



Health Care for the Homeless
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Bibliography #17

Spirituality and Health

August 2004

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Policy Research Associates, Inc. • 345 Delaware Avenue, Delmar, New York 12054
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2004

Born W, Greiner KA, Sylvia E, Butler J, Ahluwalia JS. **Knowledge, attitudes, and beliefs about end-of-life care among inner-city African Americans and Latinos.** *J Palliat Med* 7(2):247-56, 2004.

OBJECTIVE: This project explored end-of-life care preferences and barriers among low-income, urban African Americans and Latino/Hispanic Americans (Latinos) to uncover factors that may influence hospice utilization. **METHODS:** Focus groups were conducted separately for African Americans and Latinos. Transcripts were coded and analyzed using consensus and triangulation to identify primary themes. **RESULTS:** Four preference themes and four barriers were identified. Results were largely similar across the two groups. Both preferred having families provide care for loved ones but expressed desire to reduce caretaker burden. Groups emphasized spirituality as the primary means of coping and valued the holistic well-being of the patient and family. Barriers reported were closely tied to access to care. Participants reported low hospice utilization because of lack of awareness of hospice and the prohibitive cost of health care. Latinos were more likely to report language barriers, while African Americans were more likely to report mistrust of the system. **CONCLUSIONS:** African Americans and Latinos in this study were highly receptive to end-of-life care that would provide relief for patients and caregivers and emphasize spirituality and family consensus. Improving awareness of hospice services would likely increase utilization.

Canales M. **Taking care of self: Health care decision making of American Indian women.** *Health Care Women Int* 25(5):411-35, 2004.

In this article, the author reports a component of a qualitative grounded theory study on health care decision making of American Indian women (AIW) residing in the Northeastern United States. Analysis was based upon data collected from 20 women who self-identified as American Indian. Taking care of self was a primary factor influencing health care decisions among this sample of AIW. As women moved between their Native, traditional health practices and conventional Western health practices, efforts toward taking care of self were especially salient. The properties of taking care of self include knowing family history; balancing mind, body, and spirit; understanding the body; and integrating natural practices. The author also addresses some implications of the study findings for practitioners working with Native women.

Conner NE, Eller LS. **Spiritual perspectives, needs and nursing interventions of Christian African-Americans.** *J Adv Nurs* 46(6):624-32, 2004.

BACKGROUND: Although the amount of literature on spiritual needs and care has increased, in practice there has been little change in how nurses assess spiritual need. This suggests that not all spiritual needs of patients are being addressed. Based on the assumption that spiritual needs vary by culture, this study focused on one subgroup, namely Christian African-Americans. **AIMS:** The aim of this paper is to report a study examining spiritual perspectives, spiritual needs and desired nursing interventions during hospitalization identified by Christian African-Americans. **METHODS:** A descriptive correlational design was employed. A convenience sample was recruited from three African-American churches. Descriptive statistics were calculated, and one-way anovas used to examine spiritual perspectives and spiritual values. Content analysis was used to analyse and summarize qualitative data. Instruments included the Spiritual

Perspective Scale (SPS) and two open-ended questions. RESULTS: The mean age of participants was 56 years. The majority was female; 71% of respondents strongly agreed that they had spiritual needs to be met during hospitalization. Mean score for the SPS was 5.7. Respondents used a total of 103 phrases to describe spiritual needs, based on three dimensions of connectedness: connectedness to God, connectedness to others and connectedness to self. Desired nursing interventions included: participating in spiritual activities; demonstrating caring qualities; providing comforting measures; providing reassurance; recognizing the spiritual caregiver role; and incorporating diversity in care. CONCLUSIONS: The findings provide information for nurses to facilitate development of culturally appropriate spiritual nursing interventions.

Daaleman TP, Perera S, Studenski SA. **Religion, spirituality, and health status in geriatric outpatients.** Ann Fam Med 2(1):49-53, 2004.

BACKGROUND: Religion and spirituality remain important social and psychological factors in the lives of older adults, and there is continued interest in examining the effects of religion and spirituality on health status. The purpose of this study was to examine the interaction of religion and spirituality with self-reported health status in a community-dwelling geriatric population. METHODS: We performed a cross-sectional analysis of 277 geriatric outpatients participating in a cohort study in the Kansas City area. Patients underwent a home assessment of multiple health status and functional indicators by trained research assistants. A previously validated 5-item measure of religiosity and 12-item spirituality instrument were embedded during the final data collection. Univariate and multivariate analyses were performed to determine the relationship between each factor and self-reported health status. RESULTS: In univariate analyses, physical functioning, quality of life, race, depression, age, and spirituality were all associated with self-reported health status, but religiosity was not. In a model adjusted for all covariates, however, spirituality remained independently associated with self-appraised good health. CONCLUSIONS: Geriatric outpatients who report greater spirituality, but not greater religiosity, are more likely to appraise their health as good. Spirituality may be an important explanatory factor of subjective health status in older adults.

Dann NJ, Mertens WC. **Taking a "leap of faith": Acceptance and value of a cancer program-sponsored spiritual event.** Cancer Nurs 27(2):134-41, 2004.

Investigations of spiritual interventions for cancer patients are disproportionately few compared to the reported importance of religion to Americans. We report on the implementation and evaluation of a spiritual, community-based intervention developed with interdenominational community clergy. Approximately 1200 people attended a total of 3 gatherings: 2 at Roman Catholic and another at a Protestant Church. Respondents to questionnaires evaluating attendee characteristics and satisfaction were predominantly women; 50% were patients and 45% were aged 60 years and older. Men were more likely to be currently under treatment for cancer, while women were more likely to be past patients or friends. Fewer than 2% felt anger or anxiety; attendees felt the service was very or somewhat helpful and expressed appreciation for cancer program clinician attendance and for hospital sponsorship of the event. Components in order of preference were prayer, music, Scripture, and litany. Logistic regression models reveal that music was most appreciated by previously treated patients, and prayer by currently treated patients. Secular healthcare systems can offer a religious service that comforts and links attendees to a broader community, including clergy and cancer program clinicians. Surveys can identify service components that appeal to differing groups and can facilitate service development.

Dermatis H, Guschwan MT, Galanter M, Bunt G. **Orientation toward spirituality and self-help approaches in the therapeutic community.** J Addict Dis 23(1):39-54, 2004.

Although Alcoholics Anonymous and other Twelve-Step interventions are among the most widely utilized self-help options by persons with chemical dependency, little is known concerning whether this approach should be integrated with non-spirituality based self-help approaches. The purpose of this study was to assess the extent to which clients receiving inpatient treatment in a residential therapeutic community (TC) felt that spirituality based interventions should be featured in TC treatment. Three hundred twenty-two members of the Daytop TC completed a survey assessing personal orientation to spirituality and attitudes towards spirituality based treatments. The majority of clients believed that the TC program should feature spirituality more in treatment. Nearly half agreed that the Twelve-Step (AA) approach should be more a part of TC treatment. Preference for Twelve-Step meeting interventions was positively correlated with past attendance at Twelve-Step meetings. Personal spiritual orientation to life was positively correlated with endorsement of spirituality based interventions in TC treatment. These findings highlight the importance of integrating treatment approaches which address the spiritual needs of TC residents.

Dessio W, Wade C, Chao M, Kronenberg F, Cushman LE, Kalmuss D. **Religion, spirituality, and healthcare choices of African-American women: Results of a national survey.** Ethnic Disparities 14(2):189-97, 2004.

OBJECTIVE: This study describes the prevalence and patterns of use of religion and spirituality for health reasons among African-American women. **METHODS:** Respondents were asked about their use of religion/spirituality for health reasons as part of a larger study of the prevalence and correlates of complementary and alternative medicine (CAM) use among women. In 2001, a national survey of 3,172 women, aged 18 and older, was conducted in 4 languages, with over-sampling among African-, Mexican-, and Chinese-American participants. This paper focuses on the sub-sample of 812 African-American women. **RESULTS:** Overall, 43% of the African-American women reported using religion/spirituality for health reasons in the past year. Factors significantly associated with the use of religion/spirituality for health reasons included having an income of dollar 40,000-dollar 60,000, an education level of college graduate or more, or being 37-56 years of age; worse health status approached significance. African-American women utilized religion and spirituality most often for serious conditions such as cancer, heart disease, and depression. African-American women who had used religion/spirituality in the past year for health reasons were more than twice as likely to have used some form of CAM, and also more likely to have seen a medical doctor during the year prior to the interview, compared to their counterparts. **CONCLUSION:** Religion and spirituality are associated with health-seeking behaviors of African-American women. The use of religion and spirituality for health reasons warrants additional research, particularly its use for chronic and serious conditions, and its role in the health-seeking behavior of African-American women in conjunction with the utilization of conventional medicine and CAM.

Flannelly KJ, Weaver AJ, Costa KG. **A systematic review of religion and spirituality in three palliative care journals, 1990-1999.** J Palliat Care 20(1):50-6, 2004.

Fletcher CE. **Health care providers' perceptions of spirituality while caring for veterans.** Qual Health Res 14(4):546-61, 2004.

To determine health care providers' views on spirituality, its role in the health of patients, and barriers to discussing spiritual issues with patients, the author convened five focus groups at two Veterans Administration Medical Centers. Participants were nurses, physicians, social workers, psychologists, and chaplains. Common themes included (a) the lack of education for professionals regarding how to address patients' spiritual needs; and (b) systems-related issues, including communication systems that do not function well, how spiritual needs are addressed on admission, support or lack thereof by hospital administrators, and lack of support for the spiritual needs of staff. The aging and illnesses of many current veterans plus the escalated potential of war highlight the importance of addressing veterans' spiritual needs.

Furman J. **Healing the mind and spirit as the body fails.** Nursing 34(4):50-1, 2004.

Hansel NN, Wu AW, Chang B, Diette GB. **Quality of life in tuberculosis: patient and provider perspectives.** Qual Life Res 13(3):639-52, 2004.

Tuberculosis (TB) is a persistent problem in the United States; however, little is known about its impact on functioning and quality of life (QOL) among people with TB. The purpose of this study is to describe the impact of TB on patients' QOL by using focus groups to assess the domains of QOL that are affected. Participants included patients who received treatment for active TB and physicians and nurses caring for patients with TB at a public health clinic in Baltimore, Maryland. TB affected all predicted domains of QOL, including general health perceptions, somatic sensation, psychological health, spiritual well-being, and physical, social and role functioning. Social stigmatization, isolation, pill burden, long duration of therapy, sexual dysfunction, loss of income, and fear were additional specific problems related to TB. Surprisingly, 11% of the comments described benefits of TB illness, including increased spirituality and improved life perspectives. In addition, four additional QOL domains and three elements of treatment specific to TB which substantially impact QOL were identified. While patients and clinicians both identified issues in many areas of QOL, only patients mentioned the impact on sexual function, spirituality and improved life perspectives. Despite available curative therapy, TB and its treatment still have significant short and long-term consequences on patients' QOL.

Puchalski C. **Spirituality in health: The role of spirituality in critical care.** Crit Cr Clin 20(3):487-504, 2004.

Caring for critically ill patients requires that physicians and other health care professionals recognize the potential importance of spirituality in the lives of patients, families, and loved ones and in their own lives. Patients and loved ones undergo tremendous stress and suffering in facing critical illness. Professional caregivers also face similar stress and sadness. Spirituality offers people away to understand suffering and illness. Spiritual beliefs can also impact how people cope with illness. By addressing spiritual issues of patients, loved ones, and ourselves, we can create more holistic and compassionate systems of care.

Stephenson C, Wilson K. **Does spiritual care really help? A study of patient perceptions.** J Christ Nurs 21(2):26-9, 2004.

Zemore SE, Kaskutas LA. **Helping, spirituality and Alcoholics Anonymous in recovery.** J Stud Alcohol 65(3):383-91, 2004.

OBJECTIVE: The purpose of this study is to examine how helping activities and spirituality--perhaps key influences on sobriety--change over recovery. The study also explores interrelations among Alcoholics Anonymous (AA), helping and spirituality. **RESULTS:** Structural equation modeling revealed that longer sobriety predicted significantly more time spent on Community Helping, less time spent on Recovery Helping and higher levels of Theism, Self-Transcendence and AA Achievement. Model covariances revealed that both AA components were related to more Recovery Helping and higher Theism. Both spirituality components related to all forms of helping, with one exception. **CONCLUSIONS:** The findings highlight important changes in helping with length of sobriety. As their sobriety accumulates, recovering alcoholics seem to devote less time to informal helping and more time to organized community projects--perhaps indicating evolving needs and abilities. The results also suggest roles for AA and spirituality in encouraging helping, and they indicate that some forms of spirituality relate to AA affiliation. Future work might establish whether and when helping in different domains contributes to the maintenance of abstinence and to other drinking-related outcomes.

2003

Armbruster CA, Chibnall JT, Legett S. **Pediatrician beliefs about spirituality and religion in medicine: Associations with clinical practice.** Pediatrics 111(3): 227-235, 2003.

A self-report questionnaire was administered to full-time pediatric faculty and residents of an urban children's hospital affiliated with a school of medicine. The response rate was 70.8% among faculty and 78.6% among residents. Respondents indicated the extent of their SR inquiry and the frequency of their SR experiences (requests by patients or families to discuss SR or pray), routinely and during health crisis, and rated 19 belief statements about SR in pediatrics. Few pediatricians routinely ask about SR issues. Faculty were more likely than residents to ask about religious affiliation, whereas residents were more likely to be asked to pray during health crises, to believe that SR has health relevance, and to perceive pediatrician-initiated prayer as appropriate. Composite scores indicated that physicians who did not expect negative patient reactions to SR inquiry and prayer, who believed more strongly that SR is relevant to pediatric outcomes, and who felt more capable with SR inquiry were more likely to engage in SR inquiry and to experience SR requests. Pediatrician beliefs with respect to health relevance of SR, patient reactions to SR inquiry, and physician capabilities regarding SR in the clinic are strongly related to their clinical practice concerning SR inquiry and experiences. Correction of physician misperceptions about SR issues and incorporation of religious sensitivity into physician training may remove barriers to both patient and physician SR inquiry.

Begay RC. **Science and spirituality.** Am J Public Health 93(3): 363-364, 2003.

Duggleby W. **Helping Hispanic/Latino home health patients manage their pain.** Home Health Nurs 21(3): 174-179, 2003.

The research focusing on pain in Hispanic/Latino populations suggests that their cultural values and beliefs of stoicism, fatalism, the importance of family, spirituality, and folk healing have an impact on their pain experience. Based on research findings this article suggests strategies nurses can use to assess and suggest pain management interventions for patients of Hispanic/Latino culture.

Heslin K, Andersen R, Gelberg L. **Use of faith-based social service providers in a representative sample of urban homeless women.** Journal of Urban Health: Bulletin of the New York Academy of Medicine 80(3): 371-382, 2003.

There are few quantitative studies on the characteristics of homeless persons who use faith-based social service providers. To help address the lack of information in this area. The authors analyzed survey data on 974 participants in the University of California at Los Angeles (UCLA) Homeless Women's Health Study, a representative sample of homeless women at shelters and meal programs in Los Angeles County. The primary objective of this analysis was to estimate the association of religious affiliation, race/ethnicity, income, and other client characteristics with the use of faith-based programs. In interviews at 78 homeless shelters and meal programs, study respondents provided information about their religious affiliation and other social and demographic characteristics. The names of the organizations were examined, and those with names that referenced specific religions or contained words connoting religiosity were designated as "faith-based." At the time they were selected for study participation, 52 percent of respondents were using the services of faith-based providers. In multivariate logistic regression analysis, lower odds of using these providers were estimated for participants with no religious affiliation (compared with Christian respondents) and for African Americans and Latinas (compared with whites). There is evidence of systematic differences between the clients of faith-based and secular social service providers. The benefits of increased funding through a federal faith-based policy initiative may accrue primarily to subgroups of clients already using faith-based programs (authors).

Kirschner MH. **Spirituality and health.** Am J Public Health 93(2): 185-186, 2003.

Koenig HG. **Religion, spirituality and health: An American physician's response.** Med J Aust 178(2): 51-52, 2003.

Lunn JS. **Spiritual care in a multi-religious context.** J Pain Palliat Care Pharm 17(3-4):153-66, 2003.

Spiritual care is an essential component of palliative care because spirituality is an important part of suffering and the relief of pain and suffering. It is especially important in the developing world where medical and comfort resources are limited. Spiritual resources in the context of many religions are described. Understanding pain from a spiritual perspective and approaches when spiritual resources appear ineffective are discussed. The role of spiritual resources in end-of-life care are described in the context of taking a spiritual inventory. The importance of all palliative care clinicians understanding these concepts is emphasized.

MacLean CD, Susi B, Phifer N, Schultz L, Bynum D, Franco M, Klioze A, Monroe M, Garrett J, Cykert S. **Patient preference for physician discussion and practice of spirituality.** J Gen Int Med 18(1): 38-43, 2003.

OBJECTIVE: To determine patient preferences for addressing religion and spirituality in the medical encounter. DESIGN: Multicenter survey verbally administered by trained research assistants. Survey items included questions on demographics, health status, health care utilization, functional status, spiritual well-being, and patient preference for religious/spiritual involvement in their own medical encounters and in hypothetical medical situations. SETTING: Primary care clinics of 6 academic medical centers in 3 states (NC, Fla, Vt). PATIENTS/PARTICIPANTS: Patients 18 years of age and older who were systematically selected from the waiting rooms of their primary care physicians. MEASUREMENTS AND MAIN RESULTS: Four hundred fifty-six patients participated in the study. One third of patients

wanted to be asked about their religious beliefs during a routine office visit. Two thirds felt that physicians should be aware of their religious or spiritual beliefs. Patient agreement with physician spiritual interaction increased strongly with the severity of the illness setting, with 19% patient agreement with physician prayer in a routine office visit, 29% agreement in a hospitalized setting, and 50% agreement in a near-death scenario. Patient interest in religious or spiritual interaction decreased when the intensity of the interaction moved from a simple discussion of spiritual issues to physician silent prayer to physician prayer with a patient. Ten percent of patients were willing to give up time spent on medical issues in an office visit setting to discuss religious/spiritual issues with their physician. After controlling for age, gender, marital status, education, spirituality score, and health care utilization, African-American subjects were more likely to accept this time trade-off. **CONCLUSION:** Physicians should be aware that a substantial minority of patients desire spiritual interaction in routine office visits. When asked about specific prayer behaviors across a range of clinical scenarios, patient desire for spiritual interaction increased with increasing severity of illness setting and decreased when referring to more-intense spiritual interactions. For most patients, the routine office visit may not be the optimal setting for a physician-patient spiritual dialog.

Marshall ES, Olsen SF, Mandleco BL, Dyches TT, Allred KW, Sansom N. **"This is a Spiritual Experience": Perspectives of Latter-Day Saint families living with a child with disabilities.** Qual Health Res 13(1): 57-76, 2003.

The presence of a child with disabilities elicits a variety of stress demands on the family. Religion is recognized as a powerful personal, family, and cultural variable. However, little is known about the influence of religion in dealing with disability among families within particular religious groups. This descriptive study explored themes of spiritual belief and religious support among families of the Church of Jesus Christ of Latter-Day Saints (LDS, or Mormon) with a child with developmental disabilities. Parents shared perspectives of meaning that emerged from experiences with religion and family beliefs perceived to be unique. The core theme, "This is a Spiritual Experience," provides the foundation for a descriptive model that depicts aspects of finding meaning and perceived transcendence.

McEvoy M. **Culture & spirituality as an integrated concept in pediatric care.** MCN Am J Matern Child Nurse 28(1): 39-43, 2003.

The purpose of this article is to propose an integrated approach to culture and spirituality in pediatric care. In the spirit of sensitive and respectful communication with patients, pediatric nurses have become increasingly concerned with the child's and family's culture, spirituality, and religion. As a result, various approaches and models have been created to help nurses initiate discussions surrounding these topics. These models have given rise to categorizations of culture, spirituality, and religion. It is important for pediatric nurses to understand that while delineations can be made, there are also many intersecting factors that make separation of these issues difficult and perhaps unnecessary for the purpose of culturally sensitive communication. Pediatric nurses should, perhaps, focus instead on understanding the individual child's or family's traditions, values, and beliefs and how these dimensions impact the health of the child. This article suggests three areas that can be used as an organizing framework for pediatric nurses to broach culturally sensitive issues within the context of pediatric primary healthcare: (1) Family beliefs/values, (2) Family daily practices, and (3) Community involvement.

McIllmurray MB, Francis B, Harman JC, Morris SM, Soothill K, Thomas C. **Psychosocial needs in cancer patients related to religious belief.** Palliat Med 17(1): 49-54, 2003.

In a study of psychosocial needs amongst cancer patients, the possession of a religious faith has been identified as a significant factor in determining a range of psychosocial needs. Of the 354 respondents to a questionnaire, which included a comprehensive psychosocial needs inventory, 83% said they had a religious faith, and in general these patients were less reliant on health professionals, had less need for information, attached less importance to the maintenance of independence and had less need for help with feelings of guilt, with their sexuality or with some practical matters than those who said they had no religious faith. In addition, they had fewer unmet needs overall (32% compared with 52%). The knowledge of a patient's spirituality should help service providers to predict aspects of psychosocial need and to respond sensitively and appropriately to a patient's experience of cancer.

Miller WR, Thoresen CE. **Spirituality, religion, and health: An emerging research field.** American Psychologist 58(1): 24-35; 2003.

This article discusses the clinical relevance of the investigation into spiritual/religious factors in health. The authors explore the persistent predictive relationship between religious variables and health, and its implications for future research and practice. The article reviews epidemiological evidence linking religiousness to morbidity and mortality, possible biological pathways linking spirituality/religiousness to health, and advances in the assessment of spiritual/religious variables in research and practice. The authors provide an overview of this field of research and address three related methodological issues: definitions of terms, approaches to statistical control, and criteria used to judge the level of supporting evidence for specific hypotheses (authors).

Powell LH, Shahabi L, Thorensen CE. **Religion and spirituality: Linkages to physical health.** American Psychologist 58(1): 36-52, 2003.

In this article, evidence is presented that bears on nine hypotheses about the link between religion or spirituality and mortality, morality, morbidity, disability, or recovery from illness. According to the authors, in healthy participants, there is a strong, consistent, prospective, and often graded reduction in risk of mortality in church/service attendees. This reduction is approximately twenty-five percent after adjustment for confounders. Religion or spirituality protects against cardiovascular disease, largely mediated, by the healthy lifestyle it encourages. The article states that evidence fails to support a link between depth or religiousness and physical health. In patients, there are consistent failures to support hypotheses that religion or spirituality slows the progression of cancer or improves recovery from acute illness, but some evidence shows that religion or spirituality impedes recovery from acute illness. The authors conclude that church/service attendance protects health people against death, and suggest that more methodologically sound studies are needed (authors).

2002

Arnold R, Avants SK, Margolin A, Marcotte D. **Patient attitudes concerning the inclusion of spirituality into addiction treatment.** *J Subst Abuse Treat* 23(4): 319-326, 2002.

The purpose of this exploratory study was 3-fold: (a) to determine how 'spirituality' is defined by inner-city HIV-positive drug users; (b) to determine perceived relationships between spirituality and abstinence, harm reduction, and health promotion; and (c) to assess interest in a spirituality-based intervention. Opioid-dependent patients enrolled in an inner-city methadone maintenance program participated in the study; 21 participated in focus groups and 47 completed a questionnaire. In the focus groups, two predominant themes emerged: spirituality as a source of strength/protection of self, and spirituality as a source of altruism/protection of others. A large majority of the larger sample expressed an interest in receiving spirituality-focused treatment, reporting that such an intervention would be helpful for reducing craving and HIV risk behavior, following medical recommendations, and increasing hopefulness. African American women perceived spirituality as more helpful in their recovery than did African American men.

Bessinger D, Kuhne T. **Medical spirituality: Defining domains and boundaries.** *South Med J* 95(12): 1385-1388, 2002.

The rapidly accumulating evidence that personal spirituality has important influences on health care outcomes is somewhat difficult to integrate into daily medical practice, in part because accepting it requires adjustments to the standard biomedical worldview, and in part because it challenges established boundaries between chaplaincy and evidence-based medicine. We propose that the recognition of medical spirituality as a distinct, interdisciplinary field of interest, with its own well-developed body of clinical evidence, clinical skill, clinical ethics, and with well-defined clinical boundaries, can help overcome much of the current confusion about how to integrate the new knowledge, and help pre-empt developing "turf" issues. The new field would contribute significantly to reframing the worldview of healing practice, consistent with the evidence-based approach.

Boudreaux ED, O'Hea E, Chasuk R. **Spiritual role in healing. An alternative way of thinking.** *J Nerv Ment Dis* 190(10): 697-704, 2002.

Research shows convincingly that patients with serious medical illnesses commonly use spiritual methods to cope with and manage their illnesses. This reliance on spirituality seems to be associated with a range of positive outcomes in the form of an enhanced sense of well-being, improved feelings of resiliency, and decreased adverse physical symptoms (e.g., pain and fatigue) and psychologic symptoms (e.g., anxiety). The methodologic flaws and limitations of this literature, however, make more research necessary before confident conclusions can be made regarding the objective, biologic benefit. Further efforts should focus on identifying the potential mechanisms through which spirituality enhances both subjective and objective outcomes. Care should be taken to use reliable, valid spirituality assessment measures and more advanced methodologic designs, such as prospective, longitudinal studies, and randomized, controlled trials.

Culliford L. **Spirituality and clinical care.** *BMJ* 325(7378): 1434-1435, 2002.

Esser-Stuart JE, Lyons MA. **Barriers and influences in seeking health care among lower income minority women.** Prim Care 29(2): 439-454, 2002.

The purpose of this study was to identify and describe perceived barriers to seeking health care, determine perceptions of confidence in health care practitioners, and explore strategies to enhance, promote, and improve early health care intervention among low income minority women. Focus group methodology was used to collect data and content analysis was used to analyze the data. Results revealed four broad categories for discussion: (a) confidence in the physician, (b) frequency of engaging in screening procedures, (c) barriers and influences in seeking health care, and (d) a wish list for covered health care services. The study underscored the importance of both spirituality and family in the lives of aging minority women. The paper includes implications for public policy and suggests an agenda for public policy advocates in the new millennium.

Gallagher EB, Wadsworth AL, Stratton TD. **Religion, spirituality, and mental health.** Psychol Rep 91(2): 618-626, 2002.

Gonzalez M. **Mental health intervention with Hispanic immigrants: Understanding the influence of the client's worldview, language and religion.** J of Imm and Ref Svcs 1(1): 81-92, 2002.

In this article, the author discusses the underutilization of mental health services by Hispanic immigrants, as well as the obstacles faced by Hispanic immigrants when navigating through the mental health system. This article underscores the importance of understanding the influence of a Hispanic client's worldview, language, and religion on the provision of mental health services. A case vignette is presented as a means of illustrating key conceptual points. Practice principles or conclusions drawn from this article should be used as a general guide by mental health practitioners (author).

International Center for the Integration of Health and Spirituality. **Health and spirituality connection: Spirituality and addiction.** Health and Spirituality Connection 6(1), Spring 2002.

This issue of Health and Spirituality Connection focuses on Spirituality and Addiction. To the spiritually minded, it is not news that addiction and healthy spirituality are not mutually exclusive. Now, for the first time, recent attention has been paid to this issue by scientists. Early research findings converge with the reports of both clients and clinicians that spirituality is important in recovery from addictions. This issue contains articles describing this research, citing initial findings as both fascinating and encouraging, leading researchers to believe that bolstering spirituality during treatment can be understood as helping addicted persons replace a destructive approach to life with a life-enhancing one. Available From: International Center for the Integration of Health and Spirituality, 6110 Executive Boulevard, Suite 908, Rockville, MD, 20852, (301)984-7162, www.icihs.org.

McVay MR. **Medicine and spirituality: A simple path to restore compassion in medicine.** SDJ Med 55(11): 487-491, 2002.

Medical science has achieved impressive accomplishments in the diagnosis and treatment of human disease. However, the emphasis on science and technology has created a generation of physicians who find it difficult to relate to their patients about their suffering. Time constraints and economic pressures also add to the challenge of giving meaningful time to patients. Patients want to talk to their physician about their concerns, but surveys indicate that this is not being accomplished. Medical educators are developing curricula to teach how care can be given compassionately. This article reviews the importance

of addressing spiritual care in medicine. Spirituality is defined and the spiritual history is explained. Research on the role of spirituality in health care is also reviewed. The role of the physician as a healer, attending to mind, body and spirit is encouraged.

Moss D. **The circle of the soul: The role of spirituality in health care.** *Appl Psych Bio* 27(4): 283-97, 2002.

This paper examines the critical attitude of behavioral professionals toward spiritual phenomena, and the current growing openness toward a scientific study of spirituality and its effects on health. Health care professionals work amidst sickness and suffering, and become immersed in the struggles of suffering persons for meaning and spiritual direction. Biofeedback and neurofeedback training can facilitate relaxation, mental stillness, and the emergence of spiritual experiences. A growing body of empirical studies documents largely positive effects of religious involvement on health. The effects of religion and spirituality on health are diverse, ranging from such tangible and easily understood phenomena as a reduction of health-risk behaviors in church-goers, to more elusive phenomena such as the distant effects of prayer on health and physiology. Psychophysiological methods may prove useful in identifying specific physiological mechanisms mediating such effects. Spirituality is also a dimension in much of complementary and alternative medicine (CAM), and the CAM arena may offer a window of opportunity for biofeedback practice.

Russinova Z, Wewiorski N, Cash D. **Use of alternative health care practices by persons with serious mental illness: Perceived benefits.** *American Journal of Public Health* 92(10): 1600-1603, 2002.

In this article, the authors examined the perceived benefits of alternative health care practices by individuals with serious mental illness. 157 individuals (mean age 46.6 yrs) with bipolar disorder, schizophrenia spectrum disorder, or depressive disorder who reported mental health benefits from alternative health care practices completed surveys concerning the benefits of alternative practice. Results show that some subjects (Ss) seemed to benefit from a variety of alternative practices, including body-manipulation modalities such as massage and chiropractic. More frequently used practices included meditation, massage, yoga, and guided imagery. Religious or spiritual activities such as prayer, worship attendance, and religious or spiritual reading were commonly practiced and reported as beneficial. Alternative practices promoted the recovery process beyond the management of emotional and cognitive impairment by also enhancing social interaction, spirituality, and self-functioning (authors).

Struve JK. **Faith's impact on health. Implications for the practice of medicine.** *Minn Med* 85(12): 41-44, 2002.

The role of religiousness/spirituality (R/S) in health has been of growing interest in the medical literature in recent years. Studies have demonstrated enhanced health effects from religious prescriptions and proscriptions, religious/spiritual social support, and specific attitudes and behaviors linked to deep spiritual belief (e.g., compassionate view toward others and active religious surrender). This article reviews the recent literature on the role of R/S in health and offers suggestions on how physicians can explore whether their patient's R/S is a source of strength. Examples of simple questions that can be incorporated into a routine visit are presented. Physicians who ask about R/S issues may help patients recognize new ways of coping, new avenues for social support, and new sources of courage and hope.

Thompson I. **Mental health and spiritual care.** Nurs Stand 17(9): 33-38, 2002.

BACKGROUND: Achieving holistic care is an important goal for nurses. While much is made of the biopsychosocial model of holistic care, reflecting the allopathic bias inherent in the Western medical model, the issue of spirituality is mostly neglected. Where acknowledged, spirituality is often limited to recording the client's religion. This article asserts that religion and spirituality are not synonymous, although spirituality might sometimes be reflected through religious practices. **CONCLUSION:** With the move towards provision of modern mental health services in the community, the community mental health nurse will increasingly care for individuals for whom the spiritual is part of their daily lives and not a symptom of their illness. This is set against the backdrop of a multicultural society and as such will call for holistic nursing skills.

Townsend M, Kladder V, Ayele H, Mulligan T. **Systematic review of clinical trials examining the effects of religion on health.** South Med J 95(12): 1429-1434, 2002.

Using MEDLINE, (limited to the English language and the reference lists of the randomized controlled trials (RCTs), we assessed the impact of religion on health outcomes via systematic, critical review of the medical literature. All RCTs published from 1966 to 1999 and all non-RCTs published from 1996 to 1999 that assessed a relationship between religion and measurable health outcome were examined. We excluded studies dealing with non-religious spirituality, ethical issues, coping, well-being, or life satisfaction. We used the Canadian Medical Association Journal's guidelines for systematic review of the medical literature to evaluate each manuscript. Nine RCTs and 25 non-RCTs met these inclusion/exclusion criteria. Randomized controlled trials showed that intercessory prayer may improve health outcomes in patients admitted to a coronary care unit but showed no effect on alcohol abuse. Islamic-based psychotherapy speeds recovery from anxiety and depression in Muslims. Non-RCTs indicate that religious activities appear to benefit blood pressure, immune function, depression, and mortality.

Williams L, Reed S, Nelson C, Brose A. **Relations of intrinsic spirituality with health status and symptom interference.** J Clin Nurs 11(6): 843-844, 2002.

The purpose of this study was to examine the relationships between spiritual experience and current health status and between spiritual experience and subjective experience of symptom interference. Symptom interference is the extent to which symptoms of physical or psychological illness limited participants' activities of daily living. Participants were 49 volunteers who were enrolled in a spiritual fitness class at a variety of denominational Christian churches in Plano, Texas. The sample ranged in age from 22 to 65 years, and 84% were women. The Index of Core Spiritual Experiences and the Medical Symptoms Checklist were administered. Current health status and symptom interference were utilized from the self-report checklist. It was predicted that Index scores would be significantly different based on participants' health status and that Index scores would correlate significantly with participants' ratings of symptom interference. Analysis indicated that Index scores were significantly higher for participants with no current medical diagnosis than for those currently experiencing either a life-threatening or a chronic medical or psychological disorder. Also, the percentage-bend correlation between Index scores and scores for interference of symptoms in daily life was significant. These results suggest that the report of core spiritual experiences may be related to better current health status. These findings have implications for understanding the role of spirituality in the prevention of illness and in an individual's ability to cope with illness.

2001

Ameling A, Povilonis M. **Spirituality, meaning, mental health, and nursing.** J Psychosoc Nurs Ment Health Serv, 39(4):14-20, 2001.

Spirituality, defined as meaning making, is a primary motivation in life. The medical literature increasingly demonstrates an important positive relationship between spirituality and health. Nurses often feel uncomfortable or unprepared to discuss spiritual issues with patients. Through a few simple questions, nurses can easily make spiritual assessment a routine part of taking a patient's psychosocial history.

Bolletino RC. **A model of spirituality for psychotherapy and other fields of mind-body medicine.** Adv Mind Body Med, 17(2):90-101, Spring 2001.

The spiritual revolution that has permeated our culture challenges psychotherapists and other health practitioners to address the spiritual concerns of their clients and themselves. This challenge is particularly critical in view of the confused, meaningless, and faulty so-called "spiritual" ideas that affect some clients in ways that are toxic to their psychological (and possibly physical) health. However, given the nonspiritual tradition of professional psychology and medicine as a whole, practitioners as a group have no clear and cogent concept or standards with which to acknowledge and address these concerns. The aim of this article is to formulate a concept of spirituality that allows practitioners to include spirituality in their work in a clear, sound, and meaningful way. Copyright John E. Fetzer Institute 2001.

Chang SO. **The conceptual structure of physical touch in caring.** J Adv Nurs, 33(6):820-7, Mar 2001.

This study was conducted to clarify and to conceptualize the phenomena of physical touch in caring. **BACKGROUND:** Physical touch occurs frequently in patient care situations and has specific meanings within the context of caring. However, the concept of physical touch in caring has not been well articulated in the literatures, although the phenomena of touch and physical touch have been studied in relation to comfort, sense of well-being and connectedness. **DESIGN/METHOD:** The Hybrid Model of concept development was applied to develop a conceptual structure of physical touch in caring, which included a field study carried out in Seoul, South Korea using in-depth interviews with 39 adult subjects consisting of health-care professionals, in-patients, and healthy persons. **RESULTS/FINDINGS:** The concept of physical touch in caring emerged as a complex phenomenon having meanings on several different dimensions which were encompassed several attributes and the conceptual structure of physical touch in caring centred around five aspects of goals for physical touch: promoting physical comfort, promoting emotional comfort, promoting mind-body comfort, performing social role, and sharing spirituality. **CONCLUSIONS:** Physical touch in caring as a concept having the dimensions of physical, emotional, social, and spiritual significance needs to be treated in a holistic way and it is possible to enrich the meanings and methods of physical touch in nursing so that its application may have effects that have positive impacts on patients' well-being and comfort.

Cooper LA, Brown C, Vu HT, Ford DE, Powe NR. **How important is intrinsic spirituality in depression care? A comparison of white and African-American primary care patients.** J Gen Intern Med, 16(9):634-8, Sept 2001.

We used a cross-sectional survey to compare the views of African-American and white adult primary care patients regarding the importance of various aspects of depression care. Patients were asked to rate the importance of 126 aspects of depression care (derived from attitudinal domains identified in focus groups) on a 5-point Likert scale. The 30 most important items came from 9 domains: 1) health professionals' interpersonal skills, 2) primary care provider recognition of depression, 3) treatment effectiveness, 4) treatment problems, 5) patient understanding about treatment, 6) intrinsic spirituality, 7) financial access, 8) life experiences, and 9) social support. African-American and white patients rated most aspects of depression care as similarly important, except that the odds of rating spirituality as extremely important for depression care were 3 times higher for African Americans than the odds for whites.

Cooper-Effa M, Blount W, Kaslow N, Rothenberg R, Eckman J. **Role of spirituality in patients with sickle cell disease.** J AM Board Fam Pract, 14(2):116-22, Mar-Apr 2001.

BACKGROUND: Patients with sickle cell disease cope with their disease in various ways, such as psychological counseling, hypnosis, medication, and prayer. Spirituality is a coping mechanism in a variety of diseases. This study evaluates the role of spirituality in patients coping with the pain of sickle cell disease. **METHODS:** Seventy-one patients from the Georgia Sickle Cell Clinic completed a questionnaire addressing their ability to cope with the pain of sickle cell disease and their degree of spirituality. A descriptive cross-sectional design was used. Correlation and multiple regression analyses were calculated for the relation between coping with the pain of sickle cell disease and spirituality. **RESULTS:** The questionnaire provided several scales with high internal consistency for measuring spiritual well-being and its two components, existential well-being and religious well-being, that show a correlation between high levels of spirituality and life control. The study population exhibited high levels of spirituality and religiosity, but the influence of these feelings on coping with sickle cell disease was variable. Spiritual well-being was correlated with life-control but not with perceived pain severity. **CONCLUSIONS:** Existential well-being was associated with general coping ability. Spiritual well-being is important for some patients who must cope with the pain of sickle cell disease.

Graham-Pole J. **"Physician, heal thyself": How teaching holistic medicine differs from teaching CAM.** Acad Med, 76(6):662-4, Jun 2001.

The term complementary and alternative medicine (CAM) has been adopted to describe a system of health care not generally recognized as part of mainstream medical practice. It is often conflated with an older term, holistic medicine, which can briefly be defined as the art and science of healing the whole person-body, mind, and spirit-in relation to that person's community and environment. Coursework in CAM is now offered in at least two thirds of U.S. medical schools. There is also a growing number of courses in the medical humanities and in spirituality and health. However, courses explicitly designed to introduce students to the principles and practices of holistic medicine are unusual. The author describes the fundamental differences between CAM and holistic medicine, highlighting holistic medicine's emphasis on the promotion of healthy lifestyles for practitioners and patients alike. He argues that offering physicians-to-be more coursework in holistic medicine could lay the groundwork for future physicians' adopting and modeling healthy lifestyles.

Greasley P, Chiu LF, Gartland M. **The concept of spiritual care in mental health nursing.** J Adv Nurs, 33(5):629-37, Mar 2001.

In this paper we aim to clarify the issue of spiritual care in the context of mental health nursing. **BACKGROUND:** The concept of spirituality in nursing has received a great deal of attention in recent years. However, despite many articles addressed to the issue, spiritual care remains poorly understood amongst nursing professionals and, as a result, spiritual needs are often neglected within the context of health care. **RESULTS:** According to the views expressed in our focus groups, spiritual care relates to the acknowledgement of a person's sense of meaning and purpose to life which may, or may not, be expressed through formal religious beliefs and practices. The concept of spiritual care was also associated with the quality of interpersonal care in terms of the expression of love and compassion towards patients. Concerns were expressed that the ethos of mental health nursing and the atmosphere of care provision were becoming less personal, with increasing emphasis on the 'mechanics of nursing'. **CONCLUSIONS:** The perceived failure of service providers to attend adequately to this component of care may be symptomatic of a medical culture in which the more readily observable and measurable elements in care practice have assumed a prominence over the more subjective, deeply personal components. In order for staff to acknowledge these issues it is argued that a more holistic approach to care should be adopted, which would entail multidisciplinary education in spiritual care.

Hammell KW. **Intrinsicity: Reconsidering spirituality, meaning(s) and mandates.** Can J Occup Ther, 68(3):186-94, June 2001.

Canadian occupational therapists have placed spirituality as the central core of their theoretical Model, depicting inner and outer selves that contradict simultaneous declarations concerning the integration of mind/body/spirit. Even the word spirituality has discrepant meanings and failure to articulate one chosen meaning leads to ambiguity. This paper argues that occupational therapists must agree upon a single definition of spirituality that is congruent with our professional mandate and philosophical perspective; and that prevention of misunderstandings between and amongst clients and other health care professionals demands recourse to our own terminology. It is proposed that intrinsicity be employed to articulate the personal philosophy of meaning with which we interpret our lives. Influenced by environmental context and in homeostatic relationship with the body and mind, intrinsicity constitutes the essence of the self and informs occupational choices based upon personal values and priorities. Acknowledgement of intrinsicity respects the uniqueness of individuals' meanings.

Lowe J, Struthers R. **A conceptual framework of nursing in Native American culture.** J Nursing Scholarsh, 33(3):279-83, 2001.

PURPOSE: To depict the phenomenon of nursing in the Native American culture. **DESIGN:** At the 1997 annual Native American Nursing Summit held on the Flathead Reservation in Montana, 203 Native American nurses, nursing students, and others who provide health care to Native American people attended and participated in focus groups that provided the data for this qualitative study. The participants represented many tribes from across the United States. Follow-up in 1998 included a similar group of 192 participants. **FINDINGS:** Seven dimensions were identified in the data: caring, traditions, respect, connection, holism, trust, and spirituality. Each dimension is essential to the practice of nursing in Native American culture. Together they provide the basis for a systematic approach to Native American nursing practice, education, research, and administration. **CONCLUSIONS:** The conceptual framework of nursing in the Native American culture, with its seven dimensions, shares dimensions with mainstream nursing, yet it differs in many important ways. This model can be used by Native American nurses to provide a structure for engaging in the profession of nursing. Further, it can be used by nurses of other cultures to understand nursing in the Native American culture and to provide health care to Native American people.

Morris EL. **The relationship of spirituality to coronary heart disease.** *Alt Ther Hlth Med*, 7(5):96-8, 2001.

Several studies suggest that religious involvement or spiritual well-being may affect health outcomes. This study was designed to investigate whether the scores from a questionnaire measuring spiritual well-being correlated with progression or regression of coronary heart disease as measured with computerized cardiac catheterization data. Participants in Dr Dean Ornish's Lifestyle Heart Trial were given the "Spiritual Orientation Inventory." A significant difference was found in the spirituality scores between a control group and a research group that practiced daily meditation. The spirituality scores were significantly correlated with the degree of progression or regression of coronary artery obstruction over a 4-year time period. The lowest scores of spiritual well-being had the most progression of coronary obstruction and the highest scores had the most regression. This study suggests that the degree of spiritual well-being may be an important factor in the development of coronary artery disease.

Seybold KS, Hill PC. **The role of religion and spirituality in mental and physical health.** *Current Directions in Psychological Science* 10(1):21-25, 2001.

An increased interest in the effects of religion and spirituality on health is apparent in the psychological and medical literature. Although religion in particular was thought, in the past, to have a predominantly negative influence on health, recent research suggests this relationship is more complex. This article reviews the literature on the impact of religion and spirituality on physician and mental health, concluding that the influence is largely beneficial. Mechanisms for the positive effect of religion and spirituality are proposed. (Author) Available From: Kevin S. Seybold, Department of Psychology, Grove City College, 100 Campus Drive, Grove City, PA, 16127-2104, e-mail: ksseybold@gcc.edu

Storch EA. **Spirituality, meaning, mental health and nursing.** *J Psychosoc Nurs Ment Health*, 39(8):10, Aug 2001.

Tuck I, McCain NL, Elswick RK Jr. **Spirituality and psychosocial factors in persons living with HIV.** *J Adv Nurs*, 33(6):776-83, Mar 2001.

AIM OF THE STUDY: This pilot study was designed to examine the relationships among spirituality and psychosocial factors in a sample of 52 adult males living with human immunodeficiency virus (HIV) disease and to determine the most reliable spirituality measure for a proposed longitudinal study. **BACKGROUND:** HIV disease is among the most devastating of illnesses, having multiple and profound effects upon all aspects of the biopsychosocial and spiritual being. Although research has suggested relationships among various psychosocial and spiritual factors, symptomatology and physical health, much more research is needed to document their potential influences on immune function, as well as health status, disease progression, and quality of life among persons with HIV disease. **METHODS:** This descriptive correlational study explored the relationships of spirituality and psychosocial measures. Spirituality was measured in terms of spiritual perspective, well-being and health using three tools: the Spiritual Perspective Scale, the Spiritual Well-Being Scale, and the Spiritual Health Inventory. Five psychosocial instruments were used to measure aspects of stress and coping: the Mishel Uncertainty in Illness Scale, Dealing with Illness Scale, Social Provisions Scale, Impact of Events Scale, and Functional Assessment of HIV Infection Scale. The sample was recruited as part of an ongoing funded study. The procedures from the larger study were well-defined and followed in this pilot study. Correlational analyses were done to determine the relationship between spirituality and the psychosocial measures. **FINDINGS:** The findings indicate that spirituality as measured by the existential well-being (EWB) subscale of the Spiritual Well-Being Scale was positively related to quality of life, social support,

effective coping strategies and negatively related to perceived stress, uncertainty, psychological distress and emotional-focused coping. The other spirituality measures had less significant or non significant relationships with the psychological measures. CONCLUSIONS: The study findings support the inclusion of spirituality as a variable for consideration when examining the psychosocial factors and the quality of life of persons living with HIV disease. The spiritual measure that best captures these relationships is the EWB subscale of the Spiritual Well-Being Scale.

Tuck I, Wallace D, Pullen L. **Spirituality and spiritual care provided by parish nurses.** West J Nurs Res, 23(5):441-53, Aug 2001. Discussion: 454-62.

The high level of religious participation in the United States provides a venue for parish nursing, a holistic nursing specialty that emphasizes the relationship between spirituality and health. This descriptive study measured two aspects of spirituality (spiritual perspective and spiritual well-being) in a national sample of parish nurses and described variables related to their practice. Furthermore, it qualitatively examined the provision of spiritual care to clients in this parish nurse sample. Parish nurses scored high in spiritual perspective and spiritual well-being and reported an emphasis on health promotion and education in their activities. Three views of spiritual interventions (ideal, general, and specific) were reported. Types of spiritual interventions typically fell into one of four categories: religious, interactional, relational, and professional.

2000

George LK, Larson DB, Koenig HG, McCullough ME. **Spirituality and health: What we know, what we need to know.** Journal of Social and Clinical Psychology 19(1): 102-116, 2000.

Spirituality and religion have been seen as beneficial, harmful, and irrelevant to health. This article focuses on (1) defining spirituality and religion both conceptually and operationally; (2) the relationships between spirituality/religion and health; and (3) priorities for future research. Although the effect sizes are moderate, there typically are links between religious practices and reduced onset of physical and mental illnesses, reduced mortality, and likelihood of recovery from or adjustment to physical and mental illness. The three mechanisms underlying these relationships involve religion increasing health behaviors, social support, and a sense of coherence or meaning. This research is based on religion measures, however, and it should be emphasized that spirituality may be different.

Gundersen L. **Faith and healing.** Ann Intern Med, 132(2):169-72, January 18, 2000.

Matthews DA. **Prayer and spirituality.** Rheum Dis Clin North Am, 26(1):177-87, xi, February 2000.

Many patients with arthritis are strongly influenced by religious beliefs and often participate in religious healing activities such as prayer and worship attendance. Scientific studies demonstrate, and most patients confirm, that faith and involvement in religious healing activities can be helpful in preventing and treating illness, recovering from surgery, reducing pain, and improving quality of life. To improve the care of patients, clinicians should develop a patient-centered, spiritually sensitive form of medical practice in which religious issues are addressed gently and appropriately with dignity, respect, and integrity.

McCullough-Zander K. **Caring across cultures: The provider's guide to cross-cultural health care. 2nd Edition.** Minneapolis, MN: The Center for Cross-Cultural Health, 2000.

This resource guide was developed for providers concerned about cultural competence; and for use by health care and human service professionals. The authors include chapters on developing cultural competence, communication across cultures, issues in interpreting, cross cultural mental health, and spirituality and health across cultures, as well as an expanded reference section with suggestions for further reading, and recommendations for additional tools and cross cultural health models (authors). Available From: Center for Cross-Cultural Health, 1313 SE 5th Street, Suite 100B, Minneapolis, MN 55414, (612) 379-3573, www.crosshealth.com/provider.htm (COST: \$27.50).

Taylor RJ; Ellison CG; Chatters LM; Levin JS; Lincoln KD. **Mental health services in faith communities: The role of clergy in Black churches.** *Social Work* 45(1): 73-85, 2000.

A small but growing literature recognizes the varied roles that clergy play in identifying and addressing mental health needs in their congregations. This article examines the research, highlighting available information with regard to the process by which mental health needs are identified and addressed by faith communities. Areas and issues where additional information is needed also are discussed. Other topics addressed include client characteristics and factors associated with the use of ministers for personal problems, the role of ministers in mental health service delivery, factors related to the development of church-based programs and service delivery systems, and models that link churches and formal service agencies. A concluding section describes barriers to and constraints against effective partnerships between churches, formal service agencies, and the broader practice of social work.

Tsemberis S; Stefancic A. **The role of an esperitista in the treatment of a homeless, mentally ill Hispanic man.** *Psychiatric Services*, 51(12):1572-4, Dec 2000.

This paper presents a case study from an emergency psychiatric outreach team that serves homeless and mentally ill persons in New York City. Mr. V was homeless and believed that he was possessed by evil spirits who were causing his physical and mental problems. He was hospitalized involuntarily twice for medical reasons, but he refused to cooperate in his treatment and returned to the streets after his first hospitalization. After one visit by a spiritual healer during his second hospitalization, Mr. V began to participate in his treatment. He was discharged to a nursing home, and after three years he had not returned to the streets.

1999

Lukoff D, Provenzano R, Lu F, Turner R. **Religious and spiritual case reports on MEDLINE: A systematic analysis of records from 1980 to 1996.** *Altern Ther Health Med*, 5(1):64-70, January 1999.

OBJECTIVE: To undertake a systematic analysis of case reports involving religious or spiritual issues published between 1980 and 1996. **DATA SOURCES:** MEDLINE, the National Library of Medicine's bibliographic database covering the fields of medicine, nursing, dentistry, veterinary medicine, and the preclinical sciences. **STUDY SELECTION:** A search of 4,306,906 records indexed on MEDLINE from 1980 to 1996. **DATA EXTRACTION:** A total of 364 abstracts were found, then subjected to coding analysis. **DATA SYNTHESIS:** Categories were developed for (1) types of healthcare situations involving religious/spiritual issues, (2) religious and spiritual interventions, (3) collaboration between healthcare and religious professionals, (4) psychopathology and sensitivity themes, and (5) religious faith/spiritual

path. Although all of these case reports involved religious and spiritual issues, only 45 (12%) explicitly mentioned a religious professional. Of these, only 8 (2%) indicated any collaboration between healthcare and case report literature exists on religious and spiritual issues (.008% of the MEDLINE records), indicating that the increasing acceptance of these factors by patients and healthcare professionals is not yet reflected in scientific and clinical collaboration between healthcare and religious professionals.

Chase-Ziolek M, Striepe J. **A comparison of urban versus rural experiences of nurses volunteering to promote health in churches.** Public Health Nurs, 16(4):270-9, August 1999.

Recent years have seen a resurgence of the health and healing role of the church. Nurses have been involved in this movement through the development of health ministry and parish nursing with a growing number of nurses volunteering their services to congregations. This program evaluation research study compares two programs (one in an urban environment and the other in a rural environment) that use nurses who volunteer in congregations to promote health and well-being. The study found that the two programs differed significantly with regards to the location where nurses provided care. The urban nurses provided most service at the church, while the rural nurses provided service through home visits and phone calls as well as at the church. The groups were also significantly different in the ethnicity, education, work status, and age of the nurses. Further differences were also found in the type of services the nurses provided; for example, the rural nurses were more involved in case management and practical assistance than their urban peers. The two groups were similar in the program support they valued and in their appreciation of the opportunity to integrate their faith and their nursing practice.

1998

Hanson MJ. **The religious difference in clinical healthcare.** Camb Q Healthc Ethics, 7(1):57-67, 1998.

Rustoen T; Hanestad BR. **Nursing intervention to increase hope in cancer patients.** J Clin Nurs, 7(1):19-27, January 1998.

Hope is considered to be of great significance for people diagnosed as having cancer, and is thus an important aspect of nursing care. It is valuable to document ways in which hope can be strengthened in these patients. An intervention program based on Nowotny's (1986) definition of hope and designed to increase hope in groups of cancer patients with the nurse as the group leader was developed. The intervention was divided into 8 sessions, each of which focused on a different aspect of hope, including belief in oneself and one's own ability, emotional reactions, relationships with others, active involvement, spiritual beliefs and values, and acknowledging that there is a future. By focusing on these aspects through interactional group work, it was thought that the participants' hope could be strengthened.

Risberg T; Lund E; Wist E; Kaasa S; Wilsgaard T. **Cancer patients use of nonproven therapy: A 5-year follow-up study.** J Clin Oncol, 16(1):6-12, January 1998.

PURPOSE: To investigate the prospective pattern of use of alternative medicine, here called nonproven therapy (NPT), among oncologic patients during a 5-year period, and the relationship between this use and survival, a questionnaire-based follow-up study was performed at the Department of Oncology, Univ. of Tromsø, from 1990-1996. **PATIENTS AND METHODS:** 252 patients answered the first questionnaire during the period July 1990 to July 1991. Eligible patients were mailed follow-up questionnaires after 4, 12, 24 and 60 months. A telephone interview performed after the last follow-up questionnaire showed

little disagreement with the prospective collected information as regards the number of patients reported as users of NPT. RESULTS: The number of patients who reported ever using NPT in each part of the study varied between 17.4% and 27.3%. However, the estimated cumulative risk of being a user of NPT during the follow-up period was 45%. 74% of NPT users in this north Norwegian study population used faith healing or healing by hand (spiritual NPT) alone or in combination with other forms of NPT. The proportion of patients who used spiritual versus nonspiritual forms of NPT was consistent throughout the follow-up period. Women were more often users than men. Patients older than 75 seldomly used NPT. The 5-year observed survival rate was not influenced by the use of NPT. Adjusted for sex, age, and diagnosis, patients with a high educational level had a borderline higher 5-year survival rate than patients with less education. CONCLUSION: Our results demonstrate that cross-sectionally designed studies will underestimate the number of ever-users of NPT in a cancer patient population. The use of NPT does not influence observed survival among cancer patients seen in north Norway.

Faith and healing. Making a place for spirituality. Harv Health Lett, 23(4):1-3, February 1998.

Riley BB; Perna R; Tate DG; Forchheimer M; Anderson C; Luera G. **Types of spiritual well-being among persons with chronic illness: Their relation to various forms of quality of life.** Arch Phys Med Rehabil, 79(3):258-264, March 1998.

OBJECTIVES: Derive a spiritual well-being classification and thereby enhance understanding of the relation between spiritual well-being, quality of life (QOL), and health among persons with chronic illness or disability. DESIGN: Cluster analyses were performed to develop a spiritual well-being classification. Analysis of variance was used to compare cluster groups on various dimensions of QOL. SETTING: Part of a larger QOL study conducted at a midwestern medical center. PATIENTS: A convenience sample of 216 inpatients: amputation, postpolio, spinal cord injury, breast cancer, and prostate cancer. Minors were excluded from the study. MAIN OUTCOME MEASURES: Spiritual Well-Being Scale (SWBS), Functional Assessment of Cancer Therapy (FACT), Functional Living Index-Cancer (FLIC), Sickness Impact Profile (SIP), Medical Outcome Survey-Short Form (SF-36), and the Satisfaction With Life Scale (SWLS). RESULTS: Three types of spiritual well-being were identified: religious, existential, and nonspiritual. Significant cluster differences were observed across all QOL domains and life satisfaction. Compared with the other cluster groups, the nonspiritual group reported significantly lower levels of QOL and life satisfaction and the highest proportion of health status change with respect to both improvement and decline in health. CONCLUSIONS: Three types of spiritual well-being were empirically identified in this sample. Subtypes differed significantly with respect to various aspects of QOL. Further research is needed to validate this classification and to determine if type of spiritual well-being has a causal effect on treatment outcome or on the recovery process.

Weaver AJ; Flannelly LT; Flannelly KJ; Koenig HG; Larson DB. **An analysis of research on religious and spiritual variables in three major mental health nursing journals, 1991-1995.** Issues Ment Health Nurs, 19(3):263-276, May 1998.

A review of quantitative research studies published between 1991 and 1995 in three major mental health nursing journals revealed that approximately 10% (31 of 311) included a measure of religion or spirituality. This percentage (10%) is 3 to 8 times higher than that found in previous reviews of empirical research in psychological and psychiatric journals, suggesting that mental health nursing research is more sensitive to the role of religious-spiritual factors on mental health than research in related disciplines. The results are discussed in the context of the history and philosophy of nursing and in comparison to related disciplines. Methodological aspects of the research, especially the importance of multiple measures, are discussed.

Hatch RL; Burg MA; Naberhaus DS; Hellmich LK. **The spiritual involvement and beliefs scale. Development and testing of a new instrument.** J Fam Pract, 46(6):476-486, June 1998.

BACKGROUND: Spirituality is receiving greater attention in the medical literature, especially in the family practice journals. A widely applicable instrument to assess spirituality has been lacking, however, and this has hampered research on the relationship between spirituality and health in the clinical setting. **METHODS:** A new instrument, called the Spiritual Involvement and Beliefs Scale, was designed to be widely applicable across religious traditions, to assess actions as well as beliefs to address key components not assessed in other available measures, and to be easily administered and scored. The instrument is a questionnaire containing 26 items in a modified Likert-type format. Following careful pretesting, the instrument was administered to 50 family practice patients and 33 family practice educators. The validity and reliability of the instrument were then evaluated. **RESULTS:** By several measures, instrument reliability and validity are very good, with high internal consistency; strong test-retest reliability; a clear four-factor structure; and a high correlation with another established measure of spirituality, the Spiritual Well-Being Scale. **CONCLUSIONS:** The Spiritual Involvement and Beliefs Scale (SIBS) appears to have good reliability and validity. Compared with other instruments that assess spirituality, the SIBS has several theoretical advantages, including broader scope, use of terms that avoid cultural-religious bias, and assessment of both beliefs and actions. More testing is underway to further assess its usefulness.

Crawford P; Nolan PW; Brown B. **Ministering to madness: The narratives of people who have left religious orders to work in the caring professions.** J Adv Nurs, 28(1):212-220, July 1998.

This paper examines the life stories of 14 men and women who spent time in religious communities and who subsequently took up work in the caring professions. Their accounts reflect the alignment between the ethics of care and those of religious life, the centrality of contemplation and self-examination to both Christianity and psychotherapy. There are further correspondences between their narratives and recent academic interest in the spiritual aspects of health care. They also describe profound changes and moments of uncertainty which parallel other transitional experiences like grieving or unemployment. For many respondents also, caring for others is part of caring for oneself. Disappointment with the religious life and isolation on leaving it appear to have brought the respondents into a close relationship with those who suffer mental illness. It is almost as if they seek to heal the distress in their own lives by proxy.

Pusari ND. **Eight 'Cs' of caring: A holistic framework for nursing terminally ill patients.** Contemp Nurse, 7(3):156-60, September 1998.

This introductory paper describes how nurses can incorporate eight caring elements into nursing care for terminally ill patients. These caring elements can be described as: Compassion, Competence, Confidence, Conscience, Commitment, Courage, Culture and Communication. The Eight Cs of caring are comprised of Simone Roach's five Cs plus three further Cs. According to Roach (1993), who developed the Five Cs (Compassion, Competence, Confidence, Conscience and Commitment), knowledge, skills and experience make caring unique. Here, I extend Roach's work by proposing three further Cs (Courage, Culture and Communication). The paper takes as its framework the concept of holistic care, which encompasses physical, psychological, emotional, spiritual and cultural aspects. Examples are provided as to how the Eight Cs may be applied. Literature from various nursing scholars is included to support the discussion throughout.

1997

Creagan ET. **Attitude and disposition: Do they make a difference in cancer survival?** Mayo Clin Proc, 72:160-4, February 1997.

Psychosocial and spiritual factors influence a broad spectrum of medical and surgical disorders. The adverse effects of stress have been most clearly documented in cardiovascular disease. In cancer, unresolved questions include the following: Do emotional factors have a causal role in either initiating or promoting a malignant process, and can they possibly accelerate the dissemination of cancer? The literature, which consists of anecdotes, case-control methods, and randomized trials, is inconsistent and beset with major methodologic problems. Psychosocial interventions can be life enhancing in sharp contrast to the guilt-ridden programs of some alternative practitioners. A social support system and an element of spirituality and religion seem to be the most consistent predictors of quality of life and possible survival among patients with advanced malignant disease.

Elder NC; Gillcrist A; Minz R. **Use of alternative health care by family practice patients** [see comments]. Arch Fam Med, 6:181-4, March-April 1997.

In recent years, the use of alternative medicine has become more acknowledged in the United States. Many different practices are encompassed by the terms alternative, unorthodox, or complementary medicine, and their use by the population is just now being defined. The number of established family practice patients also using alternative medicine is not yet known. To help answer this question, a survey of family practice patients concerning their use of alternative medicine was performed in four family practices in a large community in the western United States. Volunteers from the survey respondents attended a focus group to discuss more fully their use of alternative medicine. Questionnaires were completed by 113 family practice patients. Fifty percent of patients had or were using some form of alternative medicine, but only 53% had told their family physician about this use. No significant difference in the percentage who used alternative medicine or who told their physician about it was attributable to gender, educational level, age, race, or clinic attended. The main reason given for using alternative medicine, alone or in combination with care from a family physician, was a belief that it would work. Many of those who worked in combination with a family physician spoke of acceptance and control, but those who did not work with their physician mentioned traditional medicine's limitations and narrow-mindedness. Physicians need to be aware that many patients may be using alternative health care. Open and nonjudgmental questioning of patients may help increase physician knowledge of this use and lead to improved patient care as physicians and patients work together.

Fowler SB. **Hope and a health-promoting lifestyle in persons with Parkinson's disease.** J Neurosci Nurs, 29:111-6, April 1997.

The purpose of this study was to determine relationships between hope and a health-promoting lifestyle in adults with varying stages of Parkinson's disease (PD) using a descriptive, correlational design. The sample of 42 adults, recruited from a PD educational symposium and support groups, completed the Herth Hope Index (HHI) and Health-Promoting Lifestyle Profile II (HPLP II). Significant correlations were found between hope and a total health-promoting lifestyle and spiritual growth and interpersonal relations subscales. Highest subscale means were in interpersonal relations and nutrition and the lowest mean was in physical activity. Despite a chronic, progressive neurological disease, adults in this study perceived themselves as hopeful and engaged in a health promoting lifestyle.

Galanter M. **Spiritual recovery movements and contemporary medical care.** Psychiatry, 60(3):211-223, 1997.

When confronted by the threat of illness, general medical and psychiatric patients may turn to treatments that have a spiritual orientation but lack empirical validation. This article examines the nature of these treatments and their impact on medical care. A typology of spiritually oriented recovery movements is presented, including those associated with established religions, holistic medicine, or programs for self-liberation. Possible mechanisms for their behavioral and physiologic impact on health status are discussed. The appeal of these treatments is analyzed in light of the way sick people may attribute meaning to illness and may then become engaged into a spiritual recovery movement, achieve a sense of self-efficacy through affiliation, and finally comply with putative "healing" practices. Although some spiritual recovery movements provide hope in the face of illness and even offer therapeutic benefits, they may also discourage patients from getting appropriate medical treatment and promote harmful regimens. Options are discussed for mental health professionals' response to the spiritual orientation of their patients and options for future research.

Hilsman GJ. **The place of spirituality in managed care. Attending to spiritual needs can help managed care systems achieve their goals.** Health Prog 1997 Jan-Feb;78(1):43-6

If managed care leaders are able to achieve their goals of enhancing total well-being within a capitated system of care, they must attend to the broad new societal interest in spiritual perspectives and find ways to integrate them into their structure of care. Imaginative and sensitive members of many professions, particularly those who acknowledge the value of spirituality in their own lives and are convinced of its value in healing, will likely spearhead this integrated movement. Promoting individuals' total well-being necessitates an acknowledgment that everyone has a unique personal spirituality that needs to be addressed at times of crisis, such as illness or hospitalization. Further, attention to the spiritual dimensions of problems that result in high healthcare costs, such as violence, alcoholism, and the fear of death, can help reduce those costs. The process of grief also needs to be addressed in healthcare settings, for professionals as well as patients, to enhance understanding, acceptance, and the quality of care. People recover and retain health through a balanced integration of physical, spiritual, and community aspects of their lives. If professional chaplains who have emphasized crisis and acute care in their ministry styles are to contribute to this integrative healing and its adoption into managed care systems, they may need to explore broader frameworks, holistic concepts of healing processes, motivations for self-care, and a personal holistic balance.

Kaplan MS; Marks G; and Mertens SB. **Distress and coping among women with HIV infection: Preliminary findings from a multiethnic sample.** Am J of Orthopsychiatry 67(1):80-91, 1997.

In a multiethnic sample of 53 women with HIV/AIDS, nearly 40% reported clinically significant levels of depressive symptomatology and anxiety. Compared to a nonpatient norm, distress levels were higher among the Latina, African-American, and white women who made up the HIV sample. Prayer and rediscovery of self were their most frequent coping responses, suggesting that clinicians working with HIV/AIDS populations not overlook the importance of spiritual faith and practices in adapting to HIV infection.

Levin JS; Larson DB; Puchalski CM. **Religion and spirituality in medicine: Research and education.** JAMA, 278(9):792-793, September 3, 1997.

Long A. **Nursing: A spiritual perspective.** Nurs Ethics, 4(6):496-510, November 1997.

This article explores and examines the fundamental need for nurses to include the promotion of the spiritual dimension of the health of human beings as well as the physical, mental and social facets if they truly wish to engage in holistic care. The author attempts to define the phenomenon of spirituality, aware of the dilemma that many individuals face when thinking and reflecting on this very personal and intangible issue. To be spiritual is to become fully human and the reverse is also true. Spirituality in health is inextricable in each person's search for the discovery of the truth about self and the meaning and purpose of life. Healthy communities are the product of healthy individuals who sow spiritual seeds such as unconditional positive regard, acceptance, respect and dignity for the benefit and advancement of individuals and humankind as a whole. The global nature of the phenomenon of spirituality is also shown by using examples of people who demonstrate compassion and communion with other human beings, in other countries in times of suffering, war and disaster. Compassion and empathy is expressed and experienced for victims of earthquakes that happen miles from home and far removed from personal or religious beliefs. Yet at such times we are all connected in the tapestry of life by our own human spirituality and earthiness. Abstract themes like compassion and justice are treated in the text within the context of spirituality. The author argues that being just and fair means that all patients have the right to achieve spiritual healing regardless of their belief systems, culture or creed. The works of some spiritual philosophers are used to reflect on this integral aspect of human care giving. Historical symbols of spirituality are examined. The need for nurses to explore and reflect on the paradoxical concepts involved in their own spirituality is highlighted. Nurses are the essential providers of care and, therefore, guardians of that essential humanity that ensures that patients never become less than full human beings, whatever their condition, faith, culture or belief, or whoever they may be.

Nolan P; Crawford P. **Towards a rhetoric of spirituality in mental health care.** J Adv Nurs, 26(2):289-294, August 1997.

The spiritual dimension of care is frequently alluded to in the nursing literature, but rarely examined in terms of what it means in practice or how it might be taught to students entering the profession. Some of those most in need of spiritual care are people suffering from mental illness or psychological distress. The aim of this paper is to explore the different meanings of spirituality and to suggest ways in which the spiritual care of clients can be implemented. It further recommends which aspects of spirituality could usefully be included in nursing curricula. The paper concludes by alerting nurses to the causes and manifestations of spiritual apathy in contemporary health care and calls for a rhetoric that will counter the jargon of cost analysis which currently prevails in the health services.

Schuster SJ. **Wholistic care. Healing a "sick" system.** Nurs Manage, 28(6):56-59, June 1997.

A contemporary health system seeks to overcome the excesses and shortcomings of the medical model by integrating wholistic concepts and practices into the medical care it provides. Established on the grounds of an acute care hospital as one of its departments, the Franciscan Wholistic Health Center's (FWHC) goal-explicit spirituality and the involvement of FWHC staff in their own as well as their client's spiritual development-distinguishes it from other efforts.

Spencer J; Davidson H; White V. **Help clients develop hopes for the future.** Am J Occup Ther, 51(3):191-198, March 1997.

The purposes of this article are (a) to examine cognitive, emotional, and spiritual aspects of hope as reflected in the literature; (b) to describe three clinical approaches that have been used in occupational therapy to engage clients in development of hopes for the future; and (c) to consider practical issues that have been raised by therapists seeking to incorporate development of hopes in their practice. Literature from health care and the social sciences indicates that cognitive, emotional, and spiritual aspects of hope are interwoven in a complex process that evolves over time after major loss. Three alternative clinical strategies for collaborating with clients in developing hopes are reviewed, including a goal-setting and goal-attainment approach, an occupational change approach, and a life history approach. These clinical strategies are illustrated by the stories of an elderly mental health client, an adult rehabilitation client, and an adolescent orthopedic client, which are drawn from research in which the authors have been involved. Discussion of issues involved in incorporating hope work into daily practice is based on the experiences of practicing therapists who participated in a workshop. These include pragmatic issues of documentation and reimbursement of this aspect of practice as well as clinical issues of how to develop hopes among clients who appear hopeless.

Stolley JM; Koenig H. **Religion/spirituality and health among elderly African Americans and Hispanics.** J Psychosoc Nurs Ment Health Serv, 35(11):32-38, November 1997.

It is important to view elders in a multicultural sense and also understand that there may be great heterogeneity within cultural or ethnic groups. Knowledge of the impact of religion and spiritual beliefs for ethnic groups can help health care professionals design interventions that are culture-specific to the beliefs of individuals. The psychiatric nurse is in a unique position to encourage the patient to use healthy religious practices to deal with their illness, whether mental or physical.

Tuck I; Pullen L; Lynn C. **Spiritual interventions provided by mental health nurses.** West J Nurs Res, 19:351-63, June 1997.

This descriptive qualitative study explored the spiritual nursing interventions provided by mental health nurses. Fifty mental health nurses responded to open-ended interrogative statements to report on nursing interventions in three situations that supported the spiritual needs of patients and families. Their responses were grouped into four categories, nurses being with the client, doing for the client, encouraging the client to look inward, and encouraging the client to look outward. Being with was demonstrated through the presence of the nurse. Doing for included interventions performed on the client's behalf and included the nurses using time, people, and space to provide care. Clients were encouraged to look inward for strength and look outward for people and objects that could be resources for them. A serendipitous finding was that mental health nurses were able to describe the ideal spiritual interventions but reported fewer instances of actually having intervened.

Turton CL. **Ways of knowing about health: An Aboriginal perspective.** Adv Nurs Sci, 19:28-36, 1997.

Because of the questionable applicability to extant health promotion models and middle-range theories to Aboriginal peoples, foundational inquiries examining the nature of cultural beliefs and ways of knowing about health within the cultures of various ethnic groups are imperative. This article describes the ways of knowing about health reported by Ojibwe people during an ethnographic inquiry in the Great Lakes region. These ways included stories from the oral tradition, authoritative knowledge of elders, "commonsense" models of illness and health, spiritual knowledge, and knowing oneself. The health-world view, a conceptual orientation for investigating health beliefs, is offered.

Vest GW; Ronnau J; Lopez BR; Gonzales G. **Alternative health practices in ethnically diverse rural areas: A collaborative research project.** Health Soc Work, 22:95-100, May 1997.

Many alternative health practices are gaining popularity in traditional medical centers throughout the country. However, social workers and allied health professionals are rarely educated in these practices. The collaborative pilot research project discussed in this article involved community health providers and a state university department of social work. The project, conducted in rural health clinics, introduced an approach to skillful, safe, and appropriate use of touch synthesized with an awareness of the breath for giver and receiver to a group of Mexican Americans diagnosed with diabetes and their families. This alternative health practice holds promise for reducing stress, promoting health and well-being, and building relationships and warrants further study.

Waldfoegel S. **Spirituality in medicine.** Prim Care, 24(4):963-976, December 1997.

Attending to the spiritual dimension of the patient can provide the physician with a more in-depth understanding of the patient and his or her needs. The physician may use a variety of spiritually informed therapeutic tools that can greatly facilitate the patient's coping ability, thus enhancing well being. Physicians' own religious or spiritual practices may impact upon their ability to function effectively in clinical practice. Specific suggestions are offered for attending to the spiritual aspects of the patient.

1996

Arnes SM; Kleiven M; Olstad R; Fnneb V. **Religious affiliation and mental health--is there a connection? Health survey in Finnmark 1990.** Tidsskr Nor Laegeforen, 116:3598-601, 1996.

The Finnmark Health Study in 1990 included questions on both mental health and religious affiliation. 7,633 individuals were invited to take part in the study, and 4,387 (58%) answered the question about religious affiliation. Members of the Norwegian Church (Lutheran Evangelical) had the highest score on all mental health variables. The group without any connection with a religious organization (non-members) contained highest proportion of persons who were not content with their life (20%) and the highest proportion who had coping problems (11%). Non-members and members of the "Laestadianer" spiritual movement showed the highest proportion with insomnia (36%). The proportion using psychotropic drugs was highest among the members of the "Laestadianer" spiritual movement (13%), which also contained the highest proportion reporting low global health. Owing to its cross-sectional design, the present study is unable to establish the causal direction of the association between religious affiliation and mental health. Various aspects of some religious beliefs and practices can probably cause mental health problems, and persons with mental health problems may be attracted to certain religious groups. Only future follow-up studies can untangle and quantify these possible causal associations.

Dowrick C; May C; Richardson M; Bundred P. **The biopsychosocial model of general practice: Rhetoric or reality?** Br J Gen Pract, 46(403):105-107, February 1996.

BACKGROUND: For more than 20 years, general practitioners have been encouraged to adopt a 'biopsychosocial' model of health care, that is, encompassing physical, psychological and social aspects. **AIM:** A study was undertaken to explore the extent to which general practitioners' views about the acceptable boundaries of their work are consistent with a biopsychosocial model. **METHOD:** A semi-structured postal questionnaire was sent to all 494 members of the Royal College of General

Practitioners in Mersey Region who were general practitioner principals. The general practitioners were asked to list up to three topics presented by patients that they considered to be appropriate, and up to three topics that they considered to be inappropriate, to a general practitioner's knowledge and skills. The general practitioners were asked to rate, on a five-point scale of appropriateness, each of a list of 12 topics about which patients might have problems and present. Responses were analyzed by sex and age of respondents. RESULTS: The response rate was 42%. Acute physical problems were most often listed appropriate by respondents, followed by chronic physical and psychological problems. The topics most often considered inappropriate were bureaucracy and social issues. Among the list of 12 specified topics, respondents considered terminal care and hypertension to be more appropriate than housing issues, spiritual worries, welfare rights or political issues. The sex of respondents did not relate to differences in results. Respondents aged 35 years and over generally considered topics presented by their patients to be more appropriate than did their younger colleagues. CONCLUSION: The general practitioner respondents in this study appeared to hold the view that general practitioners should work to a bio(psycho) rather than a biopsychosocial model of health care

Grey R. **The psychospiritual care matrix: A new paradigm for hospice care giving.** Am J Hosp Palliat Care, 13:19-25, July-August 1996.

In a changing health care environment, Hospice is having to more carefully set forth its mission and its identity. This is causing its interdisciplinary practitioners (medical, psychosocial, spiritual) to focus on what it is they have in common, what binds them together as a unique health care delivery system. This article suggests the common ground is that all hospice practitioners, irrespective of their clinical specialty, are psychospiritual care givers, providing basic psychological guidance and spiritual encouragement to patients and families. It sets forth a paradigm--the psychospiritual care matrix--in which all clinical practitioners can locate themselves and by which all can gain a greater clarity with respect to the individual care they provide and the character of their care with respect to that of their co-clinicians.

Groër MW; O'Connor B; Droppleman PG. **A course in health care spirituality.** J Nurs Educ, 35:375-7, November 1996.

Leetun MC. **Wellness spirituality in the older adult. Assessment and intervention protocol.** Nurse Pract, 21:60, 65-70, August 1996.

Supporting the spiritual dimension of life is essential to high-level wellness and wholeness. It helps one respond to the potential fullness of life despite problems that arise from illness and longevity. However, health care providers frequently fail to inquire about spiritual well-being and thus fail to nurture the spirit. This oversight has especially strong consequences when health care providers treat older adults. This article defines wellness spirituality. It discusses clinical presentation of the conditions in life and illness that indicate that an aging client's spiritual well-being is being challenged. Wellness spirituality activities to consider with history taking, both within and outside the context of religion, are outlined. Management approaches are offered to support and restore aging client's ability to achieve spiritual well-being. The article also describes virtues clinicians must hold to create a spiritually nurturing environment in all settings. A protocol is offered as a clinical guideline for clinicians to use in their assessment and management of the wellness spirituality of older adults.

Levin JS. **How prayer heals: A theoretical model.** *Altern Ther Health Med*, 2:66-73, January 1996.

This article presents a theoretical model that outlines various possible explanations for the healing effects of prayer. Four classes of mechanisms are defined on the basis of whether healing has naturalistic or supernatural origins and whether it operates locally or nonlocally. Through this framework, most of the currently proposed hypotheses for understanding absent healing and other related phenomena - hypotheses that invoke such concepts as subtle energy, psi, consciousness, morphic fields, and extended mind - are shown to be no less naturalistic than the Newtonian, mechanistic forces of allopathic biomedicine so often derided for their materialism. In proposing that prayer may heal through nonlocal means according to mechanisms and theories proposed by the new physics, Dossey is almost alone among medical scholars in suggesting the possible limitations and inadequacies of hypotheses based on energies, forces, and fields. Yet even such nonlocal effects can be conceived of as naturalistic; that is, they are explained by physical laws that may be unbelievable or unfamiliar to most physicians but that are nonetheless becoming recognized as operant laws of the natural universe. The concept of the supernatural, however, is something altogether different, and is, by definition, outside of or beyond nature. Herein may reside an either wholly or partly transcendent Creator-God who is believed by many to heal through means that transcend the laws of the created universe, both its local and nonlocal elements, and that are thus inherently inaccessible to and unknowable by science. Such an explanation for the effects of prayer merits consideration and, despite its inability to be proved by medical science, should not be dismissed out of hand.

Millet PE; Sullivan BF; Schwebel AI; Myers LJ. **Black Americans' and white Americans' views of the etiology and treatment of mental health problems.** *Community Ment Health J*, 32:235-42, June 1996.

Black Americans, in contrast to White Americans, use the mental health system in different ways. For example, Blacks tend to terminate treatment earlier than Whites. One explanation for the racial differences is that members of the two groups hold different views about mental health problems and their treatment. To test this explanation, subjects read and responded to questions about vignettes describing individuals encountering personal difficulties that ranged from adjustment challenges to severe psychiatric illness. Black American respondents rated spiritual factors as more important in the etiology and treatment of the difficulties than did Whites. The implications of these findings for theory and practice are discussed.

Moore NG. **Spirituality in medicine** [news]. *Altern Ther Health Med*, 2:24-6, 103-5, November 1996.

Narayanasamy A. **Spiritual care of chronically ill patients.** *Br J Nurs*, 5:411-6, April 11-12, 1996.

In this article, the spiritual features of chronic illness are identified and elaborated. Chronic illness can bring about disorganization and disruption in the sufferer, resulting in spiritual distress. Some guidance is offered to nurses on the skills required to provide spiritual care for chronically ill patients. An example of a problem-solving approach to spiritual care is given along with comments on evaluating the effectiveness of nursing intervention. It is within nurses' personal resources to provide effective spiritual care as part of their concern for quality of care for patients.

Pullen L; Tuck I; Mix K. **Mental health nurses' spiritual perspectives.** J Holist Nurs, 14:85-97, 1996.

Spiritual care has reemerged as a critical concern in nursing care. It is assumed that to provide spiritual care, nurses have a personal spiritual perspective. This study investigates the spiritual perspectives of a convenience sample of 50 mental health nurses employed in a public facility. The nurses' spiritual perspectives were measured using Reed's Spiritual Perspective Scale (SPS). Due to the homogeneous nature of the sample and a clustering of SPS scores, the Wilcoxin Signed-Ranks Test was used to evaluate the data. Although no variables were identified as significant contributors to an individual nurse's spiritual perspective, an overall high SPS was found among the mental health nurses surveyed. The mental health nurses' SPS score mean was notably higher than found in previous studies using the SPS

Robertson M. **Piety and poverty: The religious response to the homeless in Albuquerque, New Mexico.** In Dehavenon, AL (ed), *There's No Place Like Home: Anthropological Perspectives on Housing and Homelessness in the Unites States.* Westport, CT: Bergin & Garvey, 105-119, 1996.

This chapter examines two contrasting charitable groups with very different views of homeless people. The study is based on ethnographic research conducted in 13 religious based homeless institutions in Albuquerque. The author found that fundamentalist religious groups value self-reliance, rehabilitation, and salvation through Jesus Christ as the means of combatting homelessness, so they seek to help the "most worthy" of the homeless. Mainstream Protestant and Catholic church groups, on the other hand, value the experience of charitable work as an enriching experience for the church members. Mainstream groups obtain government help, which comes with some restrictions but allows them to assist the very poorest of the poor, including the mentally ill and addicted. The author recommends that the federal government simplify its grants processes that hinder small, poor agencies from applying, and that a greater proportions of these funds be allocated locally through Community Development Block Grants.

Wirth DP; Richardson JT; Eidelman WS. **Wound healing and complementary therapies: A review.** J Altern Complement Med, 2(4):493-502 , 1996.

A series of five innovative experiments conducted by Wirth et al. which examined the effect of various complementary healing interventions on the reepithelialization rate of full thickness human dermal wounds was assessed as to specific methodological and related factors. The treatment interventions utilized in the series included experimental derivatives of the Therapeutic Touch (TT), Reiki, LeShan, and Intercessory Prayer techniques. The results of the series indicated statistical significance for the initial two experiments and nonsignificance or reverse significance for the remaining three studies. This review article examines the methodological designs of the series of studies, along with the TT practitioners' phenomenologically based journal reports, to provide potential contributing correlative factors for the differential results obtained. These factors include methodological design restrictions, a transference/inhibitory effect, the influence of experimental assistants, healer visualization /imagery techniques, variations in subject populations, and a potential cancellation effect. While the placebo controlled double-blind methodological designs used in the series were as stringent as those used in other fields of scientific inquiry, the overall results of the experiments were inconclusive in establishing the efficacy of the treatment interventions for accelerating the rate of reepithelialization of full thickness dermal wounds.

1995

Ailinger RL; Causey ME. **Health concept of older Hispanic immigrants.** West J Nurs Res, 17(6):605-613, December 1995.

The purpose of this study was to explore the health concept of older Hispanic immigrants. In tape-recorded home interviews, 54 respondents were asked to define health, describe the characteristics of a healthy older person, identify what contributes to good health, and report what they did to maintain their health. Responses were transcribed and then analyzed qualitatively for categories and themes. Based on the findings, a concept of health evolved that included six major themes: integrating physical, emotional, and spiritual aspects; possessing mental health; feeling well; enjoying independence; practicing self-care; and orienting toward family. These themes will be useful to nurses in planning and implementing health services for similar older Hispanic immigrants.

Astedt-Kurki P. **Religiosity as a dimension of well-being: A challenge for professional nursing.** Clin Nurs Res, 4:387-96, November 1995.

The principles of holistic nursing require understanding the human individual as a complex and coherent entity consisting of physical, psychic, social, and spiritual dimensions. Considering the research evidence about people's experiences of well-being, the spiritual dimension, here regarded as synonymous with religiosity, does not seem to receive due attention in nursing. This article describes the appearance of religiosity as an integral part of people's experiences of well-being. Data from interviews with 40 adults who had contacted the primary health care system were analyzed on the basis of a qualitative, thematic analysis. Christians who belonged to the Evangelical Lutheran Church of Finland incorporated their religious values into their experiences of well-being. These values were reflected in ideas of the good life, in solutions to everyday problems, and in self-care. The results highlight the importance of a nursing concept that recognizes each patient's individual well-being.

Center for Substance Abuse Treatment. **Alcohol, tobacco, and other drug abuse: Challenges and responses for faith leaders.** Rockville, MD, Center for Substance Abuse Treatment, November 1995.

This curriculum is an outcome of CSAT's Interfaith Initiative. First developed as a training opportunity for theological students, its comprehensive structure makes it a valuable tool for any person with expertise in and knowledge of the field of addiction and treatment. Divided into modules: (1) historical view; (2) effects of commonly abused drugs; (3) understanding ATOD dependencies; and (4) substance abuse ministries: approaches to prevention, intervention, and treatment. With appendices. AVAILABLE FROM: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

Gelo F. **Spirituality: A vital component of health counseling.** J Am Coll Health, 44:38-40, July 1995.

King M; Speck P; Thomas A. **The Royal Free interview for religious and spiritual beliefs: Development and standardization.** Psychol Med, 25(6):1125-1134, November 1995.

We present the development and standardization of a measure of spiritual, religious and philosophical beliefs. An interview was constructed based on on-going studies by the authors of the nature and strength of belief held by people hospitalized with an acute illness. The interview was tested with three standard populations--staff of a teaching hospital; attenders to an inner city general practice; and people with clearly defined, devout religious beliefs--in order to establish population norms, validity and reliability for each question. The interview performed well with satisfactory validity and high internal and test-retest reliability. It is not presented as a final product which will meet all needs in this complicated area of study; rather, we attempted to refine a measure of spiritual and religious belief that applies to people with a range of personal and public faiths. It is clear that people are able to express these aspects of their lives in a way that can be measured with acceptable reliability and validity. This interview could, therefore, be applied in any medical, psychological or social setting in which a measure of belief is sought.

Kurtz ME; Wyatt G; Kurtz JC. **Psychological and sexual well-being, philosophical/spiritual views, and health habits of long-term cancer survivors.** Health Care Women Int, 16:253-62, May-June 1995.

The results of a survey on various aspects of quality of life for 191 women who were long-term cancer survivors are presented. We explored six areas--somatic concerns, health habits, psychological state, sexual satisfaction, social/emotional support giving, and philosophical/spiritual view--and whether differences existed in them among the women on the basis of age, educational level, income level, length of survival, location of residence (urban, suburban, or rural), cancer site, and whether a recurrence of the cancer had been experienced. Generally, the women reported good psychological states and relative satisfaction with their sexual lives. However, women who had experienced a recurrence of their cancer, were longer term survivors, or suffered from breast cancer all reported higher levels of somatic concerns. Women with higher levels of education or income and those who had had a recurrence of their cancer indicated a greater willingness to provide social and emotional support to other women newly diagnosed with cancer. Women who had a positive philosophical/spiritual outlook were more likely to have good health habits and be supportive of others. There was no statistically significant variation among the women in either health habits or psychological state for any of the factors considered.

Macrae J. **Nightingale's spiritual philosophy and its significance for modern nursing.** Image J Nurs Sch, 27:8-10, Spring 1995.

In her manuscript, *Suggestions for Thought*, Nightingale attempted to integrate science and mysticism. She wrote that the universe is the incarnation of a divine intelligence that regulates all things through law. For Nightingale, the laws of science are the "Thoughts of God." Because of her deep conviction about universal law, she did not believe in miraculous intervention as an answer to prayer. Human beings must discover the laws of God and apply them for health and wholeness. Prayer is attuning or joining one's personal self with the consciousness of God, which is found in the deepest recesses of one's own being. Nightingale's idea of spirituality as intrinsic to human nature and compatible with science can guide the development of future nursing practice and inquiry.

Martin MA; Rissmiller P; Beal JA. **Health-illness beliefs and practices of Haitians with HIV disease living in Boston.** J Assoc Nurses AIDS Care, 6:45-53, November-December 1995.

The authors of this qualitative study explored the health-illness beliefs and practices of Haitians with HIV disease. The authors obtained a purposive sample of five Haitian men and four Haitian women with symptomatic HIV disease or AIDS living in Boston. Five themes were identified through content analysis of interviews and medical record review: incorporation of traditional health-illness beliefs into beliefs about HIV disease; A perceived need to hide HIV disease to avoid rejection, humiliation, and isolation; use of spirituality to help cope with HIV disease; history of limited contact with doctors prior to diagnosis of HIV disease; and use of traditional healing practices for HIV disease. The findings have implications for improving cross-cultural communication between Haitians with HIV disease and their healthcare providers.

Marwick C. **Should physicians prescribe prayer for health? Spiritual aspects of well-being considered** [news]. JAMA, 273:1561-2, May 24-31, 1995.

Mickley JR; Carson V; Soeken KL. **Religion and adult mental health: State of the science in nursing.** Issues Ment Health Nurs, 16:345-60, July-August 1995.

As a part of human spirituality, religion has been theorized to influence the health of the individual, both positively and negatively. Nursing literature has focused recently on broad aspects of spirituality but the specifics of religious influences on health have been ignored or examined cursorily. This article reviews the major empirical data on religion and mental health that are pertinent to nursing. Three areas covered are mental health impact, coping, and aging. Suggestions for future research on the subject are presented.

Miller MA. **Culture, spirituality, and women's health.** J Obst Gyn Neon Nurs, 24:257-63, 1995.

A review of the literature on culture, health/women's health, and spirituality/religion reveals that the purported relationships among these variables may be tenuous. Nevertheless, there is a need for health care professionals to be aware of existing cultural/religious beliefs that may affect women's health behavior if provision of holistic health care is a goal. Implications for practice and research can be drawn from the existing evidence in the literature.

Nunes JA; Raymond SJ; Nicholas PK; Leuner JD; Webster A. **Social support, quality of life, immune function, and health in persons living with HIV.** J Holist Nurs, 13:174-98, June 1995.

This study examined the relationship between social support and quality of life in individuals with HIV. Using a descriptive, correlational design, data were collected from 50 HIV-positive individuals who were: participants in support groups at a behavioral medicine unit, inpatient or respite care patients with HIV, or respondents to advertisements at AIDS service organizations. The results of the study indicated that social support was significantly correlated with quality of life. Further, HIV status was significantly related to quality of life. However, HIV status was not significantly related to social support. No significant relationship was found between CD4 counts and HIV status, CD4 counts and social support, or CD4 counts and perceived health status. However, CD4 counts were significantly correlated with scores on the QLI. The findings indicate that social support and quality of life are significantly intercorrelated and that higher CD4 counts are related to quality of life in this sample of persons. Further areas for research include evaluation of quality of life over the span of HIV disease and interventions to enhance or maintain quality of life in persons across the spectrum of HIV disease.

Oriol MD. **Cajun traditions and their impact on health care.** J Cult Divers, 2(1):27-30, 1995.

This article explores food preparation and faith healing practices of contemporary Cajun culture. Decades of exile and oppression required early Cajuns to use scarce resources as a means of survival. Although modern society offers technological advances and information that lead to more positive health outcomes, this close-knit group of individuals frequently chooses to leave many traditional practices unchanged. Health care workers must understand the beliefs and practices of the Cajun people to meet their health needs.

Peri TA. **Promoting spirituality in persons with acquired immunodeficiency syndrome: A nursing intervention.** Holist Nurs Pract, 10:68-76, October 1995.

Holistic care addresses the physical, psychologic, emotional, and spiritual dimensions of the patient. The spiritual dimension, however, is frequently overlooked by health care providers. The development of spiritual well-being is crucial in helping the person with AIDS find meaning in life and death. Assessing spiritual needs of persons with AIDS and promoting their spirituality are important nursing roles.

Ross L. **The spiritual dimension: its importance to patients' health, well-being and quality of life and its implications for nursing practice.** Int J Nurs Stud, 32:457-68, October 1995.

The spiritual dimension is described and is interpreted as the need for: meaning, purpose and fulfillment in life; hope/will to live; belief and faith. As the spiritual dimension is important for the attainment of an overall sense of health, well-being and quality of life (referred to as the health potential) and as illness and hospitalization can precipitate spiritual distress, patients' spiritual needs should be addressed. The nurse's role in spiritual care is discussed with reference to the nursing literature.

Slaby A. **Bioethical concepts of health in medicine.** Sb Lek, 96(3):195-198, 1995.

As a fundamental human need, and consequently one of the principal ethical values, health has to be examined both from the experiential and normative aspects. The following concepts of health have successively developed and found their place in internal medicine: a) absence of manifest disorders, b) state of complete well-being, c) active process aimed at achieving consistency of functions in a dynamic equilibrium with the environment, in order to secure optimum satisfaction of biological and cultural needs. The essential unity of the somatic, psychic, social and spiritual dimensions of the human person should be considered, when assessing health of individual subjects as well as of the whole community.

Smith C. **Learning about yourself helps patient care. Using self-awareness to improve practice.** Prof Nurse, 10:390-2, March 1995.

Nurses must be able to communicate effectively with patients, relatives and other staff. Self-awareness is the recognition of the physical, social, psychological and spiritual aspects of the individual. Using a journal helps develop critical faculties and enhances personal and professional development. Reflective practice allows people to examine and explore their feelings, beliefs and attitudes.

Tucker JA. **Predictors of help-seeking and the temporal relationship of help to recovery among treated and untreated recovered problem drinkers.** *Addiction*, 90(6):805-809, June 1995.

This study investigated variables predicting different help-seeking patterns by problem drinkers who had maintained stable abstinence. Collaterals verified subjects' help-seeking and drinking status. Help-seeking was predicted by greater alcohol-related psycho-social problems, especially in interpersonal relationships, but was not associated with heavier drinking practices or demographic characteristics. Subjects' belief that they could solve their own problem deterred help-seeking, whereas relationship problems and being unable to quit on one's own facilitated help-seeking. Additional incentives specific to AA were its privacy, anonymity, spiritual aspects, opportunities to help other problem drinkers, and the convenient meetings held at times typically spent drinking. Many subjects became abstinent before they sought help, especially from treatment programs. These findings implicate interpersonal factors as primary incentives for help-seeking and suggest that interventions often consolidate, rather than initiate, positive changes in drinking practices.

Webb D. **Good Chemistry - Psychoeducational groups for seriously mentally ill chemical abusers.** Austin, TX: Good Chemistry Groups, 1995.

This manual was designed to serve as the official guide for the Good Chemistry Group Co-Leaders for use when conducting meetings for people with co-occurring mental health and substance use disorders. Good Chemistry means balance in mental, physical, spiritual, and emotional life. It involves a formatted nine-step meeting program developed by the author. This manual is updated as progression in the program develops. AVAILABLE FROM: Deborah Webb, P.O. Box 3073, Austin, TX 78764-3073. (512) 442-1168.

1994

Bergquist S; King J. **Parish nursing--a conceptual framework.** *J Holist Nurs*, 12:155-70, June 1994.

Parish nursing is a current nursing care delivery model that practices holistic health care. Parish nurses provide care to a faith community, emphasizing the relationship between faith and health. Specific nursing activities address physical, emotional, and spiritual health and well-being, closely attending to the inseparability of these dimensions. Parish nurses may assume one or more roles associated with this practice to accomplish parish nursing activities and achieve the holistic health and well-being of individuals, families, and groups within the faith community. The five broad categories of client, health, nurse, environment, and nursing process provide a framework for organizing the concept of parish nursing for future nursing theory, research, and practice.

Boisset M; Fitzcharles MA. **Alternative medicine use by rheumatology patients in a universal health care setting.** *J Rheumatol*, 21:148-52, January 1994.

OBJECTIVE: To assess the prevalence, extent of use, and cost of alternative medicine by patients attending a rheumatology clinic. METHODS: Two hundred and thirty-five unselected consecutive patients attending a rheumatology clinic were evaluated by questionnaire to record their current use of alternative medicine practices. RESULTS: Sixty-six percent of patients had used alternative medicine interventions in the preceding 12 months; 54% used over the counter products, 39% spiritual aids (including prayer, relaxation, meditation), and 13% each had visited alternative practitioners or used dietary interventions. Patients in the upper middle income group and French speaking patients used more

bought products, but no other differences were observed when the groups were analyzed according to level of education, income or cultural background. The current annual cost for the patients of alternative medical therapies was \$100. **CONCLUSION:** Our results demonstrate a moderate use of alternative medicine by rheumatology patients, mostly inexpensive products and no cost spiritual aids. Universal health care may have a negative impact on the extent of use of more costly practices.

Bonnar A; Leeks K; Tsoukas C. **A psycho/social/spiritual response to staff bereavement: A memorial gathering.** Int Conf AIDS, 10:408 (abstract no. PD0240), Aug. 7-12, 1994.

BACKGROUND: The alarming increase in mortality rates seen in the second decade of the AIDS epidemic has placed bereavement issues in the forefront at centers caring for AIDS patients. **OBJECTIVE.** To develop a psycho/social/spiritual model responding to death related issues and staff bereavement. **METHODS:** The IDTC offers comprehensive HIV care at an integrated single site and consists of a multidisciplinary team of 26 health care professionals caring for over 1,000 HIV infected persons. The annual mortality rate at the IDTC rose by 85% between 1992 and 1994. Because of this, a two-part, bi-monthly memorial gathering was developed through the collaboration of the chaplain, social worker and psychiatrist. Part One was a thematic memorial service based upon broad spiritual values. IDTC staff participated in choosing the music, readings and use of symbols. Part Two was a luncheon for staff and families to facilitate interactions. Eight gatherings commemorated 113 patients. The purpose, structure and composition of the model is based on this population. **RESULTS AND CONCLUSIONS:** The memorial gathering, expanded to encompass families and other hospital staff, experienced an eleven fold increase in attendance and increased staff participation in the service (n=4 in 1992; n=45 in 1994). Based upon the common ground of grief, the gathering provided a safe place for IDTC staff to share bereavement among colleagues/families. This is now an ongoing part of the center regular activities and has responded to other critical needs: family isolation and HIV awareness/education. This program can serve as a model to deal with bereavement in similar settings.

Bruenjes SJ. **Orchestrating health: Middle-aged women's process of living health.** Holist Nurs Pract, 8:22-32, July 1994.

Middle-aged women's definition of health was explored using grounded theory methodology. Seven middle-aged women were interviewed regarding their definition of health and what they did to achieve health. Interviews were analyzed using the constant comparison method. The core variable of "orchestrating health" became evident as women's process of living health. These middle-aged women orchestrated the physical, emotional, and spiritual aspects of their lives in the environment (orchestral pit) and in relationship with others (audience, patrons). Nurses need to become aware of the process of living health undertaken by middle-aged women and to include spiritual, physical, emotional, environmental, and relational components in their assessment and understanding of women's health.

Duran BE; Bellymule G; Geren T. **Traditional healing and holistic case management for American Indians.** Int Conf AIDS, 10:59 (abstract no. 189D), Aug. 7-12, 1994.

OBJECTIVE: Additional efforts and approaches to health care are needed because American Indians infected with HIV/AIDS have a shorter life expectancy than other populations. Traditional healing, as part of holistic case management, was examined to determine if this would meet an American Indian's spiritual and health needs - while also increasing life expectancy. **METHODS:** Traditional healing, along with Western medicine, was used with 60 HIV+ American Indian clients residing in the state of Oklahoma. Qualitative interviews tested the model that traditional healing leads to improved self-identity, that subsequently, leads to improved personal care (emotional, spiritual, and physical). A quantitative

outcome measure of life expectancy was used to compare national statistics with program client data. RESULTS: All clients chose to participate in traditional healing. Clients reported enhanced personal identity and self-esteem that lead to improved health practices and reduced risk behaviors. There was also an increase in client requests for traditional healing. DISCUSSION AND CONCLUSIONS: This model of holistic case management, that includes traditional healing, needs to be expanded to American Indian clients who are not receiving traditional healing. Health care providers need to take an active stance in researching other potential benefits of traditional healing in conjunction with Western medicine. Future research needs to address the effectiveness of this program's inter-tribal model when applied at the local reservation or tribal level.

Grey A. **The spiritual component of palliative care.** Palliat Med, 8(3):215-221, 1994.

This article discusses the concept of spirituality within palliative care. It considers aspects of religion and creativity in relation to spirituality, which may be inter-related as well as being significant in their own right. The nurse's role within the interdisciplinary team is explored. The expertise required as well as the emotional effect on nurses offering spiritual support is described.

King DE; Bushwick. **Beliefs and attitudes of hospital inpatients about faith healing and prayer.** J Fam Pract, 39:349-52, October 1994.

BACKGROUND. Physicians rarely question patients about their religious beliefs. This lack of inquiry may be contrary to patients' wishes and detrimental to patient care. This study examines whether patients want physicians to discuss religious beliefs with them. METHODS. Two hundred three family practice adult inpatients at two hospitals were interviewed regarding their views on the relationship between religion and health. RESULTS. Many patients expressed positive attitudes toward physician involvement in spiritual issues. Seventy-seven percent said physicians should consider patients' spiritual needs, 37% wanted their physicians to discuss religious beliefs with them more frequently, and 48% wanted their physicians to pray with them. However, 68% said their physician had never discussed religious beliefs with them. CONCLUSIONS. This study supports the hypothesis that although many patients desire more frequent and more in-depth discussions about religious issues with their physicians, physicians generally do not discuss these issues with their patients.

Ross LA. **Spiritual aspects of nursing.** J Adv Nurs, 19(3):439-447, March 1994.

In this paper the author relates how she initially became interested in spiritual care. A synopsis of a literature review is given in which the spiritual dimension is defined and evidence presented for its influence on health, well-being and quality of life. Spiritual care is also presented as part of the nurse's role. However, it is acknowledged that there is a lack of guidelines for the practice of spiritual care. A conceptual framework for the latter is, therefore, proposed by the author. As little is currently known about how nurses perceive the spiritual dimension and their role in spiritual care, the findings from a doctoral study, which examined these issues, are reported and discussed. The descriptive study was part of the author's PhD thesis (Waugh 1992).

Taylor EJ; Highfield M,;Amenta M. **Attitudes and beliefs regarding spiritual care. A survey of cancer nurses.** *Cancer Nurs*, 17(6):479-487, December 1994.

Why nurses neglect spiritual care issues remains unclear. Therefore, a questionnaire designed to assess oncology nurse clinicians' attitudes and beliefs about spiritual care was mailed to a stratified, random sample of 700 Oncology Nursing Society members within the United States. Data from the 181 respondents were analyzed using descriptive and multivariate statistics (for quantitative items) and content analysis (for essay questions). Analysis of data revealed both a positive regard for spiritual care within nursing, and relationships between beliefs and attitudes about spiritual care and self-reported spiritually, religiosity, ethnicity, work role, and education. Recommendations are for inclusion of theoretical and practical aspects of spiritual care in nursing education and for further investigation of nurses' attitudes and beliefs regarding spiritual care.

Wirth DP; Cram JR. **The psychophysiology of nontraditional prayer.** *Int J Psychosom*, 41:68-75, 1994

This study was a replication and extension of previous research which indicated that Non-Contact Therapeutic Touch had a significant effect in normalizing the activity of the "end organ" for the central nervous system (CNS). The study utilized a randomized double-blind within subject crossover methodological design to examine the effect of nontraditional distant prayer upon autonomic and CNS parameters. The impact of complementary healing was assessed utilizing multi-site surface electromyographic (sEMG) recordings located at the frontalis, Cervical 4 paraspinals, Thoracic 6 paraspinals, and Lumbosacral 3 paraspinals. The autonomic indicators of physiological activity included hand temperature, heart rate, skin conductance levels (SCL), and blood volume pulse (BVP). Twenty-one subjects were randomly assigned to treatment and control conditions for two thirty minute evaluation sessions for a total of forty-two psychophysiological monitoring periods. All participants were blinded to the true nature of the experimental protocol as well as the fact that a healing study was being conducted in order to control for suggestion, expectation of healing, and the placebo effect. The analysis of autonomic indicators demonstrated a slight decrease in BVP and heart rate, coupled with a minor increase in SCL suggesting a mild "anticipatory effect" arousal trend. The data also showed that two of the four muscle regions monitored-T6 and L3 paraspinals-indicated a significant reduction in electromagnetic energy during and following the distant healing treatment intervention for a majority of the subjects. (ABSTRACT TRUNCATED AT 250 WORDS)