These summaries of articles have been selected from the database of The Orere Source, a bimonthly publication of summaries of pastoral and other literature of potential value to chaplains, produced by W. Noel Brown STM BCC.

Amy L. Ai, C.L. Park, M. Shearer. “Spiritual and religious involvement related to end-of-life decision making in patients undergoing coronary bypass graft surgery,” International Journal of Psychiatry in Medicine 3, no. 1 (Jan 2008): 113-32. • Putting one’s affairs in order when faced with coronary artery bypass graft (CABG) surgery may be either distressing or beneficial to an individual—sometimes both. The imminent threat of death is not always an easy prospect to have to face. Religious thoughts, often common in this context, offer some comfort and support as the person journeys through the process. However, little research has been done to examine the impact of such thoughts on this process. In this study, 177 CABG patients agreed to be interviewed two weeks before surgery with another interview a month after the procedure. Analysis of the results showed that private religiousness increased the likelihood that individuals had engaged in end-of-life planning by nearly 50 percent over those who were characterized as publicly religious or subjectively religious. On the other hand, there was a reduced likelihood that they had advance care plans if they scored higher on experiencing reverence in religious contexts or on using petitionary prayer. The authors conclude that religious/faith factors appear to be independent and complex factors affecting end-of-life decision making in this particular group. This paper suggests that chaplains need to be mindful that patients who present as religiously active may have a greater reluctance to consider potential implications of this type of surgery.

Amy L. Ai, Kenneth I. Pargament, Hoa B. Appel, Ziad Kronfol. “Depression following open-heart surgery: A path-model involving Interleukin-6, spiritual struggle and hope under pre-operative distress,” Journal of Clinical Psychology 66, no. 10 (Oct 2010): 1057-75. • This study is one of relatively few which have looked at the negative aspects of religious coping, such as religious struggle, on surgery. Studies already published suggest that persons who are religiously conflicted tend not to function as well postoperatively. Ai and her coauthors present the results of a study designed to examine the role of stress (religious conflict) in surgical patients with coronary artery disease (CAD) and to obtain clearer information about the psychophysiological pathways to depression in these patients. Interleukin 6 (II-6) is a hormone in the body—technically a “proinflammatory cytokine”—that often has been suggested as a possible mediator among stress, depression and cardiovascular disorders. Other writers have used individuals’ appraisals of and methods of coping with stressful situations to explain their reactions to such stressors. Ai and her colleagues adopted a different approach, which involves the notion that it is the spiritual struggle/II-6 link which mediates the preoperative distress of patients and postoperative depression.

Amy L. Ai, Paul Wink, Terrence N. Tice, Steven F. Bolling, Marshall Shearer. “Prayer and reverence in naturalistic, aesthetic and sociomoral contexts predicted few complications following coronary artery bypass,” Journal of Behavioral Medicine 32, (Dec 2009): 570-81. • There still is work to be done to fully understand the faith/healing relationship. Ai and her team note the lack of consistent findings to explain the relationship between religion/spirituality (R/S), faith, religious behavior on the one hand—the “complex faith effect” as they call it—and physical/emotional results of surgery on the other. In this paper, they take a step away from the limitations of the more traditional measures of R/S by introducing the concept of “reverence.” This has the advantage of...
relating to both religious and nonreligious activities. The results of the study reinforce the growing body of evidence suggesting that the faith-health connection is more complex than previously believed. Their findings about the impact of traditional faith factors are mixed. Further, they differ from those of other researchers: “The inconsistency cautions against a simple definitive conclusion on the protection of religion, as an overarching factor, for cardiac surgery patients. Rather, future investigation should examine both positive and negative effects, concerning specific indicators of faith-related involvement ....” (p. 578) “It will be important that future research focuses more on the role of faith-based feelings as a potential mechanism explaining the salutary effects of faith, traditional or nonreligious, on health outcomes.” (p. 578)

**Sharon Begley.** “All natural: Breasts are just the beginning,” *Wired* 18, no. 11 (Nov 2010): 149-54,188. • This article is for chaplains interested in an advance in health care that is going to be quite revolutionary. In a non-technical way, Begley describes the development of tissue engineering, including a new source of stem cells that helps the body to rebuild itself. This is the field of regenerative medicine, which began with fat that was being removed by liposuction from persons who wanted to change their body shapes. Initially, this fat was simply thrown away. Then in 2002, it was found to contain stem cells, which could be turned on to become a whole variety of different cells. These in turn could be implanted in parts of the human body that had died or were dying. This article focuses on the female breast because much of the initial work in tissue regeneration was related to problems associated with reconstructing the breasts of women who had undergone complete or partial mastectomies or lumpectomies. The article may be accessed at http://www.wired.com/magazine/2010/10/ff_futureofbreasts/ or by typing Begley’s name into the publication’s search box.

**Gina M. Berg, Robin E. Crowe, Bryant Wong, Jane Siebert.** “Trends in publication of spirituality/religiosity articles in critical care populations,” *Journal of Religion and Health* 49, no. 3 (Sept 2010): 333-36. • What are the professional backgrounds of persons who publish articles on spirituality and religion (S/R) in critical health care? The authors, the last of whom is a chaplain, claim that they were looking for “trends,” but this is not apparent in their findings. Papers published between 1965 and 2008 in the major databases, e.g., Pubmed, CINAHL, Expanded Academic, PsychInfo, were selected if any of the following keywords appeared in the title: spiritual(ity), religion (religiosity), prayer, faith, pastoral/chaplain/clergy. Letters and book chapters were not included. A total of 255 papers met the criteria for inclusion. Authors came from a variety of backgrounds, including theological, behavioral and medical—the last being the majority. The results tend to validate the observation that chaplains do not publish many articles about their work; however, it should be noted that with over a third of the authors’ backgrounds unidentified, chaplains/theologically-trained individuals may be underrepresented. The conclusion of the paper states that “through published research, theologically educated professionals can provide necessary guidance to members of other disciplines so that they may be better prepared to deal with such issues, which at a time such as critical care, is vitally important to many.” (p. 336)

**Wendy Cadge, Elaine H. Ecklund.** “Prayers in the clinic: How pediatric physicians respond,” *Southern Medical Journal* 102, no. 12 (Dec 2009): 1218-21. • This paper examines an aspect of physician/patient prayer in a manner different than previous research in pediatric settings. The authors wanted to know how prayer comes up when doctors are with patients, and when it does come up, how do they behave? The study involved pediatricians from the pediatric departments of the thirteen highest ranked hospitals in the 2004 survey of *US News & World Report*. Following a mail survey, the authors conducted semi-structured interviews of fourteen pediatricians and sixteen pediatric oncologists. They present the data gathered from asking these questions: When, if at all, does the issue of prayer come up in your interactions with patients and families? Who brings it up? Do patients/families ever ask you to pray with them? If yes, how do you respond? From the results, it appears that prayer is more commonly relevant to pediatric oncologists. Also, it is rarely a simple matter of families directly asking the doctor to pray and receiving a yes or no answer.
Roy Clymer. “The puzzle of PTSD,” The Psychotherapy Networker 34, no. 6 (Nov/Dec 2010): 27-33, 60. • This is the first article of a special section within this issue titled “Wounds of War,” Clymer, a veteran of four years active duty in Vietnam, is a psychologist, and for thirteen years served as director of a program at the Walter Reed Army Medical Center where veterans returning from combat were treated. Clymer writes with passionate concern that the development widely considered to be the most important advance in the field of trauma therapy, the creating of the posttraumatic stress disorder (PTSD) diagnosis, has had a profoundly unintended negative consequence. He believes that much of current PTSD treatment, with its emphasis on technical methodology and neurobiological explanations, simply obscures the core of the experience that we call “traumatic,” the human struggle to face and live with the terrible existential experiences of war, suffering and death. He writes, “The fundamental, universal human dilemma—how to cope with overwhelming feelings, come to terms with inherently opposing realities, find meaning in meaningless chaos—is turned into a ‘psychiatric disorder’ that can be ‘treated.’ The diagnosis of PTSD paradoxically exacerbates the problems of those so diagnosed.” He presents the realities and the struggles that arise from a different therapeutic stance.

F. Susan Cowchock, J.N. Lasker, L.J. Toedter, S.A. Skumanich, Harold G. Koenig. “Religious beliefs affect grieving after pregnancy loss,” Journal of Religion and Health (19 Aug 2009, e-print): 13 pages. • While there are numerous studies reporting findings about the interrelationships of religion/spirituality and health, there are few evaluating the role of religiosity, religious beliefs or religious coping in parents dealing with pregnancy loss, hence this study. The authors hypothesized that scores from questions on each of four religiosity scales would predict the scores on the Perinatal Grief Scale at one and two years after the loss. Secondly, they hypothesized that agreement with statements asserting belief in God, in continued attachment to the baby, or that the loss was God’s will would predict lower grief scores. Finally, they expected that agreement with two statements concerning religious struggle would be associated with higher grief scores. Results of this study of 110 women showed that neither agreement with statements corresponding to extrinsic or intrinsic religiosity, nor to positive religious coping, nor frequency of attendance at religious worship could predict follow-up scores on the Perinatal Grief Scale. However, religious struggle, agreement with statements that could be labeled as negative religious coping and continuing attachment to the baby all were associated with more severe grief. The most important lesson from this study must be that women who suffer the unplanned loss of a pregnancy and who also use negative religious coping or express religious struggle are at high risk of chronic, or even pathological, grief at one year after the event or longer. As of 1 Dec 2010, this paper has not appeared in print version; however, it has been accepted for publication and is available electronically.

Gina Diddle, Sharon A. Denham. “Spirituality and its relationships with the health and illness of Appalachian people,” Journal of Transcultural Nursing 21, no. 2 (Apr 2010): 175-82. • “Appalachia is a place, a people, an idea, a culture, and it exists as much in the mind and imagination as on the map.” With these words from Richard Straw (A Handbook to Appalachia, 2006), Diddle and Denham introduce the thinking and values of the people who live in what is referred to as the Appalachian region. Denham uses a family health model, which she herself constructed, in part as a means of seeing spirituality as a contextual factor that “saturates all aspects of an ecologically lived experience and suggests numerous attributes that influence individual and family health behaviors.” (p. 175) The authors use this model to help readers to understand that spirituality, faith and religion are not merely isolated personal traits but that their influence springs from larger societal exchanges across multiple systems over time. The authors review the literature relating to spirituality, health and the culture of those living in the Appalachian area. Their review suggests that while there are connections between spirituality and health, the empirical evidence is limited in scope, somewhat dated and, most importantly, lacks viable conclusions that may be considered relevant to the diverse needs of those who live in Appalachia today.

Hal Herzog. “Cats that cure and other fluffy tales,” New Scientist 208, no. 2705 (6 Nov 2010): 30-31. • The popular press, and even some of the medical research literature, has recently
contained some appealing stories about the therapeutic effects of living with pets and bringing them into hospitals. “Therapy animals” are said to help sick people recover and swimming with dolphins purportedly alleviates autism and shrinks tumors. Herzog asks whether there is evidence to prove any of this. A professor of psychology, he has done his homework, checking the hundreds of studies—mostly poorly constructed—both published and unpublished, including research that has shown there is no therapeutic effect. One Finnish study apparently found significant negative effects from owning pets. Herzog’s conclusion is that pets are undoubtedly a healthy pleasure although not to the extent that the pet industry leads one to believe, and he challenges researchers to do better at studying this subject. Herzog recently published Some We Love. Some We Hate. Some We Eat. Why It Is so Hard to Think Straight about Animals (HarperCollins 2010).

Christopher P. Landrigan, Gareth J. Perry, Catherine B. Bones, Andrew D. Hackbarth, Donald A. Goldmann, Paul J. Sharek. “Temporal trends in rates of patient harm resulting from medical care,” New England Journal of Medicine 363, no. 22 (25 Nov 2010): 2124-34. • A report of the Institute of Religion about patient safety ten years ago scared many hospital administrators, not to mention hospital attorneys. The study concluded that approximately 100,000 deaths annually were caused by procedures/medications that were provided (or not provided) to patients in hospitals. Landrigan and his team conducted a follow-up study to see if anything has changed, and the conclusion is very little. Ten hospitals in North Carolina were carefully selected to be representative in every possible way as a national sample. Trained reviewers examined a statistically reliable number of patient records and found that there had been almost no statistical change in the number of “harms” done per 1000 patient-days compared to ten years ago. The authors conclude that “harms remain common, with little evidence of widespread improvement.” In a separate interview, Landrigan observes that clearly proven methods to reduce risk simply are not being adopted around the country. He cites as an example a checklist developed by Johns Hopkins to reduce bloodstream infections. Where that method has been adopted by hospitals in Michigan, the number of infections has been kept near zero for three years.

Judith Marston. “Meaning in life: A spiritual matter – projected changes postretirement for baby boomers,” Journal of Religion, Spirituality & Aging 22, no. 4 (2010): 329-42. • “No instinct tells him what to do, and no tradition tells him what he ought to do: sometimes he does not even know what he wishes to do. Instead he either wishes to do what other people do (conformism) or he does what other people wish him to do (totalitarianism).” These were Victor Frankl’s words about the place of meaning in life, admittedly in now dated words, yet describing an issue that faces us all. The words are Marston’s starting point for a study intended to advance understanding of the meanings people in preretirement age, (the baby boomers) are making in life and how they may see meanings change as they encounter age-related challenges. Her premise is that meaning in life is a spiritual matter. She reminds us that baby boomers have “rather unkindly” been described as being self-indulgent, self-absorbed and narcissistic. Nevertheless, they have left their mark on the world: engaging in anti-war protests in the 60s, trumpeting environmental concerns in the 70s, raising a generation of children in the 80s and beyond. Now they face the question, “is this all there is?” Marston selected a very small sample of Australians, administered a brief survey and then talked with the individuals in semi-structured interviews. Many themes emerged from her analysis, the primary one being connectedness: to significant others, to God, to nature. The survey results—limited by small sample size—are secondary to her description of the history of the concept of “meaning in life.”

Stéfanie Monod, Etienne Rochat, Christophe Büla, Brenda Spencer. “The Spiritual Needs Model: Spirituality assessment in the geriatric hospital setting,” Journal of Religion, Spirituality & Aging 22, no. 4 (2010): 271-82. • This paper reports the work of an interdisciplinary group in five different postacute care geriatric hospitals in Switzerland. The group, which included three chaplains, had three goals: to state the purpose for integrating spirituality into geriatric care in their hospitals, taking into account the ethical concerns that would arise from its integration; to decide on a definition of spirituality in elderly hospitalized persons; and to define a model for spirituality assessment in geriatric postacute care. Their model for describing spirituality, which
took four years from construction to implementation, was operationalized for use in clinical practice. It identifies four different dimensions: meaning, transcendence, values and psychosocial identity and serves to identify spiritual needs within each of the defined dimensions. This in turn facilitates decisions regarding clinical and/or pastoral interventions to address such needs. Although created specifically for their particular setting, they see the Spiritual Needs Model as having relevance to other clinical situations. Questions still under consideration by the group include the following. Who should perform assessments? Is this solely the role of the chaplain? What specific training should be provided before a person is permitted to conduct an assessment? Perhaps the most interesting question is whether health professionals accept that a chaplain may propose specific interventions that may involve them? The authors are clear in their definitions and descriptions, making this an interesting paper for persons outside Switzerland.

Carolyn R. Mueller. “Spirituality in children: Understanding and developing interventions,” Pediatric Nursing 36, no. 4 (Jul/Aug 2010): 197-203,208. • Mueller asserts that “Children are born with ‘spiritual competence’,” by which she means an inner quality or power for faith development. She defines spirituality as “self-transcendence in which self becomes embedded in something greater than self, including the sacred, leading to connectedness, meaning, purpose and contribution.” The paper is a synthesis of faith development theory (based on Fowler), the effects of spirituality in children and spiritual assessment approaches, including the seven-item questionnaire that Barnes et al. developed in 2000 for cross-cultural discussion of religious and spiritual traditions in working with families and children. Mueller concludes with thoughts about designing interventions. She also suggests some interventions and concludes with several case studies.

Shelly M. Reese. “Exclusive ethics survey: ‘Should I keep this patient alive?’,” www.medscape.com (16 Nov 2010): 3p. • During their medical school training, virtually all physicians are exposed to the question of how to respond to ethical dilemmas. Many continue to struggle with these, and chaplains may be the closest persons to provide professional support and care when they arise. End-of-life issues often present complex and gut-wrenching decisions. Last summer, Medscape electronically surveyed 10,000 physicians representing all specialties, asking them a series of ethics questions, including two relating to end-of-life care. Respondents were invited to add comments to their answers. The results make it clear that there continue to be widely diverging decisions about the kind of care to provide. Nearly 5,300 physicians responded to the question, “Would you ever recommend or give life-sustaining therapy when you considered it was futile?” Answers included the following: yes (23.6 percent), no (37.0 percent) and it depends on the circumstances (39.4 percent). Nancy Berlinger, a part-time chaplain and an ethicist at The Hastings Center is much quoted in this article, which may be accessed at no cost from the Medscape website (see URL above). The site also features a slideshow describing the top twenty issues facing physicians. This more detailed account of the survey includes statistics of responses as well as quotes about each question.

Charles G. Sasser, Christina M. Puchalski. “The humanistic physician: Traversing the science and art of health care,” Journal of Pain and Symptom Management 39, no. 5 (May 2010): 936-40. • “The most beautiful experience in the Universe is the experience of the mysterious. It is the source of all art and science.” (Albert Einstein) Can suffering be treated? Can it be reduced to a medical code? If it can, does it not risk being “medicalized” out of a universal human experience? The humanities offer a framework for more appropriately addressing the non-physical aspects of illness. It is from within the humanities that Sasser and Puchalski believe that the “humanistic physician” can be described. Such a physician, they suggest, will have six characteristics: compassion, empathy, narrative competence, a meaning-center life, trajective courage, and be at home in both worlds. Each of these is discussed in sufficient detail to provide the reader with a sense of what the concepts mean in practice. Several may be somewhat unfamiliar. For example, narrative competence means that a person has acquired a “story way of knowing,” as opposed to logical-scientific knowing. The listener has the ability to visualize the person with illness as a story s/he is writing with her/his life. “Trajective courage” means having the courage to suspend one’s
own personal agenda, no matter how disquieting this may feel personally, and to go where the patient wants to go. The writers give an example of a caregiver lacking trajective courage. Caregiver: “Have you ever been threatened or hurt by (...) or someone close to you?” Patient: “Yeah.” (pause). Caregiver: “Are you allergic to any medication?” With very little translation, what this article says about medical doctors could also be said about chaplains and clergy who minister to troubled people.

**Harry Smart.** “The mysteries drama group,” *bjr Newsletter* 20, (Nov 2010): 6-7. • Smart is the lead mental health chaplain and an Anglican priest in Lincolnshire, England. In this article, he describes, all too briefly unfortunately, how he used his interest in drama to form a group to work with mental health patients. Initially, he utilized the Lincoln Mystery Plays, which originated in mediaeval English popular culture, and subsequently, many different types of stories and myths. These become the basis for exploring a wide variety of personal issues and their theological implications, e.g., loneliness, conflict, fears of death, growing, religious topics.

**Jane Thibault.** “Activating the resources of the soul: A psychospiritual intervention for pain and suffering in later life,” *Journal of Religion, Spirituality & Aging* 22, no. 4 (2010): 245-53. • There used to be a Roman Catholic devotional practice, based on Paul’s words in Colossians 1:24: “It makes me happy to suffer for you, as I am suffering now, and in my own body to do what I can to make up all that has still to be undergone by Christ for the sake of his body, the Church.” The practice was colloquially known as “offering it up.” Thibault recalls that during an extended period of illness when she was four, her mother instructed her to offer up the pain. She found at the time that it was very effective in helping her to cope with it. Changes in both theology and social thinking have tended to discredit this practice, but Thibault asks whether this old, Catholic devotional practice can be resurrected and modernized for use today? She reports how she looked at pain and suffering and then revised the process of dedicated suffering. The results of using the approach with a group of people and with an individual outside of the group are remarkably positive. Based on her findings, she suggests that this is an approach worthy of additional study.

**Katie Watson.** “Happy,” *Atrium* 8 (Summer 2010): 26p. • *Atrium* is a publication, currently free for the asking, of the Medical Humanities and Bioethics Program of Northwestern University’s Feinberg School of Medicine. This issue looks at the concept of “happy” and what it means in life and especially within medical contexts. Articles in this issue are an eclectic mix: the challenge of mixing religion and work and the effect of enforced “happy” environments on patient satisfaction. *Atrium*’s mailing list is at: [http://bioethics.northwestern.edu/atrium/mailing/](http://bioethics.northwestern.edu/atrium/mailing/) Disclosure: I am an adjunct staff member in this program.