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# Two Women and Cancer: The Need for Addressing Spiritual Well-Being in Cancer Care

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*Spiritual well-being is a concept derived from the holistic approach, in which a person is viewed as a multifaceted totality of body, mind, and spirit. Two stories are presented of women diagnosed with cancer who attended a clinic that integrates complementary and family medicine. Both patients' stories reflect their intention and desire for improved spiritual well-being as part of coping with cancer, and through their stories, the need for addressing spiritual well-being in cancer care is well illustrated. An integrative biopsychosocial–spiritual approach is presented.*

*Keywords:* complementary alternative medicine (CAM), spiritual well-being, spirituality, patient–doctor relationship, Anthroposophic medicine

*Complementary and alternative medicine* (CAM) is a term encompassing various therapeutic methods and techniques rooted in traditional, philosophical, and empirical systems of medicine, which view health and disease in the context of human totality of body, mind, and spirit. The prevalence of CAM use ranges from 7% to 64% (Ernst & Cassileth, 1998). In recent years, a growing number of cancer patients have chosen to complement conventional cancer treatment with CAM, and CAM use may be as high as 83% in patients with breast cancer (Richardson et al., 2000). When CAM therapies are analyzed by modality, prayer tops the list (Barnes, 2004).

Cancer patients who use CAM are motivated by a desire to be treated as a whole person. Most desire to do everything possible to regain health, to feel hopeful, and to improve their quality of life (QOL). Cancer patients do not use CAM because of disappointment or dissatisfaction with conventional medicine (Kappauf et al., 2000; Morant et al., 1991; Richardson et al., 2000). Cancer patients who use CAM are characterized by a more active coping behavior

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reflected in their desire to have more control in treatment decision making (Miller et al., 1998; Sollner et al., 2000). Many report that the diagnosis of cancer has motivated them to reevaluate their outlook on life and their beliefs (Paltiel et al., 2000). In essence, people with cancer may seek CAM for spiritual as well as physical benefit. In general, cancer patients using CAM tend to be younger women of higher education and socioeconomic status, suffering from advanced disease (Paltiel et al., 2001; Rees et al., 2000).

Cancer patients seek CAM out of a desire to be treated as a whole person, but this more holistic approach is not new. A call for a more holistic view has been reverberating in mainstream medicine for the past 30 years. In 1977, Engel proposed a biopsychosocial (BPS) model aiming to extend beyond the predominantly biomedical framework (Engel, 1977). BPS has been based on clinical research and inspired by other emerging multidisciplinary approaches, such as psychoneuroimmunology (Prolo et al., 2000).

During the past 2 decades, the BPS model has further evolved to include themes of patient-centeredness (Stewart et al., 2000), mindfulness (Epstein, 2000), salutogenesis (Sagy et al., 2000), and narrative and cross-cultural approaches (Rothbaum et al., 2000). Although a holistic approach in cancer care has historically come under the umbrella of CAM, this is changing as conventional cancer care attempts to address whole-person issues of the seriously ill patient. Current cancer care has shifted toward a more holistic BPS agenda, emphasizing not only survival but also QOL, alongside supportive and palliative care.

Diagnosis of a serious or life-threatening illness often stirs spiritual issues and questions concerning the meaning of life for the patient. Historically, medical personnel have not addressed these issues, but recent surveys suggest that patients want this to change. Surveys consistently show that patients favor having their spiritual needs acknowledged by their physicians. In a recent study, 1,413 adults attending family practice clinics in Ohio were asked whether their physicians' inquiry about spirituality or religious beliefs was appropriate (McCord et al., 2004). Eighty-three percent of respondents wanted physicians to ask about their spiritual beliefs, and the most acceptable scenarios for spiritual discussion were life-threatening illnesses (77%) and serious medical conditions (74%). Another survey reported that 77% of hospital inpatients said they wanted their spiritual needs considered, 37% wanted their physicians to discuss religious beliefs more frequently, and almost half wanted physicians to pray with them (Koenig, 1991). A national survey shows that 63% wanted physicians to talk with them about spiritual issues, but only 10% reported that their doctors were willing to do so (Larson & Greenwold, 1995).

Spirituality can be defined in many ways within or outside religion. Muldoon and King (1995) defined it as "the way in which people understand their life in view of their ultimate meaning and value." McClain et al. (2003) related to the concept of spiritual well-being and defined it as "a sense of meaning and purpose in life, faith, and comfort with existential concerns." Spirituality has been acknowledged in the 1990 World Health Organization (WHO) definition of the term *palliative care*, which aims at enhancing the patient's QOL while treating the patient as a whole, encompassing his or her psychological, social and spiritual dimensions (WHO, 1990).

Incorporating aspects of spiritual well-being into cancer care has spawned approaches that address issues of faith and a sense of coherence and meaning, as well as other dimensions of QOL (Rabow et al., 2004; Surtees et al., 2003). Spiritual well-being in patients with advanced cancer correlates with reduced feelings of anxiety and hopelessness and increased ability to

cope with the process of illness (Lin & Bauer-Wu, 2003).

In essence, a serious illness can spawn both CAM-use and spiritual searching. These two are not the same, though they may overlap. A recent study of 143 cancer patients interviewed 2 to 3 years post diagnosis concluded that religious and spiritual resources, CAM, and conventional treatment can have mutually beneficial spiritual and physical effects when participants perceive a relationship between them (Tatsumura et al., 2003).

In this article, two cancer patients' stories are discussed. Both attended a clinic that integrates family medicine with various CAM modalities such as herbal remedies, nutrition, homeopathy,[1] and Anthroposophic medicine.[2] Both patients were searching for a treatment approach that would relate to their body while also addressing their feelings, thoughts, desires, spiritual well-being, and sense of meaning. These stories reflect the wisdom and "truth" of two patients and the interactions with their physician with no intention to claim for a gold standard for other interactions. These stories capture the simultaneous spiritual and physical needs that often accompany a serious illness.

## DIANE—A PATIENT WITH LOCALLY INVASIVE DUCTAL CARCINOMA OF THE BREAST

Diane was 38 years old when she first came to the clinic. She was married to Tom and had no children. She was a licensed and well-known practitioner in Oriental medicine.

Diane set an appointment after consulting her intuition by use of a pendulum. During the meeting, she presented her wish to make a thoughtful, informed decision regarding chemotherapy treatment following lumpectomy of her right breast. Although the tumor had been detected 2 years earlier, she had chosen not to undergo lumpectomy or any other oncological treatment. Her decision had been based on the counsel of a "spiritual being" through a medium who claimed that the lump was not a tumor but only "what physicians consider to be cancer." Diane chose to use various CAM modalities to treat the lump including herbs, vitamins, nutritional supplements, guided imagery, bioresonance therapy, and others. Two years after diagnosis, she found a bloody secretion in the skin in close proximity to the lump and was urged by her husband to seek a medical examination. A lumpectomy was performed, revealing a pathology of invasive ductal carcinoma with negative estrogen receptors. No evidence of metastases was found. Subsequently, Diane consulted an oncologist who offered six cycles of chemotherapy with CMF (cyclophosphamide, methotrexate, and fluorouracil) and additional radiation treatment.

Diane was confused by turbulent feelings of anxiety, fear, guilt, and loss of confidence and support. She felt she could no longer rely on the spiritual mode, yet she could not give up her *alternative* philosophy of healing. Diane sought assistance in making an informed and conscious treatment choice that might include chemotherapy, alternative treatment, or both. Diane handed me articles on chemotherapy treatment for breast cancer and expected me to appraise them with an evidence-based approach and to relate to issues of efficacy, safety, and statistics needed to treat her. In addition to this rational approach, she asked me to acknowledge her feelings and to assist her in finding meaning in the process of illness and treatment. She described herself as one suffering from spiritual crisis and viewed the disease as an uncon-

[1] Homeopathy: a medical system based on the law of similars. Patients' symptoms are treated with minute doses of herbal/mineral/biological substances that would produce in larger doses similar symptoms in a healthy individual.

[2] Anthroposophic medicine: a medical system based on a philosophical and spiritual–scientific model of human individuality as proposed by the philosopher Rudolf Steiner.

scious process necessary for healing. At the conclusion of our session, I suggested that she invite Tom, her spouse, to the following meeting aimed at formulating a treatment plan.

During the next meeting, I asked Diane to describe her feelings and thoughts about chemotherapy. She said that she yearned for a place that would give her security, confidence, and a sense of holding, but she was too reluctant to pay the price in terms of side effects and harm to her immune system. Knowing her background in Oriental medicine, I proposed viewing the pros and cons as two themes that balance each other in a manner similar to the Chinese model of yin and yang. We contemplated the two qualities, which not only contradict but also complement each other, thus enabling us to observe one quality more clearly by view of the other. I asked her to meditate on the seed of "white" inside the "black" and vice versa, imagining one becoming the other.

I suggested a metaphor of a ship finding its way to a safe bay from a storm midsea. "What is the nature of the bay?" asked Diane. "Is it death?"

"It is meaningfulness," suggested Tom. "Are you willing to go on a voyage?" I asked. "Will you consider this journey as your path to healing? Who would you choose to join you on board?"

Diane chose to undergo chemotherapy treatment as part of her holistic treatment plan, which included psychotherapy and guided imagery, herbs, mistletoe (*Viscum album*) injections, homeopathy, nutritional supplements, and acupuncture. Throughout the 6-month period of chemotherapy treatment, she called me for counsel in managing nausea, fatigue, and gastrointestinal symptoms. I suggested that she use both conventional and complementary treatments as needed. At the completion of the chemotherapy and the subsequent radiation treatment, she wrote:

> I walk along the river, a renewed kind of walking, as if only now I have found myself. . . . I remember how, in the beginning, I argued with my soul, promising it that I would work on improving myself even without the illness, that this Time I understood the "message" and *this* Time I would really change. This kind of journey into myself and outside my self, I presumably would not have made without my encounter with cancer. It is astonishing to see how the cancer has become "not the illness but the healing factor" for me.

## NORMA—A PATIENT WITH ADVANCED CANCER AND METASTASES

Norma, an 80-year-old woman, was widowed twice and lost her elder daughter, who died at the age of 50 from cancer. She devoted much time to a study of death and dying influenced by the Anthroposophical philosophy and was actively involved in aiding families in producing commemorative booklets in honor of their close relatives who had passed away.

Norma's daughter asked me to meet with her mother after an abdominal operation and subsequent diagnosis of colon adenocarcinoma with metastases to the liver. The family had consulted with an oncologist, but no chemotherapy was recommended. Norma suffered from severe fatigue and from a seemingly reactive depression. Her two daughters and son-in-law cared for her devotedly but expressed deep sorrow and sadness that the present loss had reactivated previous family losses. I asked Norma's daughter for her mother's consent for my visit, as she was reluctant to have such an intrusion into her life.

Upon receiving her approval, I went to her house and found a woman with dignity, sadness, and extreme fatigue. She walked with assistance. She could hardly speak, uttering her words in a weak voice. She told me she was willing to die and had already made all the necessary arrangements. I asked what dying meant for her.

"A release from pain and being reunited with my dear ones who have gone beyond this life," she replied. Norma told me of meetings with her dead husband on a trail in the countryside and how much she wished to meet him again after death. I asked if she were willing to part from her beloved living relatives. Norma replied that she had already parted from her daughters before the abdominal operation, presuming she would not wake up again. I wondered whether Norma felt sorrow and disappointment when she discovered that death was yet far from reach and realized her relatives' difficulty in confronting another loss. I suggested that she regard her remaining time as a precious gift to be endowed with meaning. Thus, strengthening her physical body would enable her to award farewell gifts to her close family members, helping them to part from her.

During the following weeks, she used some of the herbal medications I prescribed and felt her physical vitality come back. She was able to walk on her own again and enjoy her family. She was able to come and visit me in my office, telling me that she had accepted her grandson's request for a videotaped interview. She felt less distressed. A few weeks later, Norma was hospitalized for palliative radiation treatment of the metastases. She died in the hospital, surrounded by loving family members.

## DISCUSSION

The stories of Diane and Norma suggest that spiritual well-being is an essential element of therapy for patients with cancer. Both women suffered from an ailment that affected not only their physical bodies, emotions, and relationships with their families but also their spiritual cores. Diane encountered a crisis with her health–belief model and spiritual guide. Norma was shaken to discover that death did not take her and that she had to find meaning in life again. Like knights on a crusade, they went into the night searching for the answers to their deepest, most intimate questions and wishes. Diane's journey was directed from the past to the future, from the storm at sea to the tranquility of the bay. Her quest was directed by death. Norma's journey led her from the future to the past and enabled her to find joy in the present.

Diane and Norma had consciously sought a clinic that integrates CAM with family medicine. Both patients had sound backgrounds in spirituality, but their primary and presenting intention for counseling was CAM. They were familiar with certain CAM modalities, with reference to spirituality. Diane had practiced Oriental medicine and was familiar with traditional Chinese philosophy, which perceives health as a harmonious equilibrium between fundamental elements that correspond to physical, emotional, and spiritual manifestations in humans (Chan et al., 2001). Norma was familiar with the western Anthroposophical medicine and philosophy, which views health and disease in the context of body, mind, and soul (Cantor & Rosenzweig, 1997). The two patients' decision to approach CAM was not based on negativism toward conventional medicine but on motives shared by many other CAM users: a desire to be actively involved in decision making, attaining more control, and finding meaning in their actions.

Although patients seeking CAM may express a wish to relate to spiritual themes, many other patients who visit "conventional" treatment centers may, consciously or unconsciously, also desire a spiritual component in their cancer treatment. Physicians need to be aware of spiritual needs in many of the patients who encounter major illness and to consider their patients' spiritual well-being as equally important as other components of general well-being like pain-control, sleep quality, fatigue, and so forth.

Patients do not necessarily become existentialists when diagnosed with a serious illness, but such a diagnosis can elicit spiritual and existential questions about the meaning of life, and patients may relate

more profoundly to the wonder of life. There are a growing number of therapeutic models that integrate these dimensions of a person's life. Potter coined the phrase "the glory of the present moment, of *nowness*" (Potter, 1994). Elisabeth Kübler-Ross (1997) suggested that patients learn to get in touch with the silence within and know that everything in this life has a purpose. Wright (2004) introduced a patient- and family-centered holistic model for linking spirituality, suffering, and beliefs. Walsh (1999) also suggested a family-centered approach by proposing that bridging the gap between spirituality and therapy may be advanced by addressing religious, cultural, and spiritual resources within the family. Griffith and Griffith (2001) further suggested practical ways to open therapy to the creative and healing possibilities in people's spiritual and religious experiences.

All of these models suggest that patients, as well as their families, may look for their own biographical path and find their own story, purpose, and vision. By looking at death as a mirror, patients may relate more to life, whether perceiving it as final or as a gateway to reincarnation.

Can skills of communicating with patients on a spiritual plane be taught? It is feasible to teach physicians how to approach spirituality as much as other BPS skills in residency programs and CME courses. In order to equip physicians to be able to address the spiritual needs of their patients, more than 80 of the 126 U.S. medical schools now offer courses in spirituality and medicine, up from only two to three such courses a decade ago (Pulchalski & Larson, 1998). Guidelines now exist for taking a spiritual inventory alongside a medical history (Larson & Larson, 1994). Schools of psychology show a similar trend in spirituality courses (Brawer et al., 2002), and interest exists in incorporating spiritual content into psychotherapy (called *adjunctive psychotherapy*; Bergin, 1991).

Taking a brief spiritual inventory and/or being trained in the spiritual dimension of health could, at the very least, help medical personnel understand the ways in which patients' medical decisions of care, death, and dying may be influenced by spiritual beliefs (Meador, 2003; Payne, 2003). Spiritual discussion encompasses many questions: Does your illness have any meaning for you? Does it allow you to be more aware of yourself, to relate differently to people, family, nature, or to the meaningfulness of your being and actions?

Beyond the spiritual inventory, what might medical care look like as it integrates patients' spiritual needs? Medical personnel might, for example, identify those persons from a brief spiritual inventory who are most likely to benefit from a spiritual component in their care. Whereas some physicians may choose to have these dialogues with patients, other physicians might choose to refer patients for counseling with a pastoral counselor, minister, or psychotherapist trained in integrating spiritual content into psychotherapy (Post, 2003). Surveys indicate that patients want their physicians to refer and confer with spiritually oriented counselors (Betz, 2003; Milstein, 2003). Additionally, there is a growing focus on optimizing the spiritual and psychological well-being of caretakers—those family and friends who are the primary caregivers for someone with a life-threatening or disabling illness (Weaver, 2003). Some have suggested that medical personnel would also benefit from interventions geared toward preserving their own psychological and spiritual well-being.

A relatively recent development in health and spirituality are intervention studies. As results of randomized trials of spiritual interventions become available, medical personnel might select best practices for additional interventions. Currently, intervention studies are being conducted throughout the spectrum of medical care from screening (Holt, 2003), to acute postsurgical recovery (Jain, 2003), to living

with life-threatening disease (Tibbits, 2003).

Approaching patients' spiritual realms often requires the physician's willingness to contemplate his or her own spirituality. The physician needs to self-observe his or her own soul when approaching the sacred place of another, much as a psychotherapist needs to do it with his or her own psyche. Touching this realm is feasible and rewarding for both patients and physicians, but it requires a respectful, nonjudgmental attitude.

Many physicians may claim that spirituality should be left to spiritual "professionals" or to religious leaders. Indeed, they may claim that no one taught them how to approach spirituality in medical school or residency programs. However, leaving spirituality outside the totality of man is like stating that mind and body should be dichotomized between psychiatry and biomedical therapy. Holism in medicine should be based on a BPS–spiritual paradigm, which may be interpreted repeatedly by the dynamics of the patient–physician dialogue. Touching spirituality may be a common need of patients and physicians alike. It may alleviate the sorrow of patients and their families while healing the oft-unspeakable ache in the soul of many of the physicians who encounter cancer treatment.

Moreover, Diane and Norma have taught us the ever surprising but well-known fact that patients are the best teachers to lead us into the realm of healing.

## REFERENCES


Barnes, P. M., Power-Griner, E., McFann, K., & Nahin, R. L. (2004, May 27). Complementary and alternative medicine use among adults: United States, 2002. *Advance data from vital and health statistics (No. 343).* Hyattsville, MD: National Center for Health Statistics.

Bergin, A. E. (1991). Values and religion in psychotherapy and mental health. *American Psychology, 46,* 394–403.

Betz, M., Griffin, R., & Bowen R. (2003, April 1–3) *Spirituality and psychiatry in Canada: A survey of patients and psychiatrists.* Poster presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice, 33,* 203–206.

Cantor, I. S., & Rosenzweig, S. (1997). Anthroposophic perspectives in primary care. *Primary Care, 24,* 867–887.

Chan, C., Ho, P. S., & Chow, E. (2001). A body-mind-spirit model in health: An Eastern approach. *Social Work in Health Care, 34,* 261–282.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129–136.

Epstein, R. M. (1999). Mindful practice. *Journal of the American Medical Association, 282,* 833–839.

Ernst, E., & Cassileth, B. R. (1998). The prevalence of complementary/alternative medicine in cancer. *Cancer, 83,* 777–782.

Griffith, J., & Griffith, M. (2001). *Encountering the sacred in psychotherapy*: *How to talk to people about their spiritual lives.* New York: Guilford Press.

Holt, C. L., & Kyles, A. (2003, April 1–3). *Development of a spiritually based breast cancer educational booklet for African American women.* Poster presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Jain, M. K., & Harris, W. (2003, April 1–3). *Development of a spiritual intervention to improve medical outcomes for patients undergoing coronary bypass surgery.* Poster presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Kappauf, H., Leykauf-Ammon, D., Bruntsch, U., Horneber, M., Kaiser, G., Buschel, G., & Gallmeier, W. M. (2000). Use of and attitudes held towards unconventional medicine by patients in a department of internal medicine/oncology and haematology. *Supportive Care in Cancer, 8,* 314–322.

Koenig, H. G. (1991). Religious perspectives of doctors, nurses, patients, and families. *Journal of Pastoral Care, 45,* 254–267.

Kübler-Ross, E. (1997). *On death and dying.* New York: Simon & Schuster.

Larson, D. B., Greenwold, M. A. (1995). Are religion and spirituality clinically relevant in healthcare? *Mind/Body Medicine, 1,* 147–157.

Larson, D. B., & Larson, S. S. (1994). *The forgotten factor: What does the research show?* Rockville, MD: National Institute of Health Care Research.

Lin, H. R., & Bauer-Wu, S. M. (2003). Psychospiritual well-being in patients with advanced cancer: An integrative review of the literature. *Journal of Advanced Nursing, 44,* 69–80.

McClain, C. S., Rosenfeld, B., & Breitbart, W. (2003). Effect of spiritual well-being on end-of-life despair in terminally ill cancer patients. *Lancet, 361,* 1603–1607.

McCord, G., Gilchrist, V. J., Grossman, S. D., King, B. D., McCormick, K. F., Oprandi, A. M., et al. (2004). Discussing spirituality with patients: A rational and ethical approach. *Annals of Family Medicine, 2,* 356–361.

Meador, K. G. (2003, April 1–3). *End of life and palliative care.* Paper presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Miller, M., Boyer, M. J., Butow, P. N., Gattellari, M., Dunn, S. M., & Childs, A. (1998). The use of unproven methods of treatment by cancer patients. Frequency, expectations and cost. *Supportive Care in Cancer, 6,* 337–347.

Milstein, G., Bruce, M. L., Kennedy, G. J., & Flannelly, K. (2003, April 1–3). *Clergy roles in psychiatric care: Elder patients' viewpoint.* Poster presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Morant, R., Jungi, W. F., Koehli, C., Senn, H. J. (1991). Warum benützen tumorpatienten alternativmedizin? [Why do cancer patients use alternative medicine]? *Schweizirland Medicine Wochenschr, 121,* 1029–1034.

Muldoon, M., & King, N. (1995). Spirituality, health care, and bioethics. *Journal of Religion and Health, 34,* 329–349.

Paltiel, O., Avitzour, M., Peretz, T., Cherny, N., Kaduri, L., Pfeffer, R. M., et al. (2001). Determinants of the use of complementary therapies by patients with cancer. *Journal of Clinical Oncology, 19,* 2439–2448.

Payne, C. M. (2003, April 1–3). *Spirituality and physical health: Diabetes.* Paper presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Post, S. J. (2003, April 1–3). Ethics of integrating religious beliefs into health care. Paper presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Potter, D. (1994). *The last interview.* Britain's Channel Four. New Video Group.

Prolo, P., Chiappelli, F., Fiorucci, A., Dovio, A., Sartori, M. L., & Angeli, A. (2002). Psychoneuroimmunology: New avenues of research for the twenty-first century. *Annals of the New York Academy of Sciences, 966,* 400–408.

Pulchalski, C. M., Larson, D. B. (1998). Developing curricula in spirituality and medicine. *Academic Medicine, 73,* 970–974.

Rabow, M. W., Dibble, S. L., Pantilat, S. Z., & McPhee, S. J. (2004). The comprehensive care team: A controlled trial of outpatient palliative medicine consultation. *Archives of Internal Medicine, 164,* 83–91.

Rees, R. W., Feigel, I., Vickers, A., Zollman, C., McGurk, R., & Smith, C. (2000). Prevalence of complementary therapy use by women with breast cancer: A population-based survey. *European Journal of Cancer, 36,* 1359–1364.

Richardson, M. A., Sanders, T., Palmer, J. L., Greisinger, A., & Singletary, E. (2000). Complementary/alternative medicine in a comprehensive cancer center and the implications for oncology. *Journal of Clinical Oncology, 18,* 2505–2514.

Rothbaum, F., Rosen, K., Ujiie, T., Uchida, N. (2002). Family systems theory, attachment theory, and culture. *Family Process, 41,* 328–350.

Sagy, S., & Antonovsky, H. (2000). The development of the sense of coherence: A retrospective study of early life experiences in the family. *International Journal of Aging and Human Development, 51,* 155–166.

Sollner, W., Maislinger, S., DeVries, A., Steixner, E., Rumpold, G., & Lukas, P. (2000). Use of complementary and alternative medicine by cancer patients is not associated with perceived distress or poor compliance with standard treatment but active coping behavior: A survey. *Cancer, 89,* 873–880.

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of

patient-centered care on outcomes. *Journal of Family Practice, 49,* 796–804.

Surtees, P., Wainwright, N., Luben, R., Khaw, K. T., & Day, N. (2003). Sense of coherence and mortality in men and women in the EPIC–Norfolk United Kingdom prospective cohort study. *American Journal of Epidemiology, 158,* 1202–1209.

Tatsumura, Y., Maskarinec, G., Shumay, D. M., & Kakai, H. (2003). Religious and spiritual resources, CAM, and conventional treatment in the lives of cancer patients. *Alternative Therapies in Health and Medicine, 9,* 64–71.

Tibbits, R. M., Luskin, F., Piromelli, C., Lukman, R., & Milunski, M. (2003, April 1–3). *Hypertension reduction through forgiveness therapy.* Poster presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference. Bethesda, MD: National Institutes of Health.

Walsh, F. (1999). *Spiritual resources in family therapy.* New York: Guilford Press.

Weaver, A. J. (2003, April 1–3). *Caregiving for those with disabilities.* Paper presented at Integrating Research on Spirituality and Health and Well-Being Into Service Delivery: A Research Conference, Bethesda, MD: National Institutes of Health.

World Health Organization. (1990). Cancer pain relief and palliative care. *World Health Organization technical report series 804,* 1–75. Geneva, Switzerland: Author.

Wright, L. M. (2004). *Spirituality, suffering, and illness: Ideas for healing.* Philadelphia: FA Davis.