Posters

The posters will be exhibited in the entrance hall (see loaction plan on page 46) during the whole conference. The authors are present during lunchtime 12:00-13:00 - for impaired poster numbers on friday, May 2nd and for paired poster numbers on saturday, May 3rd.

Mindfulness-Based Coping with University Life: A New Intervention (Nr. 1)

Siobhan M. Lynch, PhD-Student; Coauthors: Marie-Louise Gander, Harald Walach
School of Social Sciences, University of Northampton, United Kingdom

Mindfulness-based coping with university life (MBCUL) is an 8-week group meditation-based programme which aims to help students cope better with the stress and strain of university life. Based on the successful mindfulness-based stress reduction (MBSR) programme developed by Jon Kabat-Zinn in the 1970s, MBCUL delivers training in the core mindfulness techniques and history, while tailoring them to the specific needs of students by means of topic focused guided meditations and group discussions. MBCUL also provides clear guidance as to how the techniques can be beneficial when both applied consciously in specific situations, and through practice, as they become a natural way of being. The first three weeks of MBCUL are very much focused on providing a general introduction to meditation per se, and mindfulness meditation specifically. The focus for these first few weeks is on students establishing their own practise of regular mindfulness meditation as part of their mental hygiene. Class sizes range from 8-14, with special care being taken to promote a supportive group environment. The next four weeks of MBCUL are more topic focused, with guided meditations and group discussions building on the earlier sessions and looking particularly at stress, learning, health and communication and relationships. The format of all the guided meditations is as a guided tour, which aims to help students explore their thoughts and feelings in relation to aspects of each topic, accept the reality of the situation and/or what they feel without judgment. This then empowers them to make positive change where appropriate. Emphasis is placed on being aware of what presents itself without judgment and students are reminded that they are in complete control of their experience. Research suggests that one of the key benefits of mindfulness meditation is, through practise, its ability to help the practitioner develop a meta-cognitive insight into their thoughts and feelings, or just 'witnessing' them. An all-day session lies between weeks 6 and 7 and serves as a mini retreat day. A mainstay of the traditional MBSR programme, this session has been shortened for this population and is approximately 4 hours long. Finally, Week 8 introduces students to the loving kindness meditation. This is a guided meditation which is focused on the cultivation of joy, love and compassion, both for oneself and for others. The course comes to a close with a discussion of what students feel they have taken from the course and how they plan to take this with them into their futures. MBCUL has been developed and pilot-tested by the researchers, with students attending MBCUL showing greater increases in mindfulness and greater decreases in stress and anxiety than students in the control group. Students also reported that MBCUL provided them with a coping toolkit, which they could call on as needed. A randomised wait-list controlled study of MBCUL has recently been completed and the fourth course of MBCUL is currently underway at the University of Northampton.

Reiki-Healing: Effect as Experienced by Cancer Patient (Nr. 2)

Hanne Bess Boelsbjerg, Research employee
Sociologisk Institut, Copenhagen University, København, Denmark

In Denmark it is estimated that approximately half of the population has used alternative treatments (Ahlin, 2007). Among those are cancer patients frequently users with the aim to supply their conventional treatment (Damkier, 2000). This research project has been initiated to investigate whether reiki-healing (1) has an experienced effect on the cancer patients and their diagnosis. The project is carried out at the research center KUFAB at the University of Copenhagen (Research Group concerning Alternative Treatment at the University of Copenhagen). KUFAB is an interdisciplinary research environment, which integrates researchers from such disciplines as medical sciences, social science, the humanities and others disciplinary areas. The research is based on both qualitative and quantitative studies. The qualitative part of the research consists of five in-depth interviews with each of the 15 cancer patients. They are all being treated by the reiki-healers eight times. The interviews are preformed with a phenomenological approach, which supports the descriptions to be as exact and vivid as possible. When analyzed and categorized the results will form the basis of a questionnaire. This will be implemented in the following study where 200 breast cancer pa-

tients receive healing during conventional treatment. Included in the interview are questions about meaning and meaninglessness, expectancy for recovery, self-estimated health and pathological understanding for the emergence of the disease. These are to investigate upon important changes in beliefs, which might occur during the period of healing. Interim results seem to show physical and psychological effects experienced as less pain, more energy and better sleep. Some report of improved digestion, softer scar tissue, increased tolerance towards the chemotherapy and faster remissions of tumors. The relevant participants interpret this to be caused by the combination of the conventional treatment and reiki-healing. Everyone finds the treatment comfortable and relaxing. The research indicates that cancer patients experience an empowerment when receiving reiki-healing. The identity as cancer patient can be altered and result in a better coping strategy. The discussion how the treatment and the attention of the reiki-healer lead to these results involves new interdisciplinary theoretical thinking, which we hope this research can contribute to. (1) Reiki (meaning universal life energy) stems from Japanese Buddhist tradition and was presented to the West after the Second World War as a spiritual technical discipline (Doi, 2003).

Patients' Views on Spiritual Care – A UK Hospital Survey (Nr. 3)

Prof. Dr. Christopher Barry Summerton; Coauthors: D. Keong, V. Gray
General Hospital, Manchester, United Kingdom

Introduction: In the changing modern climate of medicine, health has been defined as "a state of complete physical, mental and social well-being not merely the absence of disease or infirmity" [1]. In line with this, US research has turned to matters of spirituality and religion as essential components of healthcare. A recent study showed 83% of patients desiring spiritual inquiry from physicians in certain situations [2]. The proportion of regular church attenders is very different in the USA and UK, so this research on patient preference cannot be applied directly to the British context. Thus, this study was conducted to ascertain the opinion of British patients regarding matters of spirituality and health.

Method: We surveyed a random selection of patients, using a questionnaire validated in previous studies [2] but adapted to British vocabulary. The questionnaires consisted of 60 questions and took approximately 15 minutes to complete. Questionnaires were distributed to inpatients, outpatients, endoscopy patients and adult companions at a Greater Manchester hospital. Patient responses to questions on demographic details, health, spirituality and preference regarding physician inquiry into beliefs were recorded and analysed.

Results: 361 patients were invited to complete the questionnaire. 270 fully completed questionnaires were reeived and subjected to analysis. 45% of patients indicated a positive preference for doctors to address their spiritual beliefs in at least some situations. This was particularly marked when patients were asked about their views of what they migh want if facing a life-threatening diagnosis or at times of grief (27.1% and 20.8% respectively). Reasons for desiring discussion were most often to improve understanding and compassion from doctors, and to enable referral to spiritual advisors. In contract to patient preferences, only 3.3% had experienced any spiritual dialogue with their doctor.

Conclusion: The proportion of patients wanting spiritual care appeared to be lower in the UK than in US studies. However, there is still a significant proportion of patients who wish this intervention, but very few doctors who are providing it. To ascertain those patients in need of spiritual aid and to respond appropriately, doctors may need training and encouragement in asking specific questions. Medical schools may provide the solution. Curriculum could be developed to generate doctors equipped to address the issues of spirituality and healthcare.

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Staff Attitudes to the Delivery of Spiritual Care in a UK District General Hospital (Nr. 4)

Prof. Dr. Christopher Barry Summerton
General Hospital, Manchester, United Kingdom

Introduction: Holistic care is central to medicine: compassion, caring and a desire to help people in need, whether those needs are physical, psychosocial or spiritual. Research shows that healthcare professionals feel comfortable providing for patients' physical and psychosocial needs [1] but often lack the necessary skills and time to uncover and address patients' spiritual needs[2].

Objective: To explore the attitudes of NHS employees towards the delivery of spiritual care and to

investigate the factors influencing provision of this care. DESIGN An anonymous questionnaire based survey. SETTING A Manchester district general hospital. PARTICIPANTS Front-line clinical staff and allied health professionals responding to a voluntary questionnaire. MAIN OUTCOME MEASURES Quantification of attitudes towards spiritual care, current levels of spiritual care delivery, comfort in giving spiritual care, factors influencing delivery, whether education in spiritual care is desired and the extent to which it has already been received.

Results: In total 55 medical staff and 226 nursing and midwifery staff responded to the questionnaire. 82.7% of the respondents agreed that healthcare professionals should be concerned with patients' spiritual needs. 41.8% rarely or never provided spiritual care and only 38.3% reported feeling at ease when giving spiritual care. 66.2% of staff surveyed thought education in spiritual care was important although a very similar proportion (66%) did not report having received any education. The most important barriers to the delivery of spiritual care were lack of time (cited by 67.9% of respondents) and lack of knowledge (66.3%).

Conclusions: Participants in this study clearly felt spiritual care was important and relevant to their practice, yet struggled to consistently provide it. Education in spiritual care was considered valuable by the majority of those responding, but had only been received by a minority. We know from unpublished research that patients desire spiritual dialogue with their doctors, therefore these discrepancies must be addressed to ensure patient satisfaction and to provide the best possible care. Further research is required to develop effective teaching methods to enable the practical provision of spiritual care in the workplace.

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Chronic Pain and Religiosity (Nr. 5)

Dr. med. Kathrin Gerbershagen; Coauthors: Michaela Trojan, Stefan Huber, Volker Limmroth
Department of Neurology and Palliative Medicine, Hospital Cologne-Merheim, Cologne, Germany

Introduction: Modern pain medicine is based on a bio-psycho-social disease model implicating that religiosity should be included as one of its dimensions. Religiosity is seldom mentioned or even analyzed in pain treatment programs. Most research on religiosity has examined populations struggling with life threatening diseases such as cancer or disabling neurological diseases. The influence of religiosity on chronic pain patients is not sufficiently known. Patients suffering from chronic pain may have other experiences with religiosity than cancer patients since those facing a terminal illness might show different patterns on how religiosity impacts health outcomes.

Methods: 450 consecutively admitted neurological in- and outpatients completed an extensive epidemiological questionnaire. Patients with pain reported on the manifold aspects of chronic pain and estimated their pain severity employing the Chronic Pain Grading Questionnaire [1] and identified the stage of pain chronicity using the Mainz Pain Staging System [2]. Patients were asked about anxiety and depression and their health-related quality of life with standard instruments. The questionnaire also included a section with sociodemographic and socioeconomic questions. Religiosity was assessed using the Religiositäts-Struktur-Test (RST [3]). The basic structure of this test is defined by Glock`s five dimensions of religiosity, i.e. intellectual, ideological, devotional and experiental dimensions and the dimension of religious practice [4]. The RST differentiates between centrality (Bedeutsamkeit, salience) and contents of religiosity. Patients were also asked to answer questions concerning difficulties and discomfort with the very personal religious questions and their estimated relevancy of religiosity for pain treatment.

Results: 367 patients, nearly 82% complained of pain in the past three months. Pain patients showed significantly higher anxiety and depression scores and decreased health-related quality of life compared to non-pain patients. Nearly 400 patients rated their religious centrality: 19,3% presented with a high centrality score, 38,7% with a subordinate level of centrality and for 42% of the patients religion played a marginal role in their life. Pain patients showed no significant differences between the centrality allocations in regard to anxiety and depression scores and health-related quality of life. Highly religious pain and non-pain patients showed significantly higher scores concerning religious contents–both positive and negative aspects– than less religious patients.

Discussion: There was no association between the centrality of religion and psychic distress in pain patients. Therefore, merely being religious does not necessarily facilitate the religious pain coping process. This can be explained by the contents of the individual's religiosity determining the direction of religion. The more central religion is the greater the impact on the experience and behaviour of a person. The direction of religiosity among highly religious persons will identify religion religion either as a vulnerability factor or a resource. Screening for centrality (salience) of religiosity should be included in the routine as-

sessment of pain patients. At the same time negative and positive religious coping should also be analyzed. These results may indicate that religion should be integrated in the diagnostic and therapeutic assessment of chronic pain patients.

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Cortisol, Suicidality and Spiritual Well-Being in Croatian War Veterans Suffering from PTSD (Nr. 6)

Dr. med. Sanea Nađ; Coauthors: Bjanka Vuksan-Cusa, Lucija Murgic, Elvira Koic
Department for Psychiatry, University Clinic Zagreb, Zagreb, Croatia

Lately biological, psychological and spiritual parameters have been frequently associated together with the wellbeing of the psychiatric patients. War veterans suffering from PTSD reveal a low basal plasma cortisol level and an enhanced cortisol response to the dexamethasone test, what is a reflection of a hypersensitive of the hypothalamic-pituitary-adrenal axis (HHA). The level of HHA disregulation can be caused by many factors; amongst the others it depends also on the spirituality/religiosity level. The aim of our work is to observe the relationship between the cortisol level, the level of spiritual wellbeing and its components (religious and existential well-being), and suicidal tendency in Croatian war veterans suffering from PTSD. The survey has been conducted on 17 war veterans satisfying the DSM-IV criteria for the PTSD diagnosis, and who did not have any serious somatic illnesses. The spiritual wellbeing has been determined by the score on the Spiritual Well-Being Scale (SWB); suicidal risk was determined by the Suicide Assessment Scale (SUAS) and Beck Hopelessness Scale (BHS); the plasma cortisol level was obtained by venepunction from the cubital vein and we obtained an excretion curve for every examinee (8, 12, 13, 16, 22 hours). The results demonstrate higher cortisol level in the group with lower spiritual wellbeing and higher suicide risk. Only evening cortisol (at 22 p.m.) showed statistically significant correlation with suicidal risk ($p=0.001$), which is perhaps because of small sample size and adjusted pharmacotherapy.

VROID-MHAP-Study (Nr. 7)

Lic. phil. Sabine Zehnder; Coauthors: Christoph Morgenthaler, Aristide Peng, Christoph Käppeler
Faculty of Theology, University of Bern, Switzerland

Religious orientation systems and values are of significance for the formation of identity and the mental health of adolescents. Hence, it can be assumed that changes of the religious landscape are relevant for the development of adolescents. However, studies about the interaction of these factors are rare, especially in Switzerland. In an interdisciplinary project (psychology-theology), which is titled: Values and Religious Orientations in Relation to Identity Development and Mental Health: Adolescent Perspectives - The VROID-MHAP-Study“ and funded by the Swiss National Science Foundation in the framework of the National Research Program: “Religion, State and Society (NRP58)”, the significance of values as well as religious orientations for the development and mental health of adolescents from different religious backgrounds is investigated. Associations between value orientation, religious self-understanding and identity development and their impact on mental health will be analysed considering the course of their development as well as their contextual embedding. The study encompasses a quantitative survey as well as qualitative case studies. For the quantitative part of the study 750 adolescents between the ages of 12 and 17 with different religious affiliation (christian, muslim, jewish, hindu as well as a group with no religious affiliation) in different rural and urban areas of Switzerland are surveyed. The study follows a longitudinal design with two times of data collection within an interval of 1 year. The four main research questions of the study are: 1. Do adolescents with different religious and ethical backgrounds differ from each other concerning orientations of value, religiousness and identity as well as their interaction? And to what degree do they resemble each other? 2. How stable or fluctuating are orientations of value, formations of identity and religiousness during the individual courses of development in adolescence? 3. How do orientation of values, religiousness and formation of identity influence psychological health and wellbeing of adolescents? 4. How do micro- and macro contexts influence the interactions of these

constructs? Case studies, prototypical for findings of the quantitative study, will be conducted with qualitative methods in order to further elucidate influential parameters in the field and to illustrate the quantitative results. A differentiated understanding of the processes of identity formation during adolescence is of public interest. It is not only important for religious education, but also for facing the political chal-

The Influence of Psychosocial Variables on the Use of Religious/Spiritual Coping and Quality of Life among Danish Cancerpatients (Nr. 8)

MA Psych. Heidi Frølund Pedersen
Psychooncologic Research Department, University of Aarhus, Aarhus, Denmark

Aim: Use of religious/spiritual resources in coping may be prevalent in patients with cancer considering the life-threatening nature of the illness. Religious/spiritual coping has been found to have both positive and negative effects on quality of life and illness adjustment among cancer patients, with positive religious coping resulting in more favourable outcomes than negative religious coping. However, little is known about the psychosocial factors associated with the use of religious/spiritual coping style.

Purpose: The aim of this study is to explore: 1) the use of religious/spiritual coping among Danish cancer patients compared to a healthy population, 2) changes in the use of religious/spiritual coping over time, 3) the psychosocial factors associated with the use of religious/spiritual coping, and 4) influence of religious/spiritual coping on quality of life

Design/Method: A prospective study of 1.500 newly diagnosed Danish lung cancer patients, will be compared to a healthy, age and gender matched control group with respect to their use of religious/spiritual coping, quality of life, and relevant psychosocial variables. Lung cancer patients complete baseline questionnaire shortly after diagnosis and follow-up questionnaires at 6 and 12 months after diagnosis.

Perspectives: Knowledge about the use of positive and negative religious coping over time among a life-threatened group in a secular society will help health care professionals to be more attentive and responsive to the religious and spiritual needs of the patients. Furthermore, the results could identify possible psychosocial factors that may predict the use of positive and negative religious/spiritual coping, which will help healthcare professionals to identify patients at risk of using a negative religious/spiritual coping style resulting in poorer quality of life and illness adjustment.

Willingness to forgive with and without Repentance: A Study among Jews and Christians (Nr. 9)

cand. lic. phil. Noam Hertig
Department of Psychology, University of Zurich, Switzerland

The value of forgiveness is emphasized in many religions, but little is known about how members of distinct religious cultures or religious affiliations differ with respect to determinants of forgiveness. The present study investigated differences in willingness to forgive among Jews and Christians with respect to repentance versus non-repentance of the transgressor. The concept of repentance differs in Jewish and Christian theological beliefs. While Judaism sees repentance as a sine qua non for forgiveness, Christianity teaches its believers to ask and grant forgiveness without preconditions. We thus hypothesized that Christians would be more willing to forgive a transgressor who does not regret his fault than Jews. No religious culture differences were expected with respect to willingness to forgive with repentance of the transgressor. Ninety and six participants (52 Jews, 44 Christians) judged their willingness to forgive regarding repentance and non-repentance using six interpersonal transgression vignettes and the Willingness to Forgive Scale (Allemand, Sassin-Meng, Huber, & Schmitt, in press). Religiousness was assessed using an adapted version of the Centrality Scale (Huber, 2004). Results indicate that participants were generally more willing to forgive a transgressor who regrets his behavior than a transgressor who does not regret his fault. Consistent with our hypothesis, however, Christian participants were more willing to forgive without repentance than Jewish participants. No religious culture differences were found with respect to willingness to forgive with repentance. Moreover, results indicate that religiousness was positively and strongly related to willingness to forgive without repentance in Christian participants, whereas this relationship was significantly smaller in Jewish participants. Future directions concerning religious culture differences in willingness to forgive are discussed.

How the Nursing Professionals experience Death of their Patients (Nr. 10)

Georg Saltzwedel
Paracelsus-Hospital Richterswil, Switzerland

Nursing professionals are requested to participate in the fate of the patients and not just to consider their physical problems. Therefore, the death of the patients is not merely felt as a biological event, but also as a personal consternation. The main goal of this study was to examine whether and how the consternation of the nursing professionals upon death-experiences differs in hospitals with different kinds of performances, of installations and of internal structures. Other goals of the study were to find out: 1) what attitude do the nursing professionals consider to be the right one in handling and accompanying the dying patients, the deceased ones and their relatives and 2) which resources may help them to master frequent death events. Four hospitals and a total of 554 nursing professionals took part in this investigation: 40 from the Cantonal Hospital Nidwalden (return ratio 45.9%), 27 from the Paracelsus-Hospital Richterswil (67.5%), 445 from the University Hospital Zurich (36.5%) and 42 from the Hospital Zimmerberg in Waedenswil (35.8%). The study was performed following a multi-methodical design. Data collection was progressively developed with an increasing focus on the contents and a methodical standardization (focused group interviews, qualitative single interviews, and standardized questionnaires with the possibility for personal explanations). The results show that not the fact of dying and the death per se, but rather the circumstances how the patients die affect the nursing professionals most strongly. Most nursing professionals appreciate to give care to the dying patients and to the deceased ones, and are aware that the quality of the dying process depends to a large extent on them. The nursing professionals have often concrete concepts of „good dying" and most of them are willing to strongly engage themselves for the realization of those concepts. Conflicts in the interprofessional teamwork, insufficient structures and resources as well as purely organ oriented medicine represent a burden to the nursing professionals. Most of the study participants assure that they have sufficient personal resources to deal with dying experiences. However, the majority of the nursing professionals possesses only a limited formal competence to care for patients at the end of their life. Only at the Paracelsus-Hospital there is an established culture concerning the dying process as well as clear structures for decision making and a defined sequence of events during the care of those patients. Our observations indicate that at most hospitals too little attention is given to the care of the dying patients and their relatives and to the post mortem care, as well as to the support of and the meaning of the dying process to the nursing professionals. The results of our investigations reveals the need for a comprehensive inspection and the improvement of the conditions under which dying in hospitals happens. The conditions concern aspects related to the qualifications of the personal, to the structures within the hospitals and the collaboration among the various departments within the same hospital.

Hagiotherapy, Depression and the Life Values Scale (Nr. 11)

Dr. med. Sanea Nađ
Department for Psychiatry, University Clinic Zagreb, Zagreb, Croatia

There are accumulated evidence indicating beneficial influence of the usage of spiritual/religious parameters in the therapy of mental illnesses, especially of depression. In Croatia it is used an authentic model of providing spiritual help, entitled hagiotherapy founded and developed by Tomislav Ivancic, an fundamental theology professor. Hagiotherapy is based on the main principle that human person is a spiritual/ existential being who possesses a natural moral low which differs him specifically from any other created creature. The area of activity in hagiotherapy is the level of the spiritual soul where can be recognized an immediate effect of the spirit. Because the spiritual soul is connected to the body, that is, to the perishable matter, it is susceptible to fragility and vulnerability. Hagiotherapy tends to trace exact scientific ways and proof to cure man's spiritual soul, hence wounds in the human spiritual dimension. It is suitable for all people regardless their age, gender and religious affiliation. Its aim is to bring human persons to the knowledge that it is important to appreciate the natural moral laws and behave according to them, and provides assistance and supports them to start and endure this path. We present a pilot research conducted on 42 patients reverted for hagiotherapy help due to depression.

The Russian Orthodox Philosophy as the Basis of Spiritual Support in Palliative Care Issues (Nr. 12)

Dr. med. Elena S. Vvedenskaya
State Medical University, Nizhny Novgorod, Russia

Death is something that awaits all of us and yet we often avoid thinking about it. As Christians, we understand earthly death as a gateway to life eternal. Today we are facing deaths of young population due to cancer and AIDS, palliative and hospice care has become a very important part of public health. The role of spiritual care is growing day by day. More and more people go to the church and nowadays and we can see the old religious traditions revival. There is a unique tradition surrounding death, dying and funerals in the Russian Orthodox Tradition. Description: The aim of the research was to study the available literature (major works of outstanding Russian priests of the XVIII-XX centuries) and the existing experience of the Russian Orthodox Church concerning dying and funerals and prove their importance for people facing life-threatening illness. Lessons learned: The study presents the Russian Orthodox philosophy of death and death rituals: before a person's death, preparation for a funeral, funeral services in a church, blessings of a cross at a grave and burial of a dead, memorial service of a deceased on different days after death and their meanings. Recommendations: The knowledge of and following these traditions is of vital importance for terminally ill patients, their families, and for caregivers in Russia. At the moment strong cooperation between medical practice, research, community and religion is needed to make progress in palliative care and provide good quality of life at the end of life for people living with HIV/AIDS. Palliative/hospice care for people living with HIV/AIDS and their nearest in Russia must contain by all means a religious/spiritual component.

Pastoral Intervention using the STIV Assessment Tool in Cancer Patient (Nr. 13)

Marco Martinuz, Theologian
Centre Hospitalier Universitaire Vaudois, Switzerland

Patients suffering from cancer tend to be especially vulnerable in the existential dimension of their life. Hospital pastoral care teams have been involved in dealing with such patients for many years. Their goal is to help patients to express this existential suffering and to answer the spiritual and religious needs. The assessment tool STIV gives its own definition of spirituality (meaning, transcendence, identity and values). It is used by a pastoral professional in the encounters with patients and for communication with staff. We examined the relevance of use of the STIV model to interdisciplinary care. Goal of study: 1. Use of the STIV grading scale 2. Observation of evolution of patient assessed with STIV Secondary goals: 1. Adjustment of STIV scale and the comparative weighting of the different domains 2. Observation of the psychological status of patients before and after pastoral care (psychometric assessment), and comparison with patients with and without psychotherapeutic treatment. Methods: This study is an annex to the study "Psychotherapeutic intervention for oncology patients, a naturalistic study", conducted by the service of Psychiatric liaison in the CHUV (protocol 206/07). Every new patient treated in Oncology in the CHUV is eligible for the main study. The patients of this study are enrolled from the control group of the main study. They are people who consented to be assessed with psychometric tools. Four encounters of 30' each with a pastoral care giver are offered to the patients. A STIV assessment is done at each encounter. The assessment is a semi-directive one. The goal of the pastoral care giver is to explore with patients the most significant or the most difficult aspect shown by the STIV assessment. Conclusion: Based on the current recruitment of 30 people, preliminary results show that: - As with standard pastoral care, an important percentage of patients accept pastoral intervention. - The scale, as presently used appears to be relevant. However, the introduction of eighting of the different specific domains of STIV would seem to be useful. - The results should help to better define spiritual distriss of cancer patients and to shape an approach to pastoral encounters. It is foreseen that the study will to include and additional 20 patients.

Pastor's Management of Religious Delusions: A Case Vignette Study (Nr. 14)

Dr. Annemarie Noort; Coauthor: Arjan W. Braam
Utrecht, The Netherlands

Especially among members of religious congregations, the pastor takes a crucial role in the first counselling of psychosocial problems. Among the range of presentations, psychotic symptoms may occasionally occur, sometimes with a religious or spiritual content. Little is known about the recognition of core psychiatric symptoms among pastors. To explore the ability of pastors to recognize the difference between psychiatric problems with a religious content and religious problems requiring the assistance of a pastor, a vignette approach was employed. Selected in a region of the Netherlands with a population characterised by relatively high levels of orthodox Calvinist beliefs, 143 pastors of several denominational traditions were interviewed. Thirty one pastors belonged to orthodox Calvinist congregations (mostly ministers), 39 had a mainline Calvinist background (mostly ministers), 36 were Roman Catholic (mostly priests) and 37 were elders from Evangelical congregations. Three of the vignettes were derived from previous research by Milstein (2000) and a fourth was constructed based on a case described in "The Varieties of Religious Experience" by William James (1902). The vignettes pertained to (I) a young man with schizophrenic psychosis, (II) a mystical/spiritual experience, (III) a grief reaction with a religion-based moral dilemma, and (IV) a melancholic old man with religious delusions. Results About half of the pastors considered vignette I (schizophrenia) to represent a religious or spiritual problem. Medication was assumed to be advisable by the majority of the pastors (86%). Pastors from Evangelical and orthodox Calvinist congregations considered vignette II (mystical/spiritual experience) significantly more often as a serious problem, and found psychiatric medication as significantly more advisable. Vignette III (grief reaction) did not show large differences between the pastors. Fiftyeight percent of the pastors considered vignette IV (melancholia) as a religious or spiritual problem. The pastors considered mental health care less desirable compared to the other vignettes. The opinion of the Evangelical pastors was more extreme, rated the vignette significantly more often as a religious or spirituality problem compared to the other pastors, and considered mental health care and psychiatric medication less desirable. Conclusion The findings indicate that the pastors sympathized with the spiritual distress of the young man with a schizophrenic psychosis, but that they were still able to recognize the serious need for psychiatric care. The case of melancholia with religious delusions met with even higher levels of recognition as a spiritual or religious problem, especially among the Evangelical pastors. This pattern is in line with experiences in clinical practice, that melancholic patients, and those in older age in particular, seems to be referred in relatively late stages of their disease for mental health care. On the other hand, Evangelical en orthodox Calvinist pastors tended to classify a mystical/spiritual experience as a psychiatric problem. This might be due to the way of describing this religious experience, which was did not match with ways of perceiving and formulating religious experiences in orthodox Protestant traditions. Recommendation Knowledge of psychiatry is also relevant for pastors, and some additional education on psychopathology is warranted.

The Dilemma of defining Spirituality and understanding its Complexity (Nr. 15)

Wai Leng Tong
University of Essex, Department of Health & Human Sciences, Colchester, United Kingdom

Spirituality is now the concern of everyone, religious or secular, young or old, atheist or believer, educated or otherwise, because the spirit is making new and extraordinary demands in the world we live in today. Spirituality has become diverse, plural, and manifold and seems to have countless forms of expression, many of which are highly individualistic and personal. This growth of spiritual awareness is reflected in a diversity of academic disciplines that also seem to capture the emergence of spirituality. Some of these areas are broad academic disciplines like sociology, while others are more practice and professionally oriented subjects like nursing, medicine and healthcare within the human sciences. Before proceeding to these disciplines, the dilemma in defining the term 'spirituality' needs to be laid out. The emergence of literatures on the definitions and recommendations in all add to complexity, ambiguity and confusion that surround the term 'spirituality'. In this paper, current usage and definitions of spirituality are discussed and a philosophical definition of 'spirituality as a journey' that unfolds its meanings contributing the quality of one person's existence over time is proposed.

The Delivery of Spiritual Care by NHS Staff in a DGH (Nr. 16)

Daniel Moynihan
Trafford General Hospital, Manchester, United Kingdom

Declaration of involvement: Two researchers were involved in this project: Professor Chris Summerton (supervisor) and Daniel Moynihan (research student from the University of Manchester Medical School). Daniel Moynihan was responsible for adapting and compiling the questionnaire, distributing the questionnaire, data entry, analysis and the writing of this report. Chris Summerton supervised the running of the study and was responsible for devising the aims and objectives, seeking the relevant approval and giving advice on the content and wording of the questionnaire.

Abbreviations: NHS: National Health Service; DGH: District General Hospital; US: United States of America; NICE: National Institute for Clinical Excellence.

Introduction: The results of a forthcoming study by Dawn Jackson, Chris Summerton, and Victoria Gray showed that 45% of patients at Trafford General Hospital wanted to discuss spiritual issues with their doctors16. These results suggest that spirituality is important to patients, and knowing this to be the case this research project set out to discover whether healthcare professionals are equipped to provide this care.

Aims & Objectives:

- To explore the attitudes of NHS employees towards the delivery of spiritual care.
- To investigate how adequately equipped staff are to provide this care.
- To consider the factors influencing the provision of spiritual care, e.g. profession, education and personal faith.
- To examine potential barriers to providing spiritual care.

Methods: Questionnaires were distributed to front line healthcare professionals at Trafford General Hospital, Manchester in June/July 2007.

Results: 82.7% of staff agreed that healthcare professionals should be concerned with patients' spiritual needs. 66.2% of staff surveyed thought education in spiritual care was important although a similar proportion did not report having received any education. The most important barriers to spiritual care provision were lack of time (67.9%) and lack of knowledge (66.3%).

Conclusions: Spiritual care is held in high regard judging by the results of this study, however it is not being consistently provided (41.8% rarely or never provide). Education in spiritual care was considered important by the majority of those surveyed yet was only received by a minority. This must be addressed together with other barriers to spiritual care.

Crossing the Mystic River: Criteria for Psychopathology in Young People with Spiritual Experiences (17)

Dr. med. François Trümpler Moll; Coauthors: Michelle Lim1, Kath Baker, Alison R, Yung
ORYGEN Youth Health – PACE (Personal Assessment and Crisis Evaluation) Clinic, Australia

Rationale: Recent publications have raised controversial views as to what extent spiritual experiences are considered normal, a psychopathological symptom, or both.

Objective: The aim was to explore which factors indicate that the experiences are psychopathological and likely to be associated with transition to psychotic disorder.

Method: Systematic review of the literature in relation to spiritual experiences and psychosis was first undertaken. Then cases with spiritual experiences within the PACE Clinic, a service established for young people considered 'Ultra High Risk' (UHR) developing frank psychosis, were examined. Data collected with the CAARMS, an instrument for assessing subthreshold psychotic phenomena, were reviewed.

Results: We found few papers that address detecting psychopathological symptoms in the context of spiritual experiences and propose specific indications and new criteria for this population.

Conclusion: It is difficult to discern between spiritual or psychopathological experiences. Therefore, the experience should not be judged according to form and content alone; instead, other psychopathological symptoms and contextual life factors should be considered. Systematic, well-designed research studies are needed to elucidate how the criteria and the CAARMS can assist mental health professionals.