1 Religion at the Bedside: Why?

Elizabeth Johnston Taylor, PhD, RN

Religion typically is a taboo topic. Why should nurses risk embarrassment to broach the subject? For what reason should they bother to recognize religiosity in patients or in themselves?

Consider these scenarios: A Hindu wants her teeth brushed *before* breakfast. A Sikh preparing for surgery is distraught that his hair will be shaved. An atheist or neopagan patient may loathe having a chaplain visit. An Amish declines to make a treatment decision without consulting and praying with fellow believers. A bed-bound Muslim asks you for support to say daily prayers. A Buddhist is wishful about not being able to chant. A nurse colleague refuses to provide care for a patient because of a conscientious objection. Another coworker offers prayer to all her patients. Why? How do you respond ethically, legally, and therapeutically to such queries and circumstances?

Throughout this book, it is argued that when religion interacts with health and illness, it is requisite to effective and ethical nursing care to recognize this religion–health relationship. This chapter will review research and theory linking religion and health. This review provides a context and foundation for the ensuing chapters that propose how the nurse can provide religion-sensitive care.

REASONS FOR RECOGNIZING RELIGION IN PATIENT CARE

A number of reasons support why nurses should appreciate the role of religion as they provide health care.

Many Patients Are Religious

Whether caring for a patient from a first- or third-world country, it is more likely than not that they are religious. Furthermore, although this is a point that would be inappropriate to push, even nonreligious persons are often influenced by the religion of their parents or other sources of authority and society. Census data from English-speaking first-world countries indicate that the majority of people do identify themselves as religious. Conversely, self-reported nonreligiosity in the largest of these countries falls within a small and narrow range of 15%–18% (Department of Immigration and Citizenship, 2008; Kosmin & Keysar, 2008; National Statistics, 2010; Statistics Canada, 2001). Religiosity appears to be greater

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among older rather than young adults, greater among women than men, and greater among African Americans and Latinos than Asians and those of European descent (Pew Forum, 2010a). Although a large majority of citizens report a religious affiliation, this does not mean they deem religion as important. In a Gallup (2010) survey of Americans, 56% believed religion was very important in their own life, whereas 25% believed it was fairly important, and 19% thought it was not very important. Likewise, 65% said religion was an important "part of daily life."

Several recent trends have been observed in these countries. One is a trend in the movement from religious affiliation to none. While some "nones" are atheist or agnostic, many are simply "nothing in particular." Indeed, an American survey found that of the 5% who do not believe in a God or universal spirit, only 24% called themselves atheist (Pew Forum, 2010b). Another trend is the increase in non-Christian adherents, which reflects immigration patterns. While Christianity remains the dominant world faith in these countries, there have been steady increases in the numbers of non-Christians, particularly among Muslims and Hindus (e.g., Statistics Canada, 2001). Although only 4% of the American population affiliates with a non-Christian religion, this group grew 50% between 1990 and 2008 (Kosmin & Keysar, 2008). Even within Christianity, there has been a shifting away from the historic mainline churches to evangelical and nondenominational churches (Kosmin & Keysar). Among religious Americans, there is also an increase in the mixing of multiple faiths (e.g., "hyphenated Christians"). For example, 35% of Americans occasionally or regularly attend services of a different tradition from their own. This mixing and matching of beliefs often involves mixing Christian beliefs with Eastern or New Age beliefs (Pew Forum, 2009).

Religiosity Is Associated With Health Outcomes

Research examining the relationships between aspects of religiosity and health generally (but not always) show positive linkages. Whether it is frequency of attendance at religious services, use of meditational prayer, high intrinsic religiosity, or some other indicator of religiosity, findings suggest that these indicators of religiosity associate with or predict health outcomes such as mortality, morbidity, adjustment to illness, and quality of life (e.g., Koenig, McCullough, & Larson, 2001; Levin, 2001).

Levin (2001) asserts six mechanisms for explaining how religiosity can contribute to good health. These include:

- ***Religious proscriptions that support healthful lifestyles and behaviors.*** For example, most religious traditions advocate that sexual intercourse be confined to a committed, covenanted, and monogamous relationship; this behavior, if adhered to, eliminates the possibility of sexually transmitted disease. Most religions also denigrate the abuse of alcohol

or nontherapeutic substances. Observant and conservative members of several religious traditions will respect proscriptions about food (e.g., Jews, Buddhists, Hindus, Muslims). These proscriptions, although varied, generally endorse ways of eating that are now understood to be healthful (e.g., vegetarian, not overindulging, avoiding meat with higher potential for disease). Epidemiological research has demonstrated Latter-Day Saints and Seventh-Day Adventists, who characteristically observe many of these health proscriptions, do live longer (Koenig et al., 2001).

- ***Regular religious fellowship that benefits health by offering support that buffers the effects of stress and isolation.*** For many who remain in a religious organization, it is the sense of belonging that may keep them affiliated. A faith community is like an extended family for many. Furthermore, within a society, a faith community often affords persons from different social strata an opportunity to equalize with those from higher and lower strata. This mechanism for obtaining social support allows isolated and marginalized—and healthy—individuals a structure for social safety, a place to weep and laugh with others, to give and take comfort, to belong. Although any family may have its "warts," such a community typically offers social support. Krause and Ellison's (2009) findings extend this assertion further. They observed that congregants who had negative encounters in their parish were more likely to have religious doubt and that suppressing doubts about religion was associated with poorer health. In contrast, congregants who attended a Bible study group (i.e., obtained better social support) were more apt to look for spiritual growth in response to a situation that raised religious doubt.

- ***Participation in worship and prayer that benefits health through the physiological effects of positive emotions.*** There has been considerable empirical effort during the past decade to explore the mechanisms that could explain the linkage between neurobiology and religiosity (Griffith, 2010). While much mystery exists about the biology of belief, it is known that worshipful experiences often create some degree of ecstasy, which in turn creates a physical state of well-being. Similarly, prayer can (but not always) contribute to an inner state of peace or joy. Such positive feelings of deep contentment or understanding affect body chemistry, stimulating health-promoting molecules of emotion and affecting physical well-being. Offering a glimpse into this process is a clever study done by Wiech et al. (2008) that allowed functional magnetic resonance imaging (fMRI) to compare the perceived intensity of induced pain on Roman Catholics looking at a picture of the Virgin Mary with that of nonreligious subjects looking at a da Vinci picture of the "Woman with Ermine." The Catholic subjects perceived significantly less pain and were observed to have increased activation of the right ventrolateral

prefrontal cortex, known to be activated during times of cognitive control over pain.

- ***Simple faith that benefits health by leading to thoughts of hope, optimism, and positive expectation.*** For instance, most religions offer a way of making sense of why bad things happen to people, even good people (i.e., theodicies). Most religions also give believers hope in an afterlife. Many religions also provide a way of thinking about death that reframes the death in a positive light (e.g., death is sleep that ends at a second advent of Jesus, death allows the soul to go to heaven and be with God, death is a rebirth to a better existence).
- ***Mystical experiences that benefit health by activating a healing bioenergy, or life force, or altered state of consciousness.*** Whether it is a meditational state, a physically induced ecstasy (e.g., from religious dance or music or hallucinogenic substance), or a unitive moment (i.e., transient, random, experience of awareness of something greater or exceptional insight), esoteric religious experiences are accompanied by a sense of meaningfulness, happiness, and feeling of well-being.
- ***Divine intervention that allows healing.*** Although the divine is ultimately mysterious, and it is inappropriate and impossible to adequately test this assertion (Cohen, Wheeler, Scott, Edwards, Lusk, et al., 2000), many religious believers accept that the divine is omnipotent and involved with individuals in personal and intimate ways. Interpretations about how the divine intervenes in human life and earthly circumstances, of course, vary with religious tradition. Some believe that miracles continually occur as a natural result of divine laws of nature, while others accept that the divine can purposefully affect these laws to intervene and cause a magical miracle. This is illustrated in a case study of a woman with Huntington's disease who visited Lourdes and perceived that the Virgin Mary spoke to her, telling her that she was cured (Moreno & de Yebenes, 2009). Although she continued to take her medicine, this woman was ecstatic about her "miraculous cure." In subsequent examinations by two experts, a nearly complete elimination of dystonia and chorea were observed along with a 40% improvement (using a standardized score), but no cure genetically. These neurologists conjectured a placebo effect accounted for the "cure," perhaps related to the known direct relationship between anxiety and chorea (Moreno & de Yebenes). Indeed, diverse views of divine intervention can produce varying perspectives such as "without medicine, God can cure me of my illness," to "using natural pathways yet unknown, God can cure me," or "using the miracle of human knowing about medicine, God can cure me of my illness." Others may simply accept that "whether I survive cancer or not, the miracle is that I have been given breath today."

These conjectures about how religion affects health suggest that religiosity is an important topic for nurses interested in health promotion and illness management.

Religious Beliefs Influence Health Decision Making

One's religious beliefs can guide decision making by providing "an interpretive framework that helps to move forward in the face of overwhelming and intelligible circumstances" (White, 2009, p. 75). The growing body of evidence linking religious belief with health care decision making describes the influence of beliefs on varied decisions, from those related to pregnancy and genetic testing to cancer and HIV treatment (Taylor, 2011). Most of the research, however, illuminates how beliefs impact end-of-life-related decisions, such as those around resuscitation and prolongation of life and advanced directives and elder care planning.

Religions Offer Coping Strategies

Until around the turn of the century, health-related research documenting religious coping often did so by framing it in behavioral terms. That is, this research described how patients used prayer, reading holy writings, devotional and other religious practices to cope with illness (Taylor, 2002). (While many religious persons would argue that their practices are not used magically to gain outcomes, this may be true for some.) These religious coping strategies often buffer stress and provide much emotional comfort for believers.

More recently, however, this area of study is influenced by Pargament's conceptualization of religious coping as comprising positive and/or negative beliefs (Pargament, Koenig, & Perez, 2000). Ano and Vasconcelles' (2005) meta-analysis of 49 investigations exploring the relationship between religious coping and psychological adjustment to stress concluded that, in general, positive religious coping was associated with adjustment. Conversely, negative religious coping was associated with poor adjustment. This evidence calls nurses to support positive religious coping and consider how to address the deleterious effects of negative religious coping when it impacts health (Taylor, 2011).

Religious Beliefs and Practices May Have Health Implications

As this book will unpack, religious persons may practice rituals that have physical or mental health implications. These could include pilgrimages, ascetic practices, diets, "complementary" therapies, or other practices. Likewise, a religious patient will have religious beliefs about what causes illness, how to respond to suffering, what is life and death, and so forth. These beliefs will inevitably influence the way religious patients take care of their health. Furthermore, a health-related event may have religious

implications (e.g., a Hindu discharged from a hospitalization may participate in a ritual that symbolizes purification).

Some Patients Want Nurses to Support Their Religiosity

A few studies have surveyed patients about whether they would want their nurse to inquire about and be respectful of their spirituality and religion. While most patients do want clinicians to know about their spirituality, they do not view them as primary spiritual caregivers. Religious persons, as well as those who are experiencing life-threatening conditions, are especially eager for a nurse to discuss with them how best to support their religiosity (Taylor, 2007; Taylor & Mamier, 2005).

Professional Mandates

The Joint Commission (2008), the accrediting body from which most U.S. health care organizations seek approval, mandates that all patients receive a spiritual assessment. The Joint Commission recognizes religion as a salient aspect of a patient spirituality and advises that religion is to be respected and supported. Likewise, various nursing codes for ethical conduct specifically identify the religiosity of patients as a dimension of personhood the nurse must respect (see Chapter 6, Nursing Codes of Ethics).

Further endorsement for recognizing the salience of religion in nursing comes from NANDA International, which categorizes religious problems and strengths with diagnostic labels (Gordon, 2007). Although these diagnostic labels exist, nurses must be cautious about pathologizing patient religiosity. That is, although some religious problems may be unhealthful, religious distress can also be indicative of healthful spiritual maturation—spiritual growing pains perhaps. For example, a "dark night of the soul" is not depression, rather a spiritual dryness the person knows to be a gift that expands one's understanding of God.

THEORIES ABOUT RELIGION

During the last half of the 19th century, social scientists began formally theorizing about how religions originate and function in society. Varied theories arose (Pals, 2006). For example, Freud portrayed religion as wish fulfillment resulting from neuroses. Marx viewed religion as a way of coping with class struggle. Others saw religion as a cultural system of symbols played out in beliefs and practices that create community or social cohesion (e.g., Durkheim, Geertz). Another theory about religion posits that it is economically driven; that is, religious beliefs that bring about advantages are chosen (Stark & Finke). Others have proposed that religious beliefs about the divine are anthropomorphic; that is, in response to ambiguity, humans project human attributes on nonhuman entities to create a personal god (Guthrie, 2007).

Social scientists also describe facets of religion with typologies. For example, Glock and Stark (1965) propose that religions have five dimensions: doctrinal, intellectual, ethical, private devotional and public ritual, and experiential. Wallace (1966) describes the typical components of religion as prayer (addressing the supernatural); music and artistic expression; physical manipulation of one's psychological state; exhortation or addressing other humans (e.g., sermons); reciting the religion's code or aspects of belief or history; touching that transfers supernatural power through contact; taboo or not touching certain things; simulation or imitating things; feasts; sacrifice (e.g., offerings); congregation; and inspiration (i.e., recognizing the divine in human experience). Troeltsch (1991) describes the primary types of religions. He suggests three: religious organizations that are inclusive and accommodate societal institutions; sects that demand voluntary commitment of members, are perfectionistic, and critical of the social milieu; and mysticism (an individual, spiritual religiosity).

Several religionists also offer theories about how religions evolve. Older theories describe progressive stages of organized religiosity (e.g., from individualistic and shamanistic religion to communal and collective to monotheistic and ecclesiastical) (Wallace, 1966). The recent trend, however, is to explain sociobiologically how religion exists in humans. This theorizing is informed by neurobiological science and psychology. One theory that has failed to receive further support is that there is a "God gene" that biologically explains why some people are religious (Pals, 2006). Currently, there is debate about whether research using fMRI that shows brain activity during religious experiences to be like the activity found during other human experiences (e.g., intimate interpersonal relating, cognitive coping) actually proves that religiosity is a by-product of culture or manifestation of how the human species adapts (e.g., Fingelkurts & Fingelkurts, 2009; Thomson & Aukofer, 2011).

Although some would argue that religiosity is irrational—a hijacking of the human mind or result of evolutionary misfiring (Thomson & Aukofer, 2011), all would agree that humans are very vulnerable to religious belief. Those who believe their religious experience is a result of a supernatural creative Entity, of course, can still accept that no matter how their religious experience manifests biologically in association with other cognitive processes, this vulnerability to belief is nevertheless valid and a gift allowing relationship with the divine.

Regardless, the sociobiological systems innate in humans do play an important role in religious behavior (Griffith, 2010), whether they explain religion as a by-product of adaptation or not. These systems for which humans are wired include:

- Attachment or the need to feel safe and close to a secure attachment figure (e.g., manifested in religious statements such as "God is my loving Father")

- Peer affiliation or the need for feeling safe and part of a cohesive group, such as a faith community
- Kin recognition or having tradition-specific attributes and rituals that separate and unify adherents (e.g., dress, holy days, labels for religious kin like "brother," "sister," "elder")
- Social hierarchy (e.g., for theists, the ultimate "alpha male" is God; local congregations have some stratification of members)
- Social exchange and reciprocal altruism that assures the believer that ultimately life will be good and fair (e.g., righteousness will be rewarded with a blissful afterlife, evil will be condemned at a final judgment).

These systems indeed allow humans to adapt to life's challenges and protect our species.

Social scientists have theorized that religion will die due to modernization and secularization. This prediction, however, continues to be disproved (Hefner, 2009). While in some areas of the world ecclesiastical religion may be declining, overall, there has been an increase in religiosity globally. Religion, regardless of its causal factors, appears here to stay.

RELIGION DEFINED

Although over a century of scientific study of religion from the perspective of multiple disciplines has produced numerous theories, there is no one commonly used definition of religion. The definition accepted for this discussion about religion in patient care is that offered by Hill et al. (2000):

> The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term "search" refers to attempts to identify, articulate, maintain, or transform. The term "sacred" refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual. (p. 66)

This definition contains the criteria for spirituality. To define religion, Hill et al. suggest this definition of spirituality must be extended to also include or instead be "A search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has as its primary goal the facilitation of [the above criterion for spirituality]" and "the means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people" (p. 66). Thus, religion involves individuals seeking that which is ultimately sacred using prescribed means endorsed by a group.

Whereas the concept now labeled "spirituality" was until relatively recently considered an aspect of religion, most academics now distinguish spirituality from religion. Indeed, this distinction between spirituality and

religion is now common in the general public. Indeed, a few studies have documented that while the majority of Americans self-define as spiritual and religious, a substantial minority view themselves as spiritual but not religious (Grant, O'Neill, & Stephens, 2003; Zinnbauer et al., 1997). Although religion is typically thought of as institutional and objective while the very elastic and generic term spirituality is individual and subjective, these two concepts are deeply intertwined (Hill et al., 2000).

A CAVEAT: WHEN RELIGION HARMS

The evidence referenced above indicates that, overall, religion is good for one's health. This, however, is not always true. If the product of religiosity is confusion, despair, isolation, helplessness, meaninglessness, detachment, or resentment, then that religiosity is causing harm (Griffith, 2010).

Pargament and others differentiate between religious coping that is positive or is negative (Ano & Vasconcelles, 2005; Pargament, Koenig, & Perez, 2000). Negative religious coping is exemplified by Demonic reappraisals (e.g., "Decided the devil made this happen"), reappraisal of God's power (e.g., "Realized that God cannot answer all my prayers"), passive religious deferral (e.g., "Didn't do much, just expected God to solve my problems for me"), and pleading for direct intercession (e.g., "Prayed for a miracle"). Thus, when a religious person holds beliefs that are not assuring or comforting, create unhelpful guilt or shame, instill passivity, or create a sense of abandonment, this is not healthful. Numerous studies have documented that such negative religious coping is correlated with poor adjustment during health challenges (Ano & Vasconcelles).

Griffith (2010), a Christian psychiatrist, offers an in-depth explanation about how religion can become harmful or healing. Griffith asserts that religion becomes harmful when one of three core roles of religion is prioritized over the others, diminishing personal spirituality (or "whole person relatedness"). That is, if any one of the roles of religion to ensure group security, strengthen the adherent's sense of worth, or ease personal suffering becomes significantly more important to the believer than are the other two roles, then religion becomes harmful. Such imbalance is manifested then in religiosity that contributes to suffering, such as when one experiences the divine as an insecure attachment figure, when one searches for security primarily within a religious group, when one accepts religious beliefs to the exclusion of any alternative beliefs, or when a religious group protects only their own. Mental illness can also undermine religious experience. Griffith identifies how religious beliefs can be the vehicle expressing mental illness. Mood disorders, anxiety, and psychoses can distort religious experience as well.

Ultimately, religion becomes harmful when personal spirituality becomes diminished or dies (Griffith, 2010). Healthy personal spirituality involves: a whole person relatedness or "I/thou" relationship with the

divine; personal encounters with the sacred that stimulate creativity, reflection, and moral thinking; a dedication to being compassionate toward others and oneself; resilience; and an ability to prioritize the well-being of self and others over those of the religious group. Griffith's observations confirm what some research indicates as well: It is a combination of positive religiosity and intrinsic personal spirituality that may be most adaptive and healthful (Taylor, 2011).

PRIMARY PRACTICE POINTS

- Research evidence indicates direct associations between religion and health.
- Nurses have many reasons for recognizing patient religiosity. These include the fact that religion is prevalent, that some religious practices have health-related implications, and that some health-related events have religious implications for adherents of some religions, and professional mandates.
- Religion serves many functions, from social cohesion to intrapsychic comfort.
- When religion lacks personal spirituality (whole person relatedness), it becomes harmful.

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