Jamie D. Aten, Jane E. Schenck. “Reflections on religion and health research: an interview with Dr. Harold G. Koenig,” *Journal of Religion and Health* 46 no. 2 (Jun 2007): 183-90. • Harold G. Koenig is one of the best-known researchers in the medical world today who is working to disentangle and clarify the complicated links between religion/spirituality (R/S) and health. He has published widely in the fields of mental health, geriatrics and religion and has authored close to three hundred R/S and health articles in peer-reviewed literature. In addition, he has over thirty books in print or in press. This interview is wide-ranging, beginning with his attraction to psychiatry, which is where the power of religion first caught his attention. In caring for chronically ill, older patients, he found high rates of depression and sadness, but he also noticed that for many, religion was a major and valuable coping mechanism. As he trained in psychiatry, he also began studying religion in persons who were sick. He also started to talk to other doctors about what he was doing, which was not necessarily a wise career move during the eighties, but one which reflected his self-confessed rebellious streak. He talks about the current need for better research, about the topics he believes need to be investigated and about ways in which others might go about getting funding and undertake preparatory training.

Terry Badger, Chris Segrin, Paula Meek, Ann M. Lopez, Elizabeth Bonham. “Profiles of women with breast cancer: who responds to a telephone interpersonal counseling intervention?” *Journal of Psychosocial Oncology* 23, no. 2/3 (2005): 79-100. • The amount of research that has been done to investigate the use of telephone counseling to provide emotional support to people after their hospitalization is relatively limited. A notable exception is the work by Badger, the first author of this study. The purpose of this paper is to discuss the profiles of women with breast cancer for whom a telephone counseling intervention was beneficial for symptom management as well as for quality of life. The findings presented are based on the responses of twenty-four participants, who completed the telephone counseling intervention, as well as three measurements made over the course of the ten-week study. The typical participant was white, in her mid-fifties and married. Most had stage II breast cancer and were receiving chemotherapy as the primary treatment. The findings suggest that women in long-term marriages who reported no previous history of depression or cancer benefited most from the intervention. This group reported the least depression, negative affect, symptoms of stress/fatigue and improved quality of life. The authors suggest several theories, which may explain their findings and discuss the implications for future practice.

Christina Beardsley. “Not just a comic turn: clowns and healthcare chaplains,” *College of Health Care Chaplains Journal* 7, no. 1 (Spring/Summer 2006): 2-11. • In the late 1960s, Heije Faber, a Dutch pastoral theologian, wrote a book in which he presented the clown as a model for healthcare chaplaincy. Since then, a number of chaplains as well as others in healthcare have written about the analogy between the clown and the chaplain. The most recent United States contribution was authored by Jason Cusick (*Chaplaincy Today* 21, no. 2 [Autumn/Winter 2005]: 12-18). Beardsley describes the origin of the analogy of the clown in the social and religious ferment of the 1960s, and then

These abstracts have been selected from the database of *THE ORERE SOURCE*, a bimonthly publication of pastoral and related articles edited by W. Noel Brown, MDiv, BCC.
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asks whether Faber’s three points of comparison between chaplain and clown are relevant today. Having provided a brief overview of the history of clowning, mime, and physical theater, she asserts that the analogy does indeed speak to some of chaplaincy’s current concerns, e.g., the problem of transcendence, teamwork, professionalism, prophetic ministry. In this well-written article that is too brief by a measure, Beardsley’s contribution, like Cusick’s, provides a new perspective on the “foolish” work of hospital chaplains today.


Diane J. Chamberlain. “The experience of surviving traumatic brain injury,” Journal of Advanced Nursing 54 no. 4 (May 2006): 407-17. • This paper from South Australia presents the results of a study describing the experience of surviving traumatic brain injury (TBI), as related to the author by sixty individuals, one year after their injuries. She describes what she has found as “an individual and invisible experience,” concluding that healing and resolution of grief continues to be problematic. There is very little in the literature on this subject, and the aim of her study was to learn how experiences of self within survival and recovery were described by survivors of TBI. She also wanted to learn how the individuals were making meaning of the experience of surviving. The most common themes included regret and grief within the self; the insensitivity of health professionals; the stranded self; and the recovery in self, which concerned stories that the survivors reconstructed when they saw their current lives. Chamberlain illustrates the themes with heartbreaking quotes from the persons she interviewed. Because of the reality of “invisibility,” that is, the fact that so much of what needs to be attended to about these patients is invisible, chaplains will find this a useful exploration. The staff expectation is that once such patients have been treated and discharged from hospital, they will simply move on with their lives. This kind of attitude in healthcare professionals may be appropriate for persons whose visible wounds or broken bones have healed. Recovery from a TBI tests our ability to fully understand and support wholistic recovery. In that regard, it is noteworthy that there is no mention of spirituality or religion in the article.


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to better educate the public about this issue and to protect those who are the most vulnerable in our society. Doing so is not only of social responsibility; it is a moral imperative as well.” (p. 38)

**Rebecca Clarren.** “Behind the pillow angel,” *Salon.com* (9 Feb 2007): 5 pp. • Ashley is a nine-year-old girl with static encephalopathy, a very rare medical condition that causes permanent brain damage. Her parents have described her as having the mental capacity of a three-month-old; she cannot walk or talk. Last year, they asked doctors at Children’s Hospital and Medical Center in Seattle, Washington, to perform what has come to be called the “Ashley Treatment.” This involved surgically removing her breast buds, performing a hysterectomy and giving her high doses of estrogen for thirty months so that she would never increase in stature. One of the reasons for this request was to ensure that they would more easily be able to care for her than would be true if she continued to grow in size. She is presently four feet, five inches tall and weighs sixty-five pounds. She will continue to age, and with good physical care, she is expected to have a normal life span. News of the surgical intervention has caused a great deal of discussion; numerous articles have been written concerning the case and the ethical issues involved. Clarren has done her homework by going back to the start of this case in early 2004 and providing details of the process leading to the surgery. This information provides a deeper understanding of the values held by all who have been involved. Some of what she describes has not appeared in other reports, e.g., the hospital ethics committee that gave support for the treatment included a chaplain. The original medical article by the lead physicians involved, “Attenuating growth in children with profound developmental disability: a new approach to an old dilemma” by Gunther and Diekema, appeared in the *Archives of Pediatric & Adolescent Medicine* 160, no. 10 (2006): 1013-17. Clarren’s article may be downloaded. http://www.salon.com/news/feature/2007/02/09/pillow_angel.html

**Natarlie deCinque, Leanne Monterosso, Gaye Dadd, Ranita Sidhu, Rosemary Macpherson, Samar Aoun.** “Bereavement support for families, following the death of a child from cancer: experience of bereaved parents,” *Journal of Psychosocial Oncology* 24, no. 2 (2006): 65-84. • This is the second of three reports by a staff group from the Oncology Total Care Unit of Princess Margaret Hospital in Perth, Western Australia, which has been looking at the bereavement support given families after the death of a child from cancer. In this study, they set out to identify the experiences and needs of parents who received hospital-based bereavement support. The study process, which included unstructured interviews with nine parents, six mothers and three fathers, is clearly described. Four questions were utilized. Tell me a little about your child’s illness. (Prompt question: What about the last few days of your child’s life?) Thinking back to the time after your child’s death, what was that like for you? (Prompt questions: What helped you and your family during the immediate period of your loss? What wasn’t helpful during this time?) Reflecting back, what things were done by the ward or the hospital team in general that helped you and your family at the time? (Prompt questions: What other things could have been done for you and your family that would have been helpful? Was there anything the staff in the wards or the hospital as a whole did at the time that wasn’t helpful?) Are there any other suggestions you can offer that may be of help in the future to other bereaved parents? An analysis of the interviews led to the identification of six themes in the parents’ comments: personal grief, personal coping, concern for the siblings of the deceased child, hospital bereavement support, use of community supports and unmet needs. Each of these is discussed and illustrated. The take home lessons from this study, headlined here, but detailed in the paper include the following. Fathers and mothers grieve differently, which places stress on their relationship as they each do their grief work. A lack of understanding by relatives and friends as to what the parents are going through isolates them at the very time they need support. A number of parents reported that religious faith and “after death” beliefs helped them cope, suggesting that health care professionals need to develop an awareness and understanding of any parent’s belief system. These parents commonly reported needing help in order to be able in turn to help their child’s siblings with their grieving.

**Nina Eikens.** “Who’ll win the life saving kidney?” *www.radionetherlands.nl* (31 May 2007): 2 p. • Does the end justify the means? On Holland’s “De Grote Donor Show” (The Great Donor Show) a
terminally ill thirty-seven-year-old woman, identified only by the pseudonym Lisa, was placed before a panel of people, all of whom needed a donor kidney. During the program, she asked them questions about their lifestyle and their personal histories and conversed with their families and friends. Audience members were able to send her advice via text messaging, and at the end of the show, she decided who should get her kidneys when she died. The program was broadcast on June 1, 2007, on the Dutch public TV broadcaster BNN, stirring up great controversy both before and afterward. Although the program appeared to break no laws, it did cause considerable distaste, not only in Holland but also across Europe. Three days after the airing, the whole affair was revealed to be a hoax, albeit a hoax with a purpose. It had generated over 50,000 responses asking for information about organ donor cards. See http://en.wikipedia.org/wiki/The_Big_Donor_Show for the full story.

Brian Hughes, Mary Whitmer, Susan Hurst. “Innovative solutions: a plurality of vision,” Dimensions of Critical Care Nursing 26, no. 3 (May/Jun 2007): 91-95. • This is a very good article on hospital chaplaincy, written jointly by a chaplain (the lead author), an experienced palliative care nurse practitioner and a clinical care nurse specialist in critical care services. Its intent is to showcase the potential of chaplaincy in critical care units. The need for, and the training process of, the board certified chaplain are accurately described as are the needs of ICU families and the potential value of interdisciplinary teamwork. The need for teamwork is based on a Quality of Life model of care. “The spiritual component of this model addresses religion and spirituality, spiritual suffering, exploration of meaning, hope versus despair, the importance of ritual, and cultural diversity.” In part, the authors conclude that “chaplains play an important role in the plan of care and decision making, enhance the interdisciplinary team and provide an invaluable bridge between the medical staff and the hospitalized patient and family.” (p. 95) This paper would have value in enlarging the vision of some nurse managers or hospital administrators. Final factoid: In 2003, a chaplain at the center described in this article contacted the pastoral care department at every facility which had acquired Magnet status (a national recognition of nursing excellence) to inquire about chaplain staffing to bed ratios, i.e., chaplain FTEs versus average daily census. Of the 108 Magnet-recognized facilities at the time, 101 supplied figures. The as-yet-unpublished result was a ratio of 1:153.

Steven Laureys. “Eyes open, brain shut,” Scientific American 296, no. 5 (May 2007): 84-89. • Up in the neuro-ICU, life gets increasingly challenging with every passing month as more and more people who have suffered brain damage are admitted. Even after surviving acute trauma, if the damage is severe, the individual may slip into a coma. The question then turns to whether the person will recover, and what will recovery look like? The case of Terry Schiavo put the spotlight on such situations. In this overview article, Laureys, who leads a research coma group, clearly and succinctly presents what currently is understood about coma and the vegetative state. He shows how the two main components of consciousness can be completely dissociated, with wakefulness being intact, while awareness, which includes all thoughts and feelings, is lost. Thus, a person can be awake, but not aware. The wakeful patient has sleep/awake cycles, at times seeming to be awake with eyes open and wandering, and at other times eyes shut as if in sleep. In the latter, patients may even open their eyes and stir if someone touches or speaks to them. Chaplains who provide pastoral care to such patients and their families will gain a clearer understanding of what is happening and of the difficulties involved in determining who may regain consciousness and who will not.

Mary E. Madonald, Stephen Liben, Franco A. Carnevale, Janet E. Rennick, Susan L. Wolf, Donald Meloche, S. Robin Cohen. “Parental perspectives on hospital staff members’ acts of kindness and commemoration after a child’s death,” Pediatrics 116, no. 4 (Oct 2005): 884-90. • This interdisciplinary paper, written by nurses, chaplain and doctor, explores the significance of different acts of kindness by staff members toward parents following the death of their child. Twelve parents whose children had died in an ICU at a tertiary care pediatric hospital were interviewed about their experiences. The purpose of the interviews was to explore their experiences of the death. Three themes emerged. Parents placed great importance on the hospital’s memorial service and on staff members’ presence at that service. While parents found
it hard to return to the hospital after the death, they all attended the memorial service, and some found closure as a result. The parents appreciated receiving cards and greatly valued staff members’ efforts to visit or telephone and attend the funeral. Even after a significant interval, parents remembered positively those staff who had done these things. On the other hand, parents spoke of their disappointment when staff did not engage in such activities or were absent from memorial services.

Rajeev Mehta, Joshua Hauser.
“Hospital chaplains reflect on spirituality in end-of-life care,” Healing Ministry 12, no. 3 (Summer 2005): 35-43. • The objective of this study was to explore what a group of hospital chaplains believe is important in spiritual care at the end of life. The intent was to understand, in a nuanced way, the spiritual care that should be considered by all members of interdisciplinary teams for the benefit of their patients. Individual interviews were conducted with all six of the full-time chaplains of a midwest hospital. The chaplains were of Protestant, Catholic and Jewish backgrounds, and each had at least ten years of experience working in palliative care. The interviewer asked two open-ended questions in order to open discussion regarding each of three categories. May contact with religious figures be helpful? May contact with a religious figure or religious concerns in general be harmful? What is the role of specific religious beliefs for the chaplain and the patient? Using the methods of grounded theory, salient themes from the interview notes were assessed. The authors present their findings in detail under the following headings: the positive outcomes of chaplaincy, chaplaincy for those without specific beliefs, negative associations with religion and the role of specific religious beliefs. Important factors uncovered by this study include understanding that the chaplain acts as a listener for the patient, helps patients avoid a sense of guilt and feelings of isolation and provides meaning and purpose for patients. The authors suggest that physicians should be aware of the patient’s own spiritual resources. They also encourage referrals to hospital chaplains, as was proposed by Daaleman and Frey (“Prevalence and patterns of physician referral to clergy and pastoral care providers,” Archives of Family Medicine 7, no. 6 [1998]: 548-53). They conclude that since studies have demonstrated that patients desire their physicians to be involved in spiritual matters at the end of life, the physicians themselves should be aware of how another important worker of the care team—the chaplain—sees his/her role. They remind physicians that they need to keep in mind that many hospital chaplains maintain a separateness from the hospital with its medical agendas and that this often is central to how they comfort patients. Such a boundary, they suggest, needs to be respected as a way in which the hospital chaplain is distinct from other health care professionals who are also involved in caring for the needs of the patient. They suggest that further work in this area should be done to understand specific ways that physicians and hospital chaplains might relate to one another concerning the religious and spiritual needs of their patients. As a point of disclosure, the literature editor was one of the chaplains interviewed for this study.

David Mitchell. “The development of palliative care chaplaincy services in Scotland,” PowerPoint presentation (2006): 13 slides. • Mitchell is a hospice chaplain in Glasgow, Scotland, where he is also a lecturer in palliative care. He describes how, over a ten-year period, hospice chaplains in Scotland developed standards and competencies for chaplains in palliative care and how these can be measured. The standards and competencies are clearly located within and consistent with the National Health Service government standards of the United Kingdom. (NHS QIS 2002) This presentation, titled “Building bridges with the medical community: palliative care in Europe and the spiritual health care giver,” was given at a session of the consultation of the European Network of Health Care Chaplaincy, in Lisbon, Portugal, May 2006 at which chaplains and chaplaincy organizations from twenty-six countries across Europe were represented. Following Mitchell’s presentation, the consultation adopted a statement on palliative care to be used by participants throughout the European network to strengthen the basis for spiritual and religious care of the dying. Mitchell’s presentation, which is followed by a link to the statement adopted by the Network, may be downloaded. http://www.eurochaplains.org/060519_mitchell.pdf

Ann Neale. “Who really wants healthcare justice?,” Health Progress 88, no. 1 (Jan/Feb 2007): 40-43. • This article is a “conscience work
exercise," designed by a member of the Center for Clinical Bioethics at Georgetown University. Neale suggests one reason that efforts to reform health care have not been successful is that we have not brought to those efforts sufficient reflection concerning the deeper values, attitudes and dispositions. Rather, the reform movement has been concentrated on promoting particular policy solutions. She created this exercise to help an individual or group examine the personal values, attitudes and dispositions that contribute to or inhibit efforts toward healthcare justice. The exercise comprises a one-page worksheet. Persons who undertake it are invited to share their findings with the author. Further details may be found on the Web site.

www.chausa.org/consciencework

Christopher Newell. "Psychosis, spirituality and me," bjr Newsletter 18 (Apr 2007): 2-4. • Newell is a mental health chaplain. He also is recovering from a recent psychotic episode during which he was hospitalized. He courageously describes his experiences before, during and after his hospitalization. His story will be of value for those who wish to gain a deeper sense of what it is like to be mentally ill. He writes, "I want to speak of psychosis, of dream time, of inner voices that speak of the pantheon of embodied feeling, of terrors that undermine your very self and yet are strangely godly as well. What do I mean by that? What godly reason would there be for such seeming personal disintegration—disintegration to the point of death, or, at least the very serious contemplation of death—and that in order to save others too? Let me explain. You see, I was not sure I possessed a soul anymore …." (p. 3)

Louise D. Palmer. "Growing hope," Spirituality & Health 10, no. 1 (Jan/Feb 2007): 40-43. • How would you characterize or label hope? Is it a belief or an attitude, an inward disposition, or a gift? Anthony Scioli believes that it is most helpful to think of hope as an acquired skill. He believes that it is active, that one can tend and nourish it. He suggests that it is multifaceted, having fourteen distinct aspects, and self-perpetuating. Hopeful people tend to be more resilient, more trusting, more open and more motivated, so they receive more from the world, which in turn, confirms them in their hopefulness. A clearer understanding of hopefulness has been developing from early in the 1990s, through the work of Kenneth Pargament and the late C. S. Snyder. Now Scioli has developed his own Hope Scale, which, along with the theory behind it, provides an expanded understanding of the nature of hope. For him, hope is complex: its roots are in our deepest self, its foundation in our relationships, and it has a spiritual core. In his mind, hope determines our prospects for survival and health, sustains our intimate bonds and gives life purpose and meaning. Scioli has recently published a number of interesting studies, including one on the relative importance of age, hope and attitude as predictors of well-being in a sample of seventy-five persons aged eighteen to sixty-five years. Using three different measurement scales, he found that a high level of hope was the most powerful predictor of well-being, no matter the age. In a second study, he found that hope appears to buffer anxiety about death and dying. He first showed a group of young people, a ten-minute segment from the movie Philadelphia, in which Tom Hanks plays a young man dying of AIDS. Scioli then measured the fear of death and dying in the young people who had viewed the film. Those with a high hope score showed less death anxiety than those with a low hope score. Finally, he completed a study to see if hope is reflected in the body-mind connection. In a study that included thyroid cancer and HIV-positive patients, he found that the hopeful participants reported better health and less distress/worry about their health. To get some external confirmation of the subjective reports of the patients, he interviewed each person’s case manager and also did blood testing to determine patients’ immune cell count (CD4). His findings strongly support the belief that hope affects general health as well as the condition of the immune system itself. The article includes a set of practices recommended by Scioli, one for each of the hope traits he has identified. For chaplains seeking to develop their own spiritual lives, there may be opportunity here. For the chaplains seeking to be doctors to the souls of their patients, there may be interventions here for future use. The article concludes with a copy of the Hope Test. The fourteen aspects of hope are included, with two questions for each aspect. See www.spiritualityhealth.com/hopetest for a copy of the test.

women diagnosed were infected disease. Almost 80 percent of the women who are newly diagnosed with the disease account for 27 percent of those between 1985 and 1996. Women HIV positive, which nearly tripled the number of women who are infected figures about the increase in the number of women with histories of abuse, "Spirituality as a component of holistic self-care practices in human immunodeficiency virus positive women with histories of abuse," Holistic Nursing Practice 21, no. 3 (May/Jun 2007): 105-14. Peltzer and Leenerts state they wrote this article to articulate the need for a holistic theory of self-care for women with HIV that describes and places spirituality as a primary component in their model of self-care. They suggest that, by making spirituality integral to self-care, nurses and other healthcare professionals will support and educate women who are HIV positive within a holistic perspective. They begin with some frightening figures about the increase in the number of women who are HIV positive, which nearly tripled between 1985 and 1996. Women account for 27 percent of those who are newly diagnosed with the disease. Almost 80 percent of the women diagnosed were infected through heterosexual contact. In 2004, African Americans, who are approximately 12 percent of the U. S. population, accounted for half of the HIV/AIDS cases diagnosed. Almost 80 percent of the women in the country who are HIV positive are either African American or Hispanic. Research has shown that these women are typically out of touch with themselves, their own bodies and/or their own needs. The authors describe the possibilities for a holistic concept of self-care as a method of connecting to self through spirituality.

Christina M. Puchalski, Beverly Lunsford, Mary H. Harris, Tamara Miller. “Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model,” The Cancer Journal 12, no. 5 (Sept/Oct 2006): 398-416. Puchalski and her interdisciplinary colleagues—nurse, social worker and rabbi respectively—make the case that spirituality is essential to healthcare. In the clinical setting, spirituality may be manifested as spiritual distress or as resources for strength. Spirituality has an intrinsic element in that it underlies compassionate and altruistic caregiving. There is also an extrinsic element—learning a patient’s spiritual history and making a spiritual assessment. Further, each member of the interdisciplinary team has responsibilities for providing spiritual care, and “the chaplain is the trained spiritual care expert on the team.” The paper is comprehensive in scope. Following a case history, extended sections describe the role of the physician, the nurse, the social worker and the chaplain. The authors conclude: “Excellence in quality of care will depend on adherence to a biopsychosocial-spiritual model of care that is practiced by all members of the healthcare team. Good ongoing communication between the interdisciplinary team members will ensure that the patient and family have the most comprehensive compassionate treatment plan and care.”

John P. Slosar. “Father O’Rourke and beginning-of-life issues,” Health Progress 88, no. 2 (Mar/Apr 2007): 39-44. Father Kevin O’Rourke, OP, has been a significant figure in the modern world of healthcare ethics, especially in Roman Catholic healthcare ethics. This article is the fifth in a special section of Health Progress honoring his life and work, on the occasion of his eightieth birthday. Slosar highlights what he sees as two foundational elements in O’Rourke’s approach to beginning-of-life issues. The first is his consistent attempt to make explicit the connection between the norms foundational to human procreation and the meaning of human sexuality and the ways in which these influence our personal and social lives. The second focuses on his arguments for the moral status of the early embryo. Slosar describes O’Rourke’s understanding of these two foundational concerns to illustrate some of the practical guidance he has described over the years.

Mildred Z. Solomon. “Realizing bioethics’ goals in practice: ten ways ‘is’ can help ‘ought,’” The Hastings Center Report 35, no. 4 (Jul/Aug 2005): 40-47. A familiar criticism leveled at bioethics is that it is more intellectual than practical, having too little application in the “real world.” In this article, Solomon

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replies to such critical voices and suggests how bioethics can keep its feet on the ground. She argues that bioethics must use the social sciences more effectively. She suggests that empirical research could provide a bridge between conceiving a moral vision of a better world and actually making that world a reality. She makes the following specific suggestions to facilitate the move from ethical analysis to ethically justifiable behavior. Gaps between espoused ideals and actual practice need to be documented. The nature of individuals’ moral reflections and the level of their personal skill and ethical analysis need to be made more transparent. There needs to be a better description of the institutional and environmental context that mediates moral action. Data need to be provided to stimulate individual and institutional moral accountability. Consequentialist claims need to be tested. There needs to be validation, refutation or modification of principals in the light of their relevance to moral agents. We need to recognize the relevance of otherwise neglected ethical principles and to generate new normative concerns.

There needs to be an identification and documentation of new moral problems. There needs to be more clear specification and acknowledgment of problems. There needs to be greater clarification of causal mechanisms within the process of ethical analysis. Solomon concludes that bioethicists need what empirical researchers can offer: a variety of powerful means for helping get “from here to there.”

Mark Sutherland. “Spiritual focus at the interface,” bjr Newsletter 18 (Apr 2007): 8-11. Sutherland’s article is a reflection on Mark 5:1-34, healing from a madness which was the result of being possessed. Sutherland addresses aspects of the human cost of mental disturbance, most specifically problematic societal attitudes toward mental disturbance. He discusses the fear and terror that may accompany an individual’s experience, especially psychosis, and the different forms and actions in which such an experience may be expressed and released. Finally, he focuses on the “spiritual domain” and how the experience of psychosis may herald “a sudden and unexpected opening to the energies of the spiritual ground” which may be the start of new spiritual development.

Jessica Tartaro, Jonathan Roberts, Chaira Nosarti, Tim Crayford, Linda Luecken, Anthony David. “Who benefits? Distress, adjustment and benefit finding among breast cancer survivors,” Journal of Psychosocial Oncology 23 no. 2/3 (2005): 45-64. This study examined levels of distress and adjustment over time in women who are surviving breast cancer as well as their ability to find benefit in their experiences. Over seven hundred women were assessed, and thirty-nine then participated in four study assessments over a two and a half year period following diagnosis. Women who reported finding benefits in breast cancer had experienced high levels of distress prediagnostically, which then significantly declined over time. The results of this study suggest that a woman’s distress prior to receiving a breast cancer diagnosis may be related to her ability to find benefit during later stages of the illness. This is an interesting contribution to the meaning-making, or sense-making literature.