

Spirituality and Religion in Oncology

John R. Peteet, MD¹; Michael J. Balboni, PhD, ThM, MDiv²

Despite the difficulty in clearly defining and measuring spirituality, a growing literature describes its importance in oncology and survivorship. Religious/spiritual beliefs influence patients' decision-making with respect to both complementary therapies and aggressive care at the end of life. Measures of spirituality and spiritual well-being correlate with quality of life in cancer patients, cancer survivors, and caregivers. Spiritual needs, reflective of existential concerns in several domains, are a source of significant distress, and care for these needs has been correlated with better psychological and spiritual adjustment as well as with less aggressive care at the end of life. Studies show that while clinicians such as nurses and physicians regard some spiritual care as an appropriate aspect of their role, patients report that they provide it infrequently. Many clinicians report that their religious/spiritual beliefs influence their practice, and practices such as mindfulness have been shown to enhance clinician self-care and equanimity. Challenges remain in the areas of conceptualizing and measuring spirituality, developing and implementing training for spiritual care, and coordinating and partnering with chaplains and religious communities. *CA Cancer J Clin.* 2013;63:280-289. © 2013 American Cancer Society.

Keywords: supportive care, psychological/behavioral oncology, complementary, alternative, and integrative medicine, religion/spirituality

Introduction

A 45-year-old mother with a new diagnosis of breast cancer found it difficult to pray and wondered if God was trying to punish her, or to teach her a lesson. After a year of treatment for ovarian cancer, a 60-year-old woman found that practicing mindfulness made her more appreciative of each day.

Spirituality remains difficult to precisely define and measure, but there is general agreement that it refers to a connection with a larger reality that gives one's life meaning, experienced through a religious tradition or, increasingly in secular Western culture, through meditation, nature, or art.¹ Some definitions emphasize differences between spirituality and religion,^{2,3} other definitions stress their overlapping dimensions,⁴ and still others favor the concept of religion over spirituality within health research because the latter is more difficult to reliably measure.⁵ Nevertheless, a growing literature explores the role of spirituality and religion in oncology. Given the inevitable overlap between religion and spirituality, and their importance as both resources and sources of distress for patients throughout the trajectory of cancer, we review here the place of religion/spirituality (R/S) in adjustment to cancer; the provision of spiritual care; and the role of spirituality in the experience of medical decision-makers, survivors, caregivers, and providers.

Adjustment to Cancer

Research has correlated measures of spirituality and of spiritual well-being with better quality of life (QOL) and/or psychosocial functioning in the context of prostate cancer,⁶⁻⁸ breast cancer,⁹⁻¹¹ oncology-related anxiety and depression,^{12,13} radiation therapy,¹⁴ and gynecologic cancer.^{15,16} In a study by Steinhäuser et al,¹⁷ patients viewed "being at peace with God" and "freedom from pain" as the most important characteristics of QOL in terminal illness. Similarly, religious coping has been associated with better patient psychological well-being and overall QOL among patients with advanced cancer.¹⁸ At least 11 studies of posttraumatic growth have shown links to R/S, most of them beneficial.¹⁹ Investigators have found positive religious coping, readiness to face existential questions, religious participation, and intrinsic religiousness to be typically associated with posttraumatic growth.

However, distress or struggle over spiritual concerns (eg, feeling abandoned by God) has been found to be prevalent among patients with advanced cancer.^{18,20-23} In a study of 100 patients with advanced cancer in an outpatient palliative care clinic in Texas, most of whom considered themselves both spiritual and religious, spiritual pain was both common and associated with lower self-perceived religiosity and QOL.²⁴ In a Boston-based study of 75 patients with advanced cancer, the majority (86%) endorsed at least one

¹Fellowship Director (Psychiatry), Adult Psychosocial Oncology Program, Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston, MA, and Associate Professor of Psychiatry, Harvard Medical School, Boston, MA; ²Instructor, Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston, MA

Corresponding author: John R. Peteet, MD, Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, 44 Binney St, Boston, MA 02115; jpeteet@partners.org

DISCLOSURES: The authors report no conflicts of interest.

© 2013 American Cancer Society, Inc. doi: 10.1002/caac.21187. Available online at cancerjournal.com

TABLE 1. Qualitatively Grounded Religious/Spiritual Themes in Patients' Experiences of Advanced Cancer

THEME	NO. (%)	REPRESENTATIVE QUOTE
Coping through religion/spirituality	39 (74)	<i>I don't know if I will survive this cancer, but without God it is hard to stay sane sometimes. For me, religion and spirituality keep me going.</i>
Religious/spiritual practices	31 (58)	<i>I pray a lot. It helps. You find yourself praying an awful lot. Not for myself, but for those you leave behind. There will be a lot more praying.</i>
Religious/spiritual beliefs	28 (53)	<i>It is God's will, not my will. My job is to do what I can to stay healthy—eat right, think positively, get to appointments on time, and also to do what I can to become healthy again, like make sure that I have the best doctors to take care of me. After this, it is up to God.</i>
Religious/spiritual transformation	20 (38)	<i>Since I have an incurable disease that will shorten my life, it has made me focus on issues of mortality and sharpened my curiosity on religion/spirituality and what the various traditions have to say about that. I've spent a lot of time thinking about those issues, and it has enriched my psychological, intellectual, and spiritual experience of this time.</i>
Religious/spiritual community	11 (21)	<i>Well, I depend a lot upon my faith community for support. It's proven incredibly helpful for me.</i>

Adapted from Alcorn SR, Balboni MJ, Prigerson HG, et al. "If God wanted me yesterday, I wouldn't be here today": religious and spiritual themes in patients' experiences of advanced cancer. *J Palliat Med.* 2010;13:581-588.²¹

spiritual concern, with a median of 4 concerns noted per patient. Younger age was associated with a greater burden of spiritual concerns, and increased spiritual concerns were associated with worse psychological QOL.¹⁸ A longitudinal study of women with breast cancer²⁵ suggested that women who are less spiritually/religiously involved prior to the onset of breast cancer and who attempt to mobilize these resources under the stress of diagnosis may experience a process of spiritual struggle and doubt that can influence their long-term adjustment. In an effort to identify patterns of differences, Kristeller et al²⁶ distinguished 4 clusters within a study of 114 cancer patients: those with high R/S (45%), who showed the lowest levels of depression; those with low R/high S (25%), who also demonstrated good adjustment; negative religious copers (14%), who were found to have the highest levels of depression; and those with low R/S, who demonstrated the poorest adjustment to cancer.

Qualitative studies of oncology patients concerning the role of R/S in their illness^{9,21,27-29} have identified a number of recurring themes. The study by Alcorn et al²¹ of 68 randomly selected US patients with advanced cancer found 5 primary themes: coping, practices, beliefs, transformation, and community (Table 1).

Of note, approximately 78% of the patients interviewed said that R/S had been important to the cancer experience. Most interviews (75%) contained 2 or more R/S themes, with 45% mentioning 3 or more R/S themes. Furthermore, most participants (85%) identified one or more R/S concerns spanning the 5 R/S themes. Younger, more religious, and more spiritual patients identified R/S concerns more frequently.

By comparison with these findings in Western patient populations, in a Taiwanese sample of 33 patients with advanced cancer, Hsiao et al³⁰ found that less individualistic themes of hope, peacefulness, meaning, dignity, and harmony predominated. Similarly, interviews with 15

terminally ill Taiwanese patients found that they emphasized serenity in "letting go," self-reflection about responsibilities, and connectedness with others.³¹

Spiritual needs, defined to include both distressing spiritual struggles and spiritual seeking (eg, seeking forgiveness, thinking about what gives meaning to life), were found in 86% of patients with advanced cancer studied by Winkelman et al,¹⁸ and in 91% of patients with advanced cancer studied by Pearce et al.³² Unmet spiritual needs, including negative religious coping (eg, anger at God),¹³ have been associated with lower QOL^{18,33,34} and psychological adjustment.³²

Spiritual Care

A majority of patients who have been asked the question say that they consider attention to spiritual concerns to be an important part of cancer care by physicians and nurses.^{34,35} Defining spiritual care as support for specific spiritual needs, Pearce et al³² found that 150 patients with advanced cancer surveyed during their inpatient stay at a southeastern US medical center both desired and received spiritual care from their health care providers (67% and 68%, respectively), religious community (78% and 73%, respectively), and hospital chaplain (45% and 36%, respectively), but that a significant subset received less spiritual care than desired from their health care providers (17%), religious community (11%), and chaplain (40%). Patients who received less spiritual care than desired reported more depressive symptoms and less meaning and peace. By comparison, 47% of patients with advanced cancer in a multicenter US study reported that their spiritual needs were being minimally or not met by their religious community, and 72% reported that their spiritual needs were being minimally or not met by the medical system.³⁶

This is similar to the finding that 50% of patients in an inpatient palliative care center in Korea³⁴ said their spiritual needs were not addressed, but at odds with the only 18% of patients studied at St. Vincent's Hospital in New York City who reported that their spiritual needs were not being met.³³

Spiritual care as measured by patients' reports that the health care team supported their R/S needs has been correlated with better satisfaction with care,³² QOL,³⁶ psychological and spiritual adjustment,³² and less aggressive care at the end of life (EOL),³⁷ as well as with attendant lower EOL costs, particularly among racial/ethnic minorities and high religious coping patients.³⁸ By comparison, the same group found that R/S support from religious communities predicted more aggressive care at the EOL, suggesting that collaboration with and education of religious communities may be strategies to help reduce aggressive care at the EOL.³⁹ It is interesting to note that a cross-sectional survey of 3585 hospitals found significantly lower rates of hospital deaths and higher rates of hospice enrollment in those that provided chaplaincy services.⁴⁰

Attending to the spiritual needs of patients has begun to be formally recognized by professional spiritual care providers, health care councils, and regulatory agencies such as the Joint Commission,⁴¹ the National Consensus Project Guidelines for Quality Palliative Care,⁴² palliative care clinicians,² and health care delivery systems over the past 30 years. However, research on spiritual care⁴³ and chaplaincy care⁴⁴ is in its infancy, as chaplains, humanities scholars, and empirical researchers have yet to generate widely accepted research-based definitions of spirituality, spiritual care, and chaplaincy practice that could be used in studies of outcome and efficacy.⁴⁴ Existing research into the core elements of oncology spiritual care programs has shown that organizational and institutional issues are significant, often underrecognized factors in the success of such programs. Sinclair et al⁴⁵ found that spiritual care programs that were centrally located within the cancer center, reported and provided guidance to senior leaders, reflected a multifaith approach, and had an academic role were better resourced, used more frequently, and viewed as integral members of an interdisciplinary care team.

An expanding literature describes the use of specific spiritual interventions in oncology, of which the best studied are mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive behavior therapy.⁴⁶⁻⁴⁸ Two critical reviews,^{49,50} which included 3 randomized controlled clinical trials (RCTs), found consistent evidence that MBSR approaches improve psychological functioning and well-being. In a Cochrane review⁵¹ of 5 RCTs (n = 1130 participants) of spiritual and religious interventions for well-being in the terminal phase of illness, 2 evaluated meditation and the others evaluated multi-disciplinary palliative care interventions that involved a

chaplain or spiritual counselor as a member of the intervention team. The authors found inconclusive evidence of benefit on methodological grounds, and recommended more rigorous research.

RCTs have shown efficacy of meaning-centered therapy for less seriously ill oncology patients. Breitbart et al⁵² piloted a group intervention based on Victor Frankl's logotherapy and Lee et al⁵³ showed improvements in self-esteem, self-efficacy, and optimism compared with controls using 4 individual sessions designed to address existential issues by exploring meaning-making coping strategies. In a study of 441 terminally ill patients randomized to dignity-conserving therapy, standard palliative care, or client-centered care, Chochinov et al⁵⁴ found that dignity therapy significantly improved measures of spiritual well-being, and was met with greater satisfaction than standard palliative care.

Recognizing the broad relevance of existential concerns in oncology, physicians and nurses interested in providing spiritual care can begin by assessing the spiritual dimension of their patients' responses to questions that address these in the domains of identity/worth ("What is my place in the world?"), hope ("What can I hope for?"), meaning/purpose ("What is most important in life?"), and relatedness ("Who can I count on?").⁵⁵

Identity/Worth

Cancer frequently threatens roles that have defined one's sense of self, such as work or parenting.⁵⁶ When the illness or its treatment undermines control over a person's body, mind, or routine, it further presses the questions of who one is, and what she is worth.

Religious believers can sometimes remind themselves that they were created by and are still loved by God. At other times, they may feel that they have let God down, and need help to look at what they believe He expects. Secularists often reaffirm a sense of worth by recalling the kinds of people they have always been, and the ways that their families and friends continue to love them even when they are dependent. Both believers and secularists may find spiritual practices (eg, meditation or listening to music) helpful in consolidating their sense of themselves in relation to what is most important.

Hope

Cancer is most frightening when it endangers hope. Not only does a diagnosis of cancer force the question of what is a realistic object of hope (eg, cure, more time, quality of life, or a good death), but it also raises the questions of what are one's deepest hopes and ultimate basis for hope. Patients wonder: Can I trust God to be there for me in this life and the next?

Will my legacy in my life work or the lives of my children survive me? Helping individuals explore such questions is a central part of spiritual care.⁵⁷

Meaning/Purpose

Cancer raises questions not only about what one can expect in the future, but also about how to live in the present. What matters given the time available? Are my old priorities still valid? Exploring these questions sometimes gives rise to a disturbing crisis of meaning but if one can see a reason for living each day can seem precious. With enough energy, one can then more fully engage pursuits because he or she has actively chosen them. Talking with other individuals who have struggled with these questions can help the new cancer patient move from crisis to commitment.⁵²

Connectedness

Another fundamental question raised by cancer is: “Who is there for me?” Patients not only wonder whether family and friends will pick up new responsibilities for their care, but “How does this change our relationship?” and “Will anyone be able to understand, and stay the course with me?” Religious patients with cancer may feel abandoned by God or struggle to recover a sense of His presence; they may also feel more sustained by Him than by any human being. Prayer, worship, or sacraments can become very important to them. Nonreligious individuals often value sharing their ultimate concerns with another human being. Personal support provided by cards, telephone calls, or offers of help either from one’s religious community or from one’s neighborhood can be powerfully moving for those who find themselves disconnected and alone. Hospital chaplains, who typically provide care to unbelievers as well as to believers, are experienced in addressing obstacles to reconnection to one’s faith. Examples include ambivalence toward one’s religious upbringing, previous churches, or clergy; anger at God for allowing illness; guilt over being divorced; or pressure from a family member to convert.⁵⁸

Clinicians may find acronyms useful in recalling the relevance of the basic elements of a spiritual history (Table 2),^{59,60} but creative attempts are also emerging to develop and test practical ways for clinicians to provide spiritual assistance within the medical setting. For example, in a study of 118 of their patients, 4 hematology-oncologists found that using a brief (5-7 minutes), oncologist-assisted, semistructured exploration of R/S concerns was comfortable for them 85% of the time and that 76% of patients believed the intervention was “somewhat” to “very” useful. At 3 weeks, the intervention group showed greater reductions in depressive symptoms, improvement in QOL, and an improved sense of interpersonal caring from

TABLE 2. Spiritual History Tools

These acronyms remind clinicians of basic historical information that is useful in caring for oncology patients.
FICA
F: Faith and beliefs
I: Importance of spirituality in the patient’s life
C: Spiritual Community of support
A: How does the patient wish spiritual issues to be Addressed in his or her care
SPIRIT
S: Spiritual belief system
P: Personal spirituality
I: Integration with a spiritual community
R: Ritualized practices and restrictions
I: Implications for medical care
T: Terminal events planning

FICA adapted from Puchalski CM. Spirituality and end-of-life care: a time for listening and caring. *J Palliat Med.* 2002;5:289-294.⁵⁹ SPIRIT adapted from Muga TA. The SPIRITual history. *Arch Fam Med.* 1996;5:11-16.⁶⁰

their physician.⁶¹ McCauley et al⁶² assigned a 28-minute video and workbook encouraging spiritual coping to 100 chronically ill patients. Energy improved in the intervention group, and while improvements in pain, mood, health perceptions, illness intrusiveness, and self-efficacy were not statistically significant, the exercise was inoffensive to patients and required no additional clinician time.

Nonetheless, few empirical data are available on the nature of spiritual care being provided by oncology physicians and nurses,³⁷ or on the use of interventions such as patient-practitioner prayer in the setting of cancer. There are several helpful case illustrations describing how clinicians may engage patient R/S.⁶³⁻⁶⁷ Case examples in the literature have limitations, however, because practice suggestions by medical professionals have tended to be anecdotal rather than empirically grounded. For example, several clinical commentaries caution against a practice of patient-practitioner prayer based on ethical concerns.^{63,68,69} Nevertheless, in a cross-sectional, multisite, mixed-methods study of patients with advanced cancer (n = 70), oncology physicians (n = 206), and oncology nurses, Balboni et al³⁸ found that most cancer patients (71%), nurses (83%), and physicians (65%) believed that patient-initiated patient-practitioner prayer was at least occasionally appropriate, and most patients viewed prayer as spiritually supportive. The study concluded that the appropriateness of patient-specific prayer is case-specific, and requires consideration of multiple factors including a preexisting relationship, knowledge of patient openness toward R/S, and R/S concordance in the

patient-practitioner relationship. Similarly, a 2009 consensus conference focused on spiritual care within palliative care has emphasized the central role of hospital chaplains within the spiritual care of patients receiving palliative care.² The consensus conference highlighted the importance of medical professionals screening for patient spiritual issues/needs and then providing a referral to hospital chaplaincy who hold expert training in spiritual care provision. This is a common-sense, interdisciplinary⁷⁰ approach that removes some of the burden from medical professionals and upholds the underrecognized⁷¹ but key support that chaplains provide within an oncology context. However, some notable tensions associated with this model include the insufficient number of chaplains available to support patients' spiritual needs, the provision of cancer care in the outpatient setting, and the inappropriateness of chaplains providing medical advice when it is directly influenced by patients' R/S.^{37,72,73} Consequently, clinicians are in need of training in how to perform a spiritual screening and how to substantively navigate patients' spiritual issues, especially as they pertain to medical decision-making. Yet few nurses and physicians report having received spiritual care training,^{39,74} and currently there is no rigorously designed, widely disseminated conceptual model of spiritual care available for the spiritual care training of medical professionals.

Spirituality in the Experience of Medical Decision-Makers, Survivors, Caregivers, and Providers

Religion and spirituality can also influence the medical decisions of patients with cancer. In a study of 100 patients with lung cancer,⁷⁵ patients and their caregivers cited religious faith as the second most important factor influencing treatment decisions, after oncologist recommendations.

Spirituality in patients with cancer has been associated with a greater use of complementary and alternative approaches,⁷⁶ but very or moderately religious cancer survivors were less likely to use non-R/S complementary and alternative medicine, while very or moderately spiritual survivors were more likely to do so.⁷⁷ Daugherty et al⁷⁸ found that patients with advanced disease who had higher levels of spirituality more often participated in phase 1 trials, suggesting a willingness to trust both God and medicine. In an interview study of 346 patients with advanced cancer enrolled in a US multisite, prospective, longitudinal study assessing psychosocial and R/S measures, advance care planning, and EOL treatment preferences, a high level of positive religious coping at baseline predicted a greater use of mechanical ventilation, which is consistent with earlier observations that religiousness is associated with a preference for aggressive EOL care.⁷³ As with the observation noted

above that spiritual care from R/S communities is associated with more aggressive care at the EOL,³⁹ the mechanisms responsible require further study.

Spirituality is an important component in the QOL of many survivors of cancer,⁷⁹⁻⁸¹ particularly as their physical concerns recede. Measures of existential concerns (eg, experiential struggles) appear to be more relevant than those of religious activity (eg, attendance at services).^{82,83} Interviews with survivors highlight several themes, such as enhancement of peace and meaning^{80,84} and personal growth.^{47,85} Factors mediating these themes in different individuals may include restoration of a belief in a just world⁸⁶ and socio-demographic^{87,88} and psychological variables,⁸¹ emphasizing the need for an individualized, psychologically and spiritually integrated approach to survivorship.

R/S and life philosophy have been found to play a diverse but important role in the lives of most, but not all, family members of patients with ovarian,⁸⁹ pediatric,^{90,91} and prostate cancers.⁹² In a large-scale survey study of former palliative caregivers, 4.7% identified that additional spiritual support would have been helpful to them; these individuals were also more likely to say that a number of other additional supports would have been helpful, suggesting the importance of stress and its timing.⁹³ Similarly, spirituality plays an important role in some, but not all, bereaved individuals.⁹⁴⁻⁹⁶ Since bereavement is a life crisis that challenges one's assumptions about human existence and provides the grounds for spiritual change,^{97,98} it is not surprising that spiritual beliefs and practices can influence the process of grieving, reassessing one's identity, reengaging life,⁹⁹ and struggling religiously, for example with anger toward God, which has been associated with poorer adjustment to cancer and bereavement.¹⁰⁰ Meert et al⁹⁰ point out that health care providers can help parents of pediatric patients deal with their spiritual needs by providing a safe environment, opportunities to stay connected with their child at the time of death, and ways to remember their child in the future. Studies have also shown MBSR to be helpful to the caregivers of patients with cancer.^{101,102}

A national survey by Curlin et al¹⁰³ found that physicians were as religious as the general US population. However, some disciplines including psychiatry^{104,105} were less religious, and there was regional variation (eg, Northeast vs South). In a Boston-based survey, oncologists were significantly more likely to describe themselves as neither spiritual nor religious more often than oncology nurses and terminally ill patients.¹⁰⁶ A national study¹⁰⁷ found that 85% of pediatric oncology faculty described themselves as spiritual and that 60% of gynecologic oncologists surveyed "agreed" or "somewhat agreed" that R/S beliefs were a source of personal comfort. Approximately 45% of respondents in this survey reported that their R/S beliefs "sometimes," "frequently," or "always"

play a role in the medical options they offer patients, but only 34% indicated that they “frequently” or “always” take a R/S history from patients.

As noted above, several studies have suggested that most patients want their health care providers to address their R/S concerns.^{108,109} In a survey of 75 patients and 339 cancer physicians and nurses, Phelps et al¹⁰⁹ found that the majority of patients (77.9%), physicians (71.6%), and nurses (85.1%) believed that routine spiritual care would have a positive impact on patients, but that only 25% of patients had previously received spiritual care. Objections to spiritual care are frequently related to professional role conflicts. Others have found that discussion of R/S issues is a communication skill that trainees consider to be more advanced than other commonly taught communication skills.¹¹⁰ In an effort to address both of these obstacles, Todres et al¹¹¹ described an innovative, intensive, clinical pastoral experience for clinicians; graduates reported an improved awareness of spiritual distress in others and themselves, as well as new language for, and more meaningful ways of relating to, patients and families. The importance of spiritual care training for oncology professionals is highlighted in a study that found the strongest predictor of spiritual care provision by nurses and physicians was the reception of spiritual care training.³⁵ However, most oncology nurses and physicians have not received prior spiritual care training (88% and 86%, respectively; $P = .83$). Table 3 contains Web-based and print resources for those interested in learning more about such training.

Spirituality is integral to the ways that many clinicians care for themselves in order to avoid compassion fatigue and burnout.¹¹²⁻¹¹⁵ In one study, oncology clinicians who identified themselves as religious were reported to have a lower rate of burnout.¹¹⁶ Another study of 230 physicians showed an inverse correlation between spirituality and burnout.¹¹⁷

Finally, interest continues to grow in the use of mindfulness meditation by clinicians to enhance self-awareness and equanimity.^{113,118} Trials of 8 weeks of MBSR in health care professionals demonstrated significant improvements in stress reduction, quality of life, empathy, and compassion for the self.¹¹⁹⁻¹²²

Remaining Challenges

Challenging questions remain for those interested in addressing the spiritual aspects of oncology care. Perhaps the most basic is how to define spirituality in a way that allows for measurement (by researchers, clinicians, and administrators) but takes into account its complexity.¹²³ Despite a proliferation of spiritual assessment tools¹²⁴⁻¹³⁰ and suggested conceptual frameworks,^{2,131-133} no consensus yet exists on how to adequately take into account

TABLE 3. Selected Resources

WEB-BASED RESOURCES
The Association for Clinical Pastoral Education (acpe.edu and acperesearch.net/)
George Washington Institute for Spirituality and Health (gwish.org)
The Healthcare Chaplaincy (healthcarechaplaincy.org)
The Program on Medicine and Religion at the University of Chicago (pmr.uchicago.edu)
Duke Center for Spirituality, Theology and Health (spiritualityandhealth.duke.edu)
Institute for Spirituality and Health at the Texas Medical Center (ish-tmc.org)
Center for Spirituality and Healing at the University of Minnesota (csh.umn.edu)
The Tanenbaum Center for Interreligious Understanding (tanenbaum.org)
NOTABLE BOOKS ON SPIRITUALITY, RELIGION, AND MEDICINE
Amundsen DW. <i>Medicine, Society, and Faith in the Ancient and Medieval Worlds</i> . Baltimore, MD: Johns Hopkins University Press; 1996.
Cadge W. <i>Paging God: Religion in the Halls of Medicine</i> . Chicago IL: University of Chicago Press; 2012.
Carson VB, Koenig HG. <i>Spiritual Dimensions of Nursing Practice</i> . Rev ed. West Conshohocken, PA: Templeton Foundation Press; 2008.
Cobb M, Puchalski C, Rumbold B, eds. <i>Oxford Textbook on Spirituality in Healthcare</i> . New York: Oxford University Press; 2012.
Halifax J. <i>Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death</i> . Boston: Shambhala; 2008.
Koenig HG. <i>Spirituality & Health Research: Methods, Measurement, Statistics, and Resources</i> . West Conshohocken, PA: Templeton Press; 2011.
Koenig HG. <i>Spirituality in Patient Care: Why, How, When, and What</i> . Rev Expanded 2nd ed. Philadelphia: Templeton Foundation Press; 2007.
Peteet JR, D’Ambra MN. <i>The Soul of Medicine: Spiritual Perspectives and Clinical Practice</i> . Baltimore, MD: Johns Hopkins University Press; 2011.
Peteet JR. <i>Depression and the Soul: A Guide to Spiritually Integrated Treatment</i> . New York: Brunner-Routledge; 2010.
Puchalski CM. <i>A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying</i> . New York: Oxford University Press; 2006.
Puchalski CM, Ferrell B. <i>Making Health Care Whole: Integrating Spirituality into Health Care</i> . West Conshohocken, PA: Templeton Press; 2010.
Sulmasy DP. <i>The Rebirth of the Clinic: An Introduction to Spirituality in Health Care</i> . Washington, DC: Georgetown University Press; 2006.
Sloan RP. <i>Blind Faith: The Unholy Alliance of Religion and Medicine</i> . 1st ed. New York: St. Martin’s Press; 2006.

religious (supernatural) and existential (universal human) dimensions,¹³⁴ the distinction between spirituality itself and spiritual outcomes (distress or well-being), the relationship between spiritual and emotional experience (eg, as in the frequent coexistence of depression and spiritual struggle), and the heterogeneity of religious beliefs and practices across cultures. Studies cited here of Eastern populations point to meaningful differences between these and Western cohorts studied; little information is available from Africa. Religious diversity is particularly relevant at the EOL: while Buddhists want the opportunity to chant

or hear others chanting, Hindus have a strong preference for dying at home and Muslims for dying facing Mecca, surrounded by loved ones.⁶⁸ Another challenge is how to engage with forms of spirituality, such as indigenous ways of understanding cancer as a curse or the result of witchcraft,¹³⁵ or beliefs in miracles that encourage aggressive care at the EOL.^{65,78} Finding answers will depend on collaboration between religious and medical communities.

Yet another question is how to most effectively organize the delivery of spiritual care. Should clinicians focus on screening and referring patients with spiritual distress to chaplains, as the spiritual care experts on the medical team?² Can chaplains serve as specialized resources for clinicians, for example when a patient's and a clinician's traditions are discordant? How does this approach allow clinicians to respond to patients who want them to address their spiritual concerns? What kind of preparation is needed to help clinicians in dealing with their concerns about assuming this role? How much does this training need to address professional boundaries, individual

competencies, institutional priorities, and in turn beliefs about the place of spirituality within a culture of scientific medicine?

Finally, the growing emphasis on the therapeutic potential of interventions such as mindfulness meditation and prayer raises the question of how appropriate it is to divorce them from the spiritual traditions from which they come. Are patients at risk of becoming confused about whether their potential benefits are psychological, medical, or spiritual?¹³⁶ How important is it for them to receive tradition-specific spiritual care?

Conclusions

Spirituality is central to the experience of many patients with cancer and their families, and most indicate a desire for help with their spiritual needs. While challenges persist, creative models for helping oncology providers learn how to address the spiritual dimension of their work have begun to emerge. ■

References

1. Van Ness PH. *Spirituality and the Secular Quest*. New York: Crossroad; 1996.
2. Puchalski C, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *J Palliat Med*. 2009;12:885-904.
3. Puchalski CM, Lunsford B, Harris MH, Miller RT. Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model. *Cancer J*. 2006;12:398-416.
4. Pargament KI. *APA Handbook of Psychology, Religion, and Spirituality*. Washington, DC: American Psychological Association; 2013.
5. Koenig HG. *Medicine, Religion, and Health: Where Science and Spirituality Meet*. West Conshohocken, PA: Templeton Foundation Press; 2008.
6. Brady MJ, Peterman AH, Fitchett G, Mo M, Cella D. A case for including spirituality in quality of life measurement in oncology. *Psychooncology*. 1999;8:417-428.
7. Krupski TL, Kwan L, Fink A, Sonn GA, Maliski S, Litwin MS. Spirituality influences health related quality of life in men with prostate cancer. *Psychooncology*. 2006;15:121-131.
8. Zavala MW, Maliski SL, Kwan L, Fink A, Litwin MS. Spirituality and quality of life in low-income men with metastatic prostate cancer. *Psychooncology*. 2009;18:753-761.
9. Choumanova I, Wanat S, Barrett R, Koopman C. Religion and spirituality in coping with breast cancer: perspectives of Chilean women. *Breast J*. 2006;12:349-352.
10. Samuelson BT, Fromme EK, Thomas CR Jr. Changes in spirituality and quality of life in patients undergoing radiation therapy. *Am J Hosp Palliat Care*. 2012;29:449-454.
11. Yanez B, Edmondson D, Stanton AL, et al. Facets of spirituality as predictors of adjustment to cancer: relative contributions of having faith and finding meaning. *J Consult Clin Psychol*. 2009;77:730-741.
12. Johnson KS, Tulsy JA, Hays JC, et al. Which domains of spirituality are associated with anxiety and depression in patients with advanced illness? *J Gen Intern Med*. 2011;26:751-758.
13. Tarakeshwar N, Vanderwerker LC, Paulk E, Pearce MJ, Kasl SV, Prigerson HG. Religious coping is associated with the quality of life of patients with advanced cancer. *J Palliat Med*. 2006;9:646-657.
14. Vallurupalli M, Lauderdale K, Balboni MJ, et al. The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *J Support Oncol*. 2012;10:81-87.
15. Wenzel LB, Donnelly JP, Fowler JM, et al. Resilience, reflection, and residual stress in ovarian cancer survivorship: a gynecologic oncology group study. *Psychooncology*. 2002;11:142-153.
16. Boscaglia N, Clarke DM, Jobling TW, Quinn MA. The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer. *Int J Gynecol Cancer*. 2005;15:755-761.
17. Steinhauer KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsy JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*. 2000;284:2476-2482.
18. Winkelmann WD, Lauderdale K, Balboni MJ, et al. The relationship of spiritual concerns to the quality of life of advanced cancer patients: preliminary findings. *J Palliat Med*. 2011;14:1022-1028.
19. Shaw A, Joseph S, Linley P. Religion, spirituality, and posttraumatic growth: a systematic review. *Mental Health, Religion & Culture*. 2005;8:1-11.
20. Hui D, de la Cruz M, Thorney S, Parsons HA, Delgado-Guay M, Bruera E. The frequency and correlates of spiritual distress among patients with advanced cancer admitted to an acute palliative care unit. *Am J Hosp Palliat Care*. 2011;28:264-270.
21. Alcorn SR, Balboni MJ, Prigerson HG, et al. "If God wanted me yesterday, I wouldn't be here today": religious and spiritual themes in patients' experiences of advanced cancer. *J Palliat Med*. 2010;13:581-588.
22. Sharma RK, Astrow AB, Texeira K, Sulmasy DP. The Spiritual Needs Assessment for Patients (SNAP): development and validation of a comprehensive instrument to assess unmet spiritual needs. *J Pain Symptom Manage*. 2012;44:44-51.
23. Moadel A, Morgan C, Fatone A, et al. Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. *Psychooncology*. 1999;8:378-385.
24. Delgado-Guay MO, Hui D, Parsons HA, et al. Spirituality, religiosity, and spiritual pain in advanced cancer patients. *J Pain Symptom Manage*. 2011;41:986-994.
25. Gall TL, Kristjansson E, Charbonneau C, Florack P. A longitudinal study on the role of spirituality in response to the diagnosis and treatment of breast cancer. *J Behav Med*. 2009;32:174-186.
26. Kristeller JL, Sheets V, Johnson T, Frank B. Understanding religious and spiritual influences on adjustment to cancer: individual patterns and differences. *J Behav Med*. 2011;34:550-561.
27. Gall TL, Cornblat MW. Breast cancer survivors give voice: a qualitative analysis of spiritual factors in long-term adjustment. *Psychooncology*. 2002;11:524-535.
28. Walton J, Sullivan N. Men of prayer: spirituality of men with prostate cancer: a

- grounded theory study. *J Holist Nurs.* 2004;22:133-151.
29. Ahmad F, Muhammad Mb, Abdullah AA. Religion and spirituality in coping with advanced breast cancer: perspectives from Malaysian Muslim women. *J Relig Health.* 2011;50:36-45.
 30. Hsiao SM, Gau ML, Ingleton C, Ryan T, Shih FJ. An exploration of spiritual needs of Taiwanese patients with advanced cancer during the therapeutic processes. *J Clin Nurs.* 2011;20:950-959.
 31. Mok E, Wong F, Wong D. The meaning of spirituality and spiritual care among the Hong Kong Chinese terminally ill. *J Adv Nurs.* 2010;66:360-370.
 32. Pearce MJ, Coan AD, Herndon JE 2nd, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. *Support Care Cancer.* 2012;20:2269-2276.
 33. Astrow AB, Wexler A, Teixeira K, He MK, Mulsasy DP. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? *J Clin Oncol.* 2007;25:5753-5757.
 34. Kang J, Shin DW, Choi JY, et al. Addressing the religious and spiritual needs of dying patients by healthcare staff in Korea: patient perspectives in a multi-religious Asian country. *Psychooncology.* 2012;21:374-381.
 35. Balboni MJ, Sullivan A, Amobi A, et al. Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. *J Clin Oncol.* 2013;31:461-467.
 36. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *J Clin Oncol.* 2007;25:555-560.
 37. Balboni TA, Paulk ME, Balboni MJ, et al. Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. *J Clin Oncol.* 2010;28:445-452.
 38. Balboni T, Balboni M, Paulk ME, et al. Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. *Cancer.* 2011;117:5383-5391.
 39. Balboni TA BM, Phelps AC, Gallivan K, et al. Provision of spiritual support to advanced cancer patients by religious communities and associations with medical care at the end of life. *JAMA.* In press.
 40. Flannelly KJ, Emanuel LL, Handzo GF, Galek K, Silton NR, Carlson M. A national study of chaplaincy services and end-of-life outcomes. *BMC Palliat Care.* 2012;11:10.
 41. The Joint Commission. Spirituality, Religion, Beliefs, and Cultural Diversity in JCAHO's Standards/Elements of Performance: Changes between the 2008 and 2009 Certification & Accreditation Manual for Hospitals. E-dition, 2011:PC. 02.02.13.
 42. National Consensus Project Clinical Practice Guidelines for Quality Palliative Care. 3rd ed. Pittsburgh, PA: National Consensus Project; 2013. nationalconsensusproject.org/guideline.pdf. Accessed March 30, 2013.
 43. Edwards A, Pang N, Shiu V, Chan C. The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research. *Palliat Med.* 2010;24:753-770.
 44. Jankowski KR, Handzo GF, Flannelly KJ. Testing the efficacy of chaplaincy care. *J Health Care Chaplain.* 2011;17:100-125.
 45. Sinclair S, Mysak M, Hagen NA. What are the core elements of oncology spiritual care programs? *Palliat Support Care.* 2009;7:415-422.
 46. Garland SN, Carlson LE, Cook S, Lansdell L, Specia M. A non-randomized comparison of mindfulness-based stress reduction and healing arts programs for facilitating post-traumatic growth and spirituality in cancer outpatients. *Support Care Cancer.* 2007;15:949-961.
 47. Foley KL, Farmer DF, Petronis VM, et al. A qualitative exploration of the cancer experience among long-term survivors: comparisons by cancer type, ethnicity, gender, and age. *Psychooncology.* 2006;15:248-258.
 48. Hoffman CJ, Ersser SJ, Hopkinson JB, Nicholls PG, Harrington JE, Thomas PW. Effectiveness of mindfulness-based stress reduction in mood, breast- and endocrine-related quality of life, and well-being in stage 0 to III breast cancer: a randomized, controlled trial. *J Clin Oncol.* 2012;30:1335-1342.
 49. Ott MJ, Norris RL, Bauer-Wu SM. Mindfulness meditation for oncology patients: a discussion and critical review. *Integr Cancer Ther.* 2006;5:98-108.
 50. Cramer H, Lauche R, Paul A, Dobos G. Mindfulness-based stress reduction for breast cancer—a systematic review and meta-analysis. *Curr Oncol.* 2012;19:e343-e352.
 51. Candy B, Jones L, Varagunam M, Speck P, Tookman A, King M. Spiritual and religious interventions for well-being of adults in the terminal phase of disease. *Cochrane Database Syst Rev.* 2012;5:CD007544.
 52. Breitbart W, Rosenfeld B, Gibson C, et al. Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. *Psychooncology.* 2010;19:21-28.
 53. Lee V, Robin Cohen S, Edgar L, Laizner AM, Gagnon AJ. Meaning-making intervention during breast or colorectal cancer treatment improves self-esteem, optimism, and self-efficacy. *Soc Sci Med.* 2006;62:3133-3145.
 54. Chochinov HM, Kristjanson LJ, Breitbart W, et al. Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomised controlled trial. *Lancet Oncol.* 2011;12:753-762.
 55. Peteet JR. Depression and the Soul: A Guide to Spiritually Integrated Treatment. New York: Brunner-Routledge; 2010.
 56. Peteet JR. Cancer and the meaning of work. *Gen Hosp Psychiatry.* 2000;22:200-205.
 57. Rusteen T. Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nurs.* 1995;18:355-361.
 58. Sinclair S, Chochinov HM. The role of chaplains within oncology interdisciplinary teams. *Curr Opin Support Palliat Care.* 2012;6:259-268.
 59. Puchalski CM. Spirituality and end-of-life care: a time for listening and caring. *J Palliat Med.* 2002;5:289-294.
 60. Maugans TA. The SPIRITual history. *Arch Fam Med.* 1996;5:11-16.
 61. Kristeller JL, Rhodes M, Cripe LD, Sheets V. Oncologist Assisted Spiritual Intervention Study (OASIS): patient acceptability and initial evidence of effects. *Int J Psychiatry Med.* 2005;35:329-347.
 62. McCauley J, Haaz S, Tarpley MJ, Koenig HG, Bartlett SJ. A randomized controlled trial to assess effectiveness of a spiritually-based intervention to help chronically ill adults. *Int J Psychiatry Med.* 2011;41:91-105.
 63. Lo B, Kates LW, Ruston D, et al. Responding to requests regarding prayer and religious ceremonies by patients near the end of life and their families. *J Palliat Med.* 2003;6:409-415.
 64. Lo B, Ruston D, Kates LW, et al; Working Group on Religious and Spiritual Issues at the End of Life. Discussing religious and spiritual issues at the end of life: a practical guide for physicians. *JAMA.* 2002;287:749-754.
 65. Sulmasy DP. Spiritual issues in the care of dying patients: "...it's okay between me and god." *JAMA.* 2006;296:1385-1392.
 66. Widera EW, Rosenfeld KE, Fromme EK, Sulmasy DP, Arnold RM. Approaching patients and family members who hope for a miracle. *J Pain Symptom Manage.* 2011;42:119-125.
 67. Peteet JR. Case discussion: disease as punishment. *South Med J.* 2006;99:434-435.
 68. Sloan RP, Bagiella E, VandeCreek L, et al. Should physicians prescribe religious activities? *N Engl J Med.* 2000;342:1913-1916.
 69. Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. *Ann Intern Med.* 2000;132:578-583.
 70. Handzo G, Koenig HG. Spiritual care: whose job is it anyway? *South Med J.* 2004;97:1242-1244.
 71. Cadge W. Paging God: Religion in the Halls of Medicine. Chicago: University of Chicago Press; 2012.
 72. Balboni MJ, Balboni TA. Reintegrating care for the dying, body and soul. *Harvard Theolog Rev.* 2010;103:351-364.
 73. Phelps AC, Maciejewski PK, Nilsson M, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA.* 2009;301:1140-1147.
 74. Rasinski KA, Kalad YG, Yoon JD, Curlin FA. An assessment of US physicians' training in religion, spirituality, and medicine. *Med Teach.* 2011;33:944-945.
 75. White M, Verhoef M. Cancer as part of the journey: the role of spirituality in the decision to decline conventional prostate cancer treatment and to use complementary and alternative medicine. *Integr Cancer Ther.* 2006;5:117-122.

76. Silvestri GA, Knittig S, Zoller JS, Nietert PJ. Importance of faith on medical decisions regarding cancer care. *J Clin Oncol*. 2003;21:1379-1382.
77. Hsiao AF, Wong MD, Miller MF, et al. Role of religiosity and spirituality in complementary and alternative medicine use among cancer survivors in California. *Integr Cancer Ther*. 2008;7:139-146.
78. Daugherty CK, Fitchett G, Murphy PE, et al. Trusting God and medicine: spirituality in advanced cancer patients volunteering for clinical trials of experimental agents. *Psychooncology*. 2005;14:135-146.
79. Wyatt G, Friedman LL. Long-term female cancer survivors: quality of life issues and clinical implications. *Cancer Nurs*. 1996;19:1-7.
80. Ferrell BR, Smith SL, Juarez G, Melancon C. Meaning of illness and spirituality in ovarian cancer survivors. *Oncol Nurs Forum*. 2003;30:249-257.
81. Bauer-Wu S, Farran CJ. Meaning in life and psycho-spiritual functioning: a comparison of breast cancer survivors and healthy women. *J Holist Nurs*. 2005;23:172-190.
82. Edmondson D, Park CL, Blank TO, Fenster JR, Mills MA. Deconstructing spiritual well-being: existential well-being and HRQOL in cancer survivors. *Psychooncology*. 2008;17:161-169.
83. Park CL, Edmondson D, Hale-Smith A, Blank TO. Religiousness/spirituality and health behaviors in younger adult cancer survivors: does faith promote a healthier lifestyle? *J Behav Med*. 2009;32:582-591.
84. Jim HS, Purnell JQ, Richardson SA, Golden-Kreutz D, Andersen BL. Measuring meaning in life following cancer. *Qual Life Res*. 2006;15:1355-1371.
85. Denney R, Aten J, Leavell K. Posttraumatic spiritual growth: a phenomenological study of cancer survivors. *Religion, Mental Health and Culture*. 2011;14:371-391.
86. Park CL, Edmondson D, Fenster JR, Blank TO. Meaning making and psychological adjustment following cancer: the mediating roles of growth, life meaning, and restored just-world beliefs. *J Consult Clin Psychol*. 2008;76:863-875.
87. Shin HW, Noh DY, Lee ES, et al. Correlates of existential well-being and their association with health-related quality of life in breast cancer survivors compared with the general population. *Breast Cancer Res Treat*. 2009;118:139-150.
88. Canada AL, Fitchett G, Murphy PE, et al. Racial/ethnic differences in spiritual well-being among cancer survivors [published online ahead of print July 3, 2012]. *J Behav Med*.
89. Frost MH, Johnson ME, Atherton PJ, et al. Spiritual well-being and quality of life of women with ovarian cancer and their spouses. *J Support Oncol*. 2012;10:72-80.
90. Meert KL, Thurston CS, Briller SH. The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: a qualitative study. *Pediatr Crit Care Med*. 2005;6:420-427.
91. Hexem KR, Mollen CJ, Carroll K, Lanctot DA, Feudtner C. How parents of children receiving pediatric palliative care use religion, spirituality, or life philosophy in tough times. *J Palliat Med*. 2011;14:39-44.
92. Ka'opua LS, Gotay CC, Boehm PS. Spiritually based resources in adaptation to long-term prostate cancer survival: perspectives of elderly wives. *Health Soc Work*. 2007;32:29-39.
93. Hegarty MM, Abernethy AP, Olver I, Currow DC. Former palliative caregivers who identify that additional spiritual support would have been helpful in a population survey. *Palliat Med*. 2011;25:266-277.
94. Becker G, Xander CJ, Blum HE, et al. Do religious or spiritual beliefs influence bereavement? A systematic review. *Palliat Med*. 2007;21:207-217.
95. Wortmann JH, Park CL. Religion and spirituality in adjustment following bereavement: an integrative review. *Death Stud*. 2008;32:703-736.
96. Currier JM, Mallot J, Martinez TE, Charlotte S, Neimeyer RA. Bereavement, religion, and posttraumatic growth: a matched control group investigation. *Psychol Relig Spiritual*. 2012.
97. Balk DE. Bereavement and spiritual change. *Death Stud*. 1999;23:485-493.
98. Golsworthy R, Coyle A. Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Couns Psychol Q*. 2001;14:183-202.
99. Damianakis T, Marzali E. Older adults' response to the loss of a spouse: the function of spirituality in understanding the grieving process. *Aging Ment Health*. 2012;16:57-66.
100. Exline JJ, Park CL, Smyth JM, Carey MP. Anger toward God: social-cognitive predictors, prevalence, and links with adjustment to bereavement and cancer. *J Pers Soc Psychol*. 2011;100:129-148.
101. Minor HG, Carlson LE, Mackenzie MJ, Zernicke K, Jones L. Evaluation of a Mindfulness-Based Stress Reduction (MBSR) program for caregivers of children with chronic conditions. *Soc Work Health Care*. 2006;43:91-109.
102. Birnie K, Garland SN, Carlson LE. Psychological benefits for cancer patients and their partners participating in mindfulness-based stress reduction (MBSR). *Psychooncology*. 2010;19:1004-1009.
103. Curlin FA, Lantos JD, Roach CJ, Sellergren SA, Chin MH. Religious characteristics of U.S. physicians: a national survey. *J Gen Intern Med*. 2005;20:629-634.
104. Curlin FA, Lawrence RE, Odell S, et al. Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *Am J Psychiatry*. 2007;164:1825-1831.
105. Curlin FA, Odell SV, Lawrence RE, et al. The relationship between psychiatry and religion among U.S. physicians. *Psychiatr Serv*. 2007;58:1193-1198.
106. Balboni MJ, Sullivan A, Amobi A, et al. Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. *J Clin Oncol*. 2013;31:461-467.
107. Ecklund EH, Cadge W, Gage EA, Catlin EA. The religious and spiritual beliefs and practices of academic pediatric oncologists in the United States. *J Pediatr Hematol Oncol*. 2007;29:736-742.
108. Berg GM, Crowe RE, Budke G, et al. Kansas physician assistants' attitudes and beliefs regarding spirituality and religiosity in patient care [published online ahead of print September 16, 2011]. *J Relig Health*.
109. Phelps AC, Lauderdale KE, Alcorn S, et al. Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses. *J Clin Oncol*. 2012;30:2538-2544.
110. Ford DW, Downey L, Engelberg R, Back AL, Curtis JR. Discussing religion and spirituality is an advanced communication skill: an exploratory structural equation model of physician trainee self-ratings. *J Palliat Med*. 2012;15:63-70.
111. Todres ID, Catlin EA, Thiel MM. The intensivist in a spiritual care training program adapted for clinicians. *Crit Care Med*. 2005;33:2733-2736.
112. Boston PH, Mount BM. The caregiver's perspective on existential and spiritual distress in palliative care. *J Pain Symptom Manage*. 2006;32:13-26.
113. Wicks RJ. *The Resilient Clinician*. New York: Oxford University Press; 2008.
114. Harrison RL, Westwood MJ. Preventing vicarious traumatization of mental health therapists: identifying protective practices. *Psychotherapy (Chic)*. 2009;46:203-219.
115. Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: "Being connected...a key to my survival." *JAMA*. 2009;301:1155-1164, E1.
116. Kash KM, Holland JC, Breitbart W, et al. Stress and burnout in oncology. *Oncology (Williston Park)*. 2000;14:1621-1633; discussion 1633-1634, 1636-1637.
117. Huggard P. *Managing Compassion Fatigue: Implications for Medical Education*. [doctoral thesis]. Auckland, New Zealand: University of Auckland; 2009.
118. Figley CR, ed. *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner-Routledge; 1995.
119. Shapiro SL, Schwartz GE, Bonner G. Effects of mindfulness-based stress reduction on medical and premedical students. *J Behav Med*. 1998;21:581-599.
120. Shapiro S, Astin J, Bishop S, Cordova M. Mindfulness-based stress reduction for health care professionals: results from a randomized trial. *Int J Stress Manage*. 2005;15:164-176.
121. Irving JA, Dobkin PL, Park J. Cultivating mindfulness in health care professionals: a review of empirical studies of mindfulness-based stress reduction (MBSR). *Complement Ther Clin Pract*. 2009;15:61-66.
122. Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA*. 2009;302:1284-1293.
123. Salander P. The emperor's new clothes: spirituality. A concept based on questionable ontology and circular findings. *Arch Psychol Religion*. 2012;34:17-32.
124. Cole BS, Hopkins CM, Tisak J, Steel JL, Carr BI. Assessing spiritual growth and spiritual decline following a diagnosis of cancer: reliability and validity of the

- spiritual transformation scale. *Psychosomatics*. 2008;17:112-121.
125. Mack JW, Nilsson M, Balboni T, et al. Peace, Equanimity, and Acceptance in the Cancer Experience (PEACE): validation of a scale to assess acceptance and struggle with terminal illness. *Cancer*. 2008;112:2509-2517.
 126. Astrow AB, Sharma RK, Huang Y, Xu Y, Sulmasy DP. A Chinese version of the Spiritual Needs Assessment for Patients survey instrument. *J Palliat Med*. 2012;15:1297-1315.
 127. Bussing A, Balzat HJ, Heusser P. Spiritual needs of patients with chronic pain diseases and cancer-validation of the spiritual needs questionnaire. *Eur J Med Res*. 2010;15:266-273.
 128. Yong J, Kim J, Seo I, Yang Y. Examination of reliability and validity of the Spiritual Needs Scale in Korean nurses. *J Hosp Palliat Nurs*. 2011;13:153-160.
 129. Monod S, Martin E, Spencer B, Rochat E, Bula C. Validation of the Spiritual Distress Assessment Tool in older hospitalized patients. *BMC Geriatr*. 2012;12:13.
 130. Blanchard JH, Dunlap DA, Fitchett G. Screening for spiritual distress in the oncology inpatient: a quality improvement pilot project between nurses and chaplains. *J Nurs Manag*. 2012;20:1076-1084.
 131. Draper P. An integrative review of spiritual assessment: implications for nursing management. *J Nurs Manag*. 2012;20:970-980.
 132. Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist*. 2002;42(3, special issue):24-33.
 133. Kalish N. Evidence-based spiritual care: a literature review. *Curr Opin Support Palliat Care*. 2012;6:242-246.
 134. Boston P, Bruce A, Schreiber R. Existential suffering in the palliative care setting: an integrated literature review. *J Pain Symptom Manage*. 2011;41:604-618.
 135. Kale SS. Perspectives on spiritual care at Hospice Africa Uganda. *Int J Palliat Nurs*. 2011;17:177-182.
 136. Moczyński W, Haler H, Bentele K, eds. *Medical Ethics in Health Care Chaplaincy*. Berlin: LIT Verlag; 2009.