DECISIONS OF ADVANCED DIRECTIVES IMPACTED BY POSITIVE AND NEGATIVE RELIGIOUS COPING MECHANISMS

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Except where reference is made to the work of others, the work described in this thesis is my own or was done in collaboration with my advisory committee. This thesis does not include propriety or classified information.

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THESIS ABSTRACT

DECISIONS OF ADVANCED DIRECTIVES IMPACTED BY POSITIVE AND NEGATIVE RELIGIOUS COPING MECHANISMS

Aging is inevitable. However, now we have the medical technology to prolong life. This new technology gives us options when equating quantity of life versus quality of life. Patients are asked to voice their desires regarding end of life care.

The literature clearly illustrates that the preponderance of older adults use religion to cope with stress related to geriatric issues. This study examines if there is a link between positive and negative religious coping styles and decisions concerning life-sustaining treatments.

An observational study was designed in which 107 patients of nursing homes residing in south Alabama were interviewed. Scales that measured positive and negative coping were applied in the study to see if there were a correlation between religious coping mechanisms and decisions about advanced directives. The conclusions from this study did not show any direct correlation between advanced directive and positive or negative religious coping mechanisms. Age was the only factor that was positively associated with decisions regarding end of life care.

Vita

Amy Elizabeth Hood is the daughter of Danny and Debra Hood. She was born November 30, 1979 in Montgomery, Alabama. She graduated from Greenville High School in 1998. She attended Southern Union Community College, where she received her Associate of Science in 2001. She subsequently attended Faulkner University and received a Bachelor of Science degree in Psychology in 2003. She began graduate school at Auburn University at Montgomery in the summer of 2003. She married Steven Wingard, son of Sam and Barbara Wingard on June 10, 2006.

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STYLE MANUAL AND SOFTWARE USED

Publication Manual of the American Psychological Association

Microsoft Excel

SAS Computer Software

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Decisions of Advanced Directives Impacted by Positive and Negative Religious Coping Mechanisms

In the United States, the baby boom generation will average 65 years of age by 2011 (Teno, 2004). This group of people represents the largest increase in the elderly population as compared to previous generations. As this group continues to age there will be increasing morbidity and mortality as well as other issues that relate to the illnesses of this group. Medical advances have enabled individuals to live longer without necessarily maintaining a desirable quality of life. As the population ages there has been heightened awareness of the need to establish one's wishes regarding medical care nearing the end of life through the use of an advanced directives. A growing number of people have decided to take an active role in end of life decisions (Teno, 2004). Teno (2004) reported a survey from 22 states that estimated that 71% of people with terminal illnesses in these particular states had instituted an advanced directive (commonly known as living wills). These decisions are being made as people become cognizant that many chronic diseases result in a very poor quality of life due to immobility, chronic pain, and extreme dependency on others. These decisions are most often expressed as advanced directives, which are now legal throughout the United States (Winick, 1998). Many individuals do not wish to prolong life when arduous and often-painful illnesses or therapies are involved, especially when the application of these therapies is known to be ultimately futile.

Advanced directives enable people to legally articulate their formal desires about refusing or withdrawing life extending medical treatments before they are rendered physically incapable of doing so. An example of one of these decisions is whether the

patient wishes to receive nutrition through feeding tubes or intravenous methods. The advanced directive details whether the patient wishes to be resuscitated when there is cardiopulmonary collapse or to withdraw pertinent medication.

Alabama law acknowledges that most individuals are mentally competent, and, therefore, should make decisions about end of life care (Alabama Code, § 22-8A-4, 1975). Living wills and other types of advanced directives legally express the explicit wishes of the patient. Specifically, in the state of Alabama, a statute was passed in 1975, (Alabama Code § 22-8A-4, 1975) outlining the legal method for the use of advanced directives or living wills. The statute consists of detailed instruction for completion of health care proxy. The health care proxy is the final prepared document that outlines all the individual's wishes regarding end of life care. Some of the requirements for the living will are: Any competent adult may execute a living will directing the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration. Artificially provided hydration and nutrition shall not be withdrawn or withheld to the living unless specifically authorized (Alabama Code, § 22-8A-4, 1975). A competent adult may execute a living will at any time. It includes a written health care proxy designation appointing another competent adult to make decisions regarding the providing, withholding, or withdrawal of life sustaining treatment and artificially provided nutrition and hydration. The healthcare proxy clearly outlines the proper format for designating a legal guardian. "A proxy designation made pursuant to this section will be attached in writing by the individual being appointed either as a separate document or as a part of the living will" (22-8A-4, Alabama Advanced Health Care Directive, 1975, p.1). This statute's format is similar to those of other states. There is no national

standard or federal statue regarding advanced directives (Federal Patient Self-Determination Act, 123, 60 § Fed. Reg. 33294 1995).

Some individuals are not mentally competent, and therefore, cannot make decisions pertaining to living wills. If the individual is deemed incompetent then a legally appointed guardian must make decisions on his behalf regarding providing, withholding, or withdrawal of life-sustaining treatment and artificially providing nutrition and hydration. The living will becomes effective when: the attending physician determines that the declarant is no longer able to understand, appreciate, and direct his or her medical treatment, or two physicians, one of whom shall be the attending physician, and one of whom shall be qualified and experienced in making such decisions, having personally examined the individual and having diagnosed and documented in the medical record that the patient is terminally ill or injured or is in a state of permanent unconsciousness (22-8A-4, Alabama Advanced Health Care Directive, 1975).

Living wills are legal in all fifty states and the federal government now requires all hospitals to discuss and document upon admission to the hospital whether the patient has an advanced directive (Federal Patient Self-Determination Act, 123, 60 § Fed. Reg. 33294 1995). If the patient has an advanced directive that is noted in the medical record then the health care team can discuss and follow the wishes of the patient. If an advanced directive does not exist, then the legal guardian will be contacted for his or her input regarding terminal care of the patient. However, in the case of an emergency, full life sustaining measures would be taken, which may include cardiopulmonary resuscitation and/or ventilator support to maintain life processes until a decision could be reached by the appropriate legal guardian. If there is not an appointed legal guardian, then the life

sustaining treatments continue until the patient expires. The advanced directive and the federal requirements concerning advanced directives thus open the communication lines between the patient and health care providers to ensure that the patient's needs are met. The American Medical Association also encourages physicians to address end of life wishes with all of their patients (Federal Patient Self-Determination Act, 123, 60 § Fed. Reg. 33294 1995). Physicians and patients need to come together and share in the responsibility in order to make sure the needs of the patients' are documented and carried out.

As the life expectancy of the general population continues to increase more individuals are choosing to make decisions regarding advanced directives. There have been few studies in the psychological literature that have clearly addressed elements of coping used by patients in making their final decisions concerning end of life care. However, the literature is clear that the majority of older adults report using religion as a coping mechanism to deal with the many challenges of the stresses associated with geriatric issues (Emery & Pargament, 2004). The majority of this research was done by geriatric centers such as Duke University. The geriatric literature has begun to address the effects of religion on areas such as well-being and physical health as well as psychological factors such as depression. Advanced age is associated with extreme losses, which include losses of identity, functional ability, health, relationships, and autonomy. These losses often lead to depression and are expressed as anger, loneliness, and a loss of self-esteem (Koenig, O'Connor, Guarisco, & Ford, 1993). It is imperative to find some means of coping with these losses in order to preserve self-identity and self worth.

Studies have shown that the elderly often think about death. However, they actually think about death less than other age groups do (Koenig, George, & Siegler, 1998). Despite numerous problems with health and the loss of social and economic resources, older adults in general have fewer mental disorders and report better life satisfaction than the younger population (Koenig, George, & Siegler, 1988). Nonetheless, depression at any stage distorts a person's thinking and may increase thoughts about death. As the stressors of age increase, the development of depression frequently is manifested in the elderly by uneasiness about the prospect of death. There is a greater incidence of suicide in the elderly, and if suicide is entertained, it is more likely that the elderly individual will carry out the act of suicide (Hall, Hall, & Chapman, 2003). "In 1998, the rate of completed suicide for individuals age 80-84 was 26.5/100,000 persons/year, compared to a rate of 12.6/100,000 persons/year for the general public" ((Hall, Hall, & Chapman, 2003). These acts of suicide may be a passive act such as refusal to eat and accept additional medical care. These patients frequently become despondent and simply withdraw and die in hospitals or nursing homes.

Individuals who have not developed effective coping mechanisms in their formative years of life seem to have little hope of dealing with issues pertaining to aging. They do not have the proper coping skills to deal with issues such as loss of loved ones, fading health, and loss of independence (Emery & Pargament, 2004). However, frequently this same population has tools not readily available to those who are younger (Baltes, Smith, & Staudinger, 1992). These tools include life experiences and wisdom gained over time (Baltes, Smith, & Staudinger, 1992). One of the more crucial tools they possess is the resource of spirituality and religion. This has been confirmed by Gallup

poll data showing that more than 70% of older adults state that religion is a top priority in life while only 46% of younger adults have the same priority (Gallup & Lindsay, 1999). It is well documented that as one advances in age, religion becomes a more important coping mechanism for most of the population (Emery & Pargament, 2004). One of the more active components is the use of prayer that increases 40% from the age of 16 to the age of 60 (Haley, Koenig, & Bruchett, 2001). The literature also suggests that spirituality and religion can alleviate negative health factors such as high blood pressure, cancer, and can positively impact mortality (Pargament, Koenig, & Perez, 2001).

Pargament, Smith, Koenig, and Perez (1998) have described two types of religious coping: positive and negative religious coping. Pargament et al. (2001) define positive religious coping, as "an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others" (Pargament, Koenig, Tarakeshwar, & Hahn, 2001, p. 2). Negative religious coping is "an expression of a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance" (Pargament, Koenig, Tarakeshwar, & Hahn, 2001, p. 3). Studies have demonstrated better physical and mental well-being in patients who use positive religious coping, and poorer physical and mental well-being of those using negative religious coping mechanisms (Bush, 1999).

Pargament's (1988) research has identified three different styles of religious coping, which are the deferring style, collaborative style, and the self-directing style. The deferring style is based on the need to relinquish control to God. This style is marked by a sense of not placing any responsibility on the individual. This is a very passive

approach, in which accountability is deflected off the individual and onto God. Conversely, the self-directing style the control is placed squarely on the individual. In more detail, self-directing style is a coping mechanism in which the individual takes on "an active problem-solving stance" (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1998, p. 91). The individual does not involve God directly in this process of coping. However, this does not denote a negative relationship with God, but rather is seen as a higher power giving one the necessary resources and freedom to make decisions (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1998). The collaborative style consists of an alliance between God and the individual to work together and share responsibility of coping. In this style, there are no passive participants, and both the individual and God take on active roles.

Negative coping mechanisms used by patients have been demonstrated to have a significant negative impact on the mortality of these subjects. Pargament et. al (2001) noted that medically ill elderly patients who felt deprived of God's love or felt God was punishing them for transgressions had an increased death rate than those who did not (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). This negative pattern of coping was associated with religious re-evaluations that were negative and frequently associated with a questioning of God's powers and anger towards God as well as a general spiritual discontent. Thus, those who use positive mechanisms are more likely to see their religious experiences as a source of hope and love rather than one of increasing pain and punishments. The initial studies on this topic have shown that people with positive religious coping methods do have better outcomes when faced with coping with stressful health issues. Conversely negative religious coping is associated with poorer outcomes

when faced with these same stressors (Pargament, Smith, Koenig, & Perez, 2001). For example, among a sample of medically ill older adults, Koenig, Pargament, and Nielsen (1998) found that positive religious coping was associated with increased self-esteem, life satisfaction, and quality of life (Koenig, Pargament, & Nielsen, 1998, p.15). On the other hand, individuals who felt God had abandoned or were punishing them reported poorer health, quality of life, and demonstrated heightened functional impairment (Emery & Pargament, 2004).

Some studies have focused on the relationship between religious coping and other facets of mental and physical well-being. For example, Bush et al. (1999) examined the role of religious and nonreligious coping in a sample of chronic pain patients and found that positive religious coping strategies were associated with positive outcomes while negative religious coping had no significant association with outcome variables. In their research on cancer patients, Cassileth, Lusk, Strouse, and Bodenheimer (1984) and Yates, Chalmer, James, Follansbee, and McKegney (1981) demonstrated that religious beliefs and coping mechanisms were positively correlated with life satisfaction, and religious activity was significantly correlated with both happiness and life satisfaction. The patients who used religious coping mechanisms reported significantly lower levels of pain. However, there was no correlation between the religion variables and survival. Both of these studies clearly demonstrated that religious coping was an important source of support for the patients.

Kaldjian et al. (1998) demonstrated that spiritual beliefs and religious practices in a HIV positive population appeared to play a major role in end of life decisions. They established that patients who had a strong belief in a forgiving God were more accepting

of their condition than those who perceived HIV as a punishment. The study supports Pargament's same argument regarding positive and negative religious coping. Additional studies among disabled, elderly patients have confirmed that positive religious beliefs to some extent are correlated with overall well-being (Idler & Kasl, 1997).

It is apparent that the current stage of research is necessarily shifting from simply asking questions about the general effect of religion on outcomes of stressors to answering the more important question: Are there beneficial or harmful styles of religious coping? Emery and Pargament (2004) appropriately point out that the more complex question is "Does the patient use religion or spirituality to help cope with illness, or is it a source of stress and how?" (Emery & Pargament, 2004, p. 17). Once this is assessed then psychologists and health care personnel can better determine how this information can influence decisions regarding health care. Religious beliefs clearly impact the medical decisions of patients and their loved ones (Ehman, 1999). These medical decisions directly influence choices about end of life directives and other options such as hospice or continued long term medical care (Koenig, 2002).

The purpose of this study is to evaluate the potential impact of positive and negative religious coping mechanisms in relationship to the decision of enacting a living will or advanced directive. The studies of Koenig, Pargament, and Nielsen (1998) concluded, "among a sample of medically ill older adults that positive religious coping was associated with increased self-esteem, life satisfaction, and quality of life" (Koenig, Pargament, & Nielsen, 1998, p. 518). Therefore, it is hypothesized that individuals who utilize positive religious coping mechanisms will be more likely to have an advanced directive as compared to those who use negative religious coping mechanisms. It is also

further hypothesized that individuals with positive religious coping mechanisms will be more likely to desire more life sustaining treatments than individuals with negative coping religious mechanisms. Individuals, who have negative religious coping mechanisms, may believe that God is punishing them for their transgressions. Based on this finding, it is reasonable to hypothesize that they might reject life-sustaining treatments believing them futile and resulting in further physical discomfort. In contrast, individuals with positive religious coping mechanisms tend to view God as both forgiving and compassionate. They also view their relationship with God as a working alliance, in which both God and the individual work together for the well-being of the individual. People with positive religious coping mechanisms tend to be more motivated and optimistic and realize that they are in a partnership with God. This partnership further propels them to participate more vigorously in their own recovery. To reiterate, the following hypothesis will be tested: individuals who possess positive religious coping will be more likely to have an advanced directive than individuals that exhibit negative religious coping, and individuals who demonstrate positive religious coping will desire more life sustaining treatments than individuals that use negative religious coping.

Method

Participants

The study sample was comprised of 107 residents living in nursing homes in rural south Alabama. The participants were drawn from the following nursing homes: Crowne Health Center of Montgomery, Crowne Health Care of Greenville, Englewood Healthcare at Monroeville, Crowne Healthcare of Mobile, Westgate Village Incorporated

of Brewton, Georgiana Rehab and Health Facility, Evergreen Nursing Home, Luverne Nursing Facility, and Cogburn Nursing Center at Mobile.

The participants ranged in age from 55 to 99 years with a mean age of 77 years, and a standard deviation of 11.9 years. Participants were predominantly Caucasian (83.1%), female (71.03%), and widowed (56.1%). Most of participants did not have an advanced directive (59.8%). Most participants (38.3%) were high school graduates while 37.4% did not receive high school diplomas. The remaining 24.3% had at least some post-secondary education. The majority of participants acknowledged a religious affiliation. The majority were Baptist (48.6%) and18.7% were Methodist. Fewer than 10% reported no religious affiliation.

Facility social workers provided information about residents' socioeconomic status. The social workers took the following the factors into consideration when classifying the socioeconomic status of each participant: occupation, type of room such as private pay room, Medicare or Medicaid reimbursed rooms, and method of payment such as private pay, Medicare, or Medicaid. The majority of the population was classified as middle class (72.9%), and many fewer were in the higher socioeconomic status category (2.8%). Table 1 summarizes all sample demographic characteristics for the participant sample.

Table 1

Demographic Characteristics of Nursing Home Resident Sample (n=107)

Variable	n	Percent
Marital Status		
Divorced	17	15.9
Married	9	8.4
Separated	2	1.9
Single	19	17.8
Widowed	60	56.1
Race		
African American	18	16.8
Caucasian	89	83.2
Sex		
Women	76	71
Men	31	29
Mini Mental State Examination Score		
12	1	.9
18-20	16	15
21-23	26	24.3
24-26	35	32.7
27-29	26	24.3
30	3	2.8
Mini Mental State Score Classification		
Greater than 23	71	66.4
Less than 23	36	33.6
Advanced Directive		
No Advanced Directive	64	59.8
Advanced Directive	43	40.2
Education		
Less than High School	40	37.4
High School Graduate	41	38.3
Greater than High School	26	24.3
Religious Preference		
Baptist	52	48.6
Methodist	20	18.7
None	10	9.4
Other	25	23.7
Socioeconomic Status	3	2.8
High	3	2.8
Medium	78	72.9
Low	26	24.3

Table 2 shows the frequencies of occupations among the participants. Most participants were homemakers (21.5%). Other leading categories of employment were skilled laborers (20.6%), laborers (19.6%), professionals (21.5%), and individuals in the academic field (9.4%). The minority is comprised of disabled individuals (.93), military (1.9%), individuals have remained unemployed for the duration of their lives (1.9%), and business owners (2.8%).

Table 2

Occupations Reported by Nursing Home Resident Study Participants (n=107)

Occupation	n	Percent
Business Owner	3	2.8
Disabled	1	0.9
Education	10	9.3
Farmer	5	4.7
Housewife	23	21.5
Laborer	21	19.6
Military	2	1.9
None	2	1.9
Professional	13	12.1
Sales	5	4.8
Skilled Laborer	22	20.6
Total	107	

Instruments

Measures used in this study include a religious coping scale, a psychiatric symptom scale, and a dementia screening test, and a sheet for recording demographic information. Demographic information collected on the participants included age, sex, race, education, socioeconomic status, occupation, marital status, and religious affiliation (See Appendix D). The interviewer obtained the demographics by asking the participants

directly. The following is a description of the other instruments that were used in this study:

Primary Care Evaluation of Mental Disorder Patient Health Questionnaire: The Primary Care Evaluation of Mental Disorder (PRIME-MD PHQ, Spitzer, Kroenke, & Williams, 1999) is a screening device used to evaluate mental disorders in primary care settings (See Appendix B). This scale consists of 55 items about symptoms that may be answered 'yes' or 'no.' High scores are indicative of a greater likelihood of the disorder than low scores. The Primary Care Evaluation of Mental Disorder Patient Health Questionnaire also asks about the frequency and degree to which a symptom bothers the individual. This scale was modified for this study by omitting certain questions pertaining to women's health such as menstruation, pregnancy, and childbirth as well as eating disorder questions. These questions were eliminated because they do not typically impact the geriatric population. The remaining scale items screen for the following disorders: mood, anxiety, somatoform disorder, and alcohol abuse. "The scores classify as symptom screen-negative, symptom screen-positive but no psychiatric diagnosis, subthreshold psychiatric diagnosis, and threshold psychiatric diagnosis. This measure has demonstrated evidence of reliability and validity in patients in primary care settings. "The PRIME-MD PHQ has an overall accuracy rate of 85% and (Cohen's Kappa) k=0.65 (for all measures, $p<.001$)" (Spitzer, Kroenke, & Williams, 1999, p. 1737).

Brief RCOPE: This scale was developed by Pargament, Smith, Koenig, and Perez in 1998 (See Appendix C). This scale is used to assess style of religious coping. The scale consists of ten items taken from a subset of the RCOPE. The scale has ten items based on a four point Likert scale with response categories ranging from "not at all" to "a great

deal." A positive coping score of five and a negative coping score of twenty places an individual in the category of positive religious coping only. An individual that obtains a negative coping score of less than twenty and a positive coping greater than five is considered to demonstrate negative religious coping only. The scale also has two other categories in which an individual can exhibit either both positive and negative religious coping or neither. In order to be classified as both, an individual must score a positive coping score of five and a negative coping score of less than twenty. The individuals that are categorized, as neither positive nor negative religious coping will yield a positive coping score of greater than five and a negative coping score of twenty. The five positive items yield a score for benevolent religious involvement in the search for significance and five-item negative scale that yields religious struggle in coping. "The RCOPE has received factor analytical support, and it has shown evidence of internal consistency, criterion related validity and incremental validity in two diverse samples" (Pargament, 1997, p. 46).

Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975): This scale is used to systematically and thoroughly assess mental status. It consists of eleven questions that test five areas of cognitive function, which are orientation, registration, attention, calculation, and recall and language. The maximum score is 30, and a score of 23 or lower is indicative of cognitive impairment. Since its creation in 1975, the MMSE has been validated and used extensively in clinical and research modalities.

Procedure

The investigator described the research to prospective participants, explaining that it required providing demographic information and responding to questions about

religious attitudes and living wills (see Appendix E). The examiner also obtained each participant's consent to participate in the study and grant of access to information contained in medical records (See Appendix A). Nursing home staff collected all necessary information from medical records and summarized on a data sheet that was returned to the researcher. The medical records were reviewed in order to assess the participants' decision regarding advanced directives. The medical records were also examined to see if the individual had an advanced directive specifying the desire to receive artificial hydration and nutrition or any other life sustaining treatment. Participants were also informed that the results of this investigation would be contained in a published thesis and article but that no identifying information would be revealed.

The researcher allowed the participants to read and respond to the questionnaires used in the research. The researcher read the questions to any participant unable to read or respond in writing to the questionnaire items. The instruments were administered in the following order: Primary Care Evaluation of Mental Disorder Patient Health Questionnaire (PRIME-MD PHQ) and Brief RCOPE. The Mini Mental State Examination score is filed under each resident's medical records and was provided by staff, which conducted the records reviews. When they finished the questionnaires, the participants were invited to ask any questions about the study or to discuss any problems related to their participation. The purpose of the study was explained to the participants, and they were reminded once again that all information would be kept confidential.

Results

SAS programs were used for all data analysis. The Mini Mental State Examination has a cutoff of 23 for the presence of dementia. Normative data is corrected

for level of education and age (Alagiakrishnan & Masaki, 2007). These two factors should be considered when making a diagnosis of dementia with this scale. In the current study, participants had a mean of 24.1 with a standard deviation of 3.4 on the Mini Mental State Examination. The range was between 12 and 30 with this particular sample. About two-thirds of the sample obtained scores greater than 23. The staff from each nursing home provided the scores for the Mini Mental State Examination for each patient. This information was acquired from the patients' medical records. The Mini Mental State Examination is given upon admission to the nursing home, and as a result, some participants were ill at the time that the measure was administered. This may account for some of the lower scores on the Mini Mental State Examination. However, during the interview process none of the participants appeared to be cognitively impaired.

The variables PRIME-MD PHQ Somatic Disorder, PRIME-MD PHQ Anxiety Attack, and Mini Mental State Scores were categorized by yes or no to denote their presence or absence. It was anticipated that positive and negative coping scales would be negatively correlated with each other. However, the present study demonstrated otherwise. The analysis shows a very low correlation with r= -.02 (p=.82). An individual has the potential to exhibit both positive and negative religious coping or display neither styles of coping. This is indicative of the results generated by this study. Therefore, there are four religious coping groups in this model.

The positive and negative coping scale scores were used as follows to divide the sample into four religious coping groups. Positive copers were defined as those participants who had a positive coping score of five and a negative coping score of twenty. Negative copers were defined as having a negative coping score less than twenty

and a positive coping score greater than five. Mixed positive and negative copers had a positive coping of five and a negative coping score of less than twenty. Participants who exhibited neither positive nor negative religious coping styles had a positive coping score of greater than five, and a negative coping score of twenty. Table 5 demonstrates that the majority of the participants fell into the negative religious coping category (31.8%). The second largest group consisted of neither positive nor negative religious coping (27.1%), and both positive and negative coping along with the positive religious coping were coupled with 20.6%.

Table 3

Frequencies of Four Styles of Religious Coping Among Nursing Home Residents

Religious Coping	n	Percent
Negative Only	34	31.8
Neither Positive nor Negative	29	27.1
Both Positive and Negative	22	20.6
Positive Only	22	20.6

Logistic regression was used with advanced directive as the outcome variable, and religious coping group (positive coping, negative coping, positive and negative coping, neither positive nor negative coping), sex (male vs. female), race (white vs. black), age (in years), PRIME-MD PHQ Somatic Disorder (yes vs. no), PRIME-MD PHQ Anxiety Attack (yes vs. no), and Mini Mental State Score categorized as indicative of dementia or not as predictors. Table 4 presents the variables in the multivariate model and their relationship to the outcome of having an advanced directive.

Age was the only significant variable in the model (Wald $\chi^2 = 9.26$ $p < 0.002$) and was positively associated with having an advanced directive. Older participants were more likely to have an advanced directive than younger participants. The odds of having

an advanced directive increase by 8% for every year of age. Although, PRIME MD PHQ Somatic Disorder and PRIME MD PHQ Anxiety Attack were not statistically significant, a trend was detected. This trend states that if an individual does not have the presence of a PRIME MD PHQ Anxiety Attack or PRIME MD PHQ Somatic Disorder, they will be more likely to have an advanced directive.

Table 4

Analysis of Effects of Religious Coping Styles and Covariates on Decision to Implement Advanced Directives

Effect	df	Wald χ^2	*p*
Religious Coping Style	3	1.58	0.6
Sex (Male vs. Female)	1	1.29	0.2
Race (Black vs. White)	1	0.44	0.5
Age (Years)	1	9.3	0.0
PRIME-MD PHQ Somatic Disorder (Yes vs. No)	1	3.2	0.0
PRIME-MD PHQ Anxiety Attack (Yes vs. No)	1	3.5	0.0
Mini Mental State Dementia (Yes vs. No)	1	1.36	0.2

Table 5 depicts the life sustaining treatments that individuals may choose when enacting an advanced directive. The bulk of nursing home residents chose to have CPR and ventilation (67.3%). Residents were also more inclined to want feeding tubes (78.5%). Almost all of the participants did not wish to have withdrawal of medication (90.65%).

Table 5

Frequency of Authorization of Specific Life Sustaining Treatments in Nursing Home Residents' Advanced Directives

Treatment	n	Percent
Cardiopulmonary Resuscitation		
No	35	32.7
Yes	72	67.3
Ventilation		
No	35	32.7
Yes	72	67.3
Feeding Tube		
No	23	21.5
Yes	84	78.5
Medication Withdrawal		
No	97	90.7
Yes	10	9.4

Logistic regression was used with age, religious coping style (positive religious coping only, negative religious coping only, both positive and negative religious coping, neither positive nor negative religious coping), sex, race, PRIME-MD PHQ Somatic Disorder, PRIME-MD PHQ Panic Attack, and dementia as the predictor variables. A separate model was run for each outcome variable. Outcome variables were authorization of CPR, ventilation, withdrawal of medication, and feeding tube. Age was the only variable significantly associated with authorization of CPR, ventilator support, and medication continuation (see Table 6). Younger residents were more likely than older residents to have authorized these interventions. Religious coping was not associated with the desire to have life sustaining treatments.

When analyzing desires regarding feeding tubes, a Quasi-complete separation occurred during the analysis. Quasi-complete separation occurs when one of the predictor variables is almost perfectly correlated with the outcome variable. Therefore, the predictor variable must be removed from the model in order to eliminate the separation. However, in the case of the feeding tube, the religious coping variable that is causing the separation. Unfortunately, taking out the other predictor variables such as dementia, age, sex, PRIME-MD PHQ Somatic, and PRIME-MD PHQ Anxiety Attack did not correct the problem. Therefore, it is not possible to generate a valid model for the relationship between religious coping and authorization of feeding tube.

Table 6

Analysis of Effects of Age on Decision to Opt for Specific Life Sustaining Treatments

Effect	df	Wald χ^2	*p*
Cardiopulmonary Resuscitation			
Age	1	7	0.01
Ventilation			
Age	1	7	0.01
Withdrawal of Medical Treatment			
Age	1	5.91	0.02

Discussion

Results of this study demonstrate that positive and negative religious coping are not related to decisions regarding end of life care. It was hypothesized that positive religious coping would be associated with the enactment of a living will but negative religious coping would not. The results indicate that neither positive nor negative religious coping influences the decision to enact a living will. Furthermore, individuals that relied on positive religious coping did not choose more life sustaining treatments

than individuals that relied on negative religious coping. However, the results did exhibit a link between age and the signing of advanced directives.

Older individuals are more likely to have an advanced directive. Age also impacts specific advanced directive options such as CPR, ventilation, and withdrawal of medication. Younger residents are more likely to desire CPR, medication continuation, and ventilation than older residents. These findings may mean that older patients are more interested in quality of life rather than quantity of life, and therefore, would not want to prolong life via extraordinary means. Conversely, younger individuals may not be as accepting of his or her mortality, and as a result may be eager to extend life by any means necessary. Bradley et al. (1998) documented that nursing home residents under age 75 were less likely to complete an advanced directive (Bradley, Wetle, & Horwitz, 1998).

Although, this research demonstrated religious coping mechanisms did not impact choices concerning end of life care, it is important to understand how they may impact other facets of life. As noted earlier, religious coping can contribute to sense of well-being. Individuals, who have a secure, constructive relationship with God tend to report having a better quality of life (Emery & Pargament, 2004). One of the central issues raised by Pargament and Emery (2004) has yet to be answered: Whether spirituality assists in coping with illness or whether it a source of stress. Future studies will need to address whether spirituality and religion are a source of stress, and if so, how does this occur? Future studies may address other factors that influence end of life decisions.

The research from this study has several implications, even though the hypothesis was not confirmed. The methods used in this study are applicable to future studies

involving a variety of questions regarding advanced directives. It is clear from my observations; this is a growing, underserved population. Additional, future studies will allow psychologists to gain useful information in order to better treat this population as they approach death.

Study Limitations

One limitation of the study is the environment in which all of the data were collected. The data were collected from nursing homes in rural south Alabama. Data collected from areas outside of conservative, religious centered Alabama may generate different findings. The population is also relatively homogenous, and several religious affiliations were not represented in the study. It would be interesting to see if other than Protestant Christian denominations would produce different results.

Statistical Power Considerations

The study was proposed and carried out with the intention of comparing positive copers to negative copers. However, the low correlation between positive and negative coping scales meant that the groups were not mutually exclusive. In fact, besides positive and negative copers, there were participants who had both positive and negative religious coping styles and participants who had neither religious coping style. Eventual sample size of 107 would have moved the detection of an effect size of .25 at an alpha level of .05 with .73 power. In order to maintain, the same statistical power with the four groups that were obtained would have required a sample size of 150. With the four group religious coping variable, the effective statistical power was reduced to .56. If the original maximum goal of 130 participants were obtained, statistical power would have risen to .66 with the four-group variable.

Other limitations of the study were the focus on the elderly population and nursing homes. Age was the only factor that was positively associated with decisions regarding end of life care. This may mean analysis of various age groups other than the geriatric population may produce drastically different outcomes. Different age groups would probably have dramatically different views regarding religious coping and end of life decisions. Future studies may also collect participants in hospitals, assisted living, or outpatient.

Lastly, a limitation of the study was that the failure to document the type of illness that brought each participant to the nursing home. The severity of the illness was also not measured. As a result, the individuals that were very ill at the time of arrival to the nursing home might have been more likely to sign an advanced directive. Future studies may want to include the type and severity of the illness in order to decipher if that played a role in the participants' decision-making process.

Appendix A

Decisions of Advanced Directives Impacted by Positive and Negative Religious Coping Mechanisms

AUM Informed Consent

Investigator: Amy Hood

You are invited to participate in a study that is part of a graduate thesis. The study will aid in the evaluation of coping mechanisms with particular emphasis on the effect of positive and negative religious attitudes in any advanced directives or living wills. Medical records will be examined if consent is obtained. The medical records will be reviewed in order to assess your wishes regarding life-sustaining care. Life sustaining care includes artificial nutrition and hydration, medications, machines, or medical procedures that would keep you alive but would not cure you. You will be asked to respond to questionnaires. The study will take approximately one hour to complete. You may at any time terminate your participation in this exercise. Your identity in the study will remain confidential and results of the experiment will be published as part of a research project. The lead researcher is Amy Hood, who may be contacted if you have any additional questions regarding your participation in this project. The lead researcher may be contacted at 1-205-621-7388. Additional information may be obtained if I am

not available by contacting Dr. LoBello, Ph.D. at the Department of Psychology at AUM.

YOU ARE MAKING A DECISION WHETHER TO PARTICIPATE. YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THIS INFORMATION PROVIDED ABOVE.

_____ _____

Signature of Volunteer or Person Date

Authorized to Sign for Volunteer

_____

Witness

Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

DATE _____ NAME _____ AGE _____ SEX Female Male

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	[ ]	[ ]	[ ]
b. Back pain	[ ]	[ ]	[ ]
c. Pain in your arms, legs, or joints (knees, hips, etc.)	[ ]	[ ]	[ ]
d. Menstrual cramps or other problems with your periods	[ ]	[ ]	[ ]
e Pain or problems during sexual intercourse	[ ]	[ ]	[ ]
f Headaches	[ ]	[ ]	[ ]
g. Chest pain	[ ]	[ ]	[ ]
h. Dizziness	[ ]	[ ]	[ ]
i. Fainting spells	[ ]	[ ]	[ ]
j. Feeling your heart pound or race	[ ]	[ ]	[ ]
k. Shortness of breath	[ ]	[ ]	[ ]
l. Constipation, loose bowels, or diarrhea	[ ]	[ ]	[ ]
m. Nausea, gas or indigestion	[ ]	[ ]	[ ]

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
b. Feeling down, depressed, or hopeless	[ ]	[ ]	[ ]	[ ]
c. Trouble falling or staying asleep, or sleeping too much	[ ]	[ ]	[ ]	[ ]
d Feeling tired or having little energy	[ ]	[ ]	[ ]	[ ]
e. Poor appetite or overeating	[ ]	[ ]	[ ]	[ ]
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	[ ]	[ ]	[ ]	[ ]
g. Trouble concentrating on things, such as reading the newspaper or watching television	[ ]	[ ]	[ ]	[ ]
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	[ ]	[ ]	[ ]	[ ]
i. Thoughts that you would be better off dead or of hurting yourself in some way	[ ]	[ ]	[ ]	[ ]

FOR OFFICE CODING:
Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation
Maj Dep Syn if #2a or b and 5 or more of #2a-i are at least "More than half the days" (count #2i if present at all)
Other Dep Syn if #2a or b and 2, 3 or 4 of #2a-i are at least "More than half the days" (count #2i if present at all)

3. Questions about anxiety.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack - suddenly feeling fear or panic?	[ ]	[ ]

If you checked "NO", go to question #5.

	NO	YES
b. Has this ever happened before?	[ ]	[ ]
c. Do some of these attacks come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable?	[ ]	[ ]
d. Do these attacks bother you a lot or are you worried about having another attack?	[ ]	[ ]

4. Think about your last bad anxiety attack.	NO	YES
a. Were you short of breath?	[ ]	[ ]
b. Did your heart race, pound, or skip?	[ ]	[ ]
c. Did you have chest pain or pressure?	[ ]	[ ]
d. Did you sweat?	[ ]	[ ]
e. Did you feel as if you were choking?	[ ]	[ ]
f. Did you have hot flashes or chills?	[ ]	[ ]
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	[ ]	[ ]
h. Did you feel dizzy, unsteady, or faint?	[ ]	[ ]
i. Did you have tingling or numbness in parts of your body?	[ ]	[ ]
j. Did you tremble or shake?	[ ]	[ ]
k. Were you afraid you were dying?	[ ]	[ ]

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	[ ]	[ ]	[ ]

If you checked "Not at all", go to question #6.

b. Feeling restless so that it is hard to sit still	[ ]	[ ]	[ ]
c. Getting tired very easily	[ ]	[ ]	[ ]
d. Muscle tension, aches, or soreness	[ ]	[ ]	[ ]
e. Trouble falling asleep or staying asleep	[ ]	[ ]	[ ]
f. Trouble concentrating on things, such as reading a book, watching TV	[ ]	[ ]	[ ]
g. Becoming easily annoyed or irritable	[ ]	[ ]	[ ]

FOR OFFICE CODING:
Pan Syn if #3a-d are all "Yes" and 4 or more of #4a-k are "Yes"
Other Anx Syn if #5a and answers to 3 or more of #5b-g are "more than half the days"

6. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered at all	Bothered a little	Bothered a lot
a. Worrying about your health	[ ]	[ ]	[ ]
b. Your weight or how you look	[ ]	[ ]	[ ]
c. Little or no sexual desire or pleasure during sex	[ ]	[ ]	[ ]
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	[ ]	[ ]	[ ]
e. The stress of taking care of children, parents or other family members	[ ]	[ ]	[ ]
f. Stress at work or outside of the home or at school	[ ]	[ ]	[ ]
g. Financial problems or worries	[ ]	[ ]	[ ]
h. Having no one to turn to when you have a problem	[ ]	[ ]	[ ]
i. Something bad that happened recently	[ ]	[ ]	[ ]
j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	[ ]	[ ]	[ ]

	NO	YES
7. Are you taking any medicine for anxiety, depression or stress?	[ ]	[ ]

Validation:
Spitzer RL et al, Validation and Utility of a Self-report Version of PRIME-MD: The PHQ Primary Care Study. JAMA. 282 (18): 1737, 1999.

Appendix C

Time Referent

When coping is measured dispositionally (as in the Brief RCOPE Short Form), no time frame is specified. When coping is measured situationally (as in the RCOPE Long Form), the items refer to the time frame of the specific life crisis.

Estimated Completion Time

Short Form (Brief RCOPE): 90 sec.-2 min.
Long Form (RCOPE): 30 min.

Proposed Items

RELIGIOUS/SPIRITUAL COPING-LONG FORM

*Indicates item is on the 3-item version of the given subscale.

Brief RCOPE Items

Instructions (Dispositional): Think about how you try to understand and deal with major problems in your life. To what extent is each involved in the way you cope?

Positive Religious/Spiritual Coping Subscale
(factor loadings> .60)

1. I think about how my life is part of a larger spiritual force (Search for Spiritual Connection).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

2. I work together with God as partners to get through hard times (Collaborative Religious Coping).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

3. I look to God for strength, support, and guidance in crises (Seeking Spiritual Support).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

4. I try to find the lesson from God in crises (Benevolent Religious Appraisal).
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

5. I confess my sins and ask for God's forgiveness (Ritual Purification).
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

Negative Religious/Spiritual Coping Subscale
(factor loadings> .53)

1. I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality (Punishing God Reappraisal).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

2. I wonder whether God has abandoned me (Spiritual Discontent).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

3. I try to make sense of the situation and decide what to do without relying on God (Self-Directed Religious Coping).*
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

4. I question whether God really exists (Religious Doubts).
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

5. I express anger at God for letting terrible things happen (Anger at God).
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

Overall Religious/Spiritual Coping Item

To what extent is your religion involved in understanding or dealing with stressful situations in any way?*
   1 - Very involved
   2 - Somewhat involved
   3 - Not very involved
   4 - Not involved at all

Appendix D

Demographics

Participant #:

Age:

Sex:

Race:

Education:

Socioeconomic Status:

Occupation:

Marital Status:

Religious Affiliation:

Appendix E

Advanced Directive

Cardiopulmonary resuscitation	Yes	No
Ventilation support	Yes	No
Feeding tube (Nutritional support)	Yes	No
Intravenous (Nutritional support)	Yes	No
Withdrawal of medical treatment	Yes	No

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