

Andover Newton Theological School

John Bauman, *The Role of Forgiveness in Rehabilitation*. Sharon Thornton, adviser. 2005.

The author proposes that unresolved forgiveness issues may affect the motivation of rehabilitation patients to participate in their physical therapy and that therapeutic outcomes may benefit if patients work through a forgiveness process. He suggests that chaplains may have a role in helping patients address their unresolved forgiveness issues and lowered motivation by helping the patients work through a forgiveness process. For patients with conditions caused at least in part by their own behavior, or even by someone else, this dissertation offers case studies of pastoral care provided in light of unresolved forgiveness issues and a working through of a forgiveness process. It presents a revised model of a forgiveness process that informs the pastoral care provided in the two main case studies. — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3167285, DAI-A 66/03 (September 2005): 1039.

Baylor University

Russell Joseph Hobbs, *Toward a Protestant Theology of Celibacy: Protestant Thought in Dialogue with John Paul II's "Theology Of The Body"*. Ralph C. Wood, adviser. 2006.

This dissertation examines the theology of celibacy found both in John Paul II's writings and in current Protestant theology, with the

aim of developing a framework and legitimation for a richer Protestant theology of celibacy. Chapter 1 introduces the thesis. Chapter 2 reviews the Protestant literature on celibacy under two headings: first, major treatments from the Protestant era, including those by Martin Luther, John Calvin, John Wesley, various Shakers, and authors from the English Reformation; second, treatments from 1950 to the present. The chapter reveals that modern Protestants have done little theological work on celibacy. Self-help literature for singles is common and often insightful, but it is rarely theological. Chapter 3 synthesizes the best contemporary Protestant thinking on celibacy under two headings: first, major treatments by Karl Barth, Max Thurian, and Stanley Grenz; second, major Protestant themes in the theology of celibacy. The fourth chapter describes the foundation of John Paul II's theology of human sexuality and includes an overview of his life and education, an evaluation of Max Scheler's influence, and a review of Karol Wojtyla's *Love and Responsibility* and *The Acting Person*. Chapter 5 treats two topics. First, it describes John Paul II's, *Theology of the Body*, particularly the section entitled "Virginity for the Sake of the Kingdom." There it examines Jesus's instruction in Matthew 19: 11–12, celibacy as vocation, the superiority of celibacy to marriage, celibacy as redemption of the body, Paul's instructions in 1 Corinthians 7, and virginity as human destiny. Second, this chapter reviews John Paul II's statements regarding celibacy found in various encyclicals, audiences, homilies, and speeches. Finally, Chapter 6 summarizes John Paul II's theology of virginity and reviews several Roman Catholic evaluations of his understanding of human sexuality. The chapter analyzes areas of commonality and contrast between contemporary Protestant thought on

celibacy and John Paul II's thought. In addition, the chapter highlights major areas in need of further development. Chapter 7, the conclusion, reviews discoveries and makes further suggestions. — Abstract from *Dissertation Abstracts International*, publ. no. 3195292, DAI-A 66/10 (April 2006): 3684.

Boston University

Kasey S. Buckles, *Childbirth Technologies and Women's Career and Family Outcomes*. Kevin Lang, adviser. 2006.

Since the early 1980s, medical technology has significantly improved the treatment of infertility. As a result, many women who would have been unable to have a child naturally are now mothers. At the same time, physicians have been increasing their use of cesarean sections. Because childbirth is such an important event in the life-cycle, these changes should affect not only the birth process but other aspects of women's lives as well, including career decisions. The first chapter of this thesis examines the effect that access to infertility treatments has had on birth outcomes, such as the incidence of multiple births and the timing of births. The author uses state time-series/cross-section variation in insurance coverage for infertility treatments to show that improved access to the technologies does result in changes in fertility behavior. Most notably, she finds that improved access increases the average age of mothers at first birth. In the second chapter, the author presents a simple model which illustrates the conditions under which the opportunity to delay career interruptions might lead to increased lifetime wages and increased human capital investment. She then looks for changes in women's labor force participation and lifetime wage profiles as a result of improved access to infertility treatments. Mandating insurance coverage increases labor-force participation for women under 35 years of age, and decreases participation for women over 35. Furthermore, ac-

cess to infertility treatments significantly increases wages for working women of all ages. Therefore, it appears that extending the biological window for childbearing does improve the career-family tradeoff for women by making delay less costly. Finally, in the third chapter the author uses geographic variation in the use of cesarean delivery to understand the extent to which high rates reflect inappropriate procedure use. Additionally, she explores the effect of higher usage on infant and maternal mortality. She finds that in areas where more cesarean sections are done, the marginal cesarean delivery is medically less appropriate for the procedure, and that area cesarean rates are not associated with improved infant or maternal survival. — Abstract from *Dissertation Abstracts International*, publ. no. 3186491, DAI-A 66/08 (February 2006): 3039.

The Bowman Gray School of Medicine at Wake Forest University

Jason D. Hipp, *Novel Stem Cells for Regenerative Medicine*. Anthony Atala, adviser. 2005.

Patients suffering from diseased and injured organs may be treated with transplanted organs. However, there is a severe shortage of donor organs, which is worsening yearly because of the aging population. Scientists in the field of tissue engineering apply the principles of cell transplantation, materials science, and bioengineering to construct biological substitutes that will restore and maintain normal function in diseased and injured tissues. Embryonic stem cells offer a novel opportunity of engineering unlimited numbers of any cell types in the body. However, they are surrounded by numerous ethical and political controversies, and their therapeutic application would result in immunological rejection. Thus, there is an urgent need for alternative stem cell resources and a better

understanding of the genetic components of stem cells and the mechanisms of their growth and differentiation in order for stem cells to be used clinically. This study explores stem cells derived from parthenogenesis and amniotic fluid. Parthenogenesis (the chemical activation of oocytes) allows for the creation of immunocompatible embryonic-like stem cells (PGESC), which are associated with limited controversy because no sperm is used in their creation. Pluripotent stem cells can also be isolated from human amniotic fluid during a regular procedure of prenatal diagnosis (amniocentesis). These stem cells are pluripotent, immunocompatible with the fetus, and free of ethical and political controversy. Microarrays are a new technology that measures the level of gene expression. Since very little is known about the genetic control of stem cell growth and differentiation, novel high throughput methodologies are necessary. Here the author describes how microarrays are being used to understand the growth and differentiation of stem cells with applications for tissue engineering and disease modeling.— Abstract from *Dissertation Abstracts International*, DAI-B 66/04 (October 2005): 1895.

Fordham University

Matthew D. Gee, *Thought and Discussion about Stopping Dialysis among Dialysis Patients*. Lee W. Badger, adviser. 2005.

People on dialysis are in a unique situation because of their continuous reliance on life-sustaining medical technology. Additionally, dialysis patients frequently have to make crucial decisions about their medical care such as what treatment modality is best for them (hemodialysis vs. peritoneal dialysis); whether kidney transplant is an option; and when to forego or withdraw from treatment. In the United States, voluntary withdrawal from dialysis accounts for approximately 17 percent of all deaths among dialysis patients. However, little is known about how often dialysis

patients think about and discuss this issue. The author surveyed eighty-five chronic dialysis patients (seventy-six receiving in-center hemodialysis and nine receiving peritoneal dialysis) and asked them how often they thought about and discussed stopping dialysis with a family member/caregiver or health-care provider. Participants were also asked what, if any, changes in their health status or personal life would cause them to consider stopping dialysis. The survey collected demographic data and assessed the relationships among locus of control, social support, spirituality, subjective health status, and how often dialysis patients thought about and discussed stopping dialysis. Participants in the study responded in one of three ways regarding thought and discussion about stopping dialysis: Group 1 participants reported that they had never thought about stopping dialysis (32 percent); Group 2 participants had thought about stopping dialysis rarely or sometimes but never or rarely discussed it with a family member/caregiver or health-care provider (32 percent); and Group 3 participants had thought about and discussed stopping dialysis with a family member/caregiver or health-care provider at least some of the time (36 percent). Those participants who thought about and discussed stopping dialysis at least some of the time reported significantly greater role limitations due to physical health problems, role limitations due to emotional problems, less energy, and poorer general health than both those participants who thought about stopping dialysis but never or rarely discussed it and those participants who never thought about stopping dialysis. Men who thought about and discussed stopping dialysis reported greater loss of physical ability and less energy than women who thought about and discussed stopping dialysis. When asked about changes in health status that would cause one to consider stopping dialysis, the majority of participants stated “an inability to care for oneself.” A greater understanding of patients’ preferences regarding withdrawal from dialysis may improve end-of-life decision making among the dialysis patient population. A discussion among the patient, family member/caregiver, and renal treatment team regarding with-

drawal from dialysis and under what, if any, circumstances the patient would want to discontinue treatment should be held prior to a medical crisis (e.g., coma or stroke). — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3162706, DAI-A 66/01 (July 2005): 346.

Katholieke Universiteit Leuven (Belgium)

Sara Mahieu, *Do We Care for Our Parents as They Have Cared for Us? Attachment, Caregiving and Filial Maturity: Dimensions regarding the Relationship between Adult Children and Their Aged Parents* [in Dutch]. 2005.

This investigation is rooted in two research traditions. The first deals with filial caregiving for aged parents. There is a growing recognition of the usefulness of the constructs of filial and parental maturity. The author developed a new contextual definition as well as a vignette interview for the measurement of both constructs. The second research line is the attachment theory and, more specifically, the mental representations of attachment (the evaluation of one's own attachment experiences with both parents). The author considers this theory a very useful theoretical framework for the description and explanation of adult children's caregiving to their elderly parents. The central research question is whether filial maturity in middle-aged adult children who are confronted with impaired elderly parents follows naturally from their childhood attachment experiences with the parents and from their evaluation of the attachment history. Semi-structured interviews and questionnaires were used with forty-five dyads of an adult son or daughter and an elderly mother or father. The author found that early experiences with caring parents were related to a more intimate parent-child relationship in later life, more empathy toward the elderly mother or father, and less filial anxiety. Furthermore, adult children with an unresolved negative attachment history (insecure attach-

ment) displayed less filial maturity in their caregiving roles compared with children who were able to reflect coherently on their childhood experiences with their parents (secure attachment). Sons and daughters who were still mentally involved in early relationships with their parent(s) did not feel enough autonomy to restrict their caregiving and preserve their own well-being (emotional-dependent, excessive caregiving style). Adult children cut off from their non-relieved childhood need for proximity and security exhibited mainly less empathy toward their elderly father or mother (emotional-independent, businesslike caregiving style). Finally, adult children classified as secure-autonomous in their attachment representation were able to balance comprehending and distancing in their caregiving task (filial mature caregiving style). — Abstract from *Dissertation Abstracts International*, DAI-C 66/01 (Spring 2005): 245.

Loyola University Chicago

Michelle A. Clifton-Soderstrom, *Health Care in Context: The Sociality of the Body and Civic Identity* (Karl Rahner, Luce Irigaray). Susan A. Ross, Philip J. Chmielowski, advisers. 2005.

This dissertation asserts that a social interpretation of the body offers a significant foundation for ethical analyses in health care institutions. An individualistic interpretation adequately conceptualizes neither the sociality of our embodiment nor the social body. This project develops a moral anthropology based on a social understanding of the body. It further specifies "the social" by envisioning ethical civic relations that incorporate embodied difference. Embodied difference informs the defining and organizing of goods delivered by health-care institutions. A social interpretation of the body within the civic unit contributes much both to the theoretical component of institution shaping and to the way society understands the role of health-care institutions. The project begins by analyzing key medical ethics texts to show how an individualistic

emphasis inadequately frames social goods. It then builds on the work of Karl Rahner and Luce Irigaray to construct an interpretive framework for analyzing the goals of health-care institutions. The project confines the discussion to their phenomenological analyses, in which their approaches to the body sustain and complement one another. Rahner focuses on the body within symbolic exchange, while Irigaray addresses how gender informs and gives ethical vision to civic identities. Finally, the project applies this moral anthropology to the issue of abortion and public policy. It asserts that goods that emerge from the sociality of the body—full participation, material well-being, and respect for difference—advance civic flourishing. —Abstract from *Dissertation Abstracts International*, publ. no. AAT 3174233, DAI-A 66/05 (November 2005): 1816.

Princeton University

Dan Moller, *Abortion, Killing and Overdetermination: Three Essays*. Peter Singer and Anthony Appiah, advisers. 2005.

Suppose that you have considered all of the arguments you know purporting to show that abortion is wrong and have concluded that they all fail. Are your deliberations about the morality of abortion at an end? The first essay of this dissertation, “Abortion and Moral Risk,” argues that the answer is no: you must proceed to consider the possibility that you are mistaken in your assessment. Ignoring the possibility that you are mistaken about the morality of abortion involves taking a risk—the risk of unwittingly committing serious wrongdoing—that the author shows may itself be impermissible. However, not all such moral risks are wrong, and the author attempts to flesh out various countervailing factors, including costs to the agent. The second essay, “The Morality of Overdetermination,” takes up the problem that in many situations like voting or polluting the environment individual acts cannot make a difference to the outcome, since that

outcome is overdetermined. Accordingly, we might wonder why individual agents should avoid performing the relevant acts when they benefit the individual and when avoiding them does no one any good at all. The author first argues that we cannot infer from an act’s making no difference that it cannot be wrong, since we may cause or partly cause the result in an objectionable way all the same. Acting even in overdetermined circumstances may thus be wrong. He next argues that appealing to (partial) causation allows us to solve at least some of the practical problems the issue of overdetermination raises, although he also explores some lingering challenges to this approach. Finally, “Killing and Dying” advocates a harm-based approach to what makes killing wrong, and defends such an approach against respect-based views. The author begins by emphasizing that a defensible conception of the harm we suffer in dying will imply that at least one important part of the harm we inflict in killing will not vary from person to person. He marshals this point to ward off the so-called equal-wrongness objection to harm-based accounts. He goes on to discuss various mistakes which have led philosophers to misunderstand both the harm- and the respect-based views, including difficulties in explaining what the relevant notion of respect is in this context. The importance of the dispute over theories of killing for determining moral status in marginal cases emerges at the beginning and end of the essay. —Abstract from *Dissertation Abstracts International*, publ. no. AAT 3181614, DAI-A 66/07 (January 2006): 2599.

Regent University

G. C. Dilsaver, *Restoring the Image of God: Foundations of a Catholic Clinical Psychology*. William Hathaway, adviser. 2005.

The premise of this dissertation is that the Catholic Church possesses a uniquely superlative insight into the nature of the human person. The subsequent hypothesis is that locating the science of psychology within a Catholic anthropology will bring that science to an

unprecedented efficacy. It is advanced that a psychotherapy based on a Catholic anthropology seeks to restore the image of God when that image, i.e., the person's rational/volitional nature, is marred by mental illness and characterological distortion. This restoration of the image of God produces mental health. Mental health is measured in accord with a person's ability to "perceive, receive, reflect, and act upon the real." Three gradations or zones of mental health are categorized according to the Aristotelian-Thomistic conceptualization of the tripartite soul. In this conceptualization, the human person can engage reality in three degrees that accord with the three powers of the soul that appear dominant, or typify, that engagement with reality. In zone I, the vegetative power is typifying; in zone II, the sensitive power is typifying; and in zone III, the rational power is typifying. This tripartite categorization forms the basis for the development of the Thomistic Corresponding Continuums of Mental Health. These corresponding continuums consist of the above typifying powers, as well as openness to reality, cognition, volition, emotion, and clinical descriptors. Although the foundational principles identified here are subject to categorization, emphasis, and expression in various combinations, it is nonetheless believed that they are in some way integral to any truly Catholic psychology; for these principles are derived from the Catholic Church's theological and philosophical understanding of the person and are thereby deemed essential. Of utmost importance for Catholic clinical psychology are the teleological, epistemological, and moral teachings of the Church in her presentation of an adequate anthropology. An authentic Catholic clinical psychology entails both a scientific psychology that depends on the truths of philosophical psychology and a philosophical psychology that is validated by and draws on sacred theology. This direct dependence of a lower science (*viz.*, scientific psychology) upon the truths of a higher science (*viz.*, philosophical psychology) is termed subalternation. — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3180754, DAI-B 66/06 (December 2005): 3403.

Jennifer L. Hill, *A Pilot Study: Evaluating the Efficacy of Faith-Based Support Groups for Postabortive Women*. Jennifer Ripley, adviser. 2005.

Tremendous debate and controversy surround the topic of abortion in the political, moral, medical, and legal arenas of society, largely overshadowing the personal struggles of many postabortive women. Increasingly, women having difficulty coping with their abortion experience(s) are finding the courage to emerge from the shadows and are turning to abortion support groups for help and healing. Faith-based agencies and organizations are by far the leading providers of such groups. The purpose of this pilot study was to begin to examine the effects of a faith-based support group intervention for postabortive women struggling with some aspect of an abortion experience. It was hypothesized that participation in a ten-to-twelve-week faith-based support group would increase participants' self-esteem and existential and religious well-being, while also decreasing PTSD [post-traumatic-stress-disorder]-type symptoms related to the abortion. Twenty-five women completed the Rosenberg Self-Esteem Scale (RSES), the Spiritual Well-Being Scale (SWB), and the Distressing Event Questionnaire—Clinician Identified Trauma (DEQ-CIT) pre- and postintervention. As predicted, postintervention measures indicated a significant increase in participants' self-esteem, religious well-being, and existential well-being, as well as a significant reduction in PTSD-type symptoms. These promising findings, although limited, lend support for the efficacy of faith-based abortion support groups in improving women's overall well-being following an abortion. Clinical implications and future directions of research are discussed. — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3164928, DAI-B 66/02 (August 2005): 1172.

Regis College (Canada)

Rosemary C. MacDonald, *Weaving the Braided Rope: The Role of the Clinical Ethicist*. 2005.

This qualitative research study is situated within the context of the Roman Catholic Church and the practice of clinical ethics. Having once traced the historical development of the practice of ethics in health care, the focus of the study is then to explore with family members their experience of making decisions about care and treatment at the end of life. This thesis examines the following research question: How can the clinical ethicist better serve the needs of families of patients who are involved in making decisions about care and treatment? Scholars have offered a variety of methods for approaching case consultations and the role of the clinical ethicist in health care; in large part these have been physician-focused. Approaching case consultations and the role of the clinical ethicist from the perspective of the family has been overlooked. Wanting to learn from families what they need during a time of end-of-life decision making, this research study employs a phenomenological methodology. The semi-structured interview was the research tool employed to gather the data. Grounded theory method was used for data analysis. The findings indicated that family members experienced a gap in the process of end-of-life decision making. No one member of the health-care team was with them throughout the process. Seven categories were identified by the respondents about their experience of decision making. The participants' responses raised personal and professional questions, which on reflection point to a creative way to do ethics that could meet their needs and improve the process of decision making for family members. Furthermore, the findings emphasize the need for a holistic and interdisciplinary approach to be utilized by clinical ethicists. — Abstract from *Dissertation Abstracts International*, publ. no. AAT NR09949, DAI-A 66/11 (May 2006): 4066.

State University of New York at Stony Brook

Tanfer Emin-Tunc, *Technologies of Choice: A History of Abortion Techniques in the United States, 1850–1980*. Ruth Schwartz Cowan, adviser. 2005.

In the last three decades, studies in the history and sociology of technology have taught us a great deal about the processes of invention, development, and diffusion. However, almost nothing is known, historically, about the technologies of pregnancy termination. Despite the fact that these technologies are having an enormous social, ethical, and economic impact on today's world, no scholar has ever thoroughly explored the changing technologies of abortion between the years 1850 and 1980, and no effort has been made to understand how these changing technologies were connected to the politics of medical professionalization, specialization, and commercialization. This dissertation seeks to fill this historical vacuum. This study will trace the changes in pregnancy termination technology from 1850 (when herbal methods began to be replaced by surgical methods) to 1980 (by which time numerous surgical, and chemical, methods had developed and diffused). Since pregnancy termination has always been a politically charged subject, these scientific and technological changes must, of necessity, be viewed within the context of a variety of disputes: disputes between laypersons and professionals about who should be licensed to control pregnancy termination; disputes between men and women about who should be responsible for fertility control; disputes between those who want the procedure to be legal and those who want it criminalized; and disputes between advocates of one technological system over another. Thus, this dissertation is a study in both the social construction of technology and the technological construction of one very significant social process—pregnancy termination. Moreover, by placing these reproductive technologies in their proper historical context, this dissertation not only elucidates

the issues with which our predecessors struggled, but also sheds a ray of light on the current debate over abortion technologies such as the D&X (intact dilation and extraction, or “partial birth abortion”). — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3179633, DAI-A 66/06 (December 2005): 2357.

University of Calgary (Canada)

Paul Jonathan Harms, *Physician-Assisted Suicide in Antiquity*. 2005.

This thesis reevaluates the evidence used to claim that physician-assisted suicide was a common phenomenon in the Greco-Roman world. The need for such a reevaluation is demonstrated by the emergence of this claim in books by non-classicists. By critiquing and discrediting the arguments that claim that physician-assisted suicide was commonplace in antiquity, this reevaluation of the evidence, and thus this thesis, will hopefully correct this misrepresentation of ancient Greece and Rome. — Abstract from *Master's Abstracts International*, publ. no. AAT MR05400, MAI 44/02 (April 2006): 675.

University of California, San Francisco, with the University of California, Berkeley

Frances Norwood, *Euthanasia Talk: Euthanasia Discourse, General Practice and End-of-Life Care in the Netherlands*. Sharon Kaufman, adviser. 2005.

In the Netherlands, nearly one quarter of all people who die initiate a euthanasia request with their doctor, yet nine in ten of those who initiate a request do not die by euthanasia. Nine in ten die instead of natural causes. The

Netherlands legalized euthanasia (killing a person at that person's explicit request) and assisted suicide (giving a person the means to kill themselves at that person's explicit request) by court decision in 1984 and again by legislation in 2001. With nearly a quarter of people who die in Holland (not to mention their family members and health practitioners) participating in this dialogue and so few participating in the act, it raises the questions, What are Dutch people talking about when they talk euthanasia? and How does euthanasia talk affect the end of Dutch life? After a fifteen-month ethnographic study of euthanasia and end-of-life care in the Netherlands with *huisartsen* (Dutch general practitioners), their end-of-life patients, and the patients' families, the author found two things. First, in practice Dutch euthanasia is more often a discourse than it is a life-ending act, a discourse firmly embedded in the cultural and historical contexts that make Dutch people Dutch. Using a Foucauldian concept of discourse, the author argues that the Dutch have created a script that teaches citizens how to think and feel about death, and ultimately how to die. Second, the author found that euthanasia talk holds a wide array of meanings beyond the immediate or obvious (planning for death). One of the most important is to affirm social bonds and social life at the end of Dutch life. People choose not to die euthanasia deaths because of the feeling of social connection that engagement in euthanasia discourse fosters. Through engagement in euthanasia talk, dying individuals maintain connections to family and society, giving them something they need to remain living. This dissertation is intended to provide ethnographic data not currently available on the modern-day practice of euthanasia and to add to a growing body of literature on death, dying, and the role of the state. — Abstract from *Dissertation Abstracts International*, publ. no. AAT 3179958, DAI-A 66/06 (December 2005): 2274.

The University of Iowa

Jillian M. Duquaine-Watson, *Negotiating Need: Single Mother College Students in Post-Welfare-Reform America*. Ellen Lewin, adviser. 2005.

This project examines the experiences of single mothers who are students at two post-secondary educational institutions in Iowa City, Iowa—The University of Iowa and Kirkwood Community College. Through a combination of archival research, discursive analysis, interviews, and participation observation, the author examines how institutional philosophy, resources, and pedagogy influence the success and retention of single mother students, including both the supports and the barriers they encounter as they endeavor to secure postsecondary education and training. Thus, the project interrogates meanings of “good” and “acceptable” motherhood—including how those meanings are shaped by constructions of race, class, and heteronormative, nuclear family ideals—by investigating the educational institutions within and through which these discourses coalesce. By providing a historical, ethnographic, discursive, and institutional examination of the experiences of single mother students within the post-welfare-reform United States, this study offers a distinct and productive account of the continually evolving relationships between educational institutions and this important but underrepresented student population.—Abstract from *Dissertation Abstracts International*, publ. no. AAT 3172385, DAI-A 66/04 (October 2005): 1522.

University of Montreal (Canada)

Ginette Paquet, *Social Inequalities in Health, Their Origin and Their Reduction: The Determining Role of Early Childhood [in French]*. 2005.

In order to study the persistent links between social inequalities and the health sta-

tus of people in rich societies, the author chose the following approach: In the first chapter, she examines the availability of health care without financial barriers. The second chapter deals with the marked prevalence of lifestyle habits that are harmful to health among people from underprivileged social classes. The third examines the feeling of control over one’s destiny. The fourth considers early childhood in relation to the development of a feeling of control over one’s life and the expression of protective factors. Finally, the fifth chapter looks into the possibility, in an underprivileged environment, of overcoming the fatalism linked to early academic failure. The information gathered enabled the author to reach the following conclusions: There exists a health and mortality social gradient in most modern societies. Causality operates mainly in the direction of social position toward health, inverse causality being a much less important phenomenon. Across Quebec and Canada, the results are in line with international currents. For example, the author’s analyses of the data from the Quebec longitudinal study of child development show that the risks of experiencing precarious health are substantially higher for a small child who is born and raised in a family situated at the bottom of the social ladder. Furthermore, even if the lifestyle habits of individuals explain, to a large extent, their state of health, the author shows that those lifestyles only very partially explain social differences with respect to the onset of illness. Next, the author delineates the way in which the psychosocial environment brings together the possibilities offered by the social structure to respond to fundamental needs for personal efficiency and self-esteem. The feeling of control over one’s destiny is shown to be a central factor associated with one’s position in the social hierarchy, a sentiment which protects a person from illness. Our results furthermore indicate that the influence of social position on the health of preschool children diminishes in the presence of protection factors, such as breastfeeding, support from grand-parents, and a mother in very good health. The author also establishes that in an underprivileged envi-

ronment it is possible to promote the development of a feeling of control over one's destiny right from early childhood and to decrease academic failure with high-quality preschool programs. Essentially, the author submits that accessible medical services are not in themselves enough to create equal opportunities in the health. In addition, the struggle against behavior that is harmful to health will not ensure success in this respect. To counter the adversity linked to a disadvantaged social position, we must consider the explanatory potential of the feeling of control over one's destiny and recognize that early childhood is the most propitious period to develop this feeling. In addition, a childhood spent in an impoverished environment may in fact include factors that protect health. Scientific knowledge also indicates that the key element for reducing health-related social inequalities lies in early prevention of academic failure in underprivileged environments. Lastly, the author expresses misgivings concerning the orientations being adopted by Quebec in the area of childhood services designed to guarantee equal opportunities.— Abstract from *Dissertation Abstracts International*, publ. no. AAT NR04572, DAI-A 66/07 (January 2006): 2738.

University of Oulu (Finland)

Sari Anneli Koivurova, *In Vitro Fertilization in Northern Finland, 1990–1995: Prenatal and Early Childhood Outcome until Three Years of Age*. 2005.

The aim of this population-based cohort study was to evaluate prenatal and child outcome and costs resulting from prenatal and neonatal care after in vitro fertilization (IVF) in comparison to those after natural conception, using a cohort of 304 IVF-exposed children born between 1990 and 1995 in northern Finland, and two cohorts of unexposed control children (group I: $n = 569$, represent-

ing general population in proportion of multiple births; group II: $n = 103$, matched for plurality). The control children were randomly chosen from the Finnish Medical Birth Register and matched for sex, year of birth, area of residence, parity, maternal age, and socioeconomic status. Analyses were performed by comparing the whole IVF population with controls representing the general population as well as stratifying by singleton or twin status. IVF mothers carried a higher risk for vaginal bleeding, threatened preterm birth, and intrahepatic cholestasis of pregnancy than control mothers, and they used specialized antenatal care more than others. Neonatal outcome was also poorer after IVF in terms of gestational age, birthweight, morbidity, and intensive care treatment. The prevalence of congenital heart malformations (septal defects) was four-fold for IVF children in comparison to controls. The three-year follow-up study showed delayed growth and increased morbidity for IVF children, but their psychomotor development was similar to that of the control children. Health-care costs were 1.3-fold for IVF singletons in comparison to control singletons, but for twins the costs were equal. Multiple births increased the costs three-fold when compared to singleton births. IVF increased the health risks for the pregnancies and the offspring, seen mostly in the comparison between the whole IVF population and controls representing natural proportion of multiple births, indicating that multiple birth is the strongest determinant of medical outcome after IVF. The effects of fertility therapy and maternal characteristics related to infertility cannot be ruled out at this point. The increased health-care costs after IVF were mostly due to the high proportion of multiple births. To improve the outcomes and reduce the health-care costs after IVF, the number of multiple births should be limited to a minimum by using single embryo transfer when possible.— Abstract from *Dissertation Abstracts International*, DAI-C 67/01 (Spring 2006): 212.

University of Pittsburgh

Michael N. Okobia, *Estrogens, Genetic Polymorphisms and Breast Cancer Risk in Nigerian Women*. Clareann H. Bunker, adviser. 2005.

Breast cancer is a major cause of morbidity and mortality globally, and the incidence appears to be rising faster in population groups that previously experienced lower incidence. This case control study recruited 250 women with breast cancer and 250 age-matched controls from four university teaching hospitals in Nigeria and was designed to evaluate the risk factors for breast cancer in Nigerian women. Family history of breast cancer was associated with a fifteen-fold increased risk of breast cancer (odds ratio [OR], 14.99; 95% CI, 1.98–113.47). Also, waist-to-hip ratio (OR, 2.10; 95% CI, 1.44–3.06), history of abortion (OR, 2.83; 95% CI, 1.12–7.19), increasing age at first childbirth (OR, 1.39; 95% CI, 1.11–1.73), and higher level of education (OR, 1.31; 95% CI, 1.07–1.61) conferred increased risk of breast cancer. Increasing parity (OR, 0.87; 95% CI, 0.77–0.99) and increasing duration of breastfeeding (OR, 0.75; 95% CI, 0.62–0.91) conferred protection against breast cancer. In the final multivariate conditional logistic regression in all women, carrying at least one low-activity *COMT* (Met) allele was associated with a significant 43 percent reduced risk of breast cancer (OR, 0.57; 95% CI, 0.36–0.91). While harboring the CYP1A1 M1 polymorphic variant was associated with nonsignificant reduced risk of breast cancer (OR, 0.79; 95% CI, 0.48–1.29), the CYP1A1 M3 polymorphism conferred a nonsignificant 24 percent reduced risk of breast cancer (OR, 0.76; 95% CI, 0.47–1.22). Results of this study have important public health implications. The study has provided evidence for a role for reproductive and other variables in susceptibility to breast cancer in indigenous African women, thus contributing to the global epidemiologic literature on risk factors for breast cancer in populations of African ancestry. It has also provided data suggesting protection for breast cancer in women

who harbor the low-activity *COMT* (Met) allele of the codon 158 polymorphism of the *COMT* gene. In addition, the findings of this study will serve a useful resource tool in future research and policy decisions aimed at breast cancer control and prevention in these populations.— Abstract from *Dissertation Abstracts International*, publ. no. AAT 3188979, DAI-B 66/09 (March 2006): 4

The University of Texas at Austin

Michael Hyder Limerick, *The Process Used by Surrogate Decision-Makers to Withhold and Withdraw Life-Sustaining Measures in a Catholic Intensive Care Environment*. Deborah Lowe Volker, adviser. 2005.

Both families and health-care providers struggle with the decisions regarding the amount and type of care that can be given to the terminally ill. A family member most often becomes the surrogate for a loved one, whether the family member desires to do so or is prepared to do so. While this study was not designed to produce a how-to handbook, it does give some idea of the surrogate's decision-making process. The purpose of this grounded-theory, qualitative study was to generate a theory about the process used by surrogate decision makers who have decided to withhold or withdraw life-sustaining measures from those for whom they act as medical decision makers in a Catholic intensive-care environment. The study was conducted with seventeen surrogates of terminally ill persons who received care in an intensive-care environment prior to the patients death. The participants in this study were recruited with the assistance of the nursing staff of a local health-care network. Through direct mailings, surrogates of patients who died in the hospital were mailed invitation letters by the hospital staff. Stories obtained from the surrogates through face-to-face interviews

were analyzed, and through constant comparison of the data, nine themes emerged. These themes were then clustered into areas or domains representing the decision-making process. The nine themes within their respective domains include: (1) *personal domain*: rallying family support, evaluating the patient's past and present condition and preferences, and viewing the past and future quality of life for the patient; (2) *intensive-care environment domain*: chasing doctors, expressing the relationship with the health-care team, the health-care team's confirming of the probable medical outcome of continued treatment; and (3) *decision domain*: arriving at a new belief, getting alone to make the decision, and communicating the decision to withhold or withdraw life-sustaining measures. The themes and domains are expressed as a theory with an accompanying model. The study results have demonstrated opportunities for health-care providers to improve education and change practice when trying to understand and support surrogates. Additional opportunities were found for further research to expand nursing knowledge related to the broader rubric encompassed by end-of-life issues. — Abstract from *Dissertation Abstracts International*, DAI-B 66/05 (November 2005): 2514.

University of Virginia

Katharine Joy Buck, *Rights of Passage: Reforming Care of the Dying, 1965–1986*. Barbara M. Brodie, adviser. 2005.

By the end of the 1960s, care of the dying had moved from home to hospital and was becoming increasingly impersonal and technologically managed. Intractable cancer pain was frequently grossly under-treated, and patients often died in a hospital room at the end of a hall, behind a closed door, in pain and alone. During the 1970s, American health-care reformers turned to hospice as a humane and cost-effective alternative to institutionalized care of the dying. The result-

ing hospice movement cut across many professional and societal boundaries and challenged assumptions about the appropriate care of the dying. Integrating the hospice ideal of care into the American medical system without changing its nature or purpose proved to be a challenge; serious inadequacies remain in our models of end-of-life care. This study examines the transitions in care for the dying and the processes of developing an alternative to hospital-based care of the dying during the latter half of the twentieth century. It examines the juxtaposition of societal attitudes, technology, professional paradigms, and political influence on the evolution of care for the dying in the United States. Specifically, the initiation and development of the hospice movement in the state of Connecticut from 1965 to 1986 was used as a case study to examine the translation of the hospice philosophy of care into a reimbursable model of care under Medicare. Data were drawn from the archival collections of those integral to the American hospice movement, oral histories, Congressional testimony, professional journals, and the popular press. These data were analyzed within the historiographical frameworks of social and political history. Finally, lessons from the past were drawn to initiate a discussion on contemporary health-care reform.— Abstract from *Dissertation Abstracts International*, publ. no. AAT 3169641, DAI-B 66/03 (September 2005): 1389.

Wilfrid Laurier University (Canada)

Timothy William Dobbin, *Community Pastoral Care in Faith and Light: A Qualitative Study of Perpetual Parenthood from a Pastoral Care and Counseling Perspective*. 2005.

Faith and Light is a Christian community that exists for people with an intellectual disability, their families, and their friends, who

meet monthly to reflect on Scripture, to pray, and to celebrate together. It promotes presence to one another and friendship among its members. This ethnographic study explores how parents from a local community experience the “launching” phase of the family life cycle. Analysis of data from focus groups, from participant observation as a chaplain, and from informal interviews revealed particular aspects of parents’ experiences, including challenges parents face, particularly with regard to abuse and the need to advocate; concerns over the adequacy of care their offspring receive; the effects of the various life-cycle transitions; and parents’ investment in their offspring and peculiar knowledge of them. The author suggests that a phenomenon of “perpetual parenthood” undergirds these themes: parents understand their responsibilities for their offspring with an intellectual disability as being lifelong, such that launching may never occur. A central existential ambivalence for these parents is that of holding on versus letting go, where parents discover and create their own provisional balance in the dilemma. Parents identified sev-

eral attributes of Faith and Light’s community life that were helpful to them (mutual support and understanding, interaction, welcome and friendship) and to their offspring (revealing their beauty and giftedness, growth and friendship, Christian formation, listening and acceptance). Faith and Light’s provision of care to parent members models aspects of “*theological* pastoral care and counseling.” This approach locates pastoral care and counseling ecclesially, and proposes an asymmetrical relationship between the disciplines of theology and related social sciences, where the pastoral carer, working within an explicitly Christian meta-narrative, has recourse to insights from related secular disciplines on an ad hoc basis. The study concludes with an exploration of how, on the basis of this relationship, the three foci of enquiry—namely, Faith and Light, the phenomenon of perpetual parenthood, and theological pastoral care and counseling—might inform each other.— Abstract from *Dissertation Abstracts International*, publ. no. AAT NR04883, DAI-A 66/07 (January 2006): 2612.