Clients’ existential, spiritual and religious needs in clinical settings

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Session A: Women’s perspectives on prenatal screening and Suicide prevention

1. Prenatal screening, autonomy and responsibility – Women’s perspectives,
Anne Mari Røsting Strand

Prenatal screening in the Norwegian health care system is based on the conception that choice in pregnancy is a good thing and an assumption that the choice is autonomous. Based on Norwegian women’s experiences with prenatal screening, the study investigates the conception of choice and the principle of autonomy. In particular it investigates women’s ethical dilemmas and the societal challenges with autonomy and choice in prenatal screening. Within this study, the concept of responsibility seems to be an important issue: Freedom of choice, autonomy and responsibility may be intertwined concepts. Even though freedom of choice and women’s autonomy are core concepts in the Norwegian discourse on prenatal screening, responsibility is not. Results from a questionnaire answered by 18 women going through prenatal screening with severe findings indicates that the concept of responsibility seems more present to the pregnant woman in her decision-making than her right to a freedom of choice. In some cases, the pregnant woman even expresses the impression that she does not really have a choice – a termination of the pregnancy seems to be the only responsible choice based on the information she receives in the process of prenatal screening. The concept of female responsibility thus seems to be a societal challenge within the emphasis on female autonomy in the Norwegian discourse on prenatal screening.

2. Introducing an existential based suicide prevention, developed for secular contexts,
Cecilia Melder, Ullakarin Nyberg

Background: Sweden lacks studies of non-confessional existentially based suicide prevention. Melder has developed a theoretical framework for support of existential health, grounded in psychoanalytic theories and the eight aspects of the WHOQOL-SRPBs existential facet (2011).

Aims: Develop and test an existential suicide group-prevention to support health and prevent premature death.

Materials and methods: A pilot group-prevention was conducted in a psychiatric hospital as a method development within the ordinary care process. The five participants were between 23 and 47 years, four women, all had recently tried to commit suicide. The WHOQOL-SRPB questionnaire was used for a “before and after” study, open-ended questions were added for qualitative evaluation.

Results: All facets of health had increased. The participants’ satisfaction with health and life quality had increased from \((M=1,2)\) to \((M=2)\)\(^{1}\) and the feeling of life to be meaningful from

\(^{1}\) 1= Not at all, 2= Little, 3= A moderate amount/moderate, and 4= Very much.
\( (M=1,2) \) to \( (M=2,2) \). They responded that they appreciated the intervention. Everyone were alive 15 months later.

Conclusions: It is crucial to develop a non-confessional existential based suicide intervention as a complement to traditional treatment.

3. **Callers’ experiences of contacting a diaconal suicide prevention crisis line in Norway: A qualitative study,**
   Ingvild Engh Vattø

Abstract: Kirkens SOS is a 24-hour diaconal suicide prevention crisis line in Norway for people experiencing emotional and existential crisis. This study aimed to provide a deeper understanding of the significance ascribed to contacting a diaconal crisis line. In-depth qualitative interviews were conducted with nine callers. The material was analysed using systematic text condensation. The analysis revealed two master themes that reflected a) the varied circumstances of making the crisis call, and b) the interacting emotional, relational, and existential support functions of the crisis call. The findings highlight the significance of implementing bio-psycho-social-spiritual approaches to crisis care and the criticality of including socio-cultural perspectives when designing and evaluating public mental health strategies.

4. **Existential themes in conversations with patients in suicidal risk,**
   Ane Inger Bondahl Søberg

In Norway about 600 died in suicide in 2016. It is calculated that for each suicide there are ten persons conducting a suicide attempt. Thus, this area is a huge challenge for those being affected and for society as a whole. Persons who conduct suicide attempts occasionally need medical support. It is significant that existential themes are reflected in the consultations. However, the conversation in relation to existential topics can be challenging. The aim of this study was to investigate what kind of themes the patient experienced as most important after the suicide attempt, and how they were met in the specialist health care. Eight persons were interviewed in the study. The transcribed material was analysed through systematic text condensation. The majority of the informants reported that they were met with respect and understanding, some challenges were also identified in the encounter. The thematised existential themes were loss, death, religion, spirituality, and issues in relation to the suicide attempt. In addition, physical and mental health issues, shame, economy, work, and relations were seen as important themes. Preliminary findings indicate that the existential themes were varied and multilayered, also reflecting the therapists’ different ways of approaching.
1. **Religious healing experiences and earned security**,  
   Marianne Rodriguez Nygaard, Tormod Kleiven, Elisabeth Mæland, Anne Austad

This presentation focuses part of our research project ‘Healing experiences and the lived body’, specifically the question: What characterises healing experiences related to Christian faith and practise? We believe that a better understanding of the dynamics of religious healing experiences is important for professionals, both in religious contexts and in healthcare systems.

Our respondents indicated that they perceived healing experiences as intense encounters with an external power of love, a sensitive power with detailed insight into one’s burdens. They also reported feeling that they were completely accepted and loved by what they interpreted as the Christian God. They characterised these experiences as life-changing and the spur of further healing processes.

We suggest that these encounters can be understood as a perception of God as an attachment-like figure. Earlier research on religious attachment has shown that God often is approached as a safe haven in stressful times. There is less evidence that God is perceived as a secure base or a starting point for new exploration (Granqvist & Kirkpatrick, 2016). However, our respondents indicated that these experiences prompted new explorations of their life, self, others and God. We therefore argue that healing experiences may provide a sense of earned security.

2. **Clients’ existential, spiritual, and religious needs in clinical settings**,  
   Aida Hougaard Andersen, Dorte Toudal Viftrup, Heidi Frølund Pedersen, Kirsten Kaya Roessler

Objectives: Existential, spiritual, and religious needs are seldom assessed systematically in therapeutic settings. However, these needs may very well be present and a core concern for the client. Thus, psychologists risk to overlook important needs of the client. In the present study, we tested a method of assessing clients’ existential, spiritual, and religious needs in a private psycho-therapeutic clinic. We investigated how clients described these needs, and how they experienced them in relation to coping.

Methods: Written consents were obtained from 33 clients and expressions concerning existential, spiritual, or religious needs were extracted from the records. Interpretative Phenomenological Analysis was applied to analyse the qualitative data.

Results: All clients reported religious belief, and more than half described their faith as both a strength and a challenge. Case-analysis showed that psychological aspects were interwoven with religious belief and with the function of the belief. Further, the psychological approach in relation to religious challenges seemed to help clients restructure resulting in a more flexible faith and practice.

Conclusions: Assessing existential, spiritual, and religious needs is a valuable way to understand the clients’ lifeworld. Using a structured approach in clinical practice helps psychologists to prioritise this perspective in the communication with the clients.
3. **Socratic group dialogues on foundational existential questions with therapists at DPS Strømme, Sørlandet Hospital within the project “Existential rooms in mental healthcare 2017/18”,**
Magnar Øye, Thomas Bernhard Thiis-Evensen

Purpose/research question: What, if any relevance, could experience-based exploration of foundational/ontological questions, and a methodical way towards shared answers in group sessions with therapists have for clinical practice?

Focus areas: We examined the grounding questions: “What is meaning?”, “What is existential practice?”, “What does it mean to be/exist?”, “What is spirituality?”

Method: Prior piloting, modern Socratic group dialogue, Benedictine circle, participatory observation, summaries/reports, recordings, questionnaires, focus group interviews.

Operationalization: 4 days of 6 hours group dialogues with 8/9 therapists lead by philosophical practitioner. Collecting data and evaluating the experienced effect of the group sessions.

Intentional effect: Experience whether exploration of openness towards being/existence, personal presence, and personal/group meaning making can have relevance for clinical practice.

Preliminary results: Being in the process of evaluating data, collecting feedback and publicizing we will report preliminary results and recommendations for further work. From questionnaire; “I experienced a strong joy, feeling of life, safety and connection during the group work when we were together, and a hope of making use of this in my clinical work in a stronger way than before.”

4. **Psychotherapy: A profession with amnesia,**
Amalia Carli

In this presentation I refer to some of the ancient spiritual roots of psychotherapy, from the Theraputra of the Alexandrian desert, Kabbalah’s influencing, Sigmund Freud and Carl G.Jung. I will also refer to how so called New Spiritualities, contemporary psychotherapy developments like Somatic Experiencing and EMDR are integrated with shamanic or Buddhist inspired views that seem to be more and more present among the worldviews of experienced psychotherapists. Drawing from research among 15 psychotherapists from different European countries, as well as from own clinical practice I will illustrate how psychotherapy work in the XXI Century may be recovering the forgotten art of soul healing that gave name to our profession. I propose some reasons for this development towards spiritual integration in psychotherapy, grounded on findings from my current research and in contributions from scholars within Psychotherapy, Theology as well as Consciousness studies.
Session C: Spiritual/existential care for patients with severe somatic illness and disability

1. Training care workers to address existential questions in palliative care - A mobile hospice teaching team’s experience,
Kirsten Tornøe

Background: Consoling dying patients’ existential distress demands courage because it confronts nursing staff with their own vulnerability. Nursing homes and home care nursing have many unskilled care workers and must increasingly provide palliative care, due to cost cutting in specialized health care. Developing care workers’ courage and competency to provide palliative existential care is therefore important.

Aim: To illuminate a pioneering Norwegian mobile hospice nurse teaching team’s experience with training care workers in existential care for the dying in home care and nursing homes.

Methods and design: Qualitative study, focus group interview, phenomenological hermeneutical data analysis

Results: Experiential knowledge was transferred through situated “bedside teaching” and reflective dialogues. Care workers learned to identify existential suffering, initiate existential conversations and convey consolation through active presencing and silence. The team believed that this was efficient because they observed that care workers became more courageous to be with the dying.

Conclusion: Situated bedside teaching by expert mobile nurse teaching teams may be efficient to enable care workers to relieve dying patients’ existential distress.

2. Knowing the inner spiritual world of the patient,
Clara Gomis Bofill

Spirituality is an essential part of human beings and plays a crucial role at the end of life. In the process of dying, existential questions arise with urgency and have to be attended within the health care systems, for they can be a source of suffering or can promote wellbeing, affecting the whole experience of the patient. Considering this, a working Group on Spiritual Care was created (GES) within the Spanish Society for Palliative Care (SECPAL). In GES we stress the concept that spirituality deals with the most significant aspects of our relational nature: with ourselves (the need for meaning and a sense of worthiness), with others (the need to love and to feel loved, forgiveness and compassion) and with the sacred or transcendent (the need for hope and a sense of belonging). Accordingly, the GES has created a short questionnaire that helps identify in which of these three spiritual dimensions the person has needs to be attended or otherwise resources to be emphasized. The questionnaire works as a simple and yet accurate map of the inner spiritual world of the patient and enables health care professionals or volunteers to initiate a joined empowering and healing process.
3. Taking care of the existential needs of elderly persons with acquired deafblindness,
   Daniel Prause

Introduction: Focus on diagnosis and practical tasks often overshadows existential needs of elderly persons receiving health care services. Several governmental regulations specify the importance of caregivers’ ability to identify these needs and respond to them adequately. Research shows that deafblindness, which is an underreported disability, increases the risk of existential challenges, especially in elderly persons with acquired deafblindness. To facilitate the accessibility to existential care for them, the need for more research into their experiences has been recognized.

Aim: The aim of the study was to explore the existential needs of elderly persons with acquired deafblindness.

Method: Open individual narrative interviews with three elderly persons with acquired deafblindness receiving health care services in Norway were subjected to phenomenological-hermeneutic analysis.

Results: The study identified three main categories contributing to experiences with existential care:
   - Possibility to experience nature
   - Possibility to express creativity
   - Possibility to experience a sense of belonging

Conclusion: Individually adapted communication and receiving information appears to be prerequisites for the experience of existential care for the elderly person with acquired deafblindness. The caregivers’ ability to facilitate communication and to empathize with the person emerges as a crucial factor.

4. Meaning-making in persons with severe dementia,
   Tor-Arne Isene

Background: This project is about meaning-making in persons with severe dementia admitted to hospital. A key question in the research area for the psychology of religion is how the individual person creates meaning in life and existence. Dementia causes impairment of cognitive functions and abilities of communication and abstract thinking. This challenge the access to sources of meaning-making and how this happens for a person with dementia.

Aim and purpose: This study is part of a qualitative project, which aims to reveal a deeper understanding of how meaning-making appears in persons with dementia. The project has two aims where the first aim is to understand how meaning-making and experience of meaningfulness appear in persons with dementia. The second aim is to explore implications of the findings for patients and carers in dementia care.

Material and method: The data were collected by participant observation in a hospital bed unit over a period of four months. Ten patients with severe dementia were included. The researcher participated in daily activities like meals, walks outside, sing-alongs, exercise, or
just spending time with the patients, either individually or in groups. The observations were noted and written down in fieldnotes and analysed.

Result: The material from the study contained several stories about existential themes that unfold in everyday life. We labelled these stories as *existential dramas*. The stories show that meaning-making among other things happens through the body. The body has its own language and memory in the sense that it through actions and expressions communicates what there is no cognitive capacity to communicate verbally. The existential dramas that these stories are about, show that there is a person in the disease of dementia experiencing crisis of meaning and at the same time is searching for meaning in life as it is now.