Osman M. Ali, Glen Milstein, Peter M. Marzuk. "The Imam’s role in meeting the counseling needs of Muslim communities in the United States," Psychiatric Services 56, no. 2 (Feb 2005): 202-5. • Muslims are one of the most rapidly growing minority groups in the United States. They have experienced increased stress since 9/11. The purpose of this study was to better understand the roles of Imams in meeting the counseling needs of members in their communities. An anonymous self-report questionnaire was mailed to over seven hundred mosques in the United States. Sixty-two responses were received from a diverse group of Imams, few of whom had received formal counseling training. The Imams reported that prior to 9/11 their congregants came to them most often for religious or spiritual guidance and relationship or marital concerns. Since that time there has been an increased need to counsel persons regarding issues of discrimination in all congregations where the majority membership is Arab American. The Imams, who are asked to help members of their communities with mental health and social service issues, appear to need more support from mental health professionals in order to improve access to services for Muslim.

Lora E. Burke, Elizabeth A. Schlenk, Susan M. Serieka, Susan M. Cohen, Mary B. Happ, Janice S. Dorman. “Developing research competence to support evidence-based practice,” Journal of Professional Nursing 21, no. 6 (Nov/Dec 2005): 358-63. • The concept of evidence-based practice (EBP) was introduced to the medical world in 1995. Subsequently, the influential Institute of Medicine has advocated the use of EBP in the preparation of professionals within the healthcare field. The nursing profession is embracing the need to do so, and this article describes the introduction of an EBP model into the curriculum at the University of Pittsburgh School of Nursing. Such an approach has not been considered within the formal educational process for chaplains preparing for ministry in healthcare, including mental health. Some in chaplaincy may echo the response familiar within medicine and nursing, questioning whether such an approach is desirable, or even possible. Others may ask whether a discussion about EBP should be initiated within clinical pastoral education.

Marjaneh M. Fooladi. “The healing effects of crying,” Holistic Nursing Practice 19, no. 6 (Nov/Dec 2005): 248-55. • This paper is a broad examination of the world of tears and crying: how they are understood across different cultures, the relationship of tears and gender, and a brief report of the author’s study of the way Pakistani men and women perceive crying and its aftereffects. Fooladi has gathered some fascinating facts about tears. For example, medieval monastics saw tears as a heavenly gift from God, and a Jewish proverb describes tears as “soap for washing the soul.”

Linda K. George, Christopher G. Ellison, David B. Larson. “Explaining the relationships between religious involvement and health,” Psychological Enquiry 13, no. 3 (Jul 2002): 190-200. • This is a detailed review of the social and psychological factors that have been suggested to explain the health-promoting effects of religious involvement. The four potential psychosocial mechanisms suggested are health practices, social support, psychosocial resources, e.g., self-esteem, self-efficacy, and belief structures, e.g., a sense of coherence. The authors find that the evidence concerning these mediators is mixed and
inconsistent, which suggests that there is more to be learned about the pathways by which religion affects health. The authors conclude with some other possible explanations for the link between health and religion.

Jonathan Gruber. “The Massachusetts healthcare revolution: a local start for universal access,” The Hastings Center Report 36, no. 5 (Sept/Oct 2006): 14-19. • Gruber begins his article with a religious joke, which is apropos to his paper. A healthcare policy expert dies and goes to heaven. When he arrives, God himself greets him, and the Lord says to him that he may ask one question before entering heaven. The expert chooses to ask God: “Will there ever be universal health insurance coverage in the United States?” To which God answers: “Yes, but not in my lifetime.” As chaplains may be aware, Massachusetts legislators hope to reform the health insurance system in their state via legislation they approved to transform the nature of the health insurance market. Gruber describes the plan and how it unfolded, summarizing the accomplishments, the prospects and the pitfalls of the approach that Massachusetts is taking to improve the availability of healthcare for its citizens. He discusses the major issues facing attempts at universal coverage as well as the failings of the approaches suggested by policy planners and politicians on both the left and the right. He then turns to the specifics of the Massachusetts legislation, describing how it has attempted to take a path down the center to alleviate the shortcomings of extremes on both sides. The legislation changes the nature of the insurance market in the state, subsidizes a large share of the low-income population, and mandates that all residents have to be covered by health insurance. In his conclusion, Gruber discusses some remaining issues, including whether the Massachusetts approach will work in other states or on a national level.

Scott McConnaha. “Catholic teaching and disparities in care,” Health Progress 87, no. 1 (Jan/Feb 2006): 46-50. • McConnaha describes the healthcare disparities in the United States today. He quotes Scott Burns who has noted, “Disparities in healthcare offer a telling illustration of how durably racism is woven into our social fabric, and how easy it is for subtle, unconscious differences in treatment to add up to significant disparities in outcomes.” He then applies Catholic social justice teaching to what he sees. McConnaha maintains that Catholics must act in ways that will inspire others to recognize the moral implications of the healthcare problems the country is facing.

Pamela Minden. “The importance of words: suggesting comfort rather than pain,” Holistic Nursing Practice 19, no. 6 (Nov/Dec 2005): 267-71. • Words and rituals are central to the functioning of chaplains. In this article, which emphasizes the importance of words, Minden discusses and illustrates how words are used to bring comfort rather than pain. She illustrates how preoccupation with pain, or even the exaggerated use of the word itself, paradoxically may evoke or aggravate the experience of pain. Language constructs reality; as chaplains we shape our words; as humans we are shaped by our words. Minden gives several examples of this, including the words spoken at the time of a medical procedure she underwent, plus a vignette in which a patient shares a profound spiritual experience that gave meaning to his pain.

Denise Pazur. “Prevention’s legislative pioneer - interview,” Advancing Suicide Prevention - special issue: 8-12. • As of January 2007, Senator Harry Reid will be the leader of the majority party in the United States Senate. This will allow him to have a clearer voice in influencing the mental health policies of the new government. Reid has had a long commitment to mental health, a fact that might be linked to the death of his father by suicide in 1972. In this interview, he describes a number of legislative initiatives relating to healthcare, including that of the Wellstone Mental Health Equitable Treatment Act, which was designed to ensure the mental health services in health insurance plans operate under the same terms and conditions as medical and surgical services. Advancing Suicide Prevention may be requested online. (www.advancingsp.org)

Louise Penkman, Laura Scott-Lane, Wendy Pelletier. “A psychosocial program for pediatric oncology patients; a pilot study of ‘The Beaded Journey,’” Journal of Psychosocial Oncology 24, no. 2 (2006): 103-15. • “The Beaded Journey” program is a new approach to providing psychosocial support to children with cancer. This study reports its first formal evaluation. Newly diagnosed children received a beaded rope with letter beads spelling out their names. They also received beads for different aspects of their work-ups and
treatments—thirty-one different kinds of beads in all. The children and their parents also were given diaries in which they were asked to record their experiences. The diary was introduced as an additional way of validating and honoring each child’s cancer journey. Forty-five families participated in the study. Response to the program was very strong. The expected benefits from this activity were realized, and some unexpected benefits were also discovered. For example, some children took their beads to school to help them explain to classmates what was happening to them in the course of their illness and treatment. The one negative was that some participants found the program to be an added burden in what was already a difficult experience.

**Timothy Quill, Sally Norton, Mindy Shah, Yvonne Lam, Charlotte Fridd, Marsha Buckley.** “What is most important to you to achieve? An analysis of patient responses when receiving palliative care consultation,” *Journal of Palliative Medicine* 9, no. 2 (Apr 2006): 382-88. • This report comes from a palliative care team, which apparently takes its patients seriously. One of the ways in which they enact this value is simply to ask each person, when they are seen for the first time, “What is most important for you to achieve?” Responses from 215 patient records generally fell into one of four categories: improving quality and meaning (52 percent) “I want to be able to sit on the front porch and watch the farm go by”; achieving comfort and relief (34 percent) “Can you get rid of my pain?”, altering the course of the illness (22 percent) “If there is a treatment that can make me well, I want it”; preparing for dying (22 percent) “I am not afraid of dying. I just don’t want to suffer.” Approximately 5 percent of the responses could not easily be categorized.

**Carl E. Schneider.** “HIPAA-crazy,” *The Hastings Center Report* 36, no. 1 (Jan/Feb 2006): 10-11. • This article will resonate with chaplains as virtually everyone has been affected by the Health Insurance Portability and Accountability Act (HIPAA) in one way or another. In Schneider’s first sentences, he makes his own reactions clear: “The Department of Health and Human Services has recently been exercising its authority under the (wittily named) ‘administrative simplification’ part of … [HIPAA] to regulate the confidentiality of medical records. I love the goal; I loathe the means. The benefits are obscure; the costs are onerous. Putatively, the regulations protect my autonomy; practically they ensnare me in red tape and hijack my money for services I dislike.” If one wants to know why HIPAA was created and how it is justified, Schneider suggests reading the basic rules—all four hundred pages of small print. He argues that HIPAA was not necessary, has created unwarranted and unnecessary problems and “imposes extravagant costs for exiguous benefits.”

**Roxane C. Silver.** “Attacking the myths,” *Science & Spirit* (Sept/Oct 2006): 27-29. • Following the attacks of 9/11, there were many predictions as to how persons and communities would respond to the tragedy as they processed their emotions about it. Since that date, Silver and her colleagues have been tracking what exactly did happen to people and whether they responded to sudden and traumatic losses in the manner previously predicted. Silver’s findings were initially reported in the *Journal of Aggression, Maltreatment and Trauma.* (2004) In this review article, she summarizes this data, which dispel some of the major myths about how people respond to major disasters. For example, the research provides little support for the notion that there is a “right” or “wrong” way to respond to significant losses. There are simply different ways. There is no one, universal response to loss. Another myth is that psychological response to loss is predictable and that everyone goes through the subsequent process in an orderly sequence of reactions. Many clinicians expect that shortly after a significant loss, a person will have a negative emotional response, concluding that those who do not have such a response are failing to confront the experience and that they will be at high risk for delayed onset of psychological problems. According to Silver, empirical support for this position rarely has been obtained. Indeed, not everyone will respond to traumatic events with intense emotional distress. She has found that it is also a mistake to believe that people who have experienced a traumatic event inevitably will search for a way to make sense of the experience or that they will, in time, find some way to resolve the loss, finding meanings in the outcome, and be able to put the issue aside. Her post 9/11 research results are consistent with what she found through interviewing parents who experience the death of a child. Silver suggests that myths about grief may lead to the perception that
people are not coping appropriately and, further, that these myths also make it difficult for members of a social network to provide effective support. She concludes that the best thing one can do to help oneself and one's community is to recognize and respect an individual's need to respond to loss in one's own way, and on one's own timetables. Only in this way, she says, can one expect to pull through traumatic events intact.

Shane Sinclair, Jose Perreira, Shelley Raffin. “A thematic review of the spirituality literature within palliative care,” Journal of Palliative Medicine 9, no. 2 (Apr 2006): 464-79. • This paper presents a review of the literature related to spirituality and health, with a special focus on spirituality within palliative and end-of-life care. Literature was located by searching the CINHAL and Medline databases using the keywords “spirituality” and “palliative.” An initial review revealed five overarching themes that have previously been found in the general spirituality and health literature: the nature of the general relationship between spirituality and religion, the conceptual difficulties relating to the term spirituality, the relationship between spirituality and health, the general subjects usually included in the spirituality related research and the provision of spiritual care. The authors also located six specific themes in the palliative literature: general discussions of spirituality in palliative care, spiritual needs of palliative care patients, nature of hope in palliative care, tools and therapies related to spirituality, spirituality and palliative care professionals and effects of religion in palliative care. Within these headings, Sinclair and his colleagues summarize the literature, which at that time totaled 159 articles. In their conclusion, the authors suggest that a more integrated approach needs to be developed highlighting the experiential nature of spirituality that is shared by patients, family members and healthcare professionals. They also comment: “[S]pirituality as a result has been reduced largely to a concept void of religion, an instrument to be utilized in improving health, and focused predominantly on the self …. While spirituality is uniquely understood and experienced by individuals, it is also a chord that may serve to bind humanity together. This collective component of spirituality has not been explored and is largely overshadowed by an individualistic approach that has failed to take into account the common threads that may bind patient’s families and healthcare professionals together, through shared experience …. [W]hile spirituality in palliative care is a central aspect of the discipline’s history and takes on a different meaning from other areas of healthcare, these tendencies are still very much apparent, propagating a form of practice that reduces spirituality to simply another tool in our treatment repertoire, having been stripped of its mystery by empiricism, to be administered to the dying patient by the skilled practitioner.” (p. 475) The article’s lead author is a hospital chaplain in Calgary, Canada.

Liwliwa R. Villagomeza. “Spiritual distress in adult cancer patients—toward conceptual clarity,” Holistic Nursing Practice 19, no. 6 (Nov/Dec 2005): 285-94. • How does one recognize spiritual distress in the practice of chaplaincy/ministry? This well-written article uses a seven-construct model to describe spirituality. The writer uses the Walker and Avanti method of theory construction in order to clarify what is meant by the concept “spiritual distress.” It is an eight-step approach, which, as it is described, helps the reader to understand the nature of the construction theory being used, as well as the complexity of this concept. Villagomeza begins by identifying the nature of spirituality. This involves examining seven overlapping but distinct constructs that together comprise spirituality: connectedness, faith and religious belief system, value system, sense of meaning and purpose in everyday life and amidst suffering, sense of self transcendence, sense of
inner peace and harmony amidst the chaos of life and fear and uncertainty when experiencing life-altering or life-threatening illnesses, sense of inner peace strength and energy that is integrative and unifying beyond the physical realm. She then describes spiritual distress in apposition to the concept she has just described. This leads to a consideration of the empirical referents or “cues,” suggesting to the nurse or chaplain that a person may be spiritually distressed. Each of the seven constructs is associated with three to eleven cues. As an example, Villagomeza provides cues for recognizing spiritual distress in adult patients with cancer. Consistent with Walker and Avanti’s approach to theory construction, four case studies are included which further clarify the nature of the construct: a model case, a borderline case, a related case and a contrary case.


- It is a welcome sign of the times that behavioral scientists are suggesting to their medical colleagues that spirituality is a subject that requires their attention. For that reason alone, this article will be of interest to chaplains. The article is not about the philosophical implications of spirituality for medical practice, but rather the impact of spirituality on persistent pain, a practical issue of importance in medical care. It is written in a style acceptable to busy doctors: short paragraphs, telegraphic style and references to peer-reviewed literature. The authors also report the results of their own research examining how religious coping relates to adjustment to pain. Their patient sample was composed of individuals diagnosed with rheumatoid arthritis who completed a thirty-day diary.