



EC RSH14

**European Conference on
Religion, Spirituality
and Health**

May 22-24, 2014
University of Malta/Mater Dei Hospital
Malta

www.ecrsh.eu

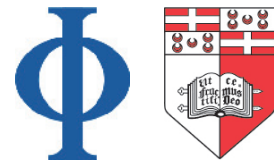
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Organisation

Organising Committee

- Dr. med. René Hefti, chair of the international committee, Research Institute for Spirituality and Health & Lecturer, University of Berne, Switzerland
- Dr. phil. Stefan Rademacher, conference office, Research Institute for Spirituality and Health, Langenthal, Switzerland
- Prof. Dr. Donia Baldacchino, chair of the local committee, University of Malta



Scientific Committee

- Prof. Dr. med. Arndt Buessing, chair of the scientific committee, Professorship for Quality of Life, Spirituality and Coping, Universität Witten/Herdecke, Germany
- Prof. Dr. Donia Baldacchino, Institute of Health Care, Faculty of Health Sciences, University of Malta, Malta
- Prof. Dr. theol. Klaus Baumann, Caritaswissenschaft, Albert-Ludwigs-Universität Freiburg, Freiburg/Bg., Germany
- Prof. Dr. med. Arjan Braam, Universiteit voor Humanistiek, Utrecht/Amsterdam, The Netherlands
- Ass.-Prof. Dr. Barbara Hanfstingl, Institut für Unterrichts- und Schulentwicklung, Alpen-Adria-Universität Klagenfurt, Austria
- Dr. med. René Hefti, Research Institute for Spirituality and Health & Lecturer for Psychosocial Medicine, University of Berne, Switzerland
- Prof. Dr. theol. Niels Christian Hvidt, University of Southern Denmark, Research Unit of Health, Man and Society, Denmark & Professorship for Spiritual Care, Ludwig-Maximilians-Universität München, Germany
- Dr. des. Constantin Klein, Department for Theology, Universität Bielefeld, Germany
- Prof. Harold G. Koenig, MD, Duke University Medical Center, Durham, NC, USA & King Abdulaziz University, Jeddah, Saudi Arabia
- Peter La Cour, PhD, Knowledgecenter for functional diseases, Psychiatry Copenhagen, Denmark
- Ass. Prof. Kevin L. Ladd, PhD, Department of Psychology, Indiana University South Bend, IN, USA
- Prof. Dr. Tatjana Schnell, Department of Psychology, Universität Innsbruck, Austria
- Prof. Dr. John Swinton, School of Divinity, History and Philosophy, King's College, University Aberdeen, UK

Conference Office

Dr. Stefan Rademacher
 Research Institute for Spirituality and Health
 Weissensteinstrasse 30
 CH-4900 Langenthal
office@ecrsh.eu

Preface

A Holistic Healing Relationship between the Caregiver and the Patient



This conference aims to address the holistic perspective of the person and care. The core component of every person is spirituality which integrates the biological, psychological, social, cultural and religious dimensions of the individual. Spirituality motivates the persons to live their suffering meaningfully and live with a purpose in this period of life and also in the afterlife. While treating patients with medical procedures and with various modes of rehabilitation, caregivers need to acknowledge the healing impact of their presence on the overall health of vulnerable persons under their care. Caregivers therefore need to discover their own spirituality which may generate more effective patient care. Similarly, patients need to be helped to discover their own spirituality in order to give meaning and purpose to their suffering and their own life and afterlife holistically. This will be supported by episodes from the Holy Bible and teachings of Pope Francis and the Church which provide inspirations to the holistic approach to patient care.

H.G. Mgr Paul Cremona O.P., Archbishop of the Diocese of Malta

Dear Participants, dear Colleagues

A warm welcome to the 4th European Conference on Religion, Spirituality and Health which is hosted by the Faculty of Health Sciences of the University of Malta. A big “thank you” to Donia Baldacchino and her local organising committee.

The conference will focus on the integration of religion and spirituality into clinical practice and therefore on health care professionals. An inspiring programme consisting of keynote lectures, symposia, free

communications and posters promotes state of the art knowledge and hopefully lively discussions. The Malta Lecture will be held by Prof. Harold G. Koenig, one of the great experts in the field.

The conference also aims to strengthen the European and international network among researchers, lecturers and clinicians and to encourage and equip young investigators in the field.

Finally we wish you all a great Malta experience!




Prof. Dr. med. Arndt Buessing
Chair of Scientific Committee




Prof. Dr. Donia Baldacchino
Local Organising Committee




Dr. med. René Hefti
Intern. Organising Committee




Dr. Stefan Rademacher
Conference Office

Schedule

4 th EUROPEAN CONFERENCE ON RELIGION, SPIRITUALITY AND HEALTH				
	Thursday May 22 nd	Friday May 23 rd	Saturday May 24 th	Sunday May 25 th
9:00	Meeting with the President of Malta /	<u>Christina Puchalski:</u> <i>Medical Education in Spirituality & Health: Creating more Compassionate and Whole Person Care</i>	<u>John Swinton:</u> <i>Re-imagining Mental Illness: Creating Communities That Care</i>	Optional Tour: A Day in Gozo Gozo General Hospital Tour Guided Victoria Tour
		Discussion	Respondents	
10:00		Coffee Break	Coffee Break	
		<u>Jacqueline Watts:</u> <i>Role-Models in Health Care: Should Spiritual Care of the Dying be the Concern of Health Professionals?</i>	<u>Christopher Cook:</u> <i>Recommendations for Psychiatrists on Rel. & Spir.: The Royal College of Psychiatrists Position Statement</i>	
11:00	Registration (starting around 11:00)	Discussion	Respondents	
		<u>Piotr Krakowiak:</u> <i>Who Should Do What? Improving End-of-Life-Care in Poland</i>	Discussion	
12:00	Welcome Lunch	Discussion	Break	
		Lunch / Poster Presentations / Meet the Expert	<u>Arndt Buessing:</u> <i>Spiritual Care for Patients with Chronic Illness: What Do They Need and How Do They Get It?</i>	
13:00	Opening		Discussion	
	<u>Donia Baldacchino:</u> <i>Spiritual Care Education of Health Care Professionals</i>	Symposia (concurrent sessions)	Closing Session, Awards, Summary, Farewell	
14:00	Discussion		Optional visit Mater Dei Hospital Guided Valletta Tour SAFE JOURNEY HOME!	
	<u>George Fitchett:</u> <i>Assessing Spiritual Needs in a Clinical Setting</i>			
15:00	Discussion			
	Coffee Break	Coffee Break		
16:00	<u>Farr Curlin:</u> <i>What has Religion to do with the Practice of Medicine</i>	Free Communication (concurrent sessions)		
	Discussion			
17:00	<u>Ewan Kelly:</u> <i>Rituals in Pastoral and Medical Care: Bridging the Gap</i>			
	Discussion			
18:00	Break	Social Evening: Guided Mdina Tour Prayers for Peace at Mdina Cathedral Paul Curmi Dancers Conference Dinner		
	Musical Performance			
19:00	<u>The Malta Lecture: Harold Koenig:</u> <i>Integrating Religion & Spirituality into Clinical Practice: An Overview</i>			
	Discussion			
20:00	Reception			
21:00	Committee Meeting			

Keynote Speakers

(in alphabetical order)



Prof. Dr. Donia Baldacchino

University of Malta, Member of the Research Ethics Committee and PhD Committee, Faculty of Health Sciences of the University of Malta; Visiting Professor, University of South Wales; Adjunct Faculty Member, Johns Hopkins University, MD, USA. Worked in the Intensive Therapy Unit, Renal Unit, St Luke's Hospital, Malta. Obtained the Certificate in Adult Education at Garnett College, London (1984). Graduated at: University of Malta (B.Sc. Hons, 1992); King's College University of London, UK (M.Sc. Nursing, 1993); University of Hull, Yorkshire UK (Ph.D. Nursing, 2002). Publications: Spirituality in Illness and Care (2003), Spiritual Care: Being in Doing (2010)



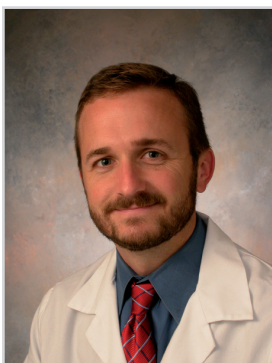
Prof. Dr. med. Arndt Büsing

Professorship for Quality of Life, Spirituality and Coping at the Chair for Theory of Medicine, Anthroposophical and Integrative Medicine, University Witten/Herdecke; External Senior Research Fellow at the Freiburg Institute for Advanced Studies (FRIAS) Freiburg/Bg., Germany. Research focus on quality of life, spirituality & coping, and non-pharmacological integrative medicine interventions to treat patients with chronic diseases. Experienced in designing clinical studies, surveys, and questionnaires for research with a focus on integrative medicine approaches. Publications: Spiritualität, Krankheit und Heilung: Bedeutung und Ausdrucksformen der Spiritualität in der Medizin (2006); Spiritualität transdisziplinär (2011)



Rev. Prof. Christopher Cook, MD, PhD

Department of Theology and Religion, Durham University, UK. Professor Chris Cook is Professor of Spirituality, Theology & Health in the Department of Theology & Religion at Durham University and an Honorary Consultant Psychiatrist with Tees, Esk & Wear Valleys NHS Foundation Trust. He trained at St George's Hospital Medical School, London, and worked in the psychiatry of substance misuse for over 25 years. He was ordained as an Anglican priest in 2001. He is Director of the Project for Spirituality, Theology & Health at Durham University and editor of Spirituality and Psychiatry (Eds Cook, Powell & Sims, RCPsych Press 2009) and Spirituality, Theology and Mental Health (SCM, 2013).



Prof. Farr A. Curlin, MD

Trent Center for Bioethics, Humanities, & History of Medicine, Duke University, Durham, NC, USA. Farr Curlin is a hospice and palliative care physician recently moved to Duke University, where he will become the Trent Professor of Medical Humanities, working with colleagues in the School of Medicine and The Divinity School to foster scholarship, study, and training regarding the intersections of medicine, ethics and religion. Before moving to Duke, Farr founded and was Co-Director of the Program on Medicine and Religion at the University of Chicago. He is particularly concerned with the moral and spiritual dimensions of medical practice and the doctor-patient relationship, and with the moral and professional formation of physicians.



Prof. George Fitchett, D.Min, PhD

Director of Research in the Department of Religion, Health, and Human Values and appointment in the Department of Preventive Medicine, Rush University Medical Center, Chicago, IL, USA.

Certified chaplain and pastoral supervisor; trained in spiritual care and in epidemiology; expert on spiritual assessment. In 1990 he developed his department's research program. George's research has examined the relationship between religion and health in a variety of community and clinical populations. It has been funded by the National Institutes of Health. Publication: *Assessing Spiritual Needs* (Academic Renewal Press, 2002)



Rev. Dr. Ewan Kelly

NHS Education for Scotland & part-time position as senior lecturer for Pastoral Theology at the University of Edinburgh, UK. He is a former junior doctor who has spent most of his working life as a healthcare chaplain and a university teacher. Ewan's experience includes chaplaincy in two large acute hospitals and a hospice in Scotland. His qualitative research has involved exploring the significance of ritual following baby death on the bereavement experience of parents. He currently works on the strategic development of spiritual care and healthcare chaplaincy in NHSScotland. Publications: *Marking Short Lives* (Peter Lang 2007), *Meaningful Funerals* (Mowbray 2008), *Personhood and Presence* (T&T Clark 2012), *Spiritual Care in Healthcare: Reflections on Practice* (co-author, Radcliffe 2011)



Prof. Harold G. Koenig, MD

Duke University Medical Center, Durham NC, USA & Distinguished Adjunct Professor King Abdulaziz University, Jeddah, Saudi Arabia. Board certified in general psychiatry, geriatric psychiatry and geriatric medicine and on the faculty at Duke University as professor of psychiatry and behavioral Sciences. Co-director of the Centre for Spirituality, Theology and Health at Duke University Medical Centre. Editor of the *International Journal of Psychiatry in Medicine*, founder and editor-in-chief of *Science and Theology News*. Publications: *Is religion good for your health? The effects of religion on physical and mental health* (1997); *Handbook of religion and mental health* (1998); *Handbook of religion and health* (co-editor, 1st ed. 2001, 2nd ed. 2012)



Dr. Piotr Krakowiak

Nicolaus Copernicus University, Torun, Poland. Theologian, psychologist and social educator, involved in hospice-palliative care in Poland since 1990. Studies and internships in hospice-palliative care in Italy and the US (1994-2000). Conducting research regarding volunteering, spiritual care, and non-medical issues of the end-of-life care. Since 2011 he has been involved as one of experts in European Academy of Palliative Care. Publications: *Living with a chronically ill patient in home care* (Gdansk 2011), *Social and educational functions of hospice-palliative care* (Gdansk 2012), *Volunteering in end-of-life care* (Torun 2012), *The art of communication towards the end-of-life: Guide for professionals and informal careers - families and volunteers* (Gdansk 2013)



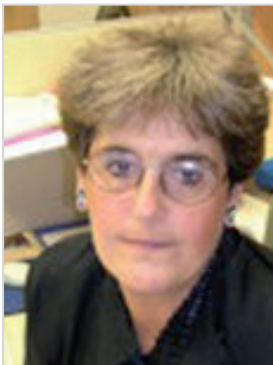
Prof. Dr. Christina Puchalski

George-Washington-University, Washington, DC, USA. M.D., M.S., FACP, Director of the George Washington Institute for Spirituality & Health, Professor of Medicine and Health Sciences at GWU School of Medicine, where she has pioneered novel and effective educational and clinical strategies to address the spiritual concerns common in patients. She is an active clinician, board-certified in Internal Medicine and Palliative Care and has demonstrated leadership in research and education in the integration of spiritual care across disciplines. She is a Fellow of the American College of Physicians and serves on the editorial board of several Palliative Care journals. Publications: Making Healthcare Whole; Time for Listening and Caring; Oxford Textbook of Spirituality and Healthcare



Rev. Prof. John Swinton

King's College University of Aberdeen, Aberdeen, UK. Professor in Practical Theology and Pastoral Care in the School of Divinity, Religious Studies and Philosophy and honorary Professor of Nursing at the University's Centre for Advanced Studies in Nursing. He has a background in mental health nursing and healthcare chaplaincy and has researched and published within the areas of ageing, dementia, mental health and illness, spirituality and human well-being and the theology and spirituality of disability. Publications: Dementia: Living in the Memories of God (2012); Spirituality in Mental Health Care: Rediscovering a "forgotten" dimension (2001); Living Gently in a Violent World: The Prophetic Witness of Weakness (2008); Practical Theology and Qualitative Research Methods (2006)



Dr. Jacqueline H. Watts

Faculty of Health & Social Care, The Open University, London, UK. Dr Jacqueline H Watts is Senior Lecturer in the Faculty of Health and Social Care at the Open University, UK. Her research and writing interests include feminist theory, gendered labour markets, professions and the social context of death and dying. Her work has been published in a number of international journals including Qualitative Research, Gender Work and Organization, Work Employment and Society, Feminism & Psychology, Illness Crisis & Loss and the European Journal of Palliative Care. Publications: Death Dying and Bereavement: Issues for Practice (2010); Gender Health and Healthcare - Men's and Women's Experience of Health and Working in Healthcare Roles (2014)

Partners and Sponsors

- Swiss Association of Psychosomatic and Psychosocial Medicine (SAPPM)
- International Association of Psychology of Religion (IAPR)
- Internationale Gesellschaft für Gesundheit und Spiritualität e.V. (IGGS)
- Faculty of Health Sciences, University of Malta
- The Ministry of Tourism, Malta
- Air Malta (www.airmalta.com)
- Maypole Caterers
- The Floral Designer
- Research Institute for Spirituality and Health RISH
- International Society of Spirituality, Religion and Health (ISSRH)

The Malta Lecture (public)

Integrating Religion/Spirituality into Clinical Practice: An Overview

Harold G. Koenig

Thursday, May 22nd, 18:30 - 20:15

Sir Temi Zammit Hall - with Musical Performance and Discussion

Dr. Koenig will begin by defining what “spiritual needs” are. He will then examine why it is important for health professionals to identify and address the spiritual need of patients, and how to accomplish this in a busy, time-pressured medical setting.

He will discuss which health professionals (physicians, nurses, social workers, or chaplains) should be responsible for conducting a spiritual history and mobilizing resources to meet patients’ spiritual needs. Dr. Koenig will then examine some of the barriers to ad-

ressing patients’ spiritual needs, including a lack of knowledge about how spiritual needs relate to medical outcomes, lack of time to address spiritual needs, and especially, lack of training on how to do so.

He will also review recent efforts by U.S. healthcare systems to integrate spirituality into patient care, and to what extent the spirituality of the health care provider may influence their capacity to provide whole person, compassionate care.

Keynote Lectures

(in chronological order)

All Keynote Lectures take place in the Main Auditorium

Spiritual Care Education of Health Care Professionals

Donia Baldacchino

Thursday May 22nd, 13:30 - 14:30

Nurses and health care professionals should have an active role in meeting the spiritual needs of patients in collaboration with the family and the chaplain. Literature criticizes the impaired holistic care as the spiritual dimension is often overlooked by the health care professionals. This could be due to feelings of incompetence due to lack of education on spiritual care, work overload, lack of time, different cultures, lack of attention to personal spirituality, ethical issues or unwillingness to deliver spiritual care.

Spiritual care is defined as recognizing, respecting, meeting patients’ spiritual needs, facilitating participation in religious rituals, communicating by listening and talking with clients, being with the patient by caring, supporting, showing empathy, promoting a sense of well-being by helping them to find meaning and purpose in their illness and overall life; and referring them to other professionals including

the chaplain/pastor. This paper outlines the systematic mode of intra-professional theoretical education on spiritual care and its integration into their clinical practice, supported by role-modeling. Examples will be given from the author’s creative and innovative ways of teaching spiritual care to undergraduate and post-graduate students. The essence of spiritual care is being in doing whereby personal spirituality and therapeutic use of self contribute towards effective holistic care.

While taking into consideration the factors which may inhibit and enhance the delivery of spiritual care, recommendations are proposed to the education, management, clinicians and further research to ameliorate patient holistic care.

Keywords: spiritual care, holistic care, education, intra-professional students, health care professionals

Assessing Spiritual Needs in a Clinical Setting

George Fitchett

Thursday, May 22nd, 14:30 - 16:00

The past 30 years have seen a remarkable growth in attention, among both researchers and clinicians, to the relationship between religion, spirituality, and health. This has included the development of numerous models for spiritual assessment. It is time for a critical review of these diverse models in order to determine and disseminate best evidence-based practices in spiritual assessment.

My presentation will have three sections. I will begin with a review of existing models for spiritual assessment and differentiate tools developed for research from those developed for clinical practice as well as three levels of inquiry about a patient's religious/spiritual needs and resources: spiritual screening, spiritual history-taking and spiritual assessment. Next I will review the limited existing research about spiritual assessment. I will conclude with a description of six issues that need to be addressed in a critical review of

models for spiritual assessment. Three of these issues are related to how we define spirituality and religion. In addition to our definitions (what are we assessing), they include the normative nature of spiritual assessment (e.g., what is spiritual distress), and the qualifications necessary to develop a model for spiritual assessment or employ one in clinical practice. The remaining three issues focus on the strengths and weaknesses of current practice in spiritual assessment. These issues are: 1) a preference for narrative vs quantitative models, 2) using the same model in all clinical contexts, and 3) using locally developed models.

To conclude I will ask whether currently there are any evidence-based models for spiritual assessment which deserve to be widely disseminated in clinical practice? If no such models exist should we develop them and if so, how should we go about that?

What has Religion to do with the *Practice* of Medicine?

Farr A. Curlin

Thursday May 22nd, 16:00 - 17:00

Although a series of patient-centered movements have brought attention to the influence of culture and religion on patients' experiences of illness, medicine has tended to think of clinicians as more or less interchangeable representatives of one biomedical profession, trained to set aside the undue influence of their "personal values." In this talk, Farr Curlin will describe a series of studies that chart the influence of physicians' religious characteristics on their clinical practices. These studies, it turns out, find that physicians in the US are more or less as religious as their patients, and physicians' religious faith matters both for their concrete practices and for how they understand their goals and responsibilities as physicians. Dr. Curlin will then provide a framework to make sense of these connections between faith and clinical practice, and to suggest that we should not be surprised

to find that medicine and religion are so intertwined. Finally, in light of these connections, he will consider what the profession of medicine might hope for from renewing and deepening its engagement with religious traditions and practices.

Participants in this session will be able to:

- Describe how physicians' religious characteristics are associated with their practices in a range of clinical domains.
- Outline a basic framework to make sense of the connections between religious faith and the practice of medicine.
- Describe ways the profession of medicine might more fully engage religious traditions and practices as resources for understanding and practicing good medicine.

Rituals in Pastoral and Medical Care: Bridging the Gap

Ewan Kelly

Thursday, May 22nd, 17:00 - 18:00

Ritual is integral to both health and pastoral care. The arts of health and pastoral care involve both embodied and performative action, including the articulation and expression as well as the hearing or

observing of individual and collective stories. Rituals are social acts which are subjectively and collectively interpreted, infused by layers of meaning. Traditionally both healthcare and faith communities

have developed rituals which enculturate and depersonalise, yet also others which provide meaning (or an opportunity to search for meaning), order and a sense of belonging which are potentially transformative. Rituals particularly mark times of transition and loss offering a means through which such experience may begin to be processed and integrated into personal and community living. The manner by which ritual is constructed and performed influences not only the lived experience of participants but how that experience is interpreted and the impact it has. This presentation will refer to pastoral or spiritual care

research performed with bereaved parents for whom ritual marking of their babies' life and death was significant. The aim of the presentation is to suggest learnings from research into ritual performed by a healthcare chaplain may have something worthwhile to say to other healthcare disciplines. Healthcare across Europe is seeking to be person-centred; ritual is significant in terms of person-centred care for recipients and care-givers. Participation in person-centred ritual has healing and transformative potential for all involved in health and pastoral care.

Medical Education in Spirituality and Health: Creating More Compassionate and Whole Person Care

Christina Puchalski

Friday, May 23rd, 09:00 - 10:00

Spirituality has played a role in health care for centuries, but by the early 20th century, technological advances in diagnosis and treatment overshadowed the more human element of medicine. In response, a core group of medical academics and practitioners launched a movement to reclaim medicine's spiritual roots, defining spirituality beyond religion and ethics, as each person's search for meaning and purpose in life. This talk describes the history of the field of Spirituality and Health—its origins, its furtherance through the AAMC's Medical School Objectives Project, and its ultimate incorporation into the curricula of over 75% of U.S. medical schools and the parallel development of clinical care guidelines in interprofessional spiritual care. The diversity of efforts in developing this field within medical education and

in national and international organizations created a need for a cohesive framework. This resulted in the creation by a consensus conference of seven medical schools of the National Competencies in Spirituality and Health. Also discussed will be a new curricular program called Reflection Rounds, the first applications of the competencies. The rounds, called GWish-Templeton Reflection Rounds initiative (G-TRR) are competency-based. Piloted in eight medical schools, G-TRR provided clerkship students with the opportunity through reflection on their patient encounters, to develop their own inner resources to address the suffering of others. These medical education initiatives in Spirituality and Health are helping create more compassionate clinicians who are more able to attend to the whole person—mind, body and spirit.

Role-Models in Health Care: Should Spiritual Care of the Dying be the Concern of Health Professionals?

Jacqueline Watts

Friday, May 23rd, 10:30 - 11:30

The domains of medicine and healthcare are replete with role models of all kinds – the caring nurse (usually a woman), the skilled surgeon (usually a man) and the expert physician are some examples that come to mind. Speaking to Goffman's paradigm, these are 'front stage' role models; others located 'back stage' might include scientists and technologists, all working to advance health and defeat disease. This illustrates how the work of caring for health comprises a number of professional subcultures each with its own demarcation and jurisdiction of practice often defended in the pursuit of enhancing specialized

knowledge and preserving disciplinary autonomy. Increasingly, however, we are seeing calls for greater cross-disciplinary collaboration amongst healthcare professionals to provide person-centred care as acknowledgement of the multiple impacts of ill health for individuals and families. This particularly has been the case in palliative care philosophy that seeks to offer integrated physical, psychosocial and spiritual care for those living with terminal illness. Although an established medical specialty, palliative care challenges the medical domain of cure, promoting holistic approaches to patient wellbeing. The

emphasis within this model on spiritual aspects of care has raised challenges for clinicians primarily concerned with cure of physical and psychological malfunction. Spiritual care of dying people contributes to a relational model of illness and death. In contrast to the medical model, the relational model helps to put the dying person 'back together again' in their full context, embedding them in a personal and social history.

Spiritual care is part, not only of hospice care, but also of general nursing practice that recognizes the importance of spirituality in patient health. Nursing, as a particular role model of professionalized care, has continued to struggle with the delivery of spiritual care with much literature devoted to considering enhancing understanding of the concept of spirituality and its application to nursing practice in ways meaningful to patients. Given the complexity of the existential realities confronting dying people for whom often the focus is on their families, unfinished business as well as a plethora of other 'legacy' concerns, is it now time to ask more fundamental questions about the appropriateness of health pro-

fessionals' involvement in the spiritual care of those facing death? A further question is whether palliative care that has received almost universal social approval, should be more discriminating in its 'domains' of practice.

In responding to these questions, this paper will argue for a different approach based on a community role model that fosters development of skills of individuals and families in seeing death as a normal part of life and spiritual care of dying people as part of our humanity. The sociologist, Allan Kellehear, has long been advocating for a shift in approaches to delivering spiritual care away from traditional professional models. This paper will explore some of his ideas together with my own that centre on connectivity through storytelling, faith, reflection, mutual enrichment and spiritual care as something we give to each other and not something we rely on 'professional others' to take responsibility for. Whilst for many, spiritual care is principally a matter of religious faith, in an age of increasing secularism this issue has taken on new dimensions and possibilities.

Who Should Do What? Improving End-of-Life-Care in Poland

Piotr Krakowiak

Friday, May 23rd, 11:30 - 12:30

The modern hospice movement in Poland has started in 1981 connecting medical and non-medical issues, integrating spiritual and religious care into teamwork practice. Today inclusion of spiritual care is a standard for most hospice-palliative care units. These good practices in Poland became inspiration for enlarging mostly sacramental and ritual pastoral service into more inclusive spiritual care. In 2011 the first edition of postgraduate training for future chaplains and pastoral assistants in Poland has been launched, and a first group of students has graduated "St. John of God School". Changing society of Poland, with great value of traditional Catholicism and sacramental participation of a large number of people, has to consider spiritual needs of a growing number of those who are far from the sacraments and faith communities. There is no adequate research regarding spiritual needs of those, who are not fully connected with faith communities. Religious needs of patients in Poland are mostly researched by experts of psychology or religion as it's described by M. Jarosz in The psychological measurement of religiosity. The international research project in spirituality regarding needs of patients towards end-of-life in Germany and Poland is led by A. Büssing. It measures spiritual and religious needs of chronically ill patients and includes validation of the Polish version of the SpREUK Questionnaire. Since 2013 another expert of spirituality in health care, C. M. Puchalski, has visited Poland and

gave lectures regarding integration of spirituality into patient care. Consequently FICA Tool for Spiritual Assessment has been translated and adapted to Polish and will be validated and used among practitioners. A set of publications, following a line of above-mentioned investigations and a textbook regarding spirituality in health care, is due to be published in Polish. Initial research regarding understanding the difference between religious and spiritual care has been conducted among those who work in pastoral teams in health and social care and ordained chaplains, continuing traditional, mostly sacramental and ritual care. Results of this initial research in Poland will be presented during this conference, showing that cooperation allows better answers for spiritual needs of patients and their families in end-of-life care.

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Re-imagining Mental Illness: Creating Communities That Care

John Swinton

Saturday, May 24th, 09:00 - 10:00

This presentation will explore ways in which we can re-think mental illness, moving away from the assumption that it is a problem to be dealt with, towards a new and healing understanding which perceives it first and foremost as a way of living in the world which requires to be understood and related to rather than simply eradicated. Mental illness occurs

in real people before they become diagnoses. These personal experiences should not be overlooked. The presentation will explore the nature and experience of mental illness and offer a spiritual perspective that can help to regain a truly holistic approach to people who experiment psychological difficulties.

Recommendations for Psychiatrists on Religion/Spirituality: The Royal College of Psychiatrists Positions Statement

Christopher Cook

Saturday, May 24th, 10:30 - 11:30

Debate about the place of spirituality and religion in clinical practice in psychiatry in the UK, as in many other countries, has generated a variety of opinions amongst professionals. The course of this debate will be charted briefly by way of introduction to the context in which a policy document was developed as a guide to clinical practice. This policy, adopted by the Royal College of Psychiatrists in 2011 and re-

vised in 2013, provides the first detailed guidance for psychiatrists in the UK concerning the place spirituality and religion in clinical practice. It includes seven recommendations, which seek to affirm the place for addressing spirituality and religion in psychiatry, whilst also protecting both patients and professionals against abuse or poor practice.

Spiritual Care for Patients with Chronic Illness: What Do They Need and How Do They Get It?

Arndt Buessing

Saturday, May 24th, 12:15 - 13:15

Patients suffering from chronic illness or life threatening diseases often report unmet spiritual needs. In most cases, these needs are neither addressed nor recognized by health care professionals. These needs can be categorized in terms of Connection, Peace, Meaning/Purpose, and Transcendence, and correspond to the underlying categories Social, Emotional, Existential, and Religious. Although it is appropriate that board-certified chaplains assess patients' spiritu-

al needs and resources, one cannot ignore that, particularly in secular societies, more and more health professionals without expertise in spiritual care are required be attentive to religious/spiritual issues. A survey among German patients with chronic pain conditions revealed that 37% preferred talking to their medical doctor about their spiritual needs; surprisingly, only 23% talked with a chaplain, and 20% had no partner with whom to discuss their spiritual

needs. Thus, there seems to be a substantial proportion of patients without an adequate partner who has the necessary time and skills to address their spiritual needs.

Although spiritual needs have been commonly addressed in palliative patients, only a few studies address these needs in patients with chronic diseases that are not primarily fatal. Using the Spiritual Needs Questionnaire (SpNQ) we surveyed predominantly secular German patients with chronic diseases. Results showed that secular spiritual needs such as the need for Inner Peace and Giving/Generativity were of outstanding importance; in contrast, Existential Needs (Reflection/Meaning) or Religious Needs were less important. Using the same instrument, predominantly atheistic patients from Shanghai were also surveyed. Similarly, Giving/Generativity and Inner Peace needs scored highest, while Religious Needs and the Reflection/Release Needs scored lower. When Catholic Polish patients with chronic diseases were surveyed, Inner Peace needs and Giving/Generativity needs along with Religious Needs and Existential Needs were considered important. Thus, when unmet spiritual needs are regarded as an important health care issue, the cultural/religious context plays a crucial role.

How are these factors related to variables of spiritual well-being and life satisfaction? In German patients, Religious Needs were positively associated with spiritual well-being and life satisfaction. However, Existential Needs and Inner Peace needs were correlated with a lack of spiritual well-being and life satisfaction. In contrast, Religious needs did not correlate with either high or low life satisfaction, both in patients from Poland and Shanghai. Interestingly, among German patients with fibromyalgia, Inner Peace needs and Existential needs correlated with different domains of reduced mental health, particularly with anxiety, the intention to escape from illness, and psychosocial restrictions.

Thus, spiritual needs among the chronically ill, whether expressed actively or not, may imply a longing for psycho-spiritual well-being. This need should be supported by health care professionals as a relevant, personal resource for patients. These specific spiritual needs have to be addressed in clinical care in order to identify potential therapeutic avenues to support and stabilize patients' psycho-emotional situation. This underlines the need for an adequate "spiritual care" as an important task of a modern health care system.

 EC RSH16

**We kindly invite you
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Religion, Spirituality and Health**

Symposia

All Symposia on Friday, May 23rd, 14:00 - 15:30

Symposium I: Spirituality in Palliative Care

Chair: Prof. Dr. theol. Klaus Baumann

A Model Combining Psychotherapy with Spirituality and Religion in the Area of Palliative Care and Bereavement

Dr. Benna Chase

DPsych, Clinical Psychologist in Palliative Care, Sir Paul Boffa Hospital, Malta



This paper presents a Model for working with the dying and the bereaved within the Maltese context arising from my years of practice in oncology and palliative care. The Model has emerged from my doctoral work, where, drawing on autoethnography, which “works to hold self and culture together, albeit not in equilibrium or stasis” (Holman Jones, 2005: 764), I focused on the interplay between self and culture, seeing that death, dying and bereavement are so strongly embedded within culture. The use of self is an important element. Self, from a Gestalt perspective, indicates cohesion over time – Integrity, and openness to change at the contact boundary – Growth (Yontef, 1993), two important characteristics in the Model. The interplay between the psychotherapeutic and the spiritual and religious is addressed, within a culture where the Roman Catholic Religion is a dominant tradition. The

Model advocates that, apart from practising presence and inclusion, a practitioner needs to be prepared to stay with the client in the long space between Withdrawal and Sensation, with its dearth of figure-formation. This requires a deep level of conviction that sustains the practitioner in the ‘between’ to allow a natural, positive figure to emerge, with the resulting growth of both practitioner and client.

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The Psychologist’s Role in the Spiritual Journey of a Child and Family During Palliative Care: A Case Study in Malta

Marisa Giordimaina

Mater Dei Hospital, Malta



The aim of this reflective account is a reflection ‘in’ and ‘on’ my personal work with this family whose child was on palliative care. Working as a psychologist, dealing with childhood cancer is often experienced as a journey where the diagnosis of a life-threatening illness raises in me key questions at the interface of medicine, palliative care and my own spirituality. Literature suggests that the dimension of spirituality and the provision of spiritual care still prove to be stumbling blocks for many health professionals. This eight-year old child suffering from cancer has been diagnosed since the age of three years. In paediatric palliative care, there is not only the child that needs support, but also the family that needs constant support. This reflection includes how the Maltese culture of ‘the family’ is influenced and how palliative care

is addressed in hospital. In Malta, 95% of the population is affiliated with the Roman Catholic religion. Although, people might not be practicing their religion, in times of illness, they may turn to God as a connection to something greater than themselves to help them make sense of their world.

By using the stages of the Gibbs (1988) Reflective Theory, namely description, feelings, evaluation, analysis, conclusion, and action plan, I am unfolding the journey as a psychologist and reflecting on the spiritual impact of this child’s palliative journey on my life. My experience of spiritual growth has been both on a professional and personal basis. The personal spiritual growth has generated a ripple effect and is reflected on my behavior in my own family and on my relationships with others in my profes-

sional life. It has affected my beliefs and meaning of life and my values on how to look on life in general. My reflections on the circumstances of accompanying this child and the family, I became aware of the impact this journey has had on me, my family, my work, and others.

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The Healing Power of Forgiveness: The Convergence of Education and Clinical Practice from a Personal Stance

Therese Bugeja

BSc (Hons)(Nurs.Stud.),P.G.Dip. (Educ.),MSc (Hlth.Educ.),P.G.Dip. Psychotherapy,S.R.N., Assistant Lecturer Nursing, Faculty of Health Sciences, University of Malta, Malta



Over the past ten years, research on forgiveness has proliferated and provides tangible reasons for unburdening ourselves of anger and resentment. Actually, forgiveness is the most powerful act that one can do for one's own health (Luskin, 2002). Mounting evidence reveals that the people who can forgive are the ones who receive the real rewards. People who are forgiving tend to have not only less stress but also better relationships, fewer general health problems and lower incidences of the most serious illnesses—including depression, heart disease, stroke and cancer (Worthington, 2006).

Moreover, recent reviews of the literature pertaining to forgiveness and health have argued that the physical and mental health benefits of forgiveness can be startling, regardless of age, gender or even the most unimaginable hurts (Worthington, 2006; Witvliet and McCullough 2007).

This paper aims to highlight experiences in forgiveness encountered both with students as a lecturer in

personal development, and clients as a psychotherapist. Each context presents both failure and success life stories.

Though most people probably feel they know what forgiveness means, researchers differ about what actually constitutes forgiveness. I have come to believe that how we define forgiveness usually depends on context.

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Faith, Hope and Love in the Experience of the Dying

Dr. Karin Tschanz

Reformed Church Aargau; Director of training in Palliative and Spiritual Care, chaplain Hirslanden Klinik Aarau, Co-Vice President www.palliative.ch, Switzerland



Spiritual care integrates the physical and psychosocial care to address client's needs holistically. Research suggests various definitions of spiritual care which include the "doing" and the "being" dimensions of care. Being refers to the personal spirituality of the care-givers which enables the therapeutic use of self in care by means of their active presence to clients. Thus, delivery of spiritual care incorporates "being in doing". Illness may increase the individual's awareness of their own personal spirituality. The aim of spiritual care is to help clients to find meaning and purpose in life which may lead to spiritual well-being

even in times of suffering. The care-giver's commitment towards providing active presence in care, may leave a positive impact on client's health. Research shows that when clinical experience is considered as a reflective journey, care-givers may acknowledge that while giving care to clients, they may also be on the receiving end. This paper presents research and the clinical model RESPECT of client's assessment of spiritual needs. Spiritual care may yield therapeutic and holistic effects on both the client and the care-giver.

Symposium II: Assessment of Spirituality in a Clinical Setting

Chair: Dr. des. Constantin Klein

Framework of Competencies in Spiritual Care for Nurses and Midwives: A Modified Delphi Study

Josephine Attard

Ass. Lecturer, Dep. of Midwifery, Faculty of Health Sciences, University of Malta, Malta



Aim: The purpose of this study was to develop a framework of competencies (knowledge, skills and attitudes), in spiritual care that guides nursing and midwifery education to ensure that new recruits in the profession will be equipped to meet the clients' holistic needs.

Background: In spite of the constant call for competence in the provision of holistic care as an essential professional skill (WHO, 1998; Human Rights Act 2000; NMC 2010; QAAHE 2001), the area of acquiring competence in spiritual care has largely been neglected in nursing and midwifery education and clinical practice. The development and validation of competencies in spiritual care is therefore important and recommended.

Method: The study utilized a mixed method approach using an eclectic framework through three main phases. The first phase involved the identification and formulation of spiritual care competency items and the development of the research tool from an in depth literature review and 5 focus group discussions with stakeholders and consumers of spiritual care. The second phase involved a consensus seeking process utilizing the modified Delphi methodology. The generated 55 generic competencies were scrutinized by a panel of 'experts' in spiritual care using a variety of sampling techniques in a 2-round Modified Delphi study. Response rates in round 1 was 75.78% (N=318, n=241) and in round 2 85.06% (N=241, n=205). Non respondents equated to 14.93% (n=36). Consensus was determined as having the proportion of experts who rated the item within the highest region of the scale on a 7-point 'Likert' form scale (5, 6, or 7) and equated to be 75% threshold or greater. The third phase of the study involved a consultation process with international and local experts in the field (N= 285, n=107) to obtain a pragmatic perspective of views on the identified domains and competency items in spiritual care, identify which competencies in spiritual care should essentially be acquired at PRE-registration level (i.e. at point of registration), which competencies should essentially be left at POST-registration level (i.e. after graduation

as qualified staff), and which competencies are not essential at either level. Thematic analysis sought to identify factors that may enhance or hinder implementation of the framework in education, research and /or clinical practice.

Results: The results for phase 2 of the study which will be presented. These were based on the response of 241 modified Delphi participants in ten different groups in round 1 of the study and 205 participants in round 2 (85.06%). 54 competency items out of the 55 presented achieved the pre-determined 75% level of consensus by the end of round 2. The majority of items (27) scoring above 90% and 25 items scoring above 80% level of agreement.

Cronbach's Alpha indicated total competency domains and competency items have reliability coefficients of 0.97 and each of the 7 domains and competency items have coefficients of between 0.79 and 0.93 indicating good to strong internal consistency. Spearman's test indicated very high correlations (0.9 to 1) for 23 items and high correlations (0.7 - 0.89) for 31 competency items. Only one item had a moderate correlation coefficient (0.5 - 0.69) (Item 35 $r_s = 0.554$).

Results for the exploratory factor analysis showed good fit of five factor model of Assessment and Implementation of spiritual care, ethical and legal issues in spiritual care, body of knowledge in spiritual care and Informatics in spiritual care. Items in the domain self-awareness and the use of self and items in the communication and interpersonal skills domain were not defined as these loaded on the various other factors. Items relating to referral to chaplains and spiritual leaders loaded as a separate factor. Only 2 items (item 8 and item 24) cross loaded on another factor while 5 competency items scored $<.04$ rotated factor loading.

Conclusion: The developed framework of competencies in spiritual care among the modified Delphi 'experts' in general, demonstrated to be a valid and reliable tool. Further testing is recommended in relation to the construct validity of the tool in particular to the use of confirmatory factor analysis is suggested.

From the Empirical Study of Religion/Spirituality to Practical Assessment in Treatment: Linking Research with Practice



Dr. des. Constantin Klein

Department of Theology, University of Bielefeld, Germany

In recent years numerous studies have deepened our understanding of the relation of religion/spirituality with mental and physical health (Koenig, King & Carson, 2012). Several pathways like social support provided by religious communities, a positive relationship with God, or religious/spiritual coping strategies which contribute to well-being and better health have been identified while different kinds of religious/spiritual struggles have been found to affect health to the worse (Klein, Silver & Zwingmann, submitted). The majority of such studies have used the methods of quantitative empirical research. Thus, the findings can be interpreted in terms of statistical probabilities.

Yet the question remains how such rather abstract research results can be helpful for the assessment of a patient's individual religious/spiritual history and for dealing with her or his concrete religious/spiritual needs in treatment. To answer this question it is important to be aware of the type of measure of religion/spirituality which has been used in a particular area of the empirical research because each type of measure relates to an underlying, more general question, e. g.:

- How important is the patient's religion/spirituality for her or him?

- Does the patient hold beliefs which are helpful to find meaning or which worry her or him?
- Is the patient member of a religious/spiritual community, and does she or he receive support from this community?
- How do the patients' religious/spiritual beliefs influence the subjective theory of her or his illness?
- Has the patient religious/spiritual needs which should be considered to improve her or his well-being? (cf. Albani & Klein, 2011).

Asking questions like these in the communication with a patient provides the opportunity to address and integrate the patient's religion/spirituality in clinical practice in a way that can be fruitful both for the patient's satisfaction with treatment and for the treatment outcome. The paper 1) gives an overview over the most important lines of research on religion/spirituality and health and 2) illustrates how the particular research topics are related to the more general questions which could (or should) be addressed in the direct communication with a patient. The possible consequences of such an assessment of religion/spirituality will be discussed, too.

Keywords: Assessment, Exploration, Measures, Empirical Findings

Assessing Religion/Spirituality with the Faith Development Interview



Prof. Dr. Heinz Streib & Dr. des. Constantin Klein

Department of Theology, University of Bielefeld, Germany

The paper gives an introduction into the assessment of an individual's worldview, in particular its religious/spiritual facets, with the Faith Development Interview (FDI). The FDI is a semi-structured interview which has been originally developed in James Fowler's (1981) research about stages of faith development. In its revised editions (Fowler, Streib & Keller, 2004; Keller & Streib, 2013) the FDI has been used for the exploration of faith biographies in numerous studies at Bielefeld University (Streib, Hood, Keller, Csöff & Silver, 2009; Streib & Hood, in preparation). By asking questions which explore the patient's life review, relationships, values and commitments, and religion/worldview, it offers space for reflection on one's life and its existential foundations (Keller, Klein, Streib & Hood, 2013).

We regularly make the observation that research participants respond to this offer and appreciate it as opportunity to self-exploration. Our research results show that the FDI permits the identification of salutogenic resources as well as of pathologic tendencies related to religion/spirituality. The growing acknowledgment of the importance of religion/spirituality for mental health suggests considering the FDI as a diagnostic tool in clinical and psychotherapeutic contexts and as an orientation for pastoral counseling (Keller, Klein & Streib, 2013).

The potential and limits of the FDI are discussed, drawing on examples from our current research.

Keywords: Assessment, Interview, Faith Development, Biography, Self-Exploration

Symposium III: Integrating Religion/Spirituality into Psychotherapy/ Psychiatry/ Neuroscience

Chair: Prof. Dr. Arjan Braam

Spirituality and Psychotherapy: A Double-Edged Sword?

Dr. Claudia Psaila

Counselling Psychologist & Social Worker, Lecturer, University of Malta, Faculty for Social Wellbeing, Department of Social Policy & Social Work, Malta



It is increasingly being acknowledged that spirituality cannot be separated from psychotherapy in the same way that spirituality cannot be differentiated from life since it is interwoven in everyday life (Pargament, 2007). Studies have highlighted a positive relationship between spirituality, religion and client functioning including their physical and psychological health (Koenig 2004; Leach 2009). In this presentation, I discuss the results of a recent qualitative study on the spiritual dimension of psychotherapy. The explorative study focused on the experience and perception of Maltese psychologists and psychotherapists of the spiritual dimension of psychotherapy. The data was collected through using a focus group approach. The findings suggest that spirituality is often considered to be an integral dimension of a person's identity and experience and as such needs to be acknowledged and addressed in psychotherapy. Both religion and spirituality may, in fact, be considered to be sources of internal strength and support. However, the opposite is also true such that a person's spirituality may underlie his/her psychological issues. At times, this is linked to a person's understanding and experience

of spirituality and religion. The study points to spirituality as a resource while also being part of the client's presenting problem either directly or indirectly. Furthermore, this duality may also be true with regards the therapist's understanding and experience of spirituality and religion with resultant implications for practice.

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Spiritual Needs of Patients in Psychiatry and Psychotherapy and their Utilization of Spirituality as Part of a Coping Strategy

Dr. Anne Zahn & Pfr. Franz Reiser

Universitätsklinikum Freiburg, Abteilung für Psychiatrie und Psychotherapie, Freiburg/Bg., Germany
Psychologischer Psychotherapeut (BDP, DFT), Psychotherapeutische Beratung und Begleitung für Berufe der Kirche, Freiburg/Bg., Germany



A clinical survey at the University Clinic for Psychiatry and Psychotherapy in Freiburg/Germany investigated psychiatric in-patients' spiritual and religious attitudes and practices along with their spiritual needs and expectations towards the clinic and its staff. Over the course of 18 months, all new in-patients received a questionnaire at the beginning and at the end of their clinical stay. Our survey consisted mainly of measures developed by A. Büssing et al. (SpREUK-15, Benefit-Scale, SpREUK-P-SF17, SpNQ 1.2) as well as socio-demographic and clinical data (e.g. diagnosis, BDI-II, WHOQOL-bref, BMLSS-10).

At admission, 248 participants took part in the survey (60% women, 40% men; mean age 39.6 ± 13.4 years; religious orientation: 77% Christian, 8.5% other, 14.5% none; self-perception: e.g. 46% regarded themselves as neither „religious“ nor „spiritual“). Our results show that intrinsic religious (Trust in Higher Guidance/Source) and quest-oriented spiritual attitudes (Search for Support/Access to Spirituality/Religiosity) are relevant for about 20-30% of patients. The meaning-making strategy Reflection: Positive Interpretation of Disease is considered important by 47% of the sample.

It seems that religion and spirituality are important for a considerable number of psychiatric in-patients, both generally and in relation to their disorder. Several patients would like these dimensions to be addressed in the clinic (this would be for 26% important) by the clinic staff (35% wish psychotherapist, 18.5% physician, 33% chaplain).

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Religious and Spiritual Attitudes of Patients in Neurological Rehabilitation and their own Concept of their Importance in Life

Dr. Anne Zahn & Carolin Schuetz

Universitätsklinikum Freiburg, Abteilung für Psychiatrie und Psychotherapie, Freiburg/Bg., Germany



Prior research has shown that religious and spiritual needs are relevant for patients with chronic diseases. However, the question how this should be integrated in therapy or not remains to be further clarified. We ask whether patients with neurological disorders have a need that spiritual and religious aspects are met in their therapy in hospital. Here, we tested the hypothesis whether subgroups of patients with high or low levels of spiritual and religious needs can be identified based on the relevance of their spiritual and religious practice in life.

To test this hypothesis, we use an adapted version of the questionnaire developed by A. Büssing. To further understand the relevance of addressing their spirituality and religion during their treatment episode we compare the results gained in the questionnaire with their values they have in life and how content they are related to the specific value. Therefore we use a

validated, semi-structured interview (Holzhausen et al., 2010; Holzhausen & Martus, 2012). 200 patients will be included, 100 will have the interview and the questionnaire; the other 100 will just have the interview. In order to see whether the additional interview is needed to understand how religious and spiritual needs must be taken care of in the clinical context. Preliminary findings of the study will be presented.

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The Progressive Impact of Burnout on Maltese Nurses

Dr. Michael Galea

Lecturer, Clinical Psychologist, Faculty of Health Sciences, University of Malta
 Malta



Nursing profession is a highly stressful vocation. Participants (N=241), who work in three different hospitals in Malta, were assessed on the impact of burnout on their holistic wellbeing. Nurses completed the Maslach Burnout Inventory-Human Services, the Satisfaction with Life Scale, the Faith Maturity Scale, the Positive and Negative Affect Scale, the Big Five Personality Inventory, and demographic variables. Results from this cross-sectional correlational study indicated that: a) professional nurses in Malta suffer

from high levels of burnout, particularly from high exhaustion and depersonalization and low professional accomplishment; b) as expected, burnout negatively correlated with subjective well-being; and c) a path analysis indicated the progressive impact of burnout, first on one's personality and affective mood, and eventually on one's wellbeing and spirituality. The implications and recommendations from these results were discussed.

Symposium IV: Doctors' Beliefs

Chair: Prof. Dr. Niels Christian Hvidt

Religiosity/Spirituality of German Doctors in Private Practice and Likelihood of Addressing R/S Issues with Patients



PD Dr. med. Edgar Voltmer

Department of Health and Behavioral Science, Friedensau Adventist University, Möckern-Friedensau, Germany
(Co-authors: Büssing A, Koenig HG, Al Zaben F.)

This study examined the self-assessed religiosity and spirituality (R/S) of a representative sample of German physicians in private practice (n = 414) and how this related to their addressing R/S issues with patients. The majority of physicians (49.3%) reported a Protestant denomination, with the remainder indicating mainly either Catholic (12.5%) or none (31.9%). A significant proportion perceived themselves as either religious (42.8%) or spiritual (29.0%). Women were more likely to rate themselves R/S than did men. Women (compared to men) were also

somewhat more likely to attend religious services (7.4 vs. 2.1% at least once a week) and participate in private religious activities (14.9 vs. 13.7% at least daily), although these differences were not statistically significant. The majority of physicians (67.2%) never/seldom addressed R/S issues with a typical patient. Physicians with higher self-perceived R/S and more frequent public and private religious activity were much more likely to address R/S issues with patients. Implications for patient care and future research are discussed.

Doctors' Beliefs and Medical Practice: Findings from two Swiss Cohorts

Dr. med. René Hefti & Dr. phil. Stefan Rademacher

Research Institute for Spirituality and Health RISH, Switzerland



To assess doctors' beliefs in Switzerland we used an adapted Curlin questionnaire (Curlin et al. 2005) adjusting the religiosity questions to the Religionsmonitor (2007). This enables us to compare religious profiles of the physicians with the general Swiss population.

We investigated 137 physicians of two religious organisations, the Swiss Association of Protestant Doctors and the Swiss Association of Catholic Physicians. 26.0% of the physicians considered themselves as protestant, 55.7% as evangelical and 18.3% as catholic. We wondered whether the three denominational groups differ in their understanding of how

religion interacts with medicine and how religion should be implemented into medical practice. A second survey was done amongst medical students at the University of Bern also using the adapted Curlin questionnaire. Results of both cohorts will be presented at the symposium.

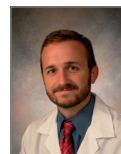
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Religion-Associated Variations in Physicians' Responses to Basic Mental Health Concerns

Prof. Farr A. Curlin, M.D.

Trent Center for Bioethics, Humanities, & History of Medicine, Duke University, Durham, NC, USA



Basic human questions underlie physicians' responses to common mental and behavior health concerns. This study uses data from a national survey of United States physicians to assess their self-predicted practices regarding depression, anxiety, medically unex-

plained symptoms, and alcoholism, and to describe the extent to which differences in physicians' practices are accounted for by differences in their religious characteristics. These data suggest that clinicians who are more religious tend to interpret common

mental and behavioural problems as having spiritual dimensions and components, and they tend to en-

courage patients to make use of spiritual resources to address such problems.

Psychiatric Staff's Religious/Spiritual Belief and its Influence on the Therapeutic Process

Dr. Eunmi Lee

Department of Caritas Science and Christian Social Welfare, Faculty of Theology, Albert-Ludwig-University Freiburg/Bg., Germany



By means of a representative study of German psychiatric staff (e.g. medical and nursing staff), this study aimed to find out 1) to what extent psychiatric staff values religiosity/spirituality in their own lives, 2) how psychiatric staff reacts to religious/spiritual issues in therapeutic process and 3) how psychiatric staff's own attitude toward religiosity/spirituality influences their clinical practice. From October 2010 to February 2011 an anonymous study was distributed to the staff of psychiatry and psychotherapy departments at German university hospitals and confessional clinics. The response rate was 24.43 % (N =404 of 1654).

Using the Duke University Religion Index, a degree of spirituality $m = 7.0$ on a scale of 12.0 was shown. On a revised version of the Curlin et al. questionnaire on Religion and Spirituality in Medicine: Physicians' Perspectives psychiatric staff indicated that they are open to religiosity/spirituality in the therapeutic setting, ready to listen and discuss religious/spiritual issues with their patients and also cooperate with chaplains. Moreover, there was significant moderate correlation between the staff's own spirituality and their attitude toward religiosity/spirituality in therapeutic setting,

that is: The more religious/spiritual psychiatric staff is, the more they believe that religiosity/spirituality is appropriate in the therapeutic process.

Interestingly chaplains working in psychiatric clinics responded that psychiatric staff is open to talk with patients about religious/spiritual topics, but psychiatric staff rated themselves more positively in this regard than chaplains. Moreover, chaplains affirmed that the personal religious/spiritual belief of psychiatric staff is an influencing factor on their attitude toward religiosity/spirituality in the clinical setting.

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The Role of Religion/Spirituality in Medical Management and Decision Making in Obstetrics and Neonatology: A Survey among Medical Professionals

Dr. Inga Wermuth & Prof. Dr. Andreas Schulze

Perinatal Centre Munich-Großhadern, Division of Neonatology, Munich, Germany



There is evidence that family members of critically ill infants wish to have more integration of their R/S from medical professionals particularly during shared critical-decision making. The purpose of our study was to analyze the perspective of perinatologists (obstetricians, midwives, neonatologists, neonatal nursing staff) on R/S in their professional environment.

1500 professionals from 20 German perinatal centers participated in an anonymous cross sectional survey. This accounts for 80% of all potential participants in these centers. The questionnaire was based on Curlin's instrument and adapted to suit perinatal and European specifics. In our cohort Roman Catholics were overrepresented (about 45%), while Protestants and those without a religious denomination represented

about one quarter each with a statistically negligible number of all other religious affiliations. The age of the participants ranged from 22 to above 60 with the mode located around 30 years.

A majority rated the general impact of R/S on patients' health as significant or moderate. Most of them felt that this influence is positive or could be positive as well as negative, while almost none felt that it is generally negative. The vast majority said that R/S has a role in coping during illness and suffering. Only about one third claimed that R/S aspects are sometimes or regularly addressed during a professional encounter with families. Less than 10% said that this never occurs. While almost all felt it to be appropriate to include R/S in counseling when parents bring

such issues up, many participants were hesitant to actively introduce such themes without a parental request. About half of the respondents indicated that specific barriers may impair communication on R/S with parents. A prevalent concern was that such conversation might be perceived as intrusive. We speculate that the high survey response rate among health

care providers in perinatology may indicate by itself that communication on R/S during the professional encounter with parents is generally regarded as important. However, the survey also reveals that the current practice of counseling in perinatology does not reflect this rating.

Symposium V: Integrating Prayer in the Clinical Setting

Chair: Ass. Prof. Kevin L. Ladd, PhD

Prayer in the Acute Phase of Myocardial Infarction

Prof. Dr. Donia Baldacchino

Ph.D. (Hull), M.Sc.(Lond), B.Sc.(Hons), Cert.Ed.(Lond), R.G.N.,
University of Malta, Malta



Prayer is multidimensional and may have a theistic or non-theistic orientation. Research provides evidence about the efficacy of spirituality and prayer during stressful situations which may yield positive outcomes in health. Prayer may yield positive beliefs that may foster meaning and purpose in illness and life, particularly when faced with a life threatening illness such as, myocardial Infarction. In contrast, prayer may yield negative outcomes for example when patients consider their illness as a punishment from God.

This paper presents part of a larger descriptive longitudinal study on patients' experiences of prayer during the onset of myocardial infarction. This study was guided by three theories: The numinous experience (Otto 1950); Cognitive Theory of Stress and Coping (Lazarus & Folkman 1984) and Relational Spirituality and Transformation (Sandage & Shults 2007). A total of 53 patients with first acute MI (34 males; 19 females), mean age of 61.9 years, affiliated with the Roman Catholic religion, were interviewed retrospectively on their transfer to the medical ward.

The qualitative data which underwent thematic analysis revealed that while patients considered the severity of their chest pain, they perceived the loss of their dear ones, experienced the fear of abandonment

from God, and fear of death. Consequently, 53% of males (n=18) and 84% females (n=16) prayed to God through the intercession of saints such as, Saint Mary, Padre Pio and Saint Gorg Preca. However, 47% of males (n=16) and 16% of females (n=3) did not pray during the immediate acute phase. The types of prayer consisted of intercessory prayer, thanksgiving to God, requesting forgiveness from God and efforts of alignment with the will of God. While considering the limitations of this study, recommendations were set for the education, management and clinical sectors in order to ameliorate patient care.

Keywords: prayer, relationship with God, acute phase, myocardial infarction, impact of heart attack.

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Functions and Topics of Prayer in Patients Dealing with Illness - A Systematic Review

Karin Jors, M.A.

Freiburg/Bg.,
Germany



Background: Private, personal prayer has been shown to both positively and negatively influence physical and mental well-being. Despite inconclu-

sive results regarding its benefit, prayer is commonly used among patients for health purposes. Therefore, in this review, we were interested in two main ques-

tions: 1) why do the people turn to prayer in times of illness and 2) what are the main topics of their prayers?

Method: We undertook a systematic literature review by searching the databases PubMed, Medline, PsycINFO and Index Theologicus for studies focused on prayer and illness. The following inclusion criteria were used: 1) participants in the study were patients dealing with an illness 2) study examined the use of private prayer rather than intercessory prayer 3) both the function and topics of prayer were investigated. **Results:** In total, 12 articles were included in the final review. The majority of the studies used a qualitative design, e.g. interviews. Study participants suffered from a variety of diseases but most often from cancer.

In all 12 studies, patients prayed for improvement in both physical and mental well-being. Nine studies showed that patients prayed for help managing their disease, e.g. decision-making. However, patients also prayed for protection, guidance, strength and hope. Prayers were not only self-focused but also included thanksgiving, adoration and prayers for others.

Conclusions: Although most patients do pray for relief from their physical and mental suffering, it appears that the effectiveness of their prayers (i.e. healing) is not the main reason they pray. Rather, prayer can be a source of strength and comfort that allows patients to positively transform the experience of their illness.

Prayer and Health: Issues for Theology and Psychology of Religion

Mary Rute Gomes Esperandio & Kevin L. Ladd

Pontifícia Universidade Católica do Paraná (PUCPR), Curitiba, Brazil
Indiana University South Bend, South Bend, IN, USA



Quantitative research has been prevalent in the studies on prayer. Using a qualitative approach based on content analysis, this study examines the relationship between prayer and health. Data come from 104 recorded interviews of participants from Catholic, Protestant and Pentecostal traditions. The analysis found four categories that describe the use of prayer: 1. Prayer as a religious coping strategy (62,5%); 2. Prayer as a discipline to keep spirituality alive (15,3%); 3. Prayer as a technique of mutual empowerment (8,6%); 4. Prayer as a turning point in the existential process (13,4%). The types of prayer corresponding to these categories are: 1. Petitionary

and Lamentation; 2. Rest and Sacramental; 3. Intercessory prayer; 4. Conversion; Calling; Movement of the Spirit. According to the current literature, prayer provides inward, outward and upward connectivity. The results indicate an additional connectivity not yet studied: the Epiphanic connectivity, which comes from sacred to human and marks a turning point in the existential process. The outcomes suggest a close relationship between prayer and spiritual and mental health by decreasing anxiety, making meaning and purpose in life, and point out the relevance and need for further studies on the interface between theology and psychology of religion.

Medicine, Faith, Religion and Science

Prof. Joseph M. Cacciottolo, MD, DSc, FRCP

Coordinator, Humanities, Medicine & Science Programme, Medical School, University of Malta, Malta



The practices of medicine and belief in the supernatural have always been closely associated, and historically, medicine has only relatively recently become an evidence-based applied science. Despite the clear separation of modern medicine from religion, several studies have shown that belief in the metaphysical and the practice of faith are very important to individuals, especially when they are concerned about their health, or undergoing life-changing events.

Any discussion of the relationship between faith and medicine is rendered complex not only because their boundaries are unclear, but also because of the personal and subjective nature of faith itself. A ma-

ajor confounding factor in such discourse is the fact that different systems of belief relate dissimilarly with medical science and practice: Often the only common ground is the search for truth.

At a conceptual level, the interface between medicine and faith needs to take into consideration matters that in general relate to science and religion, as well as issues of convergence, hurdles to discourse and divergence.

At a practical level, faith in the immaterial may occasionally affect individual medical decisions both from the patient's aspect, as well as from the physician's perspective. At an individual level, the faith of

persons facing physical adversity is at times tested, as is belief in intercessional prayer. For physicians and scientists, it is often a very personal decision to

specifically address faith and its compatibility with scientific evidence.

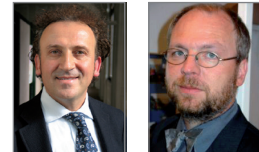
Symposium VI: Spiritual Needs in a Secular Society

Chair: Prof. Dr. Arndt Buessing

Patients' Interpretation of Illness is associated with their Spiritual Needs, and Specific Forms of Spirituality

Prof. Dr. Janusz Surzykiewicz & Prof. Dr. Arndt Büssing

Institute of Social Prevention, Warsaw University, Poland / Professorship of Pastoral Theology & Psychology, Catholic University Eichstätt-Ingolstadt, Germany
 Professorship of Quality of Life, Spirituality and Coping, Faculty of Health, University of Witten/Herdecke, Germany



Background: Based on the assumptions of the self-regulation model, the individual being an active problem solver consciously activates efforts to modulate thoughts, emotions and behaviors when facing illness or health threats. An important aspect for dealing with illness in terms of coping and illness interpretation are individual representations of disease. Relying on Diefenbach and Leventhal (1996) there are two main types of representations: cognitive and emotional. Based on numerous previous studies concerning the influence of spirituality and religiosity on illness interpretation and coping), the dimension of spirituality as a third important dimension of illness representation is introduced and discussed. Assuming that spirituality beliefs are important factors for individual coping strategies as well as behavioral reactions in the context of illness it is hypothesized that different qualities of spirituality (i.e. search for transcendence, need for inner peace, ethical sensitivity, harmony) result in different interpretations of illness (i.e. illness as a value, as a chance, as a punishment etc.), and thus different coping styles (i.e. helping others, self-transcendence, religious meaning, escaping from illness).

Method: Cross-sectional survey among 275 Polish patients (mean age 56±16; 74% women; 26% men) with both fatal and non-fatal chronic diseases: cancer (35%), diabetes mellitus (16%), chronic pain diseases (10%), and other chronic conditions. Standardized questionnaires were the Interpretation of Illness Scale; Spiritual needs Questionnaire (SpNQ), Self-description Questionnaire of Spirituality (SQS), Spirituality/Religiosity and Coping (SpREUK-15), Life Satisfaction (BMLSS), and Escape from Illness Scale.

Results: Most patients regarded their illness as something negative, i.e., 61% interruption of life, 50% enemy, 20% weakness, 8% punishment, 13% relieving

break, 22% call for help; yet, a large fraction also as something positive, i.e., 42% challenge, 18% value. Compared to patients with cancer, patients with non-fatal chronic diseases regarded their illness less often as an enemy ($F=7.3$; $p < .01$), while all other interpretations did not differ significantly between these disease groups.

Value was strongly associated with religious trust ($r=.50$), and moderately ($r>.30$) with patients' ability to reflect their life, with religious needs and needs for giving/generativity, with SQS's religious attitudes and ethical sensitivity, and other measures of spirituality. However, challenge was only weakly associated with search for a spiritual source ($r=.21$) and reflection ($r=.20$). In contrast, a negative disease perception such as enemy was strongly associated escape from illness ($r=.59$), and moderately with existential needs ($r=.30$); also other negative disease perceptions such as interruption of life ($r=.55$) or punishment ($r=.36$) were moderately or strongly associated with escape. Call for help was positively correlated with escape from illness ($r=.48$), and negatively with life satisfaction ($r=-.38$). However, weakness or relieving break is not significantly associated with measures of spirituality. Regression analysis based on these correlations show significant impact of spirituality on interpretation styles of illness as well as coping strategies.

Conclusion: Data show that the type of spirituality is an important predictor for the patients' interpretation of illness and coping. Spiritual attitudes result in a positive interpretation of illness as being something of value, indicating potentially the chance for a spiritual transformation. Negative interpretations were mainly related to the intention to escape from illness, reduced life satisfaction, and existential needs.

Faith as a Resource in German Patients with Multiple Sclerosis

Anne-Gritli Wirth

Witten/Herdecke University, Witten/Herdecke, Germany
(Co-Authors: Arndt Buessing, Peter Heusser)



To analyse how agnostic/atheist patients with multiple sclerosis (MS) cope with their illness compared to spiritual/religious patients we performed a prospective, multi-centre, anonymous study using standardised questionnaires. 213 patients (75% women; mean age 43±11 years, EDSS Score 3.7±1.8) were recruited from three hospitals that specialize in the treatment of MS.

Among them, 54% rated themselves as neither religious nor spiritual (R-S-), 16% as not religious but spiritual (R-S+), 19% as religious but not spiritual (R+S-), and 20% as both, religious and spiritual (R+S+). 29% stated that their "faith is a strong hold in difficult times" (52% rejected it, and 19% were undecided). Having this faith as a resource was not significantly influenced by gender, family status, educational level, course of disease, and it was also not related to patients' health status, life satisfaction, negative mood states, or Positive attitudes. Instead, this resource was associated with MS patients' ability

to reflect on what is essential in life, with the conviction that illness may have meaning and could be regarded as a chance for development, and to appreciate and value life. Of interest was the fact that the experience of Gratitude/Awe was lowest in R-S- patients, and the highest in R+S+ patients. When asked for their individual source of hope, orientation and inspiration in life, 53% of patients had none, 10% stated faith/religion, 22% family/partner/children, 18% other (mainly philosophical sources).

Thus, religious individuals may find hope and hold in their faith, and related engagement in individual forms of religiosity (i.e., private prayers, meditation, rituals) and/or organized forms of religiosity (i.e. church attendance), while R-S- cannot rely on this source. One may suggest that they may have either no specific interest or are less willing to reflect these issues. How these individuals could be supported requires further exploration.

Spiritual Needs of Mothers of Sick New Born or Preterm Children

Undine Waßermann

Communal Hospital Herdecke, Herdecke &
Institute of Integrative Medicine, Witten/Herdecke University, Germany
(Co-Author: Arndt Buessing)



Spirituality is part of the basic needs of all humans, yet often ignored in hospitals because it is regarded as beyond professional duties of medical doctors, nurses or psychologists. Meanwhile there is an increasing body of evidence that even in secular societies, patients with chronic diseases may have specific spiritual needs. However, less is known about the spiritual needs of mothers of preterm or sick new born children. Aim of this study was thus to identify the needs of such mothers. So far, 62 mothers from the paediatric intensive care unit of the Communal Hospital

Herdecke meeting the inclusion / exclusion criteria responded to a set of standardized questionnaires, i.e., spiritual needs questionnaire (SpNQ), spiritual well-being (FACIT-Sp), mood states (ASTS), stress perception (PSS), self-efficacy expectation (SWE), life satisfaction (BMLSS), etc. We will present first data on mothers' spiritual needs and spiritual well-being during their struggle with their new borns' health affections. By supporting their needs in hospital we hope to be able increasing mothers' well-being and binding to their children.

Spiritual Needs of Elderly Living in Residential/Nursing Homes

Jülyet Öven Uslucan

Professorship Spiritual Care; Clinic for Palliative Medicine, University Clinic Munich, Munich, Germany
(Co-Authors: Carlos Ignacio Man Ging, Eckhard Frick, Arndt Buessing)



The aim of this study was to analyze psychosocial and spiritual needs among seniors living in residential/nursing homes in the South of Germany on one

hand, and the underlying connections with their life satisfaction, moods, and meaning in life on the other hand.

112 seniors (76% women and 24% men with a mean age of 83 ± 7 years) were recruited in 9 different residential / nursing homes for elderly and assisted accommodation homes in Bavaria (predominantly with a Catholic denomination). To measure psychosocial and spiritual needs, we used the Spiritual Needs Questionnaire (SpNQ) which differentiates 4 main factors, i.e., Religious Needs, Existential Needs, need for Inner Peace, and need for Giving/Generativity. We found that Religious Needs scored highest, while all other needs were of similar, yet lower relevance. There were no significant differences between men and women; also age and educational level had no significant influence. While there were no particu-

lar differences in the magnitude of unfulfilled needs with respect to self-care ability, there were significant differences in terms of elderly living in residential homes or residential nursing homes. In fact, those living in residential nursing homes had lower Religious Needs, but higher Existential Needs and Inner Peace needs. These results clearly differ from a similar study among elderly conducted in Schleswig-Holstein (Erichsen and Büssing, 2013), located in the North of Germany (predominantly with a Protestant denomination). It could be observed that Religious needs, in which praying for oneself was placed at the first place, was the most powerful issue. The more meaning in life (SMILE questionnaire) the residents

Symposium VII: Spirituality, Judaism, Health Care

Chair: Mag. Theol. Michael Petery & Naomi Kalish, B.A., MSW

Spiritual Care in Bavarian Jewish Communities

Mag. Theol. Michael Petery

Clinic for Palliative Medicine, Ludwig-Maximilians-University Munich, Germany



The Spiritual Care Department of the Clinic for Palliative Medicine at the LMU Munich University prepared the first study ever designed to observe the situation of ill and dying people in Bavarian Jewish communities. It is an empirical study based on qualitative interviews. The participants, rabbis, community leaders, social workers etc. are all actively involved

in Jewish communities and responsible for providing end of life care. The conducted interviews (21) indicated the importance of maintaining the maximal life-quality until the very end in terms of Judaism. The communication regarding the religious aspects or questions should according to the experts, be provided based on an explicit wish of the patient.

Translation and Validation of Shalom Questionnaire Hebrew Version

Nahum Elhai

Department of Public Health, Ben Gurion University of the Negev, Israel
(Co-authors: Sara Carmel, Yaacov G. Bachner)



Introduction: The current study examined the factor structure and psychometric properties of a Hebrew version of the Shalom health and spiritual well-being questionnaire (Fisher, 2010). Shalom is one of the few research tools that include a multi-dimensional concept of spirituality and differentiate between spirituality and religiosity.

The questionnaire is based on a spiritual health model developed by Fisher and Gomez (2003), which examines the quality of relationship people have with regard to four existing dimensions: personal, communal, environmental, and transcendental. The questionnaire consists of 20 items; each requests a double reference: one of value and the other of the degree of realization this value has in the respondent's everyday life.

Method: 1. The Shalom questionnaire was translated into Hebrew according to accepted procedure; 2. A research questionnaire was built containing Shalom and addition of variables for validity assessment; 3. The questionnaire was distributed anonymously online, and 350 questionnaires were filled out by individuals from ages 19 to 90.

Tools: 1. The structure factor was evaluated using confirmatory factor analysis (CFA) with Varimax rotation; 2. Construct validity was examined by testing correlations between relevant variables; 3. Internal reliability was tested by Cronbach's alpha coefficient. **Results:** 1. Factor analysis supported the four-factor structure of Shalom as reported by Fisher (2010), 2. Construct validity was supported by negative correlation with death anxiety and depression, and posi-

tive correlation with the will to live, life satisfaction, and general well-being,³. High reliability coefficients were received for the overall scale (0.90), as well as for each of the four factors (0.80-0.94).

Conclusions: The results of this research show that the Hebrew version of the Shalom questionnaire is valid and reliable and can be used with confidence in studies of spirituality.

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Carol Gilligan's Listening Guide as a Method for Spiritual Assessment

Rabbi Naomi Kalish, ACPE, BCC, MA,

Coordinator Pastoral Care & Education, Morgan Stanley Children's Hospital & Sloane Hospital for Women & UJA-Federation, President, National Association of Jewish Chaplains, USA/Israel



Spiritual Care providers and researchers are tasked with formulating understandings of the people they encounter that informs their provision of care, educational programs, policies, and ongoing research. They must articulate understandings of spirituality and spiritual care in order to do such assessments. In this paper, the presenter will introduce participants to a tool for such a task: the Listening Guide Method, developed by acclaimed developmental psychologist Carol Gilligan. In the latter half of the twentieth century Gilligan published *In a Different Voice*, contributing not only new knowledge about psychological development, but a revolutionary approach to research methodology. Since the publication of this landmark book, Gilligan's method for discovery research has been developed and used by scholars internationally and across disciplines.

Gilligan's characterization of her method 'discovery research' is especially apropos to emerging fields, such as spiritual care, and to critiquing already established fields, such as psychology. This method can provide the crucial, often over-looked step of questioning of basic assumptions. In this presentation the presenter will also provide examples of how researchers can use Gilligan's Listening Guide Method can lead to the development of spiritual assessment tools.

The presenter will demonstrate the relevance of such a method for developing and using spiritual care tools in culturally and religiously diverse contexts.

Objectives: 1. To learn the history and context of Carol Gilligan's psychological theories and how they inform her research methods; 2. To make the steps of The Listening Guide Method; 3. To make an application of Gilligan's theories and methods to spiritual assessment; 4. To relate the relevance of The Listening Guide Method to cultural competency

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"Quality of Life" vs. "Sanctity of Life" – Traditional Jewish Spiritual Perspectives on Current Trends in Hospice and Palliative Care

Rabbi Jay Yaacov Schwartz, M.A.

Ramat Beit Shemesh, Israel



The Jewish community in the United States and Israel has been grappling with the process of end-of-life medical decision making as part of Hospital and Hospice for the last two decades, especially in situations when secular medical ethics might seem to be at odds with Jewish medical Ethics and spiritual considerations. New Palliative care research initiatives are currently studying how to serve Traditional

Jewish patients in Hospice and Palliative care settings ways that are consistent with serving their spiritual concerns and cultural orientation.

We will present actual case studies and the conclusions of these scientific research studies conducted in New York from 2003-2007 and explain the unique perspective of Judaism on these issues.

Free Communications

All Free Communications on Friday, May 23rd, 16:00 - 17:30

Session 1: How do Health Care Professionals understand Religion/Spirituality and Spiritual Care?

Spiritual Care by Hands and Heart

Liv Ødbehr

Lecturer, PhD student, Norway
(Co-Authors: Kari Kvigne, Solveig Hauge, Lars Johan Danbolt)

Aims and objectives: To investigate how nurses and care workers understood and practiced spiritual care among patients with dementia disease in nursing homes.

Background: Spiritual care in nursing practice is one aspect in the overall holistic care provided by nurses. Substantial international empirical studies describe the concept of spirituality, but fewer studies describe how nurses understand and practice spiritual care for patients with dementia disease in nursing homes.

Design: Qualitative study with an explorative design.
Methods: The study comprised eight focus group interviews of 31 nurses and care workers in Norwegian nursing homes. Data were analysed using a qualitative research method in a phenomenological–hermeneutical approach of inquiry.

Results: Initially the nurses were unsure of the meaning of spiritual care, and whether they performed such care at all. Through focus group discussion the understanding became more evident. Spiritual care was described as i) integrated in the overall general care, which highlighted practical daily care described

as “working with hands”, and nurses’ intuition and positive attitudes described as “working with the heart”; ii) togetherness, characterised by presence and reciprocity and iii) provision of meaning in the everyday life of patients and meeting patients’ religious needs.

Conclusion: The nurses seemed to lack theoretical knowledge and concepts that could describe spiritual care. However, through joint reflection in groups the nurses discovered that they carried out spiritual care in their everyday practice. Spiritual care was seen as tacit knowledge in nurses’ practice based on the nurses’ experiences with dementia patients.

Relevance to clinical practice: This study demonstrates the nurses need for arenas to discuss and reflect on what spiritual care to patients with dementia disease means, and how to practice it. In addition, there is also a need for education and theoretical knowledge to further explore spiritual needs and spiritual care.

Keywords: Spiritual care, nursing homes, dementia, focus groups, nursing practice

Religion, Spirituality and Spiritual Care of Nurses in Mental Health Care, Hospital Care and Home Care in The Netherlands

Dr. Annemiek Schep-Akkerman

Researcher, Zwolle, The Netherlands
(Co-Author: RR van Leeuwen)

Background: the religious and spiritual aspect of life is recognized as having an important part to play in health, wellbeing and quality of life. So, spiritual care is an important part of the nurses role and the expectation is that nurses will be competent in this. Literature shows that the competence in delivering spiritual care depends on a few variables: age, working experience and the importance of spirituality in the nurse’s life. However, there are different sectors in health care, so, differences in these sectors could play a role as well.

Research question: how do nurses in different sectors in health care (mental health care, hospital care and home care) perceive spirituality and spiritual care and how competent do they think they are in delivering spiritual care? Next to this, what factors appear to contribute to these perceptions and competence?
Method: nurses in mental health care, hospital care and home care were asked to complete a questionnaire. Parts of the questionnaire: demographic characteristics, perceptions of spirituality and spiritual care (SSCRS), self-assessment of spiritual care

competence (SCCS) and evaluation own spirituality (SAIL). The answers on the questionnaire and summary scores will be compared between sectors and demographic characteristics.

Results: 160 nurses in mental health care, 202 nurses in hospital care and 87 nurses in home care have completed the questionnaire. Nurses in hospital care are the youngest, nurses in home care do have a higher age. 53% of all nurses are Christian, 16% say they have no faith and 13% is atheistic/agnostic. Most nurses do have a rather general perception of

spirituality, think they are competent in delivering spiritual care and spirituality does play a role in their lives. Similarities and differences between sectors will be presented, next to factors that seems to be associated with spirituality and spiritual care.

Discussion: There seems to be associations between religiousness, spirituality, and self-assessed competence in delivering spiritual care. What could contribute to the discussion about delivering spiritual care: is it natural or can everybody learn it?

Meaning-making, Spirituality and Religion: Significance for Patients in Treatment for Substance Use Disorder.

Dr. Torgeir Sørensen

MF Norwegian School of Theology/Center for Psychology of Religion, Inlandet Hospital Trust, Oslo, Norway
(Co-Authors: Lars Lien, Anne Landheim, Lars J. Danbolt)

Background: Spirituality, religiousness, how people create meaning in life and these factors significance for patients in clinical settings are underexposed subjects in the research literature. In Norway several religiously motivated clinics treating addiction receive funding from the health authorities. Even so, little is known about meaning-making, spirituality, and religiousness among people with substance use disorder and the mentioned factors function related to treatment.

Aim: The purpose of this study is to investigate how patients with substance abuse disorder relate to activity and experiences regarding spirituality, religiousness, and to meaning-making in general. Further, we will investigate in what way such activities and experiences eventually are of significance for treatment of substance use disorders according to patients and therapists.

Material and methods: Data will be collected at a Norwegian religiously motivated addiction clinic. A focus-group interview including up to 8 patients will be conducted, hopefully generating relevant subjects for further data collection. Next, 10-12 patients will be in-depth interviewed. These patients will also fill

in the SoMe questionnaire with the possibility to link the questionnaire to each in-depth informant. The same questionnaire will also be anonymously filled in by up to 48 inpatients at Riisby Treatment Centre. Also, two focus-group interviews among therapists at the same institution will be performed to gain knowledge of the therapists' view of spirituality, religiousness and meaning-making in treatment of substance use disorders. This latter investigation will represent the main part of the presentation at the conference. The material will be analysed by qualitative content analyses, and descriptive and multivariate statistics. For an overall analysis of both the qualitative and the quantitative material a mixed-methods design will be utilized.

Results and relevance: This study will generate detailed knowledge concerning a topic rarely investigated. The findings will have relevance for treatment and care for patients with substance use disorders and generate important knowledge transferable to mental health care. Findings may be important for development of how therapists can meet and support patients regarding their resilience and coping resources.

Development of the Instrument for Measuring Spiritual Health Scale in Thai University Students

Dr. Preeya Keawpimon

Lecturer, Prince of Songkla University, Hatyai, Thailand
(Co-authors: Sureeporn Kritcharoen, Sopen Chunuan, Urairat Nayai)

Measuring the spiritual health of university students is useful for planning the student's activities. This study contributes to the development of a valid and reliable instrument, spiritual health of university student scale, as an instrument to assess university student's spiritual health. The participants were students

from Bachelor-level of 15 faculties (N= 525), Prince of Songkla University, Hatyai campus, Thailand. The items of the instrument were hypothesized from Buddhist philosophy regarding spiritual health. Content validity was examined by six experts (I-CVI=1). Construct validity was evaluated by factor analysis and

internal consistency was estimated with Cronbach's alpha and average inter-item correlation. In addition, Pearson product moment correlation coefficient of the concurrent validity was test by Thai Happiness Indicator with positive correlation (Pearson's $r = .574$). The reliability coefficient of Thai Spiritual Health Scale (short form with 30 items) was satisfactory value (Cronbach's $\alpha = .80$). The instrument comprises of four

domains including 1) Noble mind (Cronbach's 0.81), 2) Moral living (Cronbach's 0.74), 3) Mindful management (Cronbach's 0.77), and 4) Attentive learning (Cronbach's 0.86). Finding suggests that the development instrument has adequate validity and reliability to investigate the spiritual health of Thai university student.

What Happens when the Patients' Bell Rings: An Explorative Study in the Field of Palliative Care

Prof. Dr. Niels Christian Hvidt

University of Munich, Germany

(Co-Authors: Cécile Loetz, Jakob Müller, Beate Mayr, Yvonne Petersen, Piret Paal, Carlos Ignatio Man Gin, Yousef Helo, Eckhard Frick, Niels Christian Hvidt)

Background: Besides ringing the bell there are few possibilities for patients in palliative care to actively initiate the contact with nurses. The following study explores what happens when patients call for nurses by ringing the bell in palliative care settings.

Aim: This explorative study observed and described the patient-nurse interaction initiated by bell ringing. Special attention was paid at patients' distress experience.

Method: The field work lasted one week (24/7). During this period all bell-ringing occasions were recorded. Depending on the situation, interactions in patient rooms were observed and coded using a participant observation sheet. Subsequently, NCCN Distress thermometer was used both on patients and nurses to enquire about the reasons for bell ringing and measure the distress involved.

Results: During the observation period 20 palliative patients were recruited for this study. All nurses working in one of the largest palliative care units in Germany agreed to participate in this study. All in all we recorded 362 bell-ringing occasions of which 122 interactions were observed (33,7%). The results indicate that a major cause for ringing was associated with practical (68,0% of $n=122$ interactions) and physical (36,9%) needs. Regarding the practical

needs, patients sought help during bowel movement (26,2%). The most important physical concern was pain (15,6%), whereas only 5,7% expressed emotional and 3% spiritual concerns. The results indicate that patients tend to express their distress in extreme values, then again, physical needs become higher ($M=8,15$) and practical needs lower ($M=4,07$) stress values. Nurses have the tendency to use the medium values in their distress estimations. In comparison to instructive communication style the inquiring communication style leads to a higher parity between patients and nurses estimations. During basic nursing procedures and treatments the distress estimations from both sides were to great extent amenable.

Conclusion: This study describes situations that are initiated by palliative patients as they call for nurse by ringing the bell. The results of this study reflect on the nursing interventions and communication styles that occur during patient-nurse interaction. The distress estimations pointed out that in particular the patient's physical needs are connected with higher distress, which should not be underrated by nurses. The observation revealed that patients' emotional and spiritual needs are not necessarily verbally expressed, but the wordless cues may have a significant role, when it comes to distress and distress reduction.

Session 2: Religion & Spirituality in Daily Practice of Health Care Professionals

What is the Religious Conviction/Spirituality of my Patients? Austrian Medical Students' Point of View

Dr. med. univ. Anahita Paula Rassouljan

PhD-student, University of Vienna, Austria

A large number of studies have shown that religion and spirituality may play an important role in pa-

tients' life while dealing with serious illness. Besides the bio-psycho-social concept there is another part

of a person, which wants to be reflected. Patients report that they want their physician to talk to them about their religiosity/spirituality. Data demonstrated the existence of a "spiritual need" in patients and the importance of addressing spiritual issues in patient-doctor communication. To reflect these needs different concepts were developed for taking a spiritual history in a clinical setting.

What about Austria? Officially 79% of the population belong to a religious conviction but the role of patients' spirituality and religion still seems to be a taboo in the daily routine of a doctor. Do we, as physicians, neglect these important issues? Are we ready to confront ourselves with our own religious/spiritual beliefs and furthermore to open doors for our patients to talk about it? Do physicians of tomorrow, medical students, believe that the „faith factor“ plays a role while coping with illness? Do they feel comfortable to integrate religion/spirituality into their patients's care?

To find answers for precisely these questions 1410 students at the Medical University of Vienna (333 at

their first, 248 at their second, 393 at their third and 426 at their fourth year) participated in a questionnaire, between March and June 2013. This questionnaire is assessing the students' spirituality and religiosity, as well as their attitudes towards "spiritual care", particularly to its relevance in their future profession. 744 men and 656 women; mean age 22, 30, SD=2.3, were asked whether they had ever heard of the term spiritual care.

59, 5 % of the students had reflected their own belief concept, 21, 9% consider themselves as religious, and 20, 1% as spiritual individuals.

75,6% of the students agreed with the statement that religious conviction/spirituality might have an effect on cancer patients' coping. 85,9% will consider talking with their patients about religious/spiritual issues, if patients wish to do so. 85,9 % would involve chaplains if they had the feeling it is necessary.

The results of this study encourages the view that future doctors should see the patient in a wider scope than the bio-psycho-social one, by including the spiritual dimension.

Influence of Spirituality on Work Engagement in Physicians with an Anthroposophic Background

Prof. Dr. Arndt Buessing & Prof. Dr. Peter Heusser

Professorship of Quality of Life, Spirituality and Coping, Faculty of Health, University of Witten/Herdecke, Herdecke, Germany

Chair for Theory of Medicine, Integrative and Anthroposophic Medicine, Institute of Integrative Medicine, Witten/Herdecke University, Herdecke, Germany

Background: How do physicians deal with increasing stress and work burden, which may affect their life satisfaction and empathic encounter with patients? Is spirituality a resource which has an influence on physicians' emotions, perceptions and professional behaviour? How do behave physicians with an Anthroposophic background with its specific features of spirituality?

Methods: Cross-sectional survey among 197 medical doctors with an Anthroposophic background (mean age 53±12; 60% men, 40% women) using standardized questionnaires, i.e., Aspects of Spirituality (ASP) Questionnaire, Utrecht Work Engagement Scale (UWES), Cool Down Index (CDI), Life Satisfaction (BMLSS), and work pressure (VAS).

Results: In contrast to a predominantly secular normal population, Anthroposophic physicians regard themselves mostly as both religious and spiritual (80% R+S+) or at least non-religious but spiritual (14% R-S). Also in contrast to a German reference population, measures of spirituality (i.e. Religious orientation: Praying and Trust in God, Search for Insight /Wisdom, Conscious interactions, and Transcendence conviction) scored very high. Among the various aspects of spirituality, Conscious interactions (r=.23) and Search for Insight/Wisdom (r=.20) cor-

related weakly with physicians' life satisfaction, while none of the measures of spirituality correlated significantly ($p < .01$; Spearman rho) with the Cool Down Index. This Cool Down Index was negatively associated with physicians' life satisfaction ($r = -.39$) and work engagement ($r = -.24$). However, physicians' work engagement correlated moderately with Religious orientation ($r = .34$), and weakly also with Search for Insight / Wisdom ($r = .25$), Transcendence conviction ($r = .23$), and Conscious interactions ($r = .19$).

Stepwise regression analyses revealed that their work engagement can be predicted best ($R^2 = .29$) by life satisfaction, with further influences of Religious Orientation, low Cool Down behavior, Search for Insight /Wisdom, and age, while work pressure, meditation or gender were not among the significant variables.

Conclusion: Due to their Anthroposophic background with its specific spiritual implications for the professional work, physicians' spirituality correlated moderately with their work satisfaction which in turns was moderately associated with life satisfaction ($r = .41$). Thus, their spirituality might not be a buffer against Cool Down behavior (i.e., emotional exhaustion and depersonalization), but against loss of vigor and dedication in their medical work.

Emotion Work Associated with Personal Faith

Bernice Tighe

Senior Lecturer in Dietetics, Coventry University, Coventry, U.K.
(Co-Authors: C. Blackburn, A. Slowther)

Introduction: Artificial feeding can be emotive and can have deep spiritual and religious meanings¹.
Method: 16 UK registered dietitians were interviewed as part of a qualitative phenomenological study exploring their experiences of decision-making related to artificial feeding.

Results: Emotion work emerged as a theme, and for some was related to their personal beliefs. Emotion work is the modification of emotions which health care professionals (HCP) undertake in order to enable patients to feel cared for and to conform to organisational rules². One dietitian's experiences of emotion work related to her Christian beliefs are reported here. The dietitian reported feeling conflicted about feeding patients she believed were dying or suffering, 'am I just prolonging somebody's life an extra couple of weeks and prolonging their pain...for no other reason than I'm feeding them? I do struggle with that quite a lot.' These emotions seemed to be rooted in her view that patients were suffering: '...part of me thinks, "for the quality of life they have is it really worth feeding them and keeping them alive this long?"...I just think that's quite sad really...I suppose what my belief would be to let the patient go to a better place...maybe it's to do with...me being a Christian...' This dietitian had to modify her emotions because she feared the repercussions of expressing her faith: '...obviously that's something

you can't express with the patient...we live in a world ... where you can say one thing wrong and the next thing you're in the newspapers...or brought up in front of the head of department...'

Discussion: Emotion work can have health costs for the person undertaking it; it can increase stress, and has been linked to burnout². High profile cases of HCPs being disciplined influenced this participant to hide her beliefs so she needed to undertake emotion work. A dietitian's faith may influence decision-making³ and so not disclosing one's faith may not be best for transparent decision-making. **Conclusion:** Hiding personal religious beliefs due to fear of professional repercussions can lead to emotion work.

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Religious Practice as an Occupational Need

Patricia Eyres, MSc,DipCOT

Lecturer in Occupational Therapy, Faculty of Health & Human Sciences, Plymouth University, Plymouth, UK

In culturally diverse communities it is necessary for the professional therapist to be culturally competent (Odawara 2005). Occupational Therapy philosophy supports a clear link between fulfilled participation (in all and any valued activity) and health & well-being. This requires an understanding of diverse occupational needs including those related to family relationships, gender roles, diet, dress, rites of passage and religious practice. While studies relating to spirituality can be found in Occupational Therapy literature (Wilson 2010), religious practice, as an everyday activity/occupation, is largely absent. This paper will report on a project (part of a PhD study) aiming to explore religious practice as a valued activity. The study participants are drawn from a range of faiths in the UK- (Christian, Muslim, Jewish, Baha'i, Pagan, Buddhist, Sikh and Hindu). The study takes a Phenomenological approach aiming to explore

the meaning and participation needs of people who regularly engage in religious practice. However the intensely personal nature of religious practice is challenging and requires a creative approach to data gathering (Eyres 2013). A modified photovoice technique termed Participatory Photography Interview (Warren 2005) has been used to facilitate personal reflection. Participants took photographs that in some way represented their religious practice and individual interviews were held to record discussion about the images produced. The analysis of this data is being used to inform a second phase of study involving Occupational Therapists and hospital chaplaincy staff, to further explore and potentially inform the current ways in which occupational needs related to religious practice are met within clinical/rehabilitation settings in the UK.

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“Availability and Vulnerability” in Advanced Nurse Practitioner Consultations: Key Components for integration of Spirituality into Clinical Practice?

Melanie Rogers

Senior Lecturer, Advanced Nurse Practitioner, Leeds, UK
(Co-Authors: A. Topping, J. Hargreaves)

The concepts of “Availability and Vulnerability” come from part of the “Rule of Life” expressed and followed by members and companions of a Christian community (The Northumbria Community). The presenter has adapted these concepts through her doctoral research to suggest the possible integration of Availability and Vulnerability as key components of spirituality in clinical practice.

“Availability and Vulnerability” is the lens through which I conducted my research. This study is nearing completion and addressed the “Spiritual Dimensions of Primary Care Consultations by Advanced Nurse Practitioners”. A hermeneutic phenomenological approach was taken throughout the study with interviews conducted with experienced Advanced Nurse Practitioners working in Primary Care. These practitioners were interviewed twice over a period of 2 years and were asked to discuss various themes including “what spirituality meant to them”, “how

spirituality fits into clinical practice”, “where are the boundaries in practice”, “how availability and vulnerability translate for them in practice”, “what are their values in practice” and a number of other issues. These questions were revisited in the second interviews after the practitioners had read and considered the “Rule of Life”.

This presentation will explore the key findings of my research with a focus on how “Availability and Vulnerability” relates to the consultation and spirituality. Time will be given to explore the boundaries and ethical issues associated with “Availability and Vulnerability”. Consideration will be given to help clarify how “Spirituality” and “Availability and Vulnerability” are interwoven.

Finally a conceptual model of Spirituality for Advanced Nurse Practitioner consultations will be presented to assist putting the concept of “Availability and Vulnerability” into practice.

Session 3: Patients’ Needs – Research and Case Studies

The Role of Spirituality in Life Attitude of Individuals with Down Syndrome

Ayşe Burcu Goren

PhD student, Lecturer, Ankara, Turkey
(Co-Author: Alice Moscaritolo)

Spirituality has increasingly been recognized as a basic human need and is a necessary component of both mental and physical health. Studies indicate that spirituality provides meanings, inner strength, peace, and hope for people. However, the importance of the spiritual dimension of life is rarely acknowledged in care of people who live with mental

disability. Furthermore, in the field of mental disability, spirituality is frequently underused in practice. Therefore, research is needed to explore the deeper role of spirituality in living with mental disabilities and how to integrate spirituality into the practice of working with individuals with mental disabilities and their families. Literature indicates that there is a

growing awareness and interest to meet this need in the West. Situation in non-Western countries appears to be the same.

This paper explores the role of spirituality in the lives of people with Down syndrome and their parents in Turkey. For this, 8 week-long program was conducted with six young people with Down syndrome, aged between 16-26 years old living in Ankara. Researcher used her own home for weekly meeting. First, in-depth interviews conducted with mothers. Basic information about their children such as personality, vulnerability, moods, emotionality, daily routines, their expectations and what makes them happy or unhappy collected. Second, weekly pro-

gram planned. Main objective of this program was to add spiritual activities in the daily routines of children. Considering Islamic nature of the local culture, following spiritual activities were selected; helping poor, visiting nursing home, talking about friends, universe, heaven and God, marble workshop (sort of Islamic art) and visiting worship houses. Finally, after seven-week long program, mothers were re-interviewed to determine what significant changes they observed in the life attitudes and behaviors of their children. In addition to report of researcher's own observation, mothers reported increased happiness, sense of meaning and belonging, sense of subservientness, and increased sense of self-worth in their children.

Religious Needs of Dialysis Patients and their Families

Prof. Barbara A. Elliott PhD, MDiv, BCC

Family Medicine and Community Health, Center for Bioethics, University of Minnesota, USA
(Co-Author: Charles Gessert)

Background: This qualitative study investigated life experiences and end-of-life decision making among patients with end-stage renal disease. Analysis revealed that many of these patients' and their family members' religious beliefs and practices provided the basis for their coping and decision making with their circumstances and dialysis treatment.

Methods: A prospective qualitative study interviewed 31 elderly dialysis patients and their family members; interviews lasted 30-90 minutes. Interviews were transcribed and coded independently by three investigators. The codes were collected into content-specific "nodes" and themes. Investigators identified and reconciled their interpretations by returning to the transcripts to assure that conclusions reflected participants' sentiments.

Results: Five themes pertaining to religious beliefs and practices emerged as central to patient and family experiences while living with dialysis. Two themes were related to medical decision making: their faith-based beliefs and the meaning that emerges from these beliefs. Two themes described how their coping is expressed in their religious experiences: the participants' religious practices and their perceived support from the church community. The remaining theme described the participants' spiritual distress.

Conclusion: These findings offer insights into the central role religious experiences play in the lives of people living with dialysis. The results identify the issues that health care and palliative care team members can anticipate and be prepared to address in patient support and decision making in dialysis settings.

Spiritual Assessment and Care Plan

Eve Rubli Truchard

Centre hospitalier universitaire vaudois, Lausanne, Switzerland
(Co-Authors: Rochat E, Dürst AV, Monod S)

Background: Mrs X, 93, is admitted to hospital suffering from presbyoesophagus and cachexy, with oropharyngeal dysphagia causing great difficulties to eat, and infections. She suffers from mild cognitive impairment and has no longer her capacity of discernment concerning therapeutic decisions. Because of severe electrolytic disorders related to the denutrition, and without possible curative treatment of the presbyoesophagus, two therapeutic options are opposed: the placement of a nasogastric tube to feed the patient and to give her the appropriate medication vs accompanying the patient until her death.

Despite a structured multidisciplinary approach with comprehensive geriatric assessment (separate specific anamneses) and a thorough discussion with the patient and her relatives, the ambivalence of the latter leaves the health team in a dead end.

Methods: The traditional model of multidimensional geriatric assessment and the use of a narrative approach proving insufficient to allow a decision, an integrated biopsychosocial and spiritual experimental approach is applied. The chaplain carries out a standardized assessment of the spiritual dimension with the SDAT. This assessment and the ensuing dis-

discussion with the health team will allow to propose to the patient and her relatives a new care plan making sense for both patient and health team.

Results: The assessment of the spiritual dimension with the procedure SDAT reveals that the patient suffers from spiritual distress.

It allows:

- 1) to bring out the necessary elements for an ethical debate between the members of the health team,
- 2) to structure the discussion with the patient.

Thanks to these two times of the action the health team could define a therapeutic option: not to place a nasogastric probe and to accompany the patient who will die a few days later, this in accordance with the patient's presumed will.

Conclusion: An interdisciplinary model of care articulating the biopsychosocial and spiritual dimensions makes it possible to assess the elderly patient in her globality, to thus acquire a thorough knowledge of the patient and to discuss in a more adequate way the goals of the care plan.

The Creativity-Spirituality Construct and its Role in Transformative Coping

Dr. Dagmar A.S. Corry

Lecturer in Psychology, Glyndwr University, Wrexham, Wales, & The Bamford Centre for Mental Health and Wellbeing, University of Ulster, Derry/Londonderry, Northern Ireland
(Co-Authors: John Mallett, Christopher A. Lewis, Ahmed M. Abdel-Khalek)

The present study examines whether and to what extent creativity and spirituality are used in coping in a cross-cultural and cross-denominational student sample of 610 participants. Two new theory-based instruments, displaying good internal consistency and satisfactory levels of content- and construct validity, are introduced, the Creative Coping Scale (CCS-19), and the Spiritual Coping Scale (SCS-30). A positive, moderate relationship between creative and spiritual coping emerged, thus supporting the

theory of transformative coping. The findings demonstrated that participants applied both creative and spiritual coping in their lives in order to deal with acute and chronic stress.

Associations between creative and spiritual coping and demographic variables were outlined. Practical applications for the promotion of mental health were discussed. Future research should seek to replicate and extend the present findings.

Spiritual Distress and Psychological Distress in Elderly Patients: Joint Intervention?

Anne-Véronique Duerst

Service de Gériatrie et Réadaptation Gériatrique, Centre hospitalier universitaire vaudois, CHUV, Lausanne, Switzerland
(Co-Authors: Etienne Rochat, Eve Rubli Truchard, Stéphanie Monod)

Background: Ms A, 66-year-old, suffering from Parkinson disease since 6 years but fully independent, is hospitalized in a geriatric rehabilitation unit after a complicated hip replacement. Since her husband's death 8 years ago, doctors disagree on a psychosis diagnosis. At her arrival she is fully dependent, hypoactive, hallucinates and falls several times. After diagnosing a Parkinson disease dementia and a persisting fluctuating confusional state, a nursing home placement is decided. Ms A is so distressed that her care is compromised

Methods: An integrated biopsychosocial and spiritual approach is applied. A chaplain using the standardized procedure SDAT and a psychologist respectively assess the patient's spiritual and psychological dimensions. Both specialists then discuss the results to determine which type of intervention should prevail: spiritual only, psychological only or both jointly.

Results: The spiritual assessment reveals that : the need of Transcendence is covered but the needs of Sense and Values are severely unmet and the need of Identity partially unmet. The patient is thus declared in severe spiritual distress. The psychological assessment shows an adjustment disorder with depressed mood and excludes a psychosis (the hallucinations being linked to Parkinson disease). Being since the operation fully dependent, unable to walk by herself, suffering of cognitive disorders, the patient struggles to maintain a sense of identity and to find the resources to adapt to the situation. Thus a joint spiritual and psychological intervention is put in place, with a focus on the psychological dimension of identity and on the subdimension of Transcendence. Specifically, interventions on a psychological weakness and on a spiritual resource are carried on while both intervenants give new options to the health team for

the patient's care. Thanks to this joint intervention, Ms A progressively recovers a sense of identity, accepts a transfer in nursing home and cooperates fully to her care.

Conclusion: A structured interdisciplinary biopsychosocial and spiritual model of care integrating a standardized spiritual assessment makes it possible to differentiate spiritual from psychological distress in

elderly patients. This allows to design the most efficient intervention and helps to propose the care plan making the most sense for both patient and health team. When both types of distress coexist, chaplain's and psychologist's joint interventions make it possible to address simultaneously the elderly patient's needs and to treat him as a whole person.

Session 4: Coping and Quality of Life

The Role of Religious/Spiritual Well-Being in Coping with Dermatological Diseases

Prof. Dr. Elisabeth Aberer

Dept. of Dermatology, Medical University Graz, Austria

(Co-Authors: Pilch M, Lukanz M, Scharf S, Glawischnig-Goschnik M, Wutte N, Fink-Puches R, Unterrainer H)

Background: In previous research, dimensions of religiosity and spirituality turned out to be significantly linked to parameters of subjective well-being and more adequate stress coping in various clinical as well as non-clinical populations. However, studies focusing on the relevance of religious/spiritual issues in chronic inflammatory skin diseases and skin tumors are still rather sparse. Hence, in the present study we intend to address this deficit in patients with lupus erythematosus and systemic sclerosis, diseases with long term morbidity and early mortality and patients after the initial diagnosis of melanoma to lay the groundwork for approaching dimensions of religiosity and spirituality in treatment.

Methods: A total of 150 dermatologic patients (age: M=53.52, SD=13.97; 108 females) with lupus erythematosus (n=48), systemic sclerosis (n=44) and early stage of malignant melanoma without metastasis (n=58) were investigated by means of standardised instruments including the Multidimensional Inventory for Religious/Spiritual Well-Being (MI-

RSWB), the Brief Symptom Inventory (BSI-18) and a short version of the Freiburger Coping Questionnaire (FCQ-LIS). Correlation and regression statistics were conducted for data analysis.

Results: As a main finding the RSWB dimensions turned out to be relevantly associated with a lower amount of anxiety ($p < .01$) and depression ($p < .01$) as well as a more active coping style ($p < .05$) in all 3 patient groups. Furthermore, in comparison to the normal population, our patients with dermatological diseases exhibited a notably high amount of RSWB sub dimensions such as Hope Immanent or Forgiveness, which was paralleled by a better coping outcome in general.

Conclusion: In accordance with the existing literature the dimensions of religious and spiritual well-being were confirmed as being important resources for patients coping with chronic autoimmune diseases of the skin and diagnosed melanoma. Based on these promising initial results a further religiously/spiritually based intervention should be recommended.

Religiosity and Health Related Quality of Life of Elderly People: Populational Study in Sao Paulo City, Brazil

Dr. Gina Andrade Abdala

Professora do Mestrado em Promoção da Saúde - UNASP SP, Doutoranda PROESA-EE/USP, Sao Paulo, Brazil (Co-Authors: Miako Kimura, Yeda Aparecida de Oliveira Duarte, Maria Lúcia Lebrão, Bernardo dos Santos)

Objective: To test the mediating effect of religiosity on a hypothetical model of health-related quality of life (HRQoL) of elderly through Structural Equation Modeling (SEM).

Methodo: This was an observational cross-sectional study developed as part of the Study Health, Well-being and Aging (SABE). The sample consisted of

911 elderly people from Sao Paulo, Brazil, with a minimal age of 60 years, living in the community. A Structural Equation Modeling (SEM) analysis was performed in order to verify the mediating effect of religiosity on the relationship between selected variables and the HRQoL of elderly, with separated models for men and women. For these analyses,

SPSS AMOS program (IBM, 22nd version) was utilized. The independent variables were: age, literacy, family function (APGAR) and multimorbidity (more than two diseases mentioned). The outcome variable was HRQoL, measured by SF-12, which contains two components: physical (PC) and mental (MC). The mediators were: organizational religious orientation (ORA: church attendance or religious service), non-organizational religious orientation (NORA: the practice of private religious activities such as prayer) and intrinsic religiosity (IR: meaning and importance of religion). Cronbach's alpha was 0.85 for PC, MC= 0.80, RI = 0.89 and APGAR= 0.91.

Results: Higher levels of ORA and IR were predictors of better physical and mental quality of life for the elderly, as well as higher level of education, better

family functioning and fewer diseases, contributing directly to improve performance in PC and MC, independently of ORA, NORA and IR. For women, ORA influenced as mediator between age and the physical component ($\beta=2.401$; $p<0.01$), as well as the mental component ($\beta=1.661$, $p<0.01$). In the same manner, IR mediated the relationship between literacy and MC in men ($\beta=7.158$, $p<0.01$).

Conclusion: This study confirms the importance of religion, level of education, family functioning and multimorbidity as factors influencing the HRQoL of elderly, and demonstrates the beneficial effect of organizational and intrinsic religiosity in the relation of age, education on physical and mental health of elderly.

The Association of Spirituality and Quality of Life in Chronic Kidney Diseases Stage V Patients

Assist. Prof. Dr. Areewan Cheawchanwattana

Department of Social and Administrative Pharmacy. Faculty of Pharmaceutical Sciences, Khon Kaen University, Khon Kaen, Thailand

(Co-Author: Waraporn Saisunantararom)

Objectives: The deterioration of health-related quality of life (HRQoL) of chronic kidney disease (CKD) patients was well-established. Though the World Health Organization suggested the spirituality as an important component of HRQoL, there were still a limit number of spirituality studies in CKD patients. The relationship of spirituality and HRQoL was also obscure. This study was aimed to evaluate spirituality of CKD patients, and its association with HRQoL.

Methods: The study was approved by the Hospital Ethic Committee. CKD stage V patients (N=63) were asked for consent and then interviewed of spirituality and HRQoL using World Health Organization Quality of Life - Spirituality, Religiousness and Personal Beliefs (WHOQOL-SRPB) Thai version, and 9-item Thai Health status Assessment Instrument (9-THAI), respectively. The association of spirituality and HRQoL was examined by using multiple linear regression as controlling for other contributing factors including gender, age, marital status (married), glomerular filtration rate (GFR), and person characteristics of religious, spiritual, and personal beliefs. The significance level was set to be 0.05 with the 2-sided test.

Results: Based on multiple linear regression analysis, 9-THAI mental health scores (9-THAI MHS) were significantly associated with WHOQOL-SRPB total scores ($p\text{-value} = 0.009$). The increment of one score of 9-THAI MHS resulted in the increment of 0.033 score of WHOQOL-SRPB total score (95% CI; 0.008 to 0.057), and this indicated that better mental HRQoL was associated with better spirituality. In term of physical HRQoL, 9-THAI physical health scores (9-THAI PHS) were non-significantly associated with WHOQOL-SRPB total scores, even though the better physical HRQoL also resulted in the better spirituality ($p\text{-value} = 0.142$). The analysis was controlled for the contributing factors as mentioned. Apart from HRQoL, female gender, more religious and personal belief characteristics significantly associated with higher spirituality ($p\text{-value} < 0.05$).

Conclusions: The positive association of mental HRQoL and spirituality was founded in this study. This called for future research that examined whether the intervention improving spirituality might lead to the better mental HRQoL in these patients or not.

A Survey Study on the Use of Religious Coping among Cancer Patients in Sweden

Prof. Dr. Fereshteh Ahmadi

University of Gävle, Department of Social Work and Psychology, Gävle, Sweden

(Co-Author: Nader Ahmadi)

In this article based on the result of a survey study in Sweden among 2355 people who hit by cancer,

we discuss the role of religion in coping. The survey study was based on the findings of a qualitative study

among cancer patients in Sweden (Ahmadi 2006). The aim of the survey was to examine to what extent the results obtained in the qualitative study were applicable to a wider population of cancer patients in Sweden. In addition to questions relating to the former qualitative study it had also used the RCOPE questionnaire - designed by Kenneth I Pargament in the design of the new quantitative study. Result of the quantitative study indicates that Self-directed Religious Coping is the most prevalent religious coping method among cancer patients in Sweden. The study shows that few informants used praying or visiting the church as coping methods. The factor that Self-directed was ranked in fourth place, having the fourth highest average (2.3). Half of respondents (49 percent) answered that this factor helped a lot or to

quite a large extent to them feel better when they felt stressed, sad, or depressed during or after their illness. The factor "To pray to God to make things better" is in thirteenth place (mean = 1.7). Nearly three in five (58 percent) chose the option "not at all". In nineteenth place (mean = 1.5) was the factor "To go to church". Nearly two in three (64 percent) chose the option "not at all". This result may be partly because of the dominance of secularism in Swedish society and the strong position individualism plays in Swedish culture, which fosters the idea that individuals have the responsibility of tackling their own problems.

Key words: Religious coping, RCOPE, Self-directed religious coping, Cancer, Sweden

Understanding the Relationship between Religion and Well-Being: a Mixed Methods Investigation into Religious Maturity and Psychological Well-being

Dr. Julian Caruana
Malta

Background: Despite a recent resurgence of interest in the field of religion and well-being, the psychological understanding of the relationship between these 2 phenomena remains limited. A review of relevant literature indicated that focusing on the potential relationship between religious maturity (RM) as conceptualized by Allport (1950) and a multidimensional conceptualisation of psychological well-being (PWB) might represent a fruitful way forward.

Methodology: This research adopted a mixed parallel design composed of a quantitative strand (Study-1) investigating the extent to which RM predicted PWB and the mediating impact of self-actualisation, meaning in life and self-esteem and a qualitative strand (Study-2) exploring the hypothesized relationship and possible intermediary mechanisms and processes in a more open-ended manner.

Methods: A sample of 138 adult UK residents from a Catholic or Protestant religious background were recruited for Study-1's purposes while, using maximum

variation sampling, 4 interviewees were selected for Study-2 from the initial pool of participants.

Results: Study-1's findings indicated that, although RM was not a significant predictor of PWB, higher levels of master-motive predicted higher levels of PWB mainly through meaning in life, while higher levels of openness predicted lower levels of PWB mainly through self-esteem. Study-2 yielded a theoretical model postulating a set of diverse religiosity facets impacting well-being through a series of intermediary processes involving multiple psychological domains.

Conclusion: In conjunction, both studies seemed to point towards affording religiosity a central and pervasive role in life as having a salubrious effect, offered support for the explanatory benefits of employing a humanistic-existential theoretical frame in this inquiry field and placed an emphasis on meaning-making playing a primary intermediary role in the relationship of interest.

Session 5: Implementing Religion & Spirituality into Medical Practice

Developments in Spiritual Care Education in German Speaking Countries

Dr. phil. Piret Paal

Professur für Spiritual Care, Klinikum der Universität München, Munich, Germany
(Co-Authors: Traugott Roser, Eckhard Frick)

Background: This article examines spiritual care training provided to healthcare professionals in Germany,

Austria and Switzerland. The paper reveals the extent of available training, defines the target group(s) and

teaching aims, additionally providing a list of delivered competencies, applied teaching and performance assessment methods.

Methods: In 2013, an online survey was conducted among the members of the International Society for Health and Spiritual Care. The survey contained 10 questions and an open field for best practice advice. SPSS21 was used for statistical data analysis and the MAXQDA2007 for thematic content analysis.

Results: 33 educators participated in the survey. The main providers of spiritual care training are hospitals (36%, n=18). 57% (n=17) of spiritual care training forms part of palliative care education. 43% (n=13) of spiritual care education is primarily bound to the Christian tradition. 36% (n=11) of provided trainings have no direct association with any religious conviction. 64% (n=19) of respondents admitted that they do not use any specific definition for spiritual care. 22% (n=14) of available spiritual care education leads to some academic degree. 30% (n=19) of training form part of an education programme leading to a

formal qualification. Content analysis revealed that spiritual training for medical students, physicians in paediatrics, and chaplains take place only in the context of palliative care education. Courses provided for multidisciplinary team education may be part of palliative care training. Other themes, such as deep listening, compassionate presence, bedside spirituality or biographical work on the basis of logo-therapy, are discussed within the framework of spiritual care.

Conclusions: Spiritual care is often approached as an integral part of grief management, communication/interaction training, palliative care, (medical) ethics, psychological or religious counselling or cultural competencies. Educators point out the importance of competency based spiritual care education, practical training and maintaining the link between spiritual care education and clinical practice. Further elaboration on the specifics of spiritual care core competencies, teaching and performance assessment methods is needed.

Transferring Spiritual and Palliative Care Competency through Work Place Learning - A Hospice Teaching Team's Experience

Kirsten Anne Tornoe, RN

PhD student, Ass. Professor, Norwegian School of Theology, Oslo & Center for the Psychology of Religion, Innlandet Hospital, Ottestad, Norway

(Co-Authors: Lars Johan Danbolt, Kari Kvigne, Venke Sørli)

Background: Addressing terminally ill patients' existential or spiritual issues is often a source of anxiety for healthcare providers. There is an international trend towards unskilled care workers in long-term care. Registered nurses spend more time supervising unskilled staff to ensure that patients receive quality care during their final days. Researching workplace learning in palliative and spiritual care is therefore important. Few studies have been conducted concerning education and training of the work force in this field. Most spiritual care research has been conducted in Anglo-American contexts. This study is a contribution to the Scandinavian body of knowledge in spiritual care.

Design: Qualitative study.

Methods: Data was gathered through a focus group interview with three expert hospice nurses in 2012. Data was analyzed using phenomenological-hermeneutical method.

Findings: Spiritual Care was intuitively embedded in the experts' holistic practice. Key spiritual care themes that emerged were: working with one's heart, managing emotions (fear and courage), identifying spiritual needs, acting as door openers to existential

and spiritual conversations, using intuition to seize the right moment and the right approach, Talking, listening, being silent, being with the patient in the "Room of Death". Personal spiritual and palliative care knowledge was transferred through situational bedside supervision, reflective dialogue and lectures. The team observed that care workers became more courageous and skillful with existentially charged patient encounters through the supervision process. In the team's opinion "Bedside supervision" promoted a greater learning experience than listening to lectures.

Conclusion: The findings suggest that transferring experience based spiritual and palliative care knowledge through "work place learning" may be an efficient way to develop care workers' nursing competency. Further research on the effects of situated bedside supervision in palliative and spiritual care is therefore recommended.

Key words: Staff development, palliative care, spirituality, phenomenological- hermeneutical study, focus group

Spiritual Care and the Organisation of Inter-Professional Cooperation in Acute-Care Hospitals: Concepts, Implementation and Effectiveness of Interventions

Dr. phil. Regula Gasser

PhD student at the Theological Department, University of Zurich, Switzerland
(Co-Author: Ralph Kunz)

The World Health Organisation's definition of palliative care includes the treatment of spiritual issues. There is now a broad consensus that all professional groups should be involved in meeting patients' spiritual needs. A wide range of models of spiritual history have been developed to effectively assess individual patient requirements. However, existing assessment instruments provide no guidance in determining the particular competences and organisation of inter-professional cooperation. Thus far, the complex organisational structures of Swiss cantonal and university hospital departments have prevented effective assessment. Due to a lack of coordinated basic research on spirituality concepts and on systems of inter-professional cooperation, there is currently no concrete data on the implementation and effectiveness of spiritual care or on the intervention process in Switzerland. At present, the collection and interpretation of data on patients' spiritual needs and the subsequent interventions appear to be arbitrarily determined by the attitudes of the specialist

staff involved. A number of studies conducted in Britain and the USA have shown that spirituality is a vital resource in improving treatment outcomes. Equally, an assessment of spirituality captures key elements of patients' health-related quality of life that are not comprehensively measured by psychosocial medical histories. For these reasons, acute-care hospitals have shown an interest both in integrating spiritual care into palliative care, and in enabling such measures to benefit patients in other hospital departments. Our research project tackles these issues in a three-stage approach. Initially the project outlines and establishes similarities and differences in the spirituality concepts of medical staff and chaplains in three acute-care hospitals. As a second stage, case studies are used to relate those concepts to patients' needs. Lastly, the research project aims to provide important insights regarding the continued development and implementation of spiritual assessment with a view to improving inter-professional cooperation in spiritual care.

What Does the SDAT Bring to the Health Team?

Etienne Rochat

Chaplain, Centre hospitalier universitaire vaudois, Lausanne, Switzerland
(Co-Authors: Dürst AV, Rubli-Truchard E, Monod S)

Background: The SDAT is a validated tool to assess spiritual distress in elderly hospitalized patients. It consists of a 20-30 minutes semi-structured interview performed by the chaplain followed by a specific analysis. The interview addresses the different sub-dimensions characterizing the spiritual needs of the patient (need for life balance, for connection, for values acknowledgment, need to maintain control and identity). The SDAT allows to identify disturbed sub-dimensions or unmet needs, to diagnose presence and intensity of spiritual distress, to determine which sub-dimension the patient is focused on and to make recommendations to health team members. Mr L (84) living alone, in conflict with his close relatives, suffering from diabetes and from renal and cardiac insufficiency, is hospitalized. Before returning home, he must overcome gait problems. After a one week treatment, the health team sees no progress and Mr L does not seem to understand the treatments' significance but is still willing to go home. Although he has his capacity of discernment, discussions with him leave the health team in a dead end. **Methods:** Since Mr L refuses to meet the psychiatrist,

doctors require an assessment of the spiritual dimension with the SDAT the chaplain carries out. This procedure and the ensuing discussion allows the health team and the chaplain to build a new care plan.

Results: The assessment with the SDAT reveals that the patient suffers from severe spiritual distress and that the patient's focus is on the sub-dimension of Transcendence. The perturbations' specificity on the 4 sub-dimensions and the patient's focus lead the chaplain to give these recommendations: 1) to consider how Mr L relates to others in order to change the way to communicate with him, 2) to intervene on the sub-dimension of Transcendence with the goal to recover resources in it, 3) to keep in mind that Mr L will not see the treatment's advantages as a primary goal, 4) to let each health professional begin to build an alliance before to carry on its own intervention.

Conclusion: In such a blocked situation, SDAT allows to reassess the care plan on the basis of the chaplain's recommendations. It forces each health team's member to change his point of view on the patient in order to realize a really comprehensive care plan.

Session 6: Research on Patients' Understanding of Religion & Spirituality - Measures, Interpretations, and Mottoes

Validating a Patient Reported Outcome Measure of Spiritual Care

Prof. Dr. Austyn Snowden & The Rev. Iain Telfer

Chair in Mental Health, UWS, Scotland, UK & Spiritual and Pastoral Care, The Royal Infirmary of Edinburgh, UK

Background: In order to provide optimal spiritual care to people it is important to understand how they benefit from it. One of the best ways to understand the impact of complex interventions is to develop a patient reported outcome measure (PROM). PROMs are designed to be reliable and valid measures of specific interventions. They emerged from research into hip surgery recovery but soon appeared as robust measures of much more complex interventions. However, there is no PROM to measure the outcome of spiritual care.

Method: Between 2010 and 2013 NHS Education Scotland funded a project designed to construct and test a prototype spiritual care PROM. The PROM was constructed from the literature on spiritual care (Snowden et al, 2013) and refined iteratively over a series of workshops with chaplains and service experts (Snowden & Telfer, 2012a, 2012b), culminating in a five item PROM designed to capture key elements of spiritual care:

1. Honesty
2. Anxiety
3. Understanding
4. Control
5. Peace

The PROM was pilot tested in a sample of 70 people attending chaplaincy services in NHS Lothian, Scotland during 2012. Data on perceived quality of chaplaincy intervention was also collected.

Results: 39 people responded. Results showed that the five PROM items were reliable ($\alpha = 0.84$) and par-

ticipants found the items to be coherent and easy to understand, suggesting good face validity. There was a significant relationship between self-reported quality of the chaplaincy intervention and all the PROM items. In particular 'being able to talk about what was on my mind' was significantly associated with all outcomes (Snowden et al., 2012).

Discussion: The next phase of the study is to subject these promising findings to more robust validation. This presentation will begin by summarising the key findings above in order to contextualize and explain the protocol for next phase. This will include testing convergent validity with related measures in a sample of people who benefit from a Community Chaplaincy Listening (CCL) Service in General Practice settings across Scotland.

Strengths and weaknesses of this approach will be discussed and recommendations made for longitudinal follow up.

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Interpretations of Chaplaincy Care by Clients in Psychiatric Care

Prof. Dr. Martin Walton

Prof. Spiritual Care, Chaplain, Protestant Theological University Groningen, The Netherlands

How do those who receive care from chaplains interpret that care? In a qualitative research project 24 clients in psychiatric care in the Netherlands were interviewed. The interview material was analysed with the help of thematic and formal coding. Preliminary results were presented to panels of psychiatric patients and chaplains in psychiatric care for comment and validation.

The interview material provides a basis to comment on the focus of chaplaincy care and on conceptuali-

zations of chaplaincy and spiritual care. For the interviewed clients chaplaincy care is not about spirituality alone, but also tied to human dignity. They do report that chaplaincy care contributed to their wellbeing as well as to more specifically religious goals. Their statements allow for commenting on goal orientation of chaplaincy care and on reported and desired outcomes. In addition diverse perspectives on integration of chaplaincy and spiritual care in psychiatric treatment can be offered.

God Image, Personality, and Mental Health

Dr. Hanneke Schaap-Jonker

Ass.Prof. Psychology of Religion, University of Groningen; Co-ordinator Centre for Religion, Worldview, and Mental Health, Dimence Institute for Mental Health Care, Zwolle, The Netherlands
(Co-Author: Arjan Braam)

The God image (cognitive and emotional aspects of the representation of the relationship with God) is a core aspect of religious/ spiritual life, being related to psychic life. Aim of this paper is to offer insight into the complexity of God Image psychology, and to identify common patterns, both in the normal population, as well in populations of clients in mental health care. Results of various studies in the Neth-

erlands will be presented, in which the God representation was assessed with the Questionnaire God Image, as developed by Murken. Focus is on God image types in relation to personality organization and personality traits, which was investigated in different age groups and settings (population-based samples / outpatient samples).

Life Motto's in Dementia Care. Issues of Loss, Longing and Spirituality in Dementia Caregivers Stories

Dr. Hanneke Muthert

Ass.-Prof. Psychology of Religion, University Groningen, The Netherlands

In spring 2013 a Dutch website was launched: pratenovergezondheid.nl. This website is being set up as a counterpart of the international DIPEX initiative, thereby following the success story of the UK site Healthtalkonline.org. In 1999 Ann McPherson and Andrew Herxheimer began their Oxford initiative to provide reliable information about ordinary people's experiences of health and illness. In the Netherlands, the first and until now only research topic is dementia. The information for the project was collected by an interview method that explored all those issues people are confronted with and want to talk about from an insider's perspective. A fundamental underlying assumption thereby is that once being confronted with dementia as a patient, or as a family member of a loved one with dementia, one is not only interested in medical information, but in reliable personal stories as well. (They may find answers to questions like: How do other people deal with those confronting consequences of this illness? What do other people do to persist caring for their relatives day after day?) In describing a full range of experiences, visitors of the site are supported in informed decision-making. As psychologists of religion of the University of Groningen, we had the opportunity to add a number

of questions to the interviews helping us to explore some of the main existential meaning issues in the lives of the interviewed people. This paper presents our most remarkable findings. One of them highlights the difference in utterances when the interviewer specifically asked about religious or spiritual subjects comparing to what we found in other parts of the interview. Another one stresses the difficulties in the interview process in asking more precisely about exactly these existential issues. In analysing the interview material on religious and spiritual topics we used the same descriptive method like the other DIPEX researchers attached to the Dutch subproject. Additionally, we introduced a more interpretative theoretical framework with specific constructivist and psychodynamic key concepts about mourning processes and (role)-identity in caregiving, which resulted in a more comprehensive overview of the spiritual/religious topics in the interviews. The central argument of this paper focuses on life mottos as an important source of information in this context. Talking about those mottos seemed to help caregivers to give words to their more ambivalent experiences, related to their existential answers and questions.

Construction of an Instrument for Measuring Implicit Aspects of God Representations

Henk Stulp

PhD student, Reformed University of Applied Sciences, Zwolle, The Netherlands

Background: Research has demonstrated a positive influence of religiosity/spirituality on wellbeing and mental health. Religious beliefs, partly unconscious and internalized through religious socialization, have

a great impact on the way a person perceives the world and may promote a general positive attitude towards stressors. Moreover, the belief in a personal god may for followers of a theistic doctrine contrib-

ute to a sense of safety, control and protection that enables them to cope with stressful situations. A person's representation of God seems to play a central role in these processes. From the perspective of an attachment and object relation theory framework, significant relationships have been found between god representations and therapeutically relevant variables such as personality pathology and (religious) coping. Both approaches emphasize that god representations are for an important part implicit. They are based on early experiences with important caretakers that create internal working models that filter new experiences and hold unconscious knowledge and procedures about how to interpret behavior and how to behave. Important limitations of almost all research are the exclusive use of explicit (self-report) measures and the restriction to non-clinical populations. No qualitative studies with implicit measures of god representations are known. Therefore we developed an instrument for measuring implicit aspects of god representation by means of a formal analysis of narratives, evoked by an especially for this study de-

veloped religious Thematic Apperception Test (TAT-GR). Stories told about the images of this test are analyzed with the adjusted SCORS-coding system for the TAT to measure someone's representation of God. Research question: Are the measures of this new instrument reliable and valid?

Method: The study is conducted on 140 religious young adults; 70 hospitalized or day-care patients with severe personality problems and 70 non-patients. Patients' representations of God and conceptual-theoretically related variables will be measured before and after treatment. Internal consistency and inter-rater reliability of the scales of the instrument will be determined. Validity will be determined by investigating the relations between this implicit instrument and explicit and (as far as available) implicit measures of personality pathology, personality organization, object-relational functioning, wellbeing and (religious) coping.

Results: Preliminary results regarding reliability and validity will be reported and discussed.

Session 7: Religion/Spirituality and Health Behaviour

Keep Trying and Leave the Rest to Allah: How Diabetic Indonesian Muslim Adults Manage Self-Care and Religion

Iman Permana

PhD student, Manchester, UK

Background: Diabetes, as a chronic disease, is affecting the person physically, psychologically and socially, especially due to the complications. An integrated and comprehensive treatment is necessary to overcome the illness, including promotion and preventive measure which underpinned the concept of self-care. Self-care is believed to be essential in promoting wellbeing and maintaining any chronic conditions. Many studies have revealed the role of religiosity or spirituality in maintaining diabetes. This study is aimed to explore the influence of religiosity on self-care activity among Muslim adults with type 2 diabetes in Yogyakarta, Indonesia.

Method: the study used a mixed method design, with a convenient sample of type 2 diabetic Muslim adults. Two questionnaires, the Muslim Piety (Hasan, 2007) and the Summary of Diabetes Self-Care Activity (Toobert, et al., 2000) served as screening tools. Based on the responses individuals were categorised into one of four groups: high religiosity/high self-care (H/H), high religiosity/low self-care (H/L), low religiosity/ high self-care (L/H), and low religiosity/low self-care (L/L). To gain a richer understanding of the impact of religion on self-care, a 30-90 minute semi-structured interview was used to

24 participants from different groups. Polzer/Miles (2007) propose three typologies: God is Background; God is Forefront; and God is Healer. This theoretical framework informed the in-depth interviews and analysis of study data to gain a deeper theoretical understanding of the relationship between religion and self-management from the respondents.

Results: 100 responses to the questionnaire (58 female/ 42 male), average age was 58.14 ± 10.65 with 19 the youngest and 85 oldest respondent. Of the 4 categories: 86 (H/H), 8 (H/L), 4 (L/H), 2 (L/L). Based on the theoretical framework from Polzer/Miles, 24 interviews revealed: 14 respondents were affiliated with the first typology, 5 to the second, 1 to the third. A new typology from four respondents: both the person and Allah had the same role in determining the result. A key theme emerged from 6 respondents across different typologies: keep on trying and leave the rest to Allah; an individual should make a great effort managing their own health care then leave the result to Allah; an Islamic teaching of Tawakkal, the obligation of a human being to do their best and leave the result to Allah. While, the study also showed the influence of the Javanese spiritual values of Kejawen, which empathised harmony with other.

Predictors of Polish Students' Life Satisfaction and General Health Resources

Prof. Dr. Janusz Surzykiewicz & Prof. Dr. Arndt Büssing

Faculty of Applied Sciences Catholic University Eichstätt-Ingolstadt, Eichstätt, Germany/Institute of Social Prevention, Warsaw University, Warsaw, Poland

Faculty of Health, University of Witten/Herdecke, Germany

Background: Resilience is an individual's tendency to cope with adversities like stress, social vulnerability or illness. Thus, building resilience factors in youth is essential for enabling and strengthening a person to later fight against personal threads. It is assumed, that work hope and self-efficacy as well as aspects of spirituality could be resources of their life satisfaction and therefore predictors for resilience in terms of positive health cognitions.

Methods: In an anonymous survey, we enrolled 1.047 Polish students (mean age 18 ± 1.4 years; 51% female, 49% male) recruited from different middle schools in districts of Warsaw and Bialysto. Standardized self-report questionnaires were distributed, i.e., Aspects of Spirituality Questionnaire (ASP) in its 13-item student version which differentiates 4 factors (i.e., Religious Orientation: Prayer / Trust in God; Search for Insight / Wisdom; Conscious interactions; Transcendence conviction), the 10-item Brief Multidimensional Life Satisfaction Scale (BMLSS), self-efficacy expectation (SWE), and the Work Hope Scale (WHS).

Results: Although 81% of the students belong to the Catholic denomination, 42% would regard themselves as neither religious nor spiritual. Comparisons of the assessed constructs between non-religious and religious students revealed lowest life satisfaction in

non-religious students when compared to their religious counterparts ($F=7.7$; $p<.0001$); similar results were also shown for students' work hope ($F=4.1$; $p<.0001$). In contrast, religious students showed highest scores for well-being, self-efficacy and work hope.

Because we were interested which variables may predict students' life satisfaction, we performed stepwise regression analyses and found that self-efficacy expectation was the best predictor, with further influences of Conscious Interactions, Religious Orientation, lower age, and, however, low Search for Insight/Wisdom ($R^2=.32$). Gender, parental status, Work Hope and Transcendence Conviction were not among the significant predictors. Although students' work hope was predicted best by Religious Orientation and other variables, the predictive power was low ($R^2=.09$).

Conclusion: The study showed that among the strongest predictors of students' life satisfaction were self-efficacy expectation and aspects of spirituality. As expected these constructs also go along with positive health cognitions and thus can be stated as important resilience factors. Educational implications will be discussed.

The Association of Religious Affiliation and Body Mass Index (BMI): An Analysis from the Health Survey for England

Dr. Deborah Lycett

Principal Lecturer in Dietetics, Coventry University, UK

Background: Obesity and obesity-related morbidity and mortality is an on-going concern in developed countries[1]. Religion has been shown to be associated with reduced premature mortality and morbidity[2], however, the association between religion and obesity is unclear. In a systematic review seven out of 36 studies investigating the association between religion or spirituality and body weight reported a lower body weight among those who associated themselves with a religion. Thirty-nine percent reported a higher body weight, 6% reported mixed results and 36% found no association. Examination of the highest quality studies found that in cross sectional studies religious involvement was associated with a higher BMI, particularly among ethnic minorities, but in longitudinal studies there was no association[2]. All these studies were in the US, except one in the Netherlands which found no association. To

date there have been no studies in the UK to investigate this association.

Method: This is a cross-sectional study using Health Survey for England, 2004, data to investigate the association of religious affiliation and Body Mass Index(BMI). A representative sample of 6704 adults (16 years or older) were included. Interviews were administered, questionnaires self-completed, height and weight was measured. Sequential linear regression models were used and analysis according to smoking status was also conducted separately.

Results: Religious affiliation was associated with a 0.73kg/m^2 higher BMI in the English population compared to those who did not affiliate themselves to a religion. Over half of this association was explained by a variation in demographic characteristics. Patterns of alcohol consumption explained a small amount of this association, while fruit and vegetable

consumption and physical activity level did not. Less smoking in those religiously affiliated accounted for 0.06kg/m² of the association. Among never-smokers 0.45kg/m² higher BMI in religiously affiliated people remained unexplained.

Conclusion: Prospective studies with validated measures of religion to capture intrinsic religiosity and measures of dietary energy are needed in the UK and across Europe. Religious communities may need greater healthy weight promotion or benefit from

interventions tailored to complement their religious beliefs.

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Role and Influence of Christian Faith on ART Adherence and Adherence Counseling: A Case of Myung Sung Christian Medical Center, Addis Ababa, Ethiopia

Naod Mekonnen

Ethiopia

(Co-Author: Mastewal Mekonnen)

Background: Around 34 million people are living with HIV all over the world, where 2/3 of them are living in Sub-Saharan African countries. Ethiopia as one of the countries of the Sub-Saharan African country is affected by HIV and AIDS. Estimated numbers of 800 000 people are living with HIV. The introduction of free ART and the different work done in the aspect of prevention such as awareness creation contributed to significant decrement in the prevalence rate from 6.5% in 2005 to 1.5% in 2011. Beside the achieved success the issue of adherence to ART is pertinent since adherence to the medication can affect the treatment outcome either positively or negatively. Here in this prospect different studies show that there are positive and negative factors for the achievement of optimal adherence. One of the factors is the influence of religious faith on adherence and adherence counseling.

Objective: This research is aimed at explaining the role of religious faith on adherence to ART and adherence counseling.

Methods: the data's were collected qualitatively using interview guide questions. Convenient sampling technique was used to select the study area which is Myung Sung Christian Medical Center. A purposive sampling method was also used to select the study groups or subjects. In addition to these a convenient sampling method was used to select the interviewees in the health institution as well as the religious leaders. Finally, the data were interpreted and analyzed qualitatively by forming themes.

Results: The study uncovers that Christian religious faith has a positive role in the adherence to ART and it also shows that religious leaders are not playing their role to fill the gap in the work of HIV and AIDS especially on adherence to ART.

Conclusion and Recommendation: The role of the Church ministers, health care professionals and above all people living with HIV is important for the achievement of optimal ART adherence. So, these different sectors need to work hand in hand for the accomplishment of better and even optimal ART adherence in people living with the virus.

Association between Health Behaviour and Religion/Spirituality in Adolescents. A Cross-Sectional Survey of Austrian High Schools

Gabriele Gäbler, MSc

Dietitian, Villach, Austria

(Co-Authors: Hermann Toplak, René Hefti, Josef Haas, Elisabeth Pail)

Background: The prevalence of certain risk factors for chronic diseases such as smoking, alcohol abuse, low fruit and vegetable consumption, and lack of physical activity is high among young people. These lifestyle factors influence one another and are further affected by social and environmental factors. Evidence from America suggests that there is a positive asso-

ciation between religion/spirituality and these health behaviours.

The aim of this study is to explore whether a similar association exists in Austria, an European country.

Method: A cross-sectional study was carried out across seven randomly selected high schools. Whereby a total of 225 11th-grade pupils (64% girls, 36%

boys; average age 16.4 years, were interviewed by means of an online questionnaire.

Results: There are significant gender differences in the associations between health behaviours and religion/spirituality. There is a positive correlation between religion/spirituality and healthy food choices and meal frequency; in the case of boys, there is an additional positive correlation with physical activity. There is also a negative correlation with smoking and frequency of getting drunk. The results of the binary logistic regression models indicate that religion/spirituality is a significant predictor for the number of

cigarettes smoked daily and problem drinking, even after controlling for gender, stress perception and other correlated health behaviours.

Conclusion: This study shows that religion/spirituality is positively associated with several beneficial health behaviours. Further studies are needed to explore the influence of other confounding variables on this association e.g. socioeconomic status, family dynamics, social influence and personality types. Surveys investigating health behaviours among adolescents should include questions on religion/spirituality.

Pre-Conference Workshop

with Prof. Harold. G. Koenig M.D., May 18-21, 2014

Preceding the conference there was a 4-day Pre-Conference Research Workshop with Prof. Harold Koenig. The workshop was open to all interested in doing research on religion, spirituality and health (accepting participants of any educational level or degree, including theologians, chaplains, physicians, nurses, psychologists, pastoral counselors, public health specialists, epidemiologists, or other potential researchers). Professor Harold Koenig is known as senior author of the "Handbook of Religion and Health". He holds a university teaching position as full professor at Duke University Medical Center (Internal Medicine, Psychiatry, and Behavioral Sciences). Furthermore he is co-director of the Center for Spirituality, Theology and Health.

This center offers – amongst others – a 2-year post-doc program in religion and health, which Dr. Koenig has compressed into 4-day workshops.

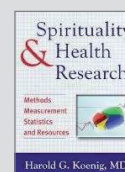
Mentorship meetings with Prof. Koenig allowed participants to discuss individual research projects.

The following topics have been discussed:

- Historical connections between religion and health care
- Previous research on religion, spirituality and health
- Strengths and weaknesses of previous research
- Theological considerations and concerns
- Highest priority studies for future research
- Strengths and weaknesses of religion/spirituality measures
- Designing different types of research projects
- Funding and managing a research project
- Writing a research paper for publication; getting it published
- Presenting research to public audiences; working with the media
- Developing an academic career in this area

Many topics of this workshop are accessible in:

Koenig, HG (2011): Spirituality and Health Research: Methods, Measurements, Statistics, and Resources.



Posters

(in alphabetical order)

The posters will be exhibited in the entrance hall during the whole conference. The authors are present at lunchtime 12:30-14:00 on Friday, May 23rd.

Dr. Gina Andrade Abdala

Professora do Mestrado em Promoção da Saúde - UNASP SP, Doutoranda PROESA-EE/USP, Sao Paulo, Brazil

Faith Community Nursing (FCN): Integrating Faith and Health Care in the Community

(Co-Authors: Maria Dyrce Dias Meira, Carlos Antônio Teixeira)

Introduction: At least five institutions can take care of our health, if well functioning: the health system, family, school, workplace and the church. Yes, churches should be conscious of its important role in maintaining the member and community's quality of life (Solari-Twadell, McDermott, 2006). **Objectives:** To report the experience of the implementation of Faith Community Nursing in Brazil, proposing the initial goal of creating spirituality workshops for hypertensive through 8 remedies of nature related to a spiritual reflection based on a Biblical story. It also intends to promote holistic health in churches and/or communities, incorporating a variety of faith traditions. **Methodology:** This activity was based on international nursing program in the faith community founded by Westberg in Chicago in 1983. He was scheduled to present the 4 modules of the academic curriculum of ECF: spirituality, holistic health, professionalism and community. A partnership between Adventist University of Sao Paulo (UNASP) and International Parish Nurse Resource Center (IPNRC) was done. **Results:** Partnership between Brazil and IPNRC was established and during the meeting of 4 days (22 to 25 November), 16 lectures on 4 modules were presented, as well as dynamics with suggestions of how to apply the workshops in communities. The 34 nurses who participated were open to the lectures. They were also engaged, touched and participated in planning the workshops on spirituality. In the end, 6 of them were willing to apply the "project" in their communities and in future these experiments will be reported and evaluated by peers for future generalizations. **Conclusion:** Due to the low income of the population, in which only 26.3% (49.1 million people) are covered by health insurance (IBGE, 2008), ECF program will be configured as a bridge to solve or try to promote religious coping in health difficulties encountered. The project will not be restricted only to people who do not have a health insurance plan, but to all who wants to satisfy this spiritual dimension, so overlooked in human life. It's philosophy is to treat the whole person: mind, body and spirit.

The nursing profession was chosen by Granger in 1983 because they are prepared for both fields: scientific and behavioral. The nurse is not to be seen as an attendant of primary care only, but someone who will facilitate the use of available sources of church and community envisioning the holistic health promotion. (Blome, 2003).

Prof. Christopher Bond

Missouri Western State University, USA

Caring for the Caregiver: Health, Spiritual and Communication Privacy Needs

Caregivers are defined as the primary facilitators of the care and needs of a patient or person in need of care. Caring for another person is both rewarding and challenging as a caregiver learns to balance and manage family, work, and caregiving responsibilities. Many times a caregiver's self-care and spiritual connections diminish as both the physical and mental stress of caregiving increases. This increased stress can lead to feelings of neglect and burnout. Often caregivers consider what they can or should do for a patient or family while neglecting themselves.

Caregivers and patients obtain the majority of their socialization and communication through one another, which in turn, affects a caregiver and a patient's Quality of Life (QoL) as measured through many factors including health outcomes, spiritual needs, communication competence and privacy. Since many disparities exist between the views and needs of the caregiver and patient, caregivers experience misunderstandings leading to decreased psychological, spiritual and physical well-being for both the patient and caregiver, which, in turn, may affect the overall QoL for both the patient and caregiver. By applying the theoretical frameworks of Self-Care Deficit Theory and the relational health communication model, this presentation will discuss my past research examining caregiver QoL scores to psychosocial variables and offer suggestions on how caregivers can increase their overall QoL as it relates to their health, spiritual and communication privacy needs. The role of health providers and training required to monitor the self-care of caregivers with a focus on spiritual needs will also be discussed. Through communication competence skills and maintaining caregiver self-care, both the caregiver and patient's QoL can be maintained and increased.

Prof. Dr. Arjan Braam

Psychiatrist, Altrecht Mental Health Care Utrecht, Altrecht, The Netherlands

Towards a Multidisciplinary Guideline Religion, Spirituality and Psychiatry: what do we need?

(Co-Authors: Carlo Leget, Piet Verhagen)

Objectives: The field of Mental Health care harbours a long tradition of Healthcare Chaplaincy and Spiritual Counselling. Due to secularization and emphasis on individual meaning making, the profession of chaplaincy is subject to change. A Multidisciplinary Guideline on Religion, Spirituality (R/S) and Psychiatry will address: (1) organizing R/S consultation in contemporary patient care, (2) categorizing research findings, and (3) professionalism with respect to R/S in psychiatric practice and education.

Methods: The following areas of particular attention are selected: (1) values with respect to R/S, (2) R/S in mental health care practice, (3) R/S counselling, and (4) collaboration. Contents are derived from two sources: brainstorm sessions with key participants in the field of R/S and psychiatry, and reviews of R/S guidelines in other settings or countries.

Results: With respect to value discussions (1), there is a rich tradition of thought. For mental health care practice (2), there is some substance of empirical studies justifying the attention for R/S. Little research is available on the level of counselling practice (3) and collaboration. The existing guidelines in palliative medicine offer valuable insights, but are not complete with respect to matters such as stigmatization.

Conclusions: Future steps include the verification of the core themes with specialists in the field, therapists, counsellors, and patients.

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Darunee Chanlertrith

Thailand

Did Spirituality of Hemodialysis Patients Differ From Chronic Kidney Disease Stage V Patients?

(Co-Authors: Areewan Cheawchanwattana, Waraporn Saisunantararom)

Objectives: Health-related quality of life (HRQoL) was recognized as an important outcome for advanced chronic diseases, especially end-stage renal diseases (ESRD). The common aspects of HRQoL, such as physical, mental and social domains, were usually

evaluated in ESRD patients, however research on spirituality in these patients were limited. This study aimed to compare spirituality of hemodialysis (HD) patients and chronic kidney disease stage V (CKD-V) patients.

Methods: The protocol of study was approved by the Hospital Ethic Committee. Total of 31 HD and 63 CKD-V patients were asked for consent and then interviewed of spirituality using Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being (FACIT-Sp). Spirituality scores (Facit Meaning, Facit Peace, Facit Faith, and Facit Total Scores) of CKD-V and HD patients were compared by using Mann-Whitney U test, since score distributions were highly skewed. Additionally, multiple linear regression analyses were applied to compare the scores between the two groups that were adjusted by contributing factors including age, gender, and marital status (married). The significance levels were set at 0.05 (2-sided tests) for all analyses.

Results: All factors, gender, age, married, and patient groups, resulted in significant differences of all spirituality scores by using Mann-Whitney U test. Since CKD-V patients had significantly more proportions of female gender and unmarried status than HD patients, and were significantly older, then the interpretation of score comparisons should be based on multiple linear regression analyses. Spirituality scores of CKD-V patients as measured by Facit-Sp were non-significantly greater than those of HD patients after adjusted by gender, age, and marital status. However, the multiple linear regression analyses of all Facit-Sp scores found that male gender had significantly lower scores of spirituality when compared to female gender [Facit Meaning -1.59 (p=0.024), Facit Peace -2.37 (p=0.004), Facit Faith -2.87 (p=0.001), Facit Total Score -6.83 (p=0.001)], while age and marital status were non-significant.

Conclusions: The spirituality did not differ by stages of chronic kidney diseases, however patient characteristic such as gender associated with spirituality. Then any intervention that designed for spirituality improvement should be considered to involve patient characteristics as un-negligible factors.

Dr. Dagmar A.S. Corry

Lecturer in Psychology, Glyndwr University, Wrexham, Wales, & The Bamford Centre for Mental Health and Wellbeing, University of Ulster, Derry/Londonderry, Northern Ireland

Testing the Theory of Transformative Coping using the Creative Coping Scale and the Spiritual Coping Scale

(Co-Authors: John Mallett, Christopher A. Lewis)

In an attempt to empirically test the theory of transformative coping (TTC), the present study examined

whether, and to which extent, creative and spiritual coping is applied in combination among a sample of 714 adults, and whether their application is associated with hope, self-esteem, and meaning in life. For these purposes, two new theory-based instruments, the Creative Coping Scale (CCS-10), and the Spiritual Coping Scale (SCS-18), were employed, undergoing confirmatory factor analysis in the process. Scores on all measures were quite low in this sample, with demographic differences evident. In keeping with the TTC, a positive, significant correlation between scores on the CCS-10 and the SCS-18 was found, along with positive, significant associations between creative and spiritual coping and measures of hope, self-esteem and meaning in life. Recommendations for further cross-cultural research were made and practical applications discussed.

Gabrielle Diederich

Missouri Western State University, USA

The Tanning Temple: Health, Spirit and Body Modification

(Co-Author: Kayte Fiset)

For this presentation, we will describe the phenomenon of tanning in the United States of America (USA). People of different ages and ethnic backgrounds use tanning beds and salons as a type of body modification as well as for meditation and relaxation. However, many Christian denominations in the USA state tanning is a sin and view the body as God's temple due to the interpretation of a specific Bible verse: "The body is God's temple ... if you destroy the temple, you destroy God." Others reject tanning due to the potential health risks due to over tanning and exposure to ultraviolet rays. Some states now have laws protecting youth from using tanning salons and beds with Illinois forbidding anyone under the age of 18 from tanning beginning January 1, 2014. Although tanning receives critiques from American society, preliminary research indicates people are tanning more frequently to fulfill both their mental and spiritual well-being. Through semi-structured interviews with frequent users of tanning salons, we determined how individuals experience spiritual benefits and if there are any differences among Christian denominations and religious beliefs. Additionally, a questionnaire was distributed at various tanning salons to assess religious demographics, body modification beliefs, why someone continues to tan, frequency, and stress relief and meditation purposes.

Jacob Dowell

Missouri Western State University, USA

Is Circumcision a Choice? An Analysis of Religious Beliefs and Health Benefits on Circumcision Decisions

(Co-Author: Stephen Solomon)

This study examines the various religious preferences, rites, and health benefits and risks of circumcision with a focus on the circumcision practices of Christianity and Islam. The study was conducted after the Council of Europe's decision to ban circumcision on males under the age of 15 which sparked Israeli and Jewish protests. Additionally, a growing number of anti-circumcision groups have formed in many countries and throughout the United States of America (USA). A multi-country sample of males answered a questionnaire sent via an online survey to support groups of men who have concerns about being previously circumcised based on their parents' religious rites, beliefs or as a standard medical practice for a particular country. The same questionnaire was sent to online support groups who support and advocate for circumcision. Specifically, the study will examine whether or not males should have a personal exemption in circumcision decisions regardless of religious doctrines and rites and why some males desire restorative surgeries.

Prof. Dr. George Fitchett

Rush University Medical Center, Chicago, USA

Case Studies in Contemporary Spiritual Care: Chaplains' Interventions with Critical Responses

(Co-Author: Steve Nolan)

Announcing a forthcoming (2014) collection of chaplain case studies (to be published later as *Case Studies in Contemporary Spiritual Care: Chaplains' Interventions with Critical Responses*), this poster argues that health care chaplaincy has reached a point where it needs to develop a body of published case studies. The poster describes the reasons why a body of chaplain case studies is necessary, it presents a model that chaplains can use for writing case studies and it details key ethical issues chaplains should consider when presenting and publishing case studies. The poster describes three reasons why a body of published chaplain case studies is needed. First, as little is understood about what chaplains actually do, a body of case studies provides empirical data about the kinds of spiritual care interventions chaplains make. This data will provide a foundation for further research into the quality and efficacy of chaplains' spiritual care. Second, case studies play an important part in both initial training and in continuing professional de-

velopment. This body of case material will play an important role in training new chaplains and will be a resource for the continuing education of experienced chaplains.

Third, case studies provide real insight into how professionals work. As such, they can help educate health care colleagues and the wider public about the work of health care chaplains.

The poster presents an outline for the contents of a chaplain case study: Introduction, detailing the subject of the case, the chaplain and the site of care; the History of the Pastoral Relationship, including significant encounters and verbatim; Discussion of Spiritual Assessment, Spiritual Needs, Spiritual Care Interventions, and Outcomes; Summary.

Finally, the poster presents key ethical issues to be considered by chaplains when presenting and publishing their case studies.

The poster will include brief summaries of two of the chaplain case studies.

Kendra Greer

Missouri Western State University, USA

An Analysis of Spiritual Meditation and Religious Beliefs on Stress Reports and Job Satisfaction of Healthcare Providers

(Co-Author: Jessica Klaus)

Many religious cultures incorporate meditation into their daily lives as part of particular spiritual beliefs. Additionally, many studies provide connections between meditation and stress reduction. However, limited studies examine how an individual's religious preferences affect the use of meditation and reports of stress especially within workplace settings. Meditation, especially spiritual mediation, can decrease heart rate and blood pressure and improve perceived well-being. Many studies show that spiritual mediation can increase an individual's self-efficacy and strengthened impulse control, which, in turn, can affect job satisfaction and an increased spiritual connection to others and the environment.

Healthcare workers are increasingly overworked and have higher than average reports of job related stress and burnout. This project will analyze the use of spiritual mediation techniques and will then survey various healthcare providers on their respective religious preferences, mediation frequency and how reports of meditation affect stress reports, job satisfaction, and reports of spiritual connection with patients and other healthcare providers.

Anna Janowicz

Fundacja Lubie Pomagac, Gdansk, Poland

Preliminary research among catholic chaplains, and professionals and volunteers involved in new method of team pastoral work from St. John of God Order in Poland

(Co-Authors: Piotr Krakowiak, Marek Krobicki)

Poland is considered one of most catholic countries in Europe. Number of vocations is still among the highest in Europe. One of catholic priest's activities here is related to chaplaincy in health and social care facilities. There are some chaplains from other denominations (protestant or orthodox). Recent changes, especially integration with EU and open borders change vision of religious and spiritual needs of population in Poland. One of the areas when this change is dramatically seen is health and social care environment. Seeing it, Polish Province of St. of John of God Order has started an innovative program in Poland of team pastoral work in health and social care institution. In 2011 first edition of postgraduate training for future chaplains and pastoral assistants in Poland had been launched. First group of 40 students (ordained priests, religious men and women and lay people - mostly women) finished "St. John of God School" in 2013, but there is still no culture of teamwork, especially with lay people. This initial study shows results from catholic environment of St. John of God Order, and students of postgraduate school for team pastoral care perception of differences in spiritual and religious needs among their patients with comparison with other catholic chaplains in health and social care institutions in Poland. Open questions were presented in an anonymous questionnaire for religious and lay people, professionals and volunteers from 10 institutions of St. John of God Order in Poland and for students of the first edition of postgraduate training "St. John of God School" and the second edition. The same questions would be sending to all catholic chaplains working in health and social care institutions (around 1000 email contacts). Results will indicate differences among those who are already working in teams in spiritual and pastoral care and those who still prefer traditional, mostly individual, ritual and religious way of dealing with spiritual dimension of care. Obtain results will inform those who want to spread the team pastoral work in Poland and Eastern Europe and include spiritual care into pastoral care in health and social care settings how to deal with these issues in the future. It will help to promote the team pastoral work with religious and lay people in the future and will show areas of difficulties, problems and fears in the shift from mainly ritual pastoral care into more open, ecumenical and intercultural approach of spiritual care with respect to catholic tradition, rituals and sacraments in health and social care setting.

Renske Kruizinga

Researcher, PhD-Student, Amsterdam, The Netherlands

Development and evaluation of a new intervention on experiences of contingency and ultimate life goals to address spiritual concerns of advanced cancer patients

(Co-Authors: M. Scherer-Rath, J.B.A.M. Schilderman, M.A. G. Sprangers, H.W.M. van Laarhoven)

Background: Spiritual care plays an important role in the well-being of cancer patients – especially for patients with incurable cancer. Nevertheless, appropriate, effective, and brief interventions to address spiritual concerns are limited.

Objectives: The objectives of this pilot are to develop and test a brief interview model with an e-application on experiences of contingency and ultimate life goals to address spiritual concerns.

Method: The interview model consists of two consultations of one hour with a spiritual caregiver. The result of Consultation I is a reconstruction of the participants' most important life events and his/her interpretation. The result of the analysis, carried out by the spiritual counsellor, is a framework for observation and interpretation. In Consultation II the participant reflects on this framework and discusses the (in)consistency between life events and life goals with the spiritual counsellor. Nine spiritual counsellors from seven hospitals participated. All counsellors had two training sessions after which they practised the intervention with students. For the pilot study the spiritual counsellors interviewed a patient with incurable cancer. All 9 interviews were recorded, transcribed and analyzed using Atlas.ti. The pilot was evaluated from participants' and counsellors' perspective.

Results: The pilot-study is ongoing. The first results of the evaluation forms and interviews afterwards show that from participants' and counsellors' perspective the intervention is evaluated positively.

Discussion: The objective of the pilot study is to improve the subsequently planned randomized controlled trial (RCT) to evaluate the effect of the intervention on quality of life and spiritual wellbeing. Insight into one's ultimate life goals is expected to help patients to integrate a life event such as cancer into their lives. A prospective study in patients is needed to empirically examine whether insight into one's ultimate life goals improves quality of life and spiritual wellbeing. The intervention can aid in further professionalization of spiritual counselling.

Prof. Dr. Christopher Alan Lewis

Department of Psychology, Glyndwr University, Wrexham, Wales, UK

Dissociation and Religiosity: The Role of Religious Experience

(Co-Author: Michael J. Breslin)

Dissociation can be conceptualized as a disruption in integrated processing of psychological information, due to alterations in consciousness. An emerging body of research has examined the relationship between dissociation and religiosity. Mixed findings suggest a weak positive association between these two constructs. There is some evidence to suggest that religious experience is the dimension of religiosity that is associated with dissociation. The present aim was to investigate if dissociation predicted religious experience over and above a religiosity measure, specifically frequency of prayer. A sample of 371 Irish respondents completed the Measure of Prayer Type, the M Scale Short Version, and the Dissociative Experiences Scale. Binary logistic regression showed that religious experience was predicted by dissociation, controlling for frequency of prayer. Results suggested that religious experience is the dimension of religiosity that is associated with dissociation.

Prof. Dr. Christopher Alan Lewis

Department of Psychology, Glyndwr University, Wrexham, Wales, UK

Understandings of the Word "Spirituality" Among a Sample of University Students in the UK

(Co-Authors: Emyr Williams, Peter la Cour, Joanne Pike)

Within the social scientific study of religion, there has been a significant amount of research on spirituality, especially in the area of health and well-being. Despite this, the term spirituality remains poorly defined and understood. There have been only a small number of studies that have examined the semantics of spirituality. The aim of the present study was to examine the understandings of the word spirituality among a sample of 120 university students in the UK. Building on the work of la Cour, Ausker, and Hvidt (2012) in Denmark, respondents evaluated which out of a list of 115 words indicated spirituality. Factor analysis of the responses resulted in six different understandings of spirituality: 1. Spirituality as affective, 2. New Age, 3. Transcendancy, 4. Embodied experiences of spirituality, 5. Mysticism, 6. Spirituality as other. These results indicate that among the present sample there was a divergence of common understanding of the term spirituality. Results were compared to those of la Cour et al. (2012) among Danish adults, and both similarities and difference were

found. Limitations of the present study are outlined and suggestions for further research are provided.

Corey Myers

Missouri Western State University, USA

Creative Artistry or Spiritual Healing? Musicians' Perceptions of Creating and Performing Music for Healing

The role of music as a healing instrument has significant historical roots within mainstream and tribal religions dating back to 50,000 B.C.E. The healing powers of music, especially within Christianity, can have meaningful effects on an individual's spiritual, mental and physiological self as altered realities and perceptions are achieved through listening and interacting to various sounds and structured musical experiences. It is through these musical experiences and manipulation of sound that listeners experience the divine and perceive themselves as healed. However, the healed individual may or may not perceive themselves as a patient nor view a musician as an actual healer. The inverse is also possibly true: the musician may not see themselves as an actual spiritual healer, but more as a musical artisan. Through both surveys and interviews of worship musicians of various Christian and non-Christian groups, this study will examine the perceptions of musicians as healers when playing and creating music. The study will also examine the Spiritual and healing connectedness among a musical experience, the musician (healer) and the listener (patient).

Dr. phil. Piret Paal

Professur für Spiritual Care, Klinikum der Universität München, Munich, Germany

Spiritual Care Trainings Provided to Healthcare Professionals – a Systematic Review

(Co-Authors: Yousef Helo, Eckhard Frick)

Background: Recent studies have pointed out that there is an urgent need for competency based spiritual care education and practical training that maintains the link between spiritual care education and care practice. To explain the reasons for incorporating spiritual care into educational models for healthcare professionals an elaboration on the specifics of spiritual care core competencies, teaching and performance assessment methods is needed.

Aims: This systematic review of available literature is conducted in order to identify spiritual care education provided to healthcare professionals and systematically and critically appraise training aims, mediated competencies and predicted outcomes or/and

measured results. The review concentrates on spiritual care education provided to undergraduate and graduate health care professionals already working the wards. The review describes the course details, target group and considers any predicted outcomes and/or measured results, such as participants' satisfaction, views on their individual advantages or overall effectiveness of provided training.

Methods: 10 databases were searched up to 2013 Week 27. The search considered original peer-reviewed journal articles and excluded letters to the editors and editorials, reviews, conference abstracts, brief communications, books and thesis. Articles published in English language were considered. The search excluded training and interventions provided to voluntary workers, general public, families, parents and ethnic/traditional healers as well as health-care services provided by faith community / parish.

Results: After removal of duplicates the electronic searching of each database resulted in 4910 hits. Excluding irrelevant articles based on title and abstract the two reviewers established 60 relevant articles for the final appraisal.

Conclusion: The findings of this review lead to a better understanding of spiritual care education provided to healthcare professionals.

Dr. Jakub Pawlikowski

Department of Ethics and Human Philosophy, Medical University of Lublin, Poland

Beliefs in Miraculous Healings, Religiosity and Meaning in Life

Background: Throughout centuries many interpretations of miraculous healings have been offered by philosophers, theologians, physicians, and psychologists. Different approaches to miracles originated from differences in understanding God (transcendent or immanent) and nature (deterministic or indeterministic) and the relationship between God and nature. Despite many sceptical arguments, a great majority of people (approximately 70%) in modern Western societies share a belief in miracles, millions of sick people pilgrimage to sanctuaries seeking for miracles and the Vatican Congregation for the Causes of Saints proclaimed hundreds decrees on miracles through the last decades.

The aim of the research was describing the social perception of miraculous healings, and the relationship between beliefs in miraculous healings, religiosity and meaning in life.

Methods: A survey was conducted on a group of 178 respondents from 18 to 30 years old (M=21,5; SD=2,31), 90% Catholics. Respondents were asked to fill out an anonymous questionnaire containing Duke University Religion Index DUREL (Koenig & Buessing, 2010); Meaning in Life Questionnaire

(MLQ), a 10-item measure of the Presence of Meaning in Life, and the Search for Meaning in Life (Steger et al., 2006); Beliefs about Miraculous Healings Scale (Wiechetek & Pawlikowki, 2012) an 8 item measure in which participants using Likert scale rate their understanding and definition of miraculous healings.

Results:

Results indicate that 88% of the respondents believe in miracles. Participants most frequently understood miraculous healings as a result of God's action, less often as the effect of still undiscovered possibilities of the human organism or the nature, and the least as the effect of medical ambiguous diagnosis or data manipulation.

Respondents with stronger religiosity and higher meaning in life, more frequently believe that miraculous healings are an act of God ($r=0,680$, $p<0,01$; $r=0,171$, $p<0,024$) and not the effect of supernatural powers activity ($p>0,05$). Those respondents are also convinced that miraculous healings are not an outcome of a medical ambiguous diagnosis ($r=-0,458$, $p<0,01$), the effect of suggestion ($r=-0,516$, $p<0,01$) or unknown natural laws ($r=-0,433$, $p<0,01$).

Conclusions:

Religiosity and meaning in life is connected with understanding miraculous healings in transcendental and non-naturalistic way. These phenomena are more often understood as caused by a specific Being rather than by an unidentified factor.

Dr. Jakub Pawlikowski & Jaroslaw Sak

Department of Ethics and Human Philosophy, Medical University of Lublin, Poland & Department of Social Psychology and Psychology of Religion, The John Paul II Catholic University of Lublin, Poland

Doctors' Religiosity and Belief in Miracles

(Co-Authors: Michal Wiechetek, Marek Jarosz)

Background: The discussion on miraculous healing has been present for centuries in philosophy, theology and also medicine. Nowadays, a miracle is one of the most important issues in the debate between science and religion. Sometimes, the conviction is expressed that scientists and physicians do not believe (or should not believe) in miracles. The aim of the survey was to verify the hypothesis that doctors do believe in miraculous healings and that this belief is connected with their religiosity.

Method: An anonymous questionnaire consisted of: standardized Polish Scale of Religious Attitudes (SReAt), questions related to the belief in miracles (understood as God's intervention) and the observation of patients' unexplained recoveries. The research was carried out on a group of 324 physicians; 51% women, 49% men; average work experience: 17.03 years; 93% Catholics.

Results: Majority of the physicians (67%) declared the belief in miracles. Significant differences between doctors with high and low religiosity were observed (92% and 27% respectively; $\chi^2 = 95,63$; $p<0,01$). Approximately one-fourth of the physicians (27%) declared that they observed miraculous healings among their patients. It was related to religiosity (31% in high religiosity group vs 14% in low religiosity group; $\chi^2 = 6,57$; $p<0,05$) and the length of medical practice (e.g. more frequently among doctors with longer medical practice; $p<0,05$).

Conclusion: Majority of the physicians is openminded to the transcendent interpretation of patients' unexplained recoveries. Religiosity is an important factor shaping doctors' beliefs in miracles and their interpretation of medically unexplained recoveries.

Lori Pollard RN, BScN

Faculty Lecturer, Faculty of Nursing, University of Alberta, Alberta, Canada

Debriefing for Spiritual Growth in Nursing Education and Practice

(Co-Authors: Jill Vihos, Gerri C. Lasiuk)

Debriefing is a pedagogical strategy used in nursing education to allow students to create personal meaning and is essential for experiential learning. During debriefing, students reflect on their practice and through various activities they are guided to understand, analyze, and synthesize their thoughts, feelings, and behaviour with the intent of applying new learning to future practice. Debriefing activities may include group reflection, the provision of one-to-one feedback to students by instructors, and dialogue after interactions with patients and their families. The practice of debriefing is fundamental to understanding who one is as an individual learner and practitioner. For nursing students, recognizing one's spirit and what it personally means to be a nurse is foundational to their moral growth. When nurses acknowledge their personal identity, they are able to set themselves aside to understand the lived experience of the patients they care for. Encouraging learners to talk about their practice can contribute to personal transformation, professional growth and lead to accumulation of nursing knowledge. When nursing students can articulate who they are as professionals, they can meet their spiritual needs, and are better able to meet the spiritual health needs of their patients. Debriefing also socializes nursing students into practice through recognizing the importance of establishing safe spaces to engage in collaboration, caring communication, role clarification and reflection about learning experiences within a peer group. In nursing education, learning outcomes from debriefing are reflected in cognitive, affective and social

growth over the duration of their nursing program. Debriefing learning experiences helps learners to engage with the lived experience of others and facilitates appreciating the humanity of others which is necessary for providing safe, competent care in nursing practice. The practice of debriefing is an essential component of the nursing students' learning process towards their spiritual and professional transformation into becoming a nurse.

Waraporn Saisunantararom

Pharmacist, Mahasarakham, Thailand

The Psychometric Property of WHOQOL-SRPB Thai Version in Chronic Kidney Diseases Stage V Patients

(Co-Authors: Areewan Cheawchanwattana, Talerngsak Kanjanabuch, Maliwan Buranapatana)

Objectives: To translate the English version of World Health Organization Quality of Life - Spirituality, Religiousness and Personal Beliefs (WHOQOL-SRPB) into Thai language version and evaluate its psychometric property.

Methods: The WHOQOL-SRPB was translated into Thai according to the protocol of World Health Organization's translation methodology. The psychometric property of WHOQOL-SRPB was examined in 63 Chronic Kidney Diseases Stage V (CKD-V) patients. The psychometric property of WHOQOL-SRPB Thai version was evaluated as the internal consistency reliability, Cronbach's alpha, and the construct validity using a spirituality concurrent measure, the Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being (FACIT-Sp). Scores of WHOQOL-SRPB and Facit-Sp were examined their relationship by using Spearman Rho correlation.

Results: WHOQOL-SRPB Thai Version is valid and reliable. The high value of Cronbach's alpha (0.94; 95% CI 0.92-0.96) of overall WHOQOL-SRPB 32 items indicated the high reliability property. The Spearman Rho correlation of total scores of WHOQOL-SRPB and Facit-Sp was 0.73. Thus the expected high correlation indicated the convergent validity, a type of construct validity, since the two questionnaires were designed to capture spirituality.

Conclusions: The Thai version of WHOQOL-SRPB is a valid and reliable instrument in CKD-V patients. However, there is still a need for future research to examine other psychometric property within this population, and psychometric property in a wide-spread of other Thai patient populations.

Dr. Hanneke Schaap-Jonker

Ass.-Prof Psych of Religion, University Groningen, The Netherlands

Autism and Religion: Anxiety or Uncertainty?

(Co-Authors: Bram Sizoo, Roanne Glas)

In an explorative study on Autism Spectrum Disorder (ASD) and God representations among Dutch orthodox Protestants, the God representation was characterized by more anxiety, compared to psychiatric patients without ASD or non-patients. The more autistic traits were reported, the more this anxiety increased. On an item level, this anxiety was typified by uncertainty (Schaap-Jonker, Sizoo, Schothorst- van Roekel & Corveleyn, 2013).

However, in this study it is not clear whether these anxious and uncertain feelings of those with ASD are specific to the religious domain, and whether these God image traits are specific to those with ASD; it could be that patients with an anxiety disorder will report comparable feelings in relationship to God. Furthermore, the sample which was investigated did not represent the general group of ASD patients in the Netherlands. Therefore, we performed a follow-up study in which patients with ASD were compared to patients with an anxiety disorder and a control group of non-patients. In this poster, the first results of the follow-up study will be presented.

Katarzyna Skrzypinska

The Threefold Nature of Spirituality Model as an explanation of Health Equilibrium

The Threefold Nature of Spirituality Model (TNS) explains how spiritual sphere works. One of the most important aspect of human existence is well-being and good health. Many authors ask about the influence of spirituality on these domains (Frankl, Antonovsky, Koenig). The theoretical premises allow for the prediction that psychological core of spirituality can be considered functionally in the threefold perspective: 1/ as the cognitive scheme (the most constricted understanding), 2/ as the dimension of personality (the broader understanding), 3/ as the attitude towards life (the widest perspective).

TNS model is the try of description of a dynamic nature of spirituality in these three functional aspects. Therapeutic work with cognitive schema as a core of spirituality may be not enough to restore health equilibrium. The next step to help the patient is work with structures of personality and his attitude to life. Only holistic understanding of spirituality and its mechanisms can give productive results in the area of human health.

Jodi Stamback

Missouri Western State University, USA

Religious Excuse or Religious Immunity? An Analysis of Religion, Veganism and Immunization Choice and Legislation in the United States of America

All 50 states in the United States of America (USA) contain legislation regarding immunizations of its citizens primarily targeted to school-aged children. Of these states, 48 allow for religious exemptions with the exception being Mississippi and West Virginia. Nineteen states allow exemptions from immunizations on the grounds of philosophical and moral dilemmas.

These exemptions present potential issues for those individuals and families who are against immunizations for a multitude of reasons including religious beliefs. For instance, some immunizations contain ingredients obtained from porcine, bovine, or stem cells harvested from aborted fetuses. While these components go directly against the teachings of some religions, what about states in which religious immunity does not apply?

For some individuals, such as Vegans and Vegetarians, the components of the immunizations are equally as offensive. While there are 19 states that allow exemptions to be made on philosophical objections, 31 states do not allow such exemptions to be made. This would, by virtue of moral reasoning, force those in question to claim religious exemptions to be excused from the immunization(s). To counteract against this, some states have legislation in place that ensure that the petitioner has claimed the religious exemption with an established religious organization, or even on some cases, prove membership to a particular religious organization. Other states allow exceptions to be made on the grounds of true moral concern.

This study will attempt to take a qualitative approach to determining the efficacy of allowing religious and philosophical exemptions to immunization legislation in the USA.

Ashley Taylor

Duke University, Durham, NC, USA

A Shifting Religiosity: The Spiritual Journeys of Duke University College Students

As a Duke University Cultural Anthropology senior, I began to explore the ways in which students conduct their own forms of spiritual exploration in an increasingly secular environment. My research suggested an intriguing trend amongst students to develop a personal spiritual journey within a variety of contexts, such as the study of academics, using

psychedelic drugs, travelling, as well as from within a particular religion. These students utilized their specific practices or religious framework for the ultimate realization of an individual spirituality, which was not necessarily concerned with the existence of God or a particular religious community. This shift of religious experience implies a cultural trend amongst the college-age generation that allows them to innovatively pursue their own creation of a spiritual path in the 21st century.

Duke University, a past Methodist and currently secular, private college provides a specific example of the larger shift within contemporary society away from institutionalized forms of religion (Dean 2002, 12). Instead of suggesting a total decline of religiosity, the recent decline of traditional forms of worship allows for a spiritual thriving within a multitude of different contexts (Dean 2012, 14). Alexander and Helen Astin, professors of higher education at UCLA, describe spirituality as "a multifaceted quality that involves an active quest for answers to life's big questions. It has to do with our interior subjective life: the values that we hold most dear, our sense of who we are and where we come from, our beliefs about why we are here, the meaning and purpose that we see in our work and our life, and our sense of connectedness to each other and to the world around us" (Astin and Astin 2010, 4). This definition is separate from an understanding of being religious.

For the purposes of this paper, religious will refer to belonging to a certain institution, as one of my interviewees, Kathryn, suggested. My research suggests that spirituality has become a major concern of college students in new contexts that are often not exclusively associated with religious institutions.

Fazilah Twining

Senior Lecturer in Mental Health Nursing, PhD student, Coventry University, Coventry, UK

What are the Experiences of Spirituality amongst People with Mental Health Problems? Findings from a Systematic Literature Review and the Implications for Mental Health Care

Little is known about the experience of spirituality and mental health from the perspective of people who are struggling with mental health problems. The aim of this presentation is to discuss the findings of a systematic literature review to examine the research on spirituality and mental health. The purpose of the review is to understand the experience of spirituality and mental health from the perspective of service users. Much of the literature focuses on professionals' understanding of spirituality however where are the voices of people with mental health problems? The majority of UK research into the relationship between spirituality and mental health

considers the main issues from the perspective of nurses (Pike 2011). Nurses' beliefs regarding spiritual needs and spiritual care have been thoroughly explored across a range of specialities. Less research however has been conducted to understand spirituality and spiritual care needs from the patient's perspective and as a result the patient voice has been lost in the evidence base. The findings indicate that the evidence base from service users is heavily linked to a Judaeo-Christian perspective. A gap within the literature is the voices of people from other cultural and religious backgrounds.

Professionally nurses are required to pay attention to spiritual needs in healthcare provision. Despite this requirement and the positive links between spiritual expression and mental wellbeing, spiritual needs fail to be addressed in current clinical practice. Service users in mental health care want to talk about their beliefs however there remains a fear that spiritual activity will be pathologised by clinicians as symptoms of mental illness rather than acknowledged as a key factor in a person's recovery (Gilbert, Kaur and Parkes 2010). Furthermore research findings suggest that spiritual experiences of service users are ignored by mental health professionals (Nicholls 2002; Turbot 2004). Lindridge (2007) argues that clinicians perceive individuals' spiritual experiences as causes or signs of mental illness and as a consequence they are reluctant to approach the subject.

The findings of the review will be presented and the implications for mental health practice will be discussed in relation to exploring ways of connecting with people and understanding how people who are experiencing distress might be better supported.

Somporn Kantharadussadee Triamchaisri
Thailand

Application Buddhism Practical Concepts to Heal Chronic Illness Patients

(Co-Authors: Pakvipa Wongwan, Pramuk Osiri)

The prevalence of migraine headaches among 164 Thai monks in Bangkok Metropolis, Thailand was 57.9% with 53.7% having sleep problems, 46.3% had throbbing pain, 68.4% were involved with daily activities, 59.9% showed left or right hemiplegic headaches, 32.6 % resulted from stress, and 58.1% showed moderate to high intensity of headaches. Migraine intensity was positively correlated with sleeping hours ($r= 0.477$, $P= 0.000$).

SKT 8 Buddhist Meditation Based Intervention was used to heal migraine headache among Thai monks. Case-control study is designed to collect data before and after intervention. Results showed that after experiment, migraine headache among cases were healed within 15 minutes session. Quality of sleep

hour also improved when compare to control group and before receiving intervention significantly. The study suggests that different religious culture should be studied to confirm the effectiveness of this modality.

Lynne E. Vanderpot

University of Aberdeen, Scotland, U.K.

The interrelationship between psychiatric medication and the spirituality of people with mental health problems: A phenomenological exploration.

Introduction: Contemporary healthcare continues to acknowledge the positive benefit of spirituality for mental health. Research shows high rates of the use of spirituality as a coping mechanism in people with mental health problems. Given the sharp rise of psychiatric medication use in the last quarter century, it is thought that a significant portion of this population would be prescribed medication. To date, little attention has been given to the interrelationship between psychiatric medication and spirituality.

The medicalization of mental health problems has been criticized for reducing human suffering to biological conditions which can be sufficiently treated by chemical intervention. How such interventions interact with spirituality is not yet known, yet there is a growing call among researchers and practitioners to document how psychiatric drugs affect people over long periods of time.

Objective: The aim of this poster is to give a brief review of the literature which shows a need for qualitative research exploring the patient's perspective regarding the interrelationship between spirituality and psychiatric medication. Examples from initial findings in an ongoing study will be reviewed. It is hoped that by listening to the voices of those who are living spiritually while taking psychiatric medication, new insights will emerge which may inform and improve treatment practices.

Method: Hermeneutic Phenomenology. This method is ideal for preserving and raising the value of a person's unique lived experience. Hermeneutic phenomenology is an empowering research strategy which recognizes subjective experience as a cornerstone of knowledge. It offers one way of interpreting the tacit, significant meanings concealed within human experience.

Discussion: Patient perspectives are a critical aspect of evidence based practices. By introducing the interrelationship between spirituality and psychiatric medication, a meaningful conversation may ensue which provides new insight into furthering the efficacy of contemporary mental health and spiritual care practices.

Prof. Dr. Kurt Weis

Former Institute of Sociology, Technical University of Munich, Germany

Body Techniques of Different Cultures for Spirituality, Holistic Experience and Healing

All sensory perceptions, all experiences, all the knowledge about the inner and outer worlds thusly gained, are made with the body. Which body techniques and which physical structural conditions did or do other cultures use to direct inner processes and consciousness expanding experiences on the search for spirituality? In the rediscovery of traditional religious cultures, in our new focus on wellness, in sports and in fashion the body is "booming". It is also being rediscovered for its ability to provide heightened spiritual and physical experiences.

The paper addresses a wide range of spiritual disciplines, techniques, rituals and related practices. Some people even run to reach a level of enlightenment. Seeking enlightenment through their own bodies, e.g., Tendai Buddhist monks on Japan's sacred Mount Hiei cover 52.5 miles daily, incredibly, for 100-day stretches. On the other side, in our Western culture, sport - reaching its pinnacle in the Olympics - is regarded primarily as a competitive enterprise. In contrast, most traditional cultures (reflected in some modern trends) practiced body mastery and control techniques for a variety of other purposes, including: 1. religious cultures and monastic traditions use fasting, silence, meditation and solitude to gain deeper insight, spiritual strength, healing and enlightenment; 2. various old cultures from Mesoamerica to the Far East use breathing techniques for relaxation, inner strength, health and spiritual experiences; 3. the highly developed Yoga techniques stemming from ancient Indian traditions aim at energetic, therapeutic and consciousness-widening experiences and, ultimately, the unification of human and godly consciousness; 4. in traditional Far Eastern martial arts, body and mind are trained and conditioned to influence each other; 5. in old tribal cultures, dancing and running were used to produce trance-like states or to expand consciousness; 6. religiously focused self-mutilation from the blood rituals of the ancient Maya to the medieval flagellants and the modern crucifixion rituals in the Philippines are used for penitence, trance, visions and other spiritual experiences; 7. old and neo-Shamanic cultures use psychoactive plants to expand states of consciousness and for healing; 8. love, the art of surrender and melting together, is one of the basic powers of the universe. All religions address it. Christian mystics reported it. Indian temples show it. Spiritual schools of Tantra teach it; 9. in modern experiential education or adventure therapy with nature prone sports, we try to foster inner stability and to develop maturity in juvenile delinquents and even top managers; 10.

people engaging in modern extreme and risky sports look for peak experiences and the sense and meaning of life; 11. modern "trendy" sports using skate, snow, surf or kite boards are touted as providing a totally new sensation of a floating and gliding body between strain and relaxation; 12. only the ancient and modern Olympic Games are not interested in any transcendence or spirituality. They have been organized primarily to ensure the fame of the winners, the fun of the spectators and the finances of promoters and the media.

This paper analyzes the methods and the goals of all twelve approaches to using the human body. It thus sheds light on the religiously and culturally different ways to holistic and spiritual experiences. The author includes reports on his own experiences. He spent the first four weeks of 2014 in the Amazon jungle and will also tell the audience, how he was able, with the help of the native shamans and their master plants, to cure his prostate cancer.

Robert Whitley

Douglas Mental Health University Institute, McGill University, Montreal, Canada

The Bio-Bio-Bio model of Psychiatry: What Room for Religion and Spirituality?

(Co-Authors: Rob Whitley, Anna Miller)

Many commentators have argued that the traditional 'bio-psycho-social' model of mental illness has now been replaced by a 'bio-bio-bio' model of genetic causation, brain disease and pharmacological intervention. This begs the question, how can religion and spirituality be integrated into a psychiatry that is becoming overwhelmingly biological? The authors argue that wider trends in medicine and rehabilitation science can be harnessed to justify the better integration of spirituality and religion into mental health care. We will discuss three trends in this regard, these being (i) the increasing popularity of the renewed concept of 'recovery', which takes a holistic perspective on mental health care; (ii) calls for more 'person-centred care' and 'cultural competence', which by definition may necessitate attention to patients' religious and spiritual needs; (iii) the imperative to practice evidence-based medicine, which must ipso facto consider the strong evidence based indicating the therapeutic role of religion and spirituality. It is our contention that these wider trends within medicine can be deployed to ensure that religious and spiritual perspectives on healing are integrated into everyday psychiatric care.

Kayla Wing

Missouri Western State University, USA

Tweet, Pray, Lift: Social Media and Religion's Affect on Perceived Physical Health

In a world that relies so heavily on social interaction, it is important to understand how social media impacts areas of human life. The most basic desire of human nature is to feel a sense of belonging or have some form of group identification. This study applies the notion of community to the perception of one's physical health. In addition to physical health, religion is examined. The affects of religious beliefs and practices are applied to physical health perceptions and social media usage. This is important since many people seek both religious and physical health information on various social media outlets. The data for this study was collected from participants (n=124) who completed an online survey. Social media usage and religion are compared and contrasted to better understand if and what influences one's perceived physical health. The study examines if and how religion and perceived physical health affect an individual's social media usage.

Key Words: Religion, Social media, physical health, physical activity

Dr. Elisabeth Ansen Zeder

Psychologist, Villars-sur-Glane, Switzerland

Implementation of a Philosophical Community of Inquiry (PCI) in an Intermediary Care Institution (Co-Author: Joëlle Gaillard Wasser)

This research Project aims the implementation of a Philosophical Community of Inquiry (PCI) in an intermediary care institution for patients suffering from temporary psychoneurosis, based on the foundations of different theories and clinical practices.

First, we refer to the recent philosophical practices of clinical psychologists (such as reported by Cinq-Mars, C. 2005; Ribalet, J., 2008 ; Loison-Apter, E. 2010 ; Remacle, M. & François, A.2011) who use PCI in a clinical perspective.

Second, concerning practical psychotherapy, existential analysis or logotherapy (Frankl, 2006 ; Yalom, I, 2008) is used.

Third, we refer to the branch of positive psychology which focuses on optimizing the forces that encourage human beings to exercise their inbuilt efficiency, their emotional and cognitive management and discover their talents, thereby increasing their development and learning capacity enabling them to deal with their suffering (Seligman, 1992; Seligman and Peterson, 2004). Fourth, concerning care, a holistic

approach to recovery and the importance of this approach by Provencher (2002).

Furthermore, we advocate the rehumanisation of psychotherapy that incorporates existential questions in relation with a transcendent or spiritual dimension as an integral part of our humanity. The work of researchers such as Huguelet (2003) and Brandt (2010), as well as the psychiatrist Hell (2002) form our basis.

This research project seeks a qualitative and exploratory approach in order to answer the following question: What are expected outcomes for the rehabilitation of the participants in a PCI?

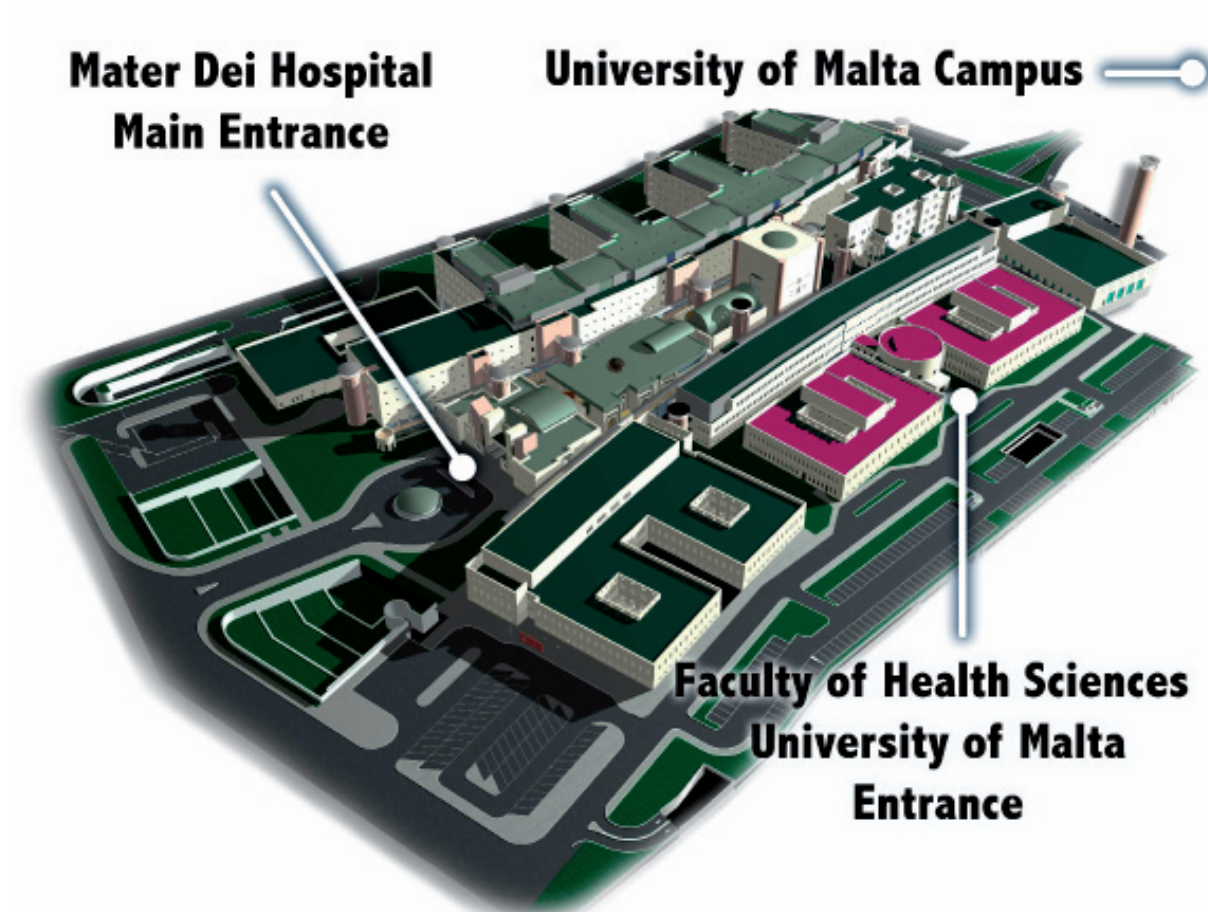
In May 2014, the conditions necessary for the implementation of the project in the aforementioned environment will be described.

Key Words: Philosophical Community of Inquiry; Recovery ; Philosophy and Care; Spirituality and Care; Positive Psychology

The Conference Venue

The graphic below shows the Conference Venue which belongs to the Faculty of Health Sciences of the University of Malta.

The South Auditorium is part of the red buildings.



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