In the Literature

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Christi Bamford, Kristin H. Lagattuta. “A new look at children’s understanding of mind and emotion: The case of prayer,” Developmental Psychology 46, no. 1 (2010): 78-92. • Studies have shown that between the ages of four and eight years, children consistently exhibit a growing understanding about the relationship between mind and emotion, including an awareness that one’s emotional state may influence how one thinks. Other research has shown that strategies for coping with negative or uncontrollable events does not develop until children reach age seven or eight. At this stage, they understand about how people may use their minds to alleviate negative emotions, for instance, by changing the focus or the content of their thoughts. In adults, one widely used method of handling negative emotions that has a clear mental component is prayer. However, until this paper, little attention had been given to young children’s knowledge about the relationship between prayer, which the authors term “nonsecular activity,” and emotions. This study examines the development of children’s understanding about the relationship between mind and emotion in the context of prayer as well as beliefs about prayer as both cause and effect of a person’s emotional state. The age-related differences in the responses provide a deeper understanding of the ways that children begin to pray and why. The methods used are described carefully, and illustrations of the printed materials that were used in the conversations with both children and adults are included.

David Bittner. “The old book switcheroo: Or anatomy of a delusion,” Journal of Religion and Health 49, no. 2 (Jun 2010): 262-73. • An article that provides an immediate view into the inner world of a person with Asperger’s Disorder—in Bittner’s case, a mild form of autism with some schizophrenic features. He describes his personal experiences with some of the “pitfalls of organized religion” as observed from his perspective as a Jew by birth and a Roman Catholic by choice.

Tami Borneman, Betty Ferrell, Christina M. Puchalski. “Evaluation of the FICA tool for spiritual assessment,” Journal of Pain and Symptom Management 40, no. 2 (Aug 2010): 163-73. • The National Consensus Project for Quality Palliative Care standards, published in 2006, named spiritual care as one of the eight essential elements of care, describing it in Domain 5: “Spiritual, Religious and Existential Concerns.” Though completely laudable in itself, the desire to provide thorough and effective spiritual care that employs a check-list approach will in all probability lose the very subjectivity and specific human elements that are at the very heart of spirituality. If spirituality is rationalized and reduced to make it manageable, it loses those ingredients that make it significant. In 1996, Puchalski and three primary care physicians devised the FICA Spiritual History Tool as a way for physicians to integrate open-ended questions about religion and spirituality in the standard medical history. It has been slightly modified since then and is currently used by some chaplains to obtain an understanding of the presence of faith, belief or meaning in a person’s life; the importance of spirituality for a person’s life and the influence that beliefs and values have on health care decisions; the person’s spiritual/religious community; the interventions to address the person’s spiritual needs. The aim of this study was to evaluate the usability of FICA. Seventy-six patients with solid tumors provided feedback about this instrument, which is printed in full in the article. Responses to FICA were placed alongside the responses patients made to a
second assessment tool, the Functional Assessment of Cancer Therapy Quality of Life (QOL), developed by Ferrell at the City of Hope Medical Center in 1995. The findings indicate that FICA does enable the spiritual life of a person to be addressed in a helpful way and lend support to the belief that spiritual care is an important part of patient care. Responses to the questions revealed the depth and breadth of spirituality and provided many opportunities for addressing patients’ search for faith, meaning, hope and relationships at the end of life.

Jami Brinton. “Hospital chaplains not required to keep information private,” www.kcrg.com (10 Apr 2010): 3 pp • This is the narrative of a television report concerning a chaplain at a hospital in Iowa City, Iowa. The chaplain spoke with a mother while her 10-month-old son was receiving treatment, and she mentioned in passing that she was pregnant. In his required notations in the medical record, the chaplain included this fact. Subsequently, a different staff member commented on her pregnant state, the mother became very upset as she considered her conversation with the chaplain confidential. She wanted the fact of her pregnancy removed from her son’s record, and it took one week for this to be done. The remainder of the story opens up the topic for comment both by hospitals and by the public. There are also numerous comments on the station’s Web site about the subject, many of them very unflattering. Clearly, this is an issue for discussion and education in chaplaincy circles. The story may be accessed at http://www.kcrg.com/news/local/91000154.html

Herbert Bronstein. “Heart transplants: Three views—the power over life and death,” Chest 136, no. 5 Supplement (1 Nov 2009): 346-48. • In a commemorative supplement to mark seventy-five years of publication, Chest includes what its editors still consider three classic essays dealing with the philosophical and theological questions raised by heart transplants. They were first published in the October 1968 issue of the journal. The first is this article, authored by a rabbi. While written from an unabashedly Jewish perspective, it states very clearly the basic questions that need to be considered by anyone of religious faith involved in some manner with heart transplantation. Bronstein refers to “historic moral and religious questions,” which he proceeds to spell out. While the answers to the questions he lifts up—both theological and practical—have been refined over the past forty years, his words are words of encouragement to push forward into the ever-new uncertainties that transplant surgery raises today: “[W]e cannot go back. We are barred as by angels with revolving swords of flame from the paradise of previous innocence.”

James D. Campbell, Dong Phil Yoon, Brick Johnstone. “Determining relationships between physical health and spiritual experience, religious practices and congregational support in a heterogeneous medical sample,” Journal of Religion and Health 49, no. 1 (Jan 2010): 3-17. • Efforts to understand the relationships between physical health and religious practices/spirituality continue to increase in sophistication. In 1999, the Fetzer Institute and the National Institute on Aging Workgroup created the Multidimensional Measure of Religiousness and Spirituality (MMRS) and its brief form, B-MMRS. Subscales were developed to measure distinct aspects of spiritual experience and religious practices. They were chosen because they held promise for determining the casual mechanisms that relate religious, spiritual and health variables. Additional work subsequently has been done to see if using B-MMRS leads to reliable results. One of Johnstone’s soon to be published studies has found that the B-MMRS may be better understood if it is used to measure three rather than two domains of religious/spiritual experience including: the emotional experiences associated with feelings of connectedness with a high power/the universe (termed spiritual experience); culturally-based activities such as prayer, meditation, reading religious texts, attending services (termed religious practices); and the support provided by others in one’s religious/spiritual community (termed congregational support). By conceptualizing B-MMRS in this way these authors suggest that it may be possible to determine the specific mechanisms by which religious and spiritual variables impact health, e.g., through emotional experiences, cultural behaviors and/or social support. It was with this model in mind that they conducted the research reported in the paper. They studied a convenience sample of 168 patients from an academic health center and a private group practice, deliberately choosing patients from a number of different patient groups. The results are limited in that they are cross-sectional in nature, so causal mechanisms that exist between religion and health cannot be determined. They also are not
completely generalizable in that the people studied were primarily Christian. With these limitations, the results indicate that persons with chronic medical conditions do not automatically turn to religious or spiritual resources following diagnosis. Further, they show physical health as positively related to frequency of attendance at religious services although this may be related to better health leading to increased ability to attend religious/spiritual gatherings. Finally, spiritual belief in a loving, higher power, and a positive worldview are associated with better health, which is consistent with psychoneuroimmunological (PNI) models of health. The authors suggest that “This encouragement/practice of spiritual interventions may be promoted by religious leaders, hospital chaplains and/or health professionals although questions still exist about the best manner … [for addressing] religious/spiritual matters in their practices. Johnstone also addresses this subject in an unpublished paper.

Donald Capps. “A spiritual person,” Journal of Religion and Health e-published on the journal’s Web site. • This is an essay about spirituality, written in Capp’s inimitable accessible style. He begins with the answer that William James gave when he was asked to describe a spiritual person. His answer instead was to name one—Phillip Brookes. Capps then uses Brookes to explore spirituality through a human subject, describing his life, his sermons and, most importantly, “his ideals and the active imagination.” Capps takes the view that “there is no spirituality in general but only individual manifestations of it.”

Daniel H. Grossoehme, Judy Ragsdale, Jamie L. Wooldridge, Sian Cotton, Michael Seid. “We can handle this: Parents’ use of religion in the first year following their child’s diagnosis with cystic fibrosis,” Journal of Health Care Chaplaincy 16, no. 3/4 (Jul/Dec 2010): 95-108. • The news that a child of theirs has a life-shortening disease sends many American parents to their religious beliefs. In this paper, Grossoehme and his colleagues describe how a small sample of parents (n=15) used their beliefs to cope in the first year following a diagnosis of cystic fibrosis (CF). The aims of this study were to develop a “grounded theory” of parental use of religion in the first-year period and to describe whether parents connected their religious beliefs with their at-home, ongoing treatment of the child. In other words, the authors did not begin with a theory but rather allowed the model they describe to emerge out of the information they collected, a model that could then be modified as data were gathered. Of the fifteen parents interviewed, twelve spontaneously named religion as being an issue during the year following the child’s diagnosis, and this was explored at greater length. There were four domains within which parental responses could be grouped; the use of religion to make sense of what was happening to their child was the central, unifying idea. The results showed that the parents imagined God as “active, benevolent and interventionist.” Parents also found hope in their beliefs, indicated that they felt supported by God and related religion to their motivation to stick to the child’s treatment program. The findings make it clear that having an understanding of the religious beliefs of parents will assist a team better plan for the care of children with CF and their families.

Jennifer W. Mack, Susan D. Block, Matthew Nilsson, Alexi Wright, Elizabeth Trice, Robert Friedlander, Elizabeth Paulk, Holly G. Prigerson. “Measuring therapeutic alliance between oncologists and patients with advanced cancer—The Human Connection Scale,” Cancer 115, no. 14 (15 Jul 2009): 3302-11. • Terminally ill patients are exquisitely sensitive to the relationship and the human connection they have with their primary physicians. This paper describes the development and validation process of a measure of the alliance between patients with advanced cancer and their physicians, in order to evaluate the therapeutic alliance’s effect on end-of-life experiences and care. The Human Connection Scale is a 16-item questionnaire that has been tested and found reliable (n=217 patients). The authors plan to use the scale to assess different aspects of end-of-life care.

Yadollah A. Momtaz, Rahiman Ibrahim, Tengku Aizin Hamid, Nurizan Yahaya. “Mediating effects of social and personal religiosity on the psychological well being of widowed elderly people,” Omega (Westport) 61, no. 2 (Mar 2010): 145-62. • The death of a spouse is one of life’s most stressful events. The authors of this study wanted to learn whether the effects of personal or social
religiosity mediate the psychological impact of a partner’s death. The literature review reflects a world-wide awareness of this topic. The subjects of the study were 1,367 widowed elderly Muslims in Malaysia. Three different instruments were used to test psychological and physical health. Gorsuch and McKenzie’s Internal External Religiosity Scale (1989) also was administered. The overall finding was that the personal comfort of Muslim religiosity appeared to decrease the negative effects of widowhood on the psychological well-being of this group. Social religiosity was not found to have a significant effect.

Robert Mundle. “The hospital chaplain as religious interpreter in bioethical dilemmas,” *Scottish Journal of Health Care Chaplaincy* 12, no. 2 (2009): 21-28. • What are the responsibilities of the hospital chaplain called to assist in a clinical situation that is causing an ethical dilemma, and how should they be carried out? In order to highlight the difficulties of the task, Mundle describes the case of a Samuel Golubcheck, whose family insisted that he be continued on life support and provided with all aggressive care. The case was of such controversy that his attending physician resigned from the case, as did two intensivists who were then called to provide care in the ICU. With this case as background, Mundle takes a fresh look at this difficult dilemma, asserting that the chaplain’s unique and complex role as interpreter of religious beliefs and values requires a full vision that includes regarding the patient and not the chaplain as the “expert” in the dilemma and embracing a variety of key images of pastoral care. Further, it suggests a process of dialogical hermeneutics. Mundle reminds his readers of the importance of Boisen’s belief about understanding people as living human documents. He quotes Charles Gerkin who in 1984 wrote that to understand persons in this way means that in pastoral relationships “chaplains require a process of dialogical hermeneutics that begin with a position of uncertainty and even vulnerability.” Mundle quotes Gerkin at some length: “To listen to stories with an effort to understand means to listen first as a stranger who does not yet fully know the language, the nuanced meanings of the other as his or her story is being told. Needless to say, one of the first lessons of life on the boundary is that it is important to avoid, at all costs, the temptation to stereotype or take for granted .... It must thus be understood as a process involving communication across the boundaries of language worlds.” (C. V. Gerkin (1984) in *The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode.*) In addition to deeply listening to patients and families, Mundle believes there must be an assessment of the validity of certain religious beliefs that may arise in these situations and he introduces a model for assessing such beliefs. It was described by Gregory Bock in 2008. (*Journal of Medical Ethics* 34, no. 6 (2008): 437-40)

Patricia E. Murphy, George Fitchett. “Introducing chaplains to research: ‘This could help me,’” *Journal of Health Care Chaplaincy* 16, no. 3-4 (Jul/Dec 2010): 79-94. • Why are a large percentage of chaplains afraid of research? The findings reported in this article shed light on this important question. For almost a decade, Fitchett, who is on the staff of Rush University Medical Center in Chicago, has been working to encourage chaplains to benefit from research. He would like to see the profession of chaplaincy become an evidence-based profession. In this paper he is joined by his colleague, Patricia Murphy, in identifying and examining the barriers to making chaplains “research literate.” In 2002, Fitchett conducted a workshop for chaplains in Australia, which gave him the opportunity to identify chaplains’ attitudes towards research and barriers to their becoming involved in research activities. With two Australian colleagues, he published the findings the following year in a discontinued journal, *Ministry, Society and Theology*. Fitchett and Murphy have built on those initial findings and in this article present data from ninety-four chaplains who attended one of the five subsequent workshops they conducted in the United States between 2004 and 2006. They describe goals and objectives, the process of gathering/analyzing the reactions and feelings of the participants and analysis of the resulting data. Many chaplains function in the medical world where the dominant research model is quantitative in nature, so it is hardly surprising that a large percentage are fearful of research. There are widely-held misconceptions about what research involves, and the insights in this paper will be of value to those seeking to effect change in chaplaincy practices. It also may encourage chaplains to take advantage of the benefits of research as well as to become better “consumers” of research results.
Jason Q. Purnell, Barbara L. Andersen. “Religious practice and spirituality in the psychological adjustment of survivors of breast cancer,” *Counseling & Values* 53, no. 3 (Apr 2009): 165-82. • The contributions of religious belief and spirituality to patients suffering from cancer and its aftereffects have been carefully studied. However, research has not adequately separated the two. That is the significance of this study. The authors looked at the relationships between religious practice, spirituality, quality-of-life (QOL) and stress in survivors of breast cancer. A total of 130 women were assessed two years after diagnosis. Analysis of the data gathered indicated that spiritual well-being was significantly associated with QOL and traumatic stress levels, but religious practice was not. The authors suggest that clinicians should address the individual’s spirituality when working with breast cancer survivors.

Ann C. Recine, Joan S. Werner, Louis Recine. “Health promotion through forgiveness intervention,” *Journal of Holistic Nursing* 27, no. 2 (Jun 2009): 115-23. • Over the past ten years, the nursing profession in the United States has worked to expand its commitment to patients who are in need of forgiveness. This paper is authored by a nurse practitioner in private practice who has specialized in helping her patients find forgiveness, often for health-related matters. She offers evidence-based forgiveness interventions that she believes will be useful to nurses in both medical and community settings. She makes the case for helping people find forgiveness, defines forgiveness, discusses recent research on interventions and describes the theoretical framework underlying her approaches. She then provides four approaches for forgiveness interventions: giving patients persuasive information; helping them vicariously to experience forgiveness; helping them with awareness of, and coping with, their own physiological responses and helping them to experience “enactive attainment.” Chaplains might add to their pastoral skills by building some of the material in this paper into their individual theological bases.

Nava R. Silton, Cecille A. Asekoff, Bonita Taylor, Paul B. Silton. “Shema, vidui, yivarechecha: What to say and how to pray with Jewish patients in chaplaincy,” *Journal of Health Care Chaplaincy* 16, no. 3/4 (Jul/Dec 2010): 149-60. • This paper describes and analyzes data gathered from the discussion of a 90-minute focus group about their work as Jewish chaplains. The group comprised five male and two female professional chaplains from Reform, Conservative and Orthodox backgrounds. Six questions were introduced by the leader of the focus group, which explains the wide-ranging information gathered. Is prayer a standard activity during a visit? What are protocols for acute versus chronic hospitalizations? Protocols for patients who spend 3+ days/week at a hospital? Which “general” or “spiritual” interventions are typically used? The greatest challenges facing them? Their best experiences? The key mentoring lessons for a new chaplain? Two researchers independently read the transcript of the focus-group discussion and identified themes, which the authors describe and discuss in detail.

Urs Winter-Pfändler, Christoph Morgenthaler. “Are surveys of quality improvement of health care chaplaincy emotionally distressing for patients? A pilot survey,” *Journal of Health Care Chaplaincy* 16, no. 3/4 (Jul/Dec 2010): 140-48. • This paper reports the results of a Swiss study which sought to clarify whether asking patients to participate in surveys focusing on the services of chaplains was emotionally distressing, and if so, how much? The lead author is a chaplain. Thirty-seven persons, eight of whom were hospital inpatients, completed a fairly extensive questionnaire designed to discover if “research on quality improvement in health care chaplaincy is emotionally distressing for patients in the Swiss context.” (p. 143) The results clearly show that the vast majority (over 90 percent) of the participants did not find this to be stressful.

William Yang, Ton Staps, Ellen Hijmans. “Existential crisis and the awareness of dying: The role of meaning and spirituality,” *Omega (Westport)* 61, no. 1 (Jan 2010): 53-69. • For over thirty years, the first two authors worked in the field of psychosocial oncology, though in different hospitals. They met at a center specializing in counseling cancer patients and their relatives. When they compared notes about their experiences in their respective hospitals as well as at the counseling center, they found that there was a clear difference in patients’ requests for support. In the hospitals, requests focused on problems related to the physical impact of their illnesses,
treatments and the immediate consequences, e.g., managing feelings of fear, decisions concerning treatment. In contrast, at the counseling center, with their medical treatment ended, their requests concerned the emotional process of the loss of meaning and the struggle to—hopefully—recover it. This paper describes the counseling work, which involved responding to what patients experienced as moments of great emotional distress where they “totally lost all anchorage,” voiced in such comments as “My world collapsed,” and “I looked into a black hole.” The authors call this loss of anchorage “existential distress.” Its implications motivated their study of “existential crisis” and the ways patients deal with it. In their research, they used grounded theory methodology, which they describe in sufficient detail for the naïve reader to understand. They also detail their data gathering process, which included interviews of fifteen persons and survey of sixty-eight by questionnaire, and their use of sensitizing concepts. They note seven characteristics of the existential crisis: awareness of finitude, dissolving of the future, loss of meaning, fear/anxiety/panic/despair, loneliness, powerlessness and identity crisis. They analyze the processes that they found occurring within the existential crisis and include a number of suggestions for those who care for this group of patients.