the prediction of patients' spiritual beliefs and attitudes. RELEVANCE TO CLINICAL PRACTICE: Addressing spiritual needs in palliative care among the dying needs to be a priority and could be a crucial aspect of psychological functioning, especially when considering certain demographic and clinical characteristics.

- Nagai, C. [Department of Social Work, California State University, Long Beach; cnagai@csulb.edu]. “**Clinicians’ self-assessment of cultural and spiritual competency: working with Asians and Asian Americans.**” *Community Mental Health Journal* 44, no. 4 (Aug 2008): 303-309.
 [Abstract:] This study examines clinicians' own assessment of their cultural and spiritual competency in working with Asians and Asian Americans. Thirty clinicians, who are Asian Ethnic Minority Mental Health Specialists in the Northwest region of the United States, were surveyed to assess their perceived levels of cultural and spiritual competency. The study found that clinicians perceived themselves as being less spiritually competent than culturally competent and that most clinicians acknowledged the need for more training in spirituality.
- Narayanasamy, A. and Narayanasamy, M. [Faculty of Medicine and Health Sciences, School of Nursing, Queen’s Medical Centre, Nottingham, UK]. “**The healing power of prayer and its implications for nursing.**” *British Journal of Nursing* 17, no. 6 (Mar 27-Apr 9, 2008): 394-398.
 [Abstract:] Prayer is widely acknowledged in both ancient and modern times as an intervention for alleviating illnesses and promoting good health. There is increasing attention on prayer in health care, in both popular and serious discourse. Advocates exalt the healing power of prayer in health care, while critics are sceptical about this claim and its healing potential is put down to coincidences or its placebo effect. Consequently, a variety of empirical studies have attempted to test its effect scientifically with no conclusive results. There is evidence to suggest that some patients and healthcare practitioners believe in the healing power of prayer. Nurses may be called upon to pray with or for patients as part of holistic care. This article sets out to explore the role of prayer in healing and its implications for nursing. To achieve this aim, this article provides a review of discourses and evidence on the power of prayer in healing. Its implications for nursing are highlighted with some suggestions on how to respond to patients’ spiritual needs. It is concluded that, although the evidence on the healing power of spirituality is inconclusive, there are indications that it has potential for the health and wellbeing of both patients and nurses. [35 refs.]
- Nath, S. B., Hirschman, K. B., Lewis, B. and Strumpf, N. E. [Graduate School of Social Work and Social Research, Bryn Mawr College, Bryn Mawr, PA; snath@brynmawr.edu]. “**A place called LIFE: exploring the advance care planning of African-American PACE enrollees.**” *Social Work in Health Care* 47, no. 3 (2008): 277-292.
 Among the findings of this study of 18 African-American enrollees in a PACE (Program of All-Inclusive Care for the Elderly) program [from the abstract:] Review of verbalized and documented preferences for end-of-life care among participants indicated that most preferred life-sustaining treatments. ...Content analysis of interviews indicated that end-of-life decision making was influenced by the desire to maintain usual activities of daily living; to avoid burdening caregivers; and to remain in control of personal health care. Furthermore, these African-American elders relied on faith in God as central to medical decision making, believing ultimately that God controls the end of life....
- Neely, D. and Minford, E. J. [Department of Medicine, Queen’s University, Belfast, UK]. “**Current status of teaching on spirituality in UK medical schools.**” 42, no. 2 (Feb 2008): 176-182. Comment on pp. 123-125.
 [Abstract:] OBJECTIVE: To investigate the current status of teaching on spirituality in medicine in UK medical schools and to establish if and how medical schools are preparing future doctors to identify patients’ spiritual needs. METHODS: We carried out a national questionnaire survey using a 2-part questionnaire. Section A contained questions relating to the quantity of teaching on spirituality and the topics covered. Section B contained questions relating to teaching on alternative health practices. Medical educators from each of the 32 medical schools in the UK were invited to participate. RESULTS: A response rate of 53% (n = 17) was achieved. A total of 59% (n = 10) of respondents stated that there is teaching on spirituality in medicine in their curricula. On extrapolation, at least 31% and a maximum of 78% of UK medical schools currently provide some form of teaching on spirituality. Of the respondents that teach spirituality, 50% (n = 5) stated that their schools include compulsory teaching on spirituality in medicine, 80% (n = 8) include optional components, and 88% stated that teaching on complementary and alternative medicine is included in the curriculum. CONCLUSIONS: Although 59% (n = 10) of respondent medical schools (the actual UK figure lies between 31% and 78%) currently provide some form of teaching on spirituality, there is significant room for improvement. There is little uniformity between medical schools with regard to content, form, amount or type of staff member delivering the teaching. It would be beneficial to introduce a standardized curriculum on spirituality across all UK medical schools. [22 refs.]
- Newberry, A. M. and Pachet, A. K. [Regional Capacity Assessment Team, Calgary Health Region, Calgary, Alberta, Canada; anewberry@aventa.org]. “**An innovative framework for psychosocial assessment in complex mental capacity evaluations.**” *Psychology Health & Medicine* 13, no. 4 (Aug 2008): 438-449.
 [Abstract:] This study describes an innovative tool developed by the Regional Capacity Assessment Team (RCAT) to assess unique psychosocial factors related to capacity evaluations. Capacity is a socio-legal construct entailing the ability to understand choices, appreciate consequences and follow through (or direct a surrogate) with chosen options. RCAT's targeted psychosocial assessment includes medico-legal factors, social history and supports, coping skills, religious/cultural factors and risk of abuse. RCAT completes the psychosocial assessment to determine whether a full capacity assessment is required (referral disposition) and to determine the impact of an adult's social functioning on their decision-making capacity (capacity determination). RCAT's psychosocial assessment protocol was developed after a comprehensive literature review of capacity assessment and incorporates recommended practices in geriatric social work and psychology. This study will synthesize the pertinent literature, discuss cultural interviewing processes significant to capacity, caregiver assessment and describe the tool itself. Suggestions for future research and appropriate implementation of this tool are provided.
- Newlin, K., Melkus, G. D., Tappen, R., Chyun, D. and Koenig, H. G. [College of Nursing, Florida Atlantic University, Boca Raton, FL; knewlin@fau.edu]. “**Relationships of religion and spirituality to glycemic control in Black women with type 2 diabetes.**” *Nursing Research* 57, no. 5 (Sep-Oct 2008): 331-339.
 [Abstract:] BACKGROUND: Although religion and spirituality are prominent in the lives of Black women with type 2 diabetes (T2DM), there is little research on the relationships of religion and spirituality to glycemic control (GC) in this population. OBJECTIVE: To examine the relations of religion and spirituality to GC. METHODS: Using a cross-sectional, descriptive, correlational design, a convenience sample of 109 Black women with T2DM was recruited. Measures of demographic (age, income, and education), clinical (body mass index and use of diabetes medications), psychosocial (emotional distress and social support), religion and spirituality (religious and existential well-being), and GC (hemoglobin A1c) factors were collected. A theoretical model, based on the work of Koenig, McCullough, and Larson (2001), informed linear regression analyses to examine the relations of religion and spirituality to GC, with psychosocial factors as putative mediators. RESULTS: With age (beta = -.133, SE = .020, p = .145), income (beta = .020, SE = .139, p = .853), education (beta = -.221, SE = .204, p = .040), body

mass index (beta = -.237, SE = .031, p = .011), and diabetes medications (beta = .338, SE = .216, p < .001) held constant, religion and spirituality demonstrated significant relations with GC (beta = .289, SE = .032, p = .028 and beta = -.358, SE = .030, p = .006, respectively). Evidence of emotional distress and social support as mediators in the relationships of religion and spirituality to GC was lacking. DISCUSSION: Religion and spirituality were related to GC, with evidence of psychosocial mediation lacking, thereby forcing revision of the model for the study population. Research is warranted to validate the findings, with further examination of theoretical mediators linking religion and spirituality to GC. Findings suggest that religion and spirituality be addressed in diabetes care to improve GC in Black women with T2DM.

Norton, M. C., Singh, A., Skoog, I., Corcoran, C., Tschanz, J. T., Zandi, P. P., Breitner, J. C., Welsh-Bohmer, K. A., Steffens, D. C., Cache County Investigators [Utah State University, Logan; maria.norton@usu.edu]. **“Church attendance and new episodes of major depression in a community study of older adults: the Cache County Study.”** *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 63, no. 3 (May 2008): P129-137.

[Abstract:] We examined the relation between church attendance, membership in the Church of Jesus Christ of Latter-Day Saints (LDS), and major depressive episode, in a population-based study of aging and dementia in Cache County, Utah. Participants included 2,989 nondemented individuals aged between 65 and 100 years who were interviewed initially in 1995 to 1996 and again in 1998 to 1999. LDS church members reported twice the rate of major depression that non-LDS members did (odds ratio = 2.56, 95% confidence interval = 1.07-6.08). Individuals attending church weekly or more often had a significantly lower risk for major depression. After controlling for demographic and health variables and the strongest predictor of future episodes of depression, a prior depression history, we found that church attendance more often than weekly remained a significant protectant (odds ratio = 0.51, 95% confidence interval = 0.28-0.92). Results suggest that there may be a threshold of church attendance that is necessary for a person to garner long-term protection from depression. We discuss sociological factors relevant to LDS culture.

O'Mahen, H. A. and Flynn, H. A. **“Preferences and perceived barriers to treatment for depression during the perinatal period.”** *Journal of Women's Health* 17, no. 8 (Oct 2008): 1301-1309.

Among the findings of this study of 447 women recruited from ob-gyn clinics in the Midwest United States [from the abstract:] Women expressed greatest confidence in treatments delivered by mental health professionals and religious leaders. African American women sought help more frequently and had significantly more confidence in religious leaders as treatment deliverers than white women. Women had greatest confidence in treatments delivered in professional and home settings, with African American women expressing greater confidence in religious settings than white women.

Oman, D., Richards, T. A., Hedberg, J. and Thoresen, C. E. [University of California, Berkeley; DougOman@post.Harvard.edu]. **“Passage meditation improves caregiving self-efficacy among health professionals: a randomized trial and qualitative assessment.”** *Journal of Health Psychology* 13, no. 8 (Nov 2008): 1119-1135.

[Abstract:] Relational caregiving skills remain seldom studied in health professionals. We evaluated effects on health professional relational caregiving self-efficacy from an eight-week, 16-hour training in self-management tools. Physicians, nurses, chaplains, and other health professionals were randomized after pretest to treatment (n = 30) or waiting list (n = 31). Training used a previously researched program of Easwaran (1991/1978) derived from spiritual wisdom traditions. Changes were measured using a 34-item caregiving self-efficacy scale. Positive effects were observed at posttest, eight- and 19-week follow-up (ds = .38, .47, .37, all ps < .05), and were mediated by adherence to practices and stress reductions (p < .05), findings also obtained in qualitative interviews (n = 24). Evidence suggests this program enhances health professional caregiving self-efficacy, and may merit inclusion in training curricula.

Padela, A. I., Shanawani, H., Greenlaw, J., Hamid, H., Aktas, M. and Chin, N. [University of Rochester Medical Center, Department of Emergency Medicine, NY; aasimpadela@yahoo.com]. **“The perceived role of Islam in immigrant Muslim medical practice within the USA: an exploratory qualitative study.”** *Journal of Medical Ethics* 34, no. 5 (May 2008): 365-369.

[Abstract:] BACKGROUND: Islam and Muslims are underrepresented in the medical literature and the influence of physician's cultural beliefs and religious values upon the clinical encounter has been understudied. OBJECTIVE: To elicit the perceived influence of Islam upon the practice patterns of immigrant Muslim physicians in the USA. DESIGN: Ten face-to-face, in-depth, semistructured interviews with Muslim physicians from various backgrounds and specialties trained outside the USA and practicing within the country. Data were analyzed according to the conventions of qualitative research using a modified grounded-theory approach. RESULTS: There were a variety of views on the role of Islam in medical practice. Several themes emerged from our interviews: (1) a trend to view Islam as enhancing virtuous professional behavior; (2) the perception of Islam as influencing the scope of medical practice through setting boundaries on career choices, defining acceptable medical procedures and shaping social interactions with physician peers; (3) a perceived need for Islamic religious experts within Islamic medical ethical deliberation. Limitations: This is a pilot study intended to yield themes and hypotheses for further investigation and is not meant to fully characterize Muslim physicians at large. CONCLUSIONS: Immigrant Muslim physicians practicing within the USA perceive Islam to play a variable role within their clinical practice, from influencing interpersonal relations and character development to affecting specialty choice and procedures performed. Areas of ethical challenges identified include catering to populations with lifestyles at odds with Islamic teachings, end-of-life care and maintaining a faith identity within the culture of medicine. Further study of the interplay between Islam and Muslim medical practice and the manner and degree to which Islamic values and law inform ethical decision-making is needed.

Pakenham, K. I. [School of Psychology, University of Queensland, Brisbane, Australia; kenp@psy.uq.edu.au]. **“Making sense of caregiving for persons with multiple sclerosis (MS): the dimensional structure of sense making and relations with positive and negative adjustment.”** *International Journal of Behavioral Medicine* 15, no. 3 (2008): 241-252.

[Abstract:] BACKGROUND: Sense making is a meaning-making process that refers to the development of explanations for adversity. Despite a growing interest in this construct within the chronic illness literature, it has been neglected in research on carers. PURPOSE: This study examines the dimensional structure of a multi-item measure of sense making in carers of people with multiple sclerosis (MS) and investigates relations between sense making and both positive and negative adjustment outcomes. METHOD: Participants were 232 carers and their care recipients. Questionnaires were completed at first assessment (time 1) and 12 months later (time 2). RESULTS: Factor analysis of the Carer Sense Making Scale (CSMS) revealed six psychometrically sound factors: catalyst for change, acceptance, spiritual perspective, incomprehensible, relationship ties, and causal attribution. Results of regression analyses indicated that the time 2 CSMS factors accounted for

significant amounts of variance in each of the time 2 adjustment outcomes (life satisfaction, positive affect, anxiety, depression, care recipient adjustment ratings of carer) after controlling for time 1 adjustment and relevant demographic and illness variables. CONCLUSION: Findings delineate the dimensional structure of sense making in caregiving and the differential links between sense-making dimensions and adjustment, and have implications for the measurement of sense making.

Pakenham, K. I. [University of Queensland, Australia; kenp@psy.uq.edu.au]. **“Making sense of illness or disability: the nature of sense making in multiple sclerosis (MS).”** *Journal of Health Psychology* 13, no. 1 (Jan 2008): 93-105.

[Abstract:] This study investigated sense making in multiple sclerosis (MS) and relations with illness, religious-spiritual beliefs and adjustment (life satisfaction, positive states of mind, depression, anxiety). Four hundred and eight persons with MS completed a questionnaire. Half the sample generated sense making explanations for their illness. Content analyses revealed 16 sense making themes. Participants who reported having a religious-spiritual belief were more likely to report sense making than those who did not have such a belief. Sense making was related to lower disability and disease severity and evidenced beneficial direct effects on positive adjustment outcomes and depression after controlling for illness and religious-spiritual belief. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/jan08.html].

Pakenham, K. I. [School of Psychology, University of Queensland, Australia; k.pakenham@psy.uq.edu.au]. **“The nature of sense making in caregiving for persons with multiple sclerosis.”** *Disability & Rehabilitation* 30, no. 17 (2008): 1263-1273.

[Abstract:] OBJECTIVE: Sense making refers to the development of explanations for adversity. This study investigated the nature of sense making in multiple sclerosis (MS) carers and relations between it and care recipient illness, caregiving context, carer religious-spiritual beliefs and carer and care recipient adjustment. SUBJECTS: A total of 232 MS carers and their care recipients completed questionnaires. METHOD: A questionnaire survey methodology was used to collect qualitative and quantitative data. Variables included: Demographics, caregiving context (caregiving duration, co-residency, carer-care recipient relationship, outside employment), care recipient illness (activities of daily living, number of symptoms, illness duration, course), sense making (anticipated sense making, number of sense making categories), carer and care recipient adjustment (positive states of mind, life satisfaction, anxiety, depression). RESULTS: Half the carers generated sense making explanations for their caregiving situation and 12 sense making themes emerged from this qualitative data. Over a third of those carers who could not make sense of their situation were able to anticipate comprehending it and the strength of this anticipation was related to greater life satisfaction. Carer sense making was related to having a religious-spiritual belief, fewer care recipient symptoms, marital status and it predicted life satisfaction after controlling for relevant covariates. Carer and care recipient sense making was positively correlated, and the sense making of one partner was positively related to life satisfaction of the other partner. CONCLUSIONS: Findings chart the nature of sense making in MS caregiving and support the notion of collective sense making within dyads and the proposed beneficial links between sense making and adjustment.

Pakenham, K. I. and Cox, S. [School of Psychology, University of Queensland, Australia; k.pakenham@psy.uq.edu.au]. **“Development of the benefit finding in multiple sclerosis (MS) caregiving scale: a longitudinal study of relations between benefit finding and adjustment.”** *British Journal of Health Psychology* 13, pt. 4 (Nov 2008): 583-602.

[Abstract:] Benefit finding (BF) is a meaning-making construct that has been shown to predict carer and care recipient adjustment. PURPOSE: This longitudinal study investigated the dimensions, stability, and validity of the benefit finding in multiple sclerosis caregiving (BFiMSCare) scale. METHODS: Participants were 232 carers of persons with MS and their care recipients. Questionnaires were completed at Time 1 and 12 months later (Time 2). RESULTS: Factor analysis of the BFiMSCare scale revealed six psychometrically sound factors: enriched relationship; spiritual growth; family relations growth; life-style gains; inspiration; and relationship opportunities. Results of regression analyses indicated that the Time 1 BFiMSCare factors and the total score accounted for significant amounts of variance in each of the Time 1 positive adjustment outcomes (life satisfaction, positive affect, dyadic adjustment) and in Time 2 positive affect and dyadic adjustment. The BFiMSCare total score predicted all Time 2 adjustment domains (positive affect, dyadic adjustment, care recipient adjustment ratings of carer) except life satisfaction and distress, whereas the six factors as a block predicted positive affect and life satisfaction. CONCLUSIONS: Findings delineate the dimensional structure of BF in caregiving and the differential links between BF dimensions and adjustment, and have implications for the measurement of BF.

Paley, J. [Department of Nursing and Midwifery, University of Stirling, Stirling, UK; j.h.paley@stir.ac.uk]. **“Spirituality and nursing: a reductionist approach.”** *Nursing Philosophy* 9, no. 1 (Jan 2008): 3-18. Comment in vol. 9, no. 2, pp. 139-140.

[Abstract:] The vast majority of contributions to the literature on spirituality in nursing make extravagant claims about transcendence, eternity, the numinous, higher powers, higher levels of existence, invisible forces, cosmic unity, the essence of humanity, or other supernatural concepts. Typically, these assertions are made without the support of argument or evidence; and, as a consequence, alternative ways of theorizing ‘spirituality’ have been closed off, while the lack of consistent scholarship has turned the topic into a metaphysical backwater. In this paper, I adopt a different premise, rejecting unsupported claims, and surveying the ‘spirituality’ terrain from a naturalistic and reductionist perspective. I argue that, if we rid ourselves of non-naturalistic assumptions, we will discover theoretical and clinical resources in health psychology, social psychology, neuropsychology, and pharmacopsychology - resources which confirm that it is possible to conceptualize the study of existential concerns, and how health professionals might respond to them, in a properly scientific manner. In order to illustrate the potential usefulness of these resources, I will take palliative care as an example.

Paley, J. [Department of Nursing and Midwifery, University of Stirling, Stirling FK9 4LA, UK; j.h.paley@stir.ac.uk]. **“Spirituality and secularization: nursing and the sociology of religion.”** *Journal of Clinical Nursing* 17, no. 2 (Jan 2008): 175-186.

[Abstract:] AIM: The concept of spirituality is much discussed in the UK nursing literature, despite the fact that Britain is one of the most secular countries in the world, and steadily becoming more so. Here, I pose the following question: given this increasing secularization, what accounts for the current interest in spirituality among UK nurses? BACKGROUND: The literature on spirituality in nursing has blossomed in the last 10 years, and various attempts have been made to define ‘spirituality’, ‘spiritual need’ and ‘spiritual care’. Most definitions distinguish between ‘spirituality’ and ‘religion’, acknowledging that the latter is more institutional, and theologically more restrictive, than the former; and they suggest that spirituality is universal, something which (unlike religion) all human beings share. METHOD: I draw on the sociology of religion - neglected, for the most part, in the nursing literature - to establish two main points. Firstly, that the UK and the USA are at opposite ends of the religion/secularity spectrum, implying that it is a mistake to assimilate USA and UK sources. Secondly, that the concept of spirituality, as currently understood, is of very recent origin, and is still ‘under construction’, having become separated from its associations

with Christian piety and mysticism only since the 1980s. CONCLUSIONS: The extension of spirituality into secular domains is part of a professionalization project in nursing, a claim to jurisdiction over a newly invented sphere of work. For the time being, it remains an academic project (in the UK) as it is not one with which many clinicians identify. Relevance to clinical practice. What counts as 'spiritual need' or 'spiritual care' may not be the same in both countries, and UK clinicians are unlikely to welcome the role of surrogate chaplain, which their USA colleagues are apparently willing to embrace. [109 refs.]

Pargament, K. I. [Department of Psychology, Bowling Green State University, Bowling Green, OH; kpargam@bgnnet.bgsu.edu]. "**The sacred character of community life.**" *American Journal of Community Psychology* 41, nos. 1-2 (Mar 2008): 22-34.

[Abstract:] Theory and research suggest that there is a basic and irreducible human yearning for a relationship with something that transcends ourselves, something sacred. The sacred can be understood not only in individual terms, but also in terms of relationships, settings, and communities. Empirical studies indicate that the sacred has powerful implications for human behavior; it can be an organizing force and a resource to people in their most difficult times, yet it can also be a source of seemingly intractable problems. This paper reviews several of the promising steps psychologists have taken to learn about the sacred, learn from spiritual communities, and collaborate with these communities in efforts to better the world. Research and practice in this area is enriching our understanding of the meaning of community and the meaning of spirituality.

Park, C. L. [Department of Psychology, University of Connecticut, Storrs; crystal.park@uconn.edu]. "**Estimated longevity and changes in spirituality in the context of advanced congestive heart failure.**" *Palliative & Supportive Care* 6, no. 1 (Mar 2008): 3-11.

[Abstract:] OBJECTIVE: To examine (1) advanced congestive heart failure (CHF) patients' estimates of their longevity and changes in these estimates over time; (2) clinical, functional, and psychological adjustment correlates of these longevity estimates; and (3) correspondence of changes in longevity and changes in multiple dimensions of spirituality over time. METHODS: Longitudinal questionnaire-based study of 111 patients diagnosed with severe CHF assessed at two time points separated by 6 months. RESULTS: Nearly half of the participants estimated their longevity as at least 5-10 years, and there was very little change in estimates across the assessment periods. Longevity estimates were minimally related to clinical or functional indicators, but longer estimates were related to fewer depressive symptoms and higher levels of life satisfaction. Multivariate regression analyses indicated that shifting longevity estimates toward less time or toward uncertainty was related to increases in religious life meaning and forgiveness and to decreased spiritual struggle over the 6-month interval. No effects were observed for daily spiritual experiences. SIGNIFICANCE OF RESULTS: Because very little is known about how individuals estimate their remaining life span, these results establish information regarding their basis (i.e., not clinical or functional) and stability, at least in the context of advanced heart failure. In addition, the notion that individuals become more spiritual as they perceive the approach of death was borne out in terms of multiple aspects of spirituality.

Park, C. L., Malone, M. R., Suresh, D. P., Bliss, D. and Rosen, R. I. [Department of Psychology, University of Connecticut, Storrs; Crystal.park@uconn.edu]. "**Coping, meaning in life, and quality of life in congestive heart failure patients.**" *Quality of Life Research* 17, no. 1 (Feb 2008): 21-26.

[Abstract:] OBJECTIVE: The present study examined (1) whether particular coping strategies used to deal with congestive heart failure (CHF) are related to meaning in life across time, and (2) whether meaning in life mediates the effect of coping on health-related quality of life. METHODS: A sample of 155 CHF patients received questionnaire packets at two time points, 6 months apart. Main outcome measures included Meaning in Life and Mental and Physical Health-Related Quality of Life (HRQOL). RESULTS: Coping (particularly acceptance/positive reinterpretation and religious coping) was not only related to meaning in life, but also to increased meaning over time. Further, meaning in life was related to both mental and physical components of HRQOL. However, coping was minimally related to HRQOL and its effects were not mediated by meaning in life. CONCLUSIONS: These results add to accumulating evidence that life meaning is important in the context of living with a chronic, life-threatening illness. Further, coping--especially acceptance and religious coping--is related to increased life meaning over time in the context of life limiting illness.

Pattison, N. [Royal Marsden Hospital, London; natalie.pattison@rmh.nhs.uk]. "**Care of patients who have died.**" *Nursing Standard* 22, no. 28 (Mar 19-25, 2008): 42-48.

Among the considerations of this article are a number of points about religious concerns for Buddhists, Catholic/Anglican/"Free Church" Christians, Mormons, Christian Scientists, Jehovah's Witnesses, Hindus, Muslims, Jews, and Sikhs.

Payman, V., George, K. and Ryburn, B. [Peter James Centre and Department of Psychological Medicine, Monash University, Melbourne, Australia; vahid.payman@peterjames.org.au]. "**Religiosity of depressed elderly inpatients.**" *International Journal of Geriatric Psychiatry* 23, no. 1 (Jan 2008): 16-21.

This study of 86 patients concludes that [from the abstract:] Depressed elderly Australian inpatients are less religious than their North American counterparts. Nevertheless, religion remains important for a large minority of such individuals. Clinicians need to be aware that such individuals may turn to religion when depressed, especially to cope with the presence of physical disability.

Pearce, M. J., Rivinoja, C. M. and Koenig, H. G. [Duke University Medical Center, Durham, NC; michelle.pearce@duke.edu]. "**Spirituality and health: empirically based reflections on recovery.**" *Recent Developments in Alcoholism* 18 (2008): 187-208.

[From the abstract:] ...[W]e explore the spiritual functioning and well-being of individuals and how this relates to mental health and recovery from alcoholism within the conceptual framework of Alcoholics Anonymous. We raise the question of whether the spiritually oriented focus of AA is a critical factor in achieving recovery. We suggest that examining the findings from a large body of research on religion and mental health may provide further insight into this question. Specifically, we assert that the mechanisms through which the spiritual focus of AA may influence recovery from alcoholism may be similar to the mechanisms through which spirituality may influence mental health. These potential explanatory mechanisms include the provision of a community, a narrative framework for meaning-making, a means of coping through submission and redemption, and prescribed lifestyle behaviors. [68 refs.] [This article is part of an issue highlighting spiritual issues. See also the article by Galanter, noted elsewhere in this bibliography. Other articles in the issue are: Hsu, S. H., et al., "Mindfulness and addiction"; Connors, G. J., et al., "Spiritual change in recovery"; Johnson, T., et al., "Issues in measuring spirituality and religiousness in alcohol research"; and Zemore, S. E., "An overview of spirituality in AA (and recovery)."]

- Pearcy, R., Waldron, D., O'Boyle, C. and MacDonagh, R. [Department of Urology, Bristol Royal Infirmary, Bristol, UK; rmpearcy@hotmail.com]. **"Proxy assessment of quality of life in patients with prostate cancer: how accurate are partners and urologists?"** *Journal of the Royal Society of Medicine* 101, no. 3 (Mar 2008): 133-138.
 Among the findings of this study of 47 patients was [from the abstract:] ...The results showed that partners were able to select similar QoL cues to those of the patients.... Comparison of the QoL scores obtained from patients and partners in proxy using the questionnaires showed no statistically significant difference (paired t-test). Urologists were poor predictors of areas of life (cues) that were important to their patients. The doctors overemphasized the importance of survival, postoperative complications, urinary symptoms, sexual ability, activities of daily living and finance, but underestimated the importance of wife, family, home and religion....
- Pembroke, N. F. [University of Queensland, Brisbane, Australia; n.pembroke@uq.edu.au]. **"Appropriate spiritual care by physicians: a theological perspective."** *Journal of Religion & Health* 47, no. 4 (Dec 2008): 549-559.
 [Abstract:] It is argued that when spiritual care by physicians is linked to the empirical research indicating the salutary effect on health of religious beliefs and practices an unintended degradation of religion is involved. It is contended that it is much more desirable to see support for the patient's spirituality as part of holistic care. A proposal for appropriate spiritual care by physicians is offered.
- Pence, B. W., Thielman, N. M., Whetten, K., Ostermann, J., Kumar, V. and Mugavero, M. J. [Health Inequalities Program, Center for Health Policy, Duke University, Durham, NC; bpence@aya.yale.edu]. **"Coping strategies and patterns of alcohol and drug use among HIV-infected patients in the United States Southeast."** *AIDS Patient Care & STDs* 22, no. 11 (Nov 2008): 869-877.
 Among the findings of this study of 611 HIV-infected patients, part of the Coping with HIV/AIDS in the Southeast (CHASE) Study, was: [from the abstract:] Stronger adaptive coping strategies were the most consistent predictor of less frequent alcohol and drug use, in particular coping through action and coping through relying on religion.
- Perkins, H. S. [Ecumenical Center for Religion and Health and The University of Texas Health Science Center, San Antonio, TX]. **"Culture as a useful conceptual tool in clinical ethics consultation."** *Cambridge Quarterly of Healthcare Ethics* 17, no. 2 (2008): 164-172.
 The author states: "A growing literature substantiates culture's significance in medicine. Yet this literature often views culture narrowly, identifying it exclusively by race or ethnicity. Such labels distinguish cultural groups imprecisely and ignore religious or other culture-defining factors" [p. 164]. He argues for a broader conceptualization of culture and uses a case illustration and comments on, among other things, differences "frameworks for understanding" based in science and religion [--see p. 167].
- Pesut, B. [Faculty of Human and Social Development, University of British Columbia Okanagan, Kelowna, British Columbia, Canada; barb.pesut@ubc.ca]. **"A conversation on diverse perspectives of spirituality in nursing literature."** *Nursing Philosophy* 9, no. 2 (Apr 2008): 98-109.
 [Abstract:] Spirituality has long been considered a dimension of holistic palliative care. However, conceptualizations of spirituality are in transition in the nursing literature. No longer rooted within religion, spirituality is increasingly being defined by the universal search for meaning, connectedness, energy, and transcendence. To be human is to be spiritual. Some have argued that the concept of spirituality in the nursing literature has become so generic that it is no longer meaningful. A conceptualization that attempts to be all-encompassing of what it means to live a human life has a tendency to render invisible the differences that make life meaningful. For palliative patients in particular, a generic approach may obscure and relativize the important values and beliefs that inform the critical questions that many patients grapple with at end of life. A different approach to conceptualizing spirituality can be achieved through the use of typologies. Rather than obscuring difference, categories are constructed to illuminate how spirituality is understood within a diverse society and how those understandings might influence patient-provider relationships. What follows in this article is a dialogue illustrating one typology of spirituality constructed from a review of selected nursing literature. The hypothetical narrator and three participants, representing the positions of theism, monism, and humanism, discuss their understandings of spirituality and religion, and how those understandings influence the intersections between nursing ontology, epistemology, and spiritual care.
- Pesut, B. [Trinity Western University, Langley, British Columbia, Canada; barb.pesut@ubc.ca]. **"Spirituality and spiritual care in nursing fundamentals textbooks."** *Journal of Nursing Education* 47, no. 4 (Apr 2008): 167-173.
 [Abstract:] Educators are increasingly being called on to teach nursing students the fundamentals of spiritual care. The purpose of this study was to investigate and analyze what was being taught to nursing students about spirituality and spiritual care through nursing fundamentals textbooks. Findings of this study suggest that although this body of literature provides comprehensive content about spirituality and spiritual care, there are some underlying conceptual problems. The clear demarcation between spirituality and religion creates problematic dichotomies between patients' individual and cultural selves and their cognitive and experiential selves. Defining spirituality primarily by positive emotional descriptors and cognitive capacity tends to pathologize the basic human experience of suffering and marginalize those most vulnerable in society. Spiritual care is problematic in that it is difficult to identify what constitutes a uniquely spiritual intervention, the outcomes being proposed for care are questionable, and there is an assumption that nurses' spiritual worldviews are biases in the context of care.
- Pesut, B., Fowler, M., Taylor, E. J., Reimer-Kirkham, S. and Sawatzky, R. [School of Nursing, UBC Okanagan, Kelowna, BC, Canada; barb.pesut@ubc.ca]. **"Conceptualising spirituality and religion for healthcare."** *Journal of Clinical Nursing* 17, no. 21 (Nov 2008): 2803-2810.
 [Abstract:] AIMS: To discuss some of the challenges of conceptualizing spirituality and religion for healthcare practice. BACKGROUND: With the growing interest in spirituality in healthcare, has come the inevitable task of trying to conceptualize spirituality, a daunting task given the amorphous nature of spirituality, the changing understandings of spirituality among individuals and the diverse globalized society within which this task is taking place. Spirituality's relationship to religion is a particularly challenging point of debate. DESIGN: Critical review. CONCLUSIONS: Three social and historical conditions - located in the context of Western thought - have contributed to current conceptualizations of spirituality and religion: the diminishment of the social authority of religion as a result of the Enlightenment focus on reason, the rise of a postmodern spirituality emphasizing spiritual experience and current tensions over the ideological and political roles of

religion in society. The trend to minimize the social influence of religion is a particular Western bias that seems to ignore the global megatrend of the resurgence of religion. Current conceptualizations are critiqued on the following grounds: that they tend to be ungrounded from a rich history of theological and philosophical thought, that a particular form of elitist spirituality is emerging and that the individualistic emphasis in recent conceptualizations of spirituality diminishes the potential for societal critique and transformation while opening the door for economic and political self interest. RELEVANCE TO CLINICAL PRACTICE: Constructing adequate conceptualizations of spirituality and religion for clinical practice entails grounding them in the wealth of centuries of philosophical and theological thinking, ensuring that they represent the diverse society that nursing serves and anchoring them within a moral view of practice.

Peterson, J. A., Yates, B. C. and Hertzog, M. [University of Missouri Kansas City; petersonja@umkc.edu]. **“Heart and Soul Physical Activity Program: social support outcomes.”** *American Journal of Health Behavior* 32, no. 5 (Sep-Oct 2008): 525-537.

[Abstract:] OBJECTIVE: To examine changes in specific social support domains following the Heart and Soul Physical Activity Program (HSPAP). METHODS: This experimental repeated-measures nested-design study tested the church-based HSPAP, a social support intervention to promote physical activity in women. RESULTS: HSPAP participants revealed greater increases in perceived appraisal and esteem support, received tangible support and in the number of physical activity supporters than did the comparison group. HSPAP participants had a borderline significant increase in received appraisal support. CONCLUSION: As conceptualized, the HSPAP intervention enhanced several domains of social support and the number of physical activity supporters in midlife women.

Petry, N. M., Lewis, M. W. and Ostvik-White, E. M. [Dept. of Psychiatry, University of Connecticut Health Center, Farmington; petry@psychiatry.uhc.edu]. **“Participation in religious activities during contingency management interventions is associated with substance use treatment outcomes.”** *American Journal on Addictions* 17, no. 5 (Sep-Oct 2008): 408-413.

[Abstract:] Many drug abuse treatment programs encourage participation in religious activities, yet there is scant research regarding their effectiveness. Contingency management (CM) interventions sometimes reinforce the completion of non-drug related activities, and church attendance is a popular activity. Cocaine abusers (n = 184) randomized to CM interventions were categorized based on whether or not they engaged in three or more religious activities. Engagers in religious activities (n = 34) remained in treatment longer, were abstinent for longer durations, and submitted more substance-negative samples than non-engagers (n = 150), even after controlling for number of activities completed overall. Thus, encouraging religious involvement during CM treatment may improve during treatment outcomes.

Pevey, C. F., Jones, T. J. and Yarber, A. [Department. of Sociology, Auburn University Montgomery, AL; epevey@aum.edu]. **“How religion comforts the dying: a qualitative inquiry.”** *Omega - Journal of Death & Dying* 58, no. 1 (2008-2009): 41-59.

[Abstract:] Although considerable social science research has explored religiosity and death anxiety, and many have theorized that religion comforts the dying, with speculations on the mechanisms by which religion comforts, very little research has asked people who were actually dying to discuss religion. This article reports on answers given by 38 hospice patients to the questions: Is religion a comfort to you? How does religion comfort you? This study found that religion, when it comforted these dying people, did so by offering a relationship to the dying, by giving the hope of life after death, through identifications, and through the assurance of cosmic order. The authors suggest theoretical perspectives accounting for these functions.

Pickard, J. G. and Guo, B. [School of Social Work, University of Missouri-St Louis; pickardj@umsl.edu]. **“Clergy as mental health service providers to older adults.”** *Aging & Mental Health* 12, no. 5 (Sep 2008): 615-624. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]

[Abstract:] Older adults tend to seek help for emotional problems from clergy at greater rates than they do from other sources. However, their help-seeking from clergy is largely understudied. We used data from the Naturally Occurring Retirement Community (NORC) Demonstration Project to examine older adults’ patterns of help-seeking from clergy. We studied a sample of adults aged 65 or older (n = 317) to determine which factors were related to help-seeking from a religious leader. This study was framed within the Behavioral Model of Health Services Utilization. Results of hierarchical logistic regression analyses indicated that having less social support and greater frequency of attendance at religious services was related to help-seeking from clergy for this sample, while other predisposing, enabling, need and religiosity variables were not found to be related to help-seeking from clergy. Discussion focuses on the need for mental health workers to be aware of the important role that clergy play in service provision and to find ways to leverage knowledge and skills to enhance provider-clergy relationships in order to improve services that older adults receive.

Piderman, K. M., Marek, D. V., Jenkins, S. M., Johnson, M. E., Buryaska, J. F. and Mueller, P. S. [Department of Chaplain Services, Mayo Clinic, Rochester, MN; piderman.katherine@mayo.edu]. **“Patients’ expectations of hospital chaplains.”** *Mayo Clinic Proceedings* 83, no. 1 (Jan 2008): 58-65.

[Abstract:] OBJECTIVE: To evaluate patients’ expectations of hospital chaplains. PATIENTS AND METHODS: From April 6, 2006, through April 25, 2006, we surveyed by mail 1500 consecutive medical and surgical patients within 3 weeks of their discharge from the hospital. The survey included questions related to demographics, duration and area of hospitalization, awareness of chaplain availability, expectations regarding chaplain visits, and reasons for wanting to see a chaplain. Measured characteristics were summarized by calculating means and SDs for continuous variables and proportions for categorical variables. Proportions were statistically compared via Fisher exact tests or Monte Carlo estimates. RESULTS: Surveys were returned by 535 of the 1500 patients to whom they were sent. Most of those who returned surveys had been hospitalized for less than 1 week (398/514 [77.4%]) and were male (265/510 [52.0%]), married (396/528 [75.0%]), 56 years or older (382/532 [71.8%]), or affiliated with either the Lutheran (177 [33.3%]) or Catholic (133 [25.0%]) churches. Most (78.9%) were aware of the availability of chaplains, and 62.3% would have appreciated chaplain visitation at least every few days. More than half (52.9%) reported that they were visited, and 86.4% reported that this visit was important to them. The primary reason selected for wanting to see a chaplain was “to be reminded of God’s care and presence.” Items related to ritual, prayer, and pastoral support were also highly endorsed. Some results were dependent on sex, age, religious affiliation, or duration of stay. CONCLUSION: Hospitalized patients value visitation by chaplains and appreciate both religious and supportive interventions. Opportunities for patient care, education, and research are apparent. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/mar08.html].

Pierce, L. L., Steiner, V., Havens, H. and Tormoehlen, K. [University of Toledo, OH; lpierce@utoledo.edu]. **“Spirituality expressed by caregivers of stroke survivors.”** *Western Journal of Nursing Research* 30, no. 5 (Aug 2008): 606-619.

[Abstract:] Thirty-six caregivers of stroke survivors who are new to that role participate in a Web-based support and education intervention over the course of a year. The authors use a secondary analysis of a total of 2,148 e-mail messages that these caregivers posted to the intervention's discussion group. Rigorous content analysis is used to analyze the narrative data coded to spirituality (n = 230 e-mails). Four themes emerge and are drawn to Friedemann's (1995) framework of systemic organization: (a) feeling the presence of a greater power, (b) practicing rituals, (c) being one with nature, and (d) interacting with family and friends. Spirituality gives these caregivers hope and sustenance, but it also helps them express themselves more fully during a difficult time of change. The e-mail discussion data presented here highlight the importance of increased awareness of addressing spirituality in nurse-client encounters and designing interventions to support the caregivers.

Pies, R. [Department of Psychiatry, S.U.N.Y. Upstate Medical University, Syracuse, NY; ronpies@massmed.org]. **"The anatomy of sorrow: a spiritual, phenomenological, and neurological perspective."** *Philosophy, Ethics, & Humanities in Medicine* 3 (2008): 17 [online at www.peh-med.com].

[Abstract:] There is considerable controversy, both within and outside the field of psychiatry, regarding the boundaries of normal sadness and clinical depression. Furthermore, while there are frequent calls for a "pluralistic", comprehensive approach to understanding depression, few writers have tried to integrate insights from the spiritual, philosophical, and neurobiological literature. The author proposes that such a synthesis is possible, and that our understanding of ordinary sorrow and clinical depression is enriched by drawing from these disparate sources. In particular, a phenomenological analysis of sorrow and depression reveals two overlapping but distinct "lifeworlds". These differ in the relational, temporal, dialectical, and intentional realms. Recent brain imaging studies are also beginning to reveal the neurobiological correlates of sorrow and depression. As we come to understand the neurobiology of these states, we may be able to correlate specific alterations in "neurocircuitry" with their phenomenological expressions.

Polzer Casarez, R. L. and Miles, M. S. [School of Nursing, University of Texas Health Science Center at Houston]. **"Spirituality: a cultural strength for African American mothers with HIV."** *Clinical Nursing Research* 17, no. 2 (May 2008): 118-132.

[Abstract:] The purpose of this study was to describe how spirituality affected the lives of African American mothers with Human Immunodeficiency Virus (HIV) in the context of coping. This qualitative descriptive study used secondary data of interviews from a larger longitudinal study of parental caregiving of infants seropositive for HIV. Participants were 38 African American mothers with HIV. Data from longitudinal semi-structured interviews were analyzed using content analysis. The women dealt with the stresses of HIV through a relationship with God. Two domains explain this relationship: God in control and God requires participation. The benefits of their relationship with God were a decrease in stress and worry about their own health and that of their infants. It is important for nurses working with mothers with HIV to acknowledge their spirituality and assess how spirituality helps them cope with and manage their illness.

Porter, W. G. [Hospice and Palliative Care Charlotte Region, Charlotte, NC; porterw@hpcpr.org]. **"The consolations of faith: a meditation on the power of religious faith."** *Journal of Palliative Medicine* 11, no. 2 (Mar 2008): 245-247.

This is a personal reflection by a physician, in light of his patient encounters.

Power, T. L. and Smith, S. M. [Colchester East Hants Health Authority, Nova Scotia, Canada; trinda.power@cehha.nshealth.ca]. **"Predictors of fear of death and self-mortality: an Atlantic Canadian perspective."** *Death Studies* 32, no. 3 (2008): 253-272.

Among the findings of this study of 144 Atlantic Canadian students, using the Multidimensional Fear of Death Scale (MFODS), [from the abstract:] ...More religious participants expressed greater fear of the dead, fear of being destroyed, and fear of conscious death, whereas participants with lower religious conviction were more fearful of the unknown....

Preau, M., Bounhnik, A. D., Roussiau, N., Lert, F. and Spire, B. [Psychology Department, Nantes University, Nantes, France; preau@marseille.inserm.fr]. **"Disclosure and religion among people living with HIV/AIDS in France."** *AIDS Care* 20, no. 5 (May 2008): 521-526.

[Abstract:] The aim of this study was to examine associations between the importance of religion and disclosure of HIV seropositivity within sero-nonconcordant couples. In 2003, a face-to-face survey was conducted among patients selected in a random stratified sample of 102 French hospital departments delivering HIV care. Respondents who reported being in a couple with a non-HIV-positive partner were asked whether they had disclosed their HIV positive status to their partner and if religion represented an important aspect of their life. Among the 2932 respondents, 1285 were in a sero-non-concordant regular partnership. Among these, 37.5% reported that religion played an important role in their life; 7.2% had not disclosed their HIV-positive status to their partner, and 11.6% were unaware of their partner's HIV status. Lack of HIV disclosure to the partner was encountered more often among those who considered religion as an important aspect of their life. After multiple adjustment for socio-demographic factors, and for partnership characteristics, the importance of religion in the respondent's life remained independently associated with a lack of HIV disclosure to the regular partner. In conclusion, individuals who place importance on religion appear to have difficulties in disclosing their HIV-positive status due to the associated stigma and fear of discrimination.

Prince-Paul, M. [Department of Nursing, Case Western Reserve University, Cleveland, OH; mxp42@case.edu]. **"Relationships among communicative acts, social well-being, and spiritual well-being on the quality of life at the end of life in patients with cancer enrolled in hospice."** *Journal of Palliative Medicine* 11, no. 1 (Jan-Feb 2008): 20-25.

[Abstract:] BACKGROUND: The importance of communication in close, personal relationships has been well-documented. At the end of life, communication, social relationships, and spirituality seem to have greater importance. Some studies suggest that the quality of life at the end of life (QOLEOL) involves these components. OBJECTIVE: The primary aim of this study was to investigate the communicative acts of love, gratitude, and forgiveness, and to explore the extent to which the communicative acts, social well-being, and spiritual well-being predict the overall QOLEOL when controlling for physical symptoms. DESIGN: Cross-sectional, descriptive, correlational design. SETTING/SUBJECTS: A convenience sample of all adult hospice patients, aged 35-80, with a cancer diagnosis, residing in their private home in a community setting, was recruited from a large, non-profit hospice program in the midwestern United States. MEASUREMENTS: Patients completed the Functional Assessment of Cancer Therapy-General (FACT-G) social/family well-being subscale, the JAREL Spiritual Well-Being tool, an investigator-designed tool to measure communicative acts, and the global, single-item QOL indicator of the QUAL-E. RESULTS: Strong, positive correlations among social and spiritual well-being, communicative acts, and QOLEOL were found ($p < 0.01$). Spiritual well-being most significantly predicted the QOLEOL, explaining 53.5% of explained variance in the QOLEOL. Although not statistically significant, the communicative acts of love and gratitude made a small contribution to the overall model. The communicative act of forgiveness did not perform well. CONCLUSIONS: The knowledge gained through this investigation laid the groundwork for future studies in

identifying the importance of explicitly assessing relationships and supporting patients and families in their communication. In order to learn more about this phenomenon and establish a foundation for intervention, confirmation is required regarding the connections between the spiritual and social domains, the relationships between the specific communicative acts and the QOLEOL, as well as establishment of valid measurement approaches.

Prince-Paul, M. [Case Western Reserve University, Cleveland, OH; mxp42@case.edu]. **“Understanding the meaning of social well-being at the end of life.”** *Oncology Nursing Forum* 35, no. 3 (May 2008): 365-371.

[Abstract:] PURPOSE/OBJECTIVES: To advance understanding of the social well-being domain, a dimension of quality of life, from the perspective of dying individuals. RESEARCH APPROACH: Qualitative, hermeneutic, and phenomenologic. SETTING: Private residences in a community setting. PARTICIPANTS: 8 terminally ill adult patients with cancer, aged 35-75, enrolled in hospice care. METHODOLOGIC APPROACH: In-depth, semistructured, tape-recorded, and transcribed interviews were analyzed using the Giorgi method. MAIN RESEARCH VARIABLES: Social well-being and quality of life at the end of life. FINDINGS: Six themes emerged that described the meaning of close personal relationships at the end of life: meaning of relationships with family, friends, and coworkers; meaning of relationships with God or a higher power; loss and gains of role function; love; gratitude; and lessons on living. CONCLUSIONS: Patients who were terminally ill with advanced cancer expressed the importance of close personal relationships at the end of life and the need to communicate their importance through love and gratitude. All participants believed that personal relationships were strengthened by the end-of-life experience. INTERPRETATION: Nurses can support terminally ill patients by understanding the importance of social relationships at the end of life. The relationships may be enhanced when nurses raise patients' conscious awareness of the relationships and encourage them to express their importance.

Puchalski, C. M. [George Washington Institute of Spirituality and Health, George Washington University School of Medicine, Washington, DC]. **“Addressing the spiritual needs of patients.”** *Cancer Treatment & Research* 140 (2008): 79-91.

This is an overview from an MD who is a leading figure in the field of Spirituality & Health.

Puchalski, C. M. [George Washington School of Medicine and Health Sciences, George Washington University, Washington, DC]. **“Spiritual issues as an essential element of quality palliative care: a commentary.”** *Journal of Clinical Ethics* 19, no. 2 (Summer 2008): 160-162.

This is a comment on Stump, B. F., Klugman, C. M. and Thornton, B., “Last hours of life: encouraging end-of-life conversations,” [Journal of Clinical Ethics 19, no. 2 (Summer 2008): 150-159], noted elsewhere in this bibliography.

Purnell, L. D. [School of Nursing, College of Health Sciences, University of Delaware, Newark]. **“Traditional Vietnamese health and healing.”** *Urologic Nursing* 28, no. 1 (Feb 2008): 63-67.

Among the topics addressed in this review is Religion & Spirituality: “The major religions practiced by the Vietnamese are Buddhism, Confucianism, and Taoism; a few Vietnamese are Christians, most of whom are Catholic. Animism is found mainly among the highland tribes. Many Vietnamese believe that deities and spirits control the universe and that the spirits of dead relatives continue to dwell in the home. A tenet of Buddhism holds that the family unit is more important than the individual, with less emphasis on the ‘self.’ Accordingly, health care decision-making is frequently a family matter.... The patient and/or family should be consulted, preferably upon admission, before suggesting a visit by the clergy because the visitation is usually associated with last rites by the Vietnamese, especially those influenced by Catholicism. Sending flowers may be startling because flowers usually are reserved for the rites of the dead....” [p. 65].

Quinn, B. [St. George's Hospital, London, UK]. **“Spirituality in cancer care.”** *European Journal of Cancer Care* 17, no. 5 (Sep 2008): 422.

This is a brief introduction to an online educational module to “provide the reader with the opportunity to develop their theoretical and practical skills in addressing spiritual care” [p. 422]. The module is available via www.onlinecancereducationforum.com.

Quinn, J. [Children's Aid Society in New York City]. **“Perspectives on spiritual development as part of youth development.”** *New Directions for Youth Development* 118 (2008): 73-77, 7-8.

This is the opening article in the journal's special issue on spirituality and youth development. [Abstract:] Speaking to the issue of spiritual development from her extensive experience as a youth work practitioner, the author notes several ideas she finds particularly compelling, among them that spiritual development interacts with, yet is distinct from, moral and religious development; that spiritual development is a core construct of identity formation, one of the central tasks of adolescence; and that the spiritual dimensions of youth development relate not only to work with young people but also to motivations for engaging in this work. Engaging young people in the fundamental questions of life and being human is a task that belongs in both secular and religious settings.

Rancour, P. [Ohio State University, Columbus, OH; rancour.1@osu.edu]. **“Using archetypes and transitions theory to help patients move from active treatment to survivorship.”** *Clinical Journal of Oncology Nursing* 12, no. 6 (Dec 2008): 935-940.

[Abstract:] Nurses historically have used the medical model to assess and intervene when individuals move transitionally into and out of the role of patients with cancer. Although assessing for clinical depression or other medical model designations is appropriate, using this as the sole model for helping patients with cancer emerge from their illness experiences and into the role of survivorship may rob them of the opportunity to actively use the illness for spiritual growth and self-actualization. The transition process is classified into three distinct stages: endings, the neutral zone, and beginnings. Each is characterized by its own unique qualities and challenges. Jungian metaphors and archetypes also can be used to evoke powerful images that help survivors find depth of meaning in their suffering and enhance healing. Nurses often are in ideal positions to create such healing experiences by helping survivors recognize "shadow" emotional experiences stemming from the recovery process, accepting the emotions as normal transitional phenomena, and using them to develop compassion for others. Individuals, therefore, are presented with opportunities to imagine newly emerging life purposes that far exceed their identification as survivors.

Rakel, D. P. and Hedgecock, J. [University of Wisconsin School of Medicine and Public Health, Madison; drakel@fammed.wisc.edu]. **“Healing the healer: a tool to encourage student reflection towards health.”** *Medical Teacher* 30, no. 6 (2008): 633-635.

[Abstract:] BACKGROUND: Research has demonstrated that students' health falters while in medical school with healthy behaviors continuing to deteriorate during residency. Medical education can be focused toward helping students find health for themselves. Physicians who are most likely to practice healthy lifestyles are more likely to encourage their patients to do so. AIMS: Create a tool that encourages self-

reflection, education and self-care for physicians-in-training. **METHOD:** Users completed a web-based tool that helped them create a personal health plan focusing on the themes of nutrition, lifestyle choices, family history, mind-body influences and spiritual connection. A six-question survey was completed by 500 users. **RESULTS:** The results support the main objectives of the tool, which were to encourage self-reflection, positive lifestyle habits and education towards key aspects of health and well-being. **CONCLUSION:** Having medical students and residents develop their own health plans can be an efficient method towards encouraging self-care, understanding foundational health concepts and instilling skills to teach health promotion to their patients.

Rao, A. S., Desphande, O. M., Jamoona, C. and Reid, C. M. [Division of Geriatrics and Gerontology, Weill Medical College, Cornell University, New York, NY; arr2003@med.cornell.edu]. **“Elderly Indo-Caribbean Hindus and end-of-life care: a community-based exploratory study.”** *Journal of the American Geriatrics Society* 56, no. 6 (Jun 2008): 1129-1133.

[Abstract:] America’s increasingly diverse older population needs clinicians to be familiar with ethnic and cultural issues pertaining to end-of-life care (EOLC). Although there has been some work addressing these issues among African-American, Hispanic-American, and some Asian-American populations, data on the Asian-Indian and Hindu populations remain sparse. This community-based exploratory study surveyed older Indo-Caribbean Hindu people (a subset of the Hindu population living in America) attending a senior center in Queens, New York. This study describes the demographic and health characteristics of this population and examines their attitudes, knowledge, and beliefs regarding some EOLC issues. Data on participants’ demographic, medical, psychosocial, and cognitive status were obtained. Previously validated scales were used to collect data on subjects’ acculturation, religiosity, and EOLC beliefs. Participants had a mean age \pm standard deviation of 71.1 \pm 5.1 years; 43% were married. Prevalent illnesses included diabetes mellitus (48%), hypertension (66%), and arthritis (57%). Subjects were socially connected, moderately acculturated, and religious. Scores on the Ethnicity and Attitudes Towards EOLC Survey indicated negative beliefs about life-sustaining or prolonging technology and positive attitudes about advance care directives (ACDs), truth-telling, and family involvement. The number of ACDs that had been completed and knowledge about ACDs was low. The Indo-Caribbean elder population in this study expressed attitudes and beliefs regarding EOLC similar to those of other ethnic elders. Many of these beliefs are in conflict with current EOLC practice patterns. This highlights the importance of being aware of differing attitudes to provide sensitive EOLC.

Regnier, S. J. **“Symposium considers the art of medicine at the end of life.”** *Bulletin of the American College of Surgeons* 93, no. 2 (Feb 2008): 13-16.

This is a brief report of a symposium held in New York in November 2007, including the consideration of religious traditions (--see p. 14).

Reiland, S. and Lauterbach, D. [Eastern Michigan University]. **“Effects of trauma and religiosity on self-esteem.”** *Psychological Reports* 102, no. 3 (Jun 2008): 779-790.

[Abstract:] Self-esteem is often lower among persons who have experienced trauma, but religiosity may ameliorate these psychological effects. The purpose of this paper was to examine the relationships among religiosity, self-esteem, and childhood exposure to trauma, utilizing data from the National Comorbidity Survey, a large (N = 8,098) nationally representative population survey in the 48 contiguous states of the USA that assessed religious practices, self-esteem, and exposure to trauma. Exposure to trauma in childhood was assessed through self-report of presence or absence of childhood physical abuse, sexual abuse, or neglect. Religiosity was assessed as the sum of responses to 4 self-report items (religious service attendance, use of religion for comfort and guidance, and importance of religion). Self-esteem was assessed on 9 self-report items adapted from the Rosenberg Self-Esteem Scale. Analysis of variance compared scores for persons who reported exposure to childhood abuse and differed in the value they placed on various religious practices on self-esteem. Persons who reported physical abuse, sexual abuse, or neglect in childhood had significantly lower mean self-esteem than those who did not report these events. There was also a main effect for religiosity in a comparison of persons who reported childhood sexual abuse with those who reported none. The High Religiosity group had higher mean self-esteem than the Medium and Low Religiosity groups. There was a significant interaction as those who reported childhood sexual abuse had lower mean self-esteem than peers who reported none in the Low and Medium Religiosity groups. Mean self-esteem for those who reported childhood sexual abuse was comparable to that of those who reported none in the High Religiosity group.

Remen, R. N. [Institute for the Study of Health and Illness at Commonweal, Bolinas, CA; drrachel@commonweal.org]. **“Practicing a medicine of the whole person: an opportunity for healing.”** *Hematology-Oncology Clinics of North America* 22, no. 4 (Aug 2008): 767-773, x.

[Abstract:] Integrative medicine has been defined in several ways. For some it is a discipline that combines such approaches to the resolution of disease as acupuncture and homeopathy, meditation and imagery with more familiar and accepted health practices, such as surgery, pediatrics, and oncology. For others it is about cultivating awareness and sensitivity beyond symptoms to the mental, emotional, and spiritual needs of the patient. But, integrative medicine is more than the weaving together of techniques, or understanding the intimate interaction of the mental, emotional, and spiritual dimensions of human experience. It is about rethinking the task of medicine and the infrastructure of relationships and beliefs that have limited its power to serve all people.

Reyes-Ortiz, C. A., Berges, I. M., Raji, M. A., Koenig, H. G., Kuo, Y. F. and Markides, K. S. [Sealy Center on Aging, Department of Internal Medicine, University of Texas Medical Branch, Galveston; careyeso@utmb.edu]. **“Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans.”** *Journals of Gerontology Series A-Biological Sciences & Medical Sciences* 63, no. 5 (May 2008): 480-486.

[Abstract:] **BACKGROUND:** The objective of this study was to examine how the effect of depressive symptoms on cognitive function is modified by church attendance. **METHODS:** We used a sample of 2759 older Mexican Americans. Cognitive function was assessed using the Mini-Mental State Examination (MMSE) at baseline, 2, 5, 7, and 11 years of follow-up. Church attendance was dichotomized as frequent attendance (e.g., going to church at least once a month) versus infrequent attendance (e.g., never or several times a year). Depressive symptoms were assessed by the Center for Epidemiologic Studies Depression Scale (CES-D; score \geq 16 vs $<$ 16). General linear mixed models with time-dependent covariates were used to explore cognitive change at follow-up. **RESULTS:** In unadjusted models, infrequent church attendees had a greater decline in MMSE scores (drop of 0.151 points more each year, standard error [SE] = 0.02, $p <$.001) compared to frequent church attendees; participants having CES-D scores \geq 16 also had greater declines in MMSE scores (drop of 0.132 points more each year, SE = 0.03, $p <$.001) compared to participants with CES-D score $<$ 16 at follow-up. In fully adjusted models, a significant Church attendance x CES-D x Time interaction ($p = .001$) indicated that, among participants with CES-D scores \geq 16, infrequent church attendees had greater decline in MMSE scores (drop of 0.236 points more each year, SE = 0.05, $p <$.001) compared to frequent church attendees at follow-up. **CONCLUSION:**

Church attendance appears to be beneficial for maintaining cognitive function of older persons. Church attendance moderates the impact of clinically relevant depressive symptoms on subsequent cognitive function. [See also the guest editorial by Hill, T. D., which comments on this research (--noted elsewhere in this bibliography).]

Reynolds, M. A. [School of Nursing, Idaho State University, Pocatello; reynmary@isu.edu]. **“Hope in adults, ages 20-59, with advanced stage cancer.”** *Palliative & Supportive Care* 6, no. 3 (Sep 2008): 259-264.

[Abstract:] OBJECTIVES: The diagnosis of terminal cancer begins one of the most complex and challenging individual experiences of human life that requires multiple coping responses, one of those being hope. There are few studies that provide descriptions of hope over time for adults, ages 20-59, with advanced stage cancer. The purpose of this study was to describe hope as defined and experienced by young and middle age adults with advanced stage cancer. METHODS: This descriptive, longitudinal qualitative research study interviewed 12 hopeful adults with advanced stage cancer once a month for 3 months. RESULTS: By definition, this population exhibited high levels of hope at study entry. Hope scores did not change overtime. Four qualities associated with high levels of hope included: reliance on strong spiritual beliefs, maintenance of positive attitudes, accommodation of cancer symptoms, and the presence of supportive resource people. The emphasis or importance of each quality and specific hope related goals were determined and defined individually. Hope goals varied in degree of expectancy and concreteness and require reassessment as conditions change. SIGNIFICANCES OF RESULTS: By identifying an individual's hope goals, palliative care clinicians can then plan and implement interventions to move toward that hope goal.

Ridge, D., Williams, I., Anderson, J. and Elford, J. [Institute of Health Sciences, City University London; d.ridge@westminster.ac.uk]. **“Like a prayer: the role of spirituality and religion for people living with HIV in the UK.”** *Sociology of Health & Illness* 30, no. 3 (Apr 2008): 413-428.

[Abstract:] Over 40,000 people are now living with diagnosed HIV in the UK. There is, however, uncertainty about how people with HIV use religion or spirituality to cope with their infection. Adopting a modified grounded theory approach, we analyzed individual and group interviews with the people most affected by HIV in the UK: black African heterosexual men and women and gay men (mostly white). For the majority of black African heterosexual men and women in our study, religion was extremely important. We found that gay men in the study were less religious than black Africans, although many were spiritual in some way. Black African individuals constructed their spiritual narratives as largely Christian or collective, while gay men described more individualistic or ‘New Age’ approaches. We developed a six-level heuristic device to examine the ways in which prayer and meditation were deployed in narratives to modulate subjective wellbeing. These were: (i) creating a dialogue with an absent counselor; (ii) constructing a compassionate ‘life scheme’; (iii) interrupting rumination; (iv) establishing mindfulness; (v) promoting positive thinking, and (vi) getting results. That people with HIV report specific subjective benefits from prayer or meditation presents a challenge to secular healthcare professionals and sociologists.

Rodrigue, J. R., Guenther, R., Kaplan, B., Mandelbrot, D. A., Pavlakakis, M. and Howard, R. J. [Beth Israel Deaconess Medical Center, Boston, MA; jrrodrig@bidmc.harvard.edu]. **“Measuring the expectations of kidney donors: initial psychometric properties of the Living Donation Expectancies Questionnaire.”** *Transplantation* 85, no. 9 (May 15, 2008): 1230-1234.

The article reports on the development and validity testing of [from the abstract:] the Living Donation Expectancies Questionnaire (LDEQ), designed to measure the expectations of living kidney donor candidates. Potential living donors (n=443) at two transplant centers were administered the LDEQ and other questionnaires, and their medical records were reviewed. Factor analysis provides support for six LDEQ scales: Interpersonal Benefit, Personal Growth, Spiritual Growth, Quid Pro Quo, Health Consequences, and Miscellaneous Consequences. All but [the Quid Pro Quo] scale showed good internal consistency....

Rogers, S., Babgi, A. and Gomez, C. [Georgetown School of Nursing & Health Studies, Washington; susan.k.rogers@verizon.net]. **“Educational interventions in end-of-life care: part I: an educational intervention responding to the moral distress of NICU nurses provided by an ethics consultation team.”** *Advances in Neonatal Care* 8, no. 1 (Feb 2008): 56-65.

[Abstract:] PURPOSE: This study was conducted to assess whether neonatal nurses who care for dying infants could be assisted in their knowledge and comfort via an educational intervention provided by hospital ethics committee members and hospice specialists. PARTICIPANTS: Eighty-two registered nurses working in a level III neonatal intensive care unit (NICU) were included. METHODS AND DESIGN: This was a quantitative pretest, intervention, post-test design with a single group undergoing educational sessions in the 6 areas of pain management, symptom management, ethical/legal issues, communication/culture, spiritual/anxiety, and prevention of compassion fatigue. MAIN OUTCOME MEASUREMENTS: An instrument, “Comfort in Caring for Dying Infants” (CLCDI), was developed to assess pre- and posteducational knowledge and comfort in these areas. RESULTS: There were statistically significant higher levels of comfort and knowledge in care for dying infants in the areas of ethical/legal issues and symptom management after the educational programs. Although not statistically significant, mean scores were higher after the educational sessions on pain management, spirituality/anxiety, and prevention of compassion fatigue. The communication/culture module scores were lower in the post-test administration. CONCLUSIONS: Education by hospice experts in the NICU can assist nurses' comfort with care of the dying infant. In addition, ongoing support is highly desirable for all staff participating in such care. The authors suggest incident debriefings from outside experts, debriefing after each infant's death, multidisciplinary meetings for the whole team, and having sessions of lessons learned on infant death cases.

Ross, L. E., Hall, I. J., Fairley, T. L., Taylor, Y. J. and Howard, D. L. [Institute for Health, Social and Community Research, Shaw University, Raleigh, NC; lross@shawu.edu]. **“Prayer and self-reported health among cancer survivors in the United States, National Health Interview Survey, 2002.”** *Journal of Alternative & Complementary Medicine* 14, no. 8 (Oct 2008): 931-938.

[Abstract:] OBJECTIVES: At least 10.8 million living Americans have been diagnosed with cancer, and about 1.5 million new cancer cases are expected to be diagnosed in 2008. The purpose of this study was to examine prayer for health and self-reported health among a sample of men and women with a personal history of cancer. METHODS: We used data from the 2002 National Health Interview Survey, which collected information on complementary and alternative medicine practices. RESULTS: Among 2262 men and women with a history of cancer, 68.5% reported having prayed for their own health and 72% reported good or better health status. Among cancer survivors, praying for one's own health was associated with several sociodemographic variables including being female, non-Hispanic black, and married. Compared to persons with a history of skin cancer, persons with a history of breast cancer, colorectal cancer, a cancer with a short survival period (e.g., pancreatic cancer), or other cancers were more likely to pray for their health. Persons who reported good or better health were more likely to be female, younger, have higher levels of education and income, and have no history of additional chronic disease. Overall, praying for one's own health

was inversely associated with good or better health status. CONCLUSIONS: Data from this nationally representative sample indicate that prayer for health is commonly used among people with a history of cancer and that use of prayer varies by cancer site. The findings should add to the current body of literature that debates issues around spirituality, decision-making about treatment, and physician care.

Rostosky, S. S., Riggle, E. D., Brodnicki, C. and Olson, A. [Educational and Counseling Psychology, University of Kentucky, Lexington; rostosky@coe.uky.edu]. “**An exploration of lived religion in same-sex couples from Judeo-Christian traditions.**” *Family Process* 47, no. 3 (Sep 2008): 389-403.

Among the conclusions and implications from this qualitative study of 14 same-sex couples: “Therapists should avoid the assumption that religious/spirituality is not important to same-sex couples” [p. 400]. [From the abstract:] [W]e found that couples used their spiritual/religious values to understand and undergird their relationships. In this process, they negotiated intra-couple differences in religious practices, involved themselves in activities that have religious or spiritual meaning to them, created religious social support for their relationships, and experienced some non-supportive or rejecting interpersonal interactions with religious family members, congregants, and strangers. These findings are instructive to therapists who work with same-sex couples and the family members of GLB individuals.

Rudaleviciene, P., Stompe, T., Narbekovas, A., Raskauskiene, N. and Bunevicius, R. [Vilnius Mental Health Center, Vilnius, Lithuania; palmirarudalev@yahoo.com]. “**Are religious delusions related to religiosity in schizophrenia?**” *Medicina (Kaunas, Lithuania)* 44, no. 7 (2008): 529-535.

This Lithuanian study of 295 patients indicates that “the religious content of delusions is not influenced by personal religiosity” [p. 529, abstract].

Ruder, S. [School of Nursing, Florida Gulf Coast University, Fort Myers, FL; sruder@fgcu.edu]. “**The challenges of family member caregiving: how the home health and hospice clinician can help at the end of life.**” *Home Healthcare Nurse* 26, no. 2 (Feb 2008): 131-136.

This review notes a handful of studies relating to the importance of spirituality. See the section: Religious and Spiritual Component, on p. 133.

Ruder, S. [School of Nursing, Florida Gulf Coast University, Fort Myers, FL; sruder@fgcu.edu]. “**Incorporating spirituality into home care at the end of life.**” *Home Healthcare Nurse* 26, no. 3 (Mar 2008): 158-163; quiz 164-165.

[Abstract:] The home health clinician may be aware that the patient has spiritual needs, but may be unable to respond to these needs. This may be due to inadequate education or the assumption that spiritual needs should be addressed by chaplains, clergy, or other “spiritual” care providers. In reality, clinicians in the home are in the best position to offer spiritual support when caring for patients in their homes at the end of life. [20 refs.]

Rungreangkulkij, S. and Wongtakee, W. [Faculty of Nursing, Khon Kaen University, Khon Kaen, Thailand; somrun@kku.ac.th]. “**The psychological impact of Buddhist counseling for patients suffering from symptoms of anxiety.**” *Archives of Psychiatric Nursing* 22, no. 3 (Jun 2008): 127-134.

[Abstract:] The purpose of this study was to examine the outcomes of individual Buddhist counseling interventions for patients suffering from symptoms of anxiety. A single-group pretest and posttest design was used to measure outcomes. Twenty-one patients participated in the study as voluntary subjects, all of whom completed two sessions of Buddhist counseling interventions. The individual Buddhist counseling program was developed by the investigators based on the Buddhist doctrine. The outcomes were evaluated with the use of the State-Trait Anxiety Inventory. Data were analyzed using the Friedman test, which provides an indicator for evidence-based outcomes related to anxiety reduction scores. The results revealed that the scores on the state anxiety test in relation to the trait anxiety test had been reduced at the 1-month follow-up. The findings from content analysis showed that when the patients practiced mindfulness, they were able to accept unpleasant situations calmly. Sixteen patients were prescribed lower doses of anti-anxiety medications. Furthermore, medication was discontinued for two patients, and three other patients continued their prescribed medication regimen completely. The study indicates that counseling as a basis from Buddhist principles has the potential to benefit patients with emotional anxiety-based problems.

Russell, K. M., Von Ah, D. M., Giesler, R. B., Storniolo, A. M. and Haase, J. E. [Indiana University, Indianapolis; katrusse@iupui.edu]. “**Quality of life of African American breast cancer survivors: how much do we know?**” *Cancer Nursing* 31, no. 6 (Nov-Dec 2008): E36-45.

Among the findings of this review of 26 studies, both qualitative and quantitative, was the following regarding spirituality: “The importance of spirituality and faith was evident in most qualitative studies. Reliance on God to get them through their breast cancer experience, engagement in frequent prayer, and the support of ministers in the initiation of their care were often used. When compared to other racial and ethnic groups, African American survivors more often identified their spirituality as a major way of coping with breast cancer and expressed a positive change in their faith as a result of having the disease. Little investigation of spirituality occurred in the quantitative studies. One study with a sample of only African American survivors did find that spirituality was positively related to hope in these survivors. Together, these findings suggest that spirituality was a dominant part of the African American survivors’ lives. They found comfort and support through their spirituality and frequently engaged in prayer.” [p. E43]

Sade, R. M. [Columbia University’s College of Physicians and Surgeons]. “**Religions and cultures of east and west: perspectives on bioethics. Introduction.**” *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 7-9.

This is the introduction to a special “symposium” on religions and cultures of East and West. The author notes that the “objective of the discussions...is to explore the limits of enhancement technologies in light of what makes us essentially human, as understood by world-wide cultures and religions” [p. 9]. Two scenarios for discussion are presented: face transplant and memory enhancement. [For other articles in the issue, see those by Athar, S., by Kirkland, R., by LaFleur, W. R., by Lustig, A., by Matthew, D. B., by Sarma, D., and by Zoloth, L, also noted in this bibliography.]

Samson, A. and Siam, H. [University of Ottawa, Faculty of Education, Ottawa, Canada; asamson@uottawa.ca]. “**Adapting to major chronic illness: a proposal for a comprehensive task-model approach.**” *Patient Education & Counseling* 70, no. 3 (Mar 2008): 426-429.

The authors' proposal of a comprehensive task-based model describing the psychosocial adaptation process to major chronic illness includes five adaptive tasks, categorized as: physical, psychological, social, spiritual, and vocational. "The spiritual task of adaptation is an effort at giving meaning to the onset of the illness and all the consequences it engenders" [p. 428].

Sarma, D. [Case Western Reserve University]. "**Hindu' bioethics?**" *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 51-58.

[Abstract:] The author offers a commentary on the question, "Are there Hindu bioethics?" After deconstructing the term "Hindu," the author shows that there are indeed no Hindu bioethics. He shows that from a classical and Brahminical perspective, medicine is an inappropriate and impure profession. [This article is part of a special "symposium" on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by Kirkland, R., by LaFleur, W. R., by Lustig, A., by Matthew, D. B., by Sade, R. M., and by Zoloth, L, also noted in this bibliography.]

Schirm, V., Sheehan, D. and Zeller, R. A. [Department of Nursing, Penn State Milton S. Hershey Medical Center, PA; vschirm@hmc.psu.edu]. "**Preferences for Care Near the End of Life: instrument validation for clinical practice.**" *Critical Care Nursing Quarterly* 31, no. 1 (Jan-Mar 2008): 24-32.

[Abstract:] This article presents descriptive data and a psychometric evaluation of the Preferences for Care Near the End of Life (PCEOL) tool developed by Gauthier and Froman. The PCEOL tool identifies dimensions related to care near end of life and asks respondents to consider personal preferences in the context of their values. Analyses were conducted on data from a convenience sample of 68 adults recruited at a workshop series on anticipatory guidance for end-of-life care. Participants included nurses, nursing students, nursing assistants, social workers, and older adults. Findings supporting a 3-factor structure (personal autonomy, healthcare provider input, and spirituality and family) are interpreted and discussed. Implications are given for using the PCEOL tool in nursing care situations.

Schjodt, U., Stodkilde-Jorgensen, H., Geertz, A. W. and Roepstorff, A. [Department of the Study of Religion, University of Aarhus, Denmark; uffeschjoedt@gmail.com]. "**Rewarding prayers.**" *Neuroscience Letters* 443, no. 3 (Oct 10, 2008): 165-168.

[Abstract:] We report a highly significant regional increase of the BOLD response in the caudate nucleus in a group of Danish Christians while performing silent religious prayer. The effect was found in a main-effect analysis of high-structured and low-structured religious recitals relative to comparable secular recitals and to a non-narrative baseline. This supports the hypothesis that religious prayer as a form of frequently recurring behavior is capable of stimulating the dopaminergic reward system in practicing individuals. It extends recent research which demonstrates a relation between interpersonal trust and activation in the dopaminergic system to also encompass relations to abstract entities.

Schleinich, M. A., Warren, S., Nikolaichuk, C., Kaasa, T. and Watanabe, S. [Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton, Alberta, Canada; mapax@primus.ca]. "**Palliative Care Rehabilitation Survey: a pilot study of patients' priorities for rehabilitation goals.**" *Palliative Medicine* 22, no. 7 (Oct 2008): 822-830.

The article presents an eleven-domain questionnaire, with Spirituality as one of those domains and religious practices as part of the Cultural Environment domain.

Schlundt, D. G., Franklin, M. D., Patel, K., McClellan, L., Larson, C., Niebler, S. and Hargreaves, M. [Department of Psychology, Vanderbilt University, Nashville, TN; David.Schlundt@vanderbilt.edu]. "**Religious affiliation, health behaviors and outcomes: Nashville REACH 2010.**" *American Journal of Health Behavior* 32, no. 6 (Nov-Dec 2008): 714-724.

[Abstract:] OBJECTIVES: To examine the relationships of religious involvement and affiliation with health behavior and conditions. METHODS: A survey (n = 3014) conducted for the Nashville REACH 2010 project included questions about religious affiliation and practice as well as health behaviors and conditions. RESULTS: Bivariate analyses indicated negative associations between religious involvement and health, along with differences between religious affiliations/groups. This relationship changed, however, after controlling for demographic differences and individual differences in religious involvement. CONCLUSIONS: Religious groups share not only beliefs, but also socioeconomic, ethnic, and cultural similarities that must be taken into account in research examining religion and health.

Schulz, E., Holt, C. L., Caplan, L., Blake, V., Southward, P., Buckner, A. and Lawrence, H. [School of Medicine, Division of Preventive Medicine, University of Alabama at Birmingham]. "**Role of spirituality in cancer coping among African Americans: a qualitative examination.**" *Journal of Cancer Survivorship* 2, no. 2 (Jun 2008): 104-115.

[Abstract:] INTRODUCTION: This study used qualitative methods to examine whether, and if so how, African American cancer survivors use spirituality in coping with the disease. Spirituality was defined using a model involving connectedness to self, others, a higher power, and the world. METHODS: Twenty-three African American patients with various forms of cancer were recruited from physician offices and completed 1-1.5 h interviews. Data were coded by multiple coders using an inductive process and open-coding. RESULTS: Themes that emerged included, but were not limited to the aforementioned types of connectedness, one theme being connections to God. Given the important role of social support in the cancer experience, participants also emphasized their connectedness to others, which is in support of the spirituality model. Participants also articulated the notion that connections with others were not always positive, indicating that some perceived certain connections as having a detrimental impact on their well-being. Participants also expressed the desire to share their cancer story with others, often gained a new perspective on life, and obtained new self-understanding as a result of their illness experience. DISCUSSION/CONCLUSIONS: Findings indicate that African Americans perceive that spirituality plays a strong role in their cancer coping and survivorship. Spirituality may address a human need for certitude in crisis. Further research is warranted for model testing, and to examine the role of spirituality in cancer coping among those of different backgrounds and cancer types/stages. IMPLICATIONS FOR CANCER SURVIVORS: These themes may have utility for the development of support interventions for cancer survivors. [See also Mao, J. J., et al., "Cancer survivors with unmet needs..." on pp. 116-124 of the same issue of the journal.]

Sessanna, L. [School of Nursing, State University of New York, University at Buffalo; ls33@buffalo.edu]. "**The role of spirituality in advance directive decision making among independent community dwelling older adults.**" *Journal of Religion & Health* 47, no. 1 (Mar 2008): 32-44.

[Abstract:] The purpose of this grounded theory study, based on Strauss and Corbin's (1998) grounded theory methodology, was to investigate the meaning, definition, and needs regarding the role of spirituality in end of life care among independent community dwelling older adults in relation to advance directive decision making (ADDM). Findings revealed that through the use of story telling, independent community

dwelling older adults were able to define spirituality and describe the important role spirituality plays in everyday life and in ADDM. A theoretical model was constructed consisting of a mirrored basic social process, Spirituality as Connecting.

Shah, M., Quill, T., Norton, S., Sada, Y., Buckley, M. and Fridd, C. [Center for Ethics, Humanities, and Palliative Care, University of Rochester Medical Center, Rochester, NY; mindy_shah@urmc.rochester.edu]. **“What bothers you the most?” Initial responses from patients receiving palliative care consultation.** *American Journal of Hospice & Palliative Care* 25, no. 2 (Apr-May 2008): 88-92.

[From the abstract:] The purpose of this investigation is to describe how hospitalized palliative care patients respond to the question “What bothers you the most?” at the time of initial consultation. A retrospective descriptive content analysis of first person responses routinely recorded during initial interview (n = 286) was carried out. Responses were grouped in 7 major categories: physical distress (44%); emotional, spiritual, existential, or nonspecific distress (16%); relationships (15%); concerns about the dying process and death (15%); loss of function and normalcy (12%); distress about location (11%); and distress with medical providers or treatment (9%). Fifteen percent of responses were unable to be reliably categorized.

Siatkowski, R. M., Cannon, S. L. and Farris, B. K. [Dean A. McGee Eye Institute/Department of Ophthalmology, University of Oklahoma College of Medicine, Oklahoma City; rmichael-siatkowski@dmei.org]. **“Patients’ perception of physician-initiated prayer prior to elective ophthalmologic surgery.”** *Southern Medical Journal* 101, no. 2 (Feb 2008): 138-141. [See comment by Snorton, T. E., noted elsewhere in this bibliography.]

[Abstract:] BACKGROUND: Prayer is an important part of many patients’ and physicians’ lives. There is little data in the literature regarding patients’ perception of prayer from or with their doctors. OBJECTIVE: To assess in a masked fashion patients’ impression of prayer’s role in a medical setting, and their perception of being offered and receiving prayer from their physician. DESIGN, SETTING, AND PARTICIPANTS: Confidential survey of 567 consecutive patients who were offered prayer by their physician before elective eye surgery. MAIN OUTCOME MEASURES: Proportion of patients favoring physician-initiated prayer and weighted Likert responses to various positive and negative sentiments regarding their experience. RESULTS: Survey response rate was 53% (300 patients). Ninety-six percent of patients identified themselves as Christian. At least 90% of Christian patients responded favorably toward their prayer experience to each Likert question. Among the non-Christian patients, the proportion of negative impressions to the prayer experience ranged from 0 to 25%. CONCLUSIONS: Physician-initiated Christian-based prayer before surgery is well-received by a strong majority of Christian patients. Although the data are few, only a minority of non-Christians felt negatively regarding this experience. [This article is part of a series in the journal, in conjunction with the Southern Medical Association’s Spirituality in Medicine project.]

Simonelli, L. E., Fowler, J., Maxwell, G. L. and Andersen, B. L. [Department of Psychology, Ohio State University, Columbus]. **“Physical sequelae and depressive symptoms in gynecologic cancer survivors: meaning in life as a mediator.”** *Annals of Behavioral Medicine* 35, no. 3 (Jun 2008): 275-284.

[From the abstract:] ...METHODS: Gynecologic cancer survivors (N = 260) participated. Measures of physical sequelae (nurse rated symptoms/signs, patient-reported gynecologic symptoms), meaning in life (harmony, life purpose, spirituality, and conversely, confusion and loss), and depressive symptoms were obtained at the time of a routine clinical follow-up visit 2-10 years following the completion of treatment. Latent variables were defined, and structural equation modeling tested a mediator model. RESULTS: Analyses support partial mediation. That is, survivors with more physical sequelae also reported lower levels of meaning in life, which was associated with higher levels of depressive symptoms....

Simonson, R. H. [College of Southern Idaho, Twin Falls; rsimonson@csi.edu]. **“Religiousness and non-hopeless suicide ideation.”** *Death Studies* 32, no. 10 (2008): 951-960.

[Abstract:] Individuals who think about suicide but do not feel suicidally hopeless tend to be less religious and can therefore entertain thoughts of suicide unabated by religiousness. Religiousness, suicide ideation, and hopelessness were surveyed among 279 Idaho college students, 37 (13%) of whom were non-hopeless suicide ideators. A total of only 21 (7%) qualified as ideator/hopeless or non-ideator/hopeless with the remaining 221 (79%) qualifying as non-ideator/non-hopeless. Lower religiousness coinciding with greater ideation supports Durkheim's position that religious social affiliation protects against suicide. The fact that non-hopeless ideators were less religious than all others suggests that religion may provide hope that buffers against suicidal ideas.

Simpson, J. L. and Carter, K. [Radford University]. **“Muslim women’s experiences with health care providers in a rural area of the United States.”** *Journal of Transcultural Nursing* 19, no. 1 (Jan 2008): 16-23.

[Abstract:] This study used phenomenology to explore the experience of Muslim women through descriptions of their encounters with health care providers in a rural area. Participants (N = 7) were eligible for inclusion if the foreign-born woman had lived in the area for at least 2 years, had interaction with a health care provider within the last 6 months, and was able to articulate her experience either in English or through an interpreter. Data were recorded, transcribed, coded, and analyzed for the emergence of reoccurring themes, employing decision trails. Constant comparative analysis was used to promote the integrity of the data. Three themes were identified: (1) perceived power of the provider, (2) religiously defined gender relations, and (3) being a stranger in the U.S. healthcare system. Education of the Muslim patient and the provider is needed to increase health care satisfaction and use by rural Muslim women.

Sinal, S. H., Cabinum-Foeller, E. and Socolar, R. [Department of Pediatrics, Wake Forest University Health Sciences, Winston-Salem, NC; ssinal@wfubmc.edu]. **“Religion and medical neglect.”** *Southern Medical Journal* 101, no. 7 (Jul 2008): 703-706.

[Abstract:] This is a literature review of religion-associated medical neglect of children. It attempts to document the most common denominations involved in religion-associated medical neglect. There is a discussion of the history of religious exemptions to medical care and health risks to children as a result of religious exemption. Suggestions are made for the clinician regarding recognition and management of religion-associated medical neglect in children.

Smith, B. W., Dalen, J., Bernard, J. F. and Baumgartner, K. B. [Department of Psychology, University of New Mexico, Albuquerque; bwsmith@unm.edu]. **“Posttraumatic growth in non-Hispanic White and Hispanic women with cervical cancer.”** *Journal of Psychosocial Oncology* 26, no. 4 (2008): 91-109. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]

[Abstract:] This study examined posttraumatic growth (PTG) in Non-Hispanic White (NHW; n = 132) and Hispanic (HISP; n = 51) women who had been diagnosed with cervical cancer. Participants completed measures of PTG, spirituality, optimism, stage of cancer, and demographics variables. The results showed that women with cervical cancer reported PTG but at lower levels than in studies of women with breast cancer. Greater spirituality and more advanced cancer stage predicted more PTG, but optimism did not predict PTG. HISP women reported higher levels of PTG than NHW women, and greater spirituality in the HISP women partially accounted for the difference.

Smith, B. W., Dalen, J., Wiggins, K. T., Christopher, P. J., Bernard, J. F. and Shelley, B. M. [Department of Psychology, University of New Mexico, Albuquerque; bwsmith@unm.edu]. **“Who is willing to use complementary and alternative medicine?”** *Explore: The Journal of Science & Healing* 4, no. 6 (Nov-Dec 2008): 359-367.

[From the abstract:] ...PARTICIPANTS: The sample consisted of 276 undergraduate students (64% female) of diverse ethnicity (43% white, 33% Hispanic, 8% Native American, 16% other) and a wide range of incomes. MEASURES: The willingness to use 16 types of CAM was assessed for six categories: whole medical systems, mind-body medicine, biologically based practices, manipulative and body-based practices, energy medicine, and spiritually based practices. The individual differences assessed included age, gender, income, ethnicity, the Big Five personality characteristics, optimism, spirituality, religiosity, and three aspects of emotional intelligence: mood attention, mood clarity, and mood repair. RESULTS: The individual differences accounted for approximately one fifth of the variance in overall willingness to use CAM. Openness to experience, spirituality, and mood attention were the strongest predictors of overall willingness to use CAM and were related to the willingness to use most of the individual types of CAM. Older age or female gender was related to greater willingness to use most of the mind-body medicines. Hispanic ethnicity was related to greater willingness to use curanderismo, and Native American ethnicity was related to greater willingness to use Native American medicine and a spiritual/faith healer.

Smith, M. L. [Cleveland Clinic]. **“Chaplaincy and clinical ethics: a common set of questions.”** *Hastings Center Report* 38, no. 6 (Nov-Dec 2008): 28-29.

This is one of five special essays in a set under the heading of, “Can We Measure Good Chaplaincy? A New Professional Identity Is Tied to Quality Improvement” and available also as a separate publication. The essays “examine the ‘professionalizing’ profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery” [--from the introductory statement by Gregory E. Kaebnick (no page number, in the separately available publication of the essays)]. Other essays in this set are by Berlinger, N., by de Vries, R., by Jacobs, M. R., and by Mohrmann, M. E.. (--noted elsewhere in this bibliography).

Snorton, T. E. **“Physician-initiated preoperative prayer.”** *Southern Medical Journal* 101, no. 2 (Feb 2008): 120-121.

This is a brief comment on the practice of--and research into--prayer initiated by physicians, written in light of the associated article: Siatkowski, R. M., et al., “Patients’ perception of physician-initiated prayer prior to elective ophthalmologic surgery,” *Southern Medical Journal* 101, no. 2 (Feb 2008): 138-141 (noted elsewhere in this bibliography). The author is the Director of the Association for Clinical Pastoral Education. This article is part of a series in the journal, in conjunction with the Southern Medical Association’s Spirituality in Medicine project.

Soukoreff, M. [Spiritual and Religious Care Services, Centre for Addiction and Mental Health, Toronto, Canada]. **“Suicide in a mental health setting: caring for staff, clients, and family members.”** *Journal of Pastoral Care & Counseling* 62, no. 4 (2008): 353-362.

[Abstract:] This is a reflection article presenting insights gained by a spiritual and religious caregiver through her experience of supporting and comforting individuals as they struggled with the societal, emotional, and spiritual issues resulting from a death by suicide, through her education in crisis management, and through her review of the relevant literature. The article outlines the needs of psychiatric patients, hospital staff, and family members when a suicide has occurred. The author's point of view is that open non-judgmental dialogue is essential for healing the intense grief often associated with suicide.

Sparks, M. B. [College of Nursing and Health Professions, University of Southern Indiana, Evansville; msparks@usi.edu]. **“Inpatient care for persons with Alzheimer’s disease.”** *Critical Care Nursing Quarterly* 31, no. 1 (Jan-Mar 2008): 65-72.

The authors note the following about Spiritual Interventions: “Maintaining usual and desired religious practices may provide comfort to the patient. Persons with AD can remember words to songs learned during childhood. For many older adults, this includes hymns. The patient may pray quietly, repeating the same phrases. Through mid-stage 2, persons with AD can read, although they may not understand the words. If reading religious materials has been important to them through their lifetime, materials can be made available or a family member or sitter can read to them. Spirituality is broader than religion. For some, meaningful relationships, the beauty of nature, inner peace, and a feeling of oneness with their world are indicative of spiritual well-being.” [p. 69]

Spinale, J., Cohen, S. D., Khetpal, P., Peterson, R. A., Clougherty, B., Puchalski, C. M., Patel, S. S. and Kimmel, P. L. [Department of Medicine, George Washington University, Washington, DC]. **“Spirituality, social support, and survival in hemodialysis patients.”** *Clinical Journal of the American Society of Nephrology: CJASN* 3, no. 6 (Nov 2008): 1620-1627.

[Abstract:] BACKGROUND AND OBJECTIVES: No studies have evaluated the relationship among spirituality, social support, and survival in patients with ESRD. This study assessed whether spirituality was an independent predictor of survival in dialysis patients with ESRD after controlling for age, diabetes, albumin, and social support. DESIGN, SETTING, PARTICIPANTS, & MEASUREMENTS: A total of 166 patients who had ESRD and were treated with hemodialysis completed questionnaires on psychosocial variables, quality of life, and religious and spiritual beliefs. The religious variables were categorized into three scores on a 0 to 20 scale (low to high levels): Spirituality, religious involvement, and religion as coping. Social support was assessed using the Multidimensional Scale for Perceived Social Support. Analyses were also performed including and excluding patients with HIV infection. Religious variables were categorized on the basis of means, medians, and tertiles. RESULTS: In analyses that used religious variables, only the responses on the spirituality scale split at the mean were associated with survival. The association of other religious variables with survival did not reach significance. Social support correlated with spirituality, religion as coping, and religious involvement measures. Only social support and age were associated with survival when controlling for diabetes, albumin concentration, HIV infection, and spirituality. CONCLUSIONS: These data suggest that the effects of spirituality may be mediated by social support. Larger, multicenter, prospective studies that use well-validated tools to measure religiosity and spirituality are needed to determine whether there is an independent association of spirituality variables with survival in patients with ESRD.

- Stansbury, K. and Schumacher, M. [School of Social Work, Eastern Washington University, Cheney; kstansbury@mail.ewu.edu]. **“An exploration of mental health literacy among African American clergy.”** *Journal of Gerontological Social Work* 51, nos. 1-2 (2008): 126-142.
- [Abstract:] The purpose of this qualitative study was to explore African American clergy's mental health literacy with older congregants 60 years of age and older. Using a grounded theory approach, we recruited a purposive sample of 9 African American clergy representing diverse ages, denominations, locales, and educational levels. Data was coded and classified according to Kevin's (1976) typology of pastoral counseling and Jorm et al.'s (1997) conceptual model of mental health literacy. Findings from data analysis revealed study respondents were adherents of Kevin's Religious-Community (R-C) model. Additionally, the following themes emerged: loss of cognitive functioning, psychosocial stressors, religiosity, and appreciation for professional assistance, cultural barriers, and key informants/familiarity with formal mental health providers which partially maps onto Jorm et al.'s conceptual model of mental health literacy.
- Steele, R. and Fitch, M. I. [School of Nursing, York University, Toronto, Canada; rsteele@yorku.ca]. **“Supportive care needs of women with gynecologic cancer.”** *Cancer Nursing* 31, no. 4 (Jul-Aug 2008): 284-291.
- Among the findings of this study of 103 patients from a comprehensive, outpatient cancer center in Ontario, Canada: “Of the 10 most frequently reported currently experienced issues across domains, 4 were from the emotional domain (feelings of sadness, feeling down or depressed, anxiety, and worry that the results of your treatment are beyond your control). Two were physical (lack of energy and not being able to do things you used to do), 2 were psychological (fears about cancer returning and fears about cancer spreading), 1 was social (concerns about the worries of those close to you), and the other was spiritual (uncertainty about the future).... Five of 11 items in both the emotional and psychological domains were reported as currently experienced by approximately one-third or more of the patients. ...Uncertainty about the future (n = 54) and feelings about death and dying (n = 35) were the 2 spiritual items.” [p. 287]
- Steinhauser, K. E., Alexander, S. C., Byock, I. R., George, L. K., Olsen, M. K. and Tulskey, J. A. [Center for Health Services Research in Primary Care, Durham VA Medical Center, Durham, NC; Karen.steinhauser@duke.edu]. **“Do preparation and life completion discussions improve functioning and quality of life in seriously ill patients? Pilot randomized control trial.”** *Journal of Palliative Medicine* 11, no. 9 (Nov 2009): 1234-1240.
- Among the findings: “Patients who were widowed, older age, had lower daily spiritual experience scores, had lung disease, and were referred from hospice or home health care all were more likely to not complete the study (either due to illness or death).”
- Steinman, K. J. and Bambakidis, A. [Division of Health Behavior and Health Promotion, Ohio State University College of Public Health, Columbus; steinman.13@osu.edu]. **“Faith-health collaboration in the United States: results from a nationally representative study.”** *American Journal of Health Promotion* 22, no. 4 (Mar-Apr 2008): 256-263.
- [Abstract:] PURPOSE: Estimate the prevalence of and identify characteristics associated with religious congregations' collaboration with health agencies. DESIGN: Cross-sectional analyses of self-report data from the National Congregations Study, a random sample of religious congregations generated from the 1998 General Social Survey. Setting: United States. SUBJECTS: Key informants from 1236 congregations. Each respondent described a single congregation. MEASURES: Respondents provided open-ended descriptions of congregational programs. Researchers coded program descriptions by content (e.g., domestic violence) and whether the program involved collaboration with a secular agency. Other congregational characteristics (e.g., denomination) were measured by validated measures and linked census tract data. RESULTS: Overall, 11.1% of congregations participated in faith-health collaboration (FHC). Logistic regression analyses found that FHC was more common among congregations with more members, with a small proportion of congregants under 35 years, and with a senior pastor with a graduate degree. Other effects were conditional; for instance, denominational differences varied depending on urban/suburban/rural location and the proportion of low-income members. CONCLUSION: This study provides the first national estimates of the prevalence of FHC. Such collaborative efforts may require different approaches in different areas. These results can help practitioners identify congregations that may be more willing to collaborate.
- Stephenson, M. T., Morgan, S. E., Roberts-Perez, S. D., Harrison, T., Afifi, W. and Long, S. D. [Department of Communication, Texas A&M University, College Station]. **“The role of religiosity, religious norms, subjective norms, and bodily integrity in signing an organ donor card.”** *Health Communication* 23, no. 5 (Sep 2008): 436-447.
- [Abstract:] This article examines the influence of religiosity, religious norms, subjective norms, and bodily integrity (the extent to which people think the body should remain unaltered after death) on intent to donate organs postmortem. A total of 4,426 participants from 6 universities completed surveys for this study. The results indicate that religiosity and religious norms had a nonsignificant effect on willingness to donate. In addition, attitudes toward donation had a weak positive relationship on intent to donate, whereas subjective norms exerted a modest positive relationship on intent to donate. Finally, the results reveal a strong direct and indirect effect of bodily integrity on intent to donate.
- Strack, J. G., Fottler, M. D. and Kilpatrick, A. O. [Boca Raton Community Hospital, Boca Raton, FL]. **“The relationship of health-care managers' spirituality to their self-perceived leadership practices.”** *Health Services Management Research* 21, no. 4 (Nov 2008): 236-247.
- [Abstract:] This exploratory survey examines the relationship between selected dimensions of spirituality and self-perceived effective leadership practices of health-care managers. Kouzes and Posner's Leadership Practices Inventory and Beazley's Spiritual Assessment Scale were administered to a sample of health-care managers. Significant statistical relationships were found between and among the dimensions of both subscales. Analysis of variance revealed a statistically significant difference in three effective leadership practices by 'more spiritual than non-spiritual' managers. The confirmatory factor analysis of our theory-based model revealed a moderately positive correlation between spirituality and leadership ($r = 0.50$). The paper concludes with a conceptual theory postulating a rationale for the relationship between spirituality and effective leadership.
- Stranahan, S. [Shell Point Retirement Community, 15100 Shell Point Blvd., Fort Myers, FL 33904; SueStranahan@ShellPoint.org]. **“A spiritual screening tool for older adults.”** *Journal of Religion & Health* 47, no. 4 (Dec 2008): 491-503.
- [Abstract:] OBJECTIVE: The purpose of this non-experimental study was to investigate the reliability and validity of a self-administered screening tool for spiritual distress in older adults. The tool was unique in that items were consistent with a conceptual definition of spirituality presented in the professional literature and supported by theories of behavioral development for older adults. METHODS: Questionnaires were

distributed to residents of a continuing care retirement community participating in a class on spirituality. RESULTS: The split-half reliability coefficient was found to be 0.776. Construct validity was established and a cutoff value for spiritual distress was determined. DISCUSSION: Tests for reliability and validity demonstrated confidence in use of the tool to screen for spiritual distress in older adults.

Stump, B. F., Klugman, C. M. and Thornton, B. [University of Nevada School of Medicine, Reno]. **“Last hours of life: encouraging end-of-life conversations.”** *Journal of Clinical Ethics* 19, no. 2 (Summer 2008): 150-159.

The authors consider *passim* how “spirituality, the search for life’s meaning, and emotional well-being are integral components of the dying process [p. 151]. This is the target article for a special feature of the journal of End-of-Life Conversations, with commentaries on pp. 160-168 and 99-109, by Christina M. Puchalski, Margaret M. Mahon, Craig D. Blinderman and Edmund G. Howe.

Sun, F., Roff, L. L., Klemmack, D. and Burgio, L. D. [Social Work Department, Arizona State University, Glendale; sun011@bama.ua.edu]. **“The influences of gender and religiousness on Alzheimer disease caregivers' use of informal support and formal services.”** *Journal of Aging & Health* 20, no. 8 (2008): 937-953. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]

Among the findings of this study that explored how male and female family caregivers of Alzheimer’s disease patients differ in their use of formal services and informal support and how religiousness may affect such differences: “We also found that religious service attendance helped explain gender differences in the use of transportation services. ...We found that frequency of service attendance and frequency of prayer partially mediated the relationship between gender and use of in-home formal services. ...Religiousness also appeared to help explain the relationship between gender and use of informal support.” [p. 949] Data were analyzed secondarily from a sample of 720 family caregivers patients who participated in the Resources for Enhancing Alzheimer’s Caregiver Health (REACH I) study from sites in Birmingham, Boston, Memphis, and Philadelphia.

Taku, K., Cann, A., Calhoun, L. G. and Tedeschi, R. G. [Department of Psychology, University of North Carolina at Charlotte; ktaku@uncc.edu]. **“The factor structure of the posttraumatic growth inventory: a comparison of five models using confirmatory factor analysis.”** *Journal of Traumatic Stress* 21, no. 2 (Apr 2008): 158-164.

This article considers Spiritual Change as one of five factors for the Posttraumatic Growth Inventory (-the other factors being Relating to Others, New Possibilities, Personal Strength, and Appreciation of Life).

Tanner, J., Anthony, D., Johnson, M., Khan, D. and Trevithick, C. [De Montfort University and University Hospitals Leicester, UK; jtanner@dmu.ac.uk]. **“Clostridium difficile, ethnicity and religion.”** *Journal of Hospital Infection* 68, no. 1 (Jan 2008): 90-91.

This is a brief report of a study examining the records of 2476 patients in the UK with *Clostridium difficile*, investigating whether there was an association between ethnic/religious groups and *Clostridium difficile*-associated diarrhea, possibly the result of culture/religion-based hand washing practices. Results indicated no such relationship, though age was indicated as a key indicator.

Tanyi, R. A. and Werner, J. S. [Loma Linda University, Loma Linda, CA]. **“Women’s experience of spirituality within end-stage renal disease and hemodialysis.”** *Clinical Nursing Research* 17, no. 1 (Feb 2008): 32-49.

[Abstract:] The purpose of this descriptive, phenomenological qualitative study is to describe women’s lived experiences of spirituality within end-stage renal disease (ESRD) and hemodialysis. The purposive volunteer sample of 16 women regularly attended two outpatient dialysis centers in a large Midwestern city. Audiotaped, transcribed interviews were analyzed using Colaizzi’s method. These women affirmed that spirituality was extremely important in living with their illness and necessary treatment regime. Four major clusters of themes pertaining to the women’s spiritual experience within their illness emerged: acceptance, understanding, fortification, and emotion modulation. Findings show that spirituality is of great importance in living with ESRD while receiving hemodialysis and suggest that spirituality may be a significant consideration in nursing and interdisciplinary health care. These findings may be used to improve holistic nursing practice and education in related areas.

Taylor, E. J. [Loma Linda University, School of Nursing, Loma Linda, CA; ejtaylor@llu.edu]. **“Promoting spiritual health in home healthcare.”** *Home Healthcare Nurse* 26, no. 6 (Jun 2008): 367-274.

[Abstract:] This article explores how clinicians can promote patient and family caregiver spiritual health. After a review of pertinent theory and research, clinical implications are identified, including appropriate goals for clinicians with regard to spiritual health promotion. [31 refs.]

Taylor, E. J. [School of Nursing, Loma Linda University, Loma Linda, CA; ejtaylor@llu.edu]. **“What is spiritual care in nursing? Findings from an exercise in content validity.”** *Holistic Nursing Practice* 22, no. 3 (May-Jun 2008): 154-159.

[Abstract:] The scope and nature of what is spiritual care in nursing are poorly defined. This article explores what is nursing spiritual care using data collected from a panel of 9 experts for the purposes of establishing content validity for an instrument to measure frequency of nurse-provided spiritual care therapeutics.

Teixeira, M. E. [Hightstown Medical Associates, East Windsor, NJ; Bet3079@verizon.net]. **“Self-transcendence: a concept analysis for nursing praxis.”** *Holistic Nursing Practice* 22, no. 1 (Jan-Feb 2008): 25-31.

This overview of the concept of self-transcendence includes discussion *passim* of it’s relation to the concept of spirituality. The authors explore self-transcendence as a coping strategy. [32 refs.]

Timmins, F. and Kelly, J. [School of Nursing and Midwifery, Trinity College Dublin, Ireland]. **“Spiritual assessment in intensive and cardiac care nursing.”** *Nursing in Critical Care* 13, no. 3 (May-Jun 2008): 124-131.

[Abstract:] AIM: The aim of this paper is to explore various approaches to spiritual assessments in contemporary intensive and cardiac care (ICU/CCU) environments. BACKGROUND: Despite the increasing recognition that spiritual care is essential for quality patient care, an agreed spiritual assessment approach and tool for use in ICU/CCU settings remains elusive. METHOD: An overview of spiritual assessment and spiritual assessment tools. CONCLUSION: It is suggested that the staff in ICU/CCU nursing settings choose or develop a formal assessment tool that most closely matches their considered collective definition of spirituality, which has been considered in light of their mission statement and philosophy of care. RELEVANCE TO CLINICAL PRACTICE: Spiritual assessment is essential to formulate a care plan as spiritual care provides a powerful inner resource to critically ill patients in acute clinical environments. [42 refs.]

- Tompkins, C. and Sorrell, J. M. [Social Work Department, George Mason University, Fairfax, VA; ctompkin@gmu.edu]. “**Older adults with Alzheimer’s disease in a faith community.**” *Journal of Psychosocial Nursing & Mental Health Services* 46, no. 1 (Jan 2008): 22-25.
 [Abstract:] In the first phase of this study, focus groups were conducted with 12 clergy to explore how to meet the needs of Alzheimer’s disease patients and their families. The clergy reported that although they do reach out to these families, they have not received formal training, so they often do not know what families need. Members of their congregations who are trained in working with Alzheimer’s patients need to partner with the clergy in reaching out to these families. Although this article mainly focuses on the clergy’s perspective, in the second phase of the study, caregivers and early-stage Alzheimer’s patients were asked to describe their experiences of spiritual connections related to Alzheimer’s disease.
- Udipi, S., Veach, P. M., Kao, J. and LeRoy, B. S. [Department of Educational Psychology, University of Minnesota, Minneapolis]. “**The psychic costs of empathic engagement: personal and demographic predictors of genetic counselor compassion fatigue.**” *Journal of Genetic Counseling* 17, no. 5 (Oct 2008): 459-471.
 Among the findings of this survey of 222 genetic counselors about their compassion fatigue and factors that predict its occurrence {from the abstract:] Respondents at higher risk of compassion fatigue were more likely to report being burned out, using self-criticism and giving up to manage stress, experiencing a greater variety of distressing clinical events, having larger patient caseloads, relying on religion as a coping strategy, having no children, and seeking support to manage stress.
- Unger, J. B., Soto, C. and Thomas, N. [Transdisciplinary Drug Abuse Prevention Research Center, University of Southern California, Alhambra]. “**Translation of health programs for American Indians in the United States.**” *Evaluation & the Health Professions* 31, no. 2 (Jun 2008): 124-144.
 The article offers the following observations about spirituality among American Indian and Alaska Native (AI/AN) cultures in the United States: “AI/AN people have unique systems of spiritual beliefs and practices with the natural world as the focal point.... AI/AN spirituality encompasses all humans, animals, plants, and geologic features, such as mountains and bodies of water, as part of the sacred life force. Mother Earth, the sun, and stars are part of the sacred circle to which humans are connected AI/AN cultures, like many other cultures worldwide, have sacred ceremonies, objects, places, animals, and plants, including eagle feathers and specific rivers, mountains, caves, and lakes.... AI/AN perspectives encompass and integrate all times, all places, and all beings.... The spiritual belief that all beings are interconnected forms the basis of cultural and social interactions, which naturally manifest in collectivistic and holistic worldviews. Many AI/AN cultures practice traditional healing methods, which involve treating the body, mind, and soul of the individual. Traditional medicine may include chanting, prayer, sand painting, dancing, sweat lodges, herbs, and using plants and objects that are symbolic of the individual, the illness, or the treatment. Some AI/ANs prefer traditional medicine over Western medicine, whereas others use Western medicine or use both approaches....” [p. 132]
- Vachon, M. L. [Department of Psychiatry, University of Toronto, Canada; Maryvachon@sympatico.ca]. “**Meaning, spirituality, and wellness in cancer survivors.**” *Seminars in Oncology Nursing* 24, no. 3 (Aug 2008): 218-225.
 [Abstract:] OBJECTIVES: To explore the concepts of meaning, spirituality, and wellness in cancer survivors. DATA SOURCES: Review and research articles, books, and personal experience as a nurse psychotherapist and as a cancer survivor. CONCLUSION: Cancer survivors often rely on their religious and spiritual beliefs as a way of deriving meaning during their illness experience and survivorship, as well as a way of coping with and coming to terms with the concept of death. The measurement of religion and spirituality in health and cancer survivorship is challenging because of the difficulty in defining terms and in developing ways of measuring the concepts. IMPLICATIONS FOR NURSING PRACTICE: Nurses have the opportunity to explore the meaning of cancer and spirituality in the lives of their patients. Such discussions can allow for the introduction of concepts of wellness including changes in lifestyle habits and social support that may improve quality of life for cancer survivors. [42 refs.]
- Vaillant, G., Templeton, J., Ardelt, M. and Meyer, S. E. [Department of Psychiatry, Harvard Medical School Boston, MA; gvaillant@partners.org]. “**The natural history of male mental health: health and religious involvement.**” *Social Science & Medicine* 66, no. 2 (Jan 2008): 221-231.
 [Abstract:] In prior studies, the effect of religious involvement upon physical health has shown generally positive results, but these studies have been marred by confounders. The 65-year-old US prospective Study of Adult Development has offered an opportunity to repeat these studies with somewhat better control over confounders. The physical and mental health of 224 Harvard University sophomores was monitored for 65 years. Their religious involvement from church attendance to private spirituality was prospectively monitored every 2-4 years from age 47 to 85. In this analysis we focus on the male respondent. We found that religious involvement, no matter how measured was uncorrelated with their late life physical, mental and social well-being. The exception was that the 44 men with major depression or with multiple negative life events were twice as likely to manifest high religious involvement as men with the least “stress.” If these findings can be generalized, they suggest that religious involvement may exert the greatest mental health benefits on people with the fewest alternative social and personal resources.
- van Leeuwen, R., Tiesinga, L. J., Middel, B., Post, D. and Jochemsen, H. [Department of Nursing, Ede Christian University, Ede, The Netherlands; rrvleeuwen@che.nl]. “**The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care.**” *Journal of Clinical Nursing* 17, no. 20 (Oct 2008): 2768-2781.
 [From the abstract:] DESIGN: Quasi-experimental crossover design (pre-post-test). METHOD: The subjects were students from Christian nursing schools in the Netherlands (n = 97). The intervention consisted of a course in spiritual care. Competencies were measured with an assessment tool, the Spiritual Care Competence Scale. Data were analysed by t-test procedures (paired-samples t-test). At T(1) vignettes were added to assess the quality of the students' own analyses. These data were analysed by a Mann-Whitney test. Regression analyses were performed on the influence of student characteristics on the subscales of the assessment tool. RESULTS: Ninety-seven students participated in this study. Analysis showed statistically significant changes in scores on three subscales of the Spiritual Care Competence Scale between groups (T(1)) and over time for the whole cohort of students on all subscales (T(2)). Clinical placement showed as a negative predictor for three subscales of the Spiritual Care Competence Scale. Experience in spiritual care and a holistic vision of nursing both showed as positive

predictors on certain competencies. A statistically significant difference was observed between groups in the student analysis of a vignette with explicit spiritual content....

Van Ness, P. H., Towle, V. R., O'Leary, J. R. and Fried, T. R. [Yale University School of Medicine, Department of Internal Medicine, Program On Aging, and Yale School of Public Health, New Haven, CT; peter.vanness@yale.edu]. **“Religion, risk, and medical decision making at the end of life.”** *Journal of Aging & Health* 20, no. 5 (Aug 2008): 545-559.

[Abstract:] OBJECTIVE: The purpose of this study is to present empirical evidence about whether religious patients are more or less willing to undergo the risks associated with potentially life-sustaining treatment. METHODS: At least every 4 months 226 older community-dwelling persons with advanced cancer, congestive heart failure, or chronic obstructive pulmonary disease were asked questions about several dimensions of religiousness and about their willingness to accept potentially life-sustaining treatment. RESULTS: Results were mixed but persons who said that during their illness they grew closer to God (odds ratio [OR] = 1.79; 95% confidence intervals [CI] = 1.15, 2.78) or those grew spiritually (OR = 1.61; 95% CI = 1.03, 2.52) were more willing to accept risk associated with potentially life-sustaining treatment than were persons who did not report such growth. DISCUSSION: Not all dimensions of religiousness have the same association with willingness to undergo potentially life-sustaining treatment. Seriously ill older, religious patients are not especially predisposed to avoid risk and resist treatment. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/dec08.html].

Van Voorhees, B. W., Paunesku, D., Kuwabara, S. A., Basu, A., Gollan, J., Hankin, B. L., Melkonian, S. and Reinecke, M. [Department of Medicine, University of Chicago, IL; bvanvoor@medicine.bsd.uchicago.edu]. **“Protective and vulnerability factors predicting new-onset depressive episode in a representative of U.S. adolescents.”** *Journal of Adolescent Health* 42, no. 6 (Jun 2008): 605-616.

[From the abstract:] ...METHODS: We conducted logistic regression analyses to identify baseline individual, family, school/peer and community factors predicting new-onset depressive episode at a 1-year follow-up in a longitudinal cohort study of 4791 U.S. adolescents.... RESULTS: African American and Hispanic ethnicity, female gender, and low-income status predicted higher risk of onset of a depressive episode. Active coping and positive self-concept, predicted lower risk, whereas poor affect regulation and greater depressed mood predicted higher risk. Family “connectedness,” parental warmth, peer acceptance, better school performance, and religious activities were protective, whereas parental conflict, delinquent activities, and greater numbers of adverse events increased risk of depressive episodes....

Vance, D. E., Struzick, T. C. and Raper, J. L. [School of Nursing, University of Alabama at Birmingham; devance@uab.edu]. **“Biopsychosocial benefits of spirituality in adults aging with HIV: implications for nursing practice and research.”**

Journal of Holistic Nursing 26, no. 2 (Jun 2008): 119-125. Comment on pp. 126-127. [This is one of several spirituality-themed research articles in this issue of the journal. See the articles by Bormann, et al. and Witte, et al. (noted elsewhere in this bibliography). See also the introduction to the issue: Cowling, W. R., 3rd., “On spirituality and holism,” p. 83.]

[From the abstract:] ...With the positive effects of spirituality on biopsychosocial functioning in aging, HIV, and chronic diseases, accessing the strengths associated with spirituality may facilitate successful aging in adults surviving to older ages. The inherent nature of the nurse-patient relationship means nurses are in a key position to actively listen, assess spiritual needs, and make clinical referrals. In providing holistic care to patients, nurse scientists are encouraged to study and address the spiritual needs in this growing population. [56 refs.]

Vanderwerker, L. C., Flannelly, K. J., Galek, K., Harding, S. R., Handzo, G. F., Oettinger, M. and Bauman, J. P. [The HealthCare Chaplaincy, New York, NY]. **“What do chaplains really do? III. Referrals in the New York Chaplaincy Study.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 57-73. [See other articles from the special journal issue on chaplaincy research by Handzo, et al.; Weaver, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography. Two articles by Handzo, et al., are companion analyses of the New York Chaplaincy Study.]

[Abstract:] The current study examines patterns of referrals to chaplains documented in the 1994-1996 New York Chaplaincy Study. The data were collected at thirteen healthcare institutions in the Greater New York City area. Of the 38,600 usable records in the sample, 18.4% were referrals, which form the sample for the current study (N = 7,094). The most common sources of referrals were nurses (27.8%) and patients themselves (22.3%), with relatively few referrals coming from physicians and social workers. The study shows the range of patient issues that are referred to chaplains, including emotional, spiritual, medical, relationship/support, and a change in diagnosis or prognosis. Although the reasons for referral varied by hospital setting and referral source, overall, patients were referred more frequently for emotional (30.0%) than for spiritual issues (19.9%). Results are discussed in relation to the need to clarify the role of the chaplain to the rest of the healthcare team, to recognize when there is a spiritual cause of emotional distress, and to establish effective referral protocols.

Vanderwerker, L. C., Handzo, G. F., Fogg, S. L. and Overvold, J. A. [Spears Research Institute of HealthCare Chaplaincy, New York, NY]. **“Selected findings from the ‘New York’ and the ‘Metropolitan’ chaplaincy studies: a 10-year comparison of chaplaincy in the New York City area.”** *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 13-24. [This article was still listed on Medline’s *In-Process* database at the time of this bibliography’s completion.]

[Abstract:] In recent years, the chaplain-to-patient ratio in U.S. hospitals has remained roughly the same while the role of the hospital chaplain has expanded. We compared data on 33,000 chaplain visits from the New York Chaplaincy Study (1994-1996) with 58,000 chaplain visits from the Metropolitan Chaplaincy Study (2005-2006), in order to explore whether changes in both the role of the healthcare chaplain and changes in the healthcare system itself have affected the amount of time that chaplains are able to spend with patients. The overall pattern of lengths of visits was stable over time, but chaplains in the Metropolitan Chaplaincy Study had proportionally fewer visits with family members and more visits with patients, more visits based on referrals, and spent more time dealing with end-of-life issues than chaplains in the earlier New York Chaplaincy Study. We discuss ways that chaplains seem to be adjusting successfully to increasing demands on their time.

Vivat, B. and Members of the Quality of Life Group of the European Organisation for Research and Treatment of Cancer [School of Health Sciences and Social Care, Brunel University, Uxbridge, Middlesex, UK; bella.vivat@brunel.ac.uk]. **“Measures of spiritual issues for palliative care patients: a literature review.”** *Palliative Medicine* 22, no. 7 (Oct 2008): 859-868.

[Abstract:] Members of the Quality of Life Group (QLG) of the European Organisation for Research and Treatment of Cancer (EORTC) are developing a stand-alone functional measure of spiritual well being for palliative care patients, which will have both a clinical and a

measurement application. This article discusses data from a literature review, conducted at two time points as part of the development process of this instrument. The review identified 29 existing measures of issues relating to patients' spirituality or spiritual well being. Twenty two are stand-alone measures of which 15 can be categorised as substantive (investigating the substance of respondents' beliefs) and seven as functional (exploring the function those beliefs serve). However, perhaps owing to the lack of consensus concerning spirituality or spiritual well being, the functional measures all have different (although sometimes overlapping) dimensions. In addition, they were all developed in a single cultural context (the United States), often with predominantly Christian participants, and most were not developed with palliative care patients. None is, therefore, entirely suitable for use with palliative care patients in the United Kingdom or continental Europe.

Vujnovich, A. [St. Mark's and Northwick Park Hospital, Middlesex, UK; angela.vujnovich@nwlh.nhs.uk]. "**Pre and post-operative assessment of patients with a stoma.**" *Nursing Standard* 22, no. 19 (Jan 16-20, 2008): 50-56.

Among the points of this article are the following comments about cultural and religious factors: "These issues should be discussed with patients. In Muslim cultures the left hand is used for cleaning and hygiene and the right hand for eating and touching clean items.... This may cause difficulties in managing the stoma and the stoma care nurse will need to work with the patient to find an appropriate appliance that the patient can use with his or her left hand only." [p. 51]

Wachholtz, A. B. and Pargament, K. I. [University of Massachusetts Medical Center, Worcester; WachholA@ummhc.org]. "**Migraines and meditation: does spirituality matter?**" *Journal of Behavioral Medicine* 31, no. 4 (Aug 2008): 351-366.

[Abstract:] Migraine headaches are associated with symptoms of depression and anxiety (Waldie and Poulton *Journal of Neurology, Neurosurgery, and Psychiatry* 72: 86-92, 2002) and feelings of low self-efficacy (French et al. *Headache*, 40: 647-656, 2000). Previous research suggests that spiritual meditation may ameliorate some of the negative traits associated with migraine headaches (Wachholtz and Pargament *Journal of Behavioral Medicine*, 30: 311-318, 2005). This study examined two primary questions: (1) Is spiritual meditation more effective in enhancing pain tolerance and reducing migraine headache related symptoms than secular meditation and relaxation? and, (2) Does spiritual meditation create better mental, physical, and spiritual health outcomes than secular meditation and relaxation techniques? Eighty-three meditation naive, frequent migraineurs were taught Spiritual Meditation, Internally Focused Secular Meditation, Externally Focused Secular Meditation, or Muscle Relaxation which participants practiced for 20 min a day for one month. Pre-post tests measured pain tolerance (with a cold pressor task), headache frequency, and mental and spiritual health variables. Compared to the other three groups, those who practiced spiritual meditation had greater decreases in the frequency of migraine headaches, anxiety, and negative affect, as well as greater increases in pain tolerance, headache-related self-efficacy, daily spiritual experiences, and existential well being. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/oct08.html].

Wade, C., Chao, M., Kronenberg, F., Cushman, L. and Kalmuss, D. [Richard & Hinda Rosenthal Center for Complementary and Alternative Medicine, Columbia University, New York, NY; wade@columbia.edu]. "**Medical pluralism among American women: results of a national survey.**" *Journal of Women's Health* 17, no. 5 (Jun 2008): 829-840. [See also the article by Mann, et al., in this journal issue (noted elsewhere in this bibliography).]

Among the results of this 2001 nationally representative telephone survey of 808 adult women was that there was 67% prevalence of Complementary and Alternative Medicine use when spirituality, religion, or prayer for health was included as CAM modalities and 53% when spirituality, religion, or prayer for health was excluded from the measure. "After spirituality, religion, or prayer (39%), vitamins (26%) and herbs (18%) were most commonly used." [See p. 831.]

Wagenfeld-Heintz, E. [Baker College, Flint, MI; emwheintz@yahoo.com]. "**One mind or two? How psychiatrists and psychologists reconcile faith and science.**" *Journal of Religion & Health* 47, no. 3 (Sep 2008): 338-353.

[Abstract:] Utilizing qualitative interviews, this study showed how, to what extent, and why psychiatrists and psychologists of Judeo-Christian religious orientations or nonaffiliated believers in Michigan were willing or reluctant to integrate religious paradigms in their mental health practices. Most of the study participants were found to believe that medical-scientific and religious paradigms are equally important and may coexist or even be integrated in psychotherapeutic practice. However, actual attempts to integrate them usually reflected the practitioners' personal religious backgrounds and initiatives and/or were client driven. Yet these integration initiatives were found to face powerful institutional impediments such as politico-cultural norms of separation of religion from secular institutions and professional norms.

Wahl, R. A., Cotton, S. and Harrison-Monroe, P. [Department of Pediatrics, University of Arizona, Tucson; rwahl@u.arizona.edu]. "**Spirituality, adolescent suicide, and the juvenile justice system.**" *Southern Medical Journal* 101, no. 7 (Jul 2008): 711-715.

[Abstract:] BACKGROUND: Spirituality is often overlooked as a coping method and resilience factor in the lives of adolescents. An improved understanding of the role of spirituality in the lives of adolescents will help in understanding the choices many teens face during times of personal crisis. Youth entering the juvenile justice system often present with high rates of mental health problems and suicidal ideation. METHOD: Two clinical vignettes of adolescents who exhibited suicidal ideation while in juvenile detention are discussed. DISCUSSION: An understanding of the role of spirituality for an adolescent in crisis can greatly enhance our ability to provide culturally competent care and offer meaningful support. This becomes increasingly important as the juvenile detention population becomes ever more diverse. Valuable information can be obtained by taking a "clinical spiritual history" which enables clinicians to have a clearer understanding of an adolescent's worldview and provide the necessary therapeutic interventions. Specific questions are suggested as a basis for obtaining this information.

Walach, H., Bosch, H., Lewith, G., Naumann, J., Schwarzer, B., Falk, S., Kohls, N., Haraldsson, E., Wiesendanger, H., Nordmann, A., Tomasson, H., Prescott, P. and Bucher, H. C. [Samueli Institute, School of Social Sciences, University of Northampton, Northampton, UK; harald.walach@northampton.ac.uk]. "**Effectiveness of distant healing for patients with chronic fatigue syndrome: a randomised controlled partially blinded trial (EUHEALS).**" *Psychotherapy & Psychosomatics* 77, no. 3 (2008): 158-166.

[Abstract:] BACKGROUND: Distant healing, a form of spiritual healing, is widely used for many conditions but little is known about its effectiveness. METHODS: In order to evaluate distant healing in patients with a stable chronic condition, we randomized 409 patients with chronic fatigue syndrome (CFS) from 14 private practices for environmental medicine in Germany and Austria in a two by two factorial design to immediate versus deferred (waiting for 6 months) distant healing. Half the patients were blinded and half knew their treatment allocation. Patients were treated for 6 months and allocated to groups of 3 healers from a pool of 462 healers in 21 European countries with different

healing traditions. Change in Mental Health Component Summary (MHCS) score (SF-36) was the primary outcome and Physical Health Component Summary score (PHCS) the secondary outcome. RESULTS: This trial population had very low quality of life and symptom scores at entry. There were no differences over 6 months in post-treatment MHCS scores between the treated and untreated groups. There was a non-significant outcome ($p = 0.11$) for healing with PHCS (1.11; 95% CI -0.255 to 2.473 at 6 months) and a significant effect ($p = 0.027$) for blinding; patients who were unblinded became worse during the trial (-1.544; 95% CI -2.913 to -0.176). We found no relevant interaction for blinding among treated patients in MHCS and PHCS. Expectation of treatment and duration of CFS added significantly to the model. CONCLUSIONS: In patients with CFS, distant healing appears to have no statistically significant effect on mental and physical health but the expectation of improvement did improve outcome.

Waldrop, D. P. [University at Buffalo, School of Social Work, Buffalo, NY]. **“Treatment at the end of life.”** *Journal of Gerontological Social Work* 50, suppl. 1 (2008): 267-292.

This review of “evidence-based psychosocial treatments at the end of life for both older adults and their caregivers” emphasizes the “greater need for evidence-based psychosocial treatment to diminish some of the prolonged emotional, psychological treatment to diminish some of the prolonged emotional, psychological, social, and spiritual distress that accompanies dying” [p. 267; abstract]. [45 refs.]

Wallace, M., Campbell, S., Grossman, S. C., Shea, J. M., Lange, J. W. and Quell, T. T. [Fairfield University; meredith.wallace@yale.edu]. **“Integrating spirituality into undergraduate nursing curricula.”** *International Journal of Nursing Education Scholarship* 5 (2008): Article 10 [online journal].

[Abstract:] Nursing programs have done a commendable job keeping pace with the rapid advances in disease management. Yet, spirituality has received far less attention in nursing curricula (Keefe, 2005) and nursing students often do not have a strong foundation in this area. The purpose of this project was to integrate spirituality into the undergraduate nursing curricula and measure student outcomes related to spiritual knowledge and attitudes. Nursing faculty participated in a spirituality education program and followed this with sessions focused on integration of spiritual content into individual nursing courses. Student pre and post-tests were administered using a standard instrument to evaluate the effectiveness of the program. Significant differences in spirituality knowledge and attitudes among senior-level nursing students ($t = -3.059$, $p = .004$) were revealed. As the healthcare system becomes increasingly complex, providing students with tools to identify and strengthen inner resources is essential to patient care.

Weaver, A. J. **“Mission to enhance the quality and quantity of chaplaincy research: preface.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 1-2.

This is a preface to the special issue of the journal on chaplaincy research. [See other articles from the issue by Weaver, et al.; Handzo, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography.]

Weaver, A. J., Flannelly, K. J. and Liu, C. **“Chaplaincy research: its value, its quality, and its future.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 3-19. [See other articles from the special journal issue on chaplaincy research by Weaver, et al.; Handzo, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography.]

[Abstract:] The article is divided into four major sections, the first of which presents and discusses various reasons given by major researchers in the field why chaplains should do research. The second section summarizes findings on the sophistication of research on religion and health published in (a) medical and other healthcare journals, and (b) specialty journals on religion and health, chaplaincy, and pastoral care and counseling. The third section revisits suggestions that have been made by prominent chaplain researchers to increase and improve research by chaplains. The last section offers some suggestions for expanding several lines of current research in the future, including research: (1) to elucidate the nature of spiritual care chaplains provide to different populations, including patients, families and staff; (2) to assess the prevalence and intensity of patients' spiritual needs and the degree to which they are being met; (3) to identify that subset of patients who are spiritually at risk in terms of having high needs and slow religious resources; (4) to identify the biological causal mechanisms by which religion influences health; and (5) to measure the effectiveness of chaplain interventions.

Weaver, A. J., Koenig, H. G. and Flannelly, L. T. [The HealthCare Chaplaincy, New York, NY]. **“Nurses and healthcare chaplains: natural allies.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 91-98. [See other articles from the special journal issue on chaplaincy research by Weaver, et al.; Handzo, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography.]

[Abstract:] The collaborative relationship between nurses and chaplains in the health care setting is well documented. The authors review research findings including survey results demonstrating the importance of religion and spirituality in the general population and the importance of the religion and faith in people suffering illnesses. Nurses and physicians show marked differences in their attention to spiritual care as evidenced by nurses' higher rates of referrals to chaplains and the greater quantity of nursing research on spirituality in professional journals. Three factors that might account for nurses' recognition of spiritual needs are: 1) the inclusion of spiritual care in the nursing curriculum, 2) personal involvement in faith communities and, 3) the historical influences of the nursing profession. Further research of this partnership and its effect on patient care should ultimately benefit the most vulnerable individuals in the health care setting.

Weaver, A. J., Vane, A. and Flannelly, K. J. [The HealthCare Chaplaincy, New York, NY]. **“A review of research on Buddhism and health: 1980-2003.”** *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 118-132. [See other articles from the special journal issue on chaplaincy research by Weaver, et al.; Handzo, et al.; Vanderwerker, et al.; Harding, et al.; and Koenig --all noted elsewhere in this bibliography.]

[Abstract:] Electronic searches of social science and biomedical literature identified 44 empirical studies that specifically investigate Buddhism, meditation, and health. The number of studies increased over time, especially in medical and other health-related fields. The studies were found to differ by geographical region with regard to the emphasis on spiritual, psychological, or physical outcomes. Results from this study are explored with respect to historical trends as well as current variations in scholarship and religious practice between the regions.

Wells, J. N., Cagle, C. S., Bradley, P. and Barnes, D. M. [Texas Christian University, Harris College of Nursing and Health Sciences, Fort Worth, TX; J.Wells@tcu.edu]. **“Voices of Mexican American caregivers for family members with cancer: on becoming stronger.”** *Journal of Transcultural Nursing* 19, no. 3 (Jul 2008): 223-233.

Among the findings of this study of 34 Mexican American female caregivers who provided care to a family member with cancer: “Both spirituality and “looking to God” served as primary coping resources previously identified in many studies that address the importance of religion and spirituality as sources of solace and hope in various ethnic populations.... Caregivers showed both strong spirituality...and religiosity...but in nonchurch settings. Caregivers may feel more supported in their spiritual needs in cancer clinics that provide an on-site prayer room and access to private pastoral care during their long waits there.” [P. 231.]

Whitford, H. S., Olver, I. N. and Peterson, M. J. [Royal Adelaide Hospital Cancer Centre, Australia; hwhitford@optusnet.com.au]. **“Spirituality as a core domain in the assessment of quality of life in oncology.”** *Psycho-Oncology* 17, no. 11 (Nov 2008): 1121-1128.

[Abstract:] OBJECTIVES: This study investigated including spiritual wellbeing as a core domain in the assessment of quality of life (QOL) in an Australian oncology population. METHODS: Four hundred and ninety consecutive cancer patients with mixed diagnoses completed the Functional Assessment of Chronic Illness Therapy--Spiritual Well-Being (FACIT-Sp) and the Mental Adjustment to Cancer (MAC) scale. RESULTS: Overall, 449 patients completed assessments. Spiritual wellbeing demonstrated a significant, positive association with QOL ($r=0.59$), fighting spirit ($r=0.49$) and a significant, negative relationship with helplessness/hopelessness ($r=-0.47$) and anxious preoccupation ($r=-0.26$). A hierarchical multiple regression showed spiritual wellbeing to be a significant, unique contributor to QOL beyond the core domains of physical, social/family, and emotional wellbeing ($R(2)$ change= 0.08 , $p=0.000$). However, high levels of meaning/peace or faith did not appear to significantly impact patients' ability to enjoy life despite chronic symptoms of pain or fatigue, making the current results inconsistent with other findings. CONCLUSION: Results lend further support to the biopsychosocialspiritual model. By failing to assess spiritual wellbeing, the 'true' burden of cancer is likely to be miscalculated. However, at this stage, the exact clinical utility of spirituality assessment is unclear.

Wiech, K., Farias, M., Kahane, G., Shackel, N., Tiede, W. and Tracey, I. [Nuffield Department of Anaesthetics, University of Oxford, John Radcliffe Hospital, Oxford, UK; kwiech@fmrib.ox.ac.uk]. **“An fMRI study measuring analgesia enhanced by religion as a belief system.”** *Pain* 139, no. 2 (Oct 15, 2008): 467-476. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] Although religious belief is often claimed to help with physical ailments including pain, it is unclear what psychological and neural mechanisms underlie the influence of religious belief on pain. By analogy to other top-down processes of pain modulation we hypothesized that religious belief helps believers reinterpret the emotional significance of pain, leading to emotional detachment from it. Recent findings on emotion regulation support a role for the right ventrolateral prefrontal cortex (VLPFC), a region also important for driving top-down pain inhibitory circuits. Using functional magnetic resonance imaging in practicing Catholics and avowed atheists and agnostics during painful stimulation, here we show the existence of a context-dependent form of analgesia that was triggered by the presentation of an image with a religious content but not by the presentation of a non-religious image. As confirmed by behavioral data, contemplation of the religious image enabled the religious group to detach themselves from the experience of pain. Critically, this context-dependent modulation of pain specifically engaged the right VLPFC, whereas group-specific preferential liking of one of the pictures was associated with activation in the ventral midbrain. We suggest that religious belief might provide a framework that allows individuals to engage known pain-regulatory brain processes.

Wijk, H. and Grimby, A. [Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg and Sahlgrenska University Hospital, Gothenburg, Sweden; helle.wijk@vgregion.se]. **“Needs of elderly patients in palliative care.”** *American Journal of Hospice & Palliative Care* 25, no. 2 (Apr-May 2008): 106-111.

Among the findings of this study of 30 patients in a Swedish geriatric palliative care ward was that [from the abstract:] Only when pain was eliminated or absent did other important needs (psychological, social, spiritual) appear frequently.

Wiklund, L. [School of Health, Care and Social Welfare, Malardalen University, Vasteras, Sweden; lena.wiklund@mdh.se]. **“Existential aspects of living with addiction - part I: meeting challenges.”** *Journal of Clinical Nursing* 17, no. 18 (Sep 2008): 2426-2434.

[Abstract:] AIM: This paper aims to explore the existential aspects of living with addiction. BACKGROUND: This study arises from data from a previous research project carried out by the author and takes as its point of departure the patient's perspective. Addiction is described as being related to traumatic experience and to loss of control, shame, guilt and low self-esteem, but also to spirituality. This causes profound suffering and drugs are used as a means of handling this suffering. DESIGN: Hermeneutic inquiry was used to explore peoples experiences of living with addiction. METHOD: The first study was based on interviews with people with rich, personal experience of addiction. This study constitutes a secondary analysis of the same data and was conducted using a hermeneutic approach. RESULTS: On an existential level the experiences of living with addiction can be understood as a striving to meet and resolve challenges associated with spirituality caused by a person's suffering and, paradoxically, also by his/her efforts to relieve that suffering through the use of drugs. These challenges are presented as themes focusing on the conflict that must be met; meaning - meaninglessness, connectedness - loneliness, life - death, freedom - adjustment, responsibility - guilt, control - chaos. CONCLUSION: Living with addiction appears as being in the midst of a struggle with existential challenges. Furthermore, the use of drugs is paradoxical as it momentarily relieves suffering but at the same time increases it. RELEVANCE TO CLINICAL PRACTICE: Addressing the challenges will facilitate nurses interaction with addicted persons. When facing challenges, including the motivational aspects, instead of focusing on problems, health can be promoted and suffering relieved.

Wiklund, L. [School of Health, Care and Social Welfare, Malardalen University, Vasteras, Sweden; lena.wiklund@mdh.se]. **“Existential aspects of living with addiction - part II: caring needs. A hermeneutic expansion of qualitative findings.”** *Journal of Clinical Nursing* 17, no. 18 (Sep 2008): 2435-2443.

[Abstract:] AIM: This paper aims to describe caring needs associated with existential aspects of living with addiction. BACKGROUND: Spirituality is considered a driving force within and the concept relates to self, others and God and the relationships between them. The spiritual dimension is of great importance in both the addiction itself as well as in recovery and addressing caring needs relating to spirituality is important in nursing. DESIGN: Hermeneutic inquiry was used to explore caring needs related to peoples experiences of living with addiction. METHOD: This paper is a hermeneutic expansion of findings presented in Part I. Existential themes in the form of spiritual challenges and caring needs are reflected upon as a process between figure and background. RESULTS: The themes presented are: meaning - meaninglessness, connectedness - loneliness, life - death, freedom - adjustment, responsibility - guilt, control - chaos. Caring needs associated

with them are identified as; the need to create a new frame of reference for interpreting of life, the need to experience coherence in life, a restored dignity as well as the need for a sense of community and attachment, confirmation and acceptance. The caring need for forgiveness and reconciliation is also identified as well as the need for continuity, comprehensibility and manageability. CONCLUSIONS: When caring for patients suffering from addiction nurses should address patients' spirituality. The caring communion is vital, as it is the foundation for meeting the patients' needs. Intervention by nurses should focus on aspects that will help patients feel alive and in communion with others. RELEVANCE TO CLINICAL PRACTICE: Understanding and being able to identify patients' caring needs associated with existential aspects of living with addiction will enable nurses to provide professional care and promote patient's recovery.

Wilkinson, J. E., Saper, R. B., Rosen, A. K., Welles, S. L. and Culpepper, L. [Department of Family Medicine, Boston University, Boston, MA; Joanne.Wilkinson@bmc.org]. **"Prayer for health and primary care: results from the 2002 National Health Interview Survey."** *Family Medicine* 40, no. 9 (Oct 2008): 638-644.

[Abstract:] BACKGROUND AND OBJECTIVES: Prayer for health (PFH) is common; in 2002, 35% of US adults prayed for their health. We examined the relationship of PFH and primary care visits, with a special focus on African American women, using data from the 2002 National Health Interview Survey (NHIS). METHODS: We used chi-square analyses to compare the demographic (age group, gender, race, region, marital status, educational level, ethnicity) and health-related covariates (alcohol use, smoking status, and selected medical conditions) between individuals who did and did not pray for their health in the past year. Univariate associations between PFH and visit to primary care provider (PCP), with Mantel-Haenszel adjustment for confounding, were determined. Multivariate regression was used to determine independent factors associated with PFH and PCP visit, with SUDAAN to adjust for the clustered survey design. RESULTS: Subjects who prayed were more likely to be female, older than 58, Black, Southern, separated, divorced or widowed, and nondrinkers. Subjects who prayed were also more likely to have seen a PCP within the past year. Black women who prayed were also more likely to see a PCP. CONCLUSIONS: These findings suggest that people who pray for their health do so in addition to, not instead of, seeking primary care. This finding is maintained but with a smaller effect size, in Black women.

Wilks, S. E. and Vonk, M. E. [LSU School of Social Work, Baton Rouge, LA; swilks@lsu.edu]. **"Private prayer among Alzheimer's caregivers: mediating burden and resiliency."** *Journal of Gerontological Social Work* 50, nos. 3-4 (2008): 113-131.

[Abstract:] This study examined whether the coping method of private prayer served as a protective factor of resiliency among a sample (N = 304) of Alzheimer's caregivers. Participants in caregiver support groups completed questionnaires that assessed a number of constructs, including caregiving burden; prayer frequency; use of private prayer as a means of coping; and perceived resiliency. The sample averaged a moderate level of burden and a great extent of prayer usage. Caregiving burden had positively affected the extent of prayer usage and negatively influenced perceived resiliency. Findings from hierarchical regression analysis showed that caregiving burden and private prayer significantly influenced variation in perceived resiliency scores. Results from a regression equation series and path analysis provided support for prayer as a mediator between burden and perceived resiliency. Implications for social work practice and education are discussed.

Williams, N., Wilkinson, C., Stott, N. and Menkes, D. B. [Department of Primary Care and Public Health, Cardiff University, North Wales Clinical School, Wrecsam, UK; williamsnh@cf.ac.uk]. **"Functional illness in primary care: dysfunction versus disease."** *BMC Family Practice* 9 (2008): 30 [online journal].

This is a consideration of the Biopsychosocial Model, including the Spiritual dimension in that model. [From the abstract:] We propose a classification of illness that includes orthogonal dimensions of pathology and dysfunction to support a broadly based clinical approach to patients; adoption of which may lead to fewer inappropriate investigations and secondary care referrals and greater use of cognitive behavioral techniques, particularly when managing functional illness.

Witte, A. S., van der Wal, D. M. and Steyn, H. C. [Glennville State College/West Virginia University Joint Nursing Program, WV; jwitte@rtol.net]. **"Mystical experience in the context of health care."** *Journal of Holistic Nursing* 26, no. 2 (Jun 2008): 84-92. Comment on pp. 93-95, and discussion on pp. 96-97. [This is one of several spirituality-themed research articles in this issue of the journal. See the articles by Bormann, et al. and Vance, et al. (noted elsewhere in this bibliography). See also the introduction to the issue: Cowling, W. R., 3rd., "On spirituality and holism," p. 83.]

[Abstract:] Eighteen participants in a rural Appalachian community were interviewed to learn about their mystical experiences in the context of health care. Semistructured interviews addressed factors initiating mystical experience and essential qualities of mystical experience. Nursing process and the nurse's response were examined. Data were analyzed using the immersion/crystallization method and concept mapping. Mystical experience was conceptualized as a process incorporating initiation, occurrence, maturation, and integration of mystical experience. Essential qualities included sensory-motor perception, interaction with the supernatural, interaction with family members, conviction of reality, cognition, dynamic tension and emotional intensity. Nursing interventions included listening and support. Subjective nursing responses included tension, intimacy and empathy, sense of awe, autonomic responses, and appreciation of the mystical in everyday life. Various stressors are associated with mystical experience. Patients having mystical experiences may benefit from nursing support. [For a review of this article for the Research Network of the Association for Clinical Pastoral Education, see: www.acperesearch.net/nov08.html].

Wittenberg-Lyles, E., Oliver, D. P., Demiris, G., Baldwin, P. and Regehr, K. [Department of Communication Studies, University of North Texas, Denton; lyles@unt.edu]. **"Communication dynamics in hospice teams: understanding the role of the chaplain in interdisciplinary team collaboration."** *Journal of Palliative Medicine* 11, no. 10 (Dec 2008): 1330-1335. [This article was still listed on Medline's *In-Process* database at the time of this bibliography's completion.]

[Abstract:] BACKGROUND: Hospice chaplains provide a specific expertise to patient and family care, however, individual roles and responsibilities that facilitate the interdisciplinary team environment are less well known. OBJECTIVE: The primary aim of this study was to investigate how hospice chaplains perceive their role in interdisciplinary team meetings and to what extent hospice chaplains share common experiences within the interdisciplinary team approach in hospice. METHOD: Hospice chaplains within a 10-state region participated in a 39-item phone survey about professional roles, group roles, and structural characteristics that influence their ability to participate in interdisciplinary collaboration. RESULTS: Findings revealed that professional role conflict is experienced, primarily with social workers. Informal group task and maintenance roles included team spiritual care advisor and conflict manager, and structural characteristics consisted of

extracurricular communication outside of the organization. CONCLUSIONS: Although chaplains foster interdisciplinary collaboration within the hospice team, future research needs to address improvements to the chaplain's role within the interdisciplinary team process.

Wolchik, S. A., Coxe, S., Tein, J. Y., Sandler, I. N. and Ayers, T. S. [Prevention Research Center, Arizona State University, Tempe; sharlene.wolchik@asu.edu]. **“Six-year longitudinal predictors of posttraumatic growth in parentally bereaved adolescents and young adults.”** *Omega - Journal of Death & Dying* 58, no. 2 (2008-2009): 107-128.

This study, involving 50 adolescents and young adults who had experienced parental death in childhood or adolescence, used the Posttraumatic Growth Inventory. Among the findings: “The set of mental health and social adaptation outcomes accounted for a medium proportion of variance in New Possibilities and Spiritual Change scores. Controlling for the other mental health and social adaptation variables as well as time since death, internalizing problems had a significant positive effect on both New Possibilities and Spiritual Change and externalizing problems had a significant negative effect on Spiritual Change.” [p. 123]

Woll, M. L., Hinshaw, D. B. and Pawlik, T. M. [Department of Surgery, Johns Hopkins Hospital, Johns Hopkins University School of Medicine, Baltimore, MD]. **“Spirituality and religion in the care of surgical oncology patients with life-threatening or advanced illnesses.”** *Annals of Surgical Oncology* 15, no. 11 (Nov 2008): 3048-3057.

[Abstract:] Spiritual and religious concerns often become of central importance in the care of surgical oncology patients confronted with their mortality. Unfortunately, surgeons are often ill prepared or reluctant to address the spiritual and religious needs of their patients. In this article, working definitions of spirituality versus religiosity will be developed in the context of the three largest monotheistic religions in America: Christianity, Islam, and Judaism. Disease, dying, and death will be explored with respect to these faiths and examples of how to address religious beliefs in practical clinical settings will be given. Finally, specific suggestions will be made for surgeons to better understand, empathize with, and address the needs of their seriously ill patients in a holistic manner.

Wright, L. M. [Faculty of Nursing, University of Calgary, Canada; lmwright@ucalgary.ca]. **“Softening suffering through spiritual care practices: one possibility for healing families.”** *Journal of Family Nursing* 14, no. 4 (Nov 2008): 394-411.

[Abstract:] Nurses are engaged and encounter suffering routinely and commonly in their everyday practice. It is therefore a moral and ethical obligation for nurses to soften the emotional, physical, and spiritual suffering of the individuals and families in their care. Softening suffering is the heart of nursing. However, this article ponders the question, “What happened to suffering in nursing care?” A discussion of suffering is explored from many aspects, such as what invites suffering and the connection of suffering to spirituality. Lessons learned from the author's clinical practice and research are described, such as acknowledging suffering, social support, hope and prayer, and individual and family counseling. Finally, seven spiritual care practices within the Trinity Model that have shown to be useful in softening suffering are offered. An actual clinical example is woven throughout to illustrate the benefits of these spiritual care practices in the mission of softening illness suffering.

Yardley, M. [mby2101@gmail.com]. **“Social work practice with Pagans, Witches, and Wiccans: guidelines for practice with children and youths.”** *Social Work* 53, no. 4 (Oct 2008): 329-336.

[Abstract:] This article introduces social workers to the beliefs and practices associated with Paganism, Witchcraft, and Wicca and describes how social workers can help to create a welcoming environment for children and youths belonging to these religious minority groups. Drawing on social science research, social work literature, and a case example, the author presents suggestions for working with Pagan children and youths in various practice settings, including child welfare agencies, schools, and family-oriented programs.

Yick, A. G. [School of Human Services, Capella University, Minneapolis, MN]. **“A metasynthesis of qualitative findings on the role of spirituality and religiosity among culturally diverse domestic violence survivors.”** *Qualitative Health Research* 18, no. 9 (Sep 2008): 1289-1306.

[Abstract:] In this metasynthesis study, the author explores, extracts, and synthesizes themes from related qualitative studies on the role of spirituality and religiosity with culturally diverse domestic violence survivors. Using Noblit and Hare's metaethnographic strategy, the main themes and concepts from eight qualitative articles (six actual research studies, as three articles were written by the same author from the same data set) were reduced to nine themes. Themes include (a) strength and resilience, (b) tension stemming from religious definition of family, (c) tension stemming from religious definition of gender role expectations, (d) spiritual vacuum, (e) reconstruction, (f) recouping spirit and self, (g) new interpretations of submission, (h) forgiveness as healing, and (i) giving back. Implications for practitioners are discussed.

Yohannes, A. M., Koenig, H. G., Baldwin, R. C. and Connolly, M. J. [Department of Physiotherapy, Manchester Metropolitan University, Manchester, UK; a.yohannes@mmu.ac.uk]. **“Health behaviour, depression and religiosity in older patients admitted to intermediate care.”** *International Journal of Geriatric Psychiatry* 23, no. 7 (Jul 2008): 735-740.

[Abstract:] OBJECTIVE: To examine health behaviour, severity of depression, gender differences and religiosity in older patients admitted to intermediate care for further rehabilitation. DESIGN: Cross-sectional survey. PARTICIPANTS: A research physiotherapist interviewed 173 older patients (113 female), 60 and older consecutively admitted to intermediate care for rehabilitation, usually after acute care. MEASUREMENTS: Religiosity was measured using the Duke University Religion Index, depressive and anxiety symptoms using the Hospital Anxiety Depression Scale, and severity of depression measured by the Montgomery Asberg Depression Rating Scale. Physical disability was assessed by the Nottingham Extended Activities of Daily Living Scale and quality of life measured by the SF-36 questionnaire. RESULTS: After controlling for other factors using multiple regression, religious attendance was associated with positive general health perception ($t = 1.9, p = 0.05$), and inversely associated with number of pack years smoked ($t = -2.05, p = 0.04$) and severity of illness (Charlson Index), [$t = -2.05, p = 0.04$]. Intrinsic religious activity was associated with older age ($t = 3.06, p < 0.003$), female gender ($t = 2.52, p = 0.01$), living situation ($t = -2.17, p < 0.03$) and with less severe depression ($t = -2.43, p = 0.01$). CONCLUSION: In older patients with chronic diseases in intermediate care, religious attendance was associated with positive perceptions of health, less severe illness, and fewer pack years. Intrinsic religious activities were associated with less severe depression and lower likelihood of living alone.

Yosef, A. R. [California School of Health Sciences]. **“Health beliefs, practice, and priorities for health care of Arab Muslims in the United States.”** *Journal of Transcultural Nursing* 19, no. 3 (Jul 2008): 284-291.

[Abstract:] The Arab Muslim population is one of the dramatically increasing minorities in the United States. In addition to other factors, religion and cultural background influence individuals' beliefs, behaviors, and attitudes toward health and illness. The author describes health

beliefs and practices of the Arab Muslim population in the United States. That population is at an increased risk for several diseases and faces many barriers to accessing the American health care system. Some barriers, such as modesty, gender preference in healthcare providers, and illness causation misconceptions, arise out of their cultural beliefs and practices. Other barriers are related to the complexity of the health care system and the lack of culturally competent services within it. Nurses need to be aware of these religious and cultural factors to provide culturally competent health promotion services for this population. Nurses also need to integrate Islamic teachings into their interventions to provide appropriate care and to motivate healthy behaviors.

Zier, L. S., Burack, J. H., Micco, G., Chipman, A. K., Frank, J. A., Luce, J. M. and White, D. B. [UC Berkeley-UC San Francisco Joint Medical Program, University of California, Berkeley]. **“Doubt and belief in physicians' ability to prognosticate during critical illness: the perspective of surrogate decision makers.”** *Critical Care Medicine* 36, no. 8 (Aug 2008): 2341-2347.

This multicenter study (i.e., intensive care units of a public hospital, a tertiary care hospital, and a veterans' hospital) notes, among the findings, the role of religious beliefs in decision-makers' views about physician prognostication (though the authors caution that their study “may underestimate the extent to which religious beliefs influence individuals' beliefs about physicians' ability to prognosticate” [p. 2346]). The theme of “Influence of God” is discussed in terms of three sub-themes: “ICU outcome predetermined by God”; Intervention by God in the course of an ICU illness”; and “Physicians as divine instruments” [--see p. 2342-2343 and Table 3 on p. 2344].

Zivin, K. and Kales, H. C. [National VA Serious Mental Illness Treatment, Research & Evaluation Center (SMITREC), Ann Arbor, MI; kzivin@umich.edu]. **“Adherence to depression treatment in older adults: a narrative review.”** *Drugs & Aging* 25, no. 7 (2008): 559-571.

This review includes a consideration of how spiritual/religious beliefs may be “important determinants of adherence to depression care” [p. 559; abstract] and thus should inform multidimensional strategies for patient care.

Zoloth, L [Director of the Bioethics Program at the Center for Genetic Medicine and Professor of Medical Ethics and Humanities, and of Religion, at Northwestern University, the Feinberg School of Medicine]. **“Go and tend the earth: a Jewish view on an enhanced world.”** *Journal of Law, Medicine & Ethics* 36, no. 1 (Spring 2008): 10-25.

[Abstract:] In this essay, the author considers how one particular faith community, contemporary Judaism, in all its internal diversity, has reflected on the issue of how far the project of genetic intervention ought to go when the subject of the future - embodied, willful, and vulnerable - is at stake. Knowing, naming, and acting to change is not only a narrative of faith traditions; it is a narrative of biological science as well. [This article is part of a special “symposium” on religions and cultures of East and West. For other articles in the issue, see those by Athar, S., by Kirkland, R., by LaFleur, W. R., by Lustig, A., by Matthew, D. B., by Sade, R. M., and by Sarma, D. also noted in this bibliography.]

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.