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**Literature search results**

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**Search details**

Spiritual care of the older person

**Resources searched**

NHS Evidence; National Library for Health; TRIP Database; Cochrane Library; BNI; CINAHL; EMBASE; MEDLINE; PsychINFO Google Scholar; Google Advanced Search

**Database search terms**: “older person”; “older people”; elderly; aged; exp AGED; seniors; “spiritual care”; exp RELIGION AND PSYCHOLOGY; spirituality; “religious care”; religion; care; SPIRITUAL CARE; “united kingdom; UK; exp UNITED KINGDOM; britain; “great britain”; England; Scotland; wales; “northern ireland”; TRANSCULTURAL CARE; CULTURE AND RELIGION

**Google search string**: "spiritual care" ("older people" OR aged OR elderly) 2005..2010 -book -site:books.google.com

**Summary**

Quite a broad topic, so unable to do much summarising. Anyway in terms of your search query, you may find some of the guidelines, and the following research studies particularly useful: 1, 2, 3, 4, 8, 16, 20, 22, 26, 27, 28, 33, 40, 45 and 50. Don’t forget the research included in the Google Scholar section.

**Guidelines**

**University of Iowa Gerontological Nursing Interventions Research Center**

Providing spiritual care to the terminally ill older adult 2007

The guideline is developed from the authors’ whole person perspective that views people as having integrated physical, emotional, social and spiritual dimensions, with spirituality at the core of human being; and the belief that alterations of well-being in one dimension affect the other dimensions.

**NHS Quality Improvement Scotland**
Best Practice Statement: management of chronic pain in adults 2006
See p 21. Spiritual issues related to the suffering of chronic pain can involve a reaction between emotions such as fear, guilt, anger, loss and despair. It may appear inseparable from physical pain and can influence the way pain is expressed.

Scottish Government
DYING WELL: a national action plan for palliative and end of life care in Scotland 2008
Care planning should also take account of any religious, cultural, spiritual or other life circumstances that are relevant to appropriate care.
Living and dying with advanced heart failure: a palliative care approach 2008
See section 6.3 Psychosocial and spiritual care

The King’s Fund
Delivering better care at end of life: the next steps 2010
a) However, the quality markers are continually evolving and should focus increasingly on all parts of the patient pathway, including spirituality and bereavement.
b) there is also a need to do more on care after death – support for families and carers (including bereavement support) – and on spiritual care.
c) The responsiveness to individual needs will vary by age (for example, the needs of older teenagers differ from those of older people), gender, the condition(s) from which they are suffering, cultural factors (ethnicity, but also life experiences and the extent of familial and social support networks), spiritual/religious beliefs, deprivation and pre-existing vulnerabilities.

Department of Health
Religion or belief: A practical guide for the NHS 2009
Both the physical and the spiritual aspects of individual patients are considered, allowing for individual religious views on the relationship between body, mind, soul and spirit. The inclusion of family is particularly relevant in religious communities where large emphasis is placed on familial bonds.

End of Life Care Strategy: Promoting high quality care for all adults at the end of life 2008
a) It is important to consider the support, care and information that is required by the person’s family and caregivers both during the illness and into bereavement. Similarly, spiritual care and support for both the person and their carers is integral to the end of life care pathway.
b) Whatever triggers the discussion with an individual about end of life care planning, an holistic assessment should be undertaken which covers the full range of physical, psychological, social, spiritual, cultural and, where appropriate, environmental needs.
c)

When a patient dies: advice on developing bereavement services in the NHS 2005
a) The quality of services can also be enhanced through access to different forms of spiritual care, which can be just as important as any other form of support.
b) The guidance mentioned in that introduction shows how flexible and innovative responses in chaplaincy-spiritual care can be made for all patients, their carers and staff according to faith, spiritual tradition or to those who have no particular affiliation.
c) The National Service Framework for Older People also recognises that the needs of family, friends and carers need to be provided for, including relieving distress, meeting
spiritual needs and offering bereavement counselling.

Mental Health Foundation

The impact of spirituality on mental health 2007

European Association for Palliative Care

White Paper on standards and norms for hospice and palliative care in Europe: parts 1 and 2. Recommendations from the European Association for Palliative Care 2009

Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount.

SIGN

Control of pain in adults with cancer 2008

See section 5 Spirituality, subjective experience and meaning making.

Patients value professionals who adopt a holistic approach to care and are competent in dealing with (and are able to communicate about) the spiritual, psychological, and emotional impact of pain.

Evidence-based reviews

Cancer Care Ontario


a) For effective pain control, the physical, functional, psychosocial, and spiritual dimensions should be assessed.

b) Utilize health care professionals such as social workers or spiritual or religious care providers, who may assist in helping patients who are experiencing extremely stressful situations.

Published research

1. Care of the older person: a Buddhist perspective.

Author(s): Wilkins, A, Mailoo, V

Citation: Nursing & Residential Care, June 2010, vol./is. 12/6(295-7), 1465-9301 (2010 Jun)

Publication Date: June 2010

Abstract: Provision of culturally appropriate care for Buddhists in care homes in the UK. Core Buddhist beliefs are explained and the importance of festivals, diet and death rituals are examined. 17 refs.

Source: BNI

Full Text: Available in fulltext at EBSCO Host

2. Care of the older person: a Hindu perspective.

Author(s): Wilkins, A, Mailoo, V

Citation: Nursing & Residential Care, May 2010, vol./is. 12/5(249-51), 1465-9301 (2010 May)

Publication Date: May 2010
Abstract: Provision of culturally appropriate care for Hindus in care homes in the UK. Core Hindu beliefs are explained and the importance of worship, festivals, self care, diet and death rituals are examined. 19 refs.

Source: BNI

Full Text:
Available in fulltext at EBSCO Host

3. Care of the older person: a Jehovah's Witness perspective.
Author(s): Smith, A
Citation: Nursing & Residential Care, April 2010, vol./is. 12/4(195-6), 1465-9301 (2010 Apr)
Publication Date: April 2010
Abstract: Provision of culturally appropriate care for Jehovah's Witnesses in care homes in the UK. Prayer, celebrations, the significance of blood and end of life care are discussed.
Source: BNI

Full Text:
Available in fulltext at EBSCO Host

4. Review: what evidence is there about the specific environmental needs of older people who are near the end of life and are cared for in hospices or similar institutions? A literature review
Author(s): Rigby J., Payne S., Froggatt K.
Citation: Palliative medicine, April 2010, vol./is. 24/3(268-285), 1477-030X (Apr 2010)
Publication Date: April 2010
Abstract: Relatively little is known about the type of physical environment which is needed and preferred by patients aged 65 and over, with a prognosis of 1 year or less, who are receiving care in hospitals, care homes and hospices, and their families and staff. A narrative literature review was conducted to identify and analyse evidence on this issue, with twenty-nine papers meeting the inclusion criteria. The patients were found to have a wide range of views on their environment, but there was some variation between the views of patients and those of their families and staff. Four main themes emerged: the physical environment should be 'homely'; it should support patients' need for social interaction and privacy; it should support the caring activities of staff, family members and patients; and it should allow opportunities for spiritual expression. It is evident that the physical environment contributes significantly to the quality of life of older people with a life-limiting illness, and there is a need for more research in this area. Regular assessment of patients' environmental needs should form part of care planning.
Source: EMBASE

5. A qualitative study exploring the experiences of African-Caribbean informal stroke carers in the UK.
Author(s): Strudwick A, Morris R
Citation: Clinical Rehabilitation, 01 February 2010, vol./is. 24/2(159-167), 02692155
Publication Date: 01 February 2010
Abstract: Objective: To explore the experiences of African-Caribbean informal stroke carers in the UK. Design: Qualitative methodology. Setting: Three urban locations in southern England. Participants: Nine African-Caribbean informal stroke carers providing support to a relative with stroke for at least six months. Method: Semi-structured interviews were used to explore both predetermined and unexpected topics relating to any aspects of the carers’ experiences. Interview transcriptions were analysed using inductive thematic analysis. Results: Several themes resembled those identified in previous qualitative studies with informal stroke carers from other ethnic backgrounds. However, new themes emerged
which were related to the carers' ethnicity and cultural values. These themes were 'understanding of individual needs', 'battle', 'independence from services', 'faith in God', 'family ties' and 'avoiding institutionalised care.' Conclusions: This small-scale study provides an insight into African-Caribbean stroke carers' own perspectives. These have much in common with those of other ethnicities, but also exhibit important areas of difference. Several themes indicate issues with existing service provision. Stereotypical assumptions about informal stroke carers based on ethnicity appear to be unwarranted; there is diversity within ethnic groups. Individual contexts of ethnicity, culture and religious beliefs shape expectations and perceptions. Several themes signpost service attributes that are perceived as relevant to acceptability by African-Caribbean stroke carers. Recruitment challenges could be addressed in future projects with ethnic minority carers by collaborative planning and the development of individual relationships with key informants.

Source: CINAHL

6. Assessment of spirituality history taking in mental health

Author(s): Raffi A., Hussein N.

Citation: European Psychiatry, 2010, vol./is. 25/, 0924-9338 (2010)

Publication Date: 2010

Abstract: Introduction: Spirituality is recognized as a key facet of a person's sense of self and wellbeing. In the UK 73% of psychiatrists reported no religious affiliation compared to 38% of their patients. 92% of psychiatrists in Britain believed that religion & mental illness were connected & religious issues should be addressed in treatment. Aims: Audit Spirituality Assessments conducted in new cases admitted to hospital and new cases seen in clinic over a 3 month period(July-September 2009) in adult/elderly services. Methods: Demographic data was collected from electronic patient records and casenotes/clinic assessment letters were reviewed for evidence of taking a spiritual history. Guidance for how to take a spiritual history was sought from Royal College of Psychiatry guidelines and recently published journal article (Advances in Psychiatric Treatment. May 2007;13:212-219). Evidence of a brief screening of spirituality, followed by a more detailed assessment were recorded. Results: 75 cases were reviewed of which 39 were male and 36 female. There was an even distribution of age within the sample over 7 decades from age 20 to age 90. Of the 75 cases, only 2 (2.7%) had a brief assessment of their spirituality whilst the larger majority (97.3%) had no assessment. No detailed assessment of spirituality history was conducted. Conclusions: The results indicate that assessment of spirituality is very poorly conducted in this sample and there is need for development. Recommendations from the audit include facilitation of further training in religion and spirituality history taking and for such training to be encompassed within induction training of junior doctors.

Source: EMBASE

7. Archetypal trajectories of social, psychological, and spiritual wellbeing and distress in family care givers of patients with lung cancer: secondary analysis of serial qualitative interviews

Author(s): Murray S.A., Kendall M., Boyd K., Grant L., Highet G., Sheikh A.

Citation: BMJ (Clinical research ed.), 2010, vol./is. 340/(c2581), 1468-5833 (2010)

Publication Date: 2010

Abstract: OBJECTIVE: To assess if family care givers of patients with lung cancer experience the patterns of social, psychological, and spiritual wellbeing and distress typical of the patient, from diagnosis to death. DESIGN: Secondary analysis of serial qualitative interviews carried out every three months for up to a year or to bereavement. SETTING: South east Scotland. PARTICIPANTS: 19 patients with lung cancer and their 19 family carers, totalling 88 interviews (42 with patients and 46 with carers). RESULTS: Carers followed clear patterns of social, psychological, and spiritual wellbeing and distress that mirrored the experiences of those for whom they were caring, with some carers also experiencing deterioration in physical health that impacted on their ability to care. Psychological and spiritual distress were particularly dynamic and commonly experienced. In addition to the "Why us?" response, witnessing suffering triggered personal reflections in carers on the meaning and purpose of life. Certain key time points in the illness tended to be particularly problematic for both carers and patients: at diagnosis, at home after initial
treatment, at recurrence, and during the terminal stage. CONCLUSIONS: Family carers witness and share much of the illness experience of the dying patient. The multidimensional experience of distress suffered by patients with lung cancer was reflected in the suffering of their carers in the social, psychological, and spiritual domains, with psychological and spiritual distress being most pronounced. Carers may need to be supported throughout the period of illness not just in the terminal phase and during bereavement, as currently tends to be the case.

Source: EMBASE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at Highwire Press
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Louth County Hospital Medical Library
Available in print at Pilgrim Hospital Staff Library

Author(s): Sable J
Citation: Nursing & Residential Care, 01 December 2009, vol./is. 11/12(621-623), 14659301
Publication Date: 01 December 2009
Abstract: Joy Sable explains why it is important for care staff to have an understanding of Jewish beliefs, customs and traditions.
Source: CINAHL
Full Text:
Available in fulltext at EBSCO Host

9. Issues affecting the care of the older Muslim.
Author(s): Al-Oraibi, S
Citation: Nursing & Residential Care, October 2009, vol./is. 11/10(517-9), 1465-9301 (2009 Oct)
Publication Date: October 2009
Abstract: Providing culturally appropriate care for elderly Muslims who are care home residents in the UK. Prayer, dress, gender issues, diet and Ramadan are discussed. 7 refs.
Source: BNI
Full Text:
Available in fulltext at EBSCO Host

10. The needs of patients with advanced, incurable cancer
Author(s): Rainbird K., Perkins J., Sanson-Fisher R., Rolfe I., Anseline P.
Citation: British Journal of Cancer, September 2009, vol./is. 101/5(759-764), 0007-0920;1532-1827 (01 Sep 2009)
Publication Date: September 2009
Abstract: Background: Limited research has investigated the specific needs of patients with advanced incurable cancer. The aim of this study was to describe the prevalence of perceived needs among this population. Methods: Medical specialists from two regions in New South Wales, Australia, identified patients with advanced, incurable cancer, who were estimated to have a life expectancy of 2 years and were not receiving formal palliative care. Of the 418 eligible patients, 246 (59%) consented to participate. Consenting patients
completed the Needs Assessment for Advanced Cancer Patients questionnaire, which has demonstrable validity and reliability. Patients' perceived needs were assessed across the seven domains of the questionnaire: psychological, daily living, medical communication and information, symptom related, social, spiritual and financial needs. Results: Patients identified the greatest areas of need in relation to psychological and medical communication/information domains. Patients' specific needs were highest in dealing with a lack of energy and tiredness, coping with fears about the cancer spreading, and coping with frustration at not being able to do the things they used to do. Conclusion: This study indicates that patients with advanced, incurable cancer have high levels of unmet needs, especially in relation to the areas of psychological and medical communication/information needs. The data have the potential to guide the development of interventions aimed at meeting the current unmet needs of patients with advanced, incurable cancer. 2009 Cancer Research UK.

Source: EMBASE

Full Text:
Available in fulltext at National Library of Medicine

11. Home away from home? A case study of bedside objects in a hospice.
Author(s): Kellehear A, Pugh E, Atter L
Citation: International Journal of Palliative Nursing, March 2009, vol./is. 15/3(148-52), 1357-6321;1357-6321 (2009 Mar)
Publication Date: March 2009
Abstract: This is a descriptive case study employing a photographic survey of the numerous objects that patients and their social networks bring to a hospice setting. Photographs were taken of all objects kept by the bedside by 31 inpatients in a hospice in the UK county of Durham. These objects ranged from assorted food and drink, greetings cards and magazines, to more specific personal items such as family photos, children's drawings, and religious icons. A total of 176 objects were analysed. There were two principle findings. First, patients appeared to bring objects to a hospice setting that reflected their desire to partially recreate their home settings or functions, however modestly. Second, despite a major diversity of objects, and the fact that most objects underlined desires for distraction, entertainment and social contact, almost every individual patient harboured at least one personally unique object. These two observations--creating some semblance of 'home' and the existence of uniqueness amid a plethora of expected patient paraphernalia--suggest important reconsideration of both hospice settings and the possibility of new ways to engage patients about meaning, illness and loss.
Source: MEDLINE
Full Text:
Available in fulltext at EBSCO Host

12. A profile of the belief system and attitudes to end-of-life decisions of senior clinicians working in a National Health Service Hospital in the United Kingdom.
Author(s): Pugh EJ, Song R, Whittaker V, Blenkinsopp J
Citation: Palliative Medicine, March 2009, vol./is. 23/2(158-64), 0269-2163;1477-030X (2009 Mar)
Publication Date: March 2009
Abstract: There is evidence from outside the United Kingdom to show that physicians' religious beliefs influence their decision making at the end of life. This UK study explores the belief system of consultants, nurse key workers and specialist registrars and their attitudes to decisions which commonly must be taken when caring for individuals who are dying. All consultants (N = 119), nurse key workers (N = 36) and specialist registrars (N = 44) working in an acute hospital in the north-east of England were asked to complete a postal questionnaire. In all, 65% of consultants, 67% of nurse key workers and 41% of specialist registrars responded. Results showed that consultants' religion and belief systems differed from those of nurses and the population they served. Consultants and
nurses had statistically significant differences in their attitudes to common end of life decisions with consultants more likely to continue hydration and not withdraw treatment. Nurses were more sympathetic to the idea of physician-assisted suicide for unbearable suffering. This study shows the variability in belief system and attitudes to end of life decision making both within and between clinical groups. This may have practical implications for the clinical care given and the place of care. The personal belief system of consultants was not shown to affect their overall attitudes to withdrawing life-sustaining treatment or physician-assisted suicide.

**Source:** MEDLINE

13. 'In need of further tuning': Using a US patient satisfaction with chaplaincy instrument in a UK multi-faith setting, including the bereaved

**Author(s):** Beardsley C.

**Citation:** Clinical Medicine, Journal of the Royal College of Physicians of London, 2009, vol./is. 9/1(53-56), 1470-2118;1473-4893 (2009)

**Publication Date:** 2009

**Abstract:** Healthcare chaplaincy research seems further advanced in the USA. Here a US patient satisfaction with chaplaincy instrument (PSI-C-R) was used in a London NHS foundation hospital with a multi-faith chaplaincy team and population. A version of the instrument was also generated for the bereaved. PSI-C-R had not been subjected to test-retest to confirm its reliability so this was done at the pilot stage. It proved only partly reliable, but in three separate surveys a cluster of highly rated factors emerged, as in earlier studies: chaplains’ prayer, competence, listening skills and spiritual sensitivity. Low-rated factors and qualitative data highlighted areas for improvement. Disappointing response rates arose from patient acuity, ethical concerns about standard follow-up protocols, and the Western Christian origins of the instrument which requires further revision for multi-faith settings, or the design of new instruments. Royal College of Physicians, 2009. All rights reserved.

**Source:** EMBASE

14. "I know he controls cancer": the meanings of religion among Black Caribbean and White British patients with advanced cancer.

**Author(s):** Koffman J, Morgan M, Edmonds P, Speck P, Higginson IJ

**Citation:** Social Science & Medicine, 01 September 2008, vol./is. 67/5(780-789), 02779536

**Publication Date:** 01 September 2008

**Abstract:** There is evidence that religion and spirituality affect psychosocial adjustment to cancer. However, little is known about the perceptions and meanings of religion and spirituality among Black and minority ethnic groups living with cancer in the UK. We conducted semi-structured interviews with 26 Black Caribbean and 19 White British patients living in South London boroughs with advanced cancer to explore how religion and spirituality influenced their self-reported cancer experience. Twenty-five Black Caribbean patients and 13/19 White British patients volunteered views on the place of religion or God in their life. Spirituality was rarely mentioned. Christianity was the only religion referred to. Strength of religious belief appeared to be more pronounced among Black Caribbean patients. Three main themes emerged from patients' accounts: the ways in which patients believed religion and belief in God helped them comprehend cancer; how they felt their faith and the emotional and practical support provided by church communities assisted them to live with the physical and psychological effects of their illness and its progression; and Black Caribbean patients identified the ways in which the experience of cancer promoted religious identity. We identified that patients from both ethnic groups appeared to derive benefit from their religious faith and belief in God. However, the manner in which these were understood and expressed in relation to their cancer was culturally shaped. We recommend that when health and social care professionals perform an assessment interview with patients from different cultural backgrounds to their own, opportunities are made for them to express information about their illness that may include religious and spiritual beliefs since these may alter perceptions of their illness and symptoms and thereby influence treatment decisions.
15. Perceived need for spiritual and religious treatment options in chronically ill individuals.

Author(s): Dale H, Hunt N

Citation: Journal of Health Psychology, 01 July 2008, vol./is. 13/5(712-718), 13591053

Publication Date: 01 July 2008

Abstract: The objective of the study was to examine the desire for spiritual and religious treatment options in chronically ill adults. Email interview data (N = 12) generated themes for religion, spirituality, and desired treatments. The resultant questionnaire data (N = 83) analysed the popularity of treatments. Thirty-five wide-ranging spiritual and religious treatment options were identified for use in the questionnaire; 47 per cent of the sample was interested in spiritual or religious treatments. There is a need for spiritual and religious treatment options, and translation of treatments into practice would assist coping for many people. Copyright © 2008 SAGE Publications Ltd.

Source: CINAHL

16. Health behaviour, depression and religiosity in older patients admitted to intermediate care.

Author(s): Yohannes, A, Koenig, H, Baldwin, R

Citation: Int J Geriatric Psychiatry, July 2008, vol./is. 23/7(735-40), 0885-6230 (2008 Jul)

Publication Date: July 2008

Abstract: Research among older people admitted to a UK intermediate care unit for rehabilitation into the relationship between health behaviour, depression, sociodemographic characteristics and religious belief and activities. The association of church attendance with a positive health attitude and less severe illness or depression is highlighted. 25 refs.

Source: BNI

Full Text: Available in print at Grantham Hospital Staff Library

17. Urinary incontinence in Muslim women.

Author(s): Sange, C, Thomas, L, Lyons, C

Citation: Nursing Times, June 2008, vol./is. 104/25(49-52), 0954-7762 (2008 24 June)

Publication Date: June 2008

Abstract: Continence Journal supplement. Qualitative research on Muslim women’s decision-making regarding seeking help for urinary incontinence, focusing on the influence of religion and culture. Women aged 21-70, of Indian and Pakistani descent living in northwest England, were interviewed about cultural and religious factors affecting their disclosure about incontinence, their choice of health professional and the effect of incontinence on their praying. 41 refs.

Source: BNI

Full Text: Available in fulltext at Ovid

Available in print at Grantham Hospital Staff Library

Available in print at Lincoln County Hospital Professional Library

Available in print at Pilgrim Hospital Staff Library


Author(s): Terry LM, Carroll J
End-of-life care, particularly for older people, is often sub-optimal in England, and the Government has introduced several initiatives to improve this care. The authors believe the twin frameworks of emotional labour and ethics of non-abandonment underpin the provision of high-quality care. This article discusses a research project that investigated first-year nursing students' encounters with patient deaths. The research found that, to the student, every death in clinical practice is a learning experience and potentially a source of emotional distress; some students reported experiencing flashbacks afterwards and were developing avoidance behaviours. Students sometimes felt unsupported by mentors and also felt that sometimes dying patients and families were inadequately cared for. The theme of abandonment was evident in the students' stories. The authors conclude that there is still room for improvement in end-of-life care. Good role modelling and pastoral care by mentors is vital to student development. Link lecturers and mentors need to be alert to student distress.

Source: MEDLINE

Full Text:
Available in fulltext at EBSCO Host
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

19. Religious affiliation and mortality in Northern Ireland: Beyond Catholic and Protestant

Author(s): O'Reilly D., Rosato M.

Citation: Social Science and Medicine, April 2008, vol./is. 66/7(1637-1645), 0277-9536 (Apr 2008)

Abstract: There has been little recent research in Europe exploring the relationship between religion and health. In Northern Ireland previous analysis has tended to divide the population dichotomously as Catholic and Protestant, ignoring the diversity inherent in the Protestant community. This study used a census-based longitudinal study of the enumerated population with five-years follow-up (covering the period 2001-2006) to examine variation in overall and cause-specific mortality by religious affiliation within Northern Ireland. Six groups were defined: Catholics; Presbyterians; Church of Ireland; Methodists; Other (mostly fundamentalist) Christians; and 'Other/not-stated'. Catholics had higher mortality than non-Catholics, though this disappeared after adjustment for socioeconomic status. Church of Ireland members had the highest overall mortality in the fully adjusted models, due to their higher risk of cardiovascular disease. 'Other Christians' had lowest all-cause mortality and particularly low mortality from alcohol-related deaths and lung cancer. These findings point to an association between religious affiliation, behaviour and lifestyle suggesting that, even in relatively secular societies, it is a population attribute that should be given more consideration in studies of population health. 2008 Elsevier Ltd. All rights reserved.

Source: EMBASE

20. Spiritual advisors and old age psychiatry in the United Kingdom.

Author(s): Lawrence RM, Head J, Christodoulou G, Andonovska B, Karamat S, Duggal A, Hillam J, Eagger S

Citation: Mental Health, Religion & Culture, 01 April 2008, vol./is. 11/3(273-286), 13674676

Abstract: This survey investigates the role and views of NHS spiritual advisors across the
United Kingdom on the provision of pastoral care for elderly people with mental health needs. The College of Health Care Chaplains provided a database, and questionnaires were sent to 405 registered NHS chaplains/spiritual advisors. The response rate was 59%. Quantitative and qualitative analyses were carried out. Spiritual advisors describe their working patterns and understanding of their roles within the modern NHS, and their observations of the level of NHS staff awareness of the importance of spiritual issues in the mental health care of older adults. They provide insights into possible negative and positive perceptions of their roles at a service level, and contribute suggestions of topics relevant to shared education between pastoral care and clinical services. This survey further highlights ethical and operational dimensions at the point of integration of the work of spiritual advisors and multidisciplinary teams.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

21. Meeting needs in dementia care.
Author(s): Dean-Osgood L
Citation: Nursing & Residential Care, 01 March 2008, vol./is. 10/3(110-110), 14659301
Publication Date: 01 March 2008
Source: CINAHL
Full Text:
Available in fulltext at EBSCO Host

22. Care approaches to spirituality and dementia.
Author(s): Bephage G
Citation: Nursing & Residential Care, 01 March 2008, vol./is. 10/3(134-137), 14659301
Publication Date: 01 March 2008
Abstract: Understanding and - needs of dementia patients can positively contribute to feelings of wellbeing. Gaetan Bephage explores the concept and importance of spirituality in care.
Source: CINAHL
Full Text:
Available in fulltext at EBSCO Host

23. U.K. clergy and people in mental distress: Community and patterns of pastoral care
Author(s): Leavey G.
Citation: Transcultural Psychiatry, March 2008, vol./is. 45/1(79-104), 1363-4615;1461-7471 (Mar 2008)
Publication Date: March 2008
Abstract: Despite the advance of secularizing influences in many western societies, religion and faith-based organizations play a significant role in the lives of many individuals and communities. Despite this, little is known about what clergy do when faced with mental health problems among their communities. Based on an analysis of in-depth interviews with U.K. Christian, Muslim and Jewish clergy this article examines models of pastoral care provided within different faith groups. The provision of such care was generally influenced by religious tradition and beliefs, community integrity and mission. Implications of the findings for collaboration with pastoral care are discussed. 2008 McGill University.
Source: EMBASE

25. The dimensions of religiosity scale: 20-item self-report measure of religious
Successful ageing in an area of deprivation: part 2--a quantitative exploration of the role of personality and beliefs in good health in old age.

Author(s): Gilhooly M, Hanlon P, Cullen B, Macdonald S, Whyte B

Citation: Public Health, November 2007, vol./is. 121/11(814-21), 0033-3506;0033-3506 (2007 Nov)

Publication Date: November 2007

Abstract: OBJECTIVES: This paper presents further analysis of a study aimed at examining the determinants of good health and successful ageing in an area of deprivation. In this paper we report findings from the quantitative data related to two of the original eight research questions: (1) To what extent can health in old age be attributed to psychological/personality variables? and (2) What is the role of religious beliefs and spirituality in healthy ageing? STUDY DESIGN: In-depth interview study in which standardized measures of personality and beliefs were administered, along with measures of beliefs devised for the study. METHODS: One hundred matched pairs of healthy and unhealthy ‘agers’ were interviewed face-to-face. Healthy ageing was assessed in terms of hospital morbidity and self-reported health. The sample comprised 106 males and 94 females (53 male matched pairs and 47 female matched pairs) ranging in age from 70 to 90 years of age with the majority (n=165) falling into the 71-80 age group and the remaining 35 in the 81-90 age group. All study participants were survivors of the Paisley/Renfrew (MIDSPAN) survey, a longitudinal study commenced in 1972 with continuous recording of morbidity and mortality since. Questionnaires assessing extraversion, neuroticism, psychoticism, health locus of control, sense of coherence, optimism, and religiosity were filled in by participants during the interviews. RESULTS: Compared to the unhealthy group, the healthy participants were less neurotic, more likely to endorse an internal locus of control belief and less likely to endorse a powerful others locus of control belief, and to report a greater sense of coherence. The unhealthy group scored higher on the religiosity/spirituality measure devised for this study. CONCLUSIONS: The findings are interesting in that, although they cannot address the issue of cause and effect, the very fact that the personality traits measured in this study were linked to health status in old age, further strengthens the argument that in general practice and hospital settings, an understanding of personality aids practitioners in dealing with patients. Finally, with the growing body of evidence that personality traits have a high degree of heritability, the routine gathering of information on personality traits would aid epidemiologists in their understanding of the determinants of healthy and successful ageing.

Source: MEDLINE
Typical trajectories of physical decline have been described for people with end-stage disease. It is possible that social, psychological, and spiritual levels of distress may also follow characteristic patterns. We sought to identify and compare changes in the psychological, social, and spiritual needs of people with end-stage disease during their last year of life by synthesizing data from two longitudinal, qualitative, in-depth interview studies investigating the experiences and needs of people with advanced illnesses. The subjects were 48 patients with advanced lung cancer (n=24) and heart failure (n=24) who gave a total of 112 in-depth interviews. Data were analyzed within individual case studies and then cross-sectionally according to the stage of physical illness. Characteristic social, psychological, and spiritual end-of-life trajectories were discernible. In lung cancer, the social trajectory mirrored physical decline, while psychological and spiritual well-being decreased together at four key transitions: diagnosis, discharge after treatment, disease progression, and the terminal stage. In advanced heart failure, social and psychological decline both tended to track the physical decline, while spiritual distress exhibited background fluctuations. Holistic end-of-life care needs to encompass all these dimensions. An appreciation of common patterns of social, psychological, and spiritual well-being may assist clinicians as they discuss the likely course of events with patients and carers and try to minimize distress as the disease progresses.

Source: MEDLINE

Full Text:
Available in print at Lincoln County Hospital Professional Library

28. Clinicians' attitudes to spirituality in old age psychiatry.
Author(s): Lawrence RM, Head J, Christodoulou G, Andonovska B, Karamat S, Duggal A, Hillam J, Eagger S
Citation: International Psychogeriatrics, 01 October 2007, vol./is. 19/5(962-973), 10416102
Publication Date: 01 October 2007
Source: CINAHL

Author(s): Kernohan WG, Waldron M, McAfee C, Cochrane B, Hasson F
Citation: Palliative Medicine, 01 September 2007, vol./is. 21/6(519-525), 02692163
Publication Date: 01 September 2007
Abstract: Palliative care encompasses spiritual as well as physical, social and psychological aspects. Spiritual care has been identified as a key concern of dying patients. During an audit of the Northern Ireland Hospice chaplaincy service against the national Standards for Hospice and Palliative Care Chaplaincy (2003), 62 patients' spiritual needs along with their interactions with the hospice chaplains were assessed by using a questionnaire survey and reviewing data recorded on their pastoral care notes. Findings suggest that the Standards were useful for assessing and addressing spiritual needs. Access to the chaplaincy service (Standard 1) was partially met and Standard 2's spiritual criteria were fully met. The participants, of whom 92% had a faith in God or a Higher Being, highlighted their top six spiritual needs as: to have the time to think; to have hope; to deal with unresolved issues; to prepare for death; to express true feelings without being judged; to speak of important relationships. The majority of the participants (82%) felt their spiritual needs had been addressed and viewed their interaction with the chaplaincy service positively. Recommendations were made relating to improve communication of chaplaincy services. Palliative Medicine 2007; 21: 519-525.
Source: CINAHL

31. Spiritual distress and integrity in palliative and non-palliative patients
Author(s): Buxton F.
Citation: British journal of nursing (Mark Allen Publishing), August 2007, vol./is. 16/15(920-924), 0966-0461 (2007 Aug 9-Sep 12)

Publication Date: August 2007

Abstract: Twenty-two patients in a Midlands acute hospital Trust supplied recorded narratives of their experience of spiritual distress, their hopes for spiritual integrity, and any means that were proving helpful in moving from distress to integrity. The research subjects included both patients in palliative care and those undergoing various therapies. There was little difference between the responses of these two groups. The most frequently expressed spiritual distress centred on the sense of 'not being myself', and concern for the family. The most frequently expressed spiritual integrities, were the hope to help others, and to use the illness as an opportunity for personal growth and acceptance. Support from hospital staff was seen as most important in facilitating change from distress to integrity.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

32. Challenges to sanctuary: the clergy as a resource for mental health care in the community.

Author(s): Leavey G, Loewenthal K, King M

Citation: Social Science & Medicine, 01 August 2007, vol./is. 65/3(548-559), 02779536

Publication Date: 01 August 2007

Abstract: The transfer of psychiatric care from the institution to the community has presented community structures including faith-based organisations (FBOs) with an additional burden of care. In recent years there has been an increasing policy interest among government departments, public and non-statutory agencies for the inclusion of FBOs as partners in health and welfare services. However, despite their long historical involvement in healing and healthcare, clergy are seldom viewed by mental health professionals as partners in healing and restitution but with suspicion [Koenig, 1988. Handbook of Religion and Mental Health San Diego: Academic Press; Larson, Hohmann, & Kessler, 1988. The couch and the cloth: The need for linkage. Hospital and Community Psychiatry, 39, 1064-1069]. This may be compounded by ignorance about mental health care provision within FBOs in the UK and the preparedness, confidence and willingness to undertake such care. This paper is based on a study which examined clergy contact with people with mental illness. Thirty-two interviews were conducted with male clergy (Christian ministers, rabbis, and imams) most of whom were London-based. We examine barriers and dilemmas for clergy in caring for people with mental illness. We found that they play an important but often confined role the scale and impact of which is not recognised by their central organisation and training bodies. Low confidence about managing psychiatric problems, underscored by anxiety, fear and stereotyped attitudes to mental illness restrain their willingness to formalise their function. We argue that any proposed extension of clergy involvement in mental health will require further research and thorough deliberation by mental health services and religious organisations.

Source: CINAHL

33. Perspectives on spirituality at the end of life: a meta-summary

Author(s): Williams A.L.

Citation: Palliative & supportive care, December 2006, vol./is. 4/4(407-417), 1478-9515 (Dec 2006)

Publication Date: December 2006

Abstract: OBJECTIVE: A meta-summary of the qualitative literature on spiritual perspectives of adults who are at the end of life was undertaken to summarily analyze the
research to date and identify areas for future research on the relationship of spirituality with physical, functional, and psychosocial outcomes in the health care setting. METHODS: Included were all English language reports from 1966 to the present catalogued in PubMed, Medline, PsycInfo, and CINAHL, identifiable as qualitative investigations of the spiritual perspectives of adults at the end of life. The final sample includes 11 articles, collectively representing data from 217 adults. RESULTS: The preponderance of participants had a diagnosis of cancer; those with HIV/AIDS, cardiovascular disease, and ALS were also represented. Approximately half the studies were conducted in the United States; others were performed in Australia, Finland, Scotland, and Taiwan. Following a process of theme extraction and abstraction, thematic patterns emerged and effect sizes were calculated. A spectrum of spirituality at the end of life encompassing spiritual despair (alienation, loss of self, dissonance), spiritual work (forgiveness, self-exploration, search for balance), and spiritual well-being (connection, self-actualization, consonance) emerged. SIGNIFICANCE: The findings from this meta-summary confirm the fundamental importance of spirituality at the end of life and highlight the shifts in spiritual health that are possible when a terminally ill person is able to do the necessary spiritual work. Existing end-of-life frameworks neglect spiritual work and consequently may be deficient in guiding research. The area of spiritual work is fertile ground for further investigation, especially interventions aimed at improving spiritual health and general quality of life among the dying.

Source: EMBASE

35. What does being Jewish mean to you? The spiritual needs of Jewish people with learning disabilities and their families.

Author(s): Hersov EK

Citation: Journal of Religion, Disability & Health, 01 September 2006, vol./is. 10/3-4(183-205), 15228967

Publication Date: 01 September 2006

Abstract: This study explores the importance of spiritual, religious, and cultural life among a sample of Jewish people with learning disabilities and their families within Greater London. Emphasis was placed on generating practical ideas and recommendations for improving opportunities for spiritual life and development, plus religious and cultural inclusion. Findings were then reviewed with professionals from Jewish support organisations to better identify and discuss service gaps, needs, and next steps.

Source: CINAHL

36. The nature of hope in hospitalized chronically ill patients

Author(s): Kim D.S., Kim H.S., Schwartz-Barcott D., Zucker D.

Citation: International Journal of Nursing Studies, July 2006, vol./is. 43/5(547-556), 0020-7489 (July 2006)

Publication Date: July 2006

Abstract: Background: Hope as a universal human phenomenon has been studied from various perspectives often conceptualized as having a unified set of attributes. In this study however hope is viewed to be experienced by people in various patterns structured by different orientations and emphases depending upon their life circumstances. There is a paucity of studies in the literature examining patterns of hope experienced by people in chronic illness or in special life circumstances. Objectives: The aim of this study was to discover patterns of hope in hospitalized chronically ill patients and to identify the major threads that structure various patterns of hope experienced by them. Design: Q-methodology, which is an approach designed to discover patterns in various subjective experiences, was used as the method for data collection and theory generation. Q-methodology involves five steps in its approach, the first two as the first phase and the last three as the second phase. The study was carried out at a general acute-care, tertiary hospital in a New England state in the US. The study obtained data from a convenient sample of 12 chronically ill patients and 16 oncology nurses for the first phase, and a different convenient sample of 20 chronically ill patients for the second phase. Results and conclusions: Five patterns of subjective experiences of hope emerged as: (a) externalism orientation, (b) pragmatism orientation, (c) reality orientation, (d) future orientation, and (e) internalism orientation. This means that chronically ill patients experience hope in various
ways by focusing on different dimensions of meaning, suggesting the conceptualization of hope as a unitary construct may not reflect people's experiences of hope accurately. The major implication of the study is to rethink ways to assess patients' hope in terms of pattern differences rather than in terms of quantity.

Source: EMBASE


Author(s): King M, Weich S, Nazroo J, Blizard B

Citation: Journal of Mental Health, 01 April 2006, vol./is. 15/2(153-162), 09638237

Publication Date: 01 April 2006

Abstract: Background: Higher levels of religious involvement are modestly associated with better health, after taking account of other influences. However, most research takes little account of spiritual beliefs that are not tied to personal or public religious practice.

Source: CINAHL

Full Text: Available in fulltext at EBSCO Host

38. Is there a correlation between spirituality and anxiety and depression in patients with advanced cancer?

Author(s): McCoubrie RC, Davies AN

Citation: Supportive Care in Cancer, April 2006, vol./is. 14/4(379-85), 0941-4355;0941-4355 (2006 Apr)

Publication Date: April 2006

Abstract: AIMS AND OBJECTIVES: To establish whether there is a correlation between spirituality and anxiety and depression in patients with advanced cancer. PATIENTS AND METHODS: Patients with a diagnosis of cancer at St. Peter's day hospice in Bristol were asked to complete three questionnaires to assess anxiety, depression and spirituality. Informed consent was obtained. Anxiety and depression are indicated by the Hospital Anxiety and Depression Scale score, and spirituality is indicated by scores on the Spiritual Well-Being Scale (SWBS) and the Royal Free Interview for Spiritual and Religious Beliefs. As will be explained, religion and spirituality are generally recognised as having different meanings--religion entailing a relationship with a higher being, while spirituality can be thought of in terms of meaning and purpose in life. RESULTS: Eighty-five complete data sets were obtained. A significant negative correlation was found between both anxiety and depression scores and overall spiritual well-being scores (p < 0.0001). When the SWBS subscale scores were analysed individually, a significant negative correlation was found between the existential well-being scores and the anxiety and depression scores (p < 0.001). However, no correlation was found between the religious well-being scores and anxiety or depression. CONCLUSIONS: This study found a significant negative correlation between spirituality (in particular, the existential aspect) and anxiety and depression in patients with advanced cancer. Religious well-being and strength of belief had no impact on psychological well-being in this study.

Source: MEDLINE

39. Suicidal ideation among young people in the UK: Churchgoing as an inhibitory influence?

Author(s): Kay W.K., Francis L.J.

Citation: Mental Health, Religion and Culture, April 2006, vol./is. 9/2(127-140), 1367-4676 (Apr 2006)

Publication Date: April 2006

Abstract: After considering suicide from four theoretical perspectives - sociology, psychology, social-psychology and theology - a database of 33,135 young individuals (aged 13-15) in England and Wales was interrogated to discover whether churchgoing
provides protection against suicidal ideation. Following the Durkheimian notion that suicide is associated with social isolation and making use of the Eysenckian three-dimensional model of personality, analysis indicated a statistically significant protection offered by churchgoing. Further analysis concentrated on vulnerable pupils. In this instance, vulnerable pupils are those who have been bereaved by the loss of at least one parent. After taking personality variations into account, church attendance is shown to offer significant protection against suicide, while the protective effects of team sports are insignificant. 2006 Taylor & Francis.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host

40. **Spiritual assessment: developing an assessment tool.**

Author(s): Power J

Citation: Nursing Older People, 01 March 2006, vol./is. 18/2(16-18), 14720795

Publication Date: 01 March 2006

Abstract: Patients' 'spirituality' is widely considered to be a factor that nurses need to consider in their assessments. But Jeanette Power suggests ways in which assessments can be undertaken, and questions whether one assessment tool can prove adequate in measuring the significance of spirituality in the lives of individuals, all of whom may interpret its meaning differently?

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

41. **Website watch: spiritual care.**

Citation: Nursing Older People, 01 March 2006, vol./is. 18/2(35-35), 14720795

Publication Date: 01 March 2006

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

43. **Ask the experts: spirituality in care.**

Author(s): Grant F, Buswell J, Clegg A, Grout G, Minardi HA, Morgan A

Citation: Nursing Older People, 01 February 2006, vol./is. 18/1(14-15), 14720795

Publication Date: 01 February 2006

Abstract: Ask the experts is a forum in which nurse consultants working with older people debate an issue in older people's care and offer advice. This month they consider a question posed by Frances Grant.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host
44. Psychoanalysis and the Self: Toward a Spiritual Point of View

Author(s): Mack J.E.

Citation: Explore: The Journal of Science and Healing, January 2006, vol/is. 2/1(30-36), 1550-8307 (Jan 2006)

Publication Date: January 2006

Abstract: One of the focus areas of Explore is the role of spirituality in health. This concern was shared by John E. Mack, MD (1929-2004), Pulitzer Prize-winning biographer and professor of psychiatry at Harvard Medical School. Dr. Mack was awarded the Pulitzer Prize for his 1977 biography of T. E. Lawrence (“Lawrence of Arabia”), A Prince of Our Disorder. At the time of his death in 2004, he was speaking in England to the T. E. Lawrence Society Symposium. Returning from dinner, walking to the home at which he was staying in North London on the night of September 27, he was struck by a car driven by a drunken driver and died instantly. Dr. Mack's interest in the spiritual side of human experience has been compared with that of fellow Harvard alum William James, the “father of American psychiatry.” And, like James, he became a controversial figure for his attempts to bridge spirituality and psychiatry. In attempting to nudge his profession toward a greater appreciation of the role of spiritual factors in health, Dr. Mack had his work cut out for him. Surveys consistently show that psychiatrists are among the most reluctant groups of healthcare professionals to consider a role for spirituality in mental and physical health. Yet his efforts, and those of many others, are bearing fruit. Medicine is being respiritualized on many levels, including the field of mental health. Dr. Mack focused on sleep and dreams early in his career. He later became an expert on the psychological effects of the nuclear arms race and became a passionate advocate for nuclear disarmament. He was always concerned with the psychoanalysis of the misunderstood or vulnerable-suicide-prone teenagers, teens troubled by the prospect of nuclear holocaust, and, later in his career, individuals disturbed by what they considered to be alien encounters. Although he was a tenured professor at Harvard, this particular interest led to an official review of his research methods. Fourteen months later, the investigating committee reaffirmed Dr. Mack's academic freedom to study what he wished and to state his opinions without impediment. I knew Dr. Mack somewhat; our paths had crossed at conferences that explored themes related to consciousness and spirituality. He was cordial to the idea of nonlocal mind, about which I have written extensively. Prior to his death, he asked me to contribute a chapter to a book he was editing, which I did. The challenge to the contributors, John said, was to imagine what human experience would be like if we took nonlocal mind for real. The book project continues after his death and is nearing completion. The following paper by Dr. Mack is a template for a spiritual orientation in psychiatry, but it is much more than that. In it, Dr. Mack reveals his own majestic, spiritual worldview, his awareness of a global environmental crisis, and his sense of responsibility as a global citizen. "Explore" is derived from the Latin explorare, which means to search out, look into closely, examine carefully, and investigate, or to travel into an area previously little known to learn more about its natural features, inhabitants, and others. John E. Mack was an explorer of the first order. He was what some native peoples call a Big Man—the individual whose lofty dreams and visions should be heeded for the welfare of everyone else. Thus, we are honored to reprint this paper of his in Explore, and we are grateful to the John E. Mack Institute for permission to do so. Further information about Dr. Mack, and additional articles by him, are available at http://www.johnemackinstitute.org. -Larry Dossey, MD. Executive Editor, EXPLORE. Not very long ago I had a dream. So bright and glowing it startled me. Into a great glow of transcendental joy. The dream? Everything around me black as sin. I, walking toward some unknown goal,. My body virginal in youth and pure., Naked, rosy and quite beautiful. And from me emanated shining light.; While all about me I could dimly see. Small swarthy men with evil weaponry., Arms thrust out to mutilate and kill., Ready to slash through my integrity. But as they came within my numinosity. They melted into darkness and were gone. And I walked on, untroubled and serene. -Harriet Robey. aged 90, Freudian trained psychiatric social worker, "reared without belief in God." August, 1991. 2006 Elsevier Inc. All rights reserved.
45. **Ageing and Belief--Between Tradition and Change.**

**Author(s):** Coleman, Peter G, Mills, Marie A, Speck, Peter

**Citation:** The futures of old age., 2006(125-134) (2006)

**Publication Date:** 2006

**Abstract:** (from the chapter) The growing interest in the subject of spirituality and ageing is a welcome recognition both of older people's central role in the transmission of cultural and religious values and also of the need for a more holistic consideration of the quality of later life. In the following account we start first with an examination of the changing context in which ageing and belief need to be considered. We examine the evidence for the view that issues of belief become more salient with age, and the implications for future cohorts of older people of the major changes in religious socialization that they experienced in their youth. We then summarize the results of a study we have recently conducted asking for older people's own views on the support they receive for their spiritual explorations in later life, and examine the consequences of a greater plurality of belief among older people within UK and other European societies. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

**Source:** PsycINFO

46. **South Asians and epilepsy: Exploring health experiences, needs and beliefs of communities in the north of England**

**Author(s):** Ismail H., Wright J., Rhodes P., Small N., Jacoby A.

**Citation:** Seizure, October 2005, vol./is. 14/7(497-503), 1059-1311 (Oct 2005)

**Publication Date:** October 2005

**Abstract:** Purpose: To examine the beliefs and experiences of South Asians with epilepsy and the extent of provision of appropriate information and accessible services for them by health professionals. Methods: Qualitative interviews with 30 South Asians with epilepsy, 16 carers and 10 health professionals. In addition, two focus groups were held with 16 South Asians without epilepsy recruited from community centers. The interview sample was divided by religious groupings (Hindus, Sikhs and Muslims). Fieldwork was conducted in Bradford and Leeds (England). Results: Beliefs that epilepsy is caused by spirit possession (Muslims) or attributable to sins committed in a past life (Sikhs and Hindus) were reported as being widely held among South Asians living both in the UK and the Indian subcontinent, although few informants themselves subscribed to such views. Compliance with conventional medication was high; however, those who experienced seizures most often were most likely to turn to traditional South Asian therapies. Most informants used both treatments simultaneously. The main issues regarding the provision of services were: lack of appropriate information and advice; language and communication barriers; problems in interaction with health professionals. Also discussed were the potential merits of attending support groups. Greatest dissatisfaction was expressed in relation to primary care, whereas the highest praise was reserved for specialist epilepsy nurses. Conclusions: Our findings show both similarities and differences between participants' experiences, where gender, age or other aspects of personal biography can be as important as religion, culture or country of origin. Furthermore, the impact of being diagnosed with epilepsy can be exacerbated by structural impediments to accessing information and appropriate services. 2005 BEA Trading Ltd. Published by Elsevier Ltd. All rights reserved.

**Source:** EMBASE

47. **The relevance of spirituality, religion and personal beliefs to health-related quality of life: Themes from focus groups in Britain**

**Author(s):** O'Connell K.A., Skevington S.M.

**Citation:** British Journal of Health Psychology, September 2005, vol./is. 10/3(379-398),

**Full Text:** Available in print at Lincoln County Hospital Professional Library
**Publication Date:** September 2005

**Abstract:** Background. Generic health-related quality of life (QoL) instruments have not routinely assessed spirituality, religion, and personal beliefs (SRPB) in their measurement. This research addresses the perceived importance of 18 facets (dimensions) of SRPB, for example, inner peace, to QoL that are not specific to a religion, but address the experience of having this belief, in relation to health. Method. Adult focus groups were structured according to beliefs from UK surveys. Quotas targeted gender and health status. Nine focus groups (N = 55, age 51, 47% male) contained sick and well people who were religious, Christians, Buddhists, Quakers (50.1%), agnostic (27.4%), or atheist (21.8%) participants. Results. Qualitative and quantitative analysis showed considerable variability in the importance attributed to some concepts, although spiritual strength, meaning in life and inner peace were relevant to all groups. Spiritual strength (4.42), the meaning of life (4.09), wholeness/integration (4.06), and inner peace (4.02) were most important. Divine love, freedom to practice beliefs, and attachment/detachment were less relevant, conceptually confusing or had religious bias; atheists rated them as unimportant and as less important (p < .04) than agnostics or religious people. Conclusions. SRPB is relevant to health-related QoL and consensually important facets should be included in generic health care assessments. Their inclusion permits a more holistic assessment and improves the case for a biopsychosociospiritual model of health. 2005 The British Psychological Society.

**Source:** EMBASE

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48. **Hymns and arias: Musical hallucinations in older people in Wales**

**Author(s):** Warner N., Aziz V.

**Citation:** International Journal of Geriatric Psychiatry, July 2005, vol./is. 20/7(658-660), 0885-6230 (Jul 2005)

**Publication Date:** July 2005

**Abstract:** This is a phenomenological study of 30 consecutive referrals of older people with musical hallucinations concentrating on the names of the melodies heard. Hymns and Christmas carols were the most common experience with 'Abide with Me' particularly frequent. Copyright 2005 John Wiley & Sons, Ltd.

**Source:** EMBASE

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49. **Quality of life at end of life: spirituality and coping mechanisms in terminally ill patients.**

**Author(s):** Scobie G, Caddell C

**Citation:** Internet Journal of Pain, Symptom Control & Palliative Care, 01 July 2005, vol./is. 4/1(0-35), 15288277

**Publication Date:** 01 July 2005

**Abstract:** The principal research aim was to investigate whether spirituality played a role in the coping strategies of patients (N = 120) undergoing palliative care over a six month period within 2 specialised hospice units (Hospices A & B). Using an adapted version of the McGill Quality of Life Questionnaire (Cohen et al, 1995), the self-assessed scores of "Believing & Practising Church Members" (B), "Believers but Non-practising Church Members" (NBP) and "Non-Believers" (NB) were compared in an attempt to determine "Quality of Life" (QOL) differences between each hospice.

**Source:** CINAHL

**Full Text:**
Available in fulltext at EBSCO Host
50. Studies on older people.
Citation: Nursing Standard, 09 March 2005, vol./is. 19/26(28-28), 00296570
Publication Date: 09 March 2005
Abstract: Research on our ageing population is blossoming. One paper presents a trial of hip protectors, another the value of religious rituals for patients with dementia.
Source: CINAHL

51. Moving towards culturally competent dementia care: have we been barking up the wrong tree?
Author(s): Mackenzie J, Bartlett R, Downs M
Citation: Reviews in Clinical Gerontology, 01 February 2005, vol./is. 15/1(39-46), 09592598
Publication Date: 01 February 2005
Source: CINAHL

52. Religious beliefs about causes and treatment of epilepsy
Author(s): Ismail H., Wright J., Rhodes P., Small N.
Citation: British Journal of General Practice, January 2005, vol./is. 55/510(26-31), 0960-1643 (Jan 2005)
Publication Date: January 2005
Abstract: Background. It has been acknowledged that religious and complementary therapies are commonly used among South Asian communities in the UK. However, little is known about their religious beliefs in relation to epilepsy and the type of South Asian therapies that they use to treat the condition. Aim. To explore the influences of spiritual and religious beliefs on explanation of the cause of epilepsy, and the choice of treatment in people of South Asian origin who have epilepsy. Design of study. Qualitative study using interviews with patients, carers, health professionals, and focus groups of people from minority ethnic communities. Setting. Bradford and Leeds. Method. Semi-structured individual interviews with 20 Muslims, six Sikhs, and four Hindus with epilepsy; 16 nominated carers (family members, friends); 10 health professionals (specialist GPs, neurologists, specialists nurses, social workers, community GPs); and two focus groups with a total of 16 South Asians without epilepsy. Results. It was found that over half of responders attributed their illness to fate and the will of God, or as punishment for sins of a past life. Some patients had experienced prejudice from people who believed that their epilepsy was contagious. A strong network of traditional healers was found, providing a parallel system of health care in the UK and on the Indian subcontinent. People turned to religiospiritual treatments in desperation for a cure, often under the influence of their families after the perceived failure of Western medicine. Such treatments were viewed as complementary rather than as an alternative to Western medication. Younger people in particular expressed considerable scepticism about the effectiveness of these traditional South Asian treatments. Conclusions. In this study's South Asian sample, patients commonly turned to traditional healers in search of better health. Health professionals should be aware of the belief systems of these patients and understand the types of treatments in common use. Although these treatments might potentially compete with Western health care, they are used as an adjunct rather than a substitute. Patients have a 'healthy' scepticism about the effectiveness of such treatments, and adherence to medical
therapy does not appear to be affected. British Journal of General Practice 2005.

**Source:** EMBASE

**Full Text:**
Available in print at Pilgrim Hospital Staff Library

**Google Scholar**

*From the first 50 results…*

**Spiritual care and ageing in a secular society** 2007

Providing spiritual care is about tapping into the concept of spirituality: core meaning, deepest life meaning, hope and connectedness. The search for meaning, connectedness and hope becomes more significant as older people are faced with the possibilities of frailty, disability and dementia. Spirituality, ageing and meaning in life can be discussed in the context of an alternative view of "successful ageing". A model of spiritual tasks in older age can help explain the spiritual dimension and provide a starting point for spiritual assessment.

**Palliative care in motor neurone disease** Healthcare Republic, 2007

Spiritual matters, which are not necessarily to do with religion, should also be considered – the more open professionals are to discussing spiritual issues, the more willing patients are to talk about them.

Apart from anxieties about struggling for breath, patients…also have fears about death and dying, with particular emphasis on reconciling their spiritual needs.

Many patients and family members find that questions of spirituality arise as the illness progresses. It is important to integrate spiritual care with healthcare and to ensure that the rest of the team is aware of these matters for each patient.

Specialists in this field suggest that the more open we are to discussing spiritual matters, the more willing patients are to talk about them. Spirituality is not necessarily to do with religion,16 but it may be helpful for a chaplain or spiritual counsellor to contact the patient a few weeks after diagnosis, or a patient may ask for this nearer the end of their life.

**Spiritual care nursing: what cancer patients and family caregivers want**

EJ Taylor, I Mamier - Journal of advanced nursing, 2005 - interscience.wiley.com...


**Nursing competencies for spiritual care**

DR Baldacchino - Journal of Clinical nursing, 2006 - interscience.wiley.com...

... A All the qualified nurses (n = 215, females n = 160; males n = 55) aged between (21 ... be due to various factors, such as nurses’ lack of interest in spiritual care and the ... a higher response rate is expected from a quantitative questionnaire (Ross 1997, Baldacchino 2003, 2005). ...

**Assessing a patient's spiritual needs: a comprehensive instrument**

JK Galek, KJ Flannelly, A Vane, RM ... - Holistic Nursing ... 2005 - journals.lww.com...

... 68 HOLISTIC NURSING PRACTICE • MARCH/APRIL 2005 ... Spiritual care needs of hospitalized children and their families: a national survey of pastoral care providers' perceptions. ... Latinen P. Participation of informal caregivers in the hospital care of elderly patients and their ...
Spiritual care of families in the intensive care unit*

RJ Wall, RA Engelberg, CJ Gries, B Glavan, … - Critical care …. 2007 - journals.lww.com

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