Literature Review

The purpose of this project is to develop and assess a sustainable arts in healthcare program model for rural communities. The project includes the development and implementation of an arts in healthcare program in Franklin County, Florida, based at the 25-bed George E. Weems Memorial Hospital. While there are many models in place for arts in healthcare programs in urban and suburban healthcare settings, review of the literature indicates that no models have yet been presented for such programs in rural areas, and that these programs have the potential to contribute to improved health outcomes in rural communities.

This literature review begins with a discussion of the patient-centered and organizational outcomes associated with arts in healthcare programs. Such programs utilize the arts including the visual, performing, and literary arts, to enhance the quality of care provided by healthcare institutions; to improve organizational satisfaction and retention among professional caregivers and staff; to enhance the environment of care; and to deliver health information. Several meta-analyses of arts in healthcare programs are reviewed as a means for summarizing the applications and benefits of arts in healthcare programs. The review then explores health disparities in rural communities and the importance of designing health promotion programs that address the unique culture of the rural community. This section includes a discussion of the roles of the arts in affecting health-related behaviors and as a means for health education. Next, the review will present research that documents the importance of planning for program sustainability throughout the program planning process and will present a useful set of guidelines for achieving sustainability in community health programs. The review will overview several theories that provide useful foundations for understanding the role of individual meaning as an important aspect of program sustainability. These theories include: a) Frankyl's theory of *meaning* as the ultimate goal of human life; b) *workplace spirituality* as defined by several theorists; and c) the theory of *self-transcendence* as defined by Frankyl, Coward, and Reed. Finally, the review will discuss Appreciative Inquiry as a suitable research methodology for assessing meaning and self-transcendence among program planners, staff, volunteers, and other stakeholders.

Arts in Healthcare

Arts in Healthcare programs in larger healthcare settings have been shown to yield significant benefits to healthcare systems including improvements in quality of care for patients,

their families, and medical staff, enhancement of the healthcare environment, support of the physical, mental, and emotional well being of patients, improvements in the communication of health information, and reductions in stress and burnout among healthcare professionals (Staricoff, 2004; Society for the Arts in Healthcare, 2009). Limited data suggest that these programs also have economic benefits to healthcare systems but further research is needed before conclusions can be drawn in this regard. Some recent data, however, do show that arts in healthcare programs result in shorter hospital stays, less medication, and fewer complications among patients, as well as in improved caregiver retention (Society for the Arts in Healthcare, 2009) - all significant factors in the delivery of care. While economic data are unclear, studies pertaining to the health benefits of the arts are abundant. As a full overview of individual arts in healthcare studies is beyond the scope of this review, broad-scope studies and meta-analyses from the field will be reviewed to evaluate and summarize the field literature.

Bygren, Konlaan, and Johanssen (1996) conducted a nine-year study of 15,198 individuals to determine the health and life-extending implications of attending cultural events, such as performances and art exhibits. After controlling for eight confounding variables (age, sex, education level, income, long term disease, social network, smoking, and physical exercise), the team found that people who regularly attend cultural events live longer. This outcome was attributed not to better health among those with higher incomes but to the effect of engagement in the arts in stimulating the immune system. The team published another study (Bygren et al., 2001) designed to assess how changes in the habit of attending cultural events might predict self-reported health among a sample of 3,793 adults over eight years. This study controlled for type of residence, geographical region of domicile, and socio-economic status (level of education), and found a 65% increase in the risk of impaired perceived health among those who were not culturally active as compared with those who were culturally active.

Matarasso's (1997) comprehensive review of over 50 studies of the health impact of the arts showed significant benefits for both individual and societal health. The study concluded that participation in the arts can: a) have a positive impact on how people feel; b) be an effective means of health education; c) contribute to a more relaxed atmosphere in health centers; d) help improve the quality of life of people with poor health; and e) provide a unique and deep source of enjoyment. Duly noted in the study is the acknowledgement that, while most community arts

programs yield positive benefits, those that are not well-planned and executed can also cause negative impacts such as damage to individual and community confidence.

In a far more extensive meta-analysis, Staricoff (2004) reviewed 385 arts in healthcare studies published between 1990 and 2004. This analysis presents evidence defining the outcomes that have been achieved through the application of the arts in healthcare settings. Staricoff concluded that the arts were found to contribute to: a) physiological and psychological changes in clinical outcomes; b) reductions in drug consumption; c) reductions in length of hospital stays; d) increases in job satisfaction among staff; e) better doctor-patient relationships; f) improved mental healthcare; and g) development of health practitioners' empathy across gender and cultural diversity.

Over the past half century in the United States, due to established practices and a growing body of evidence, the arts in healthcare has emerged as a significant field and as a recognized component of the healthcare system (Sonke, 2009). In 2004 and 2007, The Joint Commission, the national accreditation agency for healthcare institutions in the U.S., partnered with the Society for the Arts in Healthcare, Americans for the Arts, and the University of Florida Center for the Arts in Healthcare to conduct surveys that examined the presence and characteristics of the arts programs in US healthcare facilities. In both surveys, nearly half of the responding institutions (approximately 2,000 per study) reported the establishment of arts programs in their facilities (Sonke, 2009).

Despite the clear prevalence of arts in healthcare programs and the growing body of literature, no studies to date have focused on arts programs in rural healthcare communities. In all of the literature reviewed, healthcare facilities were either located in urban or suburban areas or no mention was made of facility size or urban/rural status of the community. While there is a clear need for studies assessing the impact of arts in healthcare programs in rural settings, adequate evidence and foundational theories exist to support the development and potential efficacy of rural arts in healthcare programs.

Rural Communities and the Role of the Arts in Affecting Health-related Behaviors

While research on the impact of the arts in healthcare in rural settings is lacking, so is there a lack of data pertaining to general health-related project development in rural areas. Urban bias is highly apparent in healthcare policy which results in many challenges and limitations in rural health program development (Johnson, 2001). Additionally, little data is available about

rural healthcare programs because reporting of these data-statistics tends to be limited to the regional level (Baumann et al., 2008). As a result, policies and strategies for improving health, health literacy, and healthcare delivery in rural communities have traditionally not been based on solid evidence or research (Romanow, 2002). This lack results in programs that have limited efficacy and sustainability. Over the past decade however, more attention has been given to the study of rural health issues and a field of rural health research and policy has slowly begun to immerge in the public health arena.

Recent empirical studies undertaken in this arena suggest that, "Medical care contributes relatively little to health when compared with social and societal factors, environmental factors, health behaviors, and genetics" (Hartley, 2004). Evans (1994) reports that of the four main determinants of health in the U.S., the socio-economic environment has the greatest influence, representing 50 to 60% of the overall influence on health outcomes. The *Health United States 2001, Urban and Rural Health Chartbook* presents a pattern of risky health behaviors among rural populations that suggests that "rural culture" is a significant health determinant in rural areas. In its first, and very brief, published report on the health of rural Americans since the 2001 *Chartbook*, the U.S. Department of Health and Human Services reports in *Hard Times in the Heartland: Health Care in Rural America* (Seshamani, 2007) that "The past several decades have consistently shown higher rates of poverty, mortality, uninsurance, and limited access to a primary health care provider in rural areas. In addition to these disparities, the report sites caregiver recruitment and retention as a necessary area of focus in addressing the issues.

Over the past few decades, public health professionals have come to define communities as living organisms that link individuals to organizations, neighborhoods, families, and friends, rather than simply as physical areas (Eng, 1992). This community effect is widely cited as a factor in negative health behaviors, such as poor diets, low levels of physical activity and high smoking rates. According to Hartley (2004), "health educators are increasingly aware of the need for culturally sensitive approaches to modifying health behavior, but few rural health researchers and policymakers are asking the relevant cultural question, 'Why does rural residence (culture, community, and environment) reinforce negative health behaviors?' (pp 1676)."

Recent trends in rural health research and policy suggest that effective interventions must be based on differences in rural regions (Hartley, 2004). Rural communities are as diverse and

uniquely cultured as urban ones and have characteristics that must be understood and factored into intervention program plans. It is in this context that the arts can be instrumental in the development as well as implementation of rural health programs. The arts, as cultural activities, reveal aspects of life related to its quality (Eisner, 1991) and can effect changes in behavior among individuals and communities (Burleigh & Beutler, 1996).

Use of the arts as a means to educate the public, foster social change, and influence the knowledge and behaviors of targeted populations has a long history. Arts-based health promotion has its historical roots in traditional cultures where storytelling, drama, and song are primary means for facilitating healing and for enforcing the belief systems of a given culture. Anthropologist Ellen Dissanayake (2000) recognizes art and ritual activities as universal human actions that are health promoting for both individuals and communities. She also asserts that the arts have selective value in human evolution and that they promote cooperation, harmony, and unity among group members and enable our species to cope with life's less expected or explicable events, such as illness. Art and art-making have also been shown to promote competence and self-efficacy (Evans, 2009).

McDonald, Antunez, & Gottemoeller (2006-2007) cite the arts as among the most effective tools for health education. In an article examining the potential and use of visual arts, music, textile arts, performing arts, and literature in health education practice, the authors note the extensive history of the arts in effecting social change and in communicating culturally relevant health information. They also defined six ways in which the arts can work in the service of health education: a) to get people involved; b) to facilitate understanding of a community: c) to change awareness and relay health education messages; d) to bring attention to a health issue; e) to promote community building; and f) to promote healing itself. One of the best-known examples of the arts as a means for health education is the AIDS Memorial Quilt, which was begun in 1987 and is still growing. The quilt project has been extremely effective in it mission to foster healing, heighten awareness, and inspire action in the struggle against HIV and AIDS. Knaus and Austin conducted a study assessing the impact of the quilt on impacting the students' perceptions of people with AIDS, self-efficacy, and awareness of risky behaviors associated with transmission of HIV/AIDS. The study demonstrated the efficacy of the quilt project in addressing issues centrally related to behavior change in the college population (Knaus & Austin, 1999). Numerous international health agencies, such as UNESCO, UNAIDS, and the United

Way, have adopted arts-based strategies for disseminating health information and effecting changes in health-related behaviors in rural communities throughout the world (Durden & Nduhura, 2007).

As has been previously noted, in addition to working as an effective means for health promotion and health education, the arts provide a wide array of palliative benefits to both patients and caregivers (Society for the Arts in Healthcare, 2009; Sonke et al., 2009). These benefits which are highly visible in the daily undertakings of an arts in healthcare program, compel program leaders, staff, and volunteers to maintain their commitment to and participation in the programs. Sonke et al. (2009) found that "benefits to patients" was the primary reason that healthcare organizations cited for implementing arts in healthcare programs in the U.S. In comparing fourteen potential reasons for supporting arts programs, two surveys conducted three years apart found that the humanistic reasons such as the physical and psychosocial benefits to patients, caregivers, family members, and staff and communicating health information were cited more frequently than factors such as attracting favorable publicity. The perception of the humanistic value of their efforts provides a significant potential for longevity among organizers, staff, and volunteers involved in arts in healthcare initiatives and, therefore, promotes the potential for sustainability of programs. While sustainability can be an unplanned outcome of effective programs, more thorough attention given to planning for sustainability throughout the program planning and implementation stages can increase the changes for success in effecting sustainability.

Sustainability in Program Planning

Pluye et al. (2005) demonstrate the importance of emphasizing sustainability from the onset of a community health project, rather than – as has been the established norm in health promotion programs in the past – addressing sustainability in the final stages of a project. Their review of community health programs suggests that routinization that occurs from the start of a project is a significant determinant of sustainability. In a thorough meta-analysis, Pluye et al. consolidate the literature to define eight factors, or activities, associated with the presence or absence of routinized activities: a) resource stabilization. b) risk-taking; c) incentives; d) adaptation of activities; e) objectives fit; f) transparent communication; g) sharing cultural artifacts; and h) integration of rules. The relevance of these factors to planning for sustainability in rural arts in healthcare programs warrants further elaboration here.

Resource stabilization refers to the stabilization of financial, human and material resources. According to Yin (2005), commitment to three elements can stabilize resources and encourage sustainability of programs. These include: a) renewal of material resources when needed; b) turnover in key personnel after an appropriate period of time; and c) attainment of widespread use of the new activities by all relevant components. Risk-taking, a factor that is encouraged, refers to the balance between exploitation of recognized activities and the exploration of new activities. This methodology has been shown to build confidence among planners and, therefore contribute to sustainability in new programming. Incentives are also encouraged and refer simply to benefits outweighing costs for those involved in planning and managing programs. These benefits can be derived from networking, information sharing, resources sharing, enjoyment, enhancement of one's skills, personal recognition, and involvement in a cause that individuals deem to be important. In keeping with the theories defined by Hartley, adaptation of activities refers to "the incremental adjustment of activities in accordance with local circumstances and environmental variation" (Pluye, 2005, pp. 4).

Objectives fit refers to the level to which the program's objectives fit with the values of the organizations and individuals involved. Extensive literature has documented the importance of this aspect of meaning in program sustainability as well as in organizational satisfaction and longevity among staff (Wickizer et al.,1998; Bracht et al., 1994; Cameron, Dutton & Quinn, 2003; Milliman, Czaplewski & Ferguson, 2003). This aspect of sustainability will be discussed at greater length in the following section.

Transparent communication helps program planners maintain a focus on a common purpose, increases trust and resource sharing, and allows members to discuss and resolve program challenges. Frequent meetings and well-developed systems of communication are characteristic of successful and sustainable initiatives. Florin et al. (in Pluye, 2005) looked at the routinization of neighborhood association programs, and found that more methods of communication among partners correlated with higher levels of congruence and program activity, and vice versa. The sharing of cultural artifacts is a means through which programs and organizations adapt to each other and encourage routinization. Finally, Pluye notes that sustainability is enhanced when the program's rules are integrated into the rules of the participating organizations.

Scheirer's (2005) review of empirical studies on program sustainability lacks a primary

emphasis on early attention to sustainability in the program planning process, but offers some concrete recommendations to program planners for achieving sustainability. Scheirer's cross study analysis showed support for five important factors influencing the extent of sustainability: a) a program can be modified over time; b) a champion is present; c) a program fits with its organization's mission and procedures; d) benefits to staff members and/or clients are readily perceived; and e) stakeholders in other organizations provide support.

Scheirer also offers recommendations to external funding agencies that implement community programs. Among them: a) fund projects in existing agencies with some capacity to support them and to provide the expertise needed for carrying out the many facets of sustainability; b) in order to build ownership of the project among local stakeholders, fund smaller scale projects that have local resources involved; c) Identify, work with, and strengthen local champions to provide the leadership and knowledge of local organizations needed to sustain the project over time; and d) encourage planning for sustainability early in a project's life cycle. Scheirer's recommendations are particularly relevant to the development of rural health initiatives as they focus on active engagement and empowerment of local providers and stakeholders.

Another concern pertaining to sustainability in rural health programs is related to the successful engagement of both paid and volunteer staff over time. In a 1999 study, Chinman and Wandersman explored the costs and benefits of volunteering in community organizations. They found that greater participation in volunteer programs is associated with greater benefits; thus, when volunteers can be successfully engaged in a program on a consistent basis, they will experience higher levels of satisfaction and, in turn, participate more and over a longer period of time in the program. Further review of the literature suggests that effective strategies for sustained engagement and participation should address personal meaning related to program participation (Frankyl, 1966; Millman et al.., 2003).

Role of Meaning in Sustainability

Victor Frankl (1959) describes meaning as a universal human phenomenon that reflects an attitude or idea that people have about their reality. He proposes that striving to find meaning in one's life is the primary motivational force in humans and that the fulfillment of meaning is the ultimate goal of human life (1966). This idea supports Maslow's (1965) view that the

"business of self-actualization" can best be carried out "via a commitment to an important job" (p. 136). Contemporary theorists describe similar constructs of meaning in relation to work in terms of "workplace spirituality." Workplace spirituality relates to one's effort to find ultimate purpose in life; to develop strong connections to co-workers and others associated with work; and to experience alignment between one's core beliefs and the values of their organization or work (Mitroff & Denton, 1999). Ashmos and Duchon (2000) define workplace spirituality as "the recognition that employees have an inner life that nourishes and is nourished by meaningful work that takes place in the context of community" (pp. 137). It is important to note that in this context, spirituality is distinct from religion.

Garcia-Gamor (2003) found that the fulfillment of a worker's spiritual needs can result from a recognition and acceptance of individual responsibility for the common good. This recognition enhances organizational culture by bringing humanistic practices and policies to the core of the organization or project mission and activities. Garcia-Gamor (2003) defines spirituality in the workplace as concomitant with organizational culture. Extensive longitudinal studies yield clear evidence that strong corporate culture and meaning in work correlate with profitability, organizational satisfaction, higher levels of performance, and retention.

Brown (2003) asserts that an acknowledgement of spirituality in the workplace, as defined above, can also: a) promote wholeness and integration; b) include ethics and aesthetics in the workplace; c) assist in the development of emotional and spiritual competence; d) encourage holistic ways of working; e) develop community at work; and f) empower the workforce. These qualities, along with the vital sense of meaning that is cultivated through fulfilling work all contribute to longevity among program participants and, thus, to program sustainability.

As previously noted, a significant body of research defines many of the health, social, and humanistic benefits of arts in healthcare programs (Society for the Arts in Healthcare, 2009). This empirical evidence, however, is less widely recognized in the general public than the anecdotal associations that people hold that relate the arts to enjoyment and well-being, as has been well documented by Matarasso (1997) in his extensive study entitled *Use or ornament: the social impact of participation in the arts*. It is in the context of these widely held associations that the arts are viewed as humanistic in nature, and that engagement in arts-related community programs is perceived as a meaningful activity by program organizers, staff, and volunteers. The roles of the arts in health promotion programs and in healthcare have also been widely explored

in the context of self-transcendence. Frankyl (1966), who may have been the first to coin the term, suggests that human existence is not authentic unless it is lived in terms of self-transcendence and that self-transcendence is the essence of our existence.

Self-Transcendence

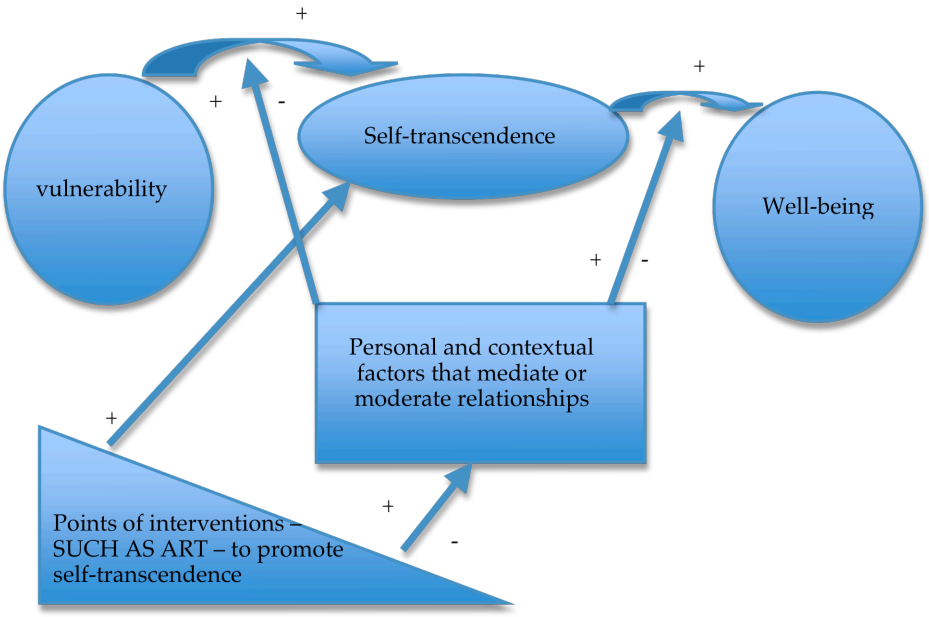
According to Frankyl (1966), the experience of self-transcendence is an inherent characteristic of being human that leads to feelings of self-confidence and the discovery of new purpose and meaning. Frankyl defines three ways in which people transcend: a) by giving to the world creatively, b) by being receptive to the world and others, and c) by choosing how to face adversity and find meaning.

That self-transcendence facilitates well-being and other positive outcomes such as Frankyl defines, has been supported in numerous studies over the past two decades with vulnerable populations such as the ill, elderly, and homeless (Coward, 1993, 1994, 1995; Ellermann & Reed, 2001; Reed, 1991; Runquist & Reed, 2007). As a basis for her studies, Reed (2003) defines self-transcendence as the expansion of one's awareness or boundaries intrapersonally (sense of wholeness within self), interpersonally (connectedness to others and the environment), temporally (connectedness to future and past situations), and transpersonally (connectedness to something greater than the self). In keeping with this concept but with greater brevity, Coward (1993) defines self-transcendence as moving beyond the known boundaries of the self to achieve a broader perspective, which in turn helps one discover or make new meaning. For the purpose of this project, Vaughan (1985) may provide the clearest definition. Vaughan's definition includes articulation of self-trancendence as the expansion of one's conceptual boundaries inward through contemplative or introspective activities and outward through a heightened concern for the welfare of others.

Reed's (2008) model of self-transcendence is helpful in understanding the concept and in identifying the role of the arts in facilitating self-transcendence. Three concepts are key to the model, that of vulnerability (awareness of one's mortality), self-transcendence (as defined above), and well-being (the sense of feeling whole and healthy in accord with one's own criteria for wholeness and well-being). In her model, Reed identifies three relationships between these concepts: a) increased vulnerability is related to increased self-transcendence; b) self-transcendence is positively related to well-being; and c) personal and contextual factors may influence these relationships. Included in the model also is the idea that points of intervention,

such as the arts, can promote self-transcendence, which in turn enhances well-being (see figure 1 below).

Figure 1. Reed's Model of Self-Transcendence



While most of the studies noted above focus on subjects dealing with illness or end of life issues, Coward (1996) studied the implications of self-transcendence on healthy populations and compared the results to studies of elderly well people and people with life-threatening illnesses. In the study, wellbeing was moderately correlated with self-transcendence overall, suggesting that self-transcendence is not limited to those experiencing life-threatening illness or at the end of life. Thus, people of any age or state of health can experience self-transcendence.

A fundamental structure of the experience of self-transcendence can be derived from these studies. In the process of self-transcendence, a person experiences an increased understanding of self as well as a sense of well-being, purpose in life, and interconnectedness with others. (Coward, 1994; Coward, 1995; Coward & Lewis, 1993, Reed, 1991). These constructs provide an important basis for understanding the role of meaning and self-transcendence in facilitating active participation in program planners and staff, and in the ultimate sustainability of health programs.

Conclusion

The potential for sustainability in arts in healthcare programs located in rural communities can be enhanced through attention in the planning process to several factors, including: a) the unique culture of the rural community; b) planning for sustainability at every stage of planning and implementation; c) development of routinization and ownership among partnering organizations; d) the experience of meaning that is cultivated in programs planners, staff, and volunteers; and e) the level of self-transcendence that can be achieved through the program.

Arts in healthcare programs have the potential to be effective mechanisms for enhancing the experience of healthcare for patients and caregivers and for impacting health-related behaviors and health education in rural communities, as they have been demonstrated to be in urban and suburban communities. Theoretical foundations and best practices in the arts in healthcare and health program planning provide a base adequate for the development of a model for arts in healthcare programs in rural communities that can be sustained over time and effect positive changes in the health of rural residents.

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References

Ashmos, D.P., & Duchon, D. (2000). Spirituality at work: a conceptualization and measure. *Journal of Management Inquiry*, 9(2), 134-45.

Baumann, A., Hunsberger, M., Blythe, J., & Crea, M. (2008, March). Sustainability of the workforce: Government policies and the rural fit. *Health Policy*, *85*(3), 372-379. Retrieved September 16, 2009, from CINAHL database.

Bracht, N., Finnegan, J.R., Rissel, C., Weisbrod, R., Gleason, J., Corbett, J. & Veblen-Mortenson, S. (1994). Community ownership and program continuation following a health demonstration project. *Health Education Research*, 9, 143–255.

Brown, R. (2003). Organizational Spirituality: The skeptic's version. *Organization*, 10(2), 393–400.

Burleigh, L. & Beutler, L. (1997). A critical analysis of two creative arts therapies. *The Arts in Psychotherapy*, 23(5), 375-381.

Bygren, L.O., Konlann, B.B., & Johansson, S. (1996). Unequal in death: Attendance at cultural events, reading books or periodicals, and making music or singing in a choir as determinants for survival. *British Medical Journal*. 313, 1577-1580.

Bygren, L.O., Konlann, B.B., & Johansson, S. (2001). Sustaining habits of attending cultural events and maintenance of health: A longitudinal study. *Health Promotion International*. 16(3), 229-234.

Cameron, K. S., Dutton, J. E., & Quinn, R. E. (Eds.). (2003). *Positive organizational scholarship*. San Francisco: Berrett-Koehler.

Chinman, M. & Wandersman, A. (1999). The benefits and costs of volunteering in community organizations: Review and practical implications. *Nonprofit and Voluntary Sector Quarterly*, 28(1), 46-64.

Cooperrider, D.L. & Whitney, D. (n.d.) "Appreciative Inquiry: A positive revolution in change." In P. Holman & T. Devane (eds.), *The Change Handbook*, Berrett-Koehler Publishers, Inc. 245-263.

Coward, D.D., Lewis, F. (1993). The lived experience of self-transcendence in gay men with AIDS. *Oncology Nursing Forum*, 20,1363-1368.

Coward, D.D. (1994). Meaning and purpose in the lives of persons with AIDS. *Public Health Nursing*, 11, 331-336.

Coward, D.D. (1995). The lived experience of self-transcendence in women with AIDS. *Journal of Obstetrics, Gynecologic and Neonatal Nursing*, 24, 314-318.

Coward, D.D. (1996). Self-transcendence and correlates in a healthy population. *Nursing Research*, 45, 116-121.

Dissanayake, E. (2000). *Art and intimacy: How the arts began*. Seattle: University of Washington Press.

Durden, E., & Nduhura, D. (2007). Use of participatory forum theatre to explore HIV/AIDS in the workplace: A research article. *Communicare: Journal for Communication Sciences*. 29(2), 56-70.

Eberhardt, M.S., Ingram D.D., Makuc D.M., et al. (2001). *Health, United States, 2001. Urban and rural health chartbook*. DHHS publication, no. (PHS) 01-1232-1. Hyattsville, MD: Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Eisner, E. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practices*. New York: Macmillan.

Ellermann, C., & Reed, P. (2001, November). Self-transcendence and depression in middle-age adults. *Western Journal of Nursing Research*, *23*(7), 698-713. Retrieved September 16, 2009, from CINAHL database.

Eng, E., Salmon, M., & Mullan, F. (1992). Community empowerment: the critical base for primary health care. *Family Community Health*, 15, 1–12.

Evans, J.E. (2008). The science of creativity and health. In J. Sonke-Henderson, R. Brandman, I. Serlin, & J. Graham-Pole (Eds.), *Whole person healthcare*: Volume 3: The arts & health, (87–105). Westport, CT: Praeger.

Evans R.G., Barer, M.L., & Marmor, T.R. (1994). *Why Are Some People Healthy & Others Not? The Determinants of Health of Populations*. New York: Aldane de Gruyter.

Florida Department of Health (2009). *County Health Profile: Franklin County*. Retrieved on September 10, 2009 from http://www.floridacharts.com/charts/mapp_report.aspx

Frankl, V. (1959). *Man's search for meaning: An introduction to logotherapy*. 3rd ed. New York: Simon & Schuster, Inc.

Frankl, V. (1966). Self-transcendence as a human phenomenon. *Journal of Humanistic Psychology*, 6, 97-106.

Garcia-Zamor, J.C. (2003). Workplace Spirituality and Organizational Performance. *Public Administration Review*, 63(3), 355-363.

Glik, D. (2002). Youth performing arts entertainment–education for HIV/aids prevention and health promotion: Practice and research. *Journal of Health Communication*, 7(1), 39-57.

Hartley, D. (2004). Public health and health care disparities. *American Journal of Public Health.* 94(10), 1675-1678.

Haase, J., Britt, T., Coward, D.D., Leidy, N., & Penn, P. (2007). Simultaneous concept analysis of spiritual perspective, hope, acceptance and self-transcendence. *Journal of Nursing Scholarship.* 24(2): 141-147.

Hepburn, K., Caron, W., & Mach, J.R., (1991). Caregivers of persons with chronic illnesses or impairments: Strategies and interventions. *In WA Myers (ed.): New techniques in the psychotherapy of older patients* (39-56). Washington, DC: American Psych. Press, Inc.

Johnson, S. (2001). Focusing on differences: a new approach for rural policy? Center for the study of rural America. Retrieved on October 2, 2009 from http://www.kansascityfed.org/RegionalAffairs/Mainstreet/MSE_0701.pdf

Knaus, C.S., Austin, E.W. (1999). The AIDS Memorial Quilt as preventative education: A developmental analysis of the quilt. *AIDS Education and Prevention*. 11(6), 525-40.

Maslow, A. (1965). *Self-Actualization and Beyond.* From Proceedings of the Conference on the Training of Counselors of Adults, sponsored by the New England Board of Higher Education, and the Center For The Study of Liberal Education For Adults, held May 22-28, 1965.

Matarasso, F. (1997). *Use or ornament? The social impact of participation in the arts.* Stroud, Gloucester, UK: Comedia.

McDonald, M., Antunez, G., & Gottemoeller, M. (2006-2007). Using the arts and literature in health education. *International Quarterly of Community Health Education*. 27(3), 265-278.

Milliman, J., Czaplewski, A., & Ferguson, J. (2004). Workplace spirituality and employee work attitudes: an exploratory empirical assessment. *Human Resources Abstracts.* 39 (2).

Mitroff, I. A., & Denton, E. A. (1999). *A spiritual audit of corporate America: A hard look at spirituality, religion, and values in the workplace*. San Francisco: Jossey-Bass.

Preskill, H., & Catsambas, T. (2006). *Reframing evaluation through appreciative inquiry*. Thousand Oaks, C.A. : Sage Publications.

Pluye, P., Potvinb, L. Denis, J.L., Pelletierd, J., & Mannonie, C. (2005). Program sustainability begins with the first events. *Evaluation and Program Planning*, 28(2), 123-137.

Reed, P. G. (1991). Self-transcendence and mental health in the oldest-old adults. *Nursing Research*, 40(1), 5-11.

Reed, P. G. (2003). The theory of self-transcendence. In M. J. Smith & P. R. Liehr (Eds.), *Middle range theory for nursing* (p. 145-165). New York: Springer.

Romanow, J.R., (2002). Building on values: the future of health care in Canada. http://www.hcsc.gc.ca/english/pdf/romanow/pdfs/HCC Final Report.pdf.

Runquist, J.; & Reed, P. (2007). Self-transcendence and well-being in homeless adults. *Journal of Holistic Nursing.* 25, 5-13.

Scheirer, M. A. (2005). Is sustainability possible? A review and commentary on empirical studies of program sustainability. *American Journal of Evaluation.* 26 (3), 320-347.

Seshamani, M. (2009). *Hard times in the heartland health care in rural America*. Washington, D.C.: HealthReform.gov. Retrieved on September 5, 2009 from http://www.healthreform.gov/reports/hardtimes/.

State of the Field Committee. (2009). *State of the field report: Arts in healthcare 2009*. Washington, DC: Society for the Arts in Healthcare.

Sonke, J., Rollins, J., Brandman, R. & Graham-Pole, J. (2009). The state of the arts in healthcare in the United States. *Arts & Health*, 1(2), 107-135.

Staricoff, R.L. (2004). *Arts in health: a review of the medical literature*. London: Arts Council England. Retrieved on September 9, 2009 from http://www.artscouncil.org.uk/documents/publications/phpc0eMaS.pdf

Staricoff, R. (2006). Arts in health: the value of evaluation. *Journal of the Royal Society for the Promotion of Health*, *126*(3), 116-120. Retrieved September 16, 2009, from CINAHL database.

United States Department of Agriculture (2009). State Fact Sheet: Florida. Economic Research Service: Washington, DC.

Vaughan, F. (1985). Discovering Transpersonal Identity. *Journal of Humanistic Psychology*. 25(3), 13-38.

Wickizer, T.M., Wagner, E., Cheadle, A., Pearson, D., Beery, W., Maeser, J., Psaty, B., VonKorff, M., Kospsell, T., Diehr, P., & Perrin, E.B. (1998). Implementation of the Henry J. Kaiser family foundation's community health promotion grant program: A process evaluation, *The Milbank Quarterly*, 76, 121–147.

Yin, R.K. (2005). *Case Study Research: Design and Methods*. London: Sage Publications.