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THEMATIC FOCUS OF THIS ISSUE:

DISCUSSED AND RELEVANT TOPICS IN PALLIATIVE AND HOSPICE CARE, ISLAMIC AND CHRISTIAN RELIGION, THE IMPACT OF THE COVID-19 PANDEMIC ON THE CURRENT PERIOD, AND OTHER INSPIRING AREAS

ACTA MISSIOLOGICA

Peer-reviewed academic journal
Our mission is to create an international platform for experts engaged in the field of Christian mission and missiology, charity, social and humanitarian development work at the theoretical, research and application levels. The journal has been creating room within this international platform for further specificities covering the aforementioned fields that will produce new relevant findings and interconnections in order to promote the journal more to the widest possible professional community and stimulate a greater interest within it. One such field is international public law with its unique scientific and relevant, direct and close link to international missionary work, and several other relevant aspects from other fields on which the journal focuses. The journal publishes a wide spectrum of articles relevant for education with special focus on assisting professions in the aforementioned areas. This area includes all educational, health, social, legal (especially international humanitarian law, international human rights law, diplomatic law and international treaty law), international organization and spiritual topics connected to the missionary context.
As of Autumn 2020, the journal will be focusing on specialised unique scientific and expert research at the international level, covering all the topics the journal has focused on thus far while also introducing new ones. One such aspect of scientific and expert research that the journal is going to focus on is the support for the family structure and its value in today's society, as well as the promotion of human dignity and value in various essential aspects of life with a view to opening up effective dialogue on various relevant and interesting ideas about non-radicalised Islam, thus also benefiting the Christian environment.

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TABLE OF CONTENTS

EDITORIAL

Dear Colleagues and Readers of Acta Missiologica,

The goal of palliative care to achieve a good death has its roots in the notions of different religions that lead to the acceptance of human mortality, to the recognition of human weakness and fall, and also to reconciliation. The concept of good death is influenced by social structures such as culture, religion and the economy, as well as personalized attitudes towards death and act of dying, so it is difficult to reach a general consensus on what a good death should look like. Sometimes a good death cannot even be achieved because it is affected by different social structures or by a lack of control over the course of a life-threatening illness. The patient's personal experience plays an important role, too. In this context, it is still necessary to ask questions such as: Does the dying patient perceive that the palliative team has done everything to be able to move towards a good death? Support for achieving a good death is the patient's growing interest in a good death itself and which can also observed in the patient's desire to accept the process of dying as part of life and not to deny it. There are several challenges for palliative care that could help the palliative care team to achieve the ideal of a good death in the most appropriate and effective ways possible. These key challenges include: to promote and develop an innovative approach to palliative care for both adults and children; to place both adult and pediatric patients into medical care center in an equal distribution; caring for both adult and pediatric patients as a whole and be understand as a human being; be a guide for both adults and children as well as their relatives; to modify, innovate and support palliative care models at home; to adapt palliative care and develop solutions from a family perspective; to educate and, at the same time, prepare a pediatric patient for what he/she needs to know; possibilities to expand professional education in the field of palliative care; to be here and now for an adult and pediatric patient; to create a plan and make the life of an adult and pediatric patient in palliative care as comfortable as possible; to be the mouthpiece of an adult and pediatric patient and fully support them in a way they can stand for themselves on their own; to share own experience and practice in a mutual and collaborative way at international levels across various fields and departments which are important for the development and access of palliative care for both adult and pediatric patients; to constantly try to improve the quality of medical care provided at both academic and applied levels, for example, by establishing new and interesting knowledge in practice and supporting new legislative proposals that we could focus more and more effectively on the concept of good death; to support palliative care providers so that they can work on more efficient and better acquisition of the skills needed for palliative care.

Similarly diverse topics and studies have been discussed in current relevant research focusing on important aspects of palliative care in the current edition of the Acta Missiologica that can be so beneficial for the international scientific and professional community. In addition, of course, attention is focused on important factors in the post-Covid-19 period related to health care and social work. In this issue, the selected topics from the Christian and Islamic religion also prove the importance of their inclusion and contribution when it comes to proposed applications in practice, as well as their contribution to new research perspectives and scientific discussions in post-Covid-19 times in various scientific fields.

THE ROLE OF REGISTRATION RIGHTS AGAINST PROPERTY OWNERSHIP CRIME IN LEGAL SYSTEMS

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Abstract

Backround: Registration rights, which is the knowledge of stability and regulating documents, property and intellectual rights, has a crime prevention function. The aim of this paper is to analyze the role of registration rights against property ownership crime in Iran and the United Arab Emirates (UAE) in line with the United Nations (UN) relevant instruments. More precisely, the paper aims to find a cause-and-effect relationship between registration rights and their preventive effect against property ownership crimes.

Conclusion: The analysis showed that the registration process with the tools of traditional law, modern registration and the mechanism of issuing international documents using the processing of creative registration system, electronic registration and application of international conventions along with applying digital technologies such as electronic signature, fingerprint scanner, smart identity card, and biometrics authentication would probably prevent financial crimes, protect property rights, financial victims and victims of property crimes in the registration system.

Keywords: Registration rights **–** Modern registration **–** Traditional registration **–** International registration **–** Crime prevention.

Introduction

The science of registration rights has evolved as a set of laws and regulations, which govern the registration of property and intellectual property. Having a long history in the humanities, it goes back to about 4000 BC. Registration rights are sovereign rights, in the developed world, and there are various registries globally, the most important of which are the compulsory and confirmatory registration systems.

It is believed that registration safeguards their possessions and properties. The issue of the registration rights has been the focus of attention for about 100 years as addressed in many books, articles and researches. However, its preventive approach from the perspective of crim-

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inology has been less discussed within the approach of comparative study[2] in a research titled "registration crimes: causes and preventive strategies in the light of judicial measures" defined registration crimes as those that occur in the process of registering documents and properties, which are considered significant crimes in terms of the number and the effects they cause. In this respect, they require special attention of criminal policymakers.

Tavasoli (2011)[3] investigated the role of the registration organization in crime prevention. The results showed that registration rights using a combination of tradition, modern and the mechanism of issuing official documents such as creative registration system, electronic registration, and fingerprint scanner would protect property rights and victims of property crimes, and help prevent financial victims .

The purpose of this article is to analyze the role of registration rights in protecting property ownership, and comparing the two registries of Iran and the United Arab Emirates (UAE) to examine how regulations of the registration rights can prevent the occurrence of crimes. By this, the enforcement of the registration rights prevents and reduces the committing of the crime. To guarantee and stabilize property rights, the legal order of property, regulation of economic and legal relations, and accreditation of contracts can prevent criminal property offences by registering property, documents and intellectual property. Consequently, it will mitigate the number of lawsuits and create legal health in the community.

The paper consists of two parts. The first section deals with the concepts of legal and registration right, such as traditional registration, modern registration, and mechanism of issuing international documents. In the second part of the paper, the function and preventive role of registration rights from three perspectives, including prevention in the traditional registration system, prevention in the modern registration system, and mechanism of issuing international documents are evaluated according to the UN's official document for the registries of Iran and the UAE. In addition to analyzing the mentioned concepts in the two registration systems of Iran and the UAE, the similarities and differences of Iran's registration rights with the UAE and preventive functioning are discussed.

The concept of registration rights

Registration rights are a branch of domestic public law that deals with ownership and domination. The registration system is a set of laws and regulations governing the registration of property and intellectual property documents. Electronic or modern registration is a sub-category of the registration rights that the registration process uses with digital and computer tools. The registration system is primarily concerned with establishing ownership through the registration of properties and documents so as to prevent property crimes.

Traditional registration

Traditional registration is a documented manuscript register in the property register or registration office. There are two major registries in the world: compulsory registration system and confirmatory registration system

Compulsory registration means the registration process creates ownership. Registry operations transmit the ownership, where individuals' bargains or their commitments to selling is not tantamount to ownership.[4] A solicitation merely creates an obligation for the parties, not the ownership itself. This registration system is a model of Justine's laws. Part of the Iranian registration system is also subject to the creative system. For instance, article 22[5] of the Iranian registration rights expresses that the government only considers the person in whose name the property is registered as an owner.

The confirmatory registration system means that the parties consent to the transfer of ownership that creates or does not affect the transfer or registration of the ownership or the right. The registration has adopted a common and fundamental principle called the theory of public trust. Notably, they have accepted the registration rights based on the theory of public trust which means that registering property rights creates public trust. Upon registration of a right in the name of a person, the community shall believe that the registered right is the registrant asset. Individuals and the government have public confidence in this registered right. The registration rights are based on three principles for effective prevention of crime.

Preventive principles of registration rights

Registration rights are based on three important preventive principles of registration on which the existential philosophy of the registration system is based . The prophylactic approach to copyright is the prevention of crime arising from these same safeguards. The registration process guarantees and ensures registered rights for those rights holders in cases of danger and damage.

The first principle in registration rights with the preventive function is information clarification. The principle of anonymity and lack of information cause crimes. The opposite of the anonymity principle is the principle of transparency in matters; online registration of information enhances transparency to prevent crime against their property. For instance, while a document is set up in the notary office, anyone with a password and document ID can have access to the information in the document by logging into the electronic document registration system. The easy access to the property information through a registration system improves the organization of information regarding owners and their properties. Also, a crime-prevention principle includes access to information by institutions, organizations, and public and non-public organizations.[6]

Protection and security principle is the second principle in registration rights owning preventive feature. Registration rights have a form of protection and security over property rights, such as a protective curtain that covers and protects property. This protection curtain is a boundary between registered property and unregistered property, and specifies and protects the registered property. As soon as a property is registered, its nature and the owners are identified. Each property will have an identification card as well as a separate boundary from unknown properties. The identification card protects the property in unnamed conditions.

Article 14 of the Iranian Registration Act defines the concept of a protective curtain as "After the expiry of the registration period, the claim of the right to property will not be denied in the course of the registration process." In other words, if the registration of the property is not a decisive claim and is not a definite cause of ownership, there will be no benefit to it and no one will

2 Ahmadi, A. Registration Offenses: Causes and Preventive Measures (in the Light of Judicial Measures). Journal of Crime Prevention, (2008) 9, pp. 73-110.

3 Tavassoli, A. The Role of the Registration Organization in the Prevention of Crimes. Monthly Journal of Notary Public Officers and Assistants, 114, (2011): 89-109.

4 Tabatabaei Hesari, N. Principles and Effects of Real Estate Registration System. (Tehran: Joint Stock Company, 2016), 167-174.

5 Article 22 of the Registration Law " Once a property has been registered with the registrar in accordance with the law, the government will only register the person in whose name the property was registered or to whom the property was transferred, and this transfer was also registered in the real estate registry."

6 Ansari, B. Review and Criticism of the Freedom of Information Bill. Quarterly Journal of Legal Affairs, 13, (2008): 206-207.

welcome the registration.[7] The legislator has predicted laws to prevent the infringement of the rights of third parties arising from the registration rights. Advertisements subject to articles 16 to 20 of the Code of Criminal Procedure are a means of preventing crime and infringing on the right not to be harmed by the process of legal registration and to have a definitive effect.[8]

The third protective principle in registration rights is the principle of guarantee and insurance which means that registering the property leads to insuring the property and guaranteeing the proprietors' ownership rights. The registration system has two forms of guarantee and insurance, the first being that when a property or right is registered after the registration formalities, the stability and security of that right or property are guaranteed by the registration of the insurance. When a trademark is registered in the name of a specific person, this right or privilege becomes exclusive and endorsed, so others cannot abuse the right. The second is that the Registry itself is the guarantor and responder of the registration operation. For example, according to article 68 of the Property Law, "where a document has been invalidated by fault or negligence of the officeholder, the said officer must also bear all the penalties incurred in." Registration is a form of guarantee and insurance for registrant services and products that illustrates the registration approach to insurance.

The concept of preventive electronic registration in Iran and the UAE

Electronic registration, i.e., electronic documents, include a secure message database that is regulated and signed by the registrar following the regulations of the registrar, in accordance with the regulations of the central electronic data processing and recording centre and the electronic signature. Electronic documents are electrons, magnetic waves, and electricity, so they are called electronic documents.[9] Electronic documents are "a string of" information that is processed in the form of message data and is different from paper writing. Electronic documents must be filled by the electronic office. Electronic registration is the submission of regulatory data by digital means in the electronic property office or the registrar's office following new registrations by the registrar or its official and approved by the electronic signature. In the UAE, all electronic registrations, including electronic documents and registries, must be digitally recorded and stored. Article 5 UAE Property Registration rights[10] say: "If the law requires for any reason the registration and storage of registered documents and documentation, the condition shall be fulfilled and observed by the registration and storage of documents. The registration and storage of electronic documents shall be such as have been created, sent or received." Because of the removal of paper in the electronic registration, material forgery of the documents, which is carried out through writing, deleting, adding or changing the texts of documents, has been prevented. In the electronic registration, the information and document contents are stored in the database in the registration organization; therefore, physical access to the registration data is difficult, contributing to the prevention of crime. Access to the data registered in the registration system requires a password and registration code, making the forgery of a document abstruse.

7 Shahri, G. Documents and Property Registration Law (10th ed). (Tehran: AllamehTabataba'i University Jihad Publication, 2002), 131.

8 Emami, H. Description of the Law on Registration of Property and Documents. (Tehran, Kanoon Book Company, 1942), 112-113.

9 VesaliNaseh, M. Political Science Encyclopedia, Official electronic document No. 25. (2015): 63.

10 Dubai Rael Estate Legislation. Available at: https://dubailand.gov.ae/media/zrrd4qw4/en-legislation.pdf, page accessed 25.4.2021.

The concept of registration-based prevention

Prevention "is a series of non-violent measures which has aimed at preventing delinquency, reducing the likelihood of a crime, and lessening the seriousness of the crime surrounding the causes of crime."[11] Preventive measures of the registration rights are more of non-criminal action measures. Types of registration rights prevention include: 1) Prevention of community-based registration[12],[13] which is environment-oriented and education-oriented, such as public and private registration right calls subjected to articles 47 and 48 of Iran registration right regulations (Mansourian, 2016); 2)Prevention of "situational-based "registration—by creating a comprehensive system of registration of documents and property using the Cadastral system and electronic registration; 3) Prevention of "punishment-based" registration, such as registration penalty imprisonment, detachable cash penalty, and revocation of licenses in registration rights. The punishment of the registered offender probably prevents the reoccurrence of crime and the effect of intimidating punishment may make the registered offenders refuse to commit the registration crimes.[14]

Preventive function of registration rights

The preventive function of registration rights can be viewed from three perspectives : preventive in the traditional registration system, in the modern registration system and the international registration system.

Preventive function of the traditional registration rights

The preventive functions of traditional registration rights in the traditional registration system include:1) preventive function of compulsory registration of immovable property in Iran and the UAE; 2) preventive function of trademark and trade name in business deals law in Iran and UAE; 3) preventive function of intellectual property; 4) preventive functionof supervisory; 5) preventive function of judiciary; and 6) preventive function of other rights.

a) Preventive function of compulsory registration of immovable property in Iran and the UAE

Registration of immovable property transactions, according to articles 47 and 48 of the Registration Act, article 62 of the Iran Permanent Protection Act, and article 9 of the UAE Property Registration rights[15], are mandatory. The property registration system is equivalent to compulsory registration. The compulsory registration of the property is a precautionary measure, the production of disputes over immovable property. In the UAE, there is also compulsory and preventive property registration.

11 Ebrahimi, S. Preventive Criminology (vol. 1). Tehran: Mizan, (2014): 38.

12 Kinia, M. Fundamentals of Criminology (Tehran: University of Tehran, 2013)

13 Article 17 of the Emirates Basic Law says that education shall be a fundamental factor for the progress of society. It shall be compulsory in its primary stage and free of charge at all stages, within the Union. The law shall prescribe the necessary plans for the propagation and spread of education at various levels and for the eradication of illiteracy.

14 SobhiJomeh, A. L. Al-Madinah Religious Law and Trade Law in the United Arab Emirates, Al-Taba Al-Awlah Encyclopedia. Dubai: Amara Dubai 2016: 38.

15 Article 9 Law of Property registration of Emirates says "All actions that create a real estate right, transfer, change, or extinguish must be recorded in the real estate registry."

b) Preventive function of trademark and trade name in business deals law in Iran and UAE

Registration rights with registered trademarks, trademarks, and other property rights are protected by voluntary registration before these rights are infringed or cheated or abused (article 16 of Iran Commercial Law[16]). According to article 57 of the UAE Commercial Transactions Law, traders must officially designate and register a business name. The existential philosophy of trademark registration is firstly to establish the 'business identity' and secondly to prevent abuse. Regarding the name, the trademark affirmation prevents trading in business relationships with other traders from misusing trademarks, fraud, deception and fraud, and trademark owners are all victims of such crimes[17]. Business trademarks also have a preventative philosophy.[18]

c) Preventive function of intellectual property

The most virtuous subject in the world of humanity is the virtue of thought, wisdom and knowledge. The thought of survival needs to be recorded. For this reason, the World Intellectual Property Organization (WIPO) was organized in the world to protect intellectual property from the risk of disappearance and aggression by preventing action.[19] In Iran, the Industrial Property Directorate registers ownership. Intellectual property is "ownership of intellectual property in industrial, commercial, scientific, literary, and artistic fields."[20] Subjects of articles 33 and 38 of the Invention Law, such as filing, describing and mapping, and registration with the Industrial Property Directorate and publishing advertisements for intellectual property registration, constitute preventative measures against intellectual property offences, so that the intellectual property has no victim. Intellectual property rights are emphasized in the UAE's Copyright Law[21].[22] Intellectual rights under the preventive protection of national and international law are as follows: 1) the Paris Convention for the Protection of Industrial Property including patents and property rights[23]; 2) document of the Madrid Agreement concerning the International Registration of Marks (approved in 1891)—the system(international application) makes it possible to protect a mark in a large number of countries by obtaining an international registration; and 3) document of the Madrid Agreement of 1989.[24]

16 Article 16 says " In the places where the Ministry of Justice deems it appropriate and establishes a commercial registration office, all persons engaged in business activities in those places, including Iranians and foreigners, with the exception of small business, must register their names in the commercial registration office within the prescribed time. A fine of two hundred to two thousand rials will be imposed."

17 Article 57 of the UAE Commercial Transactions Law: "The commercial name of an individual merchant is composed of his name and surname, and it may include information related to the type of trade assigned to it related to the type of trade designated for it."

18 Article 71 of the Emirates Commercial Transactions Law: "Commercial transactions and data are regulated by the special laws issued in this regard."

19 Amani, T. Intellectual Property Law - National and International (Tehran: Bahnami, 2008), 24.

20 Bullock, B. Criminology, vol. 3 (translated by Ali Hossein Abrandabadi). Tehran: Majd., 2003: 33.

21 Article 111 " Intellectual rights are those that are related to something immaterial.As regards the rights of the author, the inventor, the artist, trademarks and all other intellectual rights, the provisions of the special laws shall be followed."

22 Muhammad Abu Zaid, M. M Civil Transaction Law for the United Arab Emirates, (second edition). Dubai: Amara Dubai 2013: 34.

23 Shams, A. M. Trademark and Industrial Property Rights. Tehran: Samt., 2003: 12.

24 Mir Hossein, S. H. An Introduction to Intellectual Property Rights (second edition). Tehran: Mizan, 2006: 169.

d) Preventive function of supervisory

As an observation tool, monitoring watches the probable environment of a crime, performed technically by human monitoring tools, or via visuals and comments. The monitoring performed from the top to the bottom level is called top-down monitoring, and bottom-up monitoring is carried out by reporting to top-level officials. Excellent supervision by the NRA and the Inspectorate General for the notaries and registry staff is top-down. Reports and announcements of Registrars and Heads of Office in the case of registry errors and violations regarding non-compliance with supervisory authorities are examples of bottom-up monitoring. All these linear and public reports prevent crime in the law environment. Monitoring the Inspection of Notary Offices regarding compliance with laws, regulations, and enforcement of government rights and compliance with national administrative systems has a crime prevention function in the notary environment. Reports submitted by official registrars to the appropriate location and authorities are all instances of a precautionary action being taken.[25]

e) Preventive function of registration rights through the judiciary

Judiciary means the process of judging by the justice system. In the act of judgment, the criminal justice system is held from crime and the criminal via punishment. Registration rights, like their laws and regulations, have an effective and reactive jurisprudence strategy. An action strategy like property registration prevents related crimes and conflict of interest and reactive strategies such as civil, law enforcement and criminal offences.

Under articles 22 and 68 of the Law on Notaries and the Association of Registrars and Clerks, failure to own a registry, which can cause the documentary failure, has a civil guarantee. Marriage registration without obtaining a health certificate is punishable by job detention and imprisonment. The primitive law courts and the appellate reviewers, the Registrar, and the Supreme Registry Council decide on the disputes and registration claims of parties to the registration case, and can issue an appeal. Therefore, their work is inherently judgmental, and as a result, all have judicial functions and lead to dejudicialization.[26] Registration rights have the legal potential and capacity to play a part in procedural law leading to dejudicialization.

The registration right has the delicate potential to execute all the appointments under article 217 of the Code of Criminal Procedure, except for detention, because the nature of the appointments is a form of obligation, tribunal and collateral and such documents are inherent in the notary public. There will be a 50% reduction in the judiciary cases if the laws are fully implemented because preventive law does not allow victims of financial and economic crimes to go to court as a result of the crime of victimization. As a result, dejudicialization occurs, and preventive measures are functionally implemented through the dejudicialization strategy.

Preventive function of other rights

Registration rights in the field of civil rights, in such matters as civil property transactions, such as conflicting transactions, proof of claims like official document as reason and birth certificate plays a preventive role in the authentication. For example, registries are in charge of registering and regulating all contacts and transactions that are subject to civil. Also, regulating the official transaction documents prevents the claims and disputes arising from ordinary transactions. In the field of criminal law, some crimes, such as forgery, fraud, adultery, betrayal of trust, non-transfer of property, illicit education, and similar lawsuits, have shown a preventive

25 Adabi, H. R. Criminal Responsibility of Iranian and French Official Documents Officers. Tehran: Jungle, (2010): 310.

26 Tavassoli, A. Patents for Copyright Protection. (Tehran: Justice, 2010).

role, and the registration nature has been prevented. Most conflicting transactions, for instance, result from numerous transactions and opposition to a property with ordinary documents and corporation charters. Registration rights in other jurisdictions, such as e-commerce law and registration rights, have shown a preventive function.

a) Preventive function of registration rights in commercial law

Registration rights have a preventive approach to issues such as business transactions, business registration, business tax evasion, the anonymity of business identity. The registration organization is in charge of registering companies and legal institutions, and the stock transfer of liability-limited companies is under the registries control. Business people, in legal terms, need to be identified by registering their names at the business registration office. Obtaining a code or registration number in a commercial office is required to prevent commercial crime.
Notary offices identify the legal personality when conducting business transactions for the authentication of businessmen and legal entities, before conducting the transaction by inquiring from the registration organization. Business registration office implies businessmen being businessmen, businessmen being aware of each other, business activities, tax identification and business card. Commercial registries prevent tax evasion crime too.[27]

b) Preventive function of civil rights in registration rights

The role of registration rights in crime prevention is evident in the civil rights landscape. In the case of immovable property, the registration rights shall govern the ownership of the property through the registration system. From the point of view of the registration system, only registration of immovable property in the registries creates ownership. This management is preventive and protective management of the property to counter the crime of ownership and immovable property. Registration rights prevent litigation by ordinary documents in the courts of law through the registration of the right of life, competitiveness and residency by fixed leases, and advocates the right of victims whose for-profit rights are at stake due to the lack of a formal lease.

The registration system and notary offices, in the matter of contracts and transactions and their requirements, are responsible for the formalization of contracts and transactions. The registration system gives them legal existence by signing the contracts. Their credibility and formality guarantee that they will prevent litigation and transactions in the judiciary. Registry management is part of the formalization of civil contracts, under the authority of the registry and notaries. Annually with the production of approximately 20 million official documents related to the mentioned contracts, the legal health of the society is ensured and the prevention of crime due to non-formalization of contracts and transactions is sustained.

Documents, as part of the substantiation of a lawsuit, provide an immediate and equitable process of adjudication, as one of the arguments in a lawsuit, to prove them right and prevent the infringement. In the course of the investigation and restitution, the authenticity or inaccuracy of the documents affects the final judgments of the courts[28]. Official documents are the means of proving the right to the prevention of litigation and the prevention by reducing litigation in the courts. If there were no official documents as proof of the right, victims of a property crime could not reclaim their lost right in court.

In family law, marriage litigation, divorce and termination, compulsory registration of the marriage event, registration of the leased uterus contract, are within the jurisdiction with a preventive approach. In the subject of identity documents, subject to articles 992 to 1001 of Civil law, identification shall be dealt with in the registration system. From the birth registration to the death registration, the death certificate and the inheritance certificate, human rights are in the scope of registration rights. In a clearer sense, registration accompanies humans from birth to death .

c) Preventive function of Civil Registry Authority Office

The law of Civil Registry Authority Office has a preventive approach against crime. Effects of this preventive function can be found in local laws and regulations.
Following article 12 of the registration law, the birth and death of any Iranian must be declared and registered to be identified, to combat the anonymous principle which is the origin of the crimes and to establish the population statistics. A person whose identity is not registered, his civil rights and the rights arising from his status are lost. By the registration of identity, Civil registration ensures the integrity of civil rights . "Failure to disclose birth statistics by doctors and midwives in hospitals and maternities are preventable, criminalized and punishable"[29].

Civil Registry Authority Office, in addition to issuing a birth certificate, according to article 38 of the Law, should issue an identity card to persons over 15 years of age. The identity card includes the information regarding specifics, finger print, photo, address, and blood type to facilitate preventive identification, based on Article 38 of the Civil Registration Law of Iran.
The punishment for issuing unlawful birth certificates or deaths by physicians or midwives and improper identification documents, improper identification stamps, the use of fake papers and documents, are instances of preventive punitive action.

Fingerprint registration by the Bureau of Identification in Personal Identity documents of District Registration Organization is performed to identify the defendants and prevent the recurrence of the crime.
The requirement for marriage and divorce notaries to submit marriage and divorce records to the Registry to be recorded in the Registrar's birth certificate is also a preventive action.

Preventive function of modern registration system in Iran and the UAE

The proprietary function of the registration rights in the electronic registration system in Iran and the UAE is as follows. In the modern or electronic registration system, the legal status of the property is online. The database is comprehensive and responsive to any property and property risks. The latest mortgage or detention status of the property is stored in its registry to prevent conflicting transactions. The comprehensive code of conduct and the new registration system are examples of preventive electronic registration that should be referred to for further information.

Modern registry prevents new technology approaches from conflicting transactions in notary offices and from registering two conflicting documents about one property.[30] The High Council of Prevention shall prevent the occurrence of any registry errors, register disputes and complaints in the Registry, and prevents lawsuits from litigation errors and litigation in public courts. Modern registration in court proceedings and judgments make judicial decisions more reliable and robust.[31] The single-sheet electronic document with the property ID and proprietary code or security hologram increases the security factor of the document and prevents the crime of

27 SabetSaeedi, A. Commercial Law (17th ed). (Tehran: Payame Noor University, 2005), 55.

28 Paragraph 4 of Article 272 of the Law on the Procedure of Public and Revolutionary Courts " On proving the forgery of documents and violation of the sentence."

29 Article 15 of the Civil Registration Law of Iran.

30 Ghaderpour, F. The Effects of the Implementation of the Cadastre Plan on the Legal Relations of Individuals. Kanoon, 107, (2010): 26-35.

31 Barani, M. Prevention of Global Crime of International Commitment of Governments (Tehran: Mizan, 2014).

document forgery. In all the above cases, the electronic registration tries not to have victims with the electronic registration mechanism of property rights.

Electronic registration is also prevalent in UAE registration rights, and plays a preventive role in crime.[32] Article 8 of UAE Property Registration Rights[33] says that documents written or registered shall be electronic or handwritten in the Registry stating the property's status and the rights conferred thereto (to be filed as proof for ownership of the lawsuits in the courts). For example, when an owner dies in the UAE, the deceased will be registered at the property office[34] to avoid damaging inheritance rights. In the event of an inheritance dispute, it prevents the production of claims arising out of an inheritance. The electronic signature certificate also has a preventative function.

In the instant registration system in the registration agency, an electronic office designated as the Certified Electronic Signature Office is registered by article 13 of the Implementing Code of Prohibition, the electronic signature or fingerprint of the system, and the unique order number assigned by the electronic registration system. Obtaining a fingerprint scanner by scanning a person's signature in an electronic system eliminates the possibility of crime of forging and cheating the signer so that property rights do not fall victims to the crime of forgery and fraud, hence preventing the crime of forging a signature. The Office of the Register of Legal Entities also has a preventive function. The Central Registering Agency designed the e-office to have the legal entity electronically registered in that office to be used online to authenticate legal entities. Operations of legal entities from the corporation's establishment to the modification, dissolution and servicing of corporations electronically at those offices prevent legal persons from conducting state-of-the-art crime prevention prevents the violation of financial and property rights, legal entities and protects the rights of companies. In the UAE, as well, legal entities are personally registered as electronic. According to article 32 of UAE Federal Law no. 8,[35] eight types of companies are registered in electronic registries. In the United Arab Emirates, in addition to registering a business, it has to be registered electronically. The intellectual property electronic bureau which is for the electronic registration of intellectual property of individuals provides a preventive function. These offices have four characteristics of authenticity, integrity, credibility and undeniability to be recognized.[36] An electronic signature is another preventive tool in modern patent law. The electronic signature is an electronic form that is enclosed to the data to identify the signer of the message data and to show acceptance of the information contained therein.

32 Mustafa Ahmed, A. O. Al-Mojiz fi Systemat al-Sajal al-Awqari, al-Huquqiyyah al-Khwabiyah charters, al-Taba al-Awli. Beirut: al-Luban 2010.

33 Article 8 of the law on property registration: "The documents of the real estate registry registered electronically on the computer shall have validity in the proof of the original documents."

34 Article 11 Law Establishing Property Emirates (1) "The notification of inheritance shall be recorded in the real estate registry if the estate includes real estate rights, and the actions of any inheritance in any right of the rights aim shall not be taken into consideration, or their effect shall apply to others by registering them in the real estate registry."

35 Dubai Real Estate Legislation. Available at: https://dubailand.gov.ae/media/zrrd4qw4/en-legislation.pdf accessed April 25, 2021,

36 Bullock, B. Criminology, vol. 3 (translated by Ali Hossein Abrandabadi). Tehran: Majd. 2003.

In the UAE registration rights are also electronic signatures such as letters, digits, secret, voice and the like. Article 8 of The UAE's E-Commerce Act states that if the law requires a signature to exist for a document or text to result in certain signatures, the electronic signature subject to article 18[37] of the Act which contains those conditions is to be trusted. Punishment prevention is for registering as a registered prisoner of punishment, disbursement cash penalty, and revocation of license in the register.[38]

An electronic signature is a letter, a digit, a pass code, a sound, a mark, or a form, written in such a way that the signature holder permits that signature, other than his signature, in the manner specified in the Code of Trade and Electronics Trade Law to be recognizable.[39] Sometimes digital signatures are biometric based such as fingerprints or iris networks whose biological information is already stored. An electronic signature, sometimes a digital signature via cryptographic technology, holds the signature with both proprietary and monopolized public keys owned by the signatory.[40]

The process of filing electronic documents, in Iran and UAE, is finalized and registered in the offices through electronic signatures. An electronic signature is authentication and security of copyright, a means of preventing the statutory and mechanical crime of forgery. A national smart card is another crime prevention tool. When people place their smart card on the card reader to authenticate and place their fingerprints on a fingerprint sensor or scanner device, the device compares the fingerprint in the fingerprint embedded scanner on the smart card and detects if the fingerprint is the same as the embedded smart card fingerprint. With this matching, authentication is achieved and prevents the victimization of people's identities, and predictive action is taken in the field of identity crimes. National smart cards cover passports, certificates, electronic payment cards, insurance cards, elections, subsidies and other utilities. Electronic passports, such as national ID cards, are tools for the technical prevention of impersonation.[41] The UAE also has a national smart card for authentication and digital signature and biometric identification, health, e-stocks, driver's license, passport and family booklet, bank and business card, and subway. It is also a biometrics tool for crime prevention. Biometrics is a measure of the bio-behaviour of individuals.

Like fingerprints, iris scans, retinal scans, hand geometry scans, palm vein scans, and facial recognition, this biometrics information may not be altered, because it is inherent in the body's natural properties, hence not deceptive and passive. Biometric authentication is the direct cause of preventing the forgery and theft of another identity. In the electronic registration process, biometrics has a positive role in crime prevention to prevent fraud. No other smart card can be easily misused to regulate electronic documents because each person

37 Article 18 "If the law stipulates the presence of a signature on a document or stipulates the arrangement of certain results on the signature, the electronic signature on which it relies within the meaning of this law fulfills that condition."

38 Sobhi Jomeh, A. L. Al-Madinah Religious Law and Trade Law in the United Arab Emirates, Al-Taba Al-Awlah Encyclopedia. Dubai: Amara Dubai 2016.

39 Electronic signature: The signature of the component of letters, numbers, symbols, or a processed voice in an electronic form and an appendix or logically linked to an electronic message with the intention of documenting or approving that message.

40 Feizi, C., Gholam. N. Legal Validity of Electronic Reason and Signatures, Journal of Law and Policy Research, 30, (2010): 175-204.

41 Khanalipour, S. Technical Crime Prevention (first edition). Tehran: Mizan, 2011.

has unique physiological characteristics. As a result, regulating electronic documents with biometric authentication prevents identity crimes. Victimizing the identity of victims is a crime of forgery.

Preventive function of international registration system with international documents

Official international documents are regulated and registered by law enforcement agencies and international organizations and are subject to international law. All agreements under articles 77, 125, 152 and 153 of the Law Essentials regulated by competent government officials, such as United Nations (UN) resolutions and resolutions, the Security Council, political and economic commissions such as the Economic Council, Palermo, etc., are defined as official international documents and, as official documents, are part of the copyright.

Registration rights need to play a role in the global arena because international official documents have a global function in creating a global legal order. International documents contribute to international stability and security. One of the international crime prevention solutions is the use of international official documents. International official documents have different types that play the role of preventive tools.

Types of international official documents with preventive function

There are different international official documents that have a crime prevention approach. Different types of international documents with preventive function are:1) Economic and Social Council Resolution, No. 1/1992 of February 6, 1992;[42] 2) Cooperation Agreement between the United Nations and the International Criminal Police Organization (Interpol) by 8 July 1997;[43] and 3) the United Nations Convention against Transnational Organized Crimeand the Protocols Thereto by 15 November 2000 (Palermo Convention). [44]

Resolution of the United Nations Economic and Social Council no. 1/1992 adopted by the United Nations Economic and Social Council is an official international document addressing the prevention of national, transnational, organized crime, economic crime, especially money laundering, illicit proceeds of crime and human rights. The main source of prevention, at the United Nations, is the Crime Prevention Commission. There is a cause-and-effect relationship between the prevention of official crimes and the implementation of official international documents. The spread of international corruption offences is due to non-compliance with international conventions such as the Palermo Convention, known as the anti-corruption convention. International documents are highly pathological both in terms of recognition and because they are the product of the collective wisdom of the world's legislators. Therefore, their implementation protects the right of the world and prevents global victimization of international organized crime. For example, one of the reasons for prompting corruption in the Iranian economy is lack of implementation of the Palermo Convention and the law against corruption and money laundering.

Interpol Agreement with the United Nations includes crimes of the origin of money laundering, formal or unlawful transactions with the property. Property transactions are made through documents in the field of registration notaries. As a result, the crime of money laundering originates in the official document and registration area, and notaries publicly prevent such offences by

42 Establishment of the Commission on Crime Prevention and Criminal Justice, accessed May 15, 2021, https://www.unodc.org/documents/commissions/CCPCJ/ECOSOC_Resolution-1992-1_E.pdf

43 Cooperation Agreement between the United Nations and the International Criminal Police Organziation INTERPOL. accessed May 15, 2020. https://www.interpol.int/content/download/10898/file/Agreement%20UN%201997.pdf

44 Available at: https://www.unodc.org/unodc/en/organized-crime/intro/UNTOC.html accessed May 15, 2021

reporting suspicious transactions in line with governments' commitment to the United Nations. The development of illegitimate and corrupt transactions is due to the lack of reporting of such transactions by the relevant authorities and the lack of a legal monitoring network on suspicious transactions. The Interpol Agreement of July 8, 1997 is an official document for cooperation with the United Nations to combat and prevent money laundering.

Palermo Convention is a document with a preventive nature against financial crime and corruption. Under article 9 of the Palermo Convention, governments are committed to preventing crime and corruption. According to the Palermo Official Document, governments are committed to establishing a comprehensive system of monitor and control over non-financial organizations like legal entities such as the office of documents and properties and notaries. This system focuses on identifying owners, maintaining records, and reporting suspicious transactions. The monitoring system focuses on identifying owners, keeping records, and reporting suspicious transactions to prevent developing victims of money laundering offences and destroying owners' legitimate assets. Such a monitor is quite clear in article 14 of the Merida Convention,[45] and the government is actively preventing crime from occurring worldwide.[46]

Types of active prevention with international documents

United Nation official documents contain many examples that have an active preventive function against crime. According to the 2002 United Nations Guidelines for the Prevention of Crime,[47] the following types of United Nations guidelines for the prevention of crime are: 1) prevention through social development or social prevention; 2) situational crime prevention; and 3) active prevention of repeated crime.

Legal and regulatory awareness of the community to become familiar with property and property rights, and awareness of the negative effects of non-registration of property and property rights that endanger property security are social development practices that lead to social prevention. The UN Guidelines (Merida)[48] about Crime Prevention is a prominent example of the social prevention of developed mentalism. Article 25 of this guideline addresses the cause and targeting of crime risk factors and recommends that crime risk factors should be identified and responded based on the following guidelines. UN preventive social action strategies include: 1) promoting supportive factors through comprehensive programs with socio-economic development such as the establishment of legal health by the Registry, promoting the Registry of Registrants and Registry Managers, and 2) applying educational solutions, such as raising community awareness of legal documents registration, property and rights symbolize public awareness and a high level of community education.

45 United Nations Convection against Corruption, accessed May 15, 2021, https://www.unodc.org/documents/brussels/UN_Convention_Against_Corruption.pdf

46 Barani, M. Prevention of Global Crime of International Commitment of Governments (Tehran: Mizan, 2014), 131.

47 United Nations Economic and Social Council resolution 2002/13, United Nations Guidelines for the Prevention of Crime, accessed May 15, 2021, https://www.unodc.org/pdf/criminal_justice/UN_standards_and_norms_in_crime_prevention_at_your_fingertips.pdf

48 United Nations Standard and Norms in Crime Prevention, accessed May 15, 2021, https://www.unodc.org/pdf/criminal_justice/UN_standards_and_norms_in_crime_prevention_at_your_fingertips.pdf

Situational crime prevention is a knowledge of reducing criminal opportunity.[49] Article 26, Resolution 13/2003 of the United Nations[50] deals with the practical prevention of situation-centred action. The resolution recommends that governments and civil society take precautionary measures. Some of these recommendations include: 1) appropriate methods of surveillance that are sensitive to the right to privacy, e.g. enabling inspectors, supervisors, CRAs, temporary or continuous inspections of the CRA, registry of marriage and divorces, asset inspection for tax evasion and so on; and 2) crime targeting, such as electronic fingerprinting instead of traditional fingerprinting, online registration instead of traditional paper-based registration, replacement of the electronic real estate office with the real estate office to avoid the risk of destruction and loss of handwriting offices.

Active prevention of repeated crime for groups at risk is called secondary prevention.[51] This type of prevention is risk-based or offender-centred. Paragraph 6 (d) of the UN Prevention Guidelines applies to this type of prevention. The UN Economic and Social Council, in paragraph 3 of Resolution 9/1995, makes the following recommendations for this type of prevention: 1) Improving police intervention techniques, and 2) improving judicial intervention procedures and submitting alternatives.

Ineffective Electronic Crime Police, Feta police, Electronic Filing in the Field of Documents and Notaries, Prevention of Spoofing and Registry Information, and Hacking of the Property Registration Agency Site are examples of the United Nations situational crime prevention of the registration rights against the occurrence and repetition of a crime.[52]

Judicial intervention, immediate suspension of official officers upon prosecution, and deliberate indictment subject to article 13 of the notary law manifest effective judicial intervention and remedies. Judicial intervention and a suspended sentence prevent the criminal from further occurrence , and the criminal will not have the opportunity to repeat the crime. The six-month suspension, ordered by the registrar's office prescribed in article 43 of the notary law, is yet another manifestation of preventive judicial intervention to prevent commercial criminal offences from being registered and to reduce the amount of criminal damage.

Active prevention of the notaries in the Palermo Convention

Active prevention of the notaries is a type of macroeconomic, cultural, policy, and environmental prevention that emphasizes the well-being and improvement of life. By Article 31.2 of the Palermo Convention, states undertake to promote the development of rules and procedures designed to coordinate public and private bodies such as lawyers, chief executives, tax advisers and accountants. The ideals of the registration system and notaries are setting legal regulation of documents and transactions domestic law, and compliance with international standards for the prevention of organized crime such as cybercrime, corruption, international fraud, money laundering, corruption, internet corruption and online crime. Registration rights by regulating the transfer of property, the transparency of transactions, the registration of property during a legal process, the compulsory registration of contracts and transactions, the clarification of the subject Article 22 of the Registration Act, the principle of secrecy, the principle of guarantee or insurance, and the theory of public trustcan prevent organized crime such as money laundering, bribery and corruption, international fraud, land grabbing, economic corruption and cybercrime. Article 31 of the Palermo Convention considers them as preventive agents of economic crime. The notaries can prevent money laundering, illegal transaction, and tax evasion by arranging official transactions documents and contracts.

Active prevention of human rights violations with international documents

Human rights have three generations, the first of which is political and civil rights and freedoms. The second generation is economic, social and cultural rights and the third generation is collective rights, such as the right to peace and the right to a healthy environment.[53]
Second-generation rights are economic rights as linked to the registration right, such as economic rights, property rights, housing rights, property rights and private ownership. They are the same rights as stipulated in the 1996 Economic and Social Council. This international document, together with the document of the 1948 Universal Declaration of Human Rights and the 1996 International Covenant on Civil and Political Rights, are visible human rights documents. Registration rights, in the domain of property, come with the help of second-generation human rights and economic rights, and guarantee the security of those rights.[54] Consequently, registration rights have a protective role in human rights with a preventive approach. One type of human rights is the ownership right on the property. Occupying the movable and immovable properties is equivalent to occupying the proprietary rights. Registration rights via registration process issue the official documents for movable and immovable properties from registration organization of documents and lands and official registries. Therefore, these properties are recorded to be prevented from the illegal seizure of aggressors. As a result, registration rights support the ownership right as a human right by registering the individuals' ownership of their property and assets to ultimately prevent the trespass of proprietary rights. Regarding housing, in the implementation of registration rights, the registration organization issues cadastral ownership documents for individuals' residential and commercial places in order to establish the right of individuals' housing, and to protect them from encroachment. To defend the housing right is the official document supporting the housing right in a property dispute. With reference to vehicles, notaries approve the ownership right by drawing up a title deed, and conducting official transactions of individuals' vehicles to protect these personal rights from encroachment. Regarding peace and security, based on international resolutions and treaties regulated by international organizations and authorities, aggressors are convicted in the case of crime and violation of security and peace right as provisioned by international resolutions in the UN Security Council. Therefore, the issuance of official international documents would prevent relevant crimes. People right, including territorial ownership of nations and the world's security and peace, are at stake if there are no official international documents of the UN. As a result, official international documents are a means to defend human rights. Lasting peace and world security depend on the implementation of such official international documents entrusted by

49 Sardarnia, K., Salari Shahr Babaki, M. M. Reappraisal of Prevention of Crimes in Iran with Emphasis on Systemic Theory in Political Sciences. Quarterly Journal of Criminal Law Research, 27, (2018): 43-74. doi: 10.22054 / jclr.2018.20031.1374

50 United Nations Standard and Norms in Crime Prevention, accessed May 15, 2021, https://www.unodc.org/pdf/criminal_justice/UN_standards_and_norms_in_crime_prevention_at_your_fingertips.pdf

51 Sardarnia, K., Salari Shahr Babaki, M. M. (2018) Reappraisal of Prevention of Crimes in Iran with Emphasis on Systemic Theory in Political Sciences. Quarterly Journal of Criminal Law Research, 27, (2018): 43-74. doi: 10.22054 / jclr.2018.20031.1374

52 Akhshabi, F Police Interaction with Public Participation in Crime Prevention. 2nd international conference on Modern Research in Management and industrial engineering (Tehran, Iran, 2016).

53 Seyed Fatemi, S. M. Q. Human Rights in the Contemporary World: An Introduction to Theoretical Issues. (Tehran: Shahid Beheshti University, 2003).

54 Tavassolizadeh, T. Economic Crime Prevention (first ed.). Tehran: Jungle, 2013.

registration rights. Humanity is indebted to registration rights and a peaceful world is possible under the guise of registration rights. In other words, human rights also need registration rights in terms of creation and implementation.

Conclusion

Results show that there is a cause–and–effect relationship between the science of registration rights, prevention of economic crimes, property ownership and material-intellectual rights. Thus, the use of registration law and regulations, electronic registration technologies, digital tools such as electronic signature, national smart identification cards, and biometric authentication can prevent financial and property crimes, protect ownership rights and also support financial victims and victims of property crimes.

Registration rights are in the form of the compulsory registration system and confirmatory registration system. According to the compulsory registration, the registration of contracts and transactions guarantees and stabilizes property rights. Registration rights have a preventive function from the three perspectives of traditional registration, modern registration, and international registration. The global prevention of crime with international function has been a recommendation of the UN to conventions such as the Palermo Convention. Registration right is based on the preventive principles of crime and can prevent crime in its nature. In addition to the legal regulation function of documents, the property and ownership rights, the registration right has a preventive function against crime, especially soft crimes in the national and transnational spheres. One type of human rights is the ownership right on the property. Occupying the movable and immovable properties is tantamount to occupying the ownership rights. Registration rights via registration process issue the official documents for movable and immovable properties from registration organization of documents and lands and official registries, therefore these properties are recorded to be prevented from the illegal seizure of aggressors. As a result, registration right supports the ownership right as a human right by registering the individuals' ownership of their property and assets. Also, peace and security are ensured through international resolutions and treaties that prevent crime and violation of security and peace right by the laws stipulated and endorsed by international bodies such as UN Security Council, and offenders are convicted. Therefore, the issuance of official international documents would certainly protect humans' security and peace against crime. Human rights, including the territorial ownership of nations, and the security and peace of the world may not be sustained without official international documents of the United Nations. As a result, official international documents are a means to defend human rights. Lasting peace and world security depend on the implementation of such official international documents entrusted by registration rights. Humanity is therefore indebted to the registration rights and a peaceful world is possible under the guise of registration rights. On the registration rights, they function as the judiciary such as the enforcement of registrations, law registrations, law courts and registry monitor commission. Both Iran and the United Arab Emirates Registration System have common rules and principles of crime prevention from the three angles of traditional registration, electronic registration, and international registration. Both registries are transitioning from traditional to modern. The concept of proprietary registration prevention and its various forms such as active, social, and technology-oriented with preventive function are observed in the two countries' registries.

Author Contributions

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

Conflict of interest

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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TYPOLOGY OF THE BAILS IN CRIMINAL JUVENILE JUSTICE SYSTEM IN IRAN

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Abstract

Backround: Bails are of high importance in the process of legal procedure. They are issued in preliminary interrogations in order to protect social order and the rights of victims and despite the innocence presumption. They serve even a more significant role in juvenile justice proceedings considering sensitive and should follow principles of proportionality and extending alternative measure of detention.

Although Criminal Procedure Code 2013 of Iran has proportioned and developed the bails with respect to age factor, there are still some deficiencies. For instance, order of submission to the parent or other legal caretaker and his obligation to present him before judicial authority in required times as an alternative to temporary detention, lacks objective sanction. In spite of criminal procedure of adult, which counts alternatives of detention in 9 titles as bail and 2 titles of judicial monitoring, in criminal procedure of juveniles the titles reach out no more than 3.

Conclusion: Temporary detention order in juvenile justice has the same consequences as for the adult. Notwithstanding, its issuance should've had stricter conditions regarding the principle of its exceptional nature and being applied only as the last resort and for the shortest period of time according to international documents on children's rights.

Keywords: Juvenile justice system in Iran **–** Detention of juveniles **–** Proportionality principle**–** Custody.

Introduction

Differential adjudication on juvenile crimes is of greatly high importance in all stages of legal procedure. Juveniles are yet to be reached the precise perception of the society and the surrounding events and in most cases are unable to scrutinize the outcomes of their actions. That's why in procedural systems, they should not be regarded as adults or they will end up inclining even more toward delinquency and giving up rehabilitation.[56]

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56 Halvai, Farshad. "Siasate Keifari Efteraghi Iran dar rabete ba Ghararhaye Tamine Keifari Atfal va Nojavanan", (1398): 8, Master degree diss., University of Allameh Tabataba'i

One of the significant features of differential adjudication on juvenile crimes deals with bails, especially since according to the recommendations of international documents on the rights of the child temporary detention, which is the toughest bail, shall only be imposed in serious crimes as a measure of last resort and for the shortest appropriate period of time (Article 38 of the Convention on the Rights of the Child)[57]. International documents recommend a wide variety of alternatives of detention so that the child or adolescent would not be alienated from family or the society. This feature is to be reflected in statutory of the member states (Article 13 of United Nations Standard Minimum Rules for the Administration of Juvenile Justice or the so called "The Beijing Rules" enacted in 1985).

Bail, in the widest meaning, is an order made by judicial authority during legal proceeding which enables presence of the accused till end of adjudication and enforcement of the verdict. According to article 217 of Criminal Procedure Act of Iran (CPC 2013), bail is issued by interrogator after arraignment and required investigation in order to guarantee accessibility to the accused and his punctual presence, prevention of his evasion or concealment and the rights of victim on restitution.

There have been three main laws on bail concerning juveniles in Iranian regulations; the first is "Act on Establishment of Criminal Juvenile Court, enacted in 19th November 1959, which will from now on be called by its abbreviation AECJC. This act brought some innovations on substantive and procedure law regarding juveniles, such as differentiated policy on juvenile justice in bails.

Criminal juvenile courts were dissolved according to decision as unified judicial precedent[58] number 6 issued in 13th May 1985. Nonetheless, after enactment of Criminal Procedure Code in criminal matters in 1999 (CPC 1999), the legislator revived differential procedure of juvenile delinquency in 5th section, 2nd title in articles 219-231 with the topic "procedure of adjudication to juvenile criminal offences". One of the features of the act related to bail writs. Eventually, in 2013 the new Criminal Procedure Code (CPC 2013) dealt with the juvenile justice in several articles and the whole chapter 9 of 2nd title is dedicated to bails on juveniles' criminal offences in detail.

It is to be mentioned that the aforementioned codes consider different age rages. Indeed, according to regulations before the Islamic Revolution of 1979 every person bellow the age of 18 was considered juvenile. Thus in AECJC the scope of support and differential legal procedure encompassed every adolescent under 18. However, in CPC 1999 even though the legislator mentioned "child", it did not provide a definition of it and according to the Penal Code enacted in 1992 (now repealed), the term child indicated to religious puberty which included girls under the age of 9 lunar years old[59] and boys under the age of 15 lunar years old. According to note of the article 220 of CPC 1999 the criminal offences of all persons bellow 18 were also adjudicated in

57 It is to be mentioned that according to the Act of "Allowance of Accession of Islamic Republic of Iran to the Convention on the rights of child" enacted in March of 1995 Iran has accessed to the convention on condition of non-contradiction with Islamic rules and statutory regulations.

58 Decision as unified judicial precedent is taken by the Supreme Court in cases that there is inconsistency in interpretations of courts from same articles leading to contradictory decisions. This decision is obligatory for all courts and is regulated by article 471 CPC 2013.

59 A lunar year is shorter than a solar year and has 254 days. In countries in which lunar calendar is used, lunar age of subjects are accounted for. In Iran, according to Article 17 of the Constitution, both solar and lunar calendars are valid.

juvenile court according to regular rules of adults. Hence, every girl above 9 or boy above 15 lunar years old was considered as an adult and lacked any privilege in juvenile justice proceeding. In CPC 2015, the legislator differentiated between children and teenagers regarding various stages of criminal procedure, including bails. The act provided different bails for children and teenagers. This essay will focus on typology of these bails in juvenile justice system in Iran.

The main question to be answered is whether or not the provided typology in the current code conforms to the interest of the juvenile regarding developing alternative measures of detention in correctional center. The presumption is that the provided bails for juveniles do have some deficiencies and in some matters ignore the interest of juvenile regarding his age and personality.

A) The principles of bails in juvenile justice

Before dealing with the bails which are specifically provided for the juvenile, it is better to scrutinize some of general principles of bails regardless of the age. In this section principles of proportionality and necessity of expanding alternative measures of detention are examined.

1. *Proportionality*

Issuance of bail is one of the most crucial actions taken by legal authority in criminal proceeding and specifically in preliminary interrogations. One principle that should be considered in this stage is proportionality which will limit judiciary's power. According to this principle the legal authority is bound to consider severity of the crime, age, personality and mental state of the offender in issuing bail. When confronted with an adolescent, great attention should be granted to the personality of the delinquent and all of the decisions, including bails, shall consider the best interests of the child (which is also mentioned in article 3 of the Convention on the Rights of the Child). If the bail does not accord severity of the crime and age and personality of the child and thus results in his confinement or restricting his rights, the principle of proportionality and its goal is violated.

International documents in the field of children rights contain significant indications to this principle. Article 5.1 of The Beijing Rules provides:" The juvenile justice system shall emphasize the well-being of the juvenile and shall ensure that any reaction to juvenile offenders shall always be in proportion to the circumstances of both the offenders and the offence."

In Iranian codes, article 250 of CPC 2013 clarifies the proportionality principle in bails in general and though it does not explicitly remark juveniles, undoubtedly includes them as well. This article provides: "Bails and monitoring judiciary orders shall be just and reasonable and issued according to type and severity of the crime and punishment, evidence, probability of evasion or concealment and spoliation of the evidence, records of the accused, his mental and physical state, age, gender and reputation." As clear as it can be, age is one of factors that shall be considered by judicial authority. The note of the same article depicts the importance of considering proportionality as it provides: "Issuance of disproportionate bail will result in disciplinary conviction of 4th level or more"[60]

60 According to Article 13 of The Act of supervising judges' attitude, enacted in 2013, this penalty include a range of punishment ranging from reduction of salary to permanent dismissal from judicial service.

One of the other aspects of differential procedure in issuance of bails in juvenile criminal justice can be found in the lack of efficiency of criminal record as a factor in issuing bails. Although in issuance of bails for adult offender, the criminal or non-criminal record of the offender is to be considered, for the juvenile according to article 95 of Penal Code 2013, convictions of juvenile does not have any criminal effect. Therefore, judicial authority cannot include his conviction record as a basis for aggravating the bail and doing so would be an obvious violation of proportionality in juvenile justice.

Hence, proportionality should be considered in order to personalize bails according to each juvenile offender's unique personality. In order to gain such aim, personality document, which in juvenile justice proceeding is obligatory in a wide variety of offences with comparison to adults, would be helpful.[61] In these document opinions of experts including psychologists, psychiatrists and social workers on different dimensions of personality of the juvenile are gathered. As a result, it would facilitate personalizing of bails.

2. *The principle of expanding alternative measures of detention*

Freedom is a well-based initial right for everyone. Hence, policy makers should make it an exception to deprive somebody of such obvious right. As a result, in the domain of criminal policy only a few crimes may lead to detention of the perpetrator (Rahimi Nejad, 1387, 217). This principle is of more importance in juvenile justice in correctional centers. As research have demonstrated detention in such centers, either as bail or as sentence is not effective in rehabilitation. For instance, in a field research on the rate of recidivism by juveniles who were domiciled in correctional centers, it was found that one third of these detained juveniles commit recidivism. Such high rate would prove the inefficiency of correctional centers in socializing juveniles. Also in interviews with juvenile recidivists (both girls and boys) it was found that despite the endeavor of the center in raising various educating and training programs, the center has ended up becoming a lodge for detaining non-law abiding juveniles, without success in rehabilitating them.[62] Therefore, a crucial rule, which is to be considered by policy makers, is to avoid sending non-law abiding juveniles out to correctional centers.

Also in article 13.1 of The Beijing Rules, detention is considered as a measure of last resort and for the shortest possible period of time. Paragraph 2 of the same article remarks the necessity of resorting to other alternative measures such as close supervision, intensive care or placement with a family or in an educational setting or home.

In pursuit of brief introduction of necessity of applying alternatives of detention in juvenile justice system, we will now look at the quality of practicing it in regulations of Iran in chronological order.

The initial use of specific bails for juveniles was in articles 19 and 20 of the AECJC, enacted in 1959. Article 19 provided: "The court may order to submit the child to correctional center during

61 According to article 203 of CPC 2013 composition of personality document is obligatory in serious crimes, including every Ta'zir of 4th degree or higher (with more than 5 years imprisonment). However, for the juveniles according to article 286, even when the charge is Ta'zir of 6th degree or higher (with at least 6 months of imprisonment) composition of personality document is obligatory.

62 Danesh Payeh, Leila. "Tasire Tarbiati Kanoone Eslah va Tarbiat dar Bazparvari Koodakan va Nojavanane Moareze ba Ghanoon", (1393): 6, Master degree diss., University of Allameh Tabataba'i

preliminary interrogations or submit him/her to the parent or other legal caretaker provided that they bring him/her to the court whenever it is necessary and if not, pay the financial deposit." In this article the discretion of court in ordering detention in every criminal offence, without objective and precise criteria contradicted the principle of minimal employment of detention for juveniles, as it was totally based on intuition of the judge and was highly arbitrary. According to article 20 of the same code, detention was also obligatory for serious crimes which would have been sentenced by execution or life imprisonment. Therefore, in precedent legal system of Iran detention for juvenile offenders was categorized into optional (article 19) and obligatory (article 20) detention orders whereas provision of obligatory detention for juvenile is against the principles of juvenile justice system.

In CPC 1999 according to article 224, it was supposed that the initial principle in juvenile bails was the requirement of detaining them, since the article provided "if in process of preliminary interrogations the detention of the child would not be necessary, one of the bails would be issued". The note had somehow modified the principle by scripting that detention would be necessary regarding the severity of the crime and prevention of conspiracy in order to conduct interrogations. This note had reversed the false principle remarked in the article. It also it did not provide any obligatory detention order, which was a better approach comparing to the precedent code. Nonetheless, the term "necessary" was ambiguous and might have been interpreted widely by judicial authority. Thus the same deficiency as article 19 of the AECJC was still there. In addition, CPC 1999 did not provide any restriction about the age of detainee, whereas in AECJC, detainment could be ordered about juveniles between 6 and 18 years old either in optional (article 19) or obligatory (article 20) form. Thus, according to note of article 220 and note 1 of article 224 of CPC 1999, detention was plausible even about girls under the lunar age of 9 and boys under lunar age of 15. Obviously this provision did not accord common sense and social facts.

Therefore the deficiencies of the acts prior to CPC 2013 can be summarized as follow:

1. Provision of obligatory detention in AECJC 1959;

2. Lack of distinction on bails regarding the age of the juvenile; and

3. Lack of provision of several alternative measures of detention.

CPC 2013 resolved the first two listed flaws; According to note of article 237, obligatory detention in adult and juvenile proceedings is omitted. Besides, different bails are provided for juveniles under the age of 15 and those between 15 and 18 and children under the age 9 are excluded from bails in Ta'zir[63] punishments (which includes the majority of the punishments in penal codes). Notwithstanding, the 3rd defect is still there, as in the current procedure system various alternative measures of detention are not provided.

Also, in Iranian criminal system (unlike French system) the judge is not obligated to ratiocinate his decision on deficiency of alternative measures in accessing to juvenile prior to issuance of

63 In Islamic Law Ta'zir refers to crimes and also punishment in which the judge has discretion in sentencing the offender, unlike Hadd and Qisas. It contains most titles of criminal offences. In Iranian criminal system, the judge will sentence offender according to the punishment remarked in criminal codes and has discernment between minimum and maximum of the punishment. Ta'zir is mostly regulated by "The Act of Ta'zirat" enacted in 1996 (still in force).

detention order.[64] This approach, not only irremissible in juvenile criminal procedure, but also in adult's one, might have been adopted by Iranian legislator.

B. Alternative measures of detention

Bails in juvenile criminal procedure can be divided to detention and its alternatives. As the latter group plays an important role in criminal procedure law and shall be considered as the first solution, we will briefly overview these alternatives according to CPC 2013

1. *Order of submission to the parent or other legal caretaker and his obligation to present the juvenile before judicial authority*

Successful experiment of countries such New Zealand in family and local group gatherings in juvenile procedures manifests that the process of resocialization of juvenile is best achieved when the protection by family or local society is attracted (Zehr, 1386, 91). We are of the opinion that the significance of this bail should be considered not only by the legislator, but also by judicial authorities, as family and local bounds in Iranian society are much stronger than in so many other places in the world and thus the outcomes would be appropriate and tangible. So, we might be able to claim that this order is the most suitable of all.

Following the nature and warrant of this order will be examined.

1.1 *Nature of the order:* Nature of this order in adult criminal procedures is a sort of moral commitment or financial obligation which bounds the accused to present himself in interrogation, trial and sentencing.

This bail in both criminal procedure regulations of 1959 and 1999 was accompanied by an obligation of payment, but according to article 287 of the current CPC is now a mere moral obligation.

The financial nature of this order in CPC 1999 was obvious to all juristic scholars. Some scholars[65] maintained that the subsequent financial order would be bail bound. This is despite the fact that if parent, legal care taker or third party would not accept to be bound, the accused would not be detained (unlike for the adult accused). Therefore, Nature of this order is not the same as the bail bound order and that's why in CPC 2013 it was mentioned separately from that, notwithstanding it may be considered as bail bound in its warrant.

According to article 19 of AECJC 1959, submission of child was merely plausible to the parent or legal care taker. This provision was seriously flawed in one aspect; if the parent or legal care taker lacked the required capacity or refused to receive the child or were inaccessible or the child did not have parent or legal care taker, he had to be sent to correctional center.

Also the deficiency of article 234.1 of CPC 1999 was that it did not set any priority for the parent or legal care taker which is obviously nonsense, since as a rule, juvenile should not be

64 This obligation is provided in articles 137, 143 and 144 of Criminal Procedure Code of France and is also emphasized in Armed Forces Criminal Procedure Code of this country.

65 Niaz pour, Amir Hossein. Hoghooghe Keifari Koodakan va Nojavanan 2nd ed. (Teheran : Mizan, 1396), 45

separated from qualified family and involvement of third parties will be required only in cases of inaccessibility, non-existence or incompetence of the parent.

However, compared with the acts of 1959 and 1999, 2013 act provided several qualified persons to which the delinquent juvenile might be submitted. This includes every natural or legal person that the judicial authority recognized to be competent in cases of non-presence of the parent. Also the flaw of CPC 1999 is amended as the family has priority in receiving the child. Likewise, the remarked legal person might be a governmental department, such welfare or a non-governmental organization, like the NGOs mentioned in article 66. Still, the non-provision of submitting the child to other persons rather than parent in cases of incompetence of the parent might be due to negligence of the Code-Writers.[66] Since not only incompetence of the parent increases the physical and mental risks to the child, but also the probability of his/her inaccessibility for judicial authorities.

1-2 The warrant: the warrant of order of submission to the parent or other legal caretaker and his obligation to present the juvenile before judicial authority is seizure of the financial deposit (Article 230) and if it was ordered merely on basis of moral obligation, it lacks warrant.

Comparing financial deposit in the acts of 1959 and 1999 with 2013, it seems that in the precedent regulations designation of financial deposit on parent or legal care taker of third party, as deemed proper, was plausible in order to guarantee the non-compliance of the order. This is neglected in CPC 2013. Still it seems that if the order is accompanied with financial deposit, it is considered as bail bound. According to article 230 of CPC 2013 in adults' procedure the bailsman is notified to bring the accused in a month. If notification is communicated personally to the bailsman and he does not bring the accused, the prosecutor will order the seizure of financial deposit. The same process is due in juvenile procedure. It would not only guarantee the presence of the delinquent juvenile, but also the restitution of damages of the victim, especially since according article 232 of the act, if restitution would not be possible through insurance, it may be taken from financial deposit.

It should be noticed that articles 553 and 554 of Islamic Penal Code which provide punishment for acts such concealing the accused or provision or assistance in evasion are excluded from the current debate as warrant of non-compliance. Actus reus of mentioned crimes is a positive act and the crime is only established when both actus reus and mens rea are proved. They may be committed prior or after arraignment of the child or writing the bail. Also the offence may be committed by everybody, including parent, legal care taker or any other one. However, parent or legal care taker might be guilty of these crimes only if other requirements of the articles are present and proved beyond reasonable doubt.

Another point to be explained concerns article 287 of CPC 2013 which provides: "persons between 15 and 18 years old shall personally introduce self to the court." It is ambiguous and controversial whether the juvenile should introduce self to the court without any bail issued by the court or the judge should issue bail of bounding them. If the latter hypothesis is true, such bounding bail lacks any legal guarantee as juvenile of this age has yet to be reached civil capacity and the cannot be bound financially.

66 Moazen Zadegan, Hasan-ali And Gholami, Nabiollah. "Vakavi Tahavolate Ghanoone Aeene Dadrasi Keifari dar Khosoose Ghararhaye Tamine Keifari Atfal va Nojavanan". *Do Faslname Elmi Fegh va Hoghooghe Khanevade*, Vol.70. (1398): 229

It would have been proper if the legislator had provided two different bounding orders, one with oat and the other with financial deposit so that at least one of them would have had legal guarantee, just like in the case of adult's bail. Also provision of bounding without financial deposit regarding juveniles between 15 and 18 years old as the sole bail would have been sound.

2. Bail bound of juvenile

Considering Beijing Rules (article 13.2), the Iranian legislator has provided financial deposit as the initially order in juvenile proceeding. Still, other orders are plausible in case of necessity. The term "necessity" is interpretable, but it should not be interpreted in contrary to child's best interests, as interest of the child should be regarded as the first priority in all stages of judicial procedure. However, in order to guarantee rights of the victim and society and also interests of the juvenile, other bails are also prescribed which will be examined subsequently.

2-1 Nature of bail bound: The term bail bound here means guaranteeing and in civil rights is a contract according to which one party guarantees the presence of another before a third person (Katoozian, 1394, 469). As a bail, it is a judicial order issued to free accused whilst guaranteeing his regular presence in courts by another person.[67] According to article 221 of CPC 2013, only persons who are recognized to be solvent by interrogator would be accepted as bailsmen. If the interrogator does not recognize the volunteer as solvent, he declares his opinion to the prosecutor. The prosecutor reviewing the case at the same day declares his opinion which is obligatory for the interrogator. If the accused fails to introduce a bailsman, he will be detained, but he may question his arrestment in 10 days from communication of the original bail that resulted in his detainment or non-approval of the bailsman. (Article 226)

As remarked, bail bound was first prescribed for juveniles in CPC 2013. As it may lead to the arrest of the juvenile, it is a grave order and if the bailsman fails to fulfil his obligation, the financial deposit will be confiscated by an order issued by the prosecutor.

2.2 Failure of the juvenile in introducing bailsman: In adult procedure, as passed, failure to introduce bailsman will lead to arrestment of the accused. Regarding juveniles, according to article 287, court will be eligible to order his detainment or other bail, which inevitability should be collateral. As no such order is prescribes for the juveniles in the act.

Hence, unlike adult proceeding, the outcome of failure to introduce bailsman, will not necessarily be detention, rather the court may issue another order considering delinquent's personality, needs and severity of the crime. So, the judge should endeavor to issue another order, without detaining juvenile.

However, in order to restrict issuance of detainment for juveniles even more, it was better if detainment was only allowed under specific conditions such severity of the crimes and circumstances of commitment. This issue is unfortunately neglected in article 287.

67 Zera'at, Abbas and Mohajeri, Ali. Sharhe Ghanoone Aeene Dadrasi Dadgahhaye Omoomi va Enghelab (Dar Omoore Keifari). Vol.1. 1st ed. (Teheran:Feiz. 1378): 351

3- Collateral from juvenile

Collateral is tougher than bail bound, as in the latter no asset is submitted to the court, while in collateral assess, whether in cash or non-cash, should be submitted to the deposit center of the judiciary. Hence, if bailsman gets insolvent or broke after approving his solvency, he will not face any responsibility, whereas in collateral, solvency or the lack of it are irrelevant and the asses is in deposition of judiciary and so, it is a secure order and confiscation of the assess is more convenient.[68]

3-1 Nature of collateral from juvenile: The term collateral means pledge (Amid, 1384, 2450) and in legal sense, it is a property, taken as guarantee of accessibility of the accused and his punctuate presence in courts from accused or third parties during criminal proceeding by judicial authority.

In 1959 act collateral was not mentioned, meaning it was not possible for the judicial authority to order collateral on under 18 years old accused. It was initially prescribed in paragraph B of 224 article of CPC 1999. According to this article parent or legal care taker was bound to deposit collateral. This regulation was due to the fact that the article only included religious minors, who are forbidden from engaging in their assets according to Civil Code and thus are forbidden from depositing collateral as well.

In CPC 2013 it seems like obtaining collateral from juveniles between age of 15 and 18 is plausible, but in fact it is only possible if the parent or legal care taker recognizes it to be of their interest and declares the permission in written form to the judicial authority. Otherwise, according to single article on capacity of contracting parties, enacted in 1934 and article 1207 of Civil Code, such decision by juvenile is voidable unless the juvenile has had gained a judgment on reaching capacity before the age of 18.

Thus, we summarize that issuing collateral regarding juveniles is plausible in three conditions:

- The juvenile has some assets and the parent or legal care taker agrees them to be deposited as collateral
- The parent or care taker, as third party, agrees to deposit assess for the juvenile.
- The juvenile has gained judgment on reaching capacity from family court before 18 years old and own properties which may be deposited as collateral.

Finally, it should be noted that there are lots of controversies about collateral on juvenile delinquents. Tougher than the precedent orders, collateral may not be in best interest of the adolescent. Also while article 234 of 1999 CPC has allowed receiving collateral uniquely from the parent or legal care taker and did not allow receiving it from the juvenile, such consideration of interest of the child is absent in current CPC.

3-2 Failure to deposit collateral: According to article 287, if juvenile of 15-18 years old, is unavailable to deposit collateral, the judge may either order his detention or his submission to the parent or other legal care taker or bail bound. As passed, such discernment should be restricted to detention order when circumstances and other subjective conditions are present. However, in another interpretation judicial practice may adduce to note of article 287 of CPC 2013 which provides: "detention order for juveniles will have all of the consequences of detention order for the adults." Thus, if the charge of the juvenile is based on article 237 of CPC 2013 and has the conditions provided in 238, the issuance of such order would be possible. This interpretation is based on the rights of the child.

C- Order of detention in correctional centers

As we have already in numerous lines stated, detention order is the toughest bail that not only restricts adolescent's freedom, but also may lead to unfavorable consequences and risks. Following we will overview the crimes that would entitle the issuance of this order and then its sorts and conditions.

1. Entitled crimes that justify issuance of detention order

According to note of article 287, issue of detention order, either for the sake of not introducing bailsman or asset will lead to all of the outcomes of detention for juveniles, just as the adults. The legislator has counted all of the crimes that might lead to issuance of detention order.

With a brief view to articles 89 and 91 of Penal Code 2013 on reactions to juvenile delinquency, it is discernable that the legislator has followed a differential system both in Ta'zir, Hadd[69] and Qisas[70] compared with the adults. In Ta'zir none of the allocated punishments for the adults are employed for the juveniles. E.g. in paragraph A of article 89 on Ta'zir punishments of great severity of 1st to 3rd degree, adult could be condemned to 10 years of life imprisonment punishment, whereas for juvenile the same crimes would lead to detention in correctional center between 2 to 5 years. Moreover, according to note 2 of the same article, the court may decide to replace detention with residing at home in appointed times or detention in correctional center during the weekends for 3 months up to 5 years. Also regarding Hadd and Qisas, if the judge has doubts on the capacity and mental perception of the juvenile or his discernment of the nature of crime or its impermissibility, he will not order to execute Hadd and Qisas and considering the age of the delinquent, can convict him to one of the punishments prescribed in article 89.

Such legal system in sentencing juvenile demands differentiated bails with compare to adult as well. E.g. issue of detention order for juvenile is only possible for Ta'zir punishments, higher than 2nd degree and crimes with punishment of execution or assaults of higher than two third of complete Diah,[71] whereas for adult it is possible for Ta'zir punishments of higher than 4th degree.

68 Shekh Zadeh, Mahmood. "Naghde va Barresi Ghararhaye Tamine Keifari" *Faslname Pajoohesh Hoghooghe Keifari Daneshgahe Allame Tabataba'i*. Vol. 6 & 7. (1382) : 101-102

69 Hadd in Islamic Criminal System includes some counted crimes and punishments which are unalterable. It is prescribed in article 15 of Islamic Penal Code 2013.

70 Qisas, also known as retaliation is the punishment of deliberate crimes against one's physical integrity and equals the act of the perpetrator. It is prescribed in article 16 of Islamic Penal Code 2013.

71 Diah is a fund considered in sharia for undeliberate bodily harms or manslaughter or in deliberate crimes, where qisas is not possible. It is prescribed in article 17 of Islamic Penal Code 2013.

2. Substantial and formal conditions of issuing order of detention in correctional centers

According to article 287 of CPC, following issuance of order of surrender of the child to parent or legal care taker or competent persons, it is explicitly remarked that issue of bail bound or collateral is merely plausible for juveniles of between 15 and 18 years old.

As mentioned, in case of unavailability of introducing bailsman or deposing collateral or in crimes counted in article 237 of CPC 2013, court has discretion to issue detention order, considering conditions of article 238. These conditions can be overviewed from substantial and formal perspective in the following subsection.

2-1 Substantial conditions: By substantial conditions, we mean those conditions that in lack of them, the judicial authority is not permitted to issue detention order. In this context, two central issued can be raised:

2-1-1 Discernment of necessity of detention: Iranian legislator, aligned with article 37 of the Convention of the Rights of the Child and article 2 of the Rules of the Protection of Juveniles Deprived of their Liberty 1990 has obligated adjudicating authorities to issue order of detention in correctional centers only in necessary occasions. These rules have specified that deprivation of the liberty should be a disposition of last resort and for the minimum necessary period and should be limited to exceptional cases.

The term "necessity" in article 287 of CPC 2013 also means that detention order should regarded as the last resort and the judge should sufficiently argue on the basis of the case and plaint that alternative measures, which are provided in the first lines of the article, are not adequate in guaranteeing his accessibility and his interest lays in issuance of detention order. Furthermore, the judge should consider priority in adjudicating the charges of detained juvenile and alternate it to another bail in the shortest period of time and set him free.

2-1-2 Conditions on maintenance of evidence, public order and protecting the rights of life: Second category of the substantial conditions, encompasses conditions of issuing detention order which are explained in article 238 of CPC 2013. They are prescribed in three different paragraphs, existence of each might be a cause of issuing detention order:

- According to paragraph A judicial authority should sufficiently argue that if juvenile is set free, the evidence of the crime will be perished. E.g. juvenile would conspire with other perpetrators or witnesses or make them refuse to testify and as a result interrogation and truth finding would confront difficulty;
- Issue of alternative measure is inadequate in preventing evasion or concealment of the delinquent juvenile and there is no possible way of preventing it. This provision is prescribes in paragraph B; and finally
- The freedom of accused by alternative measure will disrupt public order. Life of plaintiff, witnesses or their families and even accused would be jeopardized. This provision is prescribes in paragraph C.

Hence, the issue of detention order not only requires the committed crime to be specified in article 237, but also one of the above conditions. In this matter, there is no differential procedure, but the difference lays in the fact that in juvenile delinquency, supreme interests of the delinquent should be considered and it can be satisfied only if according to paragraph C, his life is jeopardized. Otherwise, the judge is not permitted to deprive him of liberty. For instance, if these conditions, rather endangerment of life of juvenile, are satisfied but detention in correctional center negates the possibility of rehabilitation or resocialization or causes harm to his physical or mental state, it should be avoided by all means.

2-2 Formal conditions of issuing order of detention in correctional center

According to note of article 287 of CPC 2013, detention order for juveniles will be followed by all of the consequences of detention order for adults. Thus, it also features the formal conditions of detention order for adults. Articles 239 to 242 elaborate significant formal conditions of issuing detention order, one of the most crucial ones being well-founded and just. This aim will be reached through elaboration on nature and quality of necessity of such order. For instance, judicial authority should argue that for the sake of which discernments no other alternative measure can be issued regarding the juvenile.

The accused being detained in order to prevent conspiracy, the reason should be remarked in the writ (Article 239 CPC 2013). The reason behind this prescription is to avoid contact between the accused and other perpetrators or accelerators so that they prevent spoliation of evidence.

Obviously, conditions prescribed in articles 240, 241 and 242 are the most crucial ones, since they deal with the time in the process of detainment which is highly important according to aforementioned international documents. According to article 240 "detention order shall be send **immediately** to prosecutor and he shall comment on it in written form **utmost in 24 hours**…" Hence urgency is a rule to be followed in both issuing and commenting on detention order.

Article 241 also prescribes a critical formal condition in ordering detention which again deals with urgency. It provides: "If the reason behind detention is eliminated and there is no other reason for detention, interrogator with agreement of prosecutor will order end of detention." The article subsequently also recognizes the right for the accused to demand end of detention. The interrogator shall immediately (precisely in 5 days) adjudicate such request. Also, according to article 241, if the request is quashed, juvenile has the right to appeal in 10 days. He may use this right once in each month of detention.

Another formal condition concerns the utmost period of detention in correctional centers. According to article 242: "if in crimes subject to paragraphs A,B,C and D of article 302 {serious crimes} in two months and in other criminal offences in a month accused remains detained as a result of bail and his case is not followed by final decision in prosecutor's office, Interrogator shall mitigate or alter detention order. In case there is a justified reason for proceeding detention, the order, along with the reasons of justifying it, is prolonged and is notified to the accused… if detention remains, this regulation is applied every month or every other months {depending on severity of the crime}. However, accused shall not be detained for more than the minimal prescribed penalty for his charge and in cases of execution or life-imprisonment no more than 2 years and in other criminal offences no more than 1 year."

Provision of maximal period of time for detention in innovation of CPC 2013, which although has brought some practical difficulties[72], might be pretty helpful in preventing the risks of detention, especially since after the remarked one or two months, legal authority is obligated to rationalize persistence of necessity or detention will be considered illegal, which will lead to criminal, civil and disciplinary sanctions for the him.

Adducing article 239, judicial authority is obliged to stipulate the disputability of the order of detention. Additionally, the juvenile has the right of objection to detention order, its persistence or aggravating bail which has led to detention in 10 days after notification in case of residing in Iran and in a month in case of residing outside Iran (Article 270). Besides, as remarked, he may request altering detention order every month. In this case, judicial authority should immediately (precisely in five days) declare his decision well-founded. In case of rejecting the request, juvenile has the right to object in 10 days. Also in serious crimes after two months and in other crimes in a month interrogator is obliged to alter detention order or juvenile has the right to object his decision on persistence of detention. The competent court would be either juvenile court or particular criminal court 1 for juveniles depending on the case.

Obviously, the legislator has considered numerous privileges for juvenile in this domain and this is despite the fact that juvenile did not have such rights in case of getting detained as a result of failure to introduce bailsman or deposing collateral. It would have been better if some formal conditions of detention for juveniles were considered with differential perspective, without merely remarking note of article 287. E.g. the legislator could have not differentiated between serious crimes and other criminal offences on maximal period of detention of 1 or 2 months for juveniles and ultimately set a period of 1 month, so that jails' overcrowding problem would be overcome and rehabilitation of juvenile could have been achieved.

Conclusion

During the history of legislating in Iran, four sorts of bails have been recognized for juveniles: order of submission to the parent or other legal care taker or any natural or legal person with financial obligation or without it, bail is specific meaning, collateral and detention in correctional center.

Reviewing the regulations in this domain, it seems that the legislator has always considered bails on juveniles with differentiated perspective. But even though this perspective is honorable, the number of bails and their regulations were not always been in accordance with juvenile's best interest.

Although proportionality as a principle has always been considered by the legislator, the principle of expanding alternative measures of detention for juveniles in correctional centers has not always been significantly considered. This approach is reflected in low number of bails for juveniles comparing with adults, meaning a better approach is adopted in adult proceeding than in juvenile's as for adults 9 alternative measures to detention and 2 additional alternative measures to criminal offences of 7 and 8 degree (petty crimes) are prescribed, whereas for juveniles merely 3 alternative measures are provided. For instance, although according to paragraph G of article 217 CPC 2013 monitoring with electric devices is remarked as an alternative to detention

72 Fore judicial challenges of setting maximal period of time for detentions in article 242 See: (Pajooheshdake-Hoghooghe Jazava Jormshenasi Pajooheshgahe Ghove Ghazaie, 1395)

for adults, such alternative is not provided for juveniles. Obviously, such alternative not only lacks the deficiencies of detention, but also provides an atmosphere in which juvenile is able to rehabilitate in family.

Even though the conditions of detention in correctional centers are currently harder to be satisfied both from substantial and formal perspectives and thus detention order can be issued harder than before, still some revision is in demand. Interest of delinquent juvenile invokes him to remain with the family during criminal procedure as much as possible. In order to gain such purpose, crimes that would lead to detention and the period of detention should be restricted. It can be suggested that any criminal offence bellow degree 3 (with punishment of more than 10 years imprisonment) should not lead to detention. Also maximal period of detention should be mitigated for all crimes of juvenile to one month. Likewise, alternative measures should be developed and judge should be obliged to adequately rationalize on insufficiency of alternative measure in order to access to juvenile during criminal procedure.

All in all, the Iranian approach towards juvenile justice system has seen many improvements, including in the field of bails. Evidently, it is not the end of evolutions. The enact of the Act of Supporting Juveniles in 2020 and the Draft of the Professional Juvenile Police, which to the date is not enacted yet, are new steps by the Iranian legislator to evolve the rules in this field in order to be in line with the new empirical studies on what works best for the juvenile.

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EVALUATING THE YOUNG PEOPLE ATTITUDE TOWARDS COHABITATION BY INTERPRETATIVE PHENOMENOLOGICAL METHOD, IN ISLAMIC COUNTRY

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Abstract

Backround: Cohabitation (living together without marriage) is one of the most extreme forms of premarital relationships which is increasing in metropolis cities. The aim of this article is to study young people's attitude towards cohabitation and factors affecting this.

Methods: Interpretative phenomenological analysis (IPA) was used and eight people in the age group of 27 to 40 years in Tehran were selected by Snowball sampling. Data was collected by semi-structured interviews (on average of 60 minutes). After recording and analyzing interviews by MAXQDA software, 4 main themes, 20 categories and 88 open codes were obtained.

Results: Results showed that this lifestyle cannot be a good alternative to marriage because of ruin the most important periods of life and non-improvement in life due to fruitless financial investment on an open-ended relationship, increasing problems in the path of marriage and decreasing the value of marriage and childbearing. Issues such as low-cost lifestyle, easy starting and ending a relationship without the cumbersome customs of marriage and divorce problems have caused relationship without commitment. The social contradictions in accepting cohabitation and legal restrictions have led to the secret relationship, which has caused various stresses and psychological pressures.

Conclusion: Due to lack of financial support and parental agreements, this phenomenon is more common in broken families. The main reasons for the reluctance of partners to continue or formalize such a relationship are mistrust in the partner and woman's worthiness to become a mother.

Keywords: Cohabitation **–** Young people attitude **–** Phenomenology **–** Men **–** Islamic country.

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Introduction

Cohabitation is one of the changed patterns of marriage. Cohabitation is not formal, then many bureaucratic steps will not be followed during registration as well as divorce. This model is based on the interests of the partners rather than on formal commitment. Understanding people's attitudes towards this phenomenon is very important in better understanding this issue and the factors affecting it. There is various definition of attitude: Attitude is basically a way of being prepared to agree or disagree with things. Attitudes are not basically related to the present situation, but as a rule are related to the past and the future.[74] In the other words, attitude is a set of cognitions, beliefs, ideas and facts that includes positive and negative emotions and also relates to a central issue. This knowledge and emotions lead to certain behaviors.[75]

Different attitudes towards sexual behavior is based on differences in cultural, religion and social indicators.[76] Because of value and legal factors in Iran, sex is only allowed in formal marriage. Despite the different attitudes towards organizing sexual behaviors, changing attitudes towards sexual behavior is common to young people.[77] The extent of these changes in Iran is unknown. There is a sexual need in Iran, as in other countries. This issue is more prominent in Iran because this country has a large young population, and on the other hand, the age of marriage has increased. Clearly, values and consequently sexual values have changed in our society. The influence of the media, satellites, declining marriage rates, and rising divorce rates have all led to a different view towards sexual needs.[78] Numerous research has been done about cohabitation and factors affecting it. For example,[79] have studied the subculture of cohabitation and some of its effects in Tehran. Their qualitative study consisted of 56 people who had the experience of cohabitation in Tehran. An in-depth interview was conducted in this study. Their results showed that there are several factors involved in cohabitation: individualism, reflexivity, generation gap, the gap between sexual maturity and economic maturity, academic- career migration, lifestyle and desacralisation of marriage. Golchin and Safari (2017)[80] mentioned that negative attitudes toward customary marriage, feminist beliefs, lack of adherence of religious values and new patterns of male-female relationship are the reasons for cohabitations. Faramarzi et al. (2017)[81] conducted a study in Tehran based on theory of "lived experience of cohabitators". This study was interpretative and was done based on "grounded theory". Results from conducting 32 interviews showed that cohabitation is in fact a new reading of the concept of marriage in the contemporary age. A new concept in a society that is experiencing new forms of social realities in the modern world, which, although occurring in personal space, is the result of new social and economic conditions. Movahed et al. (2006)[82] studied the relation of social and cultural factors and students' attitudes towards friendship between girls and boys before marriage at Shiraz university. Results showed that the percentage of people who had a moderate, negative and positive attitude were 25.6%, 50.8% and 23.6%, respectively. Attitudes of families were more negative than students and girls' attitudes also was more negative than boys'. Oppenheimer (2003)[83] in a study in the United States showed that low level of income and education are the reasons for cohabitation. Trost (1978)[84] said that informal marriage is an old tradition in Iceland, Sweden and Denmark and it can be considered a return to ancient coexistence. He believed that changes in post-industrial society have been effective in creating changes in social factors. Through a qualitative interview in Zulu, a city in South Africa, Posel et al. (2014)[85] tried to find out the attitudes of citizens towards non-marital cohabitation. They demonstrated that cultural and religious constraints and decreasing of female value in society can lead to cohabitation. In the present study, we try to study people's attitudes toward cohabitation using interpretative phenomenology in Tehran province.

Methods and Materials

According to the purpose of the study to achieve young people's attitudes towards cohabitation, a qualitative method of interpretive phenomenological analysis (IPA) has been used in this study. The focus is on the attitudes of participants as the main source of research data. Phenomenology is the study of personal world which we experience before we think or conceptualize it. It means that the immediate experience of the world without being seen through prejudice and theoretical ideas (Gall et al., 2014). Qualitative environment is a real and natural environment.[86] Due to the purposeful sampling method and the need to record interviews, suitable and desirable places such as workplace, parks and university clinics were selected as research environment.

Interviews were done in various places such as participants' office, house, community center and café near where they live. Duration of interviews was varied depending on the samples (mean: 60 min). According to phenomenology methods and unknown population studied, it was not easy to identify these populations. Snowball sampling method was used for identifying them. This method is a purposeful sampling technique that requires the presence of early participants to identify additional items that may be gradually used in the study. This method is suitable for finding key informants. Researcher can find other examples by identifying a few key informants or cases (Mohammad poor, 2013). There is no correct information about the number of people in IPA and it depends on commitment to the level of case study, analysis and reporting, the richness of the examples and the practical constraints. Thompson

74 Aaker, D. Brand *Portfolio Strategy. Creating Relevance, Differentiation, Energy, Leverage and Clarity* (New York: Free Press, 2004).

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86 LoBiondo-Wood, G., and Haber, J. *Nursing Research. Methods and Critical Appraisal for Evidence-Based Practice* Elsevier, 2002.

believed that 6 to 8 participants are appropriate and can avoid the risk of data saturation. But results cannot be generalized to all situations.[87] In the current study, sampling continues to achieve theoretical saturation (i.e. observing obtaining similar or repetitive answers from participants). In fact, until new information cannot be found (Corbin and Strauss, 1990).[88] In our study, by sending a SMS advertising in the relevant groups and channels and then with the help of a friend, 8 young people (male, single) living in Tehran entered the interview program. Their age was between 18 and 40 (mean: 29 yrs.). All of them was living in Tehran and their education level ranged from diploma to doctorate.

Semi-structured and interactive interview was used. In this method, the interviewer encourages the participants to talk about the topic by raising the issue under study. Other questions are based on respondent's answer (Hariri, 2010). In a semi-structured interview, the researcher follows a pre-written program, so the order of the questions is not important.[89] The main interview and research questions are listed in the table below (table 1).

Table 1: interview protocols

Research questions	Interview questions	Follow-up questions
What is your attitude towards cohabitation?	1. Tell me about your relationship history	• How did you meet? • Why did you decide to live together? • Why do you prefer cohabitation to marriage? • Was that your suggestion? • Why did you agree (disagree)? • How do you predict the future of your relationship? • How do you feel when you think about ending your relationship?
	2. Can you define a normal day? for example, pick one day in last week and let me know how it went?	• How do you feel about your relationship with (his partner's name)? • What do you like about this relationship? • What bothers you about this relationship?
	3. How do you understand this relationship?	• Compared to a formal marriage, what are the pros or cons of this type of relationship? • Why do some people choose cohabitation? • Why do girls or boys prefer cohabitation to marriage? • What do you call your relationship?
	4. What did this relationship give you? What did you lose? What about your partner?	• What were the advantages of this relationship? • What were the disadvantages of this relationship?

87 Turpin, G. and Barley, V. and Beail, N. and Scaife, J. and Slade, P. and Smith, Jonathan A. and Walsh, S. "Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses." *Clinical Psychology Forum* 1997;108, 3-7.

88 Corbin, J.M., and Strauss, A. "Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology* 1990;13, 3–21.

89 Seidman, I. "Interviewing as qualitative research: a guide for researchers in education and the social sciences." Translated by: Sayyad Ali Koushazade, Ali Reza Jaberi, Sara Hosseini Arani, Mahkame publications, Tehran, 2013.

There is no fixed and rapid method to analyze data in qualitative research, because it is mental and interpretative research. It seems that there are various ways to analyze qualitative data.[90] In Interpretative phenomenological analysis (IPA), we describe the nature of the phenomenon from the participants' point of view and data (voices of the interviewee) are analyze after interview.

We used van Manen's "thematic analysis" (2006) because he is a global leader in the humanities research which performed well in preparing and compiling books on research methods, especially in the field of "lived experience" (Barqi, 2010). Van Manen proposed three approaches: holistic, selective and line-by-line.[91] In this way, after transcribing the text of each interview, the whole text is read many times and a general impression is written as a descriptive statement (holistic approach), then researcher consider all text and asks himself/herself what this sentence or this part of the sentence can describe about the phenomenon or experience related to it? (line-by-line approach). This approach is used to separate and remove themes. Finally, after reading the text several times, the statements that are supposed to be useful in revealing the phenomenon under study are selected (selective approach). To understand the lived experiences of cohabitators, holistic and line-by-line approaches were used simultaneously and the selective approach was also used to express descriptions.

In first stage, all meaningful units of themes that were in the form of words, sentences or paragraphs in the interview were extracted by reading the text several times and were written and coded separately for each participant. This process was done after interview. To find similarities and differences, the themes extracted from the interview were compared with other interviews. Then, clusters with similar themes were considered and similar extracted codes were embedded in these clusters. The clustering has changed many times and merged or separated according to new codes. After group discussion with professors, the final themes

90 Hariri, N. *Principals and methods of qualitative research* fourth edition; Tehran' Islamic Azad University, Science and Research Branch, 2010.

91 Van Manen, M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* (Zended).Ontario. Canada.The University Of Western Ontario, 2006.

appeared as groups of themes that revealed the phenomenon of cohabitation.[92] MaxQDA (2018) software was used for analyzing data. After coding and clustering, the extracted themes became the main categories of cohabitation. These categories help researcher to understand this experiences from participants' point of view. Lincoln and Guba (1985)[93] model are often used to validate qualitative research such as phenomenology research. Lincoln and Guba have used some criteria to make qualitative studies reliable: credibility, dependability, transferability and conformability.

1. **Credibility**: Samples had rich experience in cohabitation, so the criterion for attending the interview is to cohabitate for more than one year.

2. **Dependability**: A review of four experts and their agreement on the results was considered.

3. **Transferability**: Refers to the generalizability of the findings in other situations. In other words, the knowledge obtained in one particular context was appropriate for another and researchers who do similar research in other contexts will be able to apply these concepts.

4. **Confirmability**: Other researchers will be able to understand the experience of cohabitation, to track data and to achieve the similar results. In addition, the researcher's interest in the phenomenon under study, long-term contact with the data (two years), as well as reaching the opinions of participants can be considering as other factors guaranteeing the validity of the research.

Results

The current research aimed to study the attitudes towards cohabitation in Tehran by interpretative phenomenological method. Results showed 4 main themes, 20 categories and 88 basic codes (table 2).

92 Van Manen, M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* (Zended).Ontario. Canada.The University Of Western Ontario, 2006.

93

Table 2: main themes and attitudes towards cohabitation

Main themes	Main categories
Dysfunctional, informal, unstable cohabitation	ruin the most important period of life
	non-improvement in life
	Inefficient costs of cohabitation
	Decreasing the value of marriage
	Decreasing the value of childbearing
	Problems for marriage
	Lack of legal protection
	Open-ended relationship
	Deception-based relationship
	Understanding inconsistencies
Unconditional relationship	Easy starting and ending the cohabitation
	Low-cost lifestyle
	Unusual starting
	Relationship without the intention of marriage
	Incompatibility of cohabitation with spiritual- religious values
social contradiction in accepting the cohabitation	Rejection of cohabitation in traditional families
	Acceptance of cohabitation in broken families
Negative attitudes towards women to start a family	Reluctance to marry with a sexual partner
	Doubt about a partner's worthiness to become a mother
	mistrust of women

According to table 2, unstable, informal and dysfunctional cohabitation is the main phenomenological concept extracted from the interviews. As can be seen in the table above, the partners (cohabitators) believe that this lifestyle cannot be a good alternative to marriage. The most important concepts that have been repeated many times in interviews are: ruin the most important period of life, non-improvement in life due to fruitless financial investment on an open-ended relationship, problems for marriage, decreasing the value of marriage and childbearing, lack of legal protection because cohabitation is illegal in our country. Another factor that is mentioned in this theme is deception-based relationship in the form of parallel relationships, doubt about essence of this type of relationship, etc. Below are some of the interviewees' comments on the theme:

Parsa said: "My golden age is gone"

Masoud: I was in this relationship for few years, my life and talent was wasted."

Ahmad said:"Whenever we had a date, I arrive ten minutes early. I bought everything I promised her. But finally, she said that you are a simple person and left me."

Masoud told:" I think after marriage; I will not enjoy any emotional or sexual relationship."

Mehran:" I try not to have children in this informal relationship, but if it happens, the child should be aborted."

Parsa stated:"I cannot defend my rights. This 6-year relationship cost me a lot."

Reza:" They know that this type of relationship is not going to end well. My friend's partner also left him."

Majid told me:" we were together for one year. We had a good time but we had different beliefs."

The results obtained from the theme of unconditional relationship, which is one of the most challenging concepts of the present study, include five categories. Results showed that cohabitation leads to unconventional sexual relationship, which usually takes place without parental supervision. This pattern, whether for premarital acquaintance or without the purpose of marriage, does not follow any rules and regulations. Factors such as low-cost lifestyle, easy starting or ending of relationship and avoiding the cumbersome customs of marriage and the problems of divorce can cause problems and non-commitment in the relationship. Participants stated that cohabitation which turns a relationship into an unstable and unacceptable coexistence, is contrary to their religious and customary values. Some of comments in which the unconditional theme is mentioned are as followed:

Mohammad said: "I want to experience this relationship. If I do not like it, I will finish."

Majid told:" Young people like this type of relationship, because they have no commitment or financial responsibility."

Reza:"We were coworker. Our relationship developed outside of the workplace."

Reza told:" We did not see it in the form of marriage from the first day. She said that she did not want to get married, neither did I."

As you can see on table 2, social contradiction in accepting the cohabitation includes 2 categories. It showed that traditional and religious families, despite efforts to understand the sexual development of children, concern about cohabitation. In broken families, due to the lack of financial support and problems between parents, children are more likely to enter the cohabitation. Below are some of the participants' comments on this theme:

Majid said:" Families cannot accept this lifestyle. European lifestyle has no place in our society"

Reza told:" If we are invited to a party, she can come. Her family has no problem with it."

One of the most important concepts in the present study is the negative attitudes toward women to start a family. It seemed that the mistrust of girls and partner to become a mother is one of the factors influencing men's reluctance to go through a relationship and formalize it:

Masoud said:" I just wanted a log-term relationship. But after a while I didn't want that relationship anymore because I realized she was looking for marriage."

Majid stated:" She was a good partner. But she did not have the necessary conditions to become a mother, and that was very important to me."

Mohammad said:" My attitude towards women has changed. I think if I get married, I always think my wife will leave me one day; so I will not dedicate myself to her."

Discussion and Conclusion

In this interpretative phenomenological analysis (IPA), 8 people were selected by snowball sampling (men between 27 to 40 years old). After recording the interviews and analyzing them by MAXQDA 2018 software, 20 categories and 88 open codes were obtained. 4 themes were also identified: unstable, dysfunctional and informal cohabitation, unconditional relationship, social contradiction in accepting cohabitation and negative attitudes towards women to start a family. Results showed that cohabitators have considered this lifestyle as a kind of unstable, informal and dysfunctional coexistence and an unconditional relationship. Due to different attitudes towards the phenomenon of cohabitation, there is a clear conflict in accepting cohabitation in our society. The shared experience of participants indicates a change in negative attitudes toward women to start a family. i\In terms of people attitudes toward cohabitations, the results of the present study are consistent with the research of Yaseri et al. (2017).[94] Fazeli (2012) in research entitled "Family and urban life, the evolution of families in the context of modernity, urbanization and media" explained that there is no reproduction in these families and this type of relationship is not usually public. On the other hand, Azad Armaki et al. (2011) in "Sociological Explanation of Anomic Sexual Relationships in Iran" demonstrated that people try to meet their needs in cultural and legitimate ways, but if such conditions are not provided, their needs are met by illegal means (white marriage)which is consistent with the informality of cohabitation in the present study. We showed that this lifestyle cannot be a suitable alternative for marriage because it is associated with factors such as: ruin most important period of life, Lack of progress due to fruitless financial investment in an open-ended relationship, occurrence of problems in marriage, decreasing the value of marriage and childbearing. factors that lead people to cohabitate include: low-cost lifestyle, easy starting and ending of relationship without the cumbersome customs of marriage and the problems of divorce. The social contradiction in accepting cohabitation and legal restrictions keep such a relationship secret, which has led to various stresses and psychological pressures in cohabitator. The phenomenon is more common in broken families due to the lack of financial support and problems between parents. Mistrust in a partner and a woman's worthiness to become a mother can be considered as reasons for the reluctance of men to continue the relationship or formalize the relationship.

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COMPLICATED GRIEF IN THE ERA COVID-19 – SCOPING REVIEW

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Abstract

Background: the aim of this study is to investigate how complicated grief is examined in the context of the COVID-19 pandemic in current traceable sources. The following two research questions were established. What methods have been used to examine complicated grieving in the context of the COVID-19 pandemic? What conclusions do the presented studies reach?

Methods: Design: A review study. Primary research articles have been searched using a combination of keywords – complicated mourning, complicated grief, protracted (prolonged) mourning – in the Scopus, Web of Science, National Library of Medicine PubMed, EBSCO, MEDVIK, PUBMED, and BMČ databases. Exclusion criteria: Since this was not a primary study, the study was not available in full text; the research methodology was not clearly described. The data were processed using thematic analysis by sorting method.

Conclusion: The analyzed studies focused mainly on the reflection of the situation of survivors who themselves had experienced COVID-19 and at the same time found themselves in the role of survivors. However, all studies point to the importance of providing professional support to the bereaved, regardless of whether their grief is complicated or not. However, the paradigm of medicalization of grief may certainly not be the desired approach in bereavement care.

Keywords: Complicated mourning **–** Grief **–** Bereavement **–** The bereaved **–** COVID-19.

Introduction

The death of a loved one is one of life's most painful and challenging losses.[97] It is natural and normal for the bereaved to grieve in such a situation, to experience deep sorrow, to feel abandoned, despairing and helpless. Indeed, the loss of a loved one represents a significant blow to their self-concept, identity and integrity.[98] Grief is a complex psychological, social, somatic and spiritual response to the death of a loved one,[99] but these responses can vary widely among survivors. Some mourners adapt to the loss of a loved one within one to two years, while others

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97 Bui, E. (Ed.), *Clinical handbook of bereavement and grief reaction, Current Clinical Psychiatry* (eBook]: 2018). doi:10.1007/978-3-319-65241-2.

98 Kubíčková, N., *Zármutek a pomoc pozůstalým* (Prague: ISV, 2001), 24.

99 Špatenková, N., *Krize a krizová intervence* (Prague: Grada Publishing, 2017), 164.

experience severe, debilitating and often health- and life-threatening grief for years or decades.[100] Atypical forms of grief do not differ from normal grief reactions in their nature, but in the intensity and duration of reactive symptoms. Such a situation is often referred to as abnormal grief, chronic grief, pathological grief, complicated grief, etc. Shearer et al.[101] state that the development of complicated grief occurs in approximately 10% of the bereaved, and according to Látalová, Kamarádová and Prašek[102], it occurs in 9–20% of the bereaved. For bereaved parents whose child has died, this percentage is significantly higher. [103] The following measurement tools are most commonly used to identify complicated grief: the Inventory of Complicated Grief (ICG)[104], the Inventory of Complicated Grief-Revised (ICG-R)[105], the Structured Clinical Interview for Complicated Grief (SCI-CG)[106], the Work and Social Adjustment Scale (WSAS)[107], the Prolonged Grief Disorder-13 (PG-13)[108], and the Texas Revised Inventory of Grief (TRIG)[109]. In the Czech Republic, the previously unpublished Protracted Grief Scale (SPT) was created for these purposes.[110]

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Historical excursus and current situation

Complicated mourning is not an entirely new category. Already Freud had the need to define "normal" mourning in relation to depression or melancholia (Freud called depression melancholia)[111]. Lindemann[112] described delayed and distorted reactions to loss, Gorer[113] added the absence of grief. Worden[114] distinguished between chronic (protracted), delayed (inhibited) grief, exaggerated (hypertrophied) and larval pathological reactions to grief. While these concepts are clinically useful, the categories are rather vague and difficult to grasp empirically and cannot be defined in a way that can be reliably measured. For this reason, in the literature we encounter nosological units that attempt to define the phenomenon described more precisely and to specify its symptoms. Látalová, Kamarádová and Praško performed a meta-analysis of articles published in the National Library of Medicine PubMed and Web of Science databases (they entered "complicated grief", "complicated bereavement" and "traumatic grief" as keywords,) and recorded 689 relevant articles in PubMed (first text from 1969) and 811 articles in Web of Sience (first text from 1986), 204 of which dealt with diagnosis or treatment, but only 42 of which were relevant to the definition of complicated grief.[115] The question of how complicated grief should be defined (and whether it should be defined at all), or whether it should be included as a separate nosological entity in the revised classification systems of the DSM-5 and ICD-11, has been (or still is) debated extensively in the professional community. There is still no clear opinion in this respect, yet both classification systems have somehow incorporated complicated mourning. The inconsistency is now manifested not only in the terminological grasp of the issue, but also in the definition of individual diagnostic criteria (symptoms). It is now possible to encounter terms such as Complicated Grief[116], Prolonged Grief Disorder[117], Persistent Complex Bereavement Disorder[118], and Prolonged Grief Disorder[119]. The analysis of these individual entities has been conducted by e.g. Lenferink, Boelen, Smid, & Paap[120], in the Czech Republic the issue is dealt with e.g. by Bok.[121] The similarities and some partial differences between these entities are presented in Figure 1.

111 Freud, S., Práce k sexuální teorii a k učení o neurosách. Vybrané spisy III (Prague: Avicenum, 1971), 280.

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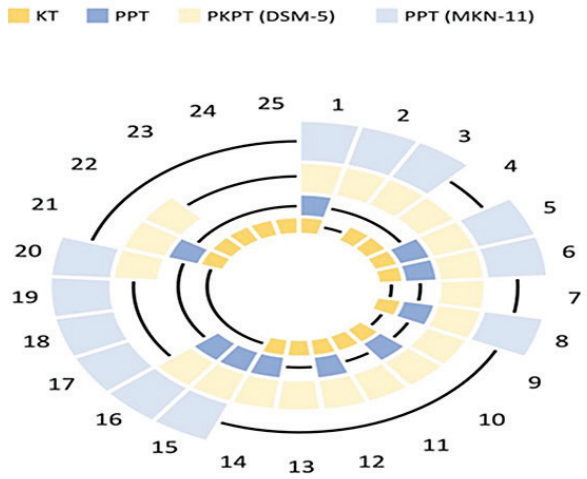
121 Bok, T., "Výskyt komplikovaného a protrahovaného truchlení a s ním související riziové skupiny pozůstalých v české populaci", (Olomouc: UP, 2020).

Figure 1: Comparison of diagnostic criteria



1. Přetrvávající touha po zemřelém.
2. Intenzivní žal a emoční bolest.
3. Zabývání se zemřelým.
4. Zabývání se okolnostmi smrti.
5. Vyjádřené obtíže s přijetím smrti.
6. Neschopnost uvěřit nebo emoční otupělost.
7. Potíže vybavit si pěkné vzpomínky na zemřelého.
8. Zahořklost nebo hněv související se ztrátou.
9. Narušené sebehodnocení.
10. Nadměrné vyhýbání se místům, lidem nebo situacím od ztráty.
11. Touha zemřít a připojit se tak k zemřelému.
12. Potíže důvěřovat ostatním lidem.
13. Pocit osamění.
14. Pocit bezesmyslnosti/prázdnoty života po ztrátě.
15. Zmatek ohledně vlastní role.
16. Potíže věnovat se zájmům nebo plánovat budoucnost.
17. Vina.
18. Popření.
19. Obviňování.
20. Neschopnost mít od ztráty dobrou náladu.
21. Pocit ochromení/šoku ze ztráty.
22. Závist směřovaná k lidem, kterým nikdo blízký nezemřel.
23. Časté projevy bolesti nebo jiných, příznaků, kterými trpěl zemřelý.
24. Intenzivní fyziologická nebo emoční reaktivita.
25. Změna chování v důsledku zaujetí zemřelou osobou.

Poznámka:
KT = komplikované truchlení (Shear et al., 2011);
PPT = porucha protrahovaného truchlení (Prigerson, 2009);
PKPT (DSM-5) = perzistentní komplexní porucha truchlení (DSM-5);
PPT (MKN-11) = porucha protrahovaného truchlení (MKN-11).

Source: Lenferink, Boelen, Smid, & Paap (2019), modified by Bok (2020).

COVID-19 and complicated mourning

Everyone has been affected in some way by the covid-19 pandemic. The number of victims of the COVID-19 pandemic has surpassed the four million mark. The Czech Republic is among the five countries with the highest number of deaths per capita.[122] But some experts believe that the number of deaths from COVID-19 is underestimated globally. The World Health Organization[123](WHO) says it estimates that the pandemic has claimed two to three times more victims than official statistics. Calculating how many survivors there are in connection with the death of a loved one from COVID-19 is difficult, if not impossible. In 2020, 129,289 people died in the Czech Republic. Compared to 2019, the number of deaths was nearly 17,000 higher, representing a 15% year-on-year increase. COVID-19 was the second leading cause of death last year.[124] Thus, it can be assumed that the loss of a loved one affected at least 400 thousand people in the Czech Republic alone, but more likely up to 650 thousand people, if not more. A total of 4,867,294 peo-

122 Roshan Abraham and Ahmed Farhatha, Global COVID-19 death toll exceeds 4 million. Reuters update June 18, 2021.

123 WHO. Coronavirus disease (COVID-19) (who.int)

124 CSO. (2021). COVID-19 was the second leading cause of death last year (Press release). Czech Statistical Office. https://www.czso.cz/csu/czso/covid-19-byl-vloni-druhou-nejcastejsi-pricinou-smrti

ple has died in the world as of 11 October 2021[125]. Survivors were confronted with the measures related to COVID-19 at the time of the pandemic, irrespective of whether their loved one died in connection with the disease or not. They had little or no opportunity to say goodbye to the dying person and to accompany or provide for him or her at death (in finem) or after death (post finem). The deceased were placed in a plastic bag, and it was impossible or forbidden to provide them with a "last service" (washing, combing, clothing). The survivors were not allowed to organize a proper funeral because they themselves were ill or quarantined. At the time, cremation was clearly preferred to burial in the ground (regardless of the wishes of the deceased or the survivors). The number of people attending the funeral was also strictly limited, the gathering of more than one person was forbidden, and restaurants were closed, making it impossible to hold a funeral feast and any memorial gatherings. Also, the form and conduct of the mourning ritual underwent a number of changes, reducing the possibility of a funeral, leading to an increase in funerals without ceremony and so-called "social funerals" (burials at the expense of the municipality)[126]. Lockdown, the requirement of social distancing and the elimination of social contact altogether to prevent the spread of disease, led to deepening feelings of loneliness and social isolation of the bereaved. The ubiquity, impersonality of death and "too much" death (the dead were reduced to mere statistics and numbers displayed on screens) all may have had a negative impact on the individual experience of grief and coping with bereavement. Access to mental health professionals such as bereavement counsellors, psychologists or other counselling services was also severely limited during the pandemic. A death from COVID-19 itself is considered a "bad" death because of the circumstances and all the aspects described above, but even if the cause of death was different, all the measures related to the COVID-19 pandemic fell on the bereaved. It can be assumed that such a situation disposes the bereaved to develop complicated grief.

In our study, we therefore asked how the situation of COVID-19 is reflected in published peer-reviewed studies and how complicated grieving is put in the context of the covid-19 pandemic.

File and methods

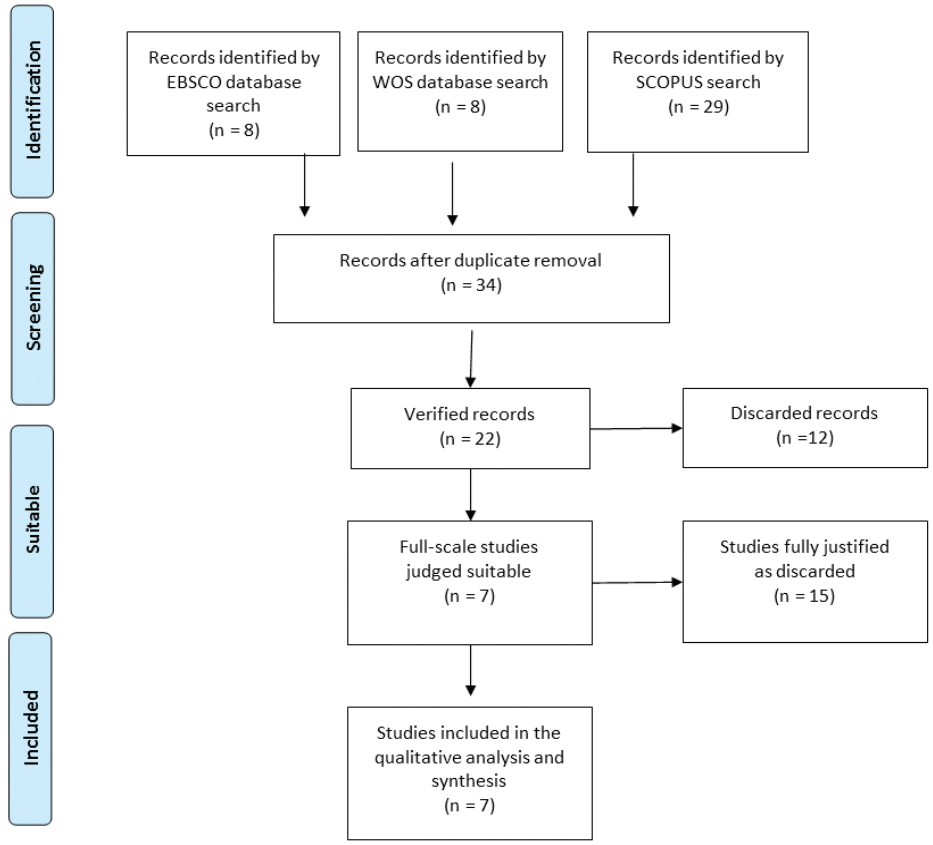
The search for primary studies was conducted based on the acronym of the scoping question:

P (Population) C (Concept) C (Context) of this logic:

P: complicated mourning
C: mourning or grief or bereavement
C: COVID-19

The primary search engines were Scopus, Ebsco and WOS. The results showed that the issue of complicated mourning is very topical, even when limited to the COVID-19 issue. The search engines were first queried in the following form: (TI (mourning, grief, or bereavement) AND AB complicated mourning). 867 resources were found in Scopus, 1,155 results were found in Ebsco and 136 resources were found in WOS. Subsequently, the query was restricted to the COVID-19 limitation: (TI (mourning, grief, or bereavement) AND TI COVID-19 AND AB complicated mourning). After entering this narrowed query, 29 results were found in Scopus, 8 results were found in Ebsco and 8 results were found in WOS. Searches in other databases (e.g. PubMed, Jstor, ScienceDirect) did not yield any new results. For the texts available in the full text, the relevance of the retrieved studies was assessed secondarily by two assessors independently. The assessment of the relevance of research studies was performed in two stages. In the first phase, the title and abstract were assessed (34 records were analyzed) with regard to the relevance of the texts to the research question. In the second phase, the full text (n=22) was then assessed in terms of the purity of the methodology used and the relevance of the results. Regarding the evaluation of the relevance of the text in terms of the research question raised, two basic exclusion criteria were applied: 1. It was not a primary quantitative or qualitative study or a case study, 2. It did not deal with research on complicated grieving in the context of the COVID-19 pandemic, 3. The study was not available in English. After applying all exclusion criteria, 7 sources were included in the analysis. The selected articles were then read thoroughly and the information contained in them was decomposed into variables and indicators and recorded in a structured sheet. See Figure 2 for details of the search strategy.

Figure 2: PRISMA Flow Diagram



125 Worldometer. COVID Live Update: 238,652,893 Cases and 4,867,294 Deaths from the Coronavirus -Worldometer (worldometers.info)

126 Act No. /2001 Coll., the Act on Funerals and on Amendments to Certain Acts, as in force on 1 July 2023.

Results

The studies were published between 2020 and 2021 and reflect the pandemic situation related to COVID-19.

In terms of the methodology used (see Table 1), only two studies used a quantitative research design, one of which (4) focused on research among health and social care professionals involved in bereavement support. Both studies used a questionnaire as a data collection method, the first (1) of the studies was conducted on a large sample of 1,600 respondents, the second (4) on a sample of 805 respondents. The remaining studies are qualitative in design and were conducted using the in-depth interview method, two of which are case studies. The predominant use of qualitative methods is understandable given the novelty of the topic. Two studies (2, 7) represent data from Italy, the others are from the Netherlands (1), Iran (3), the UK (4), Portugal (5) and the USA (6).

Studies do not identify significant differences between levels of grief in people before and during a pandemic, but they do agree that coping with loss may be more difficult during this ongoing health crisis. This aspect is particularly emphasized in the first and second studies (1, 2). Consistently, all studies highlight the importance of the support provided to the bereaved, as well as calling for greater use of remote forms of support. Study five (5) explicitly notes that knowledge and understanding of the grieving process and the online provision of bereavement care programs (e.g. bereavement counselling and bereavement therapy) should be a priority not only for mental health professionals but also for policy makers. Moreover, the seventh study calls for understanding and reflection on the meaning and function of spirituality and religiosity (7).

Table 1 Methodology of the analyzed studies

	Source	Target	Method of data collection and analysis	Size and composition of the research population	Recommendations, conclusions
1	Maarten (2020)	To test if grief severity is higher during than before the lockdown after non-COVID-19-related bereavement.	A cross-sectional survey including questions on sociodemographic and loss-related variables and a grief measure was	conducted among a sample of 1,600 bereaved adults (78% females), participating before (n=731) or during (n=869) the pandemic, including people who had experienced a loss before the pandemic (n=456) or during the pandemic (n=200) recently (five months ago or less)	No significant differences emerged between grief levels in people participating before or during the pandemic. Effects remained significant after controlling analyses for relevant loss-related variables. However, experiencing a recent loss during the pandemic elicited more severe acute grief reactions than before the pandemic, suggesting that dealing with loss may be more difficult during this ongoing health crisis.
2	Menichetti et al. (2021)	This study aimed to explore the families' experiences and needs collected during these calls, and the role that the psychologists played through the call	Multiple qualitative methods included: (i) written reports of the calls with relatives of patients who died at the hospital for COVID-19; (ii) qualitative semi-structured interviews with psychologists involved in the calls; (iii) observation of psychologists' peer group discussions. A thematic analysis was conducted.	A total of 246 families were called over 3 months.	Psychologists perceived families' reactions as close to a traumatic grief. Families' needs ranged from finding alternative rituals to giving meaning and expressing different emotions. The psychologists played both a social-institutional and a psychological-human role through the calls (e.g., they cured disrupted communication or validated feelings and choices). This study highlighted the potential of traumatic grief of families of COVID-19 victims and provided indications for supporting them within the space of a short phone call. Healthcare organizations may need to activate psychological resources, which can support the hospital in the process of managing losses. They also provide concrete indications for psychologists about how to manage a phone follow up to such families, in terms of actions, functions and roles played. Finally, findings show the need for future research on the understudied area of intersection of grief and trauma, and on first, early-stage reactions to challenging losses that may require further support.

3	Mortazavi et al. (2021)	This study aims to gain a deep understanding of the experience of mourning during COVID-19 pandemic by exploring the experiences of survivors of the death of their loved.	phenomenological approach	Participants in the study were selected purposely from the family members of people who died from coronavirus disease and were willing to participate in the study. The chosen participants were among those who have lost their loved ones to Coronavirus and were identified from records provided by organizations supporting the surviving families. 9 women and 6 men	The results of the present study indicate a distinct experience of the death of relatives by survivors during the prevalence of COVID-19 pandemic and the limitations caused by it. According to the results of the present study, the three stages of this experience can be identified as 1) before death and during the disease, 2) death and the initial ceremonies, and finally, 3) after death and the grieving process. Therefore, it seems that the best option at the current time is to provide as much social support as possible to the survivors, followed by tolerating and providing a body of knowledge to understand this emerging phenomenon for planning appropriately in the future for such people.
4	Pearce et al. (2021)	To investigate the experiences and views of practitioners in the UK and Ireland concerning changes in bereavement care during the COVID-19 pandemic.	Online survey	using a snowball sampling approach. Health and social care professionals involved in bereavement support. s 805 respondents working in hospice, community, and hospital settings across the UK and Ireland	Changes to bereavement care practice were reported in: the use of telephone, video and other forms of remote support (90%); supporting people bereaved from non-COVID conditions (76%), from COVID-19 (65%) and people bereaved before the pandemic (61%); funeral arrangements (61%); identifying bereaved people who might need support (56%); managing complex forms of grief (48%) and access to specialist services (41%). The pandemic has created major challenges for the support of bereaved people: increased needs for bereavement care, transition to remote forms of support and the stresses experienced by practitioners, among others. The extent to which services are able to adapt, meet the escalating level of need and help to prevent a 'tsunami of grief' remains to be seen. The pandemic has highlighted the need for bereavement care to be considered an integral part of health and social care provision.

5	Santos, et al. (2021)	Present a case of an 11-year-old girl referred to child psychiatry-liaison service by her neurologist due to peer relationship problems and sadness.	Case study	1 girl	Child and adolescent psychiatrists as well as other mental health professionals should be prepared to help the numerous individuals and families who are expected to struggle with complicated grief, depression, and posttraumatic stress disorder. Knowing and comprehending the grief process and developing and disseminating grief counseling and treatment programs possible to be remotely delivered should be a priority not only for clinicians but also for policy makers. Policies and rules regarding the COVID-19 pandemic have to considerate measures to protect mental health, facilitating the grief process.
6	Solomon, Hensley (2020)	This article presents a framework for treatment of grief and mourning with eye movement desensitization and reprocessing (EMDR) therapy.	Case study	A case example is presented to illustrate treatment of a client whose father died due to COVID-19.	Unresolved losses and trauma, including attachment-based memories, can contribute to the client's symptoms and reactions to present loss. EMDR therapy, guided by the AIP model and other theoretical frameworks pertinent to grief and mourning, can be utilized to treat the trauma of the loss, current distressing circumstances, and the underlying memories contributing to the current clinical picture. EMDR therapy facilitates integration of traumatic memories and enhances present functioning through processing of present triggers and the laying down of future templates. In this context, EMDR can also be understood as a paradigm of resilience, enabling positive adaptation to difficult circumstances.

7	Testoni et al. I (2021)	This work aimed to investigate the psychological experiences related to the contagion and the eventual death of colleagues as well as the resilience strategies activated by the priests during the process.	A qualitative research design was adopted, and in-depth interviews were conducted. The dialogues aimed at investigating the deep, personal and relational experiences of the priests, together with their concerns and the tools they adopted to manage anxiety. The texts obtained from the interviews were subjected to thematic analysis.	The participants were aged between 42 and 63 years (mean = 54 years; SD = 7) and were living with other priests and/or seminarians.	The areas studied concerned the experiences of the participants during the lockdown, the implications of social distancing and lack of funeral rituality and, finally, the importance of prayer as a resilience factor. It is significant and stimulating to understand and reflect on the functions and roles of the experiences of faith, particularly the act of elaborating the process of mourning due to COVID-19.

Discussion

The analyzed studies mainly reflected the situation of people who had experienced COVID-19 themselves, recovered, but found themselves in the role of survivors due to the death of a loved one from the disease. The studies presented also showed that the covid-19 pandemic, among other things, brought to the fore the theme of multiple or multidimensional loss[127] and the experience of mourning in the context of a different kind of loss than the loss of a loved one through death.[128] This could be, for example, grief for oneself, relational grief, collective grief, environmental grief, etc. Grief can have many levels and many forms.[129] Even such grieving can be important to the grieving person and may require interventions similar to those for relational grief. It is important to note that, for example, coping with collective grief implies sharing and experiencing it in the community, which means, among other things, the preparation and implementation of collective commemorative community events.

Texts on complicated mourning published before the COVID-19 pandemic pointed out that in the case of normal, uncomplicated mourning it is not necessary to provide any professional care to the bereaved and could even be counterproductive. In the case of complicated bereavement, then, therapeutic intervention is highly desirable. This narrative has changed somewhat in the context of the COVID-19 pandemic, and all of the texts analyzed point to the effectiveness of any appropriate intervention for the bereaved – even in the case of uncomplicated mourning. It is even hypothesized that adequate care for the bereaved can eliminate the risks of the development of complicated grief in the bereaved. Thus, professionals from different spheres are called upon to care for the bereaved, e.g. medical personnel, social service workers, members of the so-called integrated emergency system, community leaders and others. Various online

127 Mitchell. K. R., Anderson, H. *All our losses, all our griefs. Resourses for pastoral care,* (Philadelphia: Westminster Press, 2010).

128 Mayland, C. R., Andrew J.E., Harding, B. A., Preston, N., Payne, S., Supporting Adults Bereaved Through COVID-19: A Rapid Review of the Impact of Previous Pandemics on Grief and Bereavement, *Journal of Pain and Symptom Management, 2020,* Volume 60, Issue 2, e33-e39.

129 Chater, A., Let's talk about death openly, *The Psychologist*, 2020, 33, 23-25. Retrieved from: https://thepsychologist.bps.org.uk/when-world-grieving-please-dont-walk-eggshells

activities are also recommended to minimize or reduce the impact of the COVID-19 pandemic on survivors.[130]

Conclusion

The opinion of the professional public on the concept of so-called complicated mourning is not unanimous. It should be understood that the concept of complicated mourning is not the happiest one for counselling and therapeutic work with the bereaved. There are several serious risks involved. First of all, there is the stigmatization and self-stigmatization of the bereaved.[131] Furthermore, there is the problem of medicalization and medicalization of mourning,[132] i.e. seeing mourning, a normal and normal reaction to loss, as a medical problem, and the related pharmacological consequences, i.e. the deployment of psychopharmacological medication. In effect, this means an inappropriate narrowing of the issue of grief to the medical, or psychiatric and psychological (specifically, the field of clinical psychology). However, grieving is a necessary and natural process without which it is impossible to come to an acceptance of the loss of a loved one. Grief is not a disease, it is not a pathology, it is an appropriate reaction that allows one to accept the loss of a loved one and to adapt to it over time.

Therefore, it seems much more effective to deal with factors that can complicate grief or mourning. For example, Burke & Neimeyer[133] conducted a meta-analysis of more than 40 studies conducted between 1980 and 2010. All of these studies looked at the grieving process, with half of them exclusively looking at its risk factors. More than half of these studies used the Inventory of Complicated Grief (ICG). Burke & Neimeyer[39] identified the following risk factors that may cause grieving to become complicated:

- Low level of social support,
- Anxious or avoidant emotional attachment,
- Discovery or identification of the body of the deceased person (in the case of a violent death),
- Death of a spouse or child,
- Dependent relationship with a partner,
- Neuroticism.

Prigerson et al.[134] describe the following factors as determinants of complicated grief: the circumstances of the death (untimely, sudden, unexpected, or horrific death); the death of the child; the trauma (witnessing the death, the nature of the "event", and the circumstances under which the bereaved learn about "it"); the meaning the bereaved ascribe to the event; the centrality of the relationship between the bereaved and the deceased *("He was the most important*

130 Kumar, R., M., The Many Faces of Grief: A Systematic Literature Review of Grief During the COVID-19 Pandemic, *Illness, Crisis & Loss*, 2021, 1-20 DOI: 10.1177/10541373211038084, I

131 Ocisková, M., Praško, J.. *Stigmatizace a sebestigmatizace u psychických poruch,* (Prague: Grada Publishing, 2015).

132 Špatenková, N. et al., *O posledních věcech člověka*, (Prague: Galén, 2017).

133 Burke, L. A., & Neimeyer, R. A., Prospective risk factors for complicated grief: A review of the empirical literature. In Stroebe, M., Schut, H., & van den Bout, J. (Eds.), Complicated grief: scientific foundations for health care professionals, ([E-book], 2013), 145-161. doi:10.4324/9780203105115

134 Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., ... Miller, M., Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, 1995, 59(1-2), 65-79. doi:10.1016/0165-1781(95)02757-2

person in the world to me. Without him, I cannot and will not be able to go on living."); feelings of guilt or remorse, usually related to the perceived possibility of avoiding death; pre-existing factors; previous unprocessed grief; alcohol or other drug dependence; psychopathology; or some health problem; ambivalence of the relationship between the bereaved and the deceased; lack or reduction of social roles; lack of social support; concurrent co-morbid crises; overly prolonged dying; lack of reality.

Kubíčková[135] says the survivors themselves feel that their grief has become complicated and that they are stuck in a grieving process that they can no longer continue. For this reason, they then seek professional help. She argues that this self-diagnosis is typical for the bereaved. If the bereaved perceive a connection between their grieving and their problems, the therapist's job is in many ways made easier. If this is not the case, it is necessary to reflect on so-called risk factors, which include, for example: the impossibility or impossibility of. The inability to talk about the deceased without the bereaved experiencing acute and intense grief again; a strong emotional response to any event, even the slightest one; themes of loss coming up in the conversation; the bereaved keeping all things as left by their loved one ("mummification"); exhibit all the symptoms of the deceased; suffer from phobia of death or illness; avoid participation in rituals associated with death; radically change their lifestyle, turn away from relatives and friends, resign from activities that have any relation to the deceased person. A state of despondency and strong feelings of guilt persist, but false euphoria may also be a symptom. Survivors may also imitate or identify with the deceased person in some way, even if they consciously deny it and do not wish to behave in that way. Self-destructive behavior may occur.

Specialist care is then necessary if it is clear that the patient is: depressed; addicted to alcohol, drugs or medication; somatoform or convulsive symptoms; phobias or anxiety disorders such as thanatophobia, social phobia, nosophobia, cancerphobia, etc.; panic attacks; intense feelings of guilt and self-blame; suicide attempts; various forms of mental disorders. The task of the professional in such a situation is to assess the condition of the bereaved – for which he or she needs the appropriate tools – and to offer adequate help. The boundaries between 'normal' and complicated grieving are not entirely clear.

In the Czech Republic, bereavement care is currently considered in the context of social services, not in the context of health care (in the context of psychiatry or clinical psychology, or psychotherapy). In the context of the consideration of the amendment to the Social Services Act, a new social service is even being considered, namely "Assistance to loved ones to cope with the trauma associated with the death of a loved one".[136] There is even a professional qualification of Bereavement Counsellor, which is precisely described in the National Qualifications Framework and the National Occupational Framework. The medicalization and medicalization of bereavement in relation to the concept of complicated bereavement thus seems somewhat counterproductive in our view, as does the concept of complicated bereavement itself.

In spite of the difference of opinion on the conception of the process of (un)complicated mourning and the interdisciplinary grasp of the issue, we are united in establishing the premise of the adequacy of care for the bereaved. Adequate intervention of helping professionals in relation to bereaved persons can be very effective and to a substantial extent eliminate the negative effects of bereavement on the bereaved, "normalize" reactions to the loss and facilitate effective coping strategies (coping strategies) in the situation of loss of a loved one by death.

Implementing innovative ways of supporting the bereaved (e.g. in terms of online activities) and modifying existing funeral and mourning rituals should also be an integral part of such an approach, as rituals are very important to the bereaved.[137] This may involve, among other things, the support and coordination of events and the cooperation of various organizations involved in bereavement care.

135 Kubíčková, N., *Zármutek a pomoc pozůstalým* (Prague: ISV, 2001), 163- 165.

136 Špatenková, N. et al., *O posledních věcech člověka*, (Prague: Galén, 2017), 27-28.

137 Dobríková, P. *„Sozial-kulturelle Aspekte in der Zeit des Sterbens und Trauerns in der römisch-katholischen und griechisch-katholischen Kirche in der Slowakei."* In: Trauerbegleitung in unterschiedlichen kulturellen, sozialen und religiösen Kontexten. (Dzięgielów: Warto, 2015), 47–65.

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OPIOID ANALGETICS IN PALLIATIVE MEDICINE

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Abstract

Background: An estimated 40 million people need palliative care each year, with up to 78% living in low- and middle-income countries, and only 14% of those in need of palliative care have access to it. At present, in developed countries, the death of an individual is most often the result of a long chronic illness, whether oncological or non-oncological. Pain is the most common and most severe symptom of a palliative patient. Treatment must always be aimed at improving the quality of life remaining, and should lead to the optimization of the patient's physical and cognitive functions during the course of the disease.

Conclusion: Opioid analgesics in the treatment of pain in patients requiring palliative care are one of the basic tools for its optimal control, but of course, in combination with other drugs and non-pharmacological and interventional pain management techniques. Even in this risk group of usually seriously ill patients, their administration must follow the generally accepted principles of their administration by experienced physicians with a sufficient range of knowledge and experience with the use of opiates in the clinical practice of acute and chronic pain.

As a basic recommendation for practice - the palliative medicine physician as well as other members of the palliative care team must be able to recognize the painful syndromes of the palliative care patient and according to general recommendations, also initiate pain treatment. If the pain cannot be controlled, the patient should be referred to an algesiologist.

Keywords: Palliative medicine **–** Pain **–** Opioid analgetics.

Introduction

Palliative medicine improves the quality of life of patients and their relatives who face the challenges of life-threatening illnesses - whether physical, mental, social or spiritual. It prevents and alleviates suffering by early identification, proper assessment and treatment of pain and other problems - physical, psychosocial or spiritual. It uses a team approach, solves practical problems for the dying person, provides counseling and offers a support system that helps patients live as actively as possible until death. It is recognized explicitly, as is the fundamental human right to health.

An estimated 40 million people need palliative care each year, with up to 78% living in low- and middle-income countries, and only 14% of those in need of palliative care have access to it.[139]

In addition, as the population ages, the global need for palliative care will continue to increase.

At present, in developed countries, the death of an individual is most often the result of a long chronic illness, whether oncological or non-oncological. This fact contrasts with the data that in the last century, death was more of a rapid, sudden consequence of an acute health disorder - the most common infection or injury. The group of patients who die slowly is growing.

Today, the most common causes of death in developed countries are cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), AIDS (5.7%) and diabetes mellitus.[140]

Palliative care may be needed not only by cancer patients, but also by patients with non-cancer diseases - renal and hepatic failure, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disorders, dementia, congenital anomalies or tuberculosis. Pain is the most common and severe symptom of a palliative patient. In second place is the feeling of difficulty breathing - dyspnoea.

Treatment must always be aimed at improving the quality of life remaining, and should lead to the optimization of the patient's physical and cognitive functions during the course of the disease.

The therapeutic plan should be an appropriate combination of pharmacological and non-pharmacological procedures, with maximum attention paid to the values and needs of each patient.

Opioids are irreplaceable in the treatment of painful syndromes, but they can also solve other symptoms (dyspnoea).

Oncological patients

About two-thirds of cancer patients clearly declare pain[141]. On the trajectory of life, in the period very close to death (1 week before death), pain occurs in up to 34% - 54% of patients.[142] Uncontrolled or poorly controlled cancer pain can result in an individual's desire for rapid death, write: Price et al, 2011. The treatment of tumor pain is individualized and must clearly take into account the cancer pain syndrome.

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139 Stephen R. Connor and Maria Cecilia Sepulveda Bermedo. *The Global Atlas of Palliative Care at the End of Life* (Worldwide Hospice Palliative Care Alliance), 2014.

140 Jean S. Kutner, Lucinda L. Bryant, Brenda L. Beaty and Diane L. Fairclough, "Time Course and Characteristics of Symptom Distress and Quality of Life at the End of Life." *J Pain Symptom Manage* 34, no. 3, (2007): 227–236. DOI:https://doi.org/10.1016/j.jpainsymman.2006.11.016

141 Keith G. Wilson, Harvey Max Chochinov and Pierre Allard, "Prevalence and correlates of pain in the Canadian National Palliative Care Survey," *Pain Res Manag* 14, no. 5, (2009): 365–370. https://doi.org/10.1155/2009/251239

142 Coyle N, Adelhardt J, Foley KM et al. "Character of terminal illness in the advanced cancer patient: pain and other symptoms during the last four weeks of life [comment]." *J Pain Symptom Manage* 5, no. 2, (1990):83–93.

Non-cancer patients

These are patients suffering from incurable non-cancerous diseases, which by their nature have reached their final stage, cure is not possible and the source of escalating pain is disease progression, immobility or concomitant comorbidities (eg pressure ulcers).

These are mostly elderly patients who also have other pre-existing pain conditions, such as osteoarthritis, osteoporosis, polyneuropathy, or back pain.[143]

In terms of the end of life and death itself, there are three groups of these patients.

The first group are patients who have a serious illness that is incurable, progresses and the result of this progression is death. Then it is the second group of patients who have the underlying disease stable, relatively few symptoms, but they will experience a sudden deterioration in health and also a sudden death. The third group of patients is where the progression of their underlying disease is not so obvious, they may have periods of deterioration (then palliative care is needed) and periods of remission when they are getting better. Death also comes unexpectedly.[144]

1 HIV and AIDS patients

At present, due to antiretroviral treatment, their median survival is almost 35 years from the time of diagnosis.[145] Paradoxically, the longer survival of this group of patients means a higher risk for them to develop many comorbidities - cardiovascular, renal, hepatic, malignancies, which may predispose them to the need for palliative care.

2 Patients with advanced chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease is not just a lung disease - but rather a complex systemic disease with an individual‘s psychological response to it. It is associated with a specific syndrome - dyspnoea. Dyspnoea accompanies the patient throughout the illness, significantly reduces the patient‘s quality of life, is a source of psychological deterioration and severe psychosocial reactions of the patient.[146] The „start low-go slow“ approach has been shown to be effective in treating pain in this group of patients.[147]

3 Patients with heart failure

Cardiac failure is the last stage of heart disease of various etiologies, is one of the main causes of mortality and also a frequent reason for the need to provide palliative care. (Benjamin et al, 2018). It is associated with many symptoms - most often pain, then dyspnoea, edema, fatigue syndrome and depression.

4 Patients with dementia and other neurological diseases (ALS, Parkinson‘s disease, multiple sclerosis)

143 Tiago Coelho, Constança Paúl, Robbert J. J. Gobbens et al. “Multidimensional Frailty and Pain in Community Dwelling Elderly,” *Pain Med* 18, no.4, (2017): 693–701. https://doi.org/10.1111/pme.12746

144 Dulce M. Cruz-Oliver, “Palliative Care: An Update,” *Mo Med*. 114, no. 2, (2017): 110–115.

145 “The Antiretroviral Therapy Cohort Collaboration. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies,” *Lancet* 372, 9635, (July 26, 2008): 293-299. DOI:https://doi.org/10.1016/S0140-6736(08)61113-7

146 Marjolein Gysels and Irene J. “Higginson. Access to Services for Patients with Chronic Obstructive Pulmonary Disease: The Invisibility of Breathlessness.” *J Pain Symptom Manage* 36, no. 5, (2008): 451-460. doi: 10.1016/j.jpainsymman.2007.11.008

147 Marciniuk, Darcy D, Donna Goodridge, Paul Hernandez et al. “Managing dyspnea in patients with advanced chronic obstructive pulmonary disease: a Canadian Thoracic Society clinical practice guideline,” *Can Respir J* 18, no. 2, (2011): 69-78. doi: 10.1155/2011/745047

Cognitive deficit in patients with dementia is conditioned by the accompanying phenomena of this neurodegenerative disease - social isolation, varied psychiatric symptomatology, a significant decline in quality of life. Palliative interventions include planning follow-up care for disease progression, avoiding complex diagnostic procedures, as these are associated with a high risk of mortality.[148]

5 Patients with renal failure

Despite the possibility of hemodyalisation or transplantation treatment, there is a large group of patients who have become unavailable for various reasons.[149] Patients suffer from various syndromes - anxiety, depression, pain, pruritus, restless legs syndrome, insomnia or insomnia. Due to the variety of symptoms present, palliative care is extremely important for them.

6 Patients in the intensive care unit

Palliative care of the patient in the end of life period in the department of anesthesiology and intensive care has its specifics. This is mainly because the staff at the ICU is primarily focused on saving lives, and so the transition from life-saving care to palliative care can be very challenging in all respects.

Pain syndromes in palliative medicine

Pain in a palliative patient with non-cancerous disease

Syndromes in a palliative patient with a non-cancerous disease can be divided according to the etiology into pain caused by the underlying disease, pain caused by the treatment of the underlying disease and then painful syndromes unrelated to the underlying disease or its treatment (Table 1).

Table 1: Painful syndromes in palliative medicine (Roenn, 2006)

Pain caused by the underlying disease	Pain caused by treatment of the underlying disease	Pain unrelated to the underlying disease or its treatment
Pain caused by tissue compression or compression of nerve structures by the tumor	Peripheral neuropathy due to treatment of cancer with chemotherapy or HIV antiretroviral therapy	Ulcerations from the oppression of protruding drains, catheters
Chest pain in the last stage of heart failure	Arthralgia and myalgia in the treatment of aromatase inhibitors	Muscle atrophy and resulting myalgia
Ischemic pain in vascular diseases	Phantom pain as a consequence of surgical treatment	Joint pain in hypomobility
Abdominal pain during ascites	Postherpetic neuralgia in immunocompromised patients	Pain in contractures
Abdominal pain with transmitted pain to the chest or shoulder in hepatic failure and liver cirrhosis	Post-radiation plexopathy, osteoradyonecrosis	
Skin pain in excessive edema	Aseptic necrosis due to prolonged corticotherapy	
Cruciate pain and pruritus in renal failure		

148 T R Fried, M R Gillick and L A Lipsitz, “Whether to transfer? Factors associated with hospitalization and outcome of elderly long-term care patients with pneumonia,” *Journal of General Internal Medicine* 10, (1995): 246–250. DOI: 10.1007/BF02599879

149 UK Renal Registry. 2018. 20th Annual Report of the Renal Association. *Nephron,* 139 (Suppl. 1), 1–372.

Chest pain in pulmonary fibrosis, emphysema		
Headache in neuroinfections		
Central pain after stroke		
Trigeminal nerve neuralgia in multiple sclerosis		
Bone, muscle and visceral pain in peripheral vascular occlusion in sickle-cell anemia		
Neuromuscular pain in spasticity		

Pain in a palliative patient with cancer

Pain in a oncological patient can be didactically divided in terms of etiology and time.
In terms of etiology, the division of syndromes is as follows:
a) Syndromes in relation to the tumor and its progression
b) Syndromes caused by tumor invasion into nerve structures
c) Abdominal pain
d) Syndromes in relation to diagnostic and therapeutic procedures
In terms of time, we can divide the syndromes of the palliative patient into two groups, acute and chronic. The description of the detailed syndromology of cancer pain is not the subject of this article.

Opioid analgetics in the treatment of a palliative patient

Palliative medicine is characterized primarily by the care of a patient for whom causal treatment is largely no longer possible and requires treatments aimed at improving patient´s quality of life. Such modalities include, in particular, control, or soothing his/her pain if he/she suffers from it. In the palliative care phase, we may encounter both acute and chronic pain, with cancer, but also non-cancer pain. It can be of mild, moderate or strong intensity, it can be nociceptive (somatic, visceral), neurogenic (peripheral, central), psychogenic, mixed and of unknown origin.

In the treatment of acute, chronic and tumor pain, we can use three types of therapeutic procedures in most patients: pharmacological, non-pharmacological and invasive (interventional). We use them individually in a mutually useful combination according to the characteristics of the pain being treated. They are part of the therapeutic decisions on the treatment of an acute painful condition by a general practitioner, palliative medicine doctor, oncologist or other specialist. If the treatment is already managed by an algesiologist, after making an algesiological diagnosis, patient will usually draw up a therapeutic plan for the treatment of pain at the first examination of the patient.

While the treatment of acute pain may consist of the use of only one analgesic or adjuvant, the pharmacotherapy of chronic pain always consists in the use of a combination of drugs. Its aim is to effectively influence the most important mechanisms of pain origin, transmission and perception at the level of various receptor and modulation systems according to pain diagnosis. Therefore, the treatment is always individually selected with a combination of drugs of different groups.

In general consideration of therapeutic interventions in the field of treatment of painful conditions, we can set certain pathophysiological therapeutic goals in the form of so-called

„Chronic pain pharmacotherapy algorithm“, which we present below. However, for the treatment of all types of pain, in principle, the WHO recommendation in the form of so-called „Analgesic ladder“ applies.

Analgesic ladder

The analgesic ladder is therefore a binding recommendation of the WHO (World Health Organization) for the selection of analgesics and adjuvant drugs according to different pain intensities. A three-stage analgesic ladder is standardly mentioned and used in practice, which has its individual degrees differentiated according to the intensity of pain. The first stage is characterized by mild pain with VAS (Visual Analogue Scale) of 1-3, the second stage indicates moderate pain (with VAS of 4-7) and the third stage of the analgesic ladder is characterized by severe pain (with VAS of 8-10) (see Figure No. 1). Each step is characterized by the application of analgesics and adjuvants in various useful combinations. **Non-opioid analgesics** are used on the first level of the analgesic ladder (pain of low intensity), second level is dominated by **weak opioids**, on the third level, we use **strong opioids**. In addition to analgesics, in the chronic pain treatment it is necessary to use the so-called **adjuvant drugs**, which are divided into co-analgesics and auxiliary drugs. We draw most of the information on the use of opioids in patients in palliative care provided in this article from the textbook titled Pain Pharmacotherapy for Physicians and Pharmacists.[150]

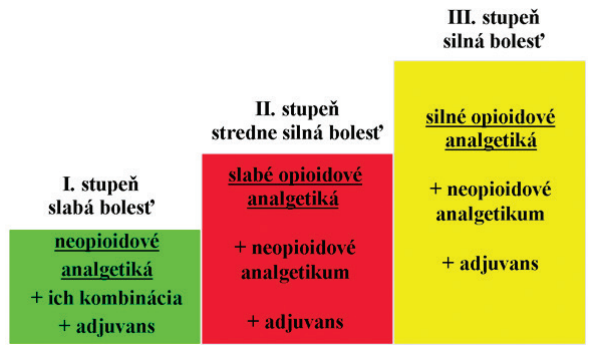

Figure 1: Analgesic ladder (source: author´s archive).

Principles of treatment of acute pain

Acute pain is always one of the symptoms of the disease that caused it, and in principle it is always protective or warning. It is therefore one of the most frequent, most common and usually the earliest symptoms of various pathological conditions associated with inflammation, damage to organs or tissues of the body. Therefore, most general practitioners and specialists naturally deal with its treatment. Acute pain can also occur at any time during a chronic illness in a patient requiring palliative care. The relief of acute pain usually occurs only after the working diagnosis of the disease that caused it has been made. However, we always pay attention to its intensity, as it can be so intense and shocking that it can itself be a source of damage to the organism and even its death. Control of acute pain is in principle symptomatic, often using pharmacological procedures, together with an effective combination with non-pharmacological procedures and interventional techniques (anesthesia). We use opioid analgesics for severe acute pain, usually in the first hours or days after its onset, and with the healing of the affected tissue, we gradually discontinue them - according to the **„inverted analgesic ladder“** scheme. This means that we initially use a combination of higher levels of the ladder (usually a “secondary” combination of a non-opioid analgesic and a weak opioid) for a patient with severe pain, and during the relief of pain in the course of tissue healing, we gradually reduce the titrated dose and gradually discontinue the individual drugs from the combination. This allows

150 Igor Martuliak, *Farmakoterapia bolesti pre lekárov a farmaceutov* (Banská Bystrica: Martimed s r.o., 2019).

us to quickly determine the required minimum effective dose and combination of drugs with their relative safety of side effects occurence. In contrast to the treatment of chronic pain, the pharmacotherapy of acute pain usually has a simpler treatment regimen, often using monotherapy with a non-opioid analgesic or a weak opioid, or in combination with a co-analgesic in their rapid-acting forms. In medical facilities, we often also use infusion of intravenous drugs, which will enable their faster and more robust effect. Due to the fact that acute pain is from the pathophysiological point of view dominated by inflammation, we usually use non-steroidal anti-inflammatory drugs (nesteroidové antiflogistiká) in the first line. We then combine them according to the principles of the analgesic ladder based on the type and intensity of pain with other non-opioid analgesics, with weak opioids and various co-analgesics.

Choice of drugs according to the type of pain

In order to decide on the choice of appropriate drugs, it is necessary to determine the type of pain that bothers the patient, or which dominates. The most common types of pain are nociceptive pain – i.e., somatic or visceral and neuropathic (neurogenic) pain. While for nociceptive pain we use a combination of analgesics and adjuvants according to the principles of the analgesic ladder, for neuropathic pain we prefer anticonvulsants, antidepressants in the first line and only in the second line we add non-opioid and possibly opioid analgesics to them.

In somatic pain, such as e.g. back and musculoskeletal pain, healing scars, and toothache are usually the most effective non-steroidal anti-inflammatory drugs (NSAIDs) and paracetamol, which can also be used in combination with each other. In case of mild analgesia, we add a gradually increasing dose of tramadol, or dihydrocodeine and often also selected adjuvants. We use rarely opioid analgesics for acute pain. Of the coanalgesics for acute pain, we administer the most commonly muscle relaxants (benzodiazepines), usually also in order to use their anxiolytic effect and the application of local anesthetics in interventional analgesics, or regional anesthetic performances. As adjuvants, we often use auxiliary drugs, especially antiemetics, but also gastroprotectives and laxatives.

We treat **visceral pain** in the acute state in a similar way, only we usually prefer the administration of metamizole to NSAIDs and paracetamol, which has, in addition to an analgesic (and antipyretic) effect, also a significant spasmolytic effect. We also often use anxiolytics and antidepressants as adjuvants, and antiemetics and prokinetics as auxiliary drugs. Here, too, strong opioid analgesics are rarely used (as opposed to chronic visceral pain). The most common examples of acute visceral pain are abdominal pain of various etiologies (postoperative pain, colic, pancreatitis, etc.) and of chest. We would like to emphasize that before relieving of acute visceral pain, it is necessary to determine the origin of the pain, i.e., the diagnosis!

Neuropathic pain is usually accompanied by direct damage to the fibers of the peripheral or central nervous system, with impulses of pain arising not at the free nerve endings, but (ectopically) at the site of the lesion. The most common examples of peripheral neurogenic pain are postherpetic neuralgia, diabetic polyneuropathy, but also neuralgia n. trigeminus, or various root irritation syndromes. Therefore, in the treatment of neuropathic pain, we primarily use drugs belonging to the group of adjuvants, and we usually use analgesics only as an additional treatment for pain. Among coanalgesics, we mainly administer anticonvulsants (especially gabapentin, pregabalin and carabmazinpine), antidepressants mainly from the group of SSRIs (Selective Serotonine Reuptake Inhibitors) and SNRIs (Serotonine Norepinephrine Reuptake Inhibitors) (as stabilizers of sensitized central nervous system and CNS) and anxiolytics, as well as („antineuropathic“) infusions with ketamine, trimecaine, magnesium, but

also thiopental, skin-glued lidocaine and capsaicin patches, and other substances. Of the analgesics, methamizol, NSAIDs, and tramadol are usually effective for neuropathic pain. For the indicated cases, we can also try one of the molecules of strong opiates. Even with this type of pain, interventional and physical treatment is a matter of course.

Principles of pharmacotherapy of postoperative and post-traumatic pain

The most common cases of acute pain include post-traumatic pain and post-operative or procedural pain. In principle, these are very similar types of pain, except that in postoperative and procedural pain, we can, in contrast to post-traumatic pain, assume its origin and intensity. Postoperative pain also has a more frequent visceral component of pain than post-traumatic pain. In both cases of acute pain, it is pain as a warning, protective symptom of the disease and with the gradual healing of the damaged tissue, it gradually alleviates until it disappears completely.

Due to the fact that the patient usually does not take orally, the first days after surgery and injury, painkillers are most often given in **the form of intravenous infusions**. These are usually 2 to 3 infusions per day, sometimes combined with other parenteral treatments with their intramuscular, subcutaneous, intravenous or other administration. We use precisely defined monocomposite infusion specialties, or effective combinations of drugs in physiological saline, the composition of which is selected according to the purpose of their administration (i.e., indication). In the case of post-traumatic and post-operative pain, their composition most often consists of:

- a non-opioid analgesic, namely NSAIDs (for the purpose of mainly analgesic, anti-inflammatory and anti-edema effects), or metamizole (as an analgesic and antispasmodic, especially for visceral pain)
- an opioid analgesic (to relieve severe pain);
- local anesthetic (cell membrane stabilizing effect, analgesic, anticonvulsant and muscle relaxant effect);
- muscle relaxant - anxiolytic (centrally relieving excessive tension in the mind and skeletal muscles);
- magnesium (usually as sulphate or magnesium sulphuricum, MgSO4) with a muscle relaxant and CNS stabilizing effect.

Overview of basic drugs designed to relieve acute pain by **intravenous analgesia**:

1. mild pain – neopiates in injectable form: metamizole, paracetamol, from the group of NSAIDs: diclofenac, ibuprofen, ketoprofen, meloxicam, lornoxin,…
2. moderate pain - weak opioids in injectable form: tramadol, pethidine,…
3. severe pain - strong opioids in injectable form: morphine, sufentanil, remifentanil, pyritramide,…

The main principles of treatment of chronic pain

The treatment of chronic pain is also usually more complex and complicated in palliative patients, compared to the treatment of acute painful conditions. The main reason is the pathophysiological changes in the nervous system accompanying chronic pain, as well as the variety of types of pain and clinical symptoms present and the resulting complexity of its treatment.

Chronic pain pharmacotherapy algorithm

The success of the treatment of chronic pain lies in understanding the pathophysiological changes associated with sensitization of the nervous system and in deploying the right combination of drugs individually for the patient. When striving for the complexity and purposefulness of the therapeutic procedure, it is necessary to appropriately influence the central and peripheral component of chronic pain and at the same time to time the individual therapeutic steps correctly. This process of complex treatment of chronic pain is structurally illustrated by **the algorithm of the principles of pharmacotherapy of chronic pain**.[151] It emphasizes the need to combine pharmaceuticals from different groups influencing several levels of the nervous system that are involved in the onset of pain.

Palliative, long-term suffering patients are usually already in the stage of more or less developed NS sensitization and chronic pain. They have often already undergone unsuccessful pharmacotherapy of pain in other specialists, mostly with non-opioid analgesics, in the case of neuropathic pain together with anticonvulsants, and due to their ineffectiveness and symptoms of anxiety-depressive disorder, possibly anxiolytics. However, this treatment is ineffective and patients often continue to suffer, mainly due to failure to recognize signs of nervous system sensitization with disruption of pain inhibitory mechanisms by the attending physician.

Pharmacotherapy of chronic pain should, in principle, focus on sufficient topical analgesia as well as adequate treatment of CNS sensitization.

Pharmacotherapy algorithm for chronic pain[152]**:**

1. Stimulation of damaged and failing central pain inhibition. In algesiological practice, it is often necessary to first stimulate and stabilize impaired mechanisms of pain inhibition (segmental, descending and central), usually by using a suitable antidepressant (from the group of tricyclic antidepressants - TCA, SSRI, SNRI,…) administered for a long time (average 1 year) in a low dose once a day. Some non-pharmacological procedures often play a key role in this indication (especially the appropriately chosen technique of individual psychotherapy, transcutaneous electrical nerve stimulation - TENS, but also others).

2. Stabilization of the present CNS sensitization. To stabilize CNS sensitization, i.e., reduction in the development of maladaptive neuroplastic changes in the nervous system, we may use NMDA receptor antagonists (e.g. ketamine, NSAIDs), TRPV channel agonists (capsaicin) and potassium channels (flupirtine), as well as antidepressants (TCA, SSRI, SNRI,…) in the role of „antinociceptives“, or „antisensitizing“ drugs, stimulating central inhibitory mechanisms, or opioids, anxiolytics, neuroleptics, calcium channel blockers and many others. Here, too, it is possible to use some non-pharmacological procedures (such as psychotherapy, autogenous training, targeted motivation, TENS,…) and others.

3. Reduction of nociceptive peripheral afferentation. In addition to strengthening the central component of pain, we must also ensure the **reduction of excessive nociceptive afferents** from the periphery in various ways. This is either by **reducing the generation of pain impulses** (the so-called „pain generator“) either by **controlling sterile inflammation** at the site of tissue damage by applying anti-inflammatory drugs (NSAIDs, corticoids) or by trying to **reduce ectopic excitation** by anti-convulsants (pregabalin, gabapentin, carbamazepine,…) and on the one hand by **reducing painful transmission** by applying regional anesthesia techniques at the level of the spinal cord, nerve plexuses and peripheral nerves (local anesthetics in the role of Na^+ channel blockers). Depending on the patient‘s condition, they can be applied either at the same time as the pharmacotherapy is started, or only after the effect of this treatment. In clinical practice, it is really interesting to observe how a few hours of limiting the supply of painful impulses from the site of origin to the spinal cord can allow reconstruction of segmental and supraspinal „defenses“ (inhibitory mechanisms) of the central nervous system with subsequent improvement in pain control and patient suffering.

4. Ensuring current analgesia. In addition to the above-mentioned therapeutic interventions, we strive to ethically ensure quality up-to-date analgesia according to the principles of the analgesic ladder with the application of non-opioid and opioid analgesics, adjuvant drugs, non-pharmacological procedures, etc.

151 Igor Martuliak, *Patofyziológia bolesti pre klinickú prax – 2. doplnené vydanie* (Banská Bystrica: Martimed s r.o., 2020).

152 Igor Martuliak, *Farmakoterapia bolesti pre lekárov a farmaceutov* (Banská Bystrica: Martimed s r.o., 2019).

Opioid analgesics

Weak opiate analgesics

If the analgesia provided by non-opioid analgesics from the first level of the „analgesic ladder“ (NSAID, paracetamol and metamizole) is insufficient, or the pain in the given patient progresses over time, to the second level of the „analgesic ladder“ to the first level analgesics and/or adjuvants we add a gradually increasing dose of the representative of the so-called „weak opioids“. Although weak opioids are not precisely defined, their common characteristic is the existence of a maximum daily defined dose of these molecules, i.e., the maximum safe daily dose, which results from their so-called „ceiling effect“. It is one of the basic characteristics of the vast majority of drugs (probably all except strong opioids), which sets the limit of the maximum (ceiling) daily dose of the drug, increasing which no longer increases the desired (in this case analgesic) effect, but only the extent and the intensity of the side effects of the given molecule. Another variant of this effect is the possibility that the desired (analgesic) effect increases with increasing dose, but at the same time the incidence of adverse drug reactions increases, up to an intolerable level (i.e., the risk-benefit ratio is greater than 1).

An opioid analgesic is indicated only for the symptomatic relief of pain, which no longer responds to the administration of drugs from the first level of the analgesic ladder and does not directly interfere with the process of generating pain impulses in peripheral tissues.

In clinical practice in Slovakia, we consider the so-called weak opioids especially the molecules of tramadol and dihydrocodeine.

1. Tramadol

Tramadol is a weak opioid analgesic with a dual CNS effect. It acts as a partial agonist of low-affinity μ opioid receptors and up to about 60% of its activity is mediated by the influence of monoaminergic receptors (indirect α2 agonist) with inhibition of the „reuptake“ of more serotonin than noradrenaline.

Therefore, in addition to the direct opioid-mediated analgesic effect, it also modulates pain perception by stimulating spinal segmental inhibition with an effect not only on nociceptive, but also on neuropathic pain, thus significantly stimulating inhibitory antinociceptive mechanisms of pain (especially descending serotonergic and noradrenalineergic inhibitory pathways). It also acts as an antagonist of various other receptor systems[153], which allows it to provide the desired analgesic effect at relatively lower doses of the drug and thus its greater safety and broader therapeutic spectrum. It should be noted that the blockade of serotonin and norepinephrine reuptake is much weaker than with conventional tricyclic antidepressants, therefore tramadol

153 Igor Martuliak, *Farmakoterapia bolesti pre lekárov a farmaceutov* (Banská Bystrica: Martimed s r.o., 2019).

has no clinically significant antidepressant or anxiolytic effect. It should not be administered with monoamine oxidase inhibitors and cautiously with SSRIs, SNRIs antidepresants.

One of the significant advantages of tramadol is its availability in a wide range of application forms. The total daily dose of tramadol hydrochloride should not exceed 400 mg, except in special clinical circumstances, such as a chronic painful condition. These usually represent the regular use of a stable dose of 200 mg tramadol twice a day in the form of retarded tablets with intermittent use (as needed) in the form of sudden (so-called intercurrent) or breakthrough pain in a dose of 20 drops (50 mg) for a maximum of 2 - 3 times a day. With good individual tolerance and analgesic effect, especially in the treatment of oncological pain, we exceptionally administer a maximum daily dose of tramadol of 500 - 600 mg, which we no longer exceed!

The single dose of tramadol is approximately 50 -100 mg at 4- to 6-hour intervals, which are 1 to 2 capsules each of 50 mg , or 20 - 40 drops. Depending on the intensity of the pain, the effect lasts 4 - 8 hours. If the pain does not subside within 30-60 minutes, another single dose of 50 mg is given. Additional doses are given at intervals of 4-6 hours up to a daily dose of 400 mg. If a higher dose is expected in severe pain, it is given as a single dose of 100 mg. Children aged 1 to 13 years are given a single dose of 1 to 2 mg tramadol hydrochloride per 1 kg body weight. The daily dose is 4 - 8 mg per 1 kg divided into 3 - 4 doses.

2. Dihydrocodeine

Dihydrocodeine is a semisynthetic opiate analgesic and antitussive. It is more analgesically potent than codeine alone, but weaker than morphine. Dihydrocodeine, like codeine, is in the liver metabolised to morphine. It acts clinically as an analgesic with mild anxiolytic effects and as an antitussive. The antitussive effect is mediated by an effect on the center of the cough in the elongated spinal cord and may occur at a dose lower than required by analgesia. Like other opiates, at an inadequately high dose, it can cause respiratory depression by acting directly on the respiratory centers in the brainstem. By acting directly on peripheral opioid receptors in the nervous plexus of the intestinal wall, it reduces the mobility of the smooth muscles of the GIT, especially the stomach, duodenum and colon, which can cause anorexia, passage disorders and constipation. There is (unfortunately) no tolerance for these side effects.

Dihydrocodeine is available on the Slovak market only in the form of retard tablets with a dose of 60, 90 and 120 mg of dihydrocodeinium hydrogen tartrate in one tablet. These are prolonged-release oral tablets with a declared 12-hour effect. It is therefore basically only used regularly twice a day.

It is therefore indicated essentially only for the alleviation of chronic persistent pain of medium and strong intensity. It is preferably administered in somatic nociceptive pain, for example in locomotor pain, post-operative and post-traumatic pain and the like. To relieve sudden intercurrent pain, either fast-acting non-opioid analgesics or tramadol drops are administered to dihydrocodine retarded tablets as needed. The usual starting dose is 60 mg every 12 hours. The dose may be increased to a maximum of 120 mg every 12 hours. It is usually administered on the 2nd level of the analgesic ladder in combination with non-opioid analgesics and adjuvants.

Strong opiate analgesics

If analgesia is insufficient using a combination of the maximum usable doses of non-opioid and opioid analgesics and adjuvants from the second level of the analgesic ladder, the intensity of the actual pain is still severe or the pain continues to progress, it is necessary to switch to the third level of the analgesic ladder. Here, as dominant drugs, we use several molecules of strong opiate, or opioid analgesics (also narcotics, anodyne) in various application forms.

Strong opiate analgesics, or strong opiates are drugs that act as agonists of various opioid receptors, especially in the CNS, with different affinities and effects.
According to Martuliak (Pathophysiology of Pain for Clinical Practice textbook), each opioid acts on all opioid receptors simultaneously, but with different intensities of the induced effect, i.e., on some of them they may have a subclinical effect.[154] It should also be noted again that the ligand-receptor relationship is very individual in clinical practice and the differences are not only in the given individual, especially according to the time of its action, but there are also significant inter-individual differences according to individual genetic equipment, between races, genders and other factors. Thus, each individual responds to endogenous ligands as well as to administered drugs more or less always individually, which needs to be taken into account especially when setting the patient for pharmacotherapy.

We currently have six molecules of potent opioid analgesics available on our market for long-term administration. Four of them are in the form of retarded tablets (also prolonged-release tablets), or capsules (morphine, oxycodone, hydromorphone and tapentadol), two in the form of patches (fentanyl and buprenorphine, prospectively sufentanil).

1. Tapentadol

Tapentadol is a relatively new molecule of a potent opioid analgesic with a dual mechanism of action, the first representative of so called MOR - NRI centrally acting analgesics in our market. It is structurally similar to tramadol in that it acts on opioid receptors as a partial mi-receptor agonist as well as on monoaminergic receptors (as an indirect alpha-2 agonist), but unlike tramadol, it inhibits the reuptake of mainly noradrenaline (not serotonin).
Data from clinical trials confirm that the analgesic efficacy of tapenetadol is comparable to that of oxycodone, with better tolerance or better risk ratio (side effects) / benefit (effective analgesia). It is suitable and usually well effective in all types of pain, including neuropathic pain associated with hyperalgesia and central sensitization. Its effect is well verified in somatic pain, e.g. in osteoarthritis, back pain, joint pain and even fibromyalgia.[155] Another advantage of tapentadol is that its gastrointestinal tolerance is better compared to other potent opioid analgesics.[156]

Despite the fact that in tapentadol the so-called „ceiling effect“ was not determined, it is recommended not to exceed the maximum daily dose, which still ensures sufficient analgesia and safe use. It is administered in doses of 500 mg for the SR (Slow releasing) form and for the IR (Immediately releasing) form 700 mg for the first day and 600 mg for the following days, as higher doses have not been studied.[157]

If you need to start your administration carefully, we usually choose to give IR 50 mg tablets 2 to 3 times a day, and after titrating the appropriate dose (after a few days), you can switch to continuous administration of the SR form of the medicine. Even with its good tolerance, patients usually do not exceed a daily dose of 500 mg for a long time (i.e., 2 x 250 mg SR tablets), with

154 Igor Martuliak, *Patofyziológia bolesti pre klinickú prax – 2. doplnené vydanie* (Banská Bystrica: Martimed s r.o., 2020).

155 Nebojsa Nick, Knezevic and Tatiana Tverdohleb, Ivana Knezevic and Kenneth D Candido. “Unique pharmacology of tapentadol for treating acute and chronic pain.” *Expert Opinion on Drug Metabolism & Toxicology* 11, no. 9, (2015): 1475-1492. https://doi.org/10.1517/17425255.2015.1072169

156 Baron R, Eberhart L, Kern KU, Regner S, Rolke R, Simanski C, and Tölle T., “Tapentadol Prolonged Release for Chronic Pain: A Review of Clinical Trials and 5 Years of Routine Clinical Practice Data.” *Pain Pract.* 17, no. 5, (2017): 678-700. doi: 10.1111/papr.1251

157 Hartrick, Craig T and Jose Rafael Rodríguez Hernandez. “Tapentadol for pain: a treatment evaluation.” *Expert Opinion on Pharmacotherapy* 13, no. 2, (2012): 283-286. doi: 10.1517/14656566.2012.648616

its shorter, acute application we allow ourselves to administer a dose of up to 700 mg per day. The IR tablet is also administered to overcome sudden, intermittent (essentially breakthrough) pain, essentially according to the patient's needs, most often as adjunctive therapy to basal analgesia with the SR form of tapentadol tablets.

2. Morphine

Morphine is a basic, standard representative of opiate analgesics, with which the various properties of other potent opiate / opioid molecules are usually compared (the "gold standard"). It acts primarily as an agonist of mi opioid receptors, to which it binds rapidly and strongly, through which it causes mainly analgesia, sedation, euphoria, physical dependence and respiratory depression. It affects the delta and kappa receptors weaker, causing mainly spinal analgesia, miosis and psychomimetic effects (kappa) and analgesia (delta).

Morphine is often the drug of choice in the treatment of acute but especially chronic pain of severe intensity. Its clinical advantage is the presence of a wide range of enterally and parenterally administrable dosage forms and generally good analgesic efficacy and tolerability. As with all other potent opioid molecules, it is necessary to think about the risk of side effects, especially the development of psychological dependence (addiction).

Like all other opiates / opioids from the group called strong opiates (pure agonists) or morphine does not have the so-called ceiling effect and therefore does not have a defined maximum daily dose. Thus, the dosage of oral fast-acting and retarded forms of morphine is governed primarily by the intensity of the pain and is limited, in principle, primarily by its tolerance, i.e., by the occurrence of side effects. As with tapentadol, morphine is available on our market in the form of 10 mg fast-release, slow-release film-coated tablets containing 10, 30, 60 and 10 mg of morphine sulphate. SR tablets are indicated for the treatment of chronic pain of severe intensity, but they can also be used to alleviate severe postoperative pain. They are given regularly at 12-hour intervals, i.e., twice a day. For slow-release morphine, treatment is usually started with a dose of 2 x 10 mg to 2 x 30 mg tablets, which is gradually increased by approximately 1/2 of the increased dose, depending on the intensity of the pain. However, setting for long-term treatment is usually started on the first day of treatment with IR morphine tablets. Each fast-release film-coated tablet contains 10 mg morphine sulfas pentahydride, equivalent to 7.5 mg of morphine.

3. Oxycodone

Oxycodone is a semisynthetic opioid prepared from the opium alkaloid thebaine. It is a pure mí and kappa2b agonist, indicated primarily for musculoskeletal, neuropathic and tumor pain.[158] The advantage of its administration over other opiate molecules is mainly in the relatively lower release of histamine. It is about twice as potent an analgesic as morphine. It is present on our market in the form of slow-release tablets in strengths of 10, 20, 40 and 80 mg of oxycodonium chloride with an effect of a pproximately 12 hours. The starting dose for opioid-naïve patients is usually 10 mg oxycodone given at 12-hour intervals.

Oxycodone-naloxone (OXY-N): prolonged-release tablets with a fixed combination of both opioids (while naloxone significantly attenuates the constipation potential of oxycodone), in which the presence of an opioid receptor antagonist significantly reduces opioid-induced constipation (by blocking opioid receptors in the plexus myentericus Auerbachi and plexus submucosus Meisneri in the intestine).[159] We have registered strengths of 5/2,5 mg, 10/5 mg, 20/10 mg, 40/20 mg and 80/40 mg of OXY-N. The usual starting dose for opioid-naïve patients is 10 mg/5 mg oxycodonium chloride/naloxonium chloride at 12-hour intervals. The maximum daily dose of OXY-N is 160 mg of oxycodonium chloride and 80 mg of naloxonium chloride.

4. Hydromorphone

Hydromorphone is a semi-synthetic derivative of morphine, compared to which it is approximately 5 times more potent. It is also more soluble in water compared to morphine. It is a potent opioid agonist acting primarily on mi receptors and only weakly on delta receptors. Its metabolites are analgesically inactive, so it can also be used for impaired renal function, in elderly patients, for tumor pain and the like. It is present on our market in the form of retardable capsules containing 2, 4, 8 and 16 mg of hydromorphonium chloride with an effect of approximately 12 hours. For a patient with severe pain who has not yet taken strong opioid analgesics, we start giving hydromorphone at a dose of 2 or 4 mg capsules twice a day. We gradually increase the dose according to the analgesic effect and the tolerance of the drug.

5. Fentanyl

Fentanyl is a synthetic opioid, highly lipophilic analgesic with a rapid onset of action and a short duration of action. It acts as a potent agonist of mi receptors. It is approximately 50- to 100-fold more potent than morphine. Several analogs of it have been synthesized, especially sufentanil, alfentanil, remifentanil and lofentanil. They are mainly used for the treatment of acute pain, general anesthesia and in the premedication of children in the form of a fentanyl lollipop. It is often used in the treatment of chronic pain. Here, both redefined dosage forms in the form of transdermal patches (for approximately 72 hours of action) and fast-acting dosage forms, in particular intranasal sprays, transbuccal and sublingual tablets and transbuccal patches, are used to alleviate sudden, breakthrough pain. The advantage of the retarded patch form is, in particular, the convenient use avoiding the often drug-laden gastrointestinal tract (dysphagia, dyspepsia, constipation,…), their effect lasting approximately 72 hours and the continuous level of the active substance in plasma. A smaller part of patients absorb it, or metabolizes more rapidly and then the patch should be applied every 48 (or every 60) hours. In our market, fentanyl in the form of patches is available in four different strengths of patches releasing 25, 50, 75 and 100 µg of fentanyl per hour. If necessary, we can apply more patches at the same time. The patches should not be cut, even for a dose lower than 25 µg per hour (25 m/hod.,), but this is often not the case in normal clinical practice. Dosing of fentanyl patches starts from the lowest dose of 25 µg per hour every 72 hours. Due to the relatively slow absorption of the active substance from the patch, analgesia does not occur until approximately 24 hours later and the full analgesic effect of the selected dose is not achieved until approximately two patches have been used. Therefore, if necessary, the dose is usually increased only after applying 2 patches, i.e., usually after 6 days. Similarly, even after peeling off the patch, its effects (including side effects) may last for up to 12 - 24 hours.

6. Buprenorphine

Like oxycodone, buprenorphine is a semisynthetic derivative of thebaine and, like fentanyl, a highly lipophilic opiate analgesic. It acts theoretically as a partial agonist of opioid receptors, but in practice it has the same strong analgesic effect in most users as the so-called pure

158 Kalso, Eija. "How different is oxycodone from morphine?" *Pain* 132, no. 3, (2007): 227-228 doi: 10.1016/j.pain.2007.09.027 ; Smith, Maree T. "Differences between and combinations of opioids re-visited." *Current Opinion in Anaesthesiology* 21, no. 5, (2008): 596-601. doi: 10.1097/ACO.0b013e32830a4c4a

159 Feliks Błaszczyk and Aleksandra Droń, "Pain therapy with oxycodone/naloxone prolonged-release combination: case report." *Contemporary oncology (Poznan, Poland)* 17, no. 4, (2013): 404-6. doi:10.5114/wo.2013.37911

agonists. It is an agonist of mi-opioid receptors with high affinity but relatively low potency. The advantage of buprenorphine is also its low potential to cause constipation and respiratory depression. Buprenorphine is approximately 20- to 40-fold more potent than morphine. On our market, buprenorphine in the form of patches is available in three different strengths of patches with a release of 35 µg per hour, 52.5 µg per hour and 70 µg of fentanyl per hour. Dosing of buprenorphine patches starts from the lowest dose of 35 µg per hour every 72 hours. Other principles for the use of buprenorphine patches are the same as those mentioned above.

The terms „opioid“ and „opiate“.

In the literature on analgesics, we often come across various terms used for opioid and opiate when discussing opioid receptor agonists. However, the use of these names is formally relatively strictly distinguished. According to Goodman and Gilman‘s The Pharmacological Basis of the Therapeutics, the following terminology is used: „Opiates“ are opium-derived drugs and include morphine, codeine, and a wide variety of semisynthetics. The term „Opioid“ has a broader meaning and includes all morphine opioid receptor agonists and antagonists with similar activity, as well as naturally occurring and synthetic opioid peptides.[160] However, these definitions partly complicate the situation with the denoting of individual preparations of six molecules of potent opioid receptor agonists, used in the treatment of pain in Slovakia. It is precisely the definition of opiates as semisynthetic molecules, as some of these drugs are opioids and some opiates. The term **„opiate“** is used for medicines derived from the opium juice of the poppy *Papaver somniferum*, including morphine and codeine, and for semisynthetic medicines derived from these alkaloids or from thebaine.[161] **„Opioid“** is a synthetic chemical - an analgesic, with a structure different from natural opiates. Thus, morphine is an opium alkaloid, oxycodone is a semisynthetic opiate derivative prepared from the inactive alkaloid thebaine, hydromorphone is a semisynthetic opiate derived from codeine, buprenorphine hydrochloride is a semisynthetic opiate derived from thebaine, fentanyl is a synthetic opioid and taepentadol hydrochloride is also a synthetic opioid. It follows that morphine, oxycodone, hydromorphone buprenorphine are opiates and fentanyl and taepentadol are opioids.

Indication of opiate analgesics

Opioid analgesics are administered in palliative medicine to patients with severe pain due to their significant analgesic and possibly sedative and euphoric effect. Although strong opiates are a commonly used weapon in the fight against severe pain, we are always careful and prudent in their indication and administration. So for what pain do we give strong opioid analgesics?

Opioid analgesics are indicated for all types of chronic pain of both tumor and non-tumor origin (regardless of etiology) in patients in whom treatment with non-opioid analgesics, adjuvants and non-pharmacological procedures has been unsuccessful or insufficiently effective, and pain significantly impairs quality of life.

160 Louis S. Goodman, Alfred Gilman, Joel G. Hardman, Alfred Goodman Gilman, and Lee E. Limbird. 1996. *Goodman & Gilman's the pharmacological basis of therapeutics*. New York: McGraw-Hill, Health Professions Division

161 See: Opioid receptors, introduction. IUPHAR database (IUPHAR-DB) [online]. 2009 http ://www.iuphar-db.org/DATABASE/ FamilyIntroduction Forward? familyId=50

Combining opiates

The simultaneous combination of two different molecules of opiates or opioids is usually avoided. This is especially true for their administration in a retarded application form. However, sometimes, especially in the treatment of complicated patients, we do not avoid these potentially risky combinations. Conversely, in cases of sudden transient exacerbation of basal persistent pain (so-called “breakthrough pain”), fast-acting enteral and parenteral forms of opioids are generally used only in patients long-term adjusted to retarded forms of various potent opioid molecules (see higher). On the other hand, strong opioid analgesics should be combined with non-opiate analgesics (NSAIDs, paracetamol and methamizole) and adjuvants according to the principles of the analgesic ladder.

Application forms and dosage of opiates

Strong opiate analgesics in patients with chronic pain are administered either enterally - most often orally in the form of rapidly dissolving or retarded tablets and capsules, or parenterally - transdermally in the form of patches. As the aim of their administration is to ensure a continuous plasma level of the active substance without unnecessary fluctuations, they are all administered strictly regularly.[162]

1. Slow-releasing tablets or capsules (official tablets or “prolonged-release capsules”) are usually given regularly, usually every 12 hours, i.e., twice a day. Within a certain coherent period, the morning and evening doses of the opiate chosen should not differ much - preferably not at all. The need for dose adjustment should be clearly consulted with the physician. Only in exceptional cases can the attending physician authorize the use of different doses of the opiate used within one day. This is possible, for example, in a patient whose pain intensity is significantly different during the day and night. Even so, this difference in lower dose should not exceed 30 to 50% of the higher dose.

2. Oral forms with normal (relatively rapid) **release** (e.g., popular IR tablets of morphine sulphate), on the other hand, are administered irregularly, usually only according to the patient‘s needs, for example in the escalation of pain and the like. However, a relatively large group of patients also take them regularly, usually 2 to 3 tablets 2 to 3 times a day, for example if they are at risk of accumulation of opiate metabolites when their metabolism or excretion is disrupted (geronts for example). We also often use IR forms of opiate tablets to gradually find the optimal dose of the drug (so-called „dose titration“).

3. Patch-retarded dosage forms of opiates (fentanyl) **or opioids** (buprenorphine) are also administered to ensure continuous plasma levels of the active substance. Therefore, it is necessary to ensure their regular administration as recommended for each of the drugs in their SPC. Fentanyl patches are applied every 72 hours (every 3 days) and buprenorphine patches even up to every 84 hours (every 3,5 days) and prospectively probably sufentanyl and buprenorphine patches up to every 7 days. Some patients (approximately 10-15%) appear to have a faster absorption and/or metabolism of the active substance from the transdermal patch and it is necessary to reduce the shelf life to 48 hours (every 2 days). When putting the new patch again, we stick it to a different place than the previous patch was applied. The place of a clean, undamaged area of skin without hair should be chosen (or after cutting any hair without disturbing the skin - not shaving them!) in the upper part of the torso (in places under the collarbone, above the deltoid muscle and on the shoulder above the trapezius muscle) on both sides of the body (together we alternate suitable 6 places). If the skin is sweaty, damp, the

162 Igor Martuliak, *Farmakoterapia bolesti pre lekárov a farmaceutov* (Banská Bystrica: Martimed s r.o., 2019).

patches on the skin may not hold well and the absorption of the active substance is reduced! In this case, gluing the edges of the patch with adhesive plasters will not help, just changing it with another type of patch, another place of application or even a different (oral) dosage form.
4. The administration of IR fentanyl in the indication of "breakthrough pain" in the form of intranasal spray, sublingual or transbuccal tablet and transbuccal patch has its own specifics, which may, however, be generalized (respecting the characteristic route of given administration): as breakthrough pain is limited by the occurrence of its episode of maximum 4 times a day and the duration of 1 episode on average of 30 minutes (1 to 240 minutes), we administer a single dose of a given application form of IR fentanyl. Thus, one dose is 1 spray, 1 sublingual or transbuccal tablet and 1 transbuccal IR patch of fentanyl. The starting dose is usually 100 µg in case of the first occurrence of breakthrough pain, and a 200 µg dose can be given immediately when using a medium or higher dose of opiate base therapy. If adequate pain relief is not achieved within 15-30 minutes of the first dose, a supplemental (the second) 100 µg dose may be given in one episode. At a total dose of FNT of 400 µg and more in a supplementary (the second) dose within one episode, we increase the dose of FNT by 100 to 200 µg. Thus, within one episode, we administer a maximum of 2 doses of the drug, therefore a maximum of 8 doses (4 x 2 doses) are administered daily. Let us not forget, however, that illogically, but legally, the administration of IR forms of FNT for the alleviation of breakthrough pain is indicated only for tumor pain.

Dose titration of opiates

The term „titration" refers to the gradual search for a suitable dose of a drug. Its aim is to find the minimum effective dose of analgesic adequate to the intensity of the pain. We always titrate only one drug at a time, and we usually avoid changing the dose of several drugs at the same time. We do not exceed the defined maximum daily dose of the drug. We start with a lower dose than the expected required dose of the drug, which we gradually increase in proportion to the intensity of the pain. We do not try to alleviate the pain completely, the optimal analgesia for acute, but especially for chronic pain is about 80 - 90% of its original intensity. If the dose of analgesic equals its intensity, or even exceed it, there would be a significant risk of side effects. We usually use fast-acting drug forms, most commonly drops or fast-release oral forms, to titrate the dose.

When switching from the 1st to the 2nd level of the analgesic ladder, we usually add tramadol in the form of drops in 3 daily doses to the already used non-opioid analgesics, carefully, from the analgesically ineffective 5, or 10 drops through their gradual increase to 15 - 20 drops and higher - according to their effectiveness and patient tolerance. In this way, we find the necessary minimum and effective dose of analgesic within 2 - 3 days without an increased risk of side effects.

If the maximum daily dose of tramadol is reached (which is 400 or 500 mg per day) and insufficient analgesia, we need to use a strong opiate for the patient, i.e., we are moving from the 2nd to the 3rd stage of the analgesic ladder. In this case, we most often use either IR 50 mg tablet form of tapentadol, or IR 10 mg tablet of morphine sulfate, or half of tablet 2 to 3 times daily. We gradually increase the dose of one of these drugs within 2 - 3 days and after finding a suitable dose, we usually switch to their retarded forms, or we switch to another molecule of a strong opiate analgesic in oral or transdermal form. Titration of a new prolonged-release analgesic is generally avoided, and in routine practice we can afford this rather exceptionally, possibly with tablet forms in a patient with trouble-free use of existing medication without the occurrence of side effects.

Rotation of opiates

The presence of a large number of strong opioids in various strengths and application forms is advantageous for the selection of a suitable molecule and method of use, but also for the need for the so-called „rotation of opiates", where we replace the medicine used with another strong opiate. The reason is usually the intolerance of the drug used due to the occurrence of intolerable side effects, the development of tolerance, the loss of analgesic efficacy of the drug, etc.[163] The dose of another opiate is recalculated on the basis of the dose of the changed molecule according to the so-called conversion table of equianalgesic doses (Table 2).

In common clinical practice, however, we also use sliding recalculation rulers, or the dose of opiate to be used is calculated by its relative potency to morphine (see Figure 2).

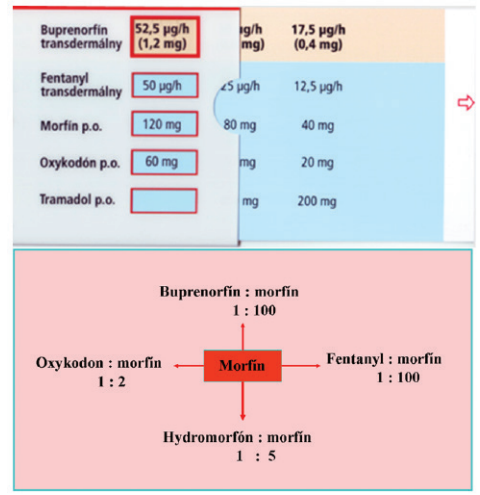

Figure 1: Recalculation of equipotent doses of opiates using a sliding ruler and a scheme for recalculating rotated opiates over their relative potency to morphine (Source: author´s archive).

Equianalgesic doses of opioid analgesics			
Opioid	**Dose**		**Relative potency**
morphine p.o. (regular administration)	30 mg	60 mg	1
morphine parenterally	10 mg	20 mg	3
fentanyl i.v. (bolus dose potency)	0,1 mg	-	300
fentanyl t.d.	12,5µg/hod	25µg/hod	100
hydromorphone p.o.	7,5 mg	8 mg	5
oxycodone p.o.	20 (30) mg	40 mg	2
dihydrocodeine p.o.	120 mg	240 mg	0,4
codeine p.o.	240 mg	480 mg	0,2
buprenorphine s.l.	0,4 mg/24hod	0,8mg	75
buprenorfpine t.d.	-	35µg/hod	75
tapendalol p.o. (accute pain)	100 mg	200 mg	0,3 – 0,5
tapendalol p.o. (chronic pain)	50 mg	100 mg	1
tramadol p.o.	200 mg	-	0,1

Table 2: Conversion table of equianalgesic opioid doses. P.o.: oral, t.d.: transdermal, s.l.: sublingual (adapted according to the Professional Guideline of the Ministry of Health of Slovak Republic, 2012)

163 Jan Lejčko, "Použití opioidů v léčbě nádorové bolesti." *Farmakoterapie* 9, no. 2, (2013): 175-179.

Specific situations for pain treatment

Opioid pain treatment in Mobile hospice

The home palliative care service provides specialized palliative care for the patient and his relatives in his home environment. In addition to medical care, it provides professional counseling, mentoring and, in addition to treating pain, focuses on treating the symptoms of the dying and providing psychosocial and spiritual support.

Opioids have an irreplaceable place in the dying and in the model of care, when in his last moments he is accompanied by a palliative team of a mobile hospice, at home.

The issues of choosing the optimal opioid, its dose, dosage tactics or choice of application form - were discussed in another part of this article.

We will only address the controversial points that are present when opioids are used in a mobile hospice.

There are several issues that a mobile hospice may encounter.

Probably the biggest problem, in the context of the ongoing opioid crisis, is opiophobia, both in healthcare professionals and patients. It is a fear and a barrier (especially in the USA) in initiating opioid treatment, where opioids for fear of using them may be deployed too late. These physician concerns may be exacerbated in the patient‘s home environment due to intimacy and closeness between the patient, relatives, and members of the palliative care team. Relatives or patients in close proximity to the palliative care team have a better opportunity to declare their fears and anxieties before starting opioid pain treatment, sometimes disagreeing with this approach, fearing the finality of their decision, a clear signal of disease progression and a clear signal of impending death. Communication is fundamental to effective palliative care and successful pain control, and therefore the fear of opioids often requires considerable effort from those involved.

Another problem - the availability of opioids, whether on the part of the home palliative care or on the part of the patient and his relatives.

This may be the unavailability of opioids in general - given the status of the country.

In a home palliative care - the availability of the necessary opioid and the required dosage form can be a problem. The mobile hospice also carries out its trips outside the opening hours of pharmacies, and when a patient visits at night, there is a need to apply e.g. fast-acting fentanyl for the treatment of procedural acute pain (pressure ulcer treatment), the hospice must reach for an available opioid (morphine) and analgesia may not be optimal.

Problems of high doses of opioids - morphine. The problem of using high doses of morphine is associated with a dying patient in his home environment. Up to 91% of deaths receive from 5 to 299 mg of morphine daily (possibly equivalent), 7.4% of deaths have doses of morphine (or equivalent) from 300 - 599 mg, and about 1.6% have doses of morphine greater than 600 mg / 24 hours.[164]

Such high doses of opioids are associated with a variety of problems - from medical (sedation, nausea, respiratory depression and other side effects of opioid treatment) to ethical issues (affecting consciousness, judgment and cognitive function in the dying) and opiophobia in both related patients and patients. also for health professionals (eg the attending physician of a dying person who is not a member of the palliative care team). There are also possible situations where the prescription for such high doses of opioid does not take place via a general practitioner, the doctor refuses - and the dying relatives have to look for another way to provide medication. For pharmacies, high doses of opioids are also suspicious and sometimes they refuse to give opioids.

Opioid treatment must be re-evaluated, its effect evaluated regularly. If pain treatment is regulated through a home pallliative care, the workload of staff increases. In case of poor and difficult pain control, possibly in case of frequent attacks of breakthrough pain, patients and their relatives often and frequently contact the doctor and the nurse of the team, sometimes several times a night, with the aim and expecting immediate help. Increased number of phone calls, SMS messages, e-mails - can lead to burnout syndrome of members of the palliative team. At a distance (as opposed to palliative care), the need for communication processes between the patient (relatives) and the mobile hospice can be significantly increased.

Palliative sedation

The purpose of palliative sedation is to relieve the patient of suffering. It takes various forms - from gentle, shallow sedation, to bringing the patient unconscious, in order to reduce and reduce the suffering of the terminally ill patient.

Opioids are part of drug combinations administered to provide sedation. Opioids in this case are used both to treat pain and to treat symptoms (dyspnoea).

However, under no circumstances do we increase the doses of opioids more than necessary, the aim of using opioids is only analgesization. Their application must not be construed as a means of inducing sedation to influence judgment or consciousness. They must never be used in a sedative mixture alone.

In the treatment of pain, the gold standard is the administration of morphine, mostly subcutaneously. Of course, other dosage forms and routes of administration (i.v., nasogastric tube, suppositories) as well as other potent opioids (fentanyl, hydromorphone, buprenorphine, etc.) are possible.

Interesting are the results of observations that focused on morphine consumption as a function of remaining life (patients in palliative sedation). In the last hours before death, patients required clearly higher doses of morphine than during the period of sedative initiation. Pain is thought to be more severe in sedated patients, so higher doses of opioids are needed than in non-sedated patients. Differences in the pharmacokinetics and pharmacodynamics of pain medications between groups of sedated and non-sedated patients may also be a problem.[165]

Treatment of pain in institutional care

Diagnosis and treatment of the patient during hospitalization provides a broader spectrum and a more comprehensive range, especially of causal treatment techniques, which we can both spread over time (although not unnecessarily long) and combine them appropriately. During inpatient treatment in our own ward, we can use the application of interventional treatment techniques in the indicated patient to a large extent, verify the effectiveness of complex treatment on a daily basis and avoid its side effects, or solve them promptly. Last but not least, hospitalization of the patient in the ward will allow us to get to know him/her better, which is often crucial for understanding the causes of CNS sensitization, failure of pain inhibitory mechanisms and its chronification. On the contrary, treatment during hospitalization is usually not suitable for its basic diagnosis, setting patients for pharmacotherapy, or socio-palliative treatment.

164 Bercovitch Michaela and Abraham Adunsky, " Patterns of high-dose morphine use in a home-care hospice service Should we be afraid of it?." Cancer 101, no.6, (September 15, 2004): 1473-1477. https://doi.org/10.1002/cncr.20485

165 A.W. Oosten, W.H. Oldenmenger, C. van Zuylen, P.J. Lieverse, J.E.C. Bromberg, C.C.D. van der Rijt et al. "Higher doses of opioids in patients who need palliative sedation prior to death: Cause or consequence?." *European Journal of Cancer* 47, no. 15, (2011): 2341-https://doi.org/10.1016/j.ejca.2011.06.057

Hospitalization of a patient with pain, for example in the Department of Palliative Medicine, is a suitable tool for adjusting a complicated patient to a suitable opiate analgesic molecule, titrating its optimal dose, combining it with other drugs and monitoring the tolerance of this molecule. In the indicated cases, the patient can be implanted in the hospital with a parenteral entrance to ensure the administration of the opiate in case of inability of its enteral or transdermal application. An example is the insertion of a subcutaneous, intravenous, intraspinal or perineural catheter. Another advantage is the possibility of performing a painful diagnostic - therapeutic procedure with adequate control of procedural pain by an experienced doctor.

Ethical aspects of opioid treatment

In palliative medicine, many problems and problematic situations are encountered in the treatment of pain with opioids.

On the one hand, it is an attempt to manage the physical and mental symptoms, on the other hand, it is an attempt to address the socio - spiritual context in the dying patient. The basis, in addition to the medical and personal erudition of the health care provider, is communication with interested relatives or with the patient about the goals of palliative care. In addition, there are many ethical, legal, and spiritual aspects of making and planning the dying process and supporting the dying family.

Any diagnostic treatment, and therefore opioid treatment, must include the principles of benefit (do good) and nonmaleficiency (do no harm).

The autonomy of the person is respected - it is the freedom in the patient‘s decision-making that has the highest degree of protection, and the ethical principles recognized by society are subordinated to it.[166] Fulfilling autonomy can mean, in our circumstances, writing and signing an informed consent of the patient or his caregiver.

Being able to make a decision means giving the patient the opportunity to accept the information, giving the patient the opportunity to understand the information offered, to consider it and to choose between alternatives. It is also possible to communicate one‘s wishes.[167]

Health and social care professionals need timely access to accurate diagnostic or prognostic information and privacy to talk to patients around treatment, prognosis, preferences for end-of-life care. Professionals require a respectful and trusting relationship with patients, underpinned by competent communication skills, so that they can pace and pitch information to suit the patient of family in a way that respects the wishes of the patients.[168]

For example, the use of opioids and sedatives, often in high doses and in combination with each other - both alleviate patient suffering and - as we know from pharmacology - combinations of opioids and co-analgesics may be responsible for respiratory depression, hypotension and other concomitant vegetative manifestations. Relatives can thus perceive, for us, a standard therapeutic procedure, also as a way to accelerate death.

166 James L. Hallenbeck, “Terminal Sedation: Ethical Implications in Different Situations.” *Journal of Palliative Medicine* 3, no. 3, (2000): 313-320.

167 Paul Rousseau,“The Ethical Validity and Clinical Experience of Palliative Sedation.” *Mayo Clin Proc* 75, no. 10, (2000): 1064-1069. DOI:https://doi.org/10.4065/75.10.1064

168 Roulston, Audrey. “The impact of time and communication on professional decision-making regarding patients with advanced lung cancer: Interpretative phenomenological analysis of focus groups with specialist palliative care professionals,” *Acta Missiologica* 15, no. 1, (2021): 7-25. https://www.actamissiologica.com/

Treatment of pain with opioids and other concomitant medications can affect an individual‘s cognitive functions, alter the quality of their consciousness, and affect their decision-making functions and judgment. Ultimately, the patient‘s ability to perform legal acts at the end of an individual‘s life may be affected.

The second important rule, in the context of the application of opioids as well as other drugs - is the principle of double effect (double effect rule). It is a set of ethical criteria that philosophers have advocated in assessing the admissibility of action, where otherwise a legitimate act of man may have an effect which he would otherwise have to avoid. Action with presumed harmful (ie adverse effects) inseparable from a good effect is justified if the nature of the act is good in itself (treatment of pain and symptoms), if the agent intends to have a good effect (alleviation of suffering) and does not intend to have a bad effect (killing) and when a good effect (reduction in pain intensity, relief of symptoms) outweighs a bad effect (side effects - respiratory depression, sedation).[169]

However, this rule also brings controversy - it is often criticized precisely because it causes death in its essence, or because clinical reasoning and intentions are ambiguous and even contradictory.[170]

Another problem - especially in the context of the ongoing opioid crisis - is the restrictive attitude of current health policies, which can be so serious that it does not reflect whether it is a treatment for tumor or non-tumor pain, or an active or palliative patient. Opiophobia can thus grow into too much caution of physicians, taking into account the intensity of pain in the palliative patient, and ultimately reduce the quality of care for the dying.[171] The doctor - a medic - thus gets into a very bad position - when he has to reflect on his intention (help), with a political-social order that forces him to be reticent in initiating opioid treatment.

In addition, the importance of spirituality and life meaningfullnes in connection with finding answers to existential questions raised by the disease, must be mentioned. Spirituality itself is an important coping mechanism and allows reflection as well reassessment of negative experiences.[172]

Conclusion

Opioid analgesics in the treatment of pain in patients requiring palliative care are one of the basic tools for its optimal control, but of course, in combination with other drugs and non-pharmacological and interventional pain management techniques. Even in this risk group of usually seriously ill patients, their administration must follow the generally accepted principles of their administration by experienced physicians with a sufficient range of knowledge and experience with the use of opiates in the clinical practice of acute and chronic pain.

As a basic recommendation for practice - the palliative medicine physician as well as other members of the palliative care team must be able to recognize the painful syndromes of the palliative care patient and according to general recommendations, also initiate pain

169 McIntyre, Alison. “Doing Away with Double Effect.” *Ethics* 111, no. 2 (2001): 219–55. https://doi.org/10.1086/233472

170 Cherny, N.I. “The use of sedation in the management of refractory pain.” Prin Pract Support Oncol Updates 2000, 3:1–11.

171 SW Sim, Ho S and Kumar RK. “Use of Opioids and Sedatives at End-of-Life.” *Indian Journal of Palliative Care* 20, no. 2, (2014): 160-165. DOI: 10.4103/0973-1075.132654

172 Dobríková Patricia and Mariana Sedliaková, “Spirituality as a meaning in life facilitator in oncological patients,” *Acta Missiologica* 15, no. 1, (2021): 37–48. https://www.actamissiologica.com/

treatment. If the pain cannot be controlled, the patient should be referred to an pain medicine specialist.

Graduate doctors in the field of palliative medicine and algesiology, as well as some other specialists, are surely such professionals also know how to provide a quality help to severely suffering palliative patients.

Author contributions

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

Conflict of interest

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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FEAR OF DEATH AND DYING IN THE CZECH POPULATION ACCORDING TO AGE, GENDER AND RELIGIOUS BELIEFS IN THE CONTEXT OF THE COVID-19 PANDEMIC

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Abstract

Backround: The paper analyses the association between fear of death and dying and selected socio-demographic characteristics (age, gender, and religious beliefs). It is part of a broader research focusing on social functioning and value attitudes.

Methods: The data was collected from 3813 respondents and it could be considered as representative of the Czech Republic. As we consider the inner connections across the factors we measured, we used the multifactorial analysis of variance to reveal the whole complexity of these relationships.

Results: Our assumption concerning the deeper inner relationships was partly confirmed. We recognized the significant influences of age, gender, and religious belief, and the influence of interference of these factors.

Conclusion: The complexity was not as complex as we assumed.

Keywords: Death **–** COVID-19 **–** Age **–** Gender **–** Religious belief.

Introduction

Human life is finite. It is necessary to come to terms with the fact that one's life will come to an end and one will die. One way to cope with death is to live a meaningful life.[174] Thinking about death is associated with a range of conflicting emotions. Malinowski[175] was referring to the two conflicting feelings that death evokes. On one hand, there is love or respect for the deceased and on the other, disgust for the dead body and fear of contact with it.[176] Thus, there may be positive connotations associated with positive and pleasant experiences, such as ‚sleep', ‚rest', ‚peace', ‚reconciliation'; other connotations are associated with unpleasant, negative experiences, such as ‚loss', ‚pain', ‚suffering', ‚torment', ‚fear', ‚sadness', ‚abandonment', etc.[177] these feelings are linked to the fact that death is a great unknown to humans,

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174 Gulášová, „Etické aspekty v eutanázii".

175 Malinowski, *Magic, science and religion and other essays*.

176 Špatenková, *O posledních věcech člověka: vybrané kapitoly z thanatologie*; Chrastina, Špatenková, a Hudcová, *Náročné, krizové a mimořádné situace v kontextu rezidenčních služeb : umírání, doprovázení a smrt uživatelů se zdravotním postižením*.

177 Marcysiak a Dąbrowska, „Acceptance of death as a life attitude for nurses and nursing students."; Raudenská a Javůrková, „Strach ze smrti u dospělých umírajících pacientů v terminální fázi onkologického onemocnění".

a phenomenon beyond everyday experience. According to Davies[178] the fear of death is related to the fear of survival. Emmons makes a similar point[179], when he argues that the fear of death is a universal human phenomenon that is related to the biological instinct for self-preservation. The fear of death is mitigated by social rituals. They are also important for maintaining mental integrity[180]. The contradictory emotions felt in relation to death manifests itself, among other things, in the funeral as a way of dealing with the dead body: the desire to keep the body intact, untouched as much as possible, but at the same time to get rid of the body, to destroy it completely. Malinowski considers the extreme manifestation of this duality[181] consisting of mummification and cremation. The alleviation of fear of one's own death and anxiety after the loss of loved ones is also done through the legitimization of death. Berger and Luckmann[182] consider the legitimization of death as one of the most serious fruits of the symbolic worlds.

Although the fear of death which is universally felt and its influence on the behaviour of individuals and communities, there are individuals who are exceptions to this rule: 1. those who are suffering and those who can understand death as a release from suffering, 2. believers, 3. people who have had near-death experiences.[183].

There are many factors that influence attitudes towards death. Significant factors include age, the level of mental ability of the individual, current emotional state, the experiences the individual has had with the death of others, the perceptions of, and attitudes towards death represented by the individual's immediate environment, sociocultural conceptions of death including value orientation, the way death is presented in the media, and the level of satisfaction with one's own life. These are therefore sociocultural and personal factors. (Kisvetrova & Kralova, 2014). According Ivo Možný[184] society's attitude to death has changed over the last 100 years, death has been marginalised, outside the family, and it is possible to see one's own death at old age without ever having encountered death, seeing a person die. Until recently, death was virtually unspoken of.

But the situation has significantly changed by recent events, when, in the context of the Covid-19 pandemic, conversations about death and dying have become part of everyday life[185]. In 2020, 129,289 people in the Czech Republic died. Compared to 2019, the number of deaths was almost 17,000 lower, representing a 15% year-on-year increase. (ČSÚ, 2021a) It was not until the end of May 2021 that the number of excessive deaths decreased significantly and the level of mortality returned to the average levels of 2015-2019. The month with the highest number of deaths in the history of the independent Czech Republic remains as March 2021, when, according to preliminary results, 16.7 thousand people died, i.e. 62% above the average. (ČSÚ, 2021b). The question is whether the more frequent experiences with death and the more frequent thematization of death have also contributed to its legitimization, whether they have changed attitudes towards death, or whether the fear of death has lessened or, on the contrary, deepened.

Methods

The aim of our research was to analyse and confirm the theoretical assumption that the fear of death in the Czech population is dependent on a group of factors (*F*) which consists of age, gender, and religious belief. To confirm this assumption, we planned and conducted a wide survey. The research was designed as cross-sectional ex-post-facto. This approach is often used to measure and analyse interferences of the social factors in specific phenomena.[186] The survey was carried out nationwide across the Czech Republic. The examined context was part of a wider examination focusing, besides on the attitudes to death and dying, on the value orientation of the respondents, their economic situation, and ways of spending their free time. The survey examined data collected using a structured questionnaire[187] from the total of 3813 respondents aged 25+ in the Czech Republic. The data collected through a questionnaire (both electronic and printed a hard paper copy) from September 2020 to June 2021, when the Covid-19 pandemic peaked. In the case of respondents who were not able to fill out the questionnaire online in person, an interview or assisted completion of the questionnaire was used.[188] The respondents selected across the country using stratified selection with stratification criteria of gender, age, and size of the municipality. Inside the stratified groups, the questionnaire was widely and randomly spread across the population thanks to more than 200 volunteers helping with delivering the survey. The collected data can be considered representative of the gender and age of respondents and size of the municipality - in most of the stratification criteria the difference between population and the research sample in stratification criteria is less than 12%.

Out of the total number of 3813 respondents in the research sample there were 1549 (40.6%) men and 2264 (59.4%) women. The age of respondents was measured using an open numeric answer and afterwards categorized into 10 years age groups: 25-34 (1115; 29.2%); 35-44 (782; 20.5%); 45-54 (865; 22.7%); 55-64 (470; 12.32%); 65+ (581; 15.23%). The youngest age group was not included because the attitudes to death so were not measured in this group.

Although the belief to God (or godly powers) can be expressed in different ways and in some special cases the person is not able to precisely formulate the own relationship to God, spirits or other forces which are believed in, we assume that most of the people know what they believe and are able to answer several fundamental questions concerning their belief. We measured the variable "religious belief" using a categorical scale containing these seven categories:

178 Davies, *Stručné dějiny smrti*.

179 Emmons, „Personal strivings: An approach to personality and subjective well-being."

180 Kearl, *Endings: A sociology of death and dying*; Malinowski, *Magic, science and religion and other essays*; Seale, „Constructing death: The sociology of dying and bereavement".

181 Malinowski, *Magic, science and religion and other essays*.

182 Berger a Luckmann, *Sociální konstrukce reality. Pojednání o sociologii vědění*.

183 Emmons, „Personal strivings: An approach to personality and subjective well-being."; Kübler-Ross et al., *Odpovědi na otázky o smrti a umírání: etický manuál pro mediky, lékaře a sestry: doplněno samostatnými příspěvky a komentáři našich i zahraničních odborníků*.

184 Možný a Jiránek, *Rodina a společnost*.

185 Bhattacharjee a Acharya, „The COVID-19 Pandemic and Its Effect on Mental Health in USA – A Review with Some Coping Strategies"; Holingue et al., „Mental Distress in the United States at the Beginning of the COVID-19 Pandemic".

186 Bryman, *Social Research Methods*; Black, *Doing Quantitative Research in the Social Sciences*.

187 Black, *Doing Quantitative Research in the Social Sciences*.

188 Olecká a Pospíšil, „Human Values and the Feel of Social and Health Threats".

1. Monotheist - believes in a personal God who looks after creation (793; 20.8%),
2. Polytheist - believes in more godly powers (72; 1.9%),
3. Ietsist - believes in a higher power ("something above us") (883; 23.2%),
4. Agnostic - believes maybe there is something above us, but we are not able to know it (574; 15.1%),
5. Atheist - doesn't believe in the existence of anything above us (1035; 27.1%),
6. Deist - believes in a god who, however, does not interfere in the world in any way (297; 7.8%),
7. Pantheist - believes in the unity of a god and nature (a god and nature are the same) (159; 4.2%).

Because of the low numbers in categories polytheist, deists, and pantheists we prefer to join these categories together for further analysis in one called Other specific religious attitudes (deists, polytheists or pantheists). Total count of this joined category is 528 (13.84%).

The questions were designed to measure attitudes toward death were taken from the standardized Death Attitude Profile-Revised (DAP-R) questionnaire. The full version of the DAP-R consists of thirty-two items measured on a seven-point Likert scale ranging from „strongly disagree" to „strongly agree." Thematically, it creates five subscales (Reconciliation, Fear of Death, Death Avoidance, Acceptance of Escape, and Neutral Acceptance). For the purpose of our data collection, five questions representing each sub score were selected from this questionnaire. They were measured on a continuous scale ranging from one, indicating „complete disagreement", to ten, indicating „complete agreement". The following attitude questions were selected for the measurement and analysis:

AQ_1: I see death as a passage to an eternal and blessed place (μ_{all} = 5.04, sd_{all} = 3.25)
AQ_2: The fact that death will mean the end of everything as I know it frightens me (μ_{all} = 4.85, sd_{all} = 3.06)
AQ_3: I view death as a relief from earthly suffering (μ_{all} = 4.41, sd_{all} = 2.95)
AQ_4: I avoid thinking about death altogether (μ_{all} = 5.75, sd_{all} = 3.05)
AQ_5: The uncertainty of not knowing what happens after death worries me (μ_{all} = 4.83, sd_{all} = 3.01)

According to the theoretical assumption mentioned above we stated the matrix of research hypotheses, which could be generally formulated using the following pattern:

In the group of factors *F* the *Cn* component significantly influences the *AQq,* where *n* represents each member of the set (gender, age, religious belief) and *q* represents each of the attitude questions *AQ1 – AQ5*. Consequently, in the group of factors *F* the *Cn x m* component interference influences the *AQq*, where *n* and *m* represent a combination of each member of the set (gender, age, religious belief) and *q* represents each of the attitude questions *AQ1 – AQ5*. Finally, in the group of factors *F* the *Cn x m x p* component interference influences the *AQq*, where m, n and p represent all items in the set (gender, age, religious belief).

For the statistical analysis and significance of all hypotheses defined according to the pattern defined above the Multifactorial Analysis of Variance (MANOVA) was used.[189] The MANOVA test was used instead of the One Way ANOVA, because of the request for analysis

189 Sheskin, *Handbook of Parametric and Nonparametric Statistical Procedures*.

of multifactorial data matrix. This statistical approach provideded a different statistical analysis and has many benefits. The most important for our approach was that the data is viewed as a block where each side is made by one partial factor. In this 3D space, the factors interference could be recognized and analysed, including the determination of statistical significance among inner relationships. The data was collected and the preliminary analysed using Social Survey Project statistical module[190] and the MANOVA tests were computed using the 14th version of the Statistica software[191].

The research published in this paper is a preliminary study and besides achieving the main research aim we also had the ambition to open a wider discussion on a topic. Thereafter we are going to extend collected data to those from foreign countries and make this preliminary analysis much deeper, especially in data analysis and the complexity of the thinking in the theoretical background.

Research results

The first question was to find out whether respondents saw death as a transition to an eternal and blessed place. Women are more likely to agree with this statement, with an average of 5.6. Men are at an average of 5.0. It is worth noting that people who believe in a personal God who looks after creation report an average response of 8.14. They agree on this statement regardless of gender. On the other hand, agnostics (μ =3.43) and atheists (μ=2.90) disagree with the statement, with a significant gender difference for agnostics. Women report a mean of 3.9 and men 2.9. Such a marked discrepancy in attitudes was not observed in any other category of religious belief. The rate of agreement increases with age from μ=5.0 for the 25-34 age group to μ=5.5 for the 65+ age group. Only the 55-64 age group, where the rate of average agreement decreased slightly compared to the previously discussed age group, prevents a completely linear increase. The difference between the genders in the age groups is noticeable for the 25-34 age group (males μ= 4.5; females μ= 5.5) and the 45-54 age group (males μ= 5.0; females μ= 5.8). The 55-64 group (men μ= 5.2; women μ= 5.4) is the least different in their opinion.

The MANOVA analysis shows us (Table 1) that for the question of eternal life, the differences are statistically significant when we consider only two factors: gender and belief. On the other hand, there are insignificant differences for age (p=0.315729). If we consider the influence of two factors, then significant differences are seen in the combination of the factors in religious belief and gender (p=0.0102). The other differences are statistically insignificant.

For people who believe in a personal God who looks after creation, the largest gender differences exists in the 35-44 age group (women μ=7.5 versus men μ=8.5). The opposite is true in the 45-54 group (women μ=8.1 versus men μ=7.9). For ietsists, the largest gender differences exist in the 65+ age group (females μ=5.6 versus males μ=4.5). Conversely, in the 35-44 group (females μ=4.6 versus males μ=4.8): for agnostics, the largest gender differences exist in the 45-54 age group (females μ=4.4 versus males μ=2.5). In general, differences are high in all age groups up to 45-54. In contrast, they are lowest in the 55-64 group (women μ=3.4 versus men μ=3.1). For atheists, the largest gender differences exist in the 65+ age group (females μ=3.7 versus males μ=2.5). The opposite is true in the 55-64 group (women

190 *SSP*.
191 TIBCO Software Inc., *Data Science Workbench*.

μ=2.8 versus men μ=2.9). For other specific religious attitudes, the largest gender differences exist in the 55-64 age group (women μ=6.0 versus men μ=5.1). The opposite is true in the 65+ group (women μ=6.1 versus men μ=5.6).

Table 1: AQ_1 - I see death as a passage to an eternal and blessed place

Effect	Univariate Tests of Significance for **AQ_1 - I see death as a passage to an eternal and blessed place** Sigma-restricted parameterization Effective hypothesis decomposition				
	SS	*df*	MS	F	*p*
Gender ***	181,96	1	181,96	26,64	0,000000
Religious belief ***	11970,97	4	2992,74	438,20	0,000000
Age group	32,34	4	8,09	1,18	0,315729
Gender X Religious belief *	90,38	4	22,60	3,31	0,010275
Gender X Age groups	32,92	4	8,23	1,21	0,306423
Religious belief X Age groups	68,16	16	4,26	0,62	0,867359
Gender X Religious belief X Age groups	103,61	16	6,48	0,95	0,512301

Statistical significance: *** p < 0.001, ** p < 0.01, * p < 0.05

In the second question we stated we tried to know the attitudes of respondents to the fact that death will mean the end of everything and whether they are frightened by that fact. Higher levels of agreement are declared by women μ=4.92 compared to men μ=4.48. The data shows that the level of agreement with this statement increases linearly with age from μ=5.27 to μ=4.4. At the same time, the older the respondents are, the smaller the difference in attitudes between the genders is. While for men aged 25-34 years, μ=4.8, for women it is μ=5.7. The highest level of agreement is shown by those who believe in a higher power (in "something above us") μ=5.16, while the lowest level is shown by those who believe in a personal God who looks after creation μ=4.04, who agree with this attitude regardless of gender. The largest gender difference was observed among agnostics (women μ=5.3 versus men μ=4.3).

The MANOVA analysis shows us (Table 2) that for the question on the finitude of existence in its current known form, statistically significant differences are evident for individual factors, but when more factors are considered, the differences are no longer statistically significant.

For people who believe in a personal God who looks after creation, the largest gender differences exist in the 35-44 age group (women μ=4.6 versus men μ=4.1). The opposite is true in the 45-54 group (women μ=3.8 versus men μ=3.9). For ietsists, the largest gender differences exist in the 25-34 age group (females μ=5.6 versus males μ=5.3). Generally, in the groups below 65+, all observed differences are significant. The opposite is true in the 65+ group (females μ=5.5 versus males μ=5.3). For agnostics, the largest gender differences exist in the 45-54 age group (females μ=5.9 versus males μ=4.3). In general, differences are high in all age group up to 65+. In contrast, the lowest are in the 55-64 group (women μ=4.5 versus men μ=4.5). For atheists, the largest gender differences exist in the 25-34 age group (females μ=5.2 versus males μ=4.3). As with agnostics and ietsist in general, all differences are noted in the under 54 groups. In contrast, the 55-64 group (females μ=4.4 versus males μ=4.4). For other specific religious attitudes, the largest gender differences exist in the 55-64 age group (females μ=5.0 versus males μ=4.3). The lowest differences were recognized in the 65+ group (women μ=6.1 vs. men μ=5.6).

Table 2: AQ_2 - The fact that death will mean the end of everything as I know it frightens me

Effect	Univariate Tests of Significance for **AQ_2 - The fact that death will mean the end of everything as I know it frightens me** Sigma-restricted parameterization Effective hypothesis decomposition				
	SS	df	MS	F	p
Gender * **	311.53	1	311.53	34.425	0.000000
Religious belief * **	429.44	4	107.36	11.863	0.000000
Age group * **	332.56	4	83.14	9.187	0.000000
Gender X Religious belief	54.66	4	13.67	1.510	0.196409
Gender X Age groups	29.75	4	7.44	0.822	0.511043
Religious belief X Age groups	203.42	16	12.71	1.405	0.129156
Gender X Religious belief X Age groups	46.02	16	2.88	0.318	0.995280

Statistical significance: *** p < 0.001, ** p < 0.01, * p < 0.05

The third question concerning the death as a relief from earthly suffering was another point of our research. Women are more likely to agree with this statement μ= 4.79 men μ= 4.47. The highest average level of agreement is declared by respondents who believe in multiple divine powers (μ= 6.01). This level of agreement is even higher than for respondents who believe in a personal God who look after creation (μ=5.07). Atheists disagree the most (μ= 3.81). The rate of agreement increases continuously with age (from μ=4.23 for the 25-34 age group to μ=5.23 for the 65+ age group) following the same pattern as for the first question, i.e. with a spike in the 45-54 age group. The most pronounced difference in attitudes between the genders is in the category of respondents who believe in multiple divine powers (women μ=6.6 versus men μ=5.5). For the other categories, the level of agreement between the genders is relatively consistent. Interestingly though, there is virtually no difference in attitudes between the genders for the 55-64 group (μ=4.8), but the largest difference is in the 65+ group (women μ=5.7 versus men μ=4.8).

The MANOVA analysis shows us that there is no statistically significant difference for gender (p=0.086605). However, it exists for belief and age, and it also exists when we combine the factors gender and belief (p=0.012135). Moreover, if we combine other factors, there is no statistically significant relationship.

For those believing in a personal God who looks after creation, the largest gender differences exist in the 45-54 age group (women μ=4.8 versus men μ=5.4). The opposite is true in the 25-34 group (women μ=4.6 versus men μ=4.7). For those believing/having higher power, the largest gender differences exist in the 65+ age group (females μ=4.7 versus males μ=5.4). The opposite

is true in the 35-54 group (females μ=4.3 versus males μ=4.4). For agnostics, the largest gender differences exist in the 35-44 age group (females μ=4.7 versus males μ=5.5). The opposite is true in the oldest age group 65+ (females μ=4.2 versus males μ=4.2). For atheists, the largest gender differences exist in the 65+ age group (women μ=4.7 versus men μ=3.8). The opposite is true in the 35-45 group (women μ=3.8 versus men μ=3.5). For other specific religious attitudes, the largest gender differences exist in the 25-34 age group (females μ=4.9 versus males μ=4.3). On the other hand for the 55-64 group there were no gender differences (women μ=4.7 versus men μ=4.7).

Table 3: AQ_3 - I view death as a relief from earthly suffering

Effect	Univariate Tests of Significance for **AQ_3 - I view death as a relief from earthly suffering** Sigma-restricted parameterization Effective hypothesis decomposition				
	SS	*df*	MS	F	*p*
Gender	24.31	1	24.31	2.938	0.086605
Religious belief ***	746.69	4	186.67	22.556	0.000000
Age group ***	318.98	4	79.75	9.636	0.000000
Gender X Religious belief *	106.34	4	26.58	3.212	0.012135
Gender X Age groups	8.60	4	2.15	0.260	0.903694
Religious belief X Age groups	43.97	16	2.75	0.332	0.993927
Gender X Religious belief X Age groups	75.23	16	4.70	0.568	0.909428

Statistical significance: *** p < 0.001, ** p < 0.01, * p < 0.05

The fourth question asked whether respondents avoided thinking about death. There is no difference between the genders of the respondents in their attitudes towards this statement (μ=5.6). Believers in a personal God who looks after creation are the least likely to avoid these thoughts (μ=4.47) and believers in a God who does not interfere in the world are the most likely to avoid them (μ=6.23). Similar attitudes are also shared by atheists and agnostics (μ=6.1). In terms of age groups, respondents share very similar attitudes, with the 65+ group agreeing most with the statement (μ=5.74) and the 35+ group agreeing least (μ=5.49). Those who believe in a God who does not intervene in the world and atheists (μ=6.2) have a practically uniform opinion between the genders. In contrast, the greatest differences in attitudes between the genders were observed among agnostics (women μ=6.4 versus men μ=5.7). There is consistency between the genders in the age group. The highest difference was observed in the 45-54 group (women μ=5.4 versus men μ=5.7).

The MANOVA analysis shows us that for the question on escape from the consideration of death, there is a statistically significant difference only in belief. For those believing in a personal God who looks after creation there are the largest gender differences in the 55-64 age group (females μ=4.7 versus males μ=4.0). The opposite is true in the 25-34 group (women μ=4.8 versus men μ=4.7).

For ietsists, the largest gender differences exist in the 55-64 age group (females μ=5.9 versus males μ=5.3). The opposite is true in the 25-34 group (females μ=5.6 versus males μ=5.7). For agnostics, the largest gender differences exist in the oldest and youngest age groups. On

the contrary in the oldest age group, 45-54 (females μ=5.8 versus males μ=6.2) were smallest differences measures. For atheists, the largest gender differences exist in the 55-64 age group (females μ=5.8 versus males μ=6.5) and the smallest in the 65+ group (women μ=6.0 versus men μ=6.0). For other specific religious attitudes, the largest gender differences exist in the 45-54 age group (females μ=5.3 versus males μ=6.2). The opposite is true in the 65+ group (women μ=5.8 versus men μ=5.8).

Table 4: AQ_4 - I avoid thinking about death altogether

Effect	Univariate Tests of Significance for **AQ4 - I avoid thinking about death altogether** Sigma-restricted parameterization Effective hypothesis decomposition				
	SS	df	MS	F	p
Gender	28.47	1	28.47	3.17	0.075159
Religious belief ***	1272.92	4	318.23	35.41	0.000000
Age group	18.88	4	4.72	0.53	0.717238
Gender X Religious belief	51.34	4	12.84	1.43	0.221796
Gender X Age groups	28.59	4	7.15	0.80	0.527889
Religious belief X Age groups	90.13	16	5.63	0.63	0.864763
Gender X Religious belief X Age groups	105.45	16	6.59	0.73	0.761764

Statistical significance: *** p < 0.001, ** p < 0.01, * p < 0.05

The final question we asked respondents concerning the death and dying expresses their level of agreement with the statement whether they were troubled by the uncertainty arising from not knowing what it will be like when they die. This is more of a concern for women (μ=5.1) than men (μ=4.7). Those who believe in a higher power express the highest level of worry (μ=5.19), while atheists (μ=4.58) and believers in a personal God who looks after creation (μ=4.51) express the least. In terms of age group, people in the 55-64 (μ=5.18), and 65+ (μ=5.04) groups are the most concerned, while the 35-44 group is the least concerned (μ=4.59). Among the genders, the biggest differences are among agnostics (women μ=5.4 versus men μ=4.6) and believers in a god who does not interfere in the world (women μ=5.5 versus men μ=4.7). The most significant differences are in the 35-44 age group (women μ=5.0 versus men μ=4.2) and the smallest in the 45-54 age group (women μ=4.7 versus men μ=4.6).

The MANOVA analysis shows us that there are significant differences between gender, beliefs and age groups for the question on fears arising from inexperience with dying. No statistically significant relationship was found for the analysis of the interaction of these factors.

For those believing in a personal God who looks after creation, the largest gender differences exist in the 35-44 age group (females μ=5.0 versus males μ=4.0) and the smallest in the 25-34 group (women μ=4.5 versus men μ=4.4). For ietsists, the largest gender differences exist in the 35-44 age group (females μ=5.3 versus males μ=4.1). In the 45-54 group there were no difference (females μ=4.6 versus males μ=4.6). For agnostics, the largest gender differences exist in the 25-34 age group (females μ=6.0 versus males μ=4.6). The opposite is true in the oldest age group 45-54 (females μ=4.8 versus males μ=4.5). For atheists, the largest gender differences exist in the 45-54 age group (women μ=5.0 versus men μ=4.1). In the 55-64 group there are

minimal differences (women μ=4.1 versus men μ=4.3). For other specific religious attitudes, the largest gender differences exist in the 35-44 age group (females μ=5.3 versus males μ=4.0). On the contrary, in the 45-54 group only small differences were measured (women μ=5.0 versus men μ=4.8).

Table 5: AQ_5 - The uncertainty of not knowing what happens after death worries me

Effect	Univariate Tests of Significance for **AQ5 - The uncertainty of not knowing what happens after death worries me** Sigma-restricted parameterization Effective hypothesis decomposition				
	SS	df	MS	F	p
Gender* **	214.78	1	214.78	23.869	0.000001
Religious belief* **	219.73	4	54.93	6.105	0.000068
Age group **	139.09	4	34.77	3.865	0.003887
Gender X Religious belief	12.05	4	3.01	0.335	0.854639
Gender X Age groups	38.37	4	9.59	1.066	0.371644
Religious belief X Age groups	167.26	16	10.45	1.162	0.291235
Gender X Religious belief X Age groups	119.23	16	7.45	0.828	0.654239

Statistical significance: *** p < 0.001, ** p < 0.01, * p < 0.05

Discussion

Death anxiety is by far the most dominant topic in empirical studies, with the fear of death and death anxiety being used interchangeably in the literature.[192] There are many reasons to fear death. To name a few: fear of losing one's life and of the unknown, fear of pain and suffering, awareness of one's own helplessness, awareness of lost opportunities for redemption and salvation, concern for surviving family members[193]. Failure to lead a meaningful life can also be a source of fear[194]. Erikson[195] assumes that the main developmental task in old age is the acceptance of one's own death. Older adults should therefore show a more neutral acceptance.

There is an assumption in the literature that different age groups differ in their attitudes towards death, partly because of their different attitudes towards death.[196] Most studies have shown that older adults have a less fear of death[197]. Wink and Scott[198] evidence shows that older participants (in their mid-70s), who have experienced more loss and illness, fear the dying process less than younger participants (in their 60s). The picture is more complex when taking

192 Dadfar et al., „The Psychometric Parameters of the Farsi Form of the Arabic Scale of Death Anxiety"; Wong, Reker, a Gesser, „Death Attitude Profile-Revised: A multidimensional measure of attitudes toward death".

193 Fry, „A factor analytic investigation of home-bound elderly individuals' concerns about death and dying, and their coping responses".

194 Butler, „1975 Why Survive? Being Old in America. New York: Harper & Row"; Erikson, *Childhood and society*.

195 Erikson, *Childhood and society*.

196 Levinson, „The mid-life transition: A period in adult psychosocial development".

197 Wass a Myers, „Psychosocial aspects of death among the elderly: A review of the literature".

198 Wink a Scott, „Does Religiousness Buffer Against the Fear of Death and Dying in Late Adulthood?"

a multidimensional approach to attitudes towards death. Keller et al.[199] measured three separate dimensions of attitudes toward death: Factor 1, Death Appreciation in General; Factor II, Belief in the Afterlife; and Factor III, Self-Related Death Anxiety. Regarding Factor 1, middle-aged adults were less anxious than their older and younger counterparts. For Factor II, the oldest group had a greater belief in the afterlife than the middle-aged groups, but did not differ significantly from the younger adults. For Factor III, the oldest group showed significantly less anxiety about their own death than all the younger groups. Older people are more likely to struggle with personal loss and physical illness. Their inability to continue many of the activities and roles that previously gave them meaning and fulfilment, together with social isolation and loneliness, will further increase their desire for freedom from drugs[200]. Our research shows a rather non-linear relationship between fear of death and age.

As expected, a significant multivariate effect of age was also found in the study Wong et al.[201] The variability in the Approach Acceptance factor across all age groups indicates that views on belief in an afterlife are more strongly divided across age categories. The examination of the means shows that women are significantly more accepting of the afterlife and significantly more accepting of death as an escape from life compared to men. Men, on the other hand, are significantly more likely to avoid all thoughts of death compared to women.

Our data clearly shows that women are more likely to agree with the claims made than men. Women agree with men only on avoiding thoughts of death. There is no consensus among researchers on gender differences. Some studies have found no differences between the genders[202]. Others have found that men have a higher anxiety than women[203]. However, most studies have confirmed higher levels of fear of death in women.[204] If we use a multidimensional approach, the situation becomes complicated again. For example, Dattel and Neimeyer[205] found that women reported greater death anxiety than men on the Death Anxiety Scale, but not on the Threat Index. Thus, the results did not support the assumption that women's greater death anxiety is due to their tendency to disclose their fear of death. The authors note further that women tend to report greater death anxiety, particularly regarding their own death. This is also in line with the findings in the Czech research.[206]

199 Keller, Sherry, a Piotrowski, „Perspectives on death: a developmental study".

200 Gesser, Wong, a Reker, „Death attitudes across the life-span: The development and validation of the Death Attitude Profile (DAP)".

201 Wong, Reker, a Gesser, „Death Attitude Profile-Revised: A multidimensional measure of attitudes toward death".

202 Aronow et al., „The value of the self in relation to fear of death"; Conte, Weiner, a Plutchik, „Measuring death anxiety: Conceptual, psychometric, and factor-analytic aspects."; Marcysiak a Dąbrowska, „Acceptance of death as a life attitude for nurses and nursing students."; Mullins a Lopez, „Death anxiety among nursing home residents: A comparison of the young-old and the old-old".

203 Cole, „Sex and marital status differences in death anxiety"; Robinson a Wood, „Fear of death and physical illness: A personal construct approach".

204 Maltby a Day, „The reliability and validity of the Death Obsession Scale among English university and adult samples"; McMordie, „Improving measurement of death anxiety"; Neimeyer, Wittkowski, a Moser, „Psychological Research on Death Attitudes: an Overview and Evaluation"; Wass a Myers, „Psychosocial aspects of death among the elderly: A review of the literature".

205 Dattel a Neimeyer, „Sex differences in death anxiety: testing the emotional expressiveness hypothesis".

206 Pospíšil, Pospíšilová, a Špatenková, „General Attitudes to the Faith, Religion, Ethics and Solidarity among the Czech Adults"; Vevodova et al., „FEAR OF DEATH AMONG OLDER ADULTS IN HOME ENVIRONMENT".

Research on attitudes toward death agrees that belief in an afterlife is related to religious beliefs, and individuals with strong religious beliefs show less fear of the afterlife.[207] These conclusions are confirmed by our data. According to Peterson and Greil, a total of 40 studies provided results supporting the conclusion that religious belief and fear of death are inversely correlated, 9 studies confirmed a curvilinear relationship, 27 studies confirmed a positive correlation, and 32 studies reported that there is no significant relationship between religious belief and fear of death. We also see research highlighting that the relationship is not linear. For example, Wink and Scott[208] found no linear relationship between religious belief and fear of death and dying, as individuals who were moderately religious feared death more than individuals who scored high or low on religious belief.

Conclusion

The questions touching the death phenomena were essential in every period of human history. All societies and communities face the finality of human existence and it was often discussed by theologians, philosophers, psychologists, cultural anthropologists, and sociologists. Moore and Williamson[209] in their comprehensive study, "The Universal Fear of Death and the Cultural Response," show how, through the ages, fear of death has been a shaping influence on cultures, religions, philosophy, and reason, as well as modern thought. In our research we tried to measure the attitudes towards several framing questions concerning this phenomenon, and we assumed these attitudes will be significantly influenced by age, gender, and religious belief. As we consider the inner connections across the factors we measured, we used the multifactorial analysis of variance to reveal the whole complexity of these relationships. Our assumption concerning the deeper inner relationships was partly confirmed. We recognized significant influence of age, gender, and religious beliefs inside this group of factors but, the influence of the interference of factors was not so complex as we assumed. However, it seems we discovered only a part of the factors which influence could be assumed. For a deeper understand and further research of the phenomena the analysis of other factors seems to be necessary.

207 Ellis a Wahab, „Religiosity and fear of death: A theory-oriented review of the empirical literature"; Peterson a Greil, „Death experience and religion".

208 Wink a Scott, „Does Religiousness Buffer Against the Fear of Death and Dying in Late Adulthood?"

209 Moore a Williamson, „The Universal Fear of Death and the Cultural Response".

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RELATIONSHIP BETWEEN SELECTED PSYCHOSOCIAL ASPECTS AND POSTTRAUMATIC GROWTH IN CANCER AND PALLIATIVE PATIENTS

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Abstract

Background: Although exposure to traumatic and stressful events may have serious consequences, people who have experienced a traumatic event appreciate their lives more and live their lives with purpose. Life philosophy of people who have dealt with a crisis becomes more mature, meaningful and valuable. The negative events, such as a cancer diagnosis, can also result in certain changes and positive impacts on life scheme and philosophy, and self-perception. This process is called posttraumatic growth. The aim of the present study is to explore the nature of relationship between posttraumatic growth, social support and self-efficacy in cancer patients during or following the completion of treatment (in remission) and in cancer patients at a terminal stage of illness who are at hospices.

Methods: Quantitative research of relationships between the studied variables performed using correlations. Demographic questionnaire, Scale of Perceived Social Support, the Short Portable Mental Status Questionnaire (SPMSQ), General Self-Efficacy Scale (GSES) and Posttraumatic Growth Inventory (PTGI) were used in the study. 176 patients participated in the study. Data for 152 patients were analysed, out of whom 76 patients were undergoing treatment for cancer or had completed it (remission) and 76 patients were at a terminal stage of cancer with terminated causal treatment and were placed in a hospice care.

Results: The results of the present study show no statistically significant difference in subjectively perceived level of self-efficacy in cancer patients at a terminal stage and cancer patients undergoing treatment/in remission. There were no significant differences between the two groups of patients in subjectively perceived social support and posttraumatic growth either. No statistically significant differences in the studied constructs were found between males and females in all cancer patients.

As regards the individual posttraumatic growth factors, cancer patients undergoing treatment or in remission were experiencing significantly higher level of posttraumatic development in relation to New Possibilities and Spiritual Change factors than terminally ill cancer patients at hospices. Females showed higher levels in these factors than males, with these differences being statistically significant.

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We found significant relationship between posttraumatic growth and self-efficacy and posttraumatic growth and social support in cancer patients undergoing treatment or in remission. No relationship was found between social support and self-efficacy. A statistically significant relationship between posttraumatic growth and self-efficacy was confirmed in terminally ill cancer patients. However, not statistically significant relationships between posttraumatic growth and social support and between social support and self-efficacy were confirmed in this group of patients.

Conclusion: The results show that the level of self-efficacy correlates with the level of posttraumatic growth. The level of social support correlates with posttraumatic growth in cancer patients undergoing treatment and in remission, but not in terminally ill cancer patients. In practice, there is a need for improvement a prognostic awareness and acceptance aiming to stimulate positive changes and growth in cancer patients at the end of their lives.

Keywords: Posttraumatic growth **–** Social support **–** Self-efficacy **–** Cancer patient **–** Terminally ill patient.

Introduction

Various traumatic events may affect the lives of many people. They are mostly followed by posttraumatic distress and suffering. However, the concept of posttraumatic growth has been studied increasingly in the last decades as well. Although problems manifested in form of mental disorders might occur in the process of coming to terms with a serious event or the recovery is reached without any previous problems, there might also be a case where an individual reaches beyond their previous functional level and reports positive changes. This phenomenon is called posttraumatic growth.

The posttraumatic growth is defined as a set of positive changes following catastrophic events in people's lives that occur during posttraumatic period and help the individuals to adapt optimally after any trauma.[211] In 1996, Tedeschi and Calhoun introduced an empirical model of posttraumatic growth. According to the model, negative life events, such as cancer, can lead to positive results in some people. The authors point out that the posttraumatic growth does not occur as a direct result of trauma, but it is rather a set of positive changes resulting from the "fight" with a traumatic event. They identified five areas in which a positive change might occur: 1) relating to others, 2) new possibilities, 3) personal (personality) growth, 4) spiritual change, 5) appreciation of life.[212]

Cancer may be perceived as traumatic, as the diagnosis itself is of a seismic nature in patient's life, and the course of the illness triggers the feeling of vulnerability and awareness of mortality, which are actually the essential characteristics of any traumatic events.[213] Understanding of the decisive factors of posttraumatic growth in incurably ill cancer patients can lead to the

211 Tanja Zoellner and Andreas Maercker, "Posttraumatic growth in clinical psychology. A critical review and introduction of a two component model", *Clinical Psychology Review* 26, no. 5 (September 2006): 626–53. https://doi.org/10.1016/j.cpr.2006.01.008.
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212 Richard G. Tedeschi and Lawrence G. Calhoun, "The posttraumatic growth inventory: measuring the positive legacy of trauma", *Journal of Traumatic Stress* 9. no. 3 (July 1996): 455–71. doi: 10.1007/BF02103658

213 Anna Casellas-Grau, Cristian Ochoa, and Chiara Ruini, "Psychological and clinical correlates of posttraumatic growth in cancer: A systematic and critical review", *Psycho-oncology* 26, no. 12 (March 2017): 2007-2018. https://doi.org/10.1002/pon.4426

development of interventions focused on the key predictors and provision of supportive social context for growth, as these patients struggle with imminent death and cumulative losses.

The posttraumatic growth is defined as a significant and beneficial posttraumatic change in cognitive and emotional life of an affected individual which is, to a great extent, based on interconnected constructs of strength, resilience and self-efficacy.[214] In Bandura's social-cognitive theory, the term "self-efficacy" emphasizes the role of observation, learning and social experience in personality development. This position is also emphasized by author's claim that people with strong conviction of their self-efficacy often come up with possibilities that may be realised even in the environment with limited conditions, while those who are not convinced of their self-efficacy will most likely not realise any significant changes, not even in the environment offering numerous potential opportunities. Self-efficacy is defined as a belief in one's ability to manage a situation or as overall personal conviction of one's abilities to cope with difficulties and challenges in life, i.e. a person's belief in their ability to control their own functioning and events affecting their life.[215] Various studies have confirmed the important role of self-efficacy in adaptive confrontational styles in various situations.[216] While being confronted with adverse and stressful events, such as cancer, the people with high levels of self-efficacy are able to control their own thoughts better and manifest greater stability. It has also been shown that high self-efficacy is associated with low manifestation of cancer symptoms and distress related to the symptoms, as well as with a higher quality of life. High self-efficacy predicts physical and emotional well-being and better overall functioning of an individual. Low level of self-efficacy is associated with more serious symptoms.[217]

The perceived social support may present another effective factor in the posttraumatic growth in cancer patients. Social support is a multidimensional concept associated with positive self-perception, self-acceptance, hope, love and satisfaction which reduce stress and generally provide individuals with opportunities for self-realisation and growth.[218] It is known that social-support is one of the strongest driving forces and is a predictor of successful and easy confrontation at times when people are fighting the cancer and related distress; it reduces the level of depression[219], improves the quality of life[220], it is the most effective and most stable pre-

214 Astier M. Almedom, "Resilience, Hardiness, Sense Of Coherence, And Posttraumatic Growth: All Paths Leading To 'Light At The End Of The Tunnel'?", *Journal of Loss and Trauma* 10, no. 3 (2005): 253-265. doi: 10.1080/15325020590928216

215 Albert Bandura, *Self-Efficacy: The Exercise of Control* (New York: Freeman, 1997).

216 Tracey J. Devenport and Andrew M. Lane, "Relationship between self-efficacy, coping and student retention", Social Behavior and Personality: an international journal, 34, no. 2 (2006): 127–38. https://doi.org/10.2224/sbp.2006.34.2.127
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217 Lynn L. White et al., "Self-Efficacy for Management of Symptoms and Symptom Distress in Adults With Cancer: An Integrative Review", Oncology Nursing Forum 46, no. 1 (January 2019): 113-128. doi: 10.1188/19.ONF.113-128

218 Sindhuja Kadambi, et al., "Social support for older adults with cancer: Young International Society of Geriatric Oncology review paper", *Journal of geriatric oncology* 11, no. 2 (March 2020): 217–224. https://doi.org/10.1016/j.jgo.2019.09.005

219 Nayereh Naseri and Fariba Taleghani, "Social Support and Depression in Iranian Cancer Patients: the Role of Demographic Variables", *Journal of caring sciences* 7, no. 3 (September 2018): 143–147. https://doi.org/10.15171/jcs.2018.023

220 Hailing Zhang, et al., "Resilience and Quality of Life: Exploring the Mediator Role of Social Support in Patients with Breast Cancer", *Medical science monitor: international medical journal of experimental and clinical research* 23 (December 2017): 5969–5979. https://doi.org/10.12659/msm.907730

condition for compliance with medical care instructions[221]; good social support also significantly and positively influences communication, searching for information and coping style through self-efficacy.[222] Understanding of patients' social environment can reveal the processes they use to cope with cancer which might involve searching for benefits and positive thinking.[223] Cancer patients with higher level of social support also show higher level of personal resilience[224] and the level of their social support can also determine how well they will adapt to cancer.[225] In order to maximise the positive medical result, health care providers must be aware of the social environment of their patients as well as of the fact, whether the members of this environment present sources of stress or provide the patients with sufficient support.[226]

The model of social-cognitive processing[227] emphasizes the meaning of cognitive processing in posttraumatic growth and the major role social interactions play in relation to improving or hindering the cognitive adaptation processes. Several studies have showed that social support as a supportive social context and key environmental source[228] can make successful confrontation with difficulties and cognitive adaptation processes related to cancer diagnosis easier, thus increasing the level of posttraumatic growth.[229] However, social support is a complex multidimensional construct, and various types of social support have various effects on posttraumatic

221 Jinjin Zhang and Marja J. Verhoef, "Illness management strategies among Chinese immigrants living with arthritis", *Social Science & Medicine* 55, no. 10 (November 2002): 1795–802. doi: 10.1016/s0277-9536(01)00311-2.

222 Zhaohui Geng et al., "Gauging the Effects of Self-efficacy, Social Support, and Coping Style on Self-management Behaviors in Chinese Cancer Survivors", Cancer Nursing 41, no. 5 (September/October 2018): E1-E10. doi: 10.1097/NCC.0000000000000571

223 Vikki Knott et al., "A grounded theory approach to understand the cancer-coping process", *British Journal of Health Psychology* 17, no. 3 (September 2012): 551–564. doi:10.1111/j.2044-8287.2011.02054.x
Jeff Dunn et al., "Benefit finding after cancer: The role of optimism, intrusive thinking and social thinking", *Journal of Health Psychology* 16, no. 1 (2011): 169–177. doi:10.1177/1359105310371555

224 Harriet Denz-Penhey and Campbell Murdoch, "Personal resiliency: Serious diagnosis and prognosis with unexpected quality outcomes", *Qualitative Health Research* 18, no. 3 (March 2008): 391–404. doi:10.1177/1049732307313431

225 Rebecca A. Shelby et al., "Optimism, social support, and adjustment in African American women with breast cancer", *Journal of Behavioral Medicine* 31, no. 5 (August 2008): 433–444. doi:10.1007/s10865-008-9167-2

226 Brenda L. Den Oudsten et al., "Personality predicts perceived availability of social support and satisfaction with social support in women with early stage breast cancer", *Supportive Care in Cancer* 18, no. 4 (April 2010): 499–508. doi:10.1007/s00520-009-0714-3

227 Richard G. Tedeschi and Lawrence G. Calhoun, "Posttraumatic growth: conceptual foundations and empirical evidence", *Psychological inquiry* 15, no. 1 (2004): 1-18. http://www.jstor.org/stable/20447194

228 Lawrence G. Calhoun and Richard G. Tedeschi, "Author´s Response: The Foundations of Posttraumatic Growth: New Considerations", *Psychological inquiry* 15, no. 1 (2004): 93-102. https://doi.org/10.1207/s15327965pli1501_03

229 Maria Nenova et al., "Posttraumatic growth, social support, and social constraint in hematopoietic stem cell transplant survivors", *Psycho-oncology* 22, no. 1 (January 2013): 195-202. doi: 10.1002/pon.2073
Sonia Martins Silva, Helena Cruz Moreira, and Maria Cristina Canavarro, "Examining the links between perceived impact of breast cancer and psychosocial adjustment: the buffering role of posttraumatic growth", *Psycho-Oncology* 21, no. 4 (April 2012): 409-418. doi: 10.1002/pon.1913
Marta Scrignaro, Sandro Barni, and Maria Elena Magrin, "The combined contribution of social support and coping strategies in predicting post-traumatic growth: a longitudinal study on cancer patients", *Psycho-oncology* 20, no. 8 (August 2011): 823-831. doi: 10.1002/pon.1782

growth.[230] Self-efficacy also appears to be a predictor, and correlates significantly with posttraumatic growth.[231]

Based on the above, we were interested, whether there were any differences in posttraumatic growth between cancer patients and terminally ill cancer patients in hospice care. We were also interested, whether there were any differences between social support and self-efficacy in relation to posttraumatic growth in the two groups of participants.

Methods

Sample and Data Collection

176 cancer patients participated in our quantitative research, out of whom 76 were undergoing treatment or had completed it (in remission) and 100 patients were at a terminal stage of cancer with terminated causal treatment and being placed in hospice care. Out of 100 assessed terminally ill cancer patients, only 76 patients completed the entire battery due to severe medical condition related to inability to complete the battery (11 cases) and presence of cognitive disorders (13 cases). In case of most terminally ill patients, the battery administration took place in several sessions with the help of an administrator, who recorded participants' answers due to increased tiredness and weakness of the patients.

The data were finally analysed for 152 patients, out of whom 76 were undergoing treatment or had completed it (in remission) and 76 were at a terminal stage of cancer, with terminated causal treatment and being placed in hospice care. The data were collected from 2020 to 2021. The average age of patients was 59.91 years (SD = 13.46). 97 females and 55 males participated in the study.

Methods Used

The data were collected using a demographic questionnaire, the Short Portable Mental Status Questionnaire (SPMSQ), the Posttraumatic Growth Inventory (PTGI), the General Self-Efficacy Scale (GSES) and the Scale of Perceived Social Support of patients.

SPMSQ[232] is used to screen cognitive disorders in adults. It has 10 items which test orientation, short-term and long-term memory and practical and mathematical abilities.

PTGI[233] (Tedeschi, Calhoun, 1996) comprises 21 statements, and respondents are supposed to indicate for each of them to what extent they have experienced changes in their lives as a result of a crisis/disaster (in our case – cancer) by using a Likert scale from 0 (I did not experience the change resulting from the crisis) to 5 (I experienced the change resulting from the crisis to a great degree).

230 Stephen J. Lepore and Tracey A. Revenson, "Social constraints on disclosure and adjustment to cancer", *Social and personality psychology compass* 1, no. 1 (October 2007): 313-333. https://doi.org/10.1111/j.1751-9004.2007.00013.x

231 Yongju Yu et al., "Effects of emotion regulation and general self-efficacy on posttraumatic growth in Chinese cancer survivors: assessing the mediating effect of positive affect", *Psycho-Oncology* 23, no. 4 (April 2014): 473-8. doi: 10.1002/pon.3434
Tang Tang et al., "Correlation of posttraumatic growth with emotion regulation, coping style and self-efficacy in cancer patients", *Journal of Third Military Medical University* 34, no. 19 (2012): 2016-2019.

232 Eduard Kolibáš, *Príručka klinickej psychiatrie* (Bratislava: Asklepios, 1996).

233 Tedeschi and Calhoun, "PTGI", 455-71.

The General Self-Efficacy Scale (GSES)[234] comprises 10 claims, and the respondents are supposed to indicate how well they characterise them, using a Likert scale from 1 (strongly disagree) to 4 (strongly agree).

The perceived social support from family, friends and health-care professionals in respondents was indicated using a Likert scale from 1 to 10.

Research Design

The statistical data analysis was performed using SPSS. The quantitative research of relationships between the studied variables was performed using correlations.

Results

Table 1 shows the average score of all studied constructs in cancer patients undergoing treatment or in remissions (Group A) and in terminally ill cancer patients with terminated causal treatment, placed in hospice care (Group B).

Table 1: Comparison of averaged scores for individual constructs between the two groups of participants

Group	Construct	M	SD
A	Posttraumatic Growth	56.7	24.09
B		52.21	21.5
A	F 1: Relating to Others	18.88	9.13
B		18.99	8.62
A	F 2: New Possibilities	12.16	6.1
B		9.71	6.27
A	F 3: Personal Growth	10.49	5.18
B		9.39	4.83
A	F 4: Spiritual Change	5.54	3.26
B		4.08	3.25
A	F 5: Appreciation of Life	9.63	3.98
B		10.04	3.66
A	Self-Efficacy	27.62	4.77
B		26.29	6.88
A	Social Support	12.03	7.28
B		10.39	6.51

There only were minor differences in average scores for the individual constructs in the two studied groups of patients. Using Mann-Whitney U-tests, no statistically significant differences in subjectively perceived levels of self-efficacy were found in terminally ill cancer patients and cancer patients undergoing treatment/in remission (U = 2665; p = 0.41). There were no significant

234 Ralf Schwarzer and Matthias Jerusalem, "Generalized Self-Efficacy scale", in *Measures in health psychology: A user's portfolio. Causal and control beliefs*, edited by J. Weinman, S. Wright, and M. Johnston, 35- 37. Windsor, England: NFER-NELSON, 1995.

differences between the two groups of patients in subjectively perceived social support (U = 2527.5; p = 0.18) and posttraumatic growth (U = 2621; p = 0.33) either. No statistically significant differences between males and females in the studied constructs were found in all cancer patients (N = 152) either.

As regards the individual posttraumatic growth factors, statistically significant differences were found between the cancer patients undergoing treatment or in remission and terminally ill cancer patients, namely in the factors of New Possibilities and Spiritual Change. The cancer patients undergoing treatment or in remission experienced significantly higher levels of posttraumatic growth in relation to the factors of New Possibilities (U = 2257.5; p = 0.02) and Spiritual Change (U = 2166; p = 0.007) than terminally ill cancer patients placed at hospices.

Statistically significant differences between females and males were found for the levels of posttraumatic growth in relation to the factors of New Possibilities (U = 2109.5; p = 0.03) and Spiritual Change (U = 2108; p = 0.03), with females reaching significantly higher levels than males.

In cancer patients undergoing treatment or in remissions, a statistically significant relationship was found between posttraumatic growth and self-efficacy (R = 0.24; p = 0.04). A statistically significant relationship between posttraumatic growth and social support was also confirmed (R = 0.31; p = 0.007). No relationship was identified between social support and self-efficacy.

In the group of terminally ill cancer patients with terminated causal treatment, placed at hospices, a statistically significant relationship between posttraumatic growth and self-efficacy (R = 0.26; p = 0.02) was confirmed. No statistically significant relationships between posttraumatic growth and social support, and between social support and self-efficacy were confirmed in this group of patients.

Discussion

The results of the present study showed there were no statistically significant differences between the cancer patients undergoing treatment or in remission and terminally ill cancer patients as regards subjectively perceived self-efficacy, social support and posttraumatic growth. Significant differences were confirmed in relation to specific posttraumatic growth factors, namely New Possibilities and Spiritual Change, with cancer patients undergoing treatment or in remission scoring significantly higher than terminally ill cancer patients in palliative care.

The fact that no significant differences were found between cancer patients undergoing treatment and terminally ill cancer patients in relation to posttraumatic growth may be explained by cancer being significantly different from other known stressors, as it is not a discreet, short-term event. The experience with cancer rather comprises a series of events, beginning with detection and diagnosis of cancer, followed up by active medical treatment and ending by recovery and post-treatment monitoring, or a stage of coming to terms with the imminent death. Family and close friends are also informed on the fact that their close person is suffering from cancer, and the patient is thus exposed to more frequent and repeated confrontation with the stressor. These events might take many months, even years, of a patient's life. These features make the effort to accurately assess the traumatic experience or even a posttraumatic stress disorder in the context of cancer diagnosis and treatment more complicated. The resulting stress might differ between the individuals and might comprise one or a combination of several cancer-related events. Furthermore, it may be difficult to identify a point in which a cancer survivor becomes a person who has beaten cancer, especially due to a possibility of relapse. It has indeed been proven that many patients and their families remain very cautious in the period following the recovery and look for any signs or symptoms of a return of the illness.[235] It is thus very difficult to determine a point in which cancer patients have overcome a traumatic event represented by cancer and initiated the process of posttraumatic growth. They either live in a constant fear of relapse of cancer, or the treatment fails, and patients begin the terminal stage of their lives. Based on the present study, the imaginary boundary between the two selected groups of patients thus appears very fragile and unclear, which has been proven by the finding, that there were no differences in posttraumatic growth between patients undergoing treatment or in remission and in dying patients at a terminal stage.

However, the fact is that posttraumatic growth is experienced by cancer patients with various forms and at various stages of cancer. The study by Tang et al.[236] shows that posttraumatic growth at the end of life may by catalysed by trauma of being exposed to mortality. They found that the process of dying might be too threatening and stressful for cancer patients to experience deep posttraumatic growth, which was manifested by low values in relation to the level of posttraumatic growth, without any significant changes associated with the imminent death. However, this study has also confirmed our findings related to inter-gender differences, with females achieving higher levels of posttraumatic growth than males in some factors. The results of the present study also showed significant differences in specific posttraumatic growth factors, namely New Possibilities and Spiritual Change, with cancer patients undergoing treatment or in remission experiencing significantly higher levels of posttraumatic growth in relation to these factors than cancer patients at a terminal stage, placed at hospices. Similarly, Lechner et al.[237] found that stage IV cancer patients reported lower levels of growth, which indicates that cancer at an advanced stage presents a threat that might paralyse individual's ability to find benefits in a life-threatening situation. The average score achieved in relation to posttraumatic growth may also be explained by the culture. The cultural aspects of values and behaviour present key variables, together with life experience, social-economic status and personality differences which affect the meaning of cancer in individuals and their families as well as the way in which they cope with this illness. Families rather frequently assume responsibility for decision-making on behalf of patients.[238] Doctors, despite providing information to patients, usually inform patients' relatives first.[239] Although theory speaks clearly about the necessity of open and clear communication between patients and healthcare professionals[240], the sad fact, which is still present in practice even today, remains that some patients arrive at hospices, where they are only provided with symptomatic treatment, without being informed of their diagnosis. This means that not only are the patients unaware of the fact their time is limited, and the prognosis of illness is bad, but they are even uninformed of the fact

235 Zygfryd Juczyński and Nina Ogińska-Bulik, "In spite of adversity–Posttraumatic growth in the aftermath of experienced negative life events", *Experiencing a suffering* 1, (2012): 301-320

236 Siew Tzuh Tang et al., "Threatened with death but growing: changes in and determinants of posttraumatic growth over the dying process for Taiwanese terminally ill cancer patients", *Psycho-Oncology* 24, no. 2 (February 2015): 147 - 154. doi:10.1002/pon.3616

237 Suzanne C. Lechner et al., "Do sociodemographic and disease-related variables influence benefit-finding in cancer patients?", *Psycho-oncology* 12, no. 5 (July-August 2003): 491-499. doi: 10.1002/pon.671

238 Kyriaki Mystakidou et al., "The families' evaluation on management, care and disclosure for terminal stage cancer patients", *BMC Palliative Care* 1, no. 1 (April 2002): 1-8. https://doi.org/10.1186/1472-684X-1-3

239 Jessica Hahne et al., "Breaking bad news about cancer in China: Concerns and conflicts faced by doctors deciding whether to inform patients", *Patient education and counselling* 103, no. 2 (February 2020): 286-291. doi: 10.1016/j.pec.2019.08.022

240 Audrey Roulston, "The impact of time and communication on professional decision-making regarding patients with advanced lung cancer: Interpretative phenomenological analysis of focus groups with specialist palliative care professionals", *Acta Missiologica* 15, no. 1 (April 2021): 7-25. https://www.actamissiologica.com/

they suffer from cancer. In the study by Iconomou et al.[241], only 37% of the patients were able to indicate their cancer diagnosis correctly. It is worth considering, whether concealing of truthful information on the diagnosis and prognosis of cancer would cause that patients might not have enough time to process and come to terms with the threatening diagnosis or even imminent death, thus not being provided with any room for posttraumatic growth. For example, the study by Tang et al.[242] showed that cancer patients who had only been informed of the terminal stage of their illness not long ago reported lower levels of posttraumatic growth. Thus, a significant difference between patients diagnosed as terminally ill 91 to 180 days prior to data collection and those diagnosed as such over 180 days before the data collection was found. In spite of the imminence of death, a longer life with terminal illness might predispose the cancer patients to come to terms with their inevitable mortality and thrive until their imminent death. Getting familiarised with the diagnosis and high level of acceptance of their prognoses make it easier for cancer patients to perceive the posttraumatic growth throughout the process of dying. However, the question whether the lack or concealing of information is a problem related to the tradition or mentality of patients and their families or healthcare professionals, and how it might affect the posttraumatic growth remains largely unanswered and should be subject to further research.

The results of the present study confirmed a statistically significant difference in posttraumatic growth in relation to the factor of Spiritual Change, with cancer patients undergoing treatment/ in remission achieving higher average scores than terminally ill cancer patients. The cross-sectional study by Rabitti et al.[243] confirmed that out of all groups of cancer patients – those who had been diagnosed with cancer a short time before, those who had survived cancer and terminally ill cancer patients, the terminally ill cancer patients scored the least in relation to spirituality and selected components related to it. There also is a connection between spirituality and posttraumatic growth; the higher level of spirituality predicts higher level of posttraumatic growth.[244] Hospitalised cancer patients show considerable interest in spiritual counselling and guidance throughout the treatment.[245] Care for the spiritual aspect of cancer patients should by included in the interventions, as it is associated with a higher level of growth and adaptation to the illness.

241 Gregoris Iconomou et al., "Information needs and awareness of diagnosis in patients with cancer receiving chemotherapy: a report from Greece", *Palliative Medicine* 16, no. 4 (July 2002): 315-321. doi: 10.1191/0269216302pm574oa

242 Tang et al., "Threatened with death but growing",147-154.

243 Elisa Rabitti et al., "The assessment of spiritual well-being in cancer patients with advanced disease: which are its meaningful dimensions?" *BMC palliative care* 19, no. 1 (March 2020): 1-8. https://doi.org/10.1186/s12904-020-0534-2

244 Ana Cristina Paredes and M. Graça Pereira, "Spirituality, Distress and Posttraumatic Growth in Breast Cancer Patients", *Journal of Religion and Health* 57, no. 5 (October, 2018): 1606–1617 (2018). https://doi.org/10.1007/s10943-017-0452-7

245 Patricia Dobríková et al., "External support factors utilized by patients in coping with cancer: a European perspective", *Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer*, (2021): 1-6. https://doi.org/10.1007/s00520-021-06487-0

The results of the present study as well as other foreign studies confirm the relationship between self-efficacy and posttraumatic growth.[246] However, the results differ as regards the relationship between posttraumatic growth and social support. The present study confirms the relationship between social support and posttraumatic growth in cancer patients undergoing treatment or in remission; however, this relationship has not been confirmed in the group of terminally ill patients. Some studies show that no direct link between social support and posttraumatic growth has been confirmed in cancer patients.[247] Other point out a significant relationship between the two constructs.[248] Social support plays and effective role in stress reduction. The perceived social support helps cancer patients to achieve posttraumatic growth earlier, as these positive changes may lead to changes in interpersonal relationships and greater gratitude for family and friends.[249] Tedeschi[250] believes that posttraumatic growth brings positive and satisfactory feeling of a person, a sense of competence and spontaneity when solving challenges in life and more specific changes of interpersonal relationships, closer relationships with family members, other relatives and friends, reconciliation, greater altruism, higher sensitivity towards others, acceptance of help from others as well as providing help to others. All of the above are achievable through existence and understanding of social support and social network.

Social support makes it possible to express negative emotions, increases the feeling of closeness, maintains relationships, improves mental well-being and supports the selection of more effective coping strategies. The main role of social support is to help the affected individuals to mobilise all sources to be able to cope better with their condition. Social support also increases the probability of positive changes occurring after a trauma. This is related to the availability of the support as well as the subjective perception of such support. Emotional support represents a particularly important type of help, especially if it is provided immediately after a traumatic event. A possibility of sharing thoughts and feelings and expressing emotions supports the processing of trauma and improves the chances of posttraumatic growth. However, the role of social support in the process of development of positive posttraumatic changes appears complicated and its effect is determined by many factors, including a type of support and its sources.[251] Cancer

246 Zumrut Bellur, Arzu Aydın and Emre Han Alpay, "Mediating role of coping styles in personal, environmental and event related factors and posttraumatic growth relationships in women with breast cancer", *Klinik Psikiyatri Dergisi* 21, no. 1 (2018): 38-51. DOI: 10.5505/kpd.2018.65365
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247 Weidan Cao et al., "Modelling posttraumatic growth among cancer patients: The roles of social support, appraisals, and adaptive coping", *Psycho-oncology* 27, no. 1 (February 2018): 208-215. https://doi.org/10.1002/pon.4395
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248 Liyan Zhang et al., L., "Post-traumatic growth and related factors among 1221 Chinese cancer survivors", *Psycho-Oncology* 29, no. 2 (February 2020): 413-422. https://doi.org/10.1002/pon.5279
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249 P. Alex Linley et al., "Positive psychology: Past, present, and (possible) future", *The Journal of Positive Psychology* 1, no. 1 (Februaty 2007): 3–16. https://doi.org/10.1080/17439760500372796

250 Tedeschi and Calhoun, "PTGI", 455-71.

251 Nina Ogińska-Bulik, "The role of social support in posttraumatic growth in people struggling with cancer", *Health Psychology Report* 1, no. 1 (2013): 1-8. https://doi.org/10.5114/hpr.2013.40464

patients who were provided with greater emotional support from their families and friends in the period following the diagnosis also reported significant posttraumatic growth from a long-term perspective. On the other hand, patients who only saw others ad available to provide emotional support did not report a significant increase in posttraumatic growth.[252] It is also important to note that the longer patients are hospitalised at hospices, the less frequent the social support from their families and close ones is.[253] This might also provide an explanation of our results that show differences in the relationship between social support and posttraumatic growth in cancer patients undergoing treatment or in remission and terminally ill patients. The process of coming to terms with cancer is dynamic, and the level of posttraumatic growth is associated with the demand for social support. However, social support is specific in terms of a clinical stage of illness, stage of treatment, sources, perception, type and timing.

Concusion

The results of the present study show that self-efficacy correlates positively with posttraumatic growth. It has been shown that perceived social support predicts the level of posttraumatic growth in cancer patients undergoing treatment or in remission, while it does not apply in case of terminal cancer patients. The recommendation for further research is to search for the existence of significant differences in the level of posttraumatic growth between cancer patients undergoing treatment and cancer patients at a terminal stage and to explore the predictors of posttraumatic growth. Future interventions should generally be designed to study personal-, family- and socially-effective determinants associated with posttraumatic growth in cancer patients and to provide the patients with adequate information concerning the diagnosis and prognosis of their illness to allow them not only to accept the diagnosis and prognosis, but also to provide them with an opportunity for positive growth and changes.

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AUTHOR CONTRIBUTIONS

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

252 Maya J. Schroevers et al., "Type of social support matters for prediction of posttraumatic growth among cancer survivors", Psycho-Oncology 19, no. 1 (January 2010): 46-53. doi: 10.1002/pon.1501

253 Patricia Dobríková, Barbora Mešková and Jana Brtáňová, "Depression syndrome and demoralization syndrome in palliative care settings", in *Proceedings from the 7th International Conference of Hospice and Palliative Care* (Olomouc: Solen, 2015).

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THE IMPACT OF INACCURATE TERMINOLOGY ON THE PROVISION OF NURSING CARE IN CASE OF THE INDICATION OF A PALLIATIVE CARE

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Abstract

Background: The article shows problems that arise due to use of inaccurate terminology during the care for hospitalized patients in the end of life at selected department of long-term intensive care.

Methods: The data were gathered through Ad hoc mixed research (Quan-Qual research design), which was based on a combination of research methods of quantitative and qualitative design.

Results: The research revealed the fact that a large number of patients in palliative regimen are incorrectly included in the group of inaccurate terminology – when the doctor does not suggest a palliative care and enters unclear terminology in the patient's documentation. Also it represents to the fact that early palliative care is not integrated into the care of incurable patients in this department. This situation is very stressing both for the patient himself and also for the nursing staff, who do not have a clearly defined procedure of treatment and the nursing care for these patients. Last but not least, this phenomenon brings inaccurate information and false hopes to patient's families.

Conclusion: The research points to the need for precise medical terminology in patients with incurable diseases. It further emphasizes the need to accept the views of nurses when deciding on the implementation of early palliative care.

Keywords: Palliative care - Early palliative care - Chronically ill patient - Inaccurate terminology - Dying - Dying patient.

Introduction

Since the end of 1950's when the first anaesthesiology and resuscitation departments and intensive care units were established in the then Czechoslovakia, there has been a significant development in medicine and in nursing as well. We have seen an incredible development of new technologies that radically affects not only the process of diagnosis and treatment, which significantly increases the chances of survival of patients. This fact has changed the health professionals' view of many acute, previously medically unsolvable conditions, and on the other hand, it was the reason why previously unknown problems in the ethical and economic fields have come into existence.[255]

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255 Drábková "Historie a vývoj", 287-289.

The new possibilities for medicine begun to appear as unlimited, human lives were prolonged to the maximum possible time, without regard to other aspects such as the quality of patient's life and their wishes. Both of these aspects became the centre of interest of the medical sector of palliative care for terminally ill and the dying patients. This type of care began to develop in the Czech Republic in the 1990's. Although the new branch of medicine is undergoing a process of great development, we can still see many weaknesses, especially in case of patients in the departments of intensive care.[256]

According to the WHO definition, we can describe the palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual". [257]In the Czech Republic was palliative care introduced into Act 372/2011 Coll. on health services (§ 5) in 2011. The palliative care is there characterized as a type of health care, the purpose of which is to alleviate suffering and maintain the quality of life in case of patients with diagnosis of the incurable disease.[258]

Palliative care is often related with only cancer patients. It is true that up to 80 % of patients in the palliative rcare have a certain type of cancer as their primary diagnosis. In these cases, we must into account the fact that directly the tumour or anti-tumour treatment can cause that the patient is in condition requiring intensive care. The remaining 20 % are patients with advanced neurodegenerative diseases, terminal stage of chronic organ diseases, AIDS patients, polymorbid geriatric patients, patients with persistent vegetative status and patients with critical irreversible multiorgan failure in intensive care. [259]

The generally accepted objective of intensive care is always to maintain life and health. In situations when it is not possible to achieve this objective, the transition from intensive to palliative treatment / care comes to the forefront with its characteristics that guarantee patients the elimination of pain and other symptoms, for example discomfort and distress, that have negative impact of their quality-of-life, while maintaining human dignity and physical satisfaction, psychological, social and spiritual needs. [260]

In light of the facts above, it is very important for the patient's medical and nursing team to be able to realize that all the possibilities of treatment have been exhausted and that is the reason why further expansion of curative therapy will not improve the patient's health. Properly named and selected palliative care results in reduction of patients suffering. It is necessary to set the treatment of unpleasant symptoms such as pain, shortness of breath, nausea and many others that are connected with specific disease.

256 Drábková and Hájková, *Následná intenzivní péče*, 23.

257 See: "Palliative care," accessed October 8, 2021, https:// Palliative HYPERLINK „https://www.who.int/health-topics/palliative-care" care (who.int)

258 See: "Zákony pro lidi," accessed October 8, 2021, https 372/2011 Sb. Zákon o zdravotních službách (zakonyprolidi.cz)

259 See: "Co je to paliativní péče", accesed October 8, 2021, https://Co je to paliativní péče (paliativnicentrum.cz)

260 Bužgová, *Paliativní péče ve zdravotnických zařízeních: potřeby, hodnocení, kvalita života*, 25- 30.

If the palliative regime process is not set right in acute and subsequent hospital departments, early palliative care is not integrated into patient care, this fact is very difficult for the dying patients, their family and the nursing staff too.[261]

The purpose of this article was to draw attention to the problems in practice that occur during the setting up a palliative regime for a selected department of long-term intensive care where the doctors use inaccurate and non-unified terminology in the documentation. The terminology relating to patients in the palliative regimen is not unified and the patient is treated inconsistently and that is the reason why there come about prolongation of the patient's suffering. We can also notice an unclear objective of care in case of the deterioration in the patient's health.

Research objectives are:

1) To evaluate the correctness of the categorization of the type of treatment and care in relation to the definition of palliative care for patients hospitalized in a selected department of subsequent intensive care in 2020.

2) To verify the impact of non-unified terminology not only on nursing staff (practice nurses and general nurses) but on their care for patients as well.

Research issue, characteristic of the research department

Patients in a research department of long-term intensive care are hospitalized there for several months or years. It is very difficult to determine the limit when the medical treatment is still a benefit for the patient and when there is no benefit for them. And for that purpose, the institution has set a procedure for initiating a palliative care. Anyone from the nursing medical team, the patient's family or persons close to family members can initiate it. The initiation of a palliative regimen should begin after record in the medical documentation and informing the patient (if it is possible in view of his or her clinical condition). The senior doctor or the head of the department informs the patient about the palliative care before it starts. The result of the decision to initiate palliative care will be determined by the palliative commission, which meets according to the needs of selected departments and on the basis of the initiative for beginning of the palliative care.

The initiation of palliative care and the decision to initiate or not to continue the ineffectual treatment must always be mentioned in medical documentation as a part of the treatment plan. The record should be written before the beginning of palliative care and must include: 1) expert assessment of patient´s health status and medical explanation of the decision to start palliative care, 2) formulation of further care and treatment objectives, 3) the priority of the palliative care plan - elimination of signs of pain, discomfort and suffering. The treatment plan must contain sufficient nursing care and analgesia according to the patient´s clinical condition. The objectives of care, the benefits and risks of planned and on-going individual diagnostic and treatment procedures should be re-evaluated and considered at regular intervals. Any already taken decision can be modified in the in duly justified cases. A record of the reasons for changes in the treatment plan must be also part of the medical records.

According to the nursing staff's claim, the selected department of subsequent intensive care has long faced the problem of poorly defined palliative care. Doctors do not use the above procedure to apply palliative care but they often choose non-standard qualification that is perceived

261 Pařízková "Paliativní léčba v intenzivní medicine",15–17.

as an improper synonym for palliative care and that is the reason why it can be often confusing for both doctors and nurses. In the case of inaccurate terminology, there is no unified procedure for medical and nursing care. In consequence of this fact there are many problems from the point of view of nursing staff.

Methodology

In the first part of the research, we took a retrospective data collection from the hospital information system, where we categorized all hospitalized patients according to the type of care that the doctor chose for them. This part of survey was realized in 2020. We divided the patients into 3 groups – curative care, palliative care and other terminology.

In the second part of the research, we focused on determining the differences in care among the 3 groups of patients. With that intention we have chosen case studies as a method of collecting qualitative research data. We randomly selected 5 patients from each group and prepared their case report. Each case report described the selected patient, respectively the aspects of their care. Then there were determined the main aspects in selected areas for each group, and the individual groups were compared with each other.

In view of the fact that the first two parts of the research showed the frequent classification of patients into a group of unclear terminology, where the differences between this type of care and palliative care practically do not exist, we are interested in the nursing health professionals' attitude on this issue. Using a qualitative method to data collection based on the recommendations of the Thematic Analysis we made 9 open interviews with general nurses working in a selected department of subsequent intensive care. The data were analysed in the following order according to individual recommendations – 1. reading and repeated reading, 2. initial notes and comments, 3. development of emerging topics, 4. open coding, 5. searching for connections across the topics, 6. searching for patterns across the topics. The data were processed using Atlas.ti software. We present the main outputs in the article help Smartart.

Results

The following text presents the results of all 3 consecutive studies. Table 1 shows the results of the first part of the research – the categorization of patients from the monitored group that were hospitalized at the research department in 2020.

Table 1: Categorization of hospitalized patients

Group	Gender	Number of patients	The average age of patients	The youngest patient's age	The oldest patent's age
Curative care	men	40	65	27	83
	women	23	64	23	88
Palliative care	men	23	65	41	87
	women	5	70	46	93
Other terminology	men	27	72	21	83
	women	17	71	26	91

The interpretation of the Table 1

During 2020, there were 135 patients admitted to the long-term intensive care department. 63 patients (40 men and 23 women) were in the curative care group in which the patients are fully treated. The second group includes patients in the palliative regimen, when all treatment procedures are exhausted and patients can no longer receive treatment that would improve their health. There were 28 patients in this group (23 men and 5 women). The last group consists of patients characterized with inaccurately used terminology (in their case doctors often use terms such as adverse prognosis or rationalization of treatment) and without clarification of the further medical treatment. There were 44 patients in this group (27 men and 17 women).

Table 2 describes the practice situation of particular types of care at research departments and it also shows the data obtained from the analysis of the patients' case reports.

Table 2: The most common characteristics of patient care during long-term intensive care

Curative care	Palliative care	Other terminology
• Continuous monitoring of physiological functions and ventilation parameters • Fluid balance • Monitoring signs of infection • Hygienic care • Curative care and rehabilitation • Pulmonary rehabilitation concerning breathing techniques, airways clearance techniques • Collection of blood and urine samples • Samples for cultivation and sensitivity • Antibiotic treatment according to the results • Aseptic changing of all invasive inputs • Inhalation therapy • Ward round • Preventive and therapeutic positioning • Pain monitoring and pain treatment • Cardiopulmonary resuscitation during cardiac arrest	• Monitoring of physiological functions and ventilation parameters according to patient's condition • Monitoring of pain symptoms, analgesic therapy • Hydration and nutrition care • Hygienic care • Analgesic rehabilitation • Care of airways / respiratory care • Aseptic changing of all invasive inputs • Ward round • Patient and relatives are information about prognosis and care • Cardiopulmonary resuscitation during cardiac arrest is not initiated	• Monitoring of physiological functions and ventilation parameters according to patient's condition • Monitoring of pain symptoms, analgesic therapy • Hydration and nutrition care • Hygienic care • Analgesic rehabilitation • Care of airways / respiratory care • Aseptic changing of all invasive • Ward round • Patient and relatives are not information about prognosis and care • Cardiopulmonary resuscitation during cardiac arrest is not specified

The interpretation of the Table 2

The first described group **is curative care** which is characterized by the fact that the patients are fully treated with the objective of complete healing. This includes continuous monitoring of blood circulation, respiration (physiological functions are recorded to the nursing documentation every hour), repeated blood collection (twice a week), appraisal of their results, antibiotic therapy according to cultivation and sensitivity, support of blood circulation with catecholamines (Noradrenaline, Dobutamine, Empressin), control of fluid intake and output. CPR is initiated in case of cardiac arrest. Doctors visit the patient during the ward round twice a day. Nursing care is provided nonstop. During the duty the medical staff care for patient's complete hygiene, aseptic changing of all invasive inputs and defects (decubits, surgical wounds, venous accesses) and carrying out the treatment recommended by a doctor. The patients are positioned every 2 hours. The nursing staff takes care of a quality airways clearance. The patients are regularly monitored for pain and analgesics are provided according to the regular medication. In case of the pain aggravation the medical staff reacts according to the doctor's prescription. Medical rehabilitation is carried out on patients twice a day depending on their current condition.

The second group describes a **palliative regimen**, where all treatment options have been exhausted. The patient is monitored continuously for blood circulation and respiration, and blood sampling. Antibiotic therapy and collection of the blood samples are reduced. Emphasis is put on treatment of the pain – it usually includes providing of continuous analgesics, as well as on patient's adequate nutrition and hydration. In case of cardiac arrest, cardiopulmonary resuscitation is not initiated. Doctors visit the patient during the ward round once a day. Nursing care is provided nonstop. During the duty the medical staff cares for patient's complete hygiene, changing of all invasive entrances and skin defects. Nurses proceed according to the doctor's prescription. The patients are positioned depending on their current condition. The nursing staff takes care of an airways cleanness. Rehabilitation is carried out on patients only if it is not painful for them and if it does not aggravate their condition. Patient and relatives are completely full information about prognosis and care.

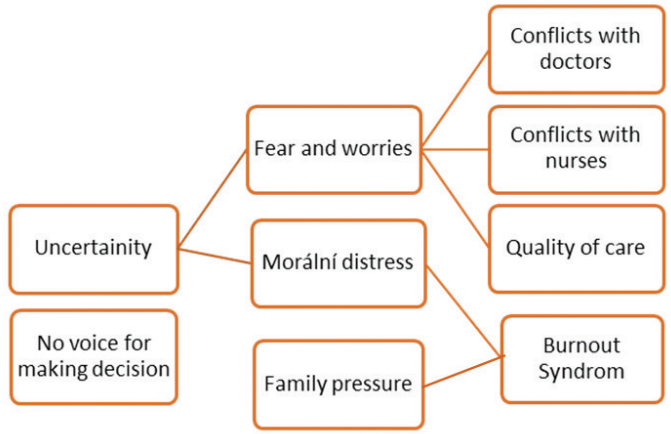
The third group is a group of **inaccurate terminology**, where the doctor enters an inaccurate term to the documentation (non-extension of therapy, rationalization of treatment or adverse prognosis). This inaccurate terminology causes that it is not evident how the patient's treatment will continue. That is the reason why there are confusion about the subsequent care for patient and question if their treatment will be continued or not. Patient's blood circulation and respiration are monitored continuously. Antibiotic therapy and collection of the blood samples are reduced. Emphasis is put on treatment of the pain – it usually includes providing of continuous analgesics, as well as on patient's adequate nutrition. The initiation of cardiopulmonary resuscitation is not clear in case of these patients. Patient and relatives are not completely full information about prognosis and care.

Doctors visit the patient during the ward round twice a day. Nursing care is provided nonstop. During the duty the medical staff cares for patient's complete hygiene, changing of all invasive entrances and skin defects. Nurses proceed according to the doctor's prescription The patients are positioned depending on their current condition. The nursing staff takes care of a quality airways cleanness. Rehabilitation is carried out on patients only if it is not painful for them and if it does not aggravate their condition.

Full nursing care is provided in all three groups of patients, regardless of the reducing of the medication in case of palliative care and inaccurate terminology.

To achieve the set research objective nr. 2, qualitative field research was apply using the approach of thematic analysis. The thematic analysis was obtained from transcripts of interviews. This research sample includes full-time Long-Term Intensive Care nurses who were willing to answer the question: "What do they think about the inaccurate terminology of the SIC patients that they care for?" Nine nurses have answered this question. Summary of the main topics is illustrated in Picture 1.

Picture 1: The main topics of interviews



The interpretation of the Picture 1

The most often topic that predominated in informants' answers was uncertainty. When the patients have in their documentation the inaccurate terminology instead of the palliative care and although the fact that this type of care is basically the synonymous with the palliative care it is not the official term in the legal terminology meaning, the nursing staff have no certainty, mainly in case of the cardiac arrest. The initiation or non-initiation of cardiopulmonary resuscitation is not clear.

"During the rationalisation of treatment, I don't know what we should include to the care for patient and what we should not."

"For example, the term rationalization does not determine the exact procedure in the case of CPR, and this makes the work of nurses very difficult. They don't know how to decide in that situation to the result of this decision is correct."

"If there is entered in the documentation: 'Due to the exhaustion of possibilities and the effect of treatment, the therapy will be aimed at a symptomatic palliative way', the palliative care is not clearly assigned to me. The used word 'will' evokes a feeling of indecision and unclear assignment."

"In the case of changes in the patient's condition, I am undecided if I should inform the doctor or not. After consulting with the team, we always call the doctor, but it still isn't clear how to proceed. Should we call a doctor? How will he or she react? In my opinion it is useful to clearly determine the procedure of care in the documentation. "

The second main topic was the fact that nurses have no advisory voice during making decision on the implementation of palliative care. They lack the medical authority for discussion.

"We are with them all time during work service with patients, we know everything about them and no one asks us anything, no one even cares. If the patient does not fit into the relevant rows of the scientific tables, he will be treated, even if he does not want to. "

From uncertainty also arises often mentioned theme of fear. Fear of the situation that the nurse would harm the patient's health if she did not inform the doctor or if the doctor would be indecisive in the subsequent procedure of patient care. That is the reason why nurses often call a doctor for any deterioration in the patient's condition, which heads towards another related topic and the fact that some doctors are irritated and think that the nurses are incompetent and call them due to every banality.

"When I don't inform the doctor of it, the patient's death causes the feeling of guilt connected with doubts that I was supposed to choose different procedure."

A frequently mentioned topic was also moral distress, when the nurse proceeds according to the doctor's prescription, which is not in accordance with her moral values and beliefs of what is and what is not correct. She abides the doctor's prescription for fear that she will be prosecuted.

"In case of patient's cardiac arrest, I will inform the doctor about the current condition of the patient and I will proceed according to his decision, although I do not always agree with resuscitation. I often wish those people rest in peace. They have experienced so much horror. Unfortunately, I properly record everything to the documentation according to the doctor's decision, with which I don't completely identify. Every decision and responsibility is up to the senior doctor."

"It's a terrible feeling to resuscitate a patient and actually wish them the end and peace."

Unfortunately, not all families are able to understand the patient's serious condition. They want full care even in situation when all medical procedures have been exhausted. If the exact procedure of care is not clarified, the families are not given a comprehensive picture of the patient's condition. That is the reason why misunderstandings and subsequent conflicts with the patient's family can arise. This situation very often prolongs the patient's suffering.

"At any costs to save the patient, at any costs to look for other treatment alternatives. – Unfortunately, it doesn't bring any benefit to the patient; on the contrary, it prolongs their suffering."

Inaccurate terminology does not provide a specific procedure in case of deterioration of patient's condition. If the doctor on duty has a different view of the procedure than the doctor who recorded inaccurate terminology in the documentation, there may be a delay in therapy in subsequent care – for example, a delay in initiating cardiopulmonary resuscitation.

"The patient's condition is often serious and these delays can harm him. If doctors no longer want to extend the patient's therapy, they should accurately describe the procedure in case of cardiac arrest."

The last topic was burnout syndrome. The nurses described themselves as burnt out or spoke openly about its symptoms.

"Then I'm tired of it all, exhausted, I don't want to be at work. I'm pretty irritated. The kids tell me it's not me. "

"Sometimes I dreamed about it, I'm standing over the bed, heart arrest in the monitor and I don't know what to do. "

Discussion

The research was emerged from problem defined by general and practical nurses working in a selected long-term intensive care in a region town hospital. The problem was focused on wrong defined palliative care for end-of-life patients in research ward. Doctors here often do not use the recommended procedure for the deployment of palliative care and often use non-standard qualifications, which is rather perceived as an inappropriate synonym for palliative care. When inaccurate terminology is used, there is no uniformity of medical and nursing case.

The research aimed to assess the accuracy of the categorization of the type of treatment and care in relation to the definition of palliative care for patients hospitalized in a selected department of long-term intensive care in 2020. The second aim of the research was to examine to impact of inconsistent terminology on nursing stuff (general and practise nurse) and their care of patients.

In 2020, a total of 135 patients were admitted to the research side, were divided into three pre-defined groups, namely curative care, palliative care and groups of inaccurate terminology. In the first group, 63 patients were hospitalized in the year, in the second group, 28 patients were hospitalized, and in the third group, 44 patients were hospitalized. The number in the third group reflects the number of patients for whom the palliative care terminology is inaccurately determined and for whom the procedure of care in case of deterioration of the patient's condition is not determined in advance.

The prognosis for these patients is also not established, so the goal of care, how follow-up treatment will proceed, and the exact course of action when the patient's condition deteriorates are not predetermined. Both the patient and his family are in uncertain information about the prognosis. However, pain therapy, nutrition and other therapies are set in advance according to the current condition, as it is in the case with the palliative care group. However, the procedure for circulatory arrest, whether to initiate cardiopulmonary resuscitation or not, is not specified. This activity then applies to the service of the doctors and their surgeries, which makes the work of the attending staff difficult.

The need for proper identification of patients for palliative care and the necessity to start early palliative care is highlighted by experts from the medical field and other disciplines such as nursing, social work, psychology and others. Greer et al. (2018) highlight the fact that early palliative care provides an opportunity for the patient and their loved ones to be well oriented in the trajectory of the disease, to receive support for coping with the diagnosis, to improve the quality of decision-making among alternatives of management to match the patient's values and preferences, as well as to have realistic expectations of treatment outcomes, anticipating further developments in time so that the patient and the family can be well prepared. [262]

Many studies also demonstrate the benefit of palliative interventions in the intensive care setting. Research shows that palliative care is beneficial for two groups of patients in particular. The first group is patients in the intensive care setting, where the main focus tends to be intensity of care appropriate to the patient's values. Through the use of invited specialist doctor in palliative care (consultative model) or palliative interventions by intensivist physicians themselves (integrative model), studies have shown that reductions in ICU and hospital stays are most often achieved, satisfaction with care is increased in some studies, and mortality is unchanged or reduced. The second group is patients with chronic advanced disease resulting in acute decom-

262 Greer, "Early integration", 349- 363.

pensation, e.g. requiring repeated acute hospital admissions (e.g. for breathlessness in COPD or heart failure) or for pain in generalised malignancy).[263]

Hospitalization after the crisis allows anticipating the further development of the disease and, in collaboration between the patient, the primary care team, the palliative care team and the patient's family, developing a plan for deterioration that matches the patient's values and preferences. [264]

We can only guess at the reasons why the number of patients included in the inaccurate terminology group is so high. According to Kopecky (2018), the most common barriers to the indication of supportive and palliative care are concerns about the communication of prognostic information related to the belief that this information can "take away hope" from patients.[265] According to researchers the most common barrier is the need for the patient's condition to be assessed as terminal. Further research would be useful to verify this.[266]

The second aim of the research was to examine the impact of inconsistent terminology on nursing staff (general and practice nurses) and their care of patients. In response to the question regarding inaccurate terminology, "What do you think about inaccurate terminology for the patients you care for." nine nurses working in the long-term intensive care unit responded. According to the nurses, caring for patients who have inaccurate terminology in their documentation is very challenging and they feel a great deal of uncertainty in caring for these patients.

With imprecise terminology, nurses do not know whether to rescue a patient when basic vital signs fail. The concept of rationalisation, which is often used, is an incomprehensible term for them and they cannot imagine how they are supposed to care for the patient. This term does not tell them whether cardiopulmonary resuscitation is initiated in the event of circulatory arrest. Nurses feel a great deal of uncertainty about the next course of care when caring for these patients. They would feel guilt if they did not inform the doctors of the patient's deteriorating condition and the patient's subsequent death occurred. In addition to this, they very often experience moral distress, where the nurse acts according to the doctor's orders, which are not in line with their moral values and beliefs about what is right and wrong. She will only perform the requested surgery for fear of being legally prosecuted.

According to Altaker et al. (2018), increased moral distress among nurses caring for terminally ill patients is associated with poor workplace ethical climate, non-integrated palliative care teams, and little or no nurse voice in decision-making about palliative care implementation. The research also highlights the need to promote palliative care education and palliative care teams that are well integrated into intensive care units.[267]

263 Nelson, "Models for structuring", 1065-1072.
264 Kopecký, "Úloha paliativní medicíny", 449-452.
265 Kopecký, "Úloha paliativní medicíny", 450-453.
266 Kyeremanteng, "Survey on Barriers", 108-116.
267 Altaker, Relationships Among, 295-302

According to Wolf et al. (2019), many critical care nurses do not feel prepared to provide palliative care. If the approach to palliative care is perceived as inadequate, nurses may experience moral distress. Again, this research highlights the need to prepare nurses for potential pitfalls and educate them in palliative care.[268]

Nurses in our research report that they want patients in the post-acute care unit not to suffer for long periods of time and to be able to leave with dignity without prolonging their suffering, which is not the norm when terminology is inaccurate. There is frequent changing of therapy according to the serving physician, thus prolonging patient suffering, which causes futility and misunderstanding of treatment procedures by nurses. Drtinová states in her work that up to 74% of nurses providing palliative care are at risk of burnout syndrome. [269] Burnout syndrome is an issue that also emerged as a theme in our research, so it is very important to listen to the issues and perceptions of care by nurses who spend a lot of time with patients. [270]
The role of the nurse has changed in recent years and the nurse has become an equal partner of the doctor. High demands are placed on nurses, as they are the closest to the patient and form a bridge in communication between the patient and their family members and the doctor. In long-term intensive care units, these demands are higher because of the long-term hospitalisation of patients, often with an unfavourable prognosis.

Each member of the nursing team has an irreplaceable role in providing care to patients admitted to the ICU. Teamwork is very essential to patient care, therefore, if there is no interplay between all team members and the goal of care is not clarified in advance, they cannot provide quality nursing care and there could be harm to patients and major discrepancies within the entire team. Therefore, the opinions and experiences of nurses should also be given more consideration by physicians. Their experience is a great asset in the care of long-term patients and their opinion on the care provided is often a great benefit to the patient.

Conclusion

The article is evidence that palliative care is an absolutely necessary part of intensive care, especially in long-term intensive units. The patient's indication for this regimen has to be clear, accurate, comprehensible to all members of the nursing team and other doctors. Uncertainties in the terminology of setting / not setting up of palliative care are the cause of a wide range of problems, especially among nurses. The severity of the problems can be also result in the onset or development of burnout syndrome. Therefore, it is very important to remove the barriers that cause this condition. In addition to the integration of early palliative care, it is also necessary to educate both nurses and doctors in this issue. In nursing teams, it is necessary to increases the position of the nurse and her voice in the decision-making process when implementing palliative care.

Author Contributions
All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

268 Wolf, "Palliative care", 38-49
269 Drtinová, "Specifikace práce", 55-75.
270 Kupka, "Paliativní péče", 23 – 35.

Conflict of interest

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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ASPECTS OF THE COMMUNICATION AND ACCOMPANYING PEOPLE IN END-STAGE OF DEMENTIA AND THEIR INFORMAL CARERS IN RELATION TO OPTIMAL PALLIATIVE CARE: A SYSTEMATIC REVIEW

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Abstract

Background: Dementia, as by now untreatable geriatric syndrome, presents an important life-limiting group of diagnoses. The prognosis survival period of people with dementia in the terminal stage ranges from 3 to 10 years. Part of the dementia trajectory is physical and cognitive problems accompanied by neuropsychiatric symptoms that limit the patient as well as his informal caregiver. In systematic review of papers published from January 2017 to July 2021 out of the total number of 24 studies 10 relevant studies were selected for further analysis.

Conclusions: The aim of this paper was to search for and present good practice examples of interventions related to the domains of optimal palliative care. Seven out of 11 domains were identified as covered by found intervention: Applicability of palliative care, Person-centred care, communication, shared decision making, Setting care goals and advance planning, Optimal treatment of symptoms and providing comfort, Psychosocial and spiritual support, Family care and involvement, and Education of the health-care team. All found interventions are related to communication and may be the inspirations for social workers and other specialists who are active in palliative care for people living with dementia.

Keywords: Dementia – Palliative care – Communication – Validation therapy.

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Introduction

Dementia, as by now untreatable geriatric syndrome, is considered as a terminal health condition.[272] The umbrella term dementia covers more than a hundred forms. According to Alzheimer's Disease International,[273] from 50 to 60 % of all dementia cases occurring in Alzheimer's disease (AD). Currently, AD and other dementias are the seventh foremost cause of death in the world.[274] It is alarming that one third of people in older age die with dementia.[275] In dementia widespread of neurons' death consequences in numerous deficits of memory, behaviour, language, movement and executive function and ability to recognize relatives or common items.[276] Failure to treat these symptoms leads to increased disability, premature institutionalization, increased financial costs of care and burden of caregivers.[277]

Progression of dementia is heterogeneous and results from types of condition and characteristics of person living with dementia.[278] Studies show that people over the age of 65 live an average of 4 to 8 years after clinical diagnosing AD, some for more than 20 years.[279] It is clear that one third to half of dementia course presents late stage dementia.[280] In literature, the "late stage dementia" is also named as "advanced dementia", "severe dementia" or "end-stage dementia"[281] and it is characterised with memory deficit, minimal verbal speech, and inability to perform daily living activities, to sit up without assistance, with double incontinence and with loss of ability to smile.[282] The prognosis survival period of **people with dementia in the terminal stage** ranges from 3 to 10 years.[283]

People living with dementia in AD usually receive help from family members, unpaid caregivers, and social service providers at home, in day-care or residential form.[284] Most people live with dementia at home. In high-income countries, more than 70 % of people with dementia live in a community, with much of their care provided by informal carers. In low-income countries with a lack of services, their number is close to 100 %.[285]

Informal caregivers usually present family members or close friends of people with dementia. In Slovakia, relatives caring persons with AD for 24 hours in a day, seven days in a week without or with financial allowance[286] belong to „primary informal caregivers". The group of "secondary informal caregivers" more often makes up of relatives of productive age, who participate in the care of a person with dementia and at the same time use available health and social care community services. **Informal caregivers of people with dementia have even been referred to in research as „invisible second patients".**[287]

Palliative care in dementia is gradually followed curative treatment. Preventing or relieving pain is a human right to health, providing patient-centred and integrated health services that reflect the specific needs and preferences of the individual in a wide range of diseases, including dementia. Palliative care uses a team approach, supporting the patient and his relatives in practical matters, including post-death counselling. An important part of the multidisciplinary palliative team is a social worker.[288] An implementation of palliative care is possible in every stage of dementia and in varied health and social care facilities.[289]

Frequently, dementia´s trajectory is not predictable and therefore the **beginning of palliative care should reflect the needs.**[290] Subjective, objective, personal and societal needs belong to unmet needs.[291] Experienced needs are for example need for comfort of living with dementia and his/her caregiver. Objective needs are diagnosed needs (e.g. elderly abuse). The onset of palliative care in the care of people with dementia in AD is not related to the proximity of death, but to advanced multimorbidity (presence of two or more diseases)[292], dementia and its burdensome consequences (physical, mental, social, and spiritual). In patients with dementia in AD, „total pain" manifests in the final stage. It manifests itself in powerlessness to communicate its difficulties, desires and needs in a generally comprehensible manner. The patient then relies on a multidimensional approach based on hospice care, palliative treatment, care and medical, nursing and human support.[293] Besides that, studies have provided evidence of less analgesia prescribing in the dementia terminal phase in com-

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283 van der Steen, et al. "White paper"

284 Fazio, Sam et al. "Alzheimer's Association Dementia Care Practice Recommendations." *Gerontologist* 58, Issue suppl_1 (February 2018) , S1, S1–S9. https://doi: 10.1093/geront/gnx182.

285 Wimo, Anders, Gauthier, Serge, and Martin Prince 2018. *Global Estimates of Informal Care.* London: Alzheimer's Disease International. https://www.alzint.org/u/global-estimates-of-informal-care.pdf

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288 World Health Organization. *Integrating Palliative Care and Symptom Relief into Primary Health Care: A WHO Guide for Planners, Implementers and Managers.* Geneva: World Health Organization, 2018. https://apps.who.int/iris/bitstream/handle/10665/274559/9789241514477-eng.pdf?ua=1

289 Hill, Emily et al. "Staff Perspectives"

290 Livingston, Gill et al. "Dementia Prevention, Intervention and Care: 2020 report the Lancet Commission." The Lancet Commisions 396, no. 10248 (July 2020): 413–446.

291 McWalter, Gregor et al. "Needs and needs assessment: their components and definitions with reference to dementia." *Health & Social Care in The Community* 2 (July 1994): 213-219. https://doi.org/10.1111/j.1365-2524.1994.tb00167.x.

292 Barnett, Karen et al. "Epidemiology of Multimorbidity and Implications for Health Care, Research, and Medical Education: a Cross-sectional Study." *The Lancet* 380, no. 9836 (July 2012): 37–43. https://doi.org/10.1016/S0140-6736(12)60240-2.

293 Heimerl, Katharina, Reitinger, Elisabeth and Eva Eggenberger. Frauen und Männer mit Demenz. Handlungsempfehlungen zur person-zentrierten und gendersensiblen Kommunikation für Menschen in Gesundheits- und Sozialberufen. (Wien: Bundesministerium für Gesundheit, 2011). https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=486

parison to people without cognitive changes.[294] Because of that, life with dementia often ends in pain.[295] Dementia is not the cause of death. Associated diseases (bronchopneumonia, septic condition, heart failure or stroke) are its causes mostly.[296]

The European Association of Palliative Care[297] defined an **optimal palliative care for people in advanced dementia** as "the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount. Palliative care is interdisciplinary in its approach and encompasses the patient, the family and the community in its scope. In a sense, palliative care encapsulates the most basic concept of care – that of providing for the needs of the patient wherever he or she is caring for, either at home or in the hospital. Palliative care affirms life and regards dying as a normal process; either hastens nor postpones death. It sets out to preserve the best quality of life until death." In 2014, the EAPC presented **57 recommendations classified into 11 domains on optimal palliative care and treatment in older people in dementia**.[298] According to the published White paper, the aim of our research work is to look for good practice examples of interventions, which are in line with these recommendations.

Methods

For a systematic review, clinical studies published in the electronic databases Lancet, MEDLINE, PsychINFO, Pubmed and Web of Science Core Collection were used. Papers published from January 2017 to July 2021 were sought and contained quantitative data of the output variables, which is commonly used in clinical practice and relates to palliative care in end-stage dementia. Studies were selected from potential papers in English. The excluding criteria were other language than English, duplication, review paper, disease symptom management study, pharmaceutical research and ethnic group study. We identified a total of 24 potential studies in the databases. Figure 1 shows a flowchart of our selection process.

After screening the abstracts, ten studies were included in the further analysis (Abreu et al, 2019; Beernaert et al, 2017; De Schreye et al, 2017; Garabedian, 2020; Hill et al, 2018; Macchi et al, 2021; McCloskey, Hughes, Parsons, 2018; Poloni et al, 2020; Rosebush et al, 2021; Tilburgs et al, 2020). Subsequently, based on van der Steen et al[299] we categorized them into six groups as follows: applicability of palliative care; person-centred care, communication, shared decision making; setting care goals and advance planning; optimal treatment of symptoms and providing comfort; psychosocial and spiritual support; and family care and involvement of people living with dementia and their informal caregivers (Table 1).

294 Murphy, Edel et al. "Palliative care interventions in advanced dementia." The Cochrane database of systematic reviews 12, no. 12, (December 2016): CD011513. https://doi.org/10.1002/14651858.CD011513.pub2

295 van der Geugten, Wendy and Anne Goossensen. "Dignifying and undignifying aspects of care for people with dementia: a narrative review." *Scandinavian Journal of Caring Sciences* 34, no. 4 (December 2020):818-838. https://doi.org/10.1111/scs.12791.

296 Holmerová, Iva, Jarolímová, Eva, and Jitka Suchá et al. *Péče o pacienty s kognitívní poruchou.* Praha: Česká alzheimerovská spoločnost, Gerontologické centrum, 2007.

297 European Association for Palliative Care. Definition of palliative care. www.eapcnet.eu/Corporate/AboutthEAPC/Definitionandaims.aspx. Europe, 1998 (last accessed 5 January 2016).

298 van der Steen, et al. "White paper"

299 van der Steen, et al. "White paper"

Figure 1: Flow chart of selection process

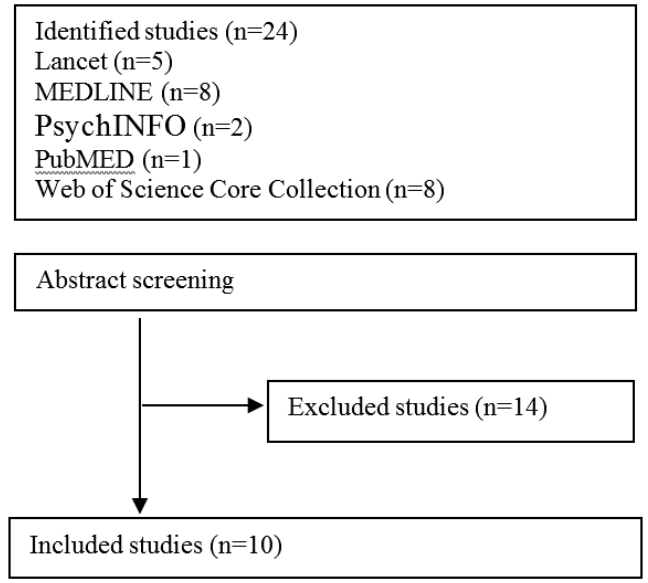

Table 1: Review of searched studies by domains of optimal palliative care and treatment in older people in dementia

Study	Country	Domain*	Target group	Research design	Achieved outcomes
Abreu et al (2019)	Portugal	1.	83 persons diagnosed with moderate or severe dementia	Cross-sectional survey	Identified unmet health needs
Garabeddian (2020)	United Kingdom	2.	1 client in long-term care facility	Innovative practice	Improved comfort with music
Beernaert et al (2017)	Belgium	3.	118 patients in control group 164 patients in program group	Cluster randomised controlled trial	Improved comfort around dying
Hill et al (2018)	Canada		22 long-term care staff	Interview study	Interpreted objectively the staff experience
McCloskey, Hughes, Parsons (2018)	United Kingdom		15 proxy decision makers	Semi-structured interview study	Emerged key themes of proxy decision
Tilburgs et al (2020)	Netherlands		38 general practitioners 140 people with dementia	Single-blinded cluster randomized controlled trial	Increased advance care planning initiation

De Schreye et al (2017)	Belgium	7.	14 general practitioners	Literature review Expert interviews	Developed set of quality indicators for AD
Rosebush et al (2021)	USA	8.	20 volunteers 25 clients and caregivers	Single-arm pilot study	Enhanced volunteer-client communication
Macchi et al study (2021)	USA	9.	108 patients 90 caregivers	Metrix design in qualitative study	Used telemedicine to improve care
Poloni et al (2020)	Italy		57 people diagnosed with dementia and COVID-19	Retrospective single-centre study	Delirium-Onset COVID-19 strongly associated with higher mortality
Beernaert et al (2017)	Belgium	10.	118 patients in control group 164 patients in program group	Cluster randomised controlled trial	Implemented program CAREFuL
Rosebush et al (2021)	USA		15 volunteers 25 clients and caregivers	Single-arm pilot study	Trained volunteers

* Domains are numbered as follows: 1. applicability of palliative care, 2. person-centred care, communication, shared decision making, 3. setting care goals and advance planning, 7. optimal treatment of symptoms and providing comfort, 8. psychosocial and spiritual support, 9. family care and involvement, and 10. education of the health-care team. 300

Results

Applicability of palliative care

Abreu et al[301] focused on care professional which are assessed and solved the **health needs**. It is possible to screen for psychosocial issues, complex symptoms and caregiver burden and palliative care needs can be identified.

Person-Centred Care, Communication, and Shared Decision Making

Person-Centred Care

An example applying the concept of **person-centred care** is a study of a professional cellist Claire Garabeddian[302] who describes her "emergency" music intervention for a highly agitated client with advanced dementia in long-term facility. After an hour on the cello playing of well-known Scottish and popular tones, a man - an amateur musician was considerably calmer. **The power of music became a connection with the person, which may not be able through verbal communication**. This unique intervention illustrates how music can complete basic human needs for occupation, inclusion, identity, comfort and attachment.[303]

300 van der Steen, et al. "White paper".

301 Abreu, Wilson et al. "The relationship between frailty".

302 Garabedian, Claire E. "Dementia".

303 Kitwood, Tom 1993. Person and Process in Dementia. *International Journal of Geriatric Psychiatry* 8, no. 7, (July 1993): 541–545. https://doi-org.proxy-ub.rug.nl/10.1002/gps.930080702.

Communication

For families is essential being inform, mostly about medical decisions not excluding those made in **long-term care institutions**.[304] As reported Hill et al,[305] there are three most common **communication problems** in long-term care facilities. These authors recorded from staff point of view three sets of information spreading problems.

S*taff – resident communication*. **Non-verbally expression of needs and pain of clients might be communicated as client´s aggression toward staff, relatives and to the other people living with dementia.**

Staff – co-worker communication. **Communication within a palliative care team** is also challenging. Nurses suggested better communications with medical doctors whose role is to identify clients as palliative and to describe medications. Physicians were responsible for many patients in different long-term care homes. Sometimes felt social workers, chaplains and occupation therapists as excluded from the palliative team. Additionally, staff perceived making end-of-life decision in care homes with absenting formal palliative care as frustrated. Difficulties brought inconsistent staffing. Relationships between clients and full-time versus part-time staff, switching of personal between floors, units.

Staff – family communication. When clients approach the end of life, their families handle it hardly. Relatives became emotional, aggressive, irrational, and distressed and had inadequate requests against staff. Family members did not respect advanced directives of their love ones, which made conflict over decision-making. Sometimes families wanted to use all potential lifesaving methods. Relatives´ will was built over client´s own will. Families wanted to move clients at the end of life to the hospital. Staff saw solution of these difficulties in education of family caregivers, as well as of the public, in issue of dying process, dementia, about care services, especially about end-of-life care in long-term care homes. In conclusion, participants of this study reported, that palliative care was more successful when staff used a team approach, with **open communication**, individualized care plans and goals, and grief counselling.

A comprehensive palliative care with its limitations occurs in several places, including hospitals. **Hospitalized people** with dementia manifest higher level of confusion.[306] On the other side, more than 50% of people in older age die in acute hospital settings. Hence, comfort around dying in hospital was a primary outcome of Belgian training program CAREFuL.[307] Its aim was to **enhance communication between target groups of palliative care -** between the dying people, family caregivers and geriatric health professionals in acute geriatric units of ten hospitals. The educational program included two-days training of staff and supported materials: a care guide for the last days; an informational leaflet and a manual for health-care staff how to use the care guide; three leaflets for informal caregivers about entering the dying phase, grief and bereavement and available facilities. Implementation of CAREFuL in comparison to control group significantly enhanced nurses' assessment of comfort.

Shared Decision Making

People in the last phase of dementia habitually cannot decide about their care and need other person to participate in **decision-making process**. McCloskey, Hughes and Parsons[308]

304 McCloskey, Bridgeen, Hughes, Carmel, and Carole Parsons. "A qualitative exploration of proxy decision" .

305 Hill, Emily et al. "Staff Perspectives".

306 Abreu, Wilson et al. "The relationship between frailty, functional dependence, and healthcare needs"

307 Beernaert, Kim et al. "Improving comfort"

308 McCloskey, Bridgeen, Hughes, Carmel, and Carole Parsons. "A qualitative exploration of proxy decision"

interviewed adult family members, friends or next of kin as proxy decision makers and recorded five key themes. Informal caregivers are in role as advocate and provide information about experienced symptoms to medical doctors, solve medicine and medicine taking. Informal caregivers are uncertain of anti-dementia drugs´ profits and stopping of medication and they experience challenging communication. Decision-making in end-of life care is for caregivers extremely difficult. **Communication between caregivers and health-care staff regarding medication prescription is crucial.** Anti-dementia drugs often give caregivers hope and bring fear about deterioration if these medications were stopped. Many of informal caregivers wish to be more involved in medication-related decisions, but the majority delegate it with trust in the hands of physicians.

Setting care goals and advance planning

Advance care planning (ACP) **addresses end-of life preferences** related to medical and nonmedical items. Medical preferences are resuscitation, mechanical ventilation, and use of antibiotics, tube feeding, and pain relief. Nonmedical preferences are social contacts, activities, housing, safety, care needs, mobility, and finances. Positive effects of ACP are on patient´s quality of life, involvement in care and on burden of informal caregivers.[309] Advanced directives include naming of proxy decision maker and determination of decisions that a person living with AD wants.

Tilburgs et al[310] figured out that general practitioners rarely initiate ACP because they are uncertain on the right timing of ACP, decisional capacity of person living with AD, changing preferences and the uncertain dementia trajectory. Educational intervention for 38 medical doctors in the Netherlands consisted of two interactive workshops, telephone consultations and booklet targeted on ACP. Results of this single-blinded cluster randomized controlled trial show that **general practitioners trained in ACP discussed** 0.8 more medical and 1.5 nonmedical preferences of people living with dementia than general practitioners in the control group.

Optimal treatment of symptoms and providing comfort

In the research of Abreu et al[311] for people with **severe dementia living at home** the needs such as for example eating, drinking and meal preparation, taking pills, looking after home, toilet use, communication and interaction, memory, usual sleep, and falls prevention were identified the most often. In contrast to long-term care facilities and hospitalization, home environment is a place for small activities, interactions, for life in the context of friendliness and own memories.

De Schreye et al[312] developed a set of quality indicators of suitable and unsuitable end-of-life care useful in care in people with AD. Twenty-eight quality indicators measure features of care, pain and symptoms treatment, palliative care, place of care, place of death and coordination and continuity of care.

309 Tilburgs, Bram et al. "Educating Dutch General Practitioners"
310 Tilburgs, Bram et al. "Educating Dutch General Practitioners"
311 Abreu, Wilson et al. "The relationship between frailty, functional dependence, and healthcare needs"
312 De Schreye, Robrecht et al. "Developing indicators"

Psychosocial and spiritual support

Community-based support to families living with AD may have many forms. Rosebush et al[313] presented an innovative older adult volunteer program named PorchLight Project in Minnesota. Aim of this pilot study was to train fifteen volunteers in age over 55 to help clients and their caregivers with daily activities and to discuss their memory concerns and care needs holistically. The volunteer psychoeducation consisted of two courses: online CARES® training and evidence-based palliative care interventions for people in older age. By **friendly visits, volunteers used a guided conversation approach.** Long-term goal of the project was to use PorchLight Project as a routine training for volunteers to people living with dementia and their families across United States.

Family care and involvement

The novel coronavirus disease 2019 (COVID-19) has led many people, including those with chronic disease such as dementia and their caregivers, to self-quarantine. Social isolation, disruption of health (palliative) care, and deterioration of dementia´s symptoms have consequences on both sides, patient and caregiver. At that time, participants of Macchi et al study[314] considered as the mostly missed services home health aides, home-based rehabilitation services and home hospice. Many people delayed placement in residential facilities for fear of rapidly spreading virus. Because of the pandemic situation caregiver spent more time by care, and experienced higher intensity of caregiver burden, depression and anxiety. For health care and personal purposes and to avoid negative results of caregiving, many caregivers tried telemedicine with its vast pluses and some minuses. The limitations of telemedicine was missing of personal contacts and required a co-operation of virtual and in-person healthcare.

Poloni et al[315] retrospectively studied in Lombard dementia care facility 57 people in older age diagnosed with dementia and simultaneously COVID-19. In findings, delirium as acute behavioural change represents initial manifestation of SARS-CoV-2 infection in 36.8 % of sample. Clients´ mean age was 85.4 years and were multimorbid. Delirium-Onset COVID-19 has higher short-term mortality rate, especially by men with dementia. In this situation **an effective communication with informal caregivers** on poor prognosis and palliative care interventions **is very important**.

Discussion

The aim of our research work was to search for good practice examples of interventions provided to people in end-stage of dementia and their caregivers. Found interventions covered seven out of 11 domains on optimal palliative care and treatment in older people in dementia.[316]

Abreu et al[317] study focused on care professional assessment and solving of the health needs of person living with dementia correspondswith the recommendation 1.1: "recognizing dementia eventual terminal nature is the basis for anticipating future problems and an impetus to the provision of the **adequate palliative care"**[318].

313 Rosebush, Christina E et al. "The Porchlight Project"
314 Macchi, Zachary A et al. "Lessons from the COVID-19"
315 Poloni, Emanuele T. et al. "Prevalence and prognostic value"
316 van der Steen, Jenny T et al. "White paper".
317 Abreu, Wilson et al. "The relationship between frailty, functional dependence, and healthcare needs".
318 van der Steen, et al. "White paper", 200.

The music intervention of Garabeddian[319] was a very apt illustration of recommendation 2.1: "Perceived problems in caring for a patient living with dementia should be **viewed from the patient's perspective**".[320] Studies of McCloskey, Hughes and Parsons[321]and Hill et al[322] reflected communication barriers in long-term care institutions. Mostly McCloskey, Hughes and Parsons[323] analysed in details the **transfer of information** from care staff point of view. The results show challenges of multidisciplinary team in line to recommendation 2.3: "The health care team should ask for and address families' and patients' information needs on the course of the dementia trajectory, palliative care and involvement in care."[324] A respond to inability to express needs of patients living with dementia in AD is a validation method.[325] Proxy decision makers' expectation and effective communication concerning the medication prescription were the crucial findings of McCloskey, Hughes and Parsons[326] and supported recommendation 2.2: "**Shared decision making** includes the patient and family caregiver as partners and is an appealing model that should be aimed for."[327]

According to recommendation 3.6, "process and plans should be revisited with patient and family on a regular basis and following any significant change in health condition.[328] Tilburgs et al[329]reported at one-side gaps of **advance care planning** in medical doctors' praxis and afterwards progress of ACP realization after their educational intervention.

De Schreye et al[330] developed a set of quality indicators of suitable and unsuitable end-of-life care usable in people with AD according to recommendations 7.3 and 7.1: "Tools to assess pain, discomfort and behaviour should be used for screening and monitoring of patients with moderate and severe dementia, evaluating effectiveness of intervention. A holistic approach to treatment of symptoms is paramount because symptoms occur frequently and may be interrelated, or expressed differently (e.g., when pain is expressed as agitation."[331] **Optimal treatment of symptoms and providing comfort** is very needed. Other authors found that people in the last phase of dementia often receive fragmented care and may die for the reason of unrecognized symptoms and needs, accompanied by apathy and suffering.[332]

An example of the fruitful **psychosocial support** is a PorchLight Project of Rosebush et al[333] that underlined recommendation 8.1: "In mild dementia, as also the later stages, patients may be aware of their condition, and patients and families may need emotional support."[334] A central part of caring for relatives of people living with dementia in AD are psychosocial interventions[335] implemented in accordance with the Global Action Plan for the Public Health Response to Dementia 2017-2025. The vision of this global document is a world in which carers live well and receive the care and support they need to fulfil their potential with dignity, respect, autonomy and equality.[336]

Time of COVID-19 pandemic brought in **family care and involvement** new features. Macchi et al study[337] and Poloni et al[338] studied people in end-stage dementia and their informal caregivers in two environments, at home and in hospital. Authors´ findings confirmed that even then, "families may need support throughout the trajectory, but especially upon diagnosis, when dealing with challenging behaviour, with health problems, with institutionalization, with a major decline in health and when death is near."[339]

Beernaert et al[340] implemented educational program with significant outcomes for health staff (nurses) and enhanced communication of all target groups of hospital palliative care team as is recommended in domain on **education of the health care team**.[341] To the recommendation 10.1: "The health care team in its entirety, including allied health professionals and volunteers, needs to have adequate skills in applying a palliative care approach to dementia" contributed Rosebush et al[342] with their older adult volunteer program.

Conclusions

The majority of interventions analysed in our study related to the second domain of optimal palliative care - Person-Centred care, Communication, and Shared Decision Making. Our findings corresponds with research priorities settled in expert's ratings of the optimal palliative care domains,[343] where this domain received the highest importance rating.

In this review paper, we found out two main challenges for dyad patient living in severe dementia and caregiver, communication and pain expression which are in close connection. In area of communication, it is possible to learn how to communicate with people with dementia. It is beneficial if family caregivers and formal caregivers of a person living with dementia jointly participate in dementia communication training.[344] Communication methods developed directly for use in communicating with people with dementia include Validation method, Empathic communication, Communication with people with dementia according to Haberstroh, and Self-main-

319 Garabedian, Claire E. "Dementia".
320 van der Steen, et al. "White paper", 200.
321 McCloskey, Bridgeen, Hughes, Carmel, and Carole Parsons. "A qualitative exploration of proxy decision".
322 Hill, Emily et al. "Staff Perspectives".
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327 van der Steen, et al. "White paper", 200.
328 van der Steen, et al. "White paper", 200.
329 Tilburgs, Bram et al. "Educating Dutch General Practitioners".
330 De Schreye, Robrecht et al. "Developing indicators".
331 van der Steen, et al. "White paper", 201.
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333 Rosebush, Christina E et al. "The Porchlight Project".
334 van der Steen, et al. "White paper", 201.
335 Deutsche Gesselschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, Deutsche Gesellschaft für Neurologie. "S3 – Leitlinie „Demenzen"". Accessed October 20, 2021. https://www.awmf.org/uploads/tx_szleitlinien/038-013l_S3-Demenzen-2016-07.pdf
336 World Health Organization. *Global Action Plan on the Public Health Response to Dementia 2017–2025*. (Geneva: World Health Organization, 2017). http://apps.who.int/iris/bitstream/handle/10665/259615/9789241513487eng.pdf;jsessionid=AF9520DDD2702DA8F0565D89CDF30FB2?sequence=1.
337 Macchi, Zachary A et al. "Lessons from the COVID-19".
338 Poloni, Emanuele T. et al. "Prevalence and prognostic value".
339 van der Steen, Jenny T et al. "White paper", 201.
340 Beernaert, Kim et al. "Improving comfort".
341 van der Steen, Jenny T et al. "White paper", 201.
342 Rosebush, Christina E et al. "The Porchlight Project".
343 van der Steen, et al. "White paper".
344 Heimerl, Katharina, Reitinger, Elisabeth and Eva Eggenberger. *Frauen und Männer mit Demenz. Handlungsempfehlungen zur person-zentrierten und gendersensiblen Kommunikation für Menschen in Gesundheits- und Sozialberufen*. (Wien: Bundesministerium für Gesundheit, 2011). https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=486

tenance therapy.[345] In Slovakia, more frequently proposed communication method in dementia is Validation method, which is provided together with the reminiscence therapy and sensory stimulation, as a part of emotion-oriented care in dementia.[346] Examples of evidence-based optimal palliative care interventions from abroad may be inspiring for Slovak social workers and other specialists who are active in palliative care and treatment for people living with dementia in AD.

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345 Philipp-Metzen, Elisabeth. *Soziale Arbeit mit Menschen mit Demenz: Grundwissen und Handlungsorientierung für Praxis*. (Stuttgart: Kohlhammer, 2015).

346 Finnema, Evelyn et al. "The effect of integrated emotion-oriented care versus usual care on elderly persons with dementia in the nursing home and on nursing assistants: a randomized clinical trial." *International Journal of Geriatric Psychiatry* 20, no. 4 (April 2005):330-43. https://doi: 10.1002/gps.1286.

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SPECIFICS OF PALLIATIVE CARE IN ITALY RELEVANT TO THE CURRENT POST-COVID-19 PERIOD

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Abstract
Background: A special survey carried out between April and September 2021 in Italy involving 600 respondents forms the basis of the present contribution. This survey focused on mapping and acquiring a deeper understanding of the possibilities of promoting a long-term vision for the development of future care for people in the pre-terminal and terminal stages of the disease and for the dying.
Conclusion: Similar surveys may provide relevant and inspiring stimuli for additional and novel specific surveys, studies and analyses, as well as scientific and professional discourses regarding the importance of establishing inspiring long-term visions for the development of future care for the dying.
Keywords: Terminally ill **–** The dying **–** Palliative care **–** Consequences of the COVID-19 pandemic. Post-COVID-19 syndrome.

Introduction

The reports of the victims of the COVID-19 pandemic as well as personal testimonies reported in the mass media have propelled the topic of death and dying into the mainstream discourse. Prior to the pandemic, people pondered and talked very little about death in public. It was an unpleasant topic to discuss. Nowadays, public attention is focused more on the quality of the living conditions at the end of a person's life. These facts enable doctors, nurses, carers, other health professionals, social workers and volunteers who have long been involved in palliative and hospice care to talk more openly about the terminal stage of life as an important part of life's journey that should be accompanied by one's loved ones and professionals who help alleviate the suffering of the dying. In this context, the development of palliative care is becoming increasingly

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important. For a relatively long period, Italy has lagged behind many other developed countries in the field of palliative care.[348] In order to support the development of palliative care in Italy, a special survey was carried out between April and September 2021. Italy was included in this survey due to the fact that it was a country that was particularly affected by the first wave of the COVID-19 pandemic. During this period, it dealt very intensely with the issue of palliative care and, consequently, the subject of euthanasia.

Methods and Results

A total of 600 respondents participated in this special survey. They have been working professionally for a long time in hospice and healthcare facilities throughout Italy.

This survey set out to:

Map the situation in the field of palliative care that was caused by the pandemic and the COVID-19 disease.

Identify the problems in the field of palliative care and propose solutions.

Present an overall vision of palliative care in the future.

These objectives were achieved with the help of the following research questions:

What are the consequences of the first and second waves of the COVID-19 pandemic for the provision of palliative care in Italy?

What are the ways of supporting the development of palliative care provision in Italy in the future?

The respondents were approached through contacts and trusted experts working in Italy in the field of healthcare and palliative care, who have a long-standing knowledge of the centres where this special survey was carried out, or who work directly in these centres. Respondents were subsequently contacted by these professionals in person, by telephone, by email or via applications. The sample of respondents was determined using the purposive sampling technique in Italy.[349] In order to participate in the special survey, respondents had to have been working in hospice and palliative care in hospice and healthcare facilities in Italy for at least 5 years.

Respondents included doctors (185), nurses (139), carers (116), other health professionals (48), social workers (52), and volunteers (60). The average age of survey respondents was under 65 years.

In order to ensure that the respondents and the survey were legally protected, the respondents submitted specialised consent/GDPR. Seeing as though the survey focused on the personal and subjective perspectives of respondents, it was suitable to use a qualitative approach and carry out in-depth online interviews with the respondents. One interview lasted 60 minutes.

348 In this context, see for example: Fabio Turone, "Italy sets up national palliative care service," *BMJ: British Medical Journal* 340 (2010): n. pag. DOI:10.1136/BMJ.C1481

349 In this context, see for example: John W. Creswell, and J. David Creswell, *Research Design. Qualitative, Quantitative, and Mixed Methods Approaches* (5th ed. SAGE Publications, Inc., 2017).

The research team consisted of all authors of the article. They interviewed the survey participants, wrote transcripts of all conducted interviews and wrote down the research notes. Under the supervision of a supervisor, they discussed the survey results together in a plenary session, with particular attention paid to uncommon answers, biases, and assumptions (e.g. cultural and religious differences). Reciprocal briefings were also conducted during the survey. These consisted of detailed descriptions of the various steps employed in the analysis and the conclusions provided to the supervisor in order to develop both the design and the analysis of the study. These briefings also consisted of interviews with eligible respondents carried out prior to the implementation of the special survey.

The survey captured the unique experience of the interviewed respondents. To a certain extent, the number of survey respondents working in different professions in palliative and hospice care (doctors, nurses, carers, other health professionals, social workers, volunteers) in Italy was limiting. For this reason, the results of this special survey need to be supplemented by further research on this topic, which will be carried out from September 2021 onwards. This is to ensure that this supplementary research can help provide a more comprehensive picture of the relevance of palliative care to the current post-COVID-19 period, as palliative care is nowadays a very serious and important field that needs to be continually addressed.

Prior to the survey, all participants attended a series of lectures as part of three joint online sessions in order to learn about the survey, the way it will be conducted, what research methods will be used and why, how participants can get involved and what their role will be, as well as its purpose, aims and benefits for palliative care practitioners and also academics who have been researching the challenges and benefits of palliative care for a long time. Participants were also assured that their identities would be kept confidential.

As part of these important ethical considerations, all survey participants were given the opportunity to decline participation in the survey to ensure that data collection sessions only included respondents who were properly prepared to participate and provide information in a straightforward manner. At the beginning of each joint survey session, the participants were asked and encouraged to be honest. The researchers attempted to establish a trusting and respectful relationship from the very first contact with the participants and to let them know that there were no right answers to the questions they were about to be asked.

The survey was conducted in the following 20 hospice and healthcare facilities:

Hospice Villa Speranza;

Ospedale San Pietro Fartebenefratelli – Roma;

Fondazione Sanità e Ricerca – Roma;

ISPRO;

Hospice MTC Seràgnoli, Bentivoglio;

Hospice Bellaria, Bologna;

Hospice c/o Presidio ospedaliero Santa Colomba di Savignano sul Rubicone AUSL Cesena;

Hospice V. Grassi, Forlimpopoli;

Hospice territoriale di Dovadola IPAB Opera Pia Zauli;

Hospice Casa della Solidarietà Associazione ADO AUSL di Ferrara;

Hospice Territoriale di Codigoro AUSL di Ferrara;

Hospice Centro oncologico Azienda Ospedaliera di Modena;

Hospice Ospedaliero di Guastalla;

Hospice Casa Madonna dell'Uliveto, Montericco di Albinea;

Hospice Centro di Cure Palliative Fidenza;

Hospice Centro di Cure Progressive Pietro Coruzzi, Langhirano;

Hospice Casa di Cura Piccole Figlie dei Sacri Cuori di Gesù e Maria, Parma;

Hospice Territoriale "Una casa per le cure palliative", Borgonovo

Hospice San Domenico AUSL di Ravenna, Lugo;

Unità di Terapia Antalgica e Cure Palliative c/o Ospedale di Rimini.

The analysis and interpretation of the results were done on the basis of verbatim transcripts of individual in-depth online interviews. The respondents' identities were kept confidential. The results can be summarised into two main topics:[350]

Topic 1: The Impact and Implications of COVID-19 in the Field of Palliative Care

The impact of COVID-19 was particularly evident in the first wave of the pandemic when it manifested, for example, in the form of misunderstanding, extreme fear of the negative consequences of the unknown COVID-19 virus when human behaviour was out of control from excessive shopping, social distancing, information hoaxes, irresponsible behaviour and refusal to wear masks due to the belief that COVID-19 was just a stronger form of influenza.[351] As was stated at the time: this "situation causes stress and results in physical inactivity that can lead to disorders of the locomotor apparatus, musculoskeletal system, and nervous system, as well as vision impairment and mental health disorders".[352] A large number of the aforementioned implications have paralysed and affected all parts of the healthcare system. The system itself has struggled to adapt to the unexpected changes that have led to an escalation of pre-existing problems but has also had to face new challenges related to logistics, shortages of health workers, protective equipment, and so on.

350 In this context, see for example: Loraine Busetto, Wolfgang Wick and Christoph Gumbinger, "How to use and assess qualitative research methods," *Neurol. Res. Pract.* 14, No. 2, (2020). https://doi.org/10.1186/s42466-020-00059-z

351 Lucia Ludvigh Cintulová, Jerzy Rottermund and Zuzana Budayová, "ANALYSIS OF MOTIVATION TO WEAR FACE MASKS IN THE SARS-COV-2 PANDEMIC RELEVANT ALSO FOR THE POST-COVID ERA," *Acta Missiologica* 15, no. 1, (2021): 119. https://www.actamissiologica.com/

352 Ján Mašán, Miron Šramka, Zuzana Prídavková, Alena Furdová, Silvia Golská, Eugen Ružický, and Oleksandr Dobrovanov. "Computer use during the COVID-19 pandemic," *International Journal of Health, New Technologies and Social Work* 16, no 1, (2021): 25.

Death as a topic has come to the forefront to a greater extent compared to the pre-pandemic period due to media coverage but also because of personal testimonies. The topics of terminal stages of life and palliative care have also been raised.

Health workers were overwhelmed physically but especially mentally. The need to improvise in managing patient care was mentally taxing, there was a lack of protocols and rules regarding patient care, and the approach to the patient was changing, not least due to the risk of disease transmission. The overall uncertainty was also enhanced by fear for one's own health, especially at a time when there was a lack of protective equipment.

The impact of the pandemic was felt particularly by patients who died alone without the opportunity to say goodbye to their loved ones. Volunteers were barred from the facilities and professional workers were overburdened with an abundance of rules and management issues. As a result, patients and their needs and problems were often overlooked. This situation brought the issue of palliative care in the home environment to the forefront.

"The presence and support (including phone conversations) of close family members proved to be very important for the patients. Staying in touch with one's loved ones increases the desire to fight the disease." (doctor)

"I hope that in the future people will no longer die alone in a foreign environment without the affection of their loved ones, in total despair, as has unfortunately often happened during this pandemic." (doctor)

COVID-19 also raised topics such as fear, loneliness and isolation, despair, and exhaustion. In addition to these negative aspects, it also highlighted the importance of greater solidarity and unity, as well as the value of human contact in the process of dying.

COVID-19 and the pandemic helped identify underlying issues that will need to be addressed in the future to avoid similar situations:

Staff shortages at all levels of healthcare.

Lack of regulations in the field of healthcare (therapeutic procedures) and logistics, the need for flexible implementation of changes in the system.

"It is necessary to abandon the 'bureaucratisation' of services and formal rigidity." (doctor), "...when the bureaucracy can be done remotely by digital means." (volunteer)

"During the pandemic, there was ongoing organisational chaos and improvisation during times when keeping a cool head and making quick decisions was essential. This should be avoided in the future." (carer)

A lack of protocols regarding contact between relatives and patients as well as consideration for their fears and concerns about the infection.

"It would be ideal to raise awareness among people about the symptoms of the infection and instruct them on what to do when their terminally-ill family members develop COVID-19 symptoms." (nurse)

The survey respondents proposed solutions regarding the future care of COVID-19 patients.

First of all, palliative care for COVID-19 patients should be standardised, and the patients should receive adequate health care based on diagnostic and treatment protocols. These protocols should be continuously updated to correspond to the current conditions and possibilities.

"Improvisation in the provision of healthcare should be avoided. Therefore, it is necessary to draw up new treatment protocols for epidemics that are updated at least annually, along with refresher courses for employees." (doctor)

It would be ideal to set up specialised facilities for terminal COVID-19 patients, where contact with relatives would be allowed.

"...for example, in rooms equipped with glass to isolate the patient's environment from that of the visiting family member." (doctor)

Establishing precautions, ensuring a sufficient supply of protective equipment and tests.

Staff and financial resources should be directed to areas that meet patients' actual needs.

A multidisciplinary approach should be ensured at the level of healthcare facilities. Professionals should share experiences and exchange information. Engagement of the younger generation in voluntary work is also suitable to ensure continuity.

"...the lack of psychologists and volunteers, often considered irrelevant during the COVID-19 pandemic." (doctor)

The pandemic period has also highlighted the importance of modern technology in regard to communication. Facilities should ensure the provision of this service as an alternative to the patient's face-to-face contact with the outside world. This contact can help patients reduce isolation and feelings of loneliness.

"Videophones (or similar equipment) should be set up in patients' rooms to enable them to communicate with the outside world without them having to exert too much effort." (doctor)

Topic 2: Palliative Care in General

In the survey, respondents described the future potential of palliative care, their expectations and suggestions on what to change.

The importance of palliative and hospice care will increase not only with the ongoing COVID-19 pandemic but also with the increasing number of patients with other terminal illnesses due to the overall ageing of the population.

Key areas include investment in human resources, including support for volunteer work. In an ideal scenario, a palliative care department should be set up in every hospital and/or palliative and hospice care centres should be established with a comprehensive approach and homogenisation of other facilities. These facilities should be more readily available throughout Italy. On the other hand, it will also be necessary to focus on moving patients into their home environment.

"There will be more and more people approaching the end of their life and we must be ready to accommodate them all." (doctor)

They agree that the quality of care provision should be increased through its customisation and responsiveness to the patient's needs and current condition. In approaching the patient, doctors are aware of the importance of not only the medical side but also the spiritual and social side.

"It will be important to surround patients with a team of different experts in order to help them in the best possible way and to take care of all their needs, including social, cultural, and spiritual ones." (doctor)

"Finally, after many years, palliative care faculties are being set up at medical universities." (another health professional)

Another key area will be public discourse aimed at promoting information about the nature of death (death is a physiological event), as well as highlighting the patient's choice of treatment and advance care planning. The discourse will also explain the issue of palliative care and the way hospices work. Enhanced palliative care will be promoted as an alternative to euthanasia. It will differentiate palliative care from the treatment of the long-term ill.

"It would also be a good idea to educate the elderly and retired about the ways hospices work, as they are often perceived only as places where people go to die, a place they never really leave." (volunteer)

"There is a need to change the perception that hospices are merely places where people go to die and palliative care is a cure for avoiding suffering before death." (volunteer)

Euthanasia

The issue of euthanasia is another topic that is currently being widely discussed by the public. Respondents view the issue of euthanasia from several perspectives.

1. As an alternative and a choice for the patient
2. As a consequence of inner uncertainty, e.g. fear of pain, of experiencing psychological, social, and spiritual distress, of loneliness, of lack of care

"Euthanasia is not considered as an option when a terminally ill patient and their family members are provided with an opportunity to live with dignity and without physical pain." (nurse)

"Sick people who feel that they are heard, loved and respected rarely request euthanasia." (volunteer)

"Palliative care and the investment of resources in its improvement indicate that the core values of human life are still relevant in a given country. It represents the level of culture in that country." (doctor)

3. As a (simpler) solution for families and ultimately for the entire system

"Perhaps facilitating death is "of interest" to certain family members who are tired of caring for a sick person with a terminal illness." (doctor)

"The introduction of euthanasia is increasingly regarded as "an expansion of the palliative care perspective and a sign of the rise in compassion in modern society", as well as an accommodation to the prevailing moral principles of patient autonomy." (doctor)

4. As a more economical solution to the terminal stage of life for society

"The death of the terminally ill saves the economic resources of the state." (another health professional)

"It is necessary to change the mentality in the younger generations. Their values are built on efficiency and tangible results but there is a lack of understanding of the value of human life beyond the physical goods that can be produced." (carer)

The answer to the issue of euthanasia, according to the respondents, is the provision of care that reduces the potential will for euthanasia, while also providing people with choices. This alternative has four main pillars: competence in all aspects of care, individualisation (listening and reflecting on the needs of the patient and relatives), education (preparing for the process of dying) and socialisation (the patient should not feel lonely in the process[353]).

"I believe that everyone should have the freedom to choose how they want to walk to the end of their life's journey. It is necessary to provide people with all the information they need and to illustrate in a clear and objective manner the different paths everyone can take." (doctor)

"It is important to consider palliative care as a common service and to facilitate access to this type of care close to where patients live." (another health professional)

"Once a patient is diagnosed with a terminal illness, preparation is necessary so that patients and their families are prepared for the process of accompanying the dying if necessary and to perceive it as "something ordinary" that does not arouse fear." (volunteer)

The community (e.g. the parish community) could also be involved in socialisation where possible.

353 See also: Józef Młyński, *Praca socjalna w bezpieczeństwie społecznym. Myśleć – widzieć – działać* (Wyd. «scriptum»,. Kraków 2021), 146.

Respondents participating in the special survey also came up with specific suggestions for palliative and hospice care that could be implemented in the future.

1. Professional training in the field of palliative care, including implementation in standard medical studies. Support also in other disciplines (helping professions) on the topic of palliative care and establishing a relationship with patients in terminal stages.
2. Treatment protocols for palliative patients appropriate to the patient's current condition (not only in relation to COVID-19 but also other serious conditions).
3. Establishment of multidisciplinary teams in inpatient and home hospices and an increase in the number of non-medical staff. According to their level of experience, non-medical staff may bring a more human dimension to care that was missing during the pandemic and the period of restrictions.
4. An increase and stabilisation of financial resources to ensure that individual facilities are able to plan their investments and not just react to current needs.
5. Other therapy alternatives such as pet therapy.

"Daily meetings (briefings) of these teams and joint planning of specialised care and assistive interventions." (doctor)

6. Development of strategies and programmes to support home palliative care that incorporate multidisciplinary community palliative care. The intention is that teams comprising health professionals, social and voluntary workers, community support workers and clergy will be available in local health districts for family members, carers and informal support providers during the course of the patient's care as part of these strategies and programmes.

"Many patients in the terminal stages of illness would prefer to die at home, but only a relatively small number of patients have this wish fulfilled. To some extent, this is due to the fact that patients and their families do not have the support they need for caring for a dying person at home." (doctor)

"Increased support for home palliative care could thus meet the goal of supporting patients who wish to die at home and also their families who care for them." (doctor)

7. The respondents expressed an interest in participating in special modular training programmes or workshops that would provide them with comprehensive and in-depth education, as well as resources that they could actually use in practice. These education programmes, according to respondents' statements, should also include training in counselling skills and compassion-focused therapy.

"The role of social workers is an integral part of palliative care. During contact with family members, social workers should not anticipate the death of their relative, but rather accompany them on the journey towards understanding the importance of being present – here and now, where every moment and every emotion counts. This reassurance is a source of strength for all people who want to experience the period of palliative care for their relative not in fear, but in peace." (social worker)

In addition to providing suggestions, respondents to the special survey also reflected on their own needs during the pandemic and articulated what their expectations were for the future. In addition to specialised education and training for all those involved in the care process (doctors, nurses, social workers, etc.), they would expect streamlined work management. This rationalisation is also associated with a higher quality of work and, together with psychological support, helps prevent burnout syndrome. Last but not least, adequate financial remuneration and recognition, as well as respect for all employees, contribute to the overall satisfaction of staff members.

"It is important that palliative care teams are able to recognise and meet social, psychological, and spiritual needs (including, of course, clinical needs related to illnesses) early on because neglecting these needs on a regular basis fuels requests for euthanasia in chronically-ill patients with the prospect of near death." (doctor)

"It is important to prepare health professionals not only to help provide physical relief but also to respond to the psychological, social, and spiritual needs of the terminally ill at the end of their days." (carer)

"Palliative care needs to be seen as an integral part of the process of care and support and not as an exception or, worse still, a waste of public economic resources." (carer)

Discussion

The survey identified problems in palliative and hospice care, provided proposals for solutions and presented an overall vision for palliative and hospice care in the future. The pandemic itself (hospitalisations, deaths) highlighted the importance of palliative care in society and its necessary integration into medical sectors. The role of palliative care will be crucial in the future in relation to the ageing population and the increase in patients with terminal illnesses. The increasing demand for palliative care will require systemic changes as well as changes at the education level, but also a greater public discourse about the terminal phase of life.[354] In this regard, it will also be necessary to come up with various effective types of measures, as well as the possibilities of using the latest available means of distance therapy during similar pandemics or crises with the help of telerehabilitation, virtual reality, and artificial intelligence.[355] It is important that these models of telerehabilitation, virtual reality and artificial intelligence include, for example, the training of slow and deep breathing.[356] Medical practice has been increasingly demonstrating that "controlled slow breathing techniques may be an effective non-pharmacological treatment of augmented emotions, while it decreases anxiety, depression and stress."[357] Furthermore, with

354 In this context, see for example: Jana Snopková and Igor Martuliak, "Management ošetrovateľskej starostlivosti na Algeziologickej klinike," *XXI. Česko - Slovenské dialógy o bolesti, október 2019*, Stará Lesná. in *Vedecký program a abstrakty, SOLEN. 2019,* 17; Igor Martuliak, "Farmakologické zaujímavosti z kongresu EAP – EFIC," *Pain in Europe XI, Valencia 2019*; Igor Martuliak, *XXI. Česko - Slovenské dialógy o bolesti, október 2019*, Stará Lesná. in *Vedecký program a abstrakty, SOLEN. 2019,* 24; Igor Martuliak,"Patofyziológia bolesti," Abstrakty - *V. kurz CEEA, 27.-29.11. 2019, IVVL Košice.*

355 Ján Mašán, Miron Šramka, Zuzana Prídavková, Alena Furdová, Silvia Golská, Eugen Ružický, and Oleksandr Dobrovanov. "Computer use during the COVID-19 pandemic," *International Journal of Health, New Technologies and Social Work* 16, no 1, (2021): 24.

356 See: Čelko, J., Gúth, A., Mašán, J, and Malay, M., "Effects of slow diaphragmatic breathing *Rehabilitácia* 56, no. 4, (2019): 275-287.

357 Čelko, J., Gúth, A., Mašán, J, and Malay, M., "Effects of slow diaphragmatic breathing Rehabilitácia 56, no. 4, (2019): 275-276.

such breathing, "pain decrease and improvement of gnostic and cognitive functions was also showed".[358] With similar techniques that significantly contribute to reducing anxiety, depression and stress[359], it is important that staff are led towards their full autonomy, for example, in naming the feelings they experience[360] in these difficult situations.

The pandemic highlighted the importance of human contact even in the terminal stage of life and the process of dying. Doctors and health professionals considered one of the biggest negatives to be dying in isolation and without being able to share the final moments of life with one's loved ones. As a result, the topic of dying and planned care, including home hospices at the end of life, has come to the forefront in discussions held by both the professional and non-professional public. Patient-centred care during a pandemic is a challenge that needs to be handled in a way that is safe for all those involved.[361] The issue of euthanasia is also relevant in this context, as it has begun to resonate in society as a solution to the situation.

The anticipated greater shift of hospice care to the home environment will require new ways of preparation and logistics.

The pandemic has also highlighted the need to modernise palliative care facilities, create a sufficient financial reserve, and prepare for similar threats in the future.

Despite all the negatives, there were certain positive aspects of the pandemic: for example, it lead to greater solidarity and unity, opened up new topics, and reminded us of the importance of human contact in the process of dying[362]. This also reminds us of the importance of the concept of a neighbour. When we see our neighbour suffering we are "called to penetrate the depth of the mystery of the Cross and resurrection, which gives them the gift of trust, hope and power."[363] As we see, for example, in the parable of the Good Samaritan, we cannot refuse to provide help

358 Čelko, J., Gúth, A., Mašán, J, and Malay, M., "Effects of slow diaphragmatic breathing Rehabilitácia 56, no. 4, (2019): 275-276.

359 Jan Masan, Kamil Kolejak, and Mariana Hamarova, "The Emphasis on the Relevant Needs of the Parents of Extremely Premature Infants with Special Regard to the Impact of COVID-19," *Clinical Social Work and Health Intervention* 12, no. 1, (2021): 12-13. DOI: 10.22359/cswhi_12_1_01

360 Jan Masan and Mariana Hamarova "Potential Solutions to Selected Consequences of the COVID-19 Pandemic on Mental Health Relevant Also for the Post-COVID Era," *Clinical Social Work and Health Intervention* 12, no. 3, (2021): 9. DOI: 10.22359/cswhi_12_3_01

361 Michael J. Byrne, and Daniel R. Nuzum, "Pastoral closeness in physical distancing: The use of technology in pastoral ministry during COVID-19," *Health and Social Care Chaplaincy* 8, no. 2, (2020): 206-217. https://doi.org/10.1558/hscc.41625

362 See also: José Carlos Bermejo, "Acompañamiento en el duelo," in: Rafael Amo Usanos, Federico de Montalvo Jääskeläinen ed, *La humanidad puesta a prueba. Bioética y Covid-19* (Comillas, 2020) 347- 360.

363 Miloš Lichner, Ľubica Ilievová, and Erika Juríková, "STRENGTHENING THE PERCEPTION OF CHRISTIAN VALUES IN THE POST-COVID ERA ON THE BASIS OF SIGNIFICANT HISTORICAL EVENTS: THE CONGREGATION OF THE SISTERS OF MERCY OF THE HOLY CROSS AND THEIR FUNDAMENTAL INFLUENCE ON THE DEVELOPMENT OF NURSING EDUCATION IN SLOVAKIA," *Acta Missiologica*. 15, no. 1, (2021): 155. https://www.actamissiologica.com/

to anyone.[364] "Indeed, our Lord extends this rule to our enemies, too, when he says: 'love your enemies, do good to those who hate you'."[365]

Conclusion

The special survey that was carried out has demonstrated that the development of care for the dying is of fundamental and irreplaceable importance for society both in the present and in the future. The COVID-19 pandemic has also highlighted its importance in various aspects, as it has drawn even more attention to the concept of death and the process of dying. The results of the survey provided thought-provoking inspiration, suggestions, ideas, recommendations and experiences of doctors, nurses, carers, other health professionals, social workers and volunteers working long-term in the field of palliative and hospice care throughout Italy. These visions regarding the development of future care for the dying are also affected by the COVID-19 pandemic and are focused mainly on ways to improve future care for the dying, on highlighting its importance despite euthanasia, on visions that can be applied in the field of this care, and on the possibilities that are available to support them[366]. The current practice and the ongoing exploration of emerging findings regarding the development of palliative care have demonstrated that conducting similar research, studies, and analyses is also important during the critical periods brought about by various global crises and their impact on the lives of the entire population.

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CONFLICT OF INTEREST All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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364 Józef Kulisz, Miloš Lichner, Andrej Filipek, Jozef Kyselica, Helena Lukianová and Silvia Sýkorová, "RETURN OF THE ENCYCLICAL FRATELLI TUTTI TO THE PATRISTIC ROOTS OF CHRISTIAN SOCIAL TRADITION," *Acta Missiologica* 15, no. 1, (2021): 173. https://www.actamissiologica.com/

365 Józef Kulisz, Miloš Lichner, Andrej Filipek, Jozef Kyselica, Helena Lukianová, and Silvia Sýkorová, "RETURN OF THE ENCYCLICAL FRATELLI TUTTI," *Acta Missiologica* 15, no. 1, (2021): 174. https://www.actamissiologica.com/

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COMPARISON OF DEPRESSION AND RUMINATION BETWEEN CANCER PATIENTS AND A HEALTHY POPULATION

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Abstract

Background: Depression has a significant impact on the quality of life of cancer patients. Cancer patients suffering from depression have a lower quality of life, are less satisfied with medical care, have a longer hospital stay, and have a higher mortality rate. Rumination encourages people in a negative mood to engage in negative thoughts that emphasize their negative mood. The aim of the study was to compare depression and rumination between cancer patients and healthy individuals. Another aim was to examine the relationship between rumination and depression.

Methods: We examined depression using the Beck Depression Scale BDI-II. The Ruminative Response Scale questionnaire was used for the examination of rumination. The survey involved 207 respondents, aged 18-82 years (SD = 14). 104 respondents (97.1% women, 2.9% men) formed a sample of cancer patients, and the control group of 103 (60.2% women, 39.8% men) consisted of healthy individuals.

Results: The results demonstrated no differences in depression and rumination between healthy and oncological individuals. We have found out that rumination and depression strongly positively correlated with each other both in group of cancer patients and in the group of healthy population.

Conclusion: Our results show that no significant differences between oncological patients and healthy population in depression and rumination. The relationship between rumination and depression was stronger in the group of healthy population.

Keywords: Depression. Rumination. Oncological disease.

Introduction

Depressed patients experience higher somatic symptoms, which are often associated with negative effects on the development and management of the disease. The way individuals think about their condition, after the diagnosis of chronic disease, is an important mediator between the course of the disease and the physical or mental well-being of the individual.[368] It is therefore important to know how the patient thinks about himself and his diagnosis. Specific ways of thinking about a disease may relate to its symptoms, causation, experiences with the disease,

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and treatment regimens, along with expectations of negative outcomes and frustration with the expected impact of the disease.[369] Major depression is a common, severely disruptive, and often recurrent mental disorder.[370] Depression can be considered a highly heritable disease,[371] and does not occur suddenly, its development is tedious and a frequent trigger can be a very stressful and distressing event, which can be for example a diagnosis of cancer or the death of a partner or employment loss.[372] Beck characterizes depression by low self-esteem, self-blame, and negative expectations.[373] Beck's negative cognitive triad presents three basic areas, which are the negative perception of oneself, the environment, and the future. He suggests that a negative cognitive triad is a sufficient cause of depression and is therefore responsible for the onset of depressive symptoms, such as deficits in affective, motivational, behavioural, and physiological functioning.[374] Cancer patients suffering from depression have a lower quality of life, are less satisfied with medical care, have a longer hospital stay, and have a higher mortality rate.[375] The pessimistic style of thinking in depressed individuals can lead to an increased sense of possible disappointment with the expected outcome.[376] Anxiety and depression are prevalent among chronically ill patients and serve to reinforce the physical, psychological and social demands imposed by the disease.[377] If a significant part of mental disorders is hidden and not treated, it has a negative impact on the patient. Anxiety, depression, fatigue, and sleeping problems are common symptoms in patients with cancer.[378] The negative aspects, situations, and life traumas of an individual are related to his view of his life, his future, and his present, which can lead to depressive symptoms or even depression.[379] Individuals experiencing depressive episodes feel that they are experiencing more negative life events and thus adapt more to a pessimistic assessment style, which further exacerbates depression.[380] The achievement of goals is considered to be

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a predisposition to the feeling of positive well-being, in cancer patients the goal is to successfully manage treatment. He also suggests that negative self-beliefs, feelings of hopelessness, and a lack of perceived social support are significant in predicting depression in cancer patients.[381]

We were interested not only in depression in cancer patients but also rumination, which is considered negative thinking of the patient about his illness, causes, and possible negative consequences. The tendency to rumination is associated with lower adherence to treatment among cancer patients.[382] It was examined rumination in cancer patients but did not link it to depression.[383] According to Trapnell and Campbell, rumination is defined as a tendency toward neurotic self-attention and recurring, primarily past-oriented thoughts related to threats, losses, or perceived injustice.[384] It is often a way of thinking that usually leads to a depressed mood that is difficult to alleviate or regulate.[385] Rumination is defined as „repetitive thinking, which does not necessarily have to be disturbing and which involves remembering, solving problems, and trying to make sense of a desperate event".[386] So rumination is considered as thoughts to be immersive, convincing, and self-serving, probably persistent during trivial but also important everyday activities, thus disrupting concentration and performance.[387] Rumination, as a type of repetitive thought, is also defined as the cognitive process of active thinking about the stressor, the thoughts, and feelings it evokes, and their implications for a person's life and his future.[388] Rumination encourages people in a negative mood to engage in negative thoughts that emphasize their negative mood.[389] Therefore, it is advisable to bring attention to rumination with depressive symptoms. Repetitive rumination of the consequences of depressive symptoms sustains or impairs a person's ability to solve a problem and results in a variety of negative consequences.[390]

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Stress can trigger rumination, and rumination responses after stressful life events predict detrimental mental health consequences.[391] Since the diagnosis of cancer is a very stressful obstacle in the patient's life, we can assume an increased presence of negative thoughts about the disease, resulting in rumination.

Theories from different authors divide rumination in different ways. On the other hand, they always agree on two types of rumination, one is negative and the other has a positive effect on the ideas and subsequent solution of the individual's problem.

Treynor, Gonzalez, Nolen-Hoeksema proposed a two-factor model of rumination.[392] According to them, the first type of rumination is brooding. This brooding concerns a passive comparison of the current situation of an individual with unfulfilled goals. It is rather an intrusive process associated with depression, and especially if it is associated with disease prevention it has the potential to lead to self-blame.[393] Rumination such as brooding is generally perceived as maladaptive, and an individual with this form of rumination tends to inadequately respond to the internal and external stimuli that life brings to him.[394] It is the kind of rumination that is considered to be persistent and passively focused on negative events, emotions, elusive goals, or obstacles to progress.[395] A negatively oriented type of rumination, such as brooding, is associated with depression, anxiety, and stress.[396] Contrary to brooding is reflective rumination, which is related to a purposeful focus on oneself and is considered a more deliberate form of rumination.[397] It involves active involvement in problem-solving, which can reduce the rate of depressive symptoms.[398] Reflective rumination refers to active involvement in solving cognitive problems to alleviate depressive symptoms.[399] Reflective rumination, as a positively oriented aspect of rumination, is associated with post-traumatic growth.[400] In a disease as severe as cancer, rumination is an

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important factor in other affective conditions, especially anxiety and adherence to treatment.[401] The combination of depressed or anxious mood and rumination can affect problem-solving abilities, due to reduced levels of motivation and instrumental behaviour.[402] Rumination perpetuates and deepens depression by increasing negative mood thinking, impairing problem-solving and instrumental behaviour, plus discouraging social support.[403] In a study by Aymanns, Filipp, Klauer, families of ruminative cancer patients were more likely to avoid communication about their disease and tended to urge patients to take personal initiative.[404]

Based on the above the aim of our study was to investigate the difference between rumination and depression between cancer patients and healthy individuals. Furthermore, we are interested to find out the relationship between rumination and depression in cancer patients. And also, in a group of healthy individuals.

Methods

Sample and Data Collection

A total of 207 respondents in two groups took part in the research work. The first group consisted of respondents diagnosed with cancer, their number was 104. Of this sample, 101 (97.1%) were women and 3 (2.9%) men. The group of healthy respondents (N = 103) consisted of 62 (60.2%) women and 41 (39.8%) men. The average age in both groups was 37.5 (min 18, max 82, SD = 14), whereas an average age of women was 40.2 (min 18, max 82, SD = 13.7) and average age of men was 27.5 (min 18, max 58, SD = 9.92). Among patients diagnosed with cancer, the most common was breast cancer by a count of 39, Hodgkin's lymphoma and colorectal cancer by the count of 6, other diseases included cervical cancer, leukaemia, colorectal cancer, thyroid cancer, MTS lung recurrence, and skin cancer.

Online questionnaire consisting of several sections was used to gather the information needed for the research. It was quantitative research. We at first inquired demographic data including gender, age, highest educational attainment, medical condition, type and stage of cancer, date of diagnosis, and completion of treatment. Respondents were in advance asked for informed consent and it was also made clear to them that the questionnaire is voluntary and its completion can be quitted at any time.

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Methods Used

We diagnosed depression by BDI-II (Beck's Depression Questionnaire). It is a self-assessing scale of depressive symptoms, which consists of 21 statements. Participants have a choice of 4, in some questions 6 options. They are expected to label the statement that best describes their feelings over the past 7 days. Among the questions are, for example, the following statements: „I am worried that I look older or unattractive". The answers are numerically rated as 0,1,2 or 3. The total score is derived from individual responses, with a higher score indicating a higher degree of depressive symptoms. The Cronbach's alpha of this questionnaire has a value of 0.847.

A questionnaire called the Ruminative Response Scale (Treynor, Gonzalez, and Nolen-Hoeksema) was used to examine rumination.[405] This scale was translated by a double translation, first, the questionnaire was independently translated into Slovak by Šuhajdová and Werkman, and their unified translation was translated into English by Závodská for verification. In this work, we used the Slovak version Šuhajdová, Werkman. It consists of 22 items measuring rumination. Each item is rated on a 4-point liqueur scale (almost never - almost always) while the answer reflects the respondent's thoughts or behaviour, in a situation where he feels sad or upset. We used the total of the individual items to evaluate the degree of rumination. The Cronbach's alpha of this questionnaire is 0.949.

Results

In the following part, we analysed the results of the research, where we compared depression and rumination between cancer patients and a healthy population. It is shown in table 1.

Table 1: Comparison of averaged scores for individual constructs between the two groups of participants

Group	Construct	M	SD
Cancer patients	depression	11.1	7.85
Healthy population		11	8.05
Cancer patients	rumination	41.26	13.93
Healthy population		47.3	16

To investigate the difference in depression rates between cancer patients (M = 11.1; SD = 7.85; Mdn = 10) and healthy individuals (M = 11; SD = 8.05; Mdn = 9), we used Mann-Whitney U test as the data did not have a normal distribution. We did not find a statistically significant difference in the rate of depression in these groups (M-W U = 5257; p = 0.409). We used the Mann-Whitney U test to examine the difference in rumination between cancer patients (M = 41.26; SD = 13.93; Mdn = 39) and healthy individuals (M = 47.3; SD = 16; Mdn = 46), as the data did not have a normal distribution. We also did not find a statistically significant difference in rumination in these groups (M-W U = 4126; p = 0.998).

Moreover, we wanted to investigate the relationship between rumination and depression in different groups. To investigate the relationship between rumination and depression in cancer patients (N = 104), we used Spearman's correlation coefficient, since in our data set the normal distribution of data was not met. We found a statistically significant positive strong relationship, between depression and rumination (r = 0.672; p <0.001) in cancer patients.

We further examined the relationship between rumination and depression in individuals without diagnosed cancer (N = 103). We used Spearman's correlation coefficient because the normal distribution of data was not observed in our data set. We found a statistically significant positive very strong relationship, between depression and rumination (r = 0.703; p <0.001) in individuals from the healthy population.

Discussion

We were interested in the difference in depression between cancer patients and healthy individuals. We hypothesized that respondents with cancer will show an increased rate of depressive symptoms, in contrast to healthy individuals. There was no significant difference among the groups of respondents. There may be several reasons. First of all, we would mention the insufficient number in the given groups, it would be appropriate if we could examine this issue in a higher number of respondents. As another reason, we would mention that depressive symptoms are mainly related to the personality of the individual and his strength to cope with a negative life situation.[406] Stress factors is considered to be determinants of depression.[407] From these two findings, we conclude that the extent to which cancer is stressful for a person depends on his personality and perception. At the same time, an individual who has a high degree of negative emotionality perceives any negative situation more seriously than an extroverted individual. Therefore, for someone, diagnosing cancer can be as serious as losing money, work, or a partner.

We also wanted to find the difference in rumination between cancer patients and healthy individuals. We know that in addition to the patient's physical pain, there is also a combination of fear, depression, and other side effects of chemotherapy, radiotherapy, and other treatments.[408] Rumination is considered as a closely related symptom in patients with depression.[409]

The finding that there were no differences between cancer patients and the healthy population in depression and rumination are, in our view, associated with an insufficient number of respondents in both groups. Unconfirmed hypotheses may also be related to the ongoing pandemic-related situation involving Covid-19. According to Ustun[410], quarantine measures taken to combat a pandemic, affect many aspects of life on an individual and social level. Individuals who had to change their residence during the quarantine felt loneliness, fear of death, hopelessness, had trouble sleeping, felt useless and worthless, started smoking and drinking alcohol, and were diagnosed with depression. We believe that healthy individuals currently have a higher rate of depressive symptoms associated with a pandemic, so there is no significant difference between the two samples.

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407 Hammen, Constance. "Stress and Depression," *Annual Review of Clinical Psychology* 1, (April 2005): 293-319. https://doi.org/10.1146/annurev.clinpsy.1.102803.143938

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409 Lyubomirsky, Sonja, and Chris Tkach. "The consequences of dysphoric rumination" In: C. Papageorgiou & A. Wells (Eds.), *Rumination: Nature, theory, and treatment of negative thinking in depression* (pp. 21-41). Chichester, England: John Wiley & Sons (2003)

410 Ustun, Gonca. "Determining depression and related factors in a society affected by COVID-19 pandemic," *International Journal of Social Psychiatry* 67, no. 1 (June 2020): 1-11. https://doi.org/10.1177/0020764020938807

Rumination was examined in relation to depression, along with negative emotionality.[411] However, it was not examined on a sample of cancer patients. Cancer along with rumination was investigated.[412] We assumed that the two constructs were interrelated. Rumination can prolong depression by enhancing the effects of negative mood on cognition and interfering with instrumental behaviour.[413]

The relationship between depression and rumination is very strong in the group of cancer patients. And it is even stronger in a healthy population. We justify this by understanding that the questionnaire we used to examine rumination contained 12 questions that define rumination as closely related to depression, and the questions are very similar to what we can see in Beck's Depression Questionnaire, which we also used. Our results support the theory that describes rumination as the individual's predisposition to think negatively about their problems and their consequences.[414]

Unconsciously, by triggering several cognitive, motivational, and behavioural deficits, ruminating individuals may end up deepening their problems and increasing their stress levels, further exacerbating symptoms.[415] Rumination is also considered as a negative focus of the individual, which is a predictor of depressive symptoms such as a negative moody mindset, impaired motivation to solve a problem, and discouragement of social support.[416]

Doctors focus primarily on dealing with a serious illness that requires demanding and painful treatment, rather than taking high regard for the individual's mental state. Educating medical workers, as well as patients, about rumination, its risks, and ways to suppress it could lead to reducing the number of negative consequences associated with cancer.[417] In addition to physical treatment, attention in cancer should be focused on the psychosocial area.[418]

We consider the unequal representation of men and women in our research to be a limitation. We consider the ongoing pandemic situation related to Covid-19 to be another significant limitation of our research. This situation is a negative aspect of an individual's life, mainly the changes resulting from anti-pandemic measures, the lack of social interaction, and the fear of illness. We are of the opinion that our results in the degree of depression were thus to some extent skewed. Since depression is related to rumination, we also consider the results of rumination to be affected. As the other negative side of our research, we consider our sample of oncology patients was in different stages of cancer. Among the patients, some were in remission or have already overcome cancer.

411 Nolan, Susan A, John E. Roberts, and Ian H. Gotlib. "Neuroticism and Ruminative Response Style as Predictors of Change in Depressive Symptomatology, " *Cognitive Therapy and Research 22*, no. 5 (October 1998): 445-455. https://doi.org/10.1023/A:1018769531641

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413 Nolen-Hoeksema Susan., and Jannay. Morrow. "A Prospective Study of Depression and Posttraumatic Stress Symptoms After a Natural Disaster: The 1989 Loma Prieta Earthquake," *Journal of Personality and Social Psychology, vol. 61*, no.1 (July 1991): 115-121. https://doi.org/10.1037/0022-3514.61.1.115

414 Nolen-Hoeksema Susan.,Blair E Wisco, and Sonja Lyubomirsky. "Rethinking rumination," *Perspectives on Psychological Science 3*, no. 5 (September 2008): 400-424. https://doi.org/10.1111/j.1745-6924.2008.00088.x

415 Lyubomirsky, Sonja, and Chris Tkach. "The consequences of dysphoric rumination" In: C. Papageorgiou & A. Wells (Eds.), *Rumination: Nature, theory, and treatment of negative thinking in depression* (pp. 21-41). Chichester, England: John Wiley & Sons (2003)

416 Nolen-Hoeksema Susan. "Responses to depression and their effects on the duration of depressive episodes," *Journal of Abnormal Psychology 100*, no. 4 (November 1991): 569-582. doi: 10.1037//0021-843x.100.4.569.

417 Lyubomirsky, Sonja, Fazilet Kasri, Olivia Chang, and Irene Chung. "Ruminative response styles and delay of seeking diagnosis for breast cancer symptoms," *Journal of Social and Clinical Psychology 25*, no. 3 (2006): 276-304. https://doi.org/10.1521/jscp.2006.25.3.276

418 Dobríková, Patricia, Dana Stachurová, Daniel West, Manwa Hegde, and Bernardo Ramirez. "External support factors utilized by patients in coping with cancer: a European perspective," *Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer*, (2021): 1-6. https://doi.org/10.1007/s00520-021-06487-0.

Conclusion

We can conclude that there were no differences between cancer patients and the healthy population in depression and rumination. And there were found out strong correlation between depression and rumination both in cancer patients and healthy population. We recommend that future research on this issue should also focus on gender differences. It would also be interesting to examine rumination in different age categories. The connection between rumination and post-traumatic growth would be appropriate to explore in the future.

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AUTHOR CONTRIBUTIONS

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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STRESS MANAGEMENT STRATEGIES FOR HOSPICE CARE PROFESSIONALS DURING THE COVID-19 PANDEMIC

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Abstract

Backround: The present paper deals with the issue of stress management of hospice care workers during the COVID-19 pandemic. Working in hospice care facilities is very demanding from a physical and mental point of view, workers are very often confronted with borderline life situations, such as death, suffering, loss of meaning in life, etc. Coping with this, together with the risks, isolation, and threat of deterioration associated with a pandemic, required workers to be highly resilient to stress. The aim of the paper is to identify stress management strategies for hospice care workers during the COVID-19 pandemic and compare them with management strategies for the general population in Slovakia. At the same time, it identifies the link between stress management strategies and the well-being of workers, assuming that workers using positive stress management strategies have a higher level of well-being. The methodological tools used include the Stress Management Strategies Questionnaire - SVF 78 and the Well-Being Questionnaire (WHO). The research sample consisted of 110 employees of hospice facilities.

Conclusion: The primary results of the research include the finding that hospice staff use guilt and devaluation strategies, as well as diversion strategies, the need for social support and avoidance significantly more often than the general population. Those workers who use more negative coping strategies and the need for social support have a worse level of well-being.

Keywords: Stress management strategies – Well-being – Hospice care – SVF-78.

Introduction

Stress can be perceived as a factor that disturbs an individual or a group during the performance of a particular activity, as a result of which it becomes difficult and thus impossible to achieve a set goal. It is a condition that threatens the elemental satisfaction of the organism. Stressful circumstances initiate irritability, mental tension, fatigue, feeling weak, disturbs the concentration of perception, disorganization of behavior. Due to the effects of stress, the physiological and mental state of the individual is transformed.

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Kupka[422] points to the care of a dying client as the most demanding activity in the medical field, because workers need to have enormous resilience and the ability to handle stressful situations. Workers can often see incurability or therapy failure as their personal failure. For this reason, interpersonal and professional relationships in the workplace play an important role in the quality of palliative care provision. The increased burden on employees is also caused by considerations and uncertainty about the correctness of the chosen procedure or causing suffering to clients during certain care tasks. The author sets out the following most common indicators causing a burden on the worker during the provision of palliative care:

- permanent presence of death and dying - it is considered the most common source of stress, it increases if the client has a different idea than the worker about how to die. It is based on the fact that palliative care is provided through the interpersonal relationship between the worker and the client,
- identification with the client - if the client reminds the employee of a close person,
- feeling incapacitated and helpless - in case the worker sees the inevitable end, but the client is not yet in the phase of reconciliation and refuses to accept his fate,
- Lack of control over the situation and a sense of self-failure - employees often place high demands on themselves, resulting in a sense of professional failure and helplessness, without taking into account organizational and professional opportunities. Instead of the possibility of personal growth, finding a solution or organizational change, conflicts are perceived negatively by employees and are deliberately avoided. With the increased lack of time per client in providing care, these problems are exacerbated,
- constant losses and grief - there are losses of relationships with clients, in the absence of expectations and goals, unresolved losses from the past and their expectations in the future, as well as own death as a loss,
- problems in the team - especially the lack of support from team members, can cause depression in individuals. Conflicts with colleagues contribute greatly to the emotional exhaustion and depersonalization of workers.

Theoretical background

Kmeť [423] attaches great importance to time constraints in the provision of palliative care. Based on research from a sample of 1704 respondents, it cites as pathogenic factors causing workload mainly many overtime, above-average working time, lack of time for individual tasks related to care and a lot of administration, which intensify emotional exhaustion. Such a workload affects not only the worker's professional performance and health, but also his private and social life, which causes a further number of crises and problems. The low experience of autonomy in the work process, the impossibility of self-realization and free action also have a risky effect on the worker. A highly authoritative environment with the requirement of inappropriate discipline and submission, the inability of the worker to adapt to working conditions and the nature of the care provided, significantly condition the emergence of the burnout syndrome. If there is no social support and teamwork in the work environment and there is a feeling of non-recognition, unhealthy competition or mobbing, then the worker is in a very stressful, long-term and unsolvable situation for him, which does not allow him to grow either

422 Martin Kupka, *Psychosociální aspekty paliatívní péče* (Praha: Grada Publishing, 2014).

423 Ľuboslav Kmeť,"Možnosti prevencie syndrómu vyhorenia (burnout) v zdravotníckom prostredí," 72-79 in *Psychológia zdravia* (Bratislava: ULTRA PRINT, 2010).

professionally or personally. Vachon[424] points to the experience of the positive contribution of spiritual and religious systems in the care of oncological and palliative clients. Perception of spirituality helps workers in these areas find meaning in the work they do. According to a study conducted at the MSK Cancer Center (New York City), the workers who come into the most frequent contact with a client are more religiously based than their other colleagues. Those who stated that they were extreme believers evidently had lower scores of reduced empathy, depersonalization, and especially lower emotional exhaustion. Compared to oncology workers, palliative care workers more often provide spiritual care, have a deeper perception of the client's spirituality and the needs arising from it, and thus have a positive approach to its evaluation in its provision. For many workers, it is the religious conviction that focuses on serving and helping other people and their own spirituality to help them find meaning in life, especially in difficult, seemingly unmanageable situations.

Workload can be perceived by employees, as Selko[425] states objectively as well as subjectively, and they may not be in accordance at all. The growing trend in the incidence of burnout is becoming alarming, so organizational staff and responsible leaders should pay more attention, despite the low motivation for active cooperation of employees themselves. The level of a person's personality is a factor where one can look for a connection with the burnout syndrome. Through cognitive assessment of stressful situations and their redirection into meaningful challenges, it can be protected and increased, because workers with its increased level more competently manage the demands presented by providing palliative care and alternately assess their physical and mental abilities, choose appropriate strategies to manage them, which again leads to a positive cognitive evaluation of their mood. The external influence of social support, which comes from the family, from work colleagues, friends or acquaintances, acts as an external factor. In connection with the burnout syndrome, support from co-workers in the same position is of the greatest importance for the worker. Burnout syndrome can also be prevented through Balint groups, workshops or therapeutic training, but especially through a thorough and appropriate selection of workers.

Štencl[426] argues that prevention should result from stress management strategies aimed at the worker, his social support and working conditions in the facility. He emphasizes the need to see and fulfill the needs and interests of the people around him, which also helps them to prevent burnout.

Vavricová[427] defines coping with stressful situations as mobilizing, organizing or coordinating behavior, her emotions and attention in times of stress. If it is not possible to influence a stressful situation, with the help of emotional regulation, which is one of the coping strategies, it is possible to manage one's emotions and reactions resulting from a stressful situation. Through self-control, it allows the worker to reduce distress emotions and tension, thus allowing him to be more controllable and maintain his goals, even though he is limited in his efforts.

424 Mary Vachon,"Psychická zátěž v paliatívní péči." 42-50. in *Paliatívní péče pro sestry všech oborů* (Praha: Grada Publishing. 2005).

425 Selko, Dušan. "Syndróm vyhorenia a zdravotné riziko," 59-71. in *Psychológia zdravia* (Bratislava: ULTRA PRINT, 2010).

426 Miženková, Ľudmila and Požonská, Martina and Kilíková, Mária. "Komplexný prístup k syndrómu vyhorenia," in *Molisa 6*. (Prešov: Prešovská univerzita v Prešove, 2009).

427 Monika Vavricová,"Sebakontrola ako faktor zvládania záťaže: teoretické koncepty a výskumné zistenia," in *Prohuman*. 2012. https://www.prohuman.sk/psychologia/sebakontrola-ako-faktor-zvladania-zataze-teoreticke-koncepty-a-vyskumne-zistenia

If a worker wants to keep his original fire, enthusiasm and the ideals of why he decided to perform palliative care, he must not forget, as Křivohlavý [428] claims, to regularly add to this fire.

Research methods

The methodological tools used include the Stress Management Strategies Questionnaire - SVF 78 and the Well-Being Questionnaire (WHO).

The SVF (Stress Management Strategies) questionnaire is a multidimensional, self-observing inventory that allows you to identify the variability of the ways that an individual develops and applies in managing and processing stressful situations. It allows you to analyze strategies aimed at reducing stress (these are positive strategies) or strategies leading to the escalation of stress (these are negative strategies). It consists of 79 items, which are divided into 13 subtests: underestimation (admitting less stress compared to others), denial (emphasizing the fact that we are not responsible for the situation), diversion (avoiding situations and activities that are stressful and stressful), substitute satisfaction (inclination to positive activities), situation control (analysis and planning of actions, in order to control the situation and solve the problem), control of reactions (securing or controlling one's own reactions), positive self-instruction (assigning competencies and self-control ability), the need for social support (need for conversation, social support and help), avoidance (commitment to reduce or avoid burdens), escape tendency (resignation tendency to escape from a stressful situation), perservation (inability to mentally disengage from the situation), resignation (giving up associated with feelings of helplessness and hopelessness), self-blame (attributing the burden to one's own in action). The questionnaire is evaluated individually for the mentioned subtests and secondary. The positive and negative strategies are evaluated secondarily, and the positive strategy evaluates the underestimation and devaluation strategy, the diversion strategy, and the control strategy. The questionnaire can be administered individually or in groups. The internal consistency of individual subscales ranged from 0.77 to 0.94.[429]

Feeling and feeling personal well-being has led people to explore what is needed to achieve it more effectively. This subject of interest has historically led many researchers to think about the possibilities of fulfilling the set goal.[430] At this time, for situations in which the individual experiences mainly emotions of a positive nature and is successful in life, positive psychology uses certain ranges of simile terms, such as satisfaction, personal well-being, psychological wealth, happiness. , optimal flourishing. In literary sources, authors select terms as needed, but in essence, phenomena of the same aspect are named.[431] Well-being as a personal well-being was taken up terminologically, especially in 1948, when the World Health Organization (WHO) outlined a definition that explains well-being as an extremely important component of health. It is a state of experiencing overall physical, mental and social well-being, where it is not necessary to consider whether the individual suffers from a disease or other disorder that disrupts his life.[432]

428 Jaro Křivohlavý, *Horieť, ale nevyhorieť* (Varín: Varínska tlačiareň, 2012).

429 Josef Švancara, *Strategie zvládání stresu – SVF 78. Príručka 124-2* (Praha: Testcentrum, 2003).

430 Jaro Křivohlavý, *Pozitívní psychologie. Odpuštění, smiřování, překonávání negativních emocí, radost, naděje* (Veľký Slavkov: Portal, 2010).

431 Alena Slezáčková, *Průvodce pozitivní psychologii. Nové přístupy, aktuální poznatky, praktické aplikace* (Bratislava: Grada Publishing, 2012).

432 Vladimír Kebza, and Iva Šolcová, "Well-being jako psychologický a zároveň mezioborově založený pojem." *Československá psychologie* 47, no. 4, (2003): 333-345.

Data processing methods

The obtained data were processed in the program IBM SPSS, version 27. Before the selection of adequate statistical tests, the normality of the distribution of variables was first performed. Based on the Kolmogorov-Smirn test, we can state that the variables were normally distributed (p> 0.05), so we use parametric tests in the analyzes. Only the well-being variable was not normally distributed, so we use Spearman's correlation coefficient.

Research file

The research group consisted of 110 respondents, of which 92 were women (83.6%) and 18 men (16.4%). The average age was 46.4 years (SD 10.67 years), the youngest respondent was 20 years old, the oldest 70 years. The average length of practice was 7.47 years (SD 6.54 years), the shortest length of practice was 1 year, the longest 44 years.

The research group was dominated by secondary education (48.2%), followed by higher education II. degree (18%), university education I. degree (13%), further university education III. degree (6.4%), higher professional (7.3%) and basic (0.9%). 10 respondents did not answer the question.

In terms of marital status, respondents in marriage predominated (N 55, 5%), followed by single (24%), divorced (12%), partner (9%) and widowed (4.5%). One respondent did not answer.

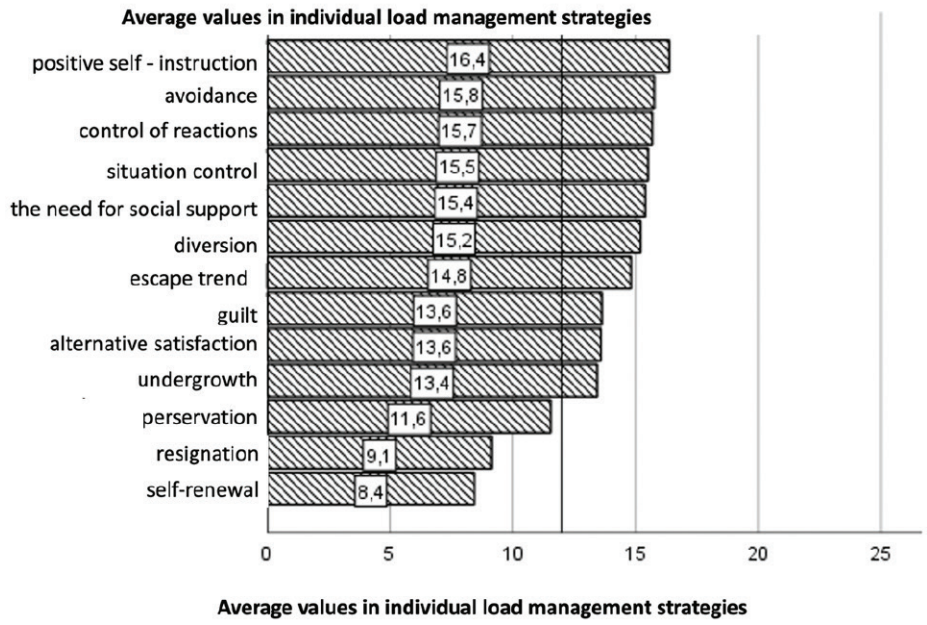
In terms of religion, Roman Catholicism predominated, followed by Greek Catholic / Orthodox (9.1%), non-religious (8.2%), Evangelical (4.5%) and other Christian (2%). The majority of respondents (84.2%) practice the faith, 15.8% do not practice it, 9 respondents did not answer.

Results

Objective 1: To identify stress management strategies for hospice care workers during the COVID-19 pandemic.

Graph 1 visualizes the average values of individual coping strategies for hospice care workers. We see that they use positive self-instruction, avoidance, control of reactions and situations, the need for social support and diversion to the greatest extent. To a lesser extent, they use escape, guilt, substitute satisfaction. They use perseverance, resignation and self-blame to the lowest extent.

The reliability of individual subscales was satisfactory, from α = 0.757 to 0.870. Only in subscales deviation (α = 0.549) and control of reactions (α = 0.534) was the reliability lower.



Graph 1 Average values in individual subscales of coping strategies for hospice care workers

Subsequently, we evaluated the individual scales secondarily, ie for positive and negative strategies. Positive strategies are made up of subscales: underestimation, guilt, diversion, substitute satisfaction, situation control, reaction control, and positive self-instruction. Positive strategies are classified into three sub-areas:

- Strategy of underestimation and devaluation of guilt - this consists of underestimation and rejection of guilt,
- Diversion strategy - consists of diversion and alternative satisfaction,
- Control strategy - consists of situation control, reaction control and positive self-instruction.

Negative strategies are formed by subscales: escape tendency, perservation, resignation and self-blame.

Table 1 shows the descriptive characteristics of the secondary subscales. We state the mean, standard deviation, median, confidence intervals, minimum and maximum value. We can state that, on average, workers use positive coping strategies to a greater extent than negative ones. However, in order to obtain a more realistic picture, we consider it important to compare the values of workers in hospice care with the general population, which is the subject of the second goal.

Table 1 Descriptive characteristics of secondary subscales of load management strategies

positive strategies	AM		14,78
	SD		2,468
	ME		14,86
	95 % CI	LL	14,30
		UL	15,26
	Min		6,57
	Max		20,43
strategy of underestimation and devaluation of guilt	AM		13,53
	SD		3,83
	ME		13,00
	95 % CI	LL	12,79
		UL	14,28
	Min		2,50
	Max		23,00
diversion strategy	AM		14,40
	SD		3,48
	ME		14,50
	95 % CI	LL	13,72
		UL	15,08
	Min		4,50
	Max		22,00
strategy of controls	AM		15,86
	SD		2,99
	ME		16,00
	95 % CI	LL	15,27
		UL	16,44
	Min		6,00
	Max		23,33
negative strategies	AM		10,99
	SD		3,66
	ME		11,50
	95 % CI	LL	10,27
		UL	11,70
	Min		1,50
	Max		20,25

Legend 1: AM - arithmetic mean, SD - standard deviation, ME - median, 95% CI - 95% confidence intervals, LL - lower limit, UP - upper limit, min - minimum, max – maximum

Objective 2: to compare the stress management strategies of hospice care workers with the stress management strategies of the general population in Slovakia.

As can be seen from Table 2, the significance value is lower than the set significance level of 0.05, which means that there is a significant difference in the strategy of underestimation and devaluation of guilt between hospice care workers and the general population in Slovakia. The average of the general population in the strategy of underestimation and guilt is 10.09 points, the average for hospice care workers is 13.53 points.

From the values of Cohen's d = 0.941, it follows that this is a large effect of differences. If there is no difference between the groups in the averages of the observed trait (d = 0), the value of the trait is higher for half (50%) of the members of the first group than for the average member of the second group. In the case of a small difference (d = 0.2), 58% of the members of the first group have a character value higher than the average member of the second group. In the case of a medium difference (d = 0.05) it already has 69% and in the case of a large difference (d = 0.8) almost four-fifths (79%).[433]

Table 2 Result of Student's t-test for one selection (strategy of underestimation and devaluation of guilt)

	N	AM	SD	t	p	Cohen´s d
strategy of underestimation and devaluation of guilt	103	13,53	3,826	9,135	0,000	0,941

Legend 2 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

As can be seen from Table 3, the significance value is lower than the set significance level of 0.05, which means that there is a significant difference in the diversion strategy between hospice care workers and the general population in Slovakia. The average of the general population in the diversion strategy is 10.37 points, the average for hospice care workers is 14.40 points. From the values of Cohen's d = 1,159, it follows that this is a large effect of differences.

Table 3 Student's t-test result for one selection (deviation)

	N	AM	SD	t	p	Cohen´s d
Diversion strategy	103	14,40	3,479	11,965	0,000	1,159

Legend 3 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

As can be seen from Table 4, the significance value is higher than the set significance level of 0.05, which means that there is no significant difference in the control strategy between hospice care workers and the general population in Slovakia. The average of the general population in the control strategy is 16.19 points, the average for hospice care workers is 15.86 points.

433 Petr Soukup, "Věcná významnost výsledků a její možnosti měření," *Data a výzkum – SDA Info* 7, no. 2, (2013): 125-148.

Table 4 Student‘s t-test result for one selection (control strategy)

	N	AM	SD	t	p	Cohen´s d
control strategy	103	15,86	2,990	-1,128	0,262	0,111

Legend 4 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

As can be seen from Table 5, the significance value is higher than the set significance level of 0.05, which means that there is no significant difference in negative strategies between hospice care workers and the general population in Slovakia. The average of the general population in negative strategies is 10.52 points, the average for hospice care workers is 10.99 points.

Table 5 Student‘s t-test result for one selection (negative strategies)

	N	AM	SD	t	p	Cohen´s d
negative strategies	103	10,99	3,660	1,297	0,197	0,128

Legend 5 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

The next two subscales are evaluated separately - the need for social support and avoidance.

As can be seen from Table 6, the significance value is higher than the set significance level of 0.05, which means that there is a significant difference in the need for social support between hospice care workers and the general population in Slovakia. The average of the general population in social support is 12.89 points, the average for hospice care workers is 15.39 points.

From the values of Cohen‘s d = 0.587, it follows that this is a medium effect of differences.

Table 6 Result of Student‘s t-test for one selection (need for social support)

	N	AM	SD	t	p	Cohen´s d
need for social support	103	15,39	4,258	5,956	0,000	0,587

Legend 6 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

As can be seen from Table 7, the significance value is higher than the set significance level of 0.05, which means that there is a significant difference in avoidance between hospice care workers and the general population in Slovakia. The average of the general population in avoidance is 11.97 points, the average for hospice care workers is 15.78 points.

From the values of Cohen‘s d = 1,060, it follows that this is a large effect of differences.

Table 7 Student‘s t-test result for one selection (avoidance)

	N	AM	SD	t	p	Cohen´s d
avoidance	103	15,78	3,592	10,756	0,000	1,060

Legend 7 N - number, AM - arithmetic mean, SD - standard deviation, p - significance value - Cohen´s d - effect size

Since the SVF-78 questionnaire manual states that the last two strategies need to be interpreted in the context of the whole profile, we performed correlation analyzes with other secondary subscales.

As can be seen from the correlation coefficients given in Table 8, the need for social support correlates with both positive strategies, namely the control strategy (r = 0.392 **) in a positive medium-strong relationship, and with negative strategies (r = 0.485 **) in a strong relationship. .

Avoidance correlates with positive strategies (r = 0.508 **) in a strong relationship and equally in a strong relationship correlates with a control strategy (r = 0.542 **).

Table 8 Correlation analysis: need for social support, avoidance and secondary coping strategies

		the need for social support	avoidance	positive strategy	strategy of underestimation and devaluation of guilt	diversion strategy	control strategy	negative strategy
the need for social support	r		,267**	,262**	-0,106	,262**	,392**	,**485****
avoidance	r	,267**		,**508****	,262**	,274**	,**542****	,297**

*Legend 8: r = correlation coefficient, ** = correlation is significant at 0.01*

Objective 3: To identify the relationship between stress management strategies and well-being in hospice care workers.

As can be seen from the correlation coefficients given in Table 9, well-being correlates with negative strategies (r = -0.537 **) in a negative strong relationship and with the need for social support (r = -0.322) in a negative, moderate relationship.

Table 9 Correlation analysis: well-being and stress management strategies

		the need for social support	avoidance	positive strategy	strategy of underestimation and devaluation of guilt	diversion strategy	control strategy	negative strategy
well-being	r	-,**322****	-0,171	-0,011	0,125	-0,068	-0,076	-,**537****

*Legend 9: r = correlation coefficient, ** = correlation is significant at 0.01*

Discussion

The primary results of our research include the finding that hospice care workers use significantly more a strategy of underestimating and devaluing guilt, a strategy of diversion, the need for social support, and avoidance than the general population.

The strategy of underestimation and devaluation is characterized by an effort to re-evaluate and especially to reduce the severity of the stressor, stress experience and stress response. Underestimation captures the tendency to underestimate one‘s own reactions compared to others, or to evaluate them more favorably. Devaluation strategies resp. the denial expresses the lack of personal responsibility for the burden. This strategy expresses

defensive strategies for coping with stress.[434] Finding that hospice care workers in these subscales score significantly higher may be due to the specifics of their work, often facing uncontrollable stressors (such as unpredictable, often inappropriate client reactions, death and other borderline situations), with underestimation, blame, aimed at reducing the severity of the stressor appear to be appropriate and relevant.

Diversion strategies are also used by hospice staff significantly more often. These strategies are characterized by a tendency to act to deviate from a stressful event, or to move towards alternative situations / states or activities. This includes diversion strategies, which are characterized by averting stress and a tendency to induce stress-relieving mental states. This may include emotions and feelings with positive valence, which is incompatible with existing feelings with negative valence. Diversion strategies also include substitute satisfaction, which means action aimed at positive feelings that are not compatible with stress and relate to self-empowerment through external rewards (eg, buying something, eating something good).[435] As mentioned above, we think that given the nature of workers' work and the stressors they face on a daily basis, diversion strategies may be those that help workers manage stress and, in particular, maintain a more positive emotional attitude.

In the control strategies, as well as in the negative strategies, the hospice staff did not differ from the general population. Control strategies are among the positive and most constructive coping strategies. Situation control focuses on the tendency to gain control over stressful situations by analyzing the situation, planning measures leading to change and actively intervening in the situation.[436] This form of strategy is used by hospice workers very similarly to other people, and, again, due to the nature of the work, it is sometimes not possible to use these strategies to a greater extent (some types of stressful situations in hospice care are not under control).

Negative strategies form a range of strategies that are characterized by the use of unfavorable, rather stress-enhancing processing methods. Hospice staff use them to a comparable extent as the general population. The escape tendency lies in the resignation tendency to get out of the stressful situation. It limits the individual's readiness and ability to cope with a stressful situation. Perservation means the inability of an idea to disengage from an experienced burden. Negative thoughts and ideas about the burden are constantly imposed and take up the individual's thinking capacity for a long time. Resignation represents a subjective lack of the ability to cope with a stressful situation. These include feelings of helplessness and hopelessness in relation to a particular stressful situation and one's own ability to cope, which means that the individual gives up further efforts to overcome the situation. Self-blame captures the tendency to be discouraged and attributing mistakes to one's own actions in relation to the burden.[437]

Separate categories are strategies focused on the need for social support and avoidance. The need for social support captures the tendency of an individual who, under stress, wishes to make contact with others in order to gain support in processing or solving a problem. This tendency can be an expression of rather passive resignation, helpless attitudes, and can indicate an active search for specific support (it is necessary to interpret in the context of the whole profile of strategies - whether correlations with positive - active or passive or negative strategies).[438] Hospice care workers use this strategy significantly to a greater extent than the general population. Based on the correlation analysis of the need for social support with positive and negative coping strategies, we can state that we have experienced a stronger relationship with negative strategies, somewhat weaker with the control strategy. Based on this, we can conclude that some employees use this strategy rather in an active form in the context of a control strategy. Seeking social support can be part of a strategy to gain control, such as a form of concrete assistance from the other in resolving a stressful situation. On the other hand, there are also workers who use it more passively in the form of a helpless attitude, where the individual seeks social support in order to complain, overwhelm others with their own problems, and so on.

Avoidance is the second separate category and, based on a comparison with the general population, we can state that employees of hospice facilities use it to a significantly higher extent. This strategy captures the tendency to avoid burdens and includes the intention and effort to avoid confrontation with a similar situation. It can be a positive way of processing if the individual tries to avoid the situation based on his regulatory possibilities, but also a negative way of processing if it is only a matter of avoiding the burden.[439] In our cohort, this strategy was associated with predominantly positive strategies, especially the control strategy. This means that employees use this strategy rather constructively.

The last goal of our paper was to identify the relationship between coping strategies and the well-being of hospice staff. We can state that there is a strong negative relationship with negative load strategies. This means that those workers who use negative strategies to a greater extent have a lower level of well-being. A moderately strong relationship has also been shown with the need for social support, ie the more the worker uses this strategy (as follows from the previous text rather in its passive form), the worse the well-being it achieves.

According to the research, the use of negative strategies can be risky in relation to maintaining optimal well-being of hospice staff. We consider it important, especially in the context of mental health care for employees, to strengthen constructive strategies and strategies aimed at managing negative emotions and minimizing negative stress management strategies (eg resignation, persecution, etc.).

Conclusion

The aim of the paper was to identify stress management strategies for hospice care workers during the COVID-19 pandemic and to compare them with management strategies for the general population in Slovakia. At the same time, we investigated the relationship between stress management strategies and employee well-being, assuming that workers using positive stress management strategies have a higher level of well-being. The methodological tools used included the Stress Management Strategies Questionnaire - SVF 78 and the Well-Being Questionnaire (WHO). The research sample consisted of 110 employees of hospice facilities. We found that hospice staff used guilt and devaluation strategies, as well as diversion strategies, the need for social support, and avoidance significantly more often than the general population. Those workers who used more negative coping strategies and the need for social support had a worse level of well-being.

434 Josef Švancara, *Strategie zvládání stresu – SVF 78. Príručka 124-2* (Praha: Testcentrum, 2003).
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Conflict of interest
All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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RUMINATION, POSTTRAUMATIC GROWTH AND FORGIVENESS IN PEOPLE WHO OVERCOME ONCOLOGICAL DISEASE

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Abstract
Background: Much attention is paid to cancer patients in the researches. However, less research has focused on those patients who have overcome cancer. Rumination can cause a variety of emotional disorders. On the other hand, forgiveness can help people overcome disease. Because overcoming of the disease can lead to a change that patients perceive as personal growth. So, the aim of the study was to find out what kind of relationships exist among rumination, forgiveness and post-traumatic growth in people who have overcome cancer.
Methods: Data were obtained using the Situational Rumination Scale, the Post-Traumatic Development Questionnaire, and the Heartland Forgiveness Questionnaire. The research sample consisted of 68 respondents, all of whom overcame cancer. 44 women and 24 men took part in the research. The average age of the respondents was 43.62 years (SD = 16.03).
Results: The results indicated a negative relationship between intrusive rumination and self-forgiveness and a positive relationship between intentional rumination and situation-forgiveness and total forgiveness. We also found that intentional rumination correlated with three of the five dimensions of post-traumatic growth, specifically with the dimensions of new possibilities, personal strength, appreciation of life, and at the same time with overall post-traumatic growth. Furthermore, our results pointed to positive relationships between total forgiveness and total post-traumatic growth. Forgiveness was positively correlated with the dimensions of post-traumatic growth, new possibilities, spiritual change, personal strength, and also with overall post-traumatic growth. Situation-forgiveness was positively correlated with the overall post-traumatic growth and its dimensions of new possibilities, personal strength and appreciation of life.
Conclusion: We have found out no significant relationship between intrusive rumination and post-traumatic growth. But on the other hand adaptive, intentional rumination in those who have overcome cancer is positively associated with a higher rate of post-traumatic growth. The relationship between the intentional rumination and situation-forgiveness was positive very strong.
Keywords: Ruminations. Posttraumatic growth. Forgiveness. Overcoming cancer.

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Introduction

Much attention is paid to cancer patients in the researches. However, less research has focused on those patients who have overcome cancer and in their everyday life have to deal with its consequences or the fear that the disease may return.[441] According to Naughton and Weaver,[442] former cancer patients may have permanent consequences after overcoming the disease, which will accompany the patient for the rest of his life. In some cases, patients who overcome cancer may also need constant monitoring by specialists in order to detect early recurrence of cancer or the development of new types of cancer. Even after its completion, the oncological disease remains a chronic condition, in which various recommendations concerning the care of the treated patient appear. According to Foster et al.[443] as well as according to Arndt et al.[444] cancer-related mortality is high, but more people would survive.

The term rumination has gained negative meaning in recent years, especially in the clinical literature on depression and post-traumatic impairment. The term has been used in this literature in the context of self-centred negative thinking about symptoms, or has often been defined as a concern.[445] Nolen and Hoksema[446] consider ruminative thinking as a passive process, of which is the main essence to focus attention on perceived negative emotions. From this point of view, rumination is associated primarily with the symptoms of pathology, especially depression and anxiety. However, rumination is generally defined as repeated thinking or meditating on information — in other words, so-called cognitive „chewing." Ruminative thoughts evoked by a highly stressful event may involve different types of repetitive thoughts. As an example, we can include unpleasant thoughts, which are often undesirable, or thoughts that are considered a symptom of anxiety, but may also include more controlled thoughts focused on understanding experience, problem solving, reminiscence, and anticipation.[447] Individuals who have overcome cancer face many challenges, and this traumatic event largely affects their thinking. Therefore, it would be expected that rumination in connection with oncological diagnosis should not be quite exceptional. However, there is insufficient amount of literature on rumination in cancer patients.[448] It should also be noted that even less literature deals with rumination in individuals cured of cancer.

Rumination is one of the key cognitive phenomena that cause and report a variety of emotional disorders.[449] For example, in depression, rumination has been found to herald the onset and duration of a depressive episode and is also associated with depressive symptoms and impaired resolution. Ruminations are also associated with social phobia, post-traumatic stress disorder and anxiety. Oginska - Bulik[450] divides rumination into two types. The first type is rumination intrusive. Intrusive rumination or intrusive thinking is more destructive. It is based on automatically emerging thoughts that the individual is unable to control and that are not related to attempts to solve the problem. The second type of rumination, or rumination thinking, is intentional rumination, which is more constructive than intrusive rumination. This rumination encourages the individual to analyse the situation and find ways to resolve it. Examination of rumination in cancer patients has shown that intrusive rumination was associated with post-traumatic stress disorder, whereas intentional rumination was associated with post-traumatic growth.[451] Individuals can be assisted in developing various coping strategies in connection with trauma, for example by turning intrusive rumination into intentional rumination.[452] The authors Oginska-Bulik and Michalska[453] dealt with rumination and its influence on emotional coping and the symptoms of post-traumatic stress disorder. Mediation analysis concluded that intrusive rumination plays a key role in the relationship between emotional management problems and the symptoms of post-traumatic stress disorder.

In addition to the negative changes that trauma brings, individuals in some cases also experience positive changes, which are defined as post-traumatic growth. Post-traumatic growth is defined as an individual's struggle with a new reality due to trauma, which is crucial in determining the extent to which post-traumatic growth occurs. According to the model of Tedeschi and Calhoun[454], post-traumatic growth is a beneficial result of combating a traumatic event and conceptually differs from negative results related to psychological distress. Tadeschi and Cal-

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houn[455] state that the two initiation conditions on which its triggering depends are important for understanding the process of post-traumatic growth. It is the very perception of the stressor by the individual and also the intentional involvement of the individual in this stress. An example of a connection can be, for example, ruminating.

Although, cancer and its treatment are considered a traumatic event and can have a negative impact on an individual's functioning and quality of life, some individuals who have overcome the disease also perceive its positive aspects. According to these individuals, their overcoming of the disease has led to a change that they themselves perceive as a huge contribution to their lives likewise to personal growth.[456] More than half of cancer survivors experience at least one beneficial change and personal growth after their experience with cancer, which we can call post-traumatic growth.[457]

When we talk about post-traumatic growth, a recent systematic review showed that almost 52.6% of people who have experienced trauma report moderate to high scores in post-traumatic growth. In those who survived cancer, these medium and high scores in post-traumatic growth were more frequent compared to the group of those with accidental injuries.[458] Other authors[459] also point to the fact that many people who have survived cancer and other life-threatening diseases report positive changes in their lives after this diagnosis. Most notably, breast cancer survivors report positive changes in their relationships with others, in their appreciation of life as such, as well as positive changes in their life priorities. [460] Various personality and social factors are involved in the development of post-traumatic growth, but one of the most interesting findings, according to Stockton, Hunt, and Joseph[461], is that the predominant intrusive rumination in an individual is associated with a higher level of post-traumatic growth. This is an interesting finding because intrusive rumination is traditionally considered as a marker of post-traumatic stress, which is also stated in the study by the author Oginska-Bulik.[462] According to her, intrusive rumination is associated with persistent symptoms of post-traumatic stress disorder, while rumination intentionally serves as a means of overcoming trauma and acts as a factor that promotes the development of post-traumatic growth. Furthermore, she states that both types of rumination are important for the very occurrence of post-traumatic growth. Stockton, Hunt, and Joseph[463] agree with the common view of intrusive rumination and post-traumatic growth. Based on the results, the authors evaluate that an intrusive rumination is an unproductive form of cognitive processing, which is associated with negative changes in the individual after trauma and is not related to post-traumatic growth. In contrast, intentional rumination is a more productive form of cognitive processing that is associated with post-traumatic growth. Ramos and Leal[464] say that both types of rumination may coexist during the process of cognitive understanding of trauma, although some theoretically suggest that intrusive thinking prevails immediately after trauma and intentional rumination occurs later.

The research results are therefore inconsistent in this case, but we can say that they call on theorists to reconceptualize the role of intrusive rumination and consider them as a possible positive component in recovery from a traumatic event. Oginska - Bulik and Ciechomska[465] state that the role of rumination in the process of creating positive changes after overcoming trauma is still a new direction for study. Their study points to a positive correlation of rumination (mainly intentional) with the presence of post-traumatic growth. This type of correlation has been shown in people with HIV, in people who have had a heart attack, but last but not least in people with cancer and people who have survived cancer. The ability to forgive is an integral part of a balanced mental state and experience in people. After surviving a traumatic event, forgiveness is an essential component of the coping process.

Edwards et al.[466] define forgiveness as the release of the belief that we are the victim and the act of personal strength that leads to the healing of the person determined to forgive. This decision to take personal responsibility for oneself and to forgive another person leads to enhanced self-efficacy. The act of forgiveness is the result of the individual giving up his reluctance and desire for revenge and deciding not to pursue his outrage and forgiving those who have hurt him. The authors add that others-forgiveness, and also self-forgiveness, are important aspects of the grief process for many individuals. In the past, forgiveness was mentioned mainly in the context of religious teaching and tradition, but in the last quarter of the twentieth century, experts and their research focused on aspects of forgiveness in mental health. Some authors have emphasized forgiveness as a multifactorial construct.[467] The relationship between forgiveness and adaptation to disease has only recently emerged. Positive correlation between forgiveness and mental

455 Tedeschi, Richard G. and Lawrence G. Calhoun. "The posttraumatic growth inventory: measuring the positive legacy of trauma," *Journal of Traumatic Stress* 9, no. 3. (July 1996): 455-471. doi: 10.1007/BF02103658.

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460 Bellizzi, Keith M., and Thomas O. Blank. "Predicting posttraumatic growth in breast cancer survivors," *Health psychology* 25, no. 1 (2006): 47-56. https://doi.org/10.1037/0278-6133.25.1.47

461 Stockton, Hannah, Nigel Hunt, and Stephen Joseph. "Cognitive Processing, Rumination and Posttraumatic Growth," *Journal of Traumatic Stress* 24, no. 1, (February 2011): 85-92. doi: 10.1002/jts.20606.

462 Oginska-Bulik, Nina. "The negative and positive effects of trauma resulting from cancer- the role of personality and rumination," *Current issues in personality psychology* 5, no. 4. (2017): 232-243. https://doi.org/10.5114/cipp.2017.67016

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464 Ramos, Catarina, and Isabel Leal. „Posttraumatic Growth in the Aftermath of Trauma: A Literature Review About Related Factors and Application," *Psychology, Community and Health* 2, no. 1. (2013): 43–54. https://pch.psychopen.eu/article/view/39

465 Oginska-Bulik, Nina, and Monika Ciechomska. "Posttraumatic growth of parents struggling with cancer disease of their child- the role of rumination," *Advances in Psychiatry and Neurology* 25, (2016): 99-110. https://daneshyari.com/article/preview/331715.pdf

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adaptation was reported.[468] Their study focused on women with breast cancer. A similar positive correlation was also found in a study by Friedman et al.[469] These authors also focused on women with breast cancer, with their respondents attending a private clinic. Thus, we can say that women suffering from cancer, or women who have overcome cancer and are able to forgive themselves, less blame themselves for the development of cancer. This is also associated with an increased quality of life and fewer mood disorders. Research on forgiveness in connection with cancer and cancer survival has mostly focused on self-forgiveness. This dimension is frequently explored. Mainly because individuals suffering from cancer or those who have overcome cancer tend to blame themselves for the disease entering their lives.

Van Laarhoven et al.[470] in their research compared the dimension of others-forgiveness between healthy individuals and cancer patients. The research did not show any differences in others-forgiveness between the groups. Therefore, these authors, as well as Romero et al.[471] and Friedman et al.[472] agree that forgiveness is particularly important for individuals facing a potential life-threatening illness such as cancer. Although other dimensions of forgiveness may be less relevant for such patients.

Based on the above the aim of our study was to find out whether there are relationships between rumination and forgiveness in individuals who have overcome cancer, as well as to examine what relationships exist between rumination and post-traumatic growth. We were interested what relationship exists between posttraumatic growth and forgiveness.

Methods

Sample and Data Collection

Our research sample consisted of 68 respondents who overcame cancer. Of these, 44 were women and 24 were men. The average age of the respondents was 43.62 (SD 16.03) years. Respondents were addressed virtually through groups on social networks. By completing the questionnaire, the respondents agreed to the processing of data for research purposes.

468 Romero, Catherine, Lois C. Friedman, Mamta Kalidas, Richard Elledge, Jenny Chang, Kathleen R. Liscum. "Self-forgiveness, spirituality, and psychological adjustment in women with breast cancer," *Journal of Behavioral Medicine* 29, no. 1. (February 2006): 29–36. doi: 10.1007/s10865-005-9038-z.

469 Friedman, Lois C., Catherine Romero, Richard Elledge, Jenny Chang, Mamta Kalidas, Mario F. Dulay, Garrett R. Lynch, and C. Kent Osborne. "Attribution of blame, self-forgiving attitude and psychological adjustment in women with breast cancer," *Journal of Behavioral Medicine* 30, no. 4. (August 2007): 351–357. doi: 10.1007/s10865-007-9108-5.

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472 Friedman, Lois C., Catherine Romero, Richard Elledge, Jenny Chang, Mamta Kalidas, Mario F. Dulay, Garrett R. Lynch, and C. Kent Osborne. "Attribution of blame, self-forgiving attitude and psychological adjustment in women with breast cancer," *Journal of Behavioral Medicine* 30, no. 4. (August 2007): 351–357. doi: 10.1007/s10865-007-9108-5

Methods Used

In our research, we used 3 questionnaires, which were sent to the respondents in electronic form. The main questionnaire also included informed consent, in which the respondents agreed to the processing of data for research purposes.

To measure rumination, we used the Slovak version of the Scale of Situationally Focused Rumination by Cann et al.[473] The scale measures two dimensions - intentional and intrusive rumination. It contains 20 items, 10 of which measure rumination intentionally (e.g., „I forced myself to think about my feelings about this event") and another 10-measure rumination intrusively (e.g., „I was thinking about the event even though I didn't intend it"). Respondents rated statements on a four-point Likert scale from the answer often to the answer at all.

To measure post-traumatic growth, we used the Slovak version of the Post-Traumatic Development Questionnaire by Tadeschi and Calhoun[474] This questionnaire measures 5 dimensions of post-traumatic growth. These are the dimensions of relationships with others (7 items - e.g., „have compassion for others"), new possibilities (5 items - e.g., „development of new interests"), personal strength (4 items - e.g., „feeling confident"), spiritual change (2 items - e.g. „I have a stronger religious faith") and appreciation of life (3 items - e.g., „my priorities about what is important in life"). The questionnaire contains a total of 21 items. The statements were evaluated by the respondents on a six-point Likert scale.

We measured forgiveness by the Heartland Forgiveness Questionnaire (HFS), originally written by Thompson and Snyder. For our purposes, we used his Slovak adaptation by the authors Chlebcová and Greškovičová. This questionnaire measures 3 dimensions of forgiveness, namely self-forgiveness (6 items - e.g., „although I feel bad at first when I go wrong, I can relax in time") others-forgiveness (6 items - for example „I have an understanding for others for mistakes over time, which they did") and situation-forgiveness (6 items - for example, "over time I can understand the bad circumstances in my life"). The questionnaire contains a total of 18 items. Respondents rated statements on a seven-point Likert scale.

473 Cann, Arnie, Lawrence G. Calhoun, Richard G. Tedeschi, Kelli N. Triplett, Tanya Vishnevsky, Cassie M. Lindstrom. "Assessing posttraumatic cognitive processes: the Event Related Rumination Inventory," *Anxiety, Stress & Coping: An International Journal* 24, no. 2 (March 2011): 137-156. doi: 10.1080/10615806.2010.529901.

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Results

To explore the relationship between forgiveness and rumination, we used correlation analysis, the results of which are shown in table 1.

Table 1 - Spearman correlation coefficient between rumination dimensions and forgiveness dimensions

	Intrusive rumination		Intentional rumination	
	ρ	Sig.	ρ	Sig.
Self-forgiveness	**-0.263**	**0.030**	0.176	0.150
Others-forgiveness	0.068	0.582	0.180	0.141
Situation-forgiveness	0.129	0.294	**0.972**	**0.000**
Total forgiveness	-0.066	0.594	**0.589**	**0.000**

Correlation analysis between the variables of *intrusive rumination* and the dimensions of *forgiveness* in the group of individuals who overcame cancer showed one statistically significant relationship, namely the relationship between *intrusive rumination* and the dimension of self-*forgiveness* (ρ = -0.263).

As part of the analysis of the relationship between *intentional rumination* and the dimensions of *forgiveness*, the analysis pointed to two statistically significant relationships. The value of the Spearman correlation coefficient of the relationship between the *intentional rumination* and *situation-forgiveness* is ρ = 0.972, indicating that there is a very strong, positive, linear relationship between these variables. In the second correlation, Spearman's correlation coefficient was ρ = 0.589, which also suggests that there is a strong, positive, linear relationship between *intentional rumination* and *total-forgiveness*. In both cases, it is a direct proportionality, and thus, as the score of one variable increases, the score of the other variable will also increase.

We further examined the relationships between the dimensions of rumination and the dimensions of post-traumatic growth. Its results are shown in table 2.

Table 2 - Spearman correlation coefficient between dimensions of rumination and dimensions of posttraumatic growth

	Intrusive rumination		Intentional rumination	
	ρ	Sig.	P	Sig.
Relationships with others	-0.071	0.565	0.214	0.079
New possibilities	0.024	0.846	**0.547**	**0.000**
Spiritual change	-0.152	0.215	0.067	0.585
Personal strength	-0.138	0.261	**0.394**	**0.001**
Appreciation of life	-0.015	0.905	**0.394**	**0.001**
Posttraumatic growth	-0.089	0.470	**0.423**	**0.000**

The analysis pointed to a statistically non-significant relationship between *intrusive rumination* and *post-traumatic growth* dimensions.

However, we found statistically significant relationships between the variables of *intentional rumination* and the dimensions of *post-traumatic growth*. We record a very strong relationship between the variables of *intentional rumination* and the dimension of *new possibility* (ρ = 0.547). A moderately strong statistically significant positive relationship was further demonstrated between the *intentional rumination* and the *total post-traumatic growth* score (ρ = 0.423).

Our next goal was to expand the relationships between the dimensions of forgiveness and the dimensions of post-traumatic growth. The results are shown in table 3.

Table 3 - Spearman's correlation matrix between the dimensions of forgiveness and the dimensions of post-traumatic growth

	Self-forgiveness		Others-forgiveness		Situation-forgiveness		Total forgiveness	
	ρ	Sig.	ρ	Sig.	P	Sig.	ρ	Sig.
Relationships with others	0.138	0.262	-0.125	0.310	0.202	0.098	0.138	0.262
New possibilities	**0.291**	**0.016**	-0.227	0.062	**0.549**	**0.000**	**0.281**	**0.020**
Spiritual change	**0.311**	**0.010**	-0.084	0.495	0.011	0.929	0.183	0.135
Personal strength	**0.357**	**0.003**	-0.141	0.252	**0.389**	**0.001**	**0.319**	**0.008**
Appreciation of life	0.235	0.054	0.226	0.064	**0.349**	**0.004**	**0.418**	**0.000**
Posttraumatic growth	**0.362**	**0.002**	-0.104	0.397	**0.408**	**0.001**	**0.362**	**0.002**

The correlation matrix of the relationships of the observed variables pointed to significant relationships between the dimension of *self-forgiveness* and the dimensions of *post-traumatic growth* such as *new possibilities, spiritual change, and personal strength*. The values of the Spearman correlation coefficient were in the range of 0.29 - 0.36, so it could be said that there are moderately strong relationships between these variables, or they are close to this moderately strong intensity.

Furthermore, the analysis did not show statistically significant relationships between the *others-forgiveness dimension* and *the post-traumatic growth* dimensions.

In the table, we can further observe significant relationships, namely between the dimension of *situation-forgiveness* and the dimensions of *post-traumatic growth* such as *new possibilities, personal strength and appreciation of life*. The value of the Spearman correlation coefficient was in the range of 0.3 - 0.5, which indicates moderately strong positive relationships.

For the overall *post-traumatic growth*, 3 moderately strong positive relationships were demonstrated at the level of statistical significance Sig. <0.01 with *self-forgiveness, situation-forgiveness and total forgiveness*.

Furthermore, the correlation matrix of the relationships of the monitored variables is shown in table 3 pointed out the significant relationships between *total forgiveness* and dimensions of *post-traumatic growth* such as *new possibilities, personal strength, and appreciation of life*.

Discussion

The aim of our research was to examine in more detail the relationships between rumination, post-traumatic growth and forgiveness in people who have overcome cancer.

Intrusive rumination, as a less adaptive form of rumination, is related in our research sample to lower self-forgiveness. This may play an important role in the further existence of the individual after overcoming cancer. On the other hand, intentional rumination, which is an adaptive form of rumination, is related to a higher forgiveness of the situation, which in our research sample may be just a cancer disease and the fact that individuals had to fight it. A very strong positive relationship emerged between these dimensions of constructs. The above results entitle us to believe that intentional rumination is almost identical to forgiving the situation. We also found in our research sample that intentional rumination is associated with higher total forgiveness. Total forgiveness is also very important after overcoming cancer. However, it should be pointed out that rumination is also an important part of the life of an individual who has overcome cancer. It is in his interest to try to ruminate adaptively, which then brings other benefits.

The results of available research that have addressed this relationship have been inconsistent. Several authors (for expmle Berry et al.[475] and McCollough et al.[476]) agree that rumination is associated with lower forgiveness because rumination in individuals promoted vengeance and a tendency to avoid other individuals who offend them. However, these studies saw rumination as a non-adaptive form of coping with a traumatic event. Other authors have focused on rumination as a multidimensional construct that includes adaptive forms of rumination.[477] More adaptive forms of rumination, such as intentional rumination, positively influenced forgiveness. Based on our results we emphasize the need to look at rumination as a multidimensional construct. The authors Ramos and Leal[478] , Oginska-Bulik and Ciechomska[479] state that rumination after overcoming a trauma such as cancer needs to be further explored and at the same time point to the occurrence of both types of rumination in individuals who have overcome cancer.

Our next goal was to examine the relationship between the dimensions of rumination and post-traumatic growth. The authors Stockton, Hunt, and Joseph[480] and Oginska – Bulik[481] confirmed in their research that individuals who ruminate intentionally show higher rates of post-traumatic growth. Individuals in our study who overcame cancer and ruminate intentionally showed higher overall post-traumatic growth. Thus, we can reaffirm the importance of looking at rumination as a multidimensional construct, as well as the fact that intentional, adaptive rumination is beneficial to individuals who have overcome cancer because it promotes post-traumatic growth. Intentional rumination correlated positively with three of the five dimensions of post-traumatic growth, namely with the dimensions of new possibilities, personal strength, and appreciation of life. In contrast, in intrusive rumination, was found no relationship with the dimensions of post-traumatic growth, and thus this result again points to the importance of adaptive rumination after overcoming cancer. Although some theoretical backgrounds pointed to the fact that intrusive rumination may also be associated with post-traumatic growth,[482] this relationship was not confirmed in our research sample.

The aim of our research was also to explore the relationships between the dimensions of forgiveness and post-traumatic growth. Our results pointed to the positive relationships between total forgiveness and the dimensions of post-traumatic growth of new possibilities, personal strength, and appreciation of life. We can therefore say that forgiveness is a very important component in overcoming the consequences of cancer. The analysis of the dimensions of forgiveness in relation to post-traumatic growth also offered interesting results. The dimension of forgiveness correlated positively with the three dimensions of post-traumatic growth, namely with new possibilities, spiritual change, and personal strength. From the point of view of cancer survivals, these results tell us about the importance of forgiving oneself for all the things that an individual has done and could have led to cancer. Likewise, interesting are the relationships of the forgiveness dimension, which was positively correlated with the dimensions of post-traumatic growth, specifically with new possibilities and personal strength. We can interpret the forgiveness of the situation as forgiveness of the disease itself and the trauma arising from it. Individuals who have forgiven the situation tend to grow post-traumatically. Total post-traumatic growth has correlated with all dimensions of forgiveness, which points to the importance of forgiving oneself, others, and the situation after individuals overcome cancer. In accordance with the results of Dobríková, Sedliaková,[483] who found that spirituality helps to change the cognitive framework of a life-threatening disease in a positive direction. One of the limits was the uneven distribution of women and men in our research sample, which may have affected our results.

Further research in this area requires deeper research into people who have overcome cancer, due to the lack of literature on this specific group. Alike Dobríková et al.[484] found that patients in smaller health care facilities still face a lack of psychological help. As the number of cancer survivors continues to grow today, it is crucial that we disseminate knowledge that could help them in everyday life.

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480 Stockton, Hannah, Nigel Hunt, and Stephen Joseph. "Cognitive Processing, Rumination and Posttraumatic Growth," *Journal of Traumatic Stress* 24, no. 1, (February 2011): 85-92. doi: 10.1002/jts.20606.

481 Oginska-Bulik, Nina. "The negative and positive effects of trauma resulting from cancer- the role of personality and rumination," *Current issues in personality psychology* 5, no. 4. (2017): 232-243. https://doi.org/10.5114/cipp.2017.67016

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483 Dobríková, Patricia, and Mariana Sedliaková. "Spirituality As a Meaning in Life Facilitator in Oncological Patients," *Acta Missiologica* 15, no. 1, (April 2021): 37 – 48. https://www.actamissiologica.com/sub/am_1_2021.pdf

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Conclusion

Our research has shown the need to look at rumination as a multidimensional construct. In relation to forgiveness, we have found that rumination is intentionally related to higher total forgiveness, as well as to the forgiveness of the situation. Individuals who have overcome cancer should try to ruminate intentionally, which would lead to better total forgiveness. Individuals who have overcome cancer are in a very difficult life situation, in which they have to face the various consequences of the disease. The fear that the disease may return, but also misunderstanding by the family and the environment. The results of this work can help these individuals to better manage life after trauma. In our opinion, this specific group of people deserves further research attention. This statement is based on the knowledge that previous research that has dealt with this group has yielded inconsistent results. For further research, we recommend extending the research sample to a higher number of respondents, in which the number of men and women would be evenly distributed. It could also be interesting and beneficial to divide the research sample into several groups, for example, based on how long they have been battling cancer, how much time has passed since the cure, or the type of cancer the respondents were suffering from.

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All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances hat could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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SELECTED PREDICTORS OF POSTTRAUMATIC GROWTH IN CANCER SURVIVORS WITH RESPECT TO SOCIAL SUPPORT AND PSYCHOLOGICAL CARE

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Abstract

Background: Changes in experiencing do not only present a reaction to the presence of adverse physical symptoms, but they can also play an important role in etiopathogenesis and, at the same time, modify the course of an oncological illness. Perception of social support leads to a higher number of positive changes which has been called posttraumatic growth by Tedeschi and Calhoun. Aim of the present study is to determine the importance of social support, perceived self-efficacy and dispositional optimism as potential predictors of posttraumatic growth in cancer patients. The objective also is to compare psychosocial variables in cancer patients and a control group of adults who are not cancer survivors or cancer patients.

Methods: The quantitative research of relationships between the studied variables was conducted using comparative and correlation analyses. The set of questionnaires used included a demographic questionnaire, Multidimensional Scale of Perceived Social Support (Zimet, et al., 1988), General Self-Efficacy Scale (Schwarzer & Jerusalem; 1995), LOT-R – Life Orientation Test Revised (Scheier, Carver, Bridges, 1994) and Posttraumatic Growth Inventory (Tedeschi, Calhoun, 1996). 604 cancer patients, 19 to 83 years of age, participated in the study; the control group comprised 435 respondents. Participation in the research was anonymous and voluntary. The study was conducted online and in person with personal participation of researchers.

Results: The results of the present study showed weak relationships between posttraumatic growth and self-efficacy, social support and dispositional optimism. In case of posttraumatic stress disorder symptoms, negative moderately strong relationship with self-efficacy, as well as weaker significant relationships with social support and optimism were found. The multiple regression analysis showed that the studied variables (self-efficacy, social support, dispositional optimism) explained 6.6% of posttraumatic growth variance; in case of posttraumatic stress disorder, they explained a slightly higher proportion (11.4%) of variance. The comparative analysis showed no significant differences between the patients with shorter and longer periods following the completion of treatment in the levels of posttraumatic growth and posttraumatic stress disorder symptoms. The results showed significantly higher levels of optimism and self-efficacy in the control group in comparison with the group with shorter period following the completion of treatment. The control group also reported higher levels of optimism and self-efficacy than the group with longer (over 18 months) period following the completion of treatment.

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Conclusion: The results confirmed existence of a relationship between posttraumatic growth and self-efficacy, perceived social support and dispositional optimism. The clinical practice has shown the need for stronger social support from families, friends, healthcare professionals and other significant persons for cancer patients. Strengthening of personality traits, self-efficacy, optimism in coping with cancer is definitely an important role of psycho-oncologists.
Keywords: Dispositional optimism **–** Posttraumatic growth **– S**ocial support **– S**elf-efficacy **–** Cancer patient.

Introduction

The adoption of bio-psycho-social perspective in the last decades has encouraged the interest of researchers in psychosocial aspects of chronic illnesses. The key feature of most oncological diseases is unclear etiology, demanding treatment process as well as unpredictability of the course and prognosis, including the concerns of potential death which are the source of continuous distress and uncertainty in patients. The psychological interventions in patients suffering from reactive emotional issues often is the enhancement of the subjective feeling of control over the present situation and health problems as well as searching for the sources of social support. On the other hand, apart from the losses associated with the illness, the psychologists also focus on the potential benefits the source of which might be the acceptance of the illness as a challenge. In this context, the experience with cancer is seen as an opportunity with a potential for the so-called posttraumatic growth.

Social support as a salutogenic factor is one of the key areas of researchers' interest in the field of health psychology[486]. Research in the last decades has brought a lot of evidence regarding the effects of social support on health and subjective wellbeing, as well as in the adaptation to the diagnosed illness. At physiological level, a relationship between social support and production of immunoglobulins and increased NK (natural-killer) cells, which are closely related to the activity of immune system, was found[487]. The positive impact on cardiovascular, nervous and endocrinal system has been confirmed on the metanalysis of the findings of 81 studies.[488] The research has pointed out the significant influence of social support on resilience and quality of life of cancer patients [489][490][491], its positive effect on reducing of strain and stress caused by cancer [492] [493]. The perception of social support correlates positively with adaptive and negatively with maladaptive

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coping strategies [494] [495]. It is possible to confirm the link between social support and higher tendency to experiencing of posttraumatic growth in confrontation with the illness [496] [497] [498].

Perceived self-efficacy is a central term of Bandura's socio-cognitive theory. It is defined as a subjective belief of one's ability to face various obstacles and problems, achieve the desired performance and influence the course of events. It is also an important motivational and protective factor[499]. More optimistic perspective on life, higher level of subjective wellbeing, academic success and higher level of social integration as well as higher quality of decision-making and motivational processes linked with preferring of objectives of a challenging nature were found in the individuals with higher level of perceived self-efficacy. At the same time, lower levels of anxiety, depression and perceived stress were found in these individuals [500][501][502][503]. Lower level of self-efficacy is related to negative impact of stress on physiological functions (e.g. immunosuppression) [16] [17]. Self-efficacy thus presents an important factor in adaptation to a chronic illness.

Dispositional optimism as a personality trait is defined as expectation of positive outcomes with a belief that good rather than bad things will happen [504]. Dispositional optimism correlates positively with perception of social support, with optimistic patients perceiving higher social sup-

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port [505][506], using more adaptive coping strategies[507] [508] and experiencing higher quality of life [509]. Optimism, resilience and self-efficacy were proven to correlate positively with posttraumatic growth[510]. A positive relationship between dispositional optimism and posttraumatic growth has been confirmed in patients who have experienced trauma, such as cancer [511][512][513][514].

Awareness of potential positive effects of experienced suffering has been present in religion and culture for centuries[515]. In philosophy and psychology, this concept has been especially within the existentialist movements which understand suffering, crises and stress as an invitation to re-evaluate the meaning and "courage to be"[516]. On the other hand, the concept of the so-called posttraumatic growth is relatively new and has not been clearly defined yet. Tedeschi and Calhoun[31] define it as a personality change which transcends the ability of resistance and resilience to highly-stressful circumstances, with the result being a shift to a level of adaptation which transcends the state prior to trauma. Researches[31] note that the growth can even occur while experiencing extremely difficult situations, while not necessarily being related to the elimination of distress which might coexist with the growth. It is a process and a result of the process at the same time, where one experiences changes in emotional and cognitive areas that might have behavioural consequences. The authors (ibidem) also note that the posttraumatic growth is associated with the overall personality transformation and, as such, it cannot only be seen as another coping strategy.
The relation of posttraumatic growth to chronic illnesses only started to be considered after these illnesses were included in the group of events which might lead to a posttraumatic stress disorder.

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The aim of the present study is to explore the role of social support, personal control represented by the perceived self-efficacy, and dispositional optimism as potential predictors of positive changes associated with surviving cancer. The objective is to compare psychosocial variables in cancer patients and a control group of adults who are not cancer survivors or cancer patients.

Methods

Participants and Data Collection

604 cancer patients, 19 to 83 years of age, participated in the study; the control group comprised 435 respondents. The participants were informed on voluntary participation in the study and the confidentiality of their data. The number of participants depended on their willingness to complete the set of questionnaires. The data were collected on-line as well as personally by the researchers. The study was approved by the Ethics Committee of TU and the National Oncology Institute in Bratislava. The inclusion criteria were being 18 or older, being diagnosed with cancer, not having severe mental health or physical condition, and not being terminally ill – data collection was not carried out in the palliative care unit.

Used Methods

Multidimensional Scale of Perceived Social Support[517] (MSPSS). MSPSS is a 12-item scale which measures a current level of social supports as well as its overall level. It is used to evaluate the perceived social support from family, friends and important people. The individual items are measured using a 7-point Likert scale from 1 ("strongly disagree") to 7 ("strongly agree"). Higher values are associated with a higher level of perceived social support (Zimet, et al., 1988). Results of the study confirm high reliability of the social support variable (a = .95).

Self-efficacy[518] (GSE; General Self-Efficacy Scale) The questionnaire consists of 10 items which measure the level of self-efficacy as an ability to be in control over the course of life. Respondents assess the individual items using a 4-point Likert scale from 1 to 4 (1 – strongly disagree, 2 – disagree, 3 – agree. 4 – strongly agree). The score of the scale is in a range from 10 to 40, with high score indicating a higher level of self-efficacy. The scale has high reliability and validity (a = .91).

LOT-R – Life orientation test revised[519] (1994). This instrument comprises 10 items, but only 6 items being in a form of a declarative sentence were used. The respondents expressed their agreement/disagreement using a Likert scale (0 –strongly disagree, 1 –disagree, 2 –neither agree, nor disagree, 3 –agree, 4 –strongly agree). The final score for each scale represents a value of the variables of optimism (a =.78) and pessimism (a = .73).

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PTGI (Posttraumatic Growth Inventory)[520] (1996). The questionnaire comprises 21 items which are divided into 5 subscales: relating to others (7 items), new possibilities (5 items), personal development (4 items), spiritual change (2 items), appreciation of life (3 items). The items are formulated as statements which are used to find how an individual who has experienced a traumatic situation, i.e. cancer, has changed. PTGI is a self-report questionnaire in which respondents provide answers using a 6-point Likert scale. PTGI has good psychometric features, such as reliability and validity (a = .95).

Research Design

The statistical data analysis was conducted using SPSS. The quantitative research of the studied variables was performed using a correlation and comparative analysis.

Results

Table 1 shows the results of a correlation analysis of the relationships between the selected psychosocial variables with the level of posttraumatic growth and symptoms of a posttraumatic stress disorder.

Table 1 Correlation analysis – cancer patients (entire group)

		Self-efficacy	Social Support	Optimism
PTSD	r	-0.298**	-0.186**	-0.147**
	Sig.	0.000	0.000	0.000
	N	700	700	700
PTG	r	0.135**	0.203**	0.164**
	Sig.	0.000	0.000	0.000
	N	700	700	700

PTSD – posttraumatic stress disorder, PTG – posttraumatic growth
** p <0.01, * p <0.05

The results showed significant, albeit weak relationships between PTG with self-efficacy (r = 0.135**), social support (r = 0.203**) and optimism (r = 0.164**). In case of PTSD symptoms, negative moderately strong correlation with self-efficacy (r = - 0.298**), moderately significant relationship with social support (r = - 0.186**) and optimism (r = - 0.146**) were found.
According to the results of multiple regression analysis, the studied variables explained 6.6% of the variance of posttraumatic growth (F = 16.279, p = 0.000, r^2 = 0.066). In case of PTSD symptoms, the explained proportion of the variance is slightly higher (11.4%) (F = 29.704, p = 0.000, r^2 = 0.114).

The comparative analysis showed no significant differences in the levels of posttraumatic growth (p = 0.068) and PTSD symptoms (p = 0.769) between the patients with shorter or longer period elapsed since overcoming the illness.

A correlation analysis was performed subsequently in both groups of cancer patients. More significant differences in the strength of confirmed relationships were found especially in patients

520 R. G. Tedeschi, R. G., and L. G. Calhoun, "The Posttraumatic Growth Inventory-Measuring the Positive Legacy of trauma" *Journal of traumatic stress, 9, no.* 3, (Jul 1996): 455-471. doi: 10.1007/BF02103658 .

with longer period elapsed from overcoming the illness. A moderately strong negative significant relationship of self-efficacy (r = - 0.342**) and optimism (r = - 0.302**) with PTSD symptoms as well as a weaker negative relationship with social support (r = - 0.258**) were found in this group.

Table 2: Correlation analysis – Groups of cancer patients based on the period from the completion of treatment

0 – 18 months		Self-efficacy	Social Support	Optimism
PTSD	r	-0.316**	-0.152**	-0.106*
	Sig.	0.000	0.004	0.047
	N	353	353	353
PTG	r	0.085	0.241**	0.167**
	Sig.	0.000	0.000	0,000
	N	353	353	353
over 18 months				
PTSD	r	-0.342**	-0.258**	-0.302**
	Sig.	0.000	0.004	0.000
	N	251	251	251
PTG	r	0.162*	0.106	0.177**
	Sig.	0.000	0.000	0.000
	N	251	251	251

A comparative analysis of the selected psychosocial variables was subsequently performed in for cancer patients and the control group of adults who were not cancer survivors or patients (N = 435). The clinical group was divided into two subgroups: patients with short (0 – 18 months) versus longer (over 18 months) period elapsed from the completion of their treatment. The results showed significantly higher levels of optimism (U = 32110, p = 0.000) and self-efficacy (U = 60287.500, p = 0.000) in the control group in comparison to the group with shorter period elapsed from the completion of treatment. The difference in the level of optimism was of medium effect (r = 0.5), while the difference in the level of self-efficacy was of lower effect (r = 0.19). At the same time, higher levels of optimism (U = 25580, p = 0.000) and self-efficacy (U = 46239, p = 0.000) were found in the control group in comparison to the group with a longer (over 18 months) period elapsed from the completion of treatment. The difference in the level of optimism was of medium effect (r = 0.4); the effect of the difference in the level of self-efficacy was lower (r = 0.12).

The results (Table 3) indicate that the most significant differences between the groups were manifested in the levels of optimism, while the lowest values were reported in the group of cancer patients with a short period elapsed from the completion of the treatment. The lowest level of self-efficacy was also found in this group; however, the differences between the remaining groups had only little effect.

Table 3: Comparative analysis – control group vs. patients (0 – 18 months post-treatment)

Table 3: Comparative analysis – control group vs. patients (0 – 18 months post-treatment)

	Category	N	Average Order	p / r
Optimism	0 – 18 months post-treatment	353	267.96	p = 0.000
	control group	435	497.18	r = 0.5
	over 18 months post-treatment	251	227.93	p = 0.000
	control group	435	410.19	r = 0.4
	0 – 18 months post-treatment	353	289.95	p = 0.000
	over 18 months post-treatment	251	320.15	r = 0.47
Social Support	0 – 18 months post-treatment	353	411.01	p = 0.066
	control group	435	381.11	-
	over 18 months post-treatment	251	344.72	p = 0.902
	control group	435	342.79	-
	0 – 18 months post-treatment	353	311.55	p = 0.902
	over 18 months post-treatment	251	289.78	-
Self-efficacy	0 – 18 months post-treatment	353	347.79	p = 0.000
	control group	435	432.41	r = 0.19
	over 18 months post-treatment	251	310.22	p = 0.001
	control group	435	262.70	r = 0.12
	0 – 18 months post-treatment	353	294.70	p = 0.001
	over 18 months post-treatment	251	313.47	r = 0.14

Discussion

Aim of the present study was to explore the positive changes in patients resulting from surviving cancer. The objective was to study the roles of social support, personal control, represented by perceived self-efficacy, and dispositional optimism as potential predictors of positive changes related to cancer survivorship.

The results of the present study showed weak relationships between posttraumatic growth and self-efficacy, social support and dispositional optimism. In case of posttraumatic stress disorder symptoms, a negative moderately strong relationship with self-efficacy as well as weaker significant relationships social support and optimism were found. The multiple regression analysis showed that the variables studies (self-efficacy, social support, dispositional optimism) explained 6.6% of posttraumatic growth variance; in case of posttraumatic stress disorder, the proportion of variance explained was slightly higher (11.4%). The level of perceived social support[521][522][523], self-efficacy, a personality variable of dispositional optimism[524][525] are factors which

521 Maja J. Schroevers, et al., "Type of social support matters for prediction of posttraumatic growth among cancer survivors." *Psychooncology* 19, no. 1 (January 2010): 46-53. doi: 10.1002/pon.1501.

522 Derya Tanriverd, Esen Savas and Ganime Can, "Posttraumatic growth and social support in Turkish patients with cancer." *Asian Pacific Journal of Cancer Prevention* 13, no. 9 (September 2012): 4311-4314. doi: 10.7314/apjcp.2012.13.9.4311

523 Rabee Rahimi, Mehdi Heidarzadeh, and Rahimeh Shoaee, "The Relationship between Posttraumatic Growth and Social Support in Patients with Myocardial Infarction." *Canadian Journal of Cardiovascular Nursing* 26, no. 2 (March 2016): 19 -24.

524 J. Zhai et al., "Post-trauma growth in a mainland Chinese population with chronic skin disease", *International Journal of Dermatology, 53*, no. 4 (2014): 450-7. doi: 10.1111/j.1365-4632.2012.05734.x.

525 K.R. Urcuyo et al., "Finding benefit in breast cancer: Relations with personality,coping, and concurrent well-being," Psychology of Health, 20, no. 2 (2005): 175-192. doi: 10.1080/08870440512331317634.

affect the level of posttraumatic growth. More intense perception of social support leads to a higher number of perceived positive changes[526] . Most authors work with two basic models of the protective effect of social support. The effects model assumes its direct impact on health and subjective wellbeing, for example, through modelling and strengthening of health-supporting behaviour, while, in the *stress inhibition model* (the so-called "buffer" model), it performs a function of a middle variable – "buffer" – which can absorb the adverse impact of aversive stimuli[527]. Social support is directly associated with posttraumatic growth[528]. The dimensions of social support and hope are the factors which influence posttraumatic growth. Perceived social support relates to various forms of help (emotional, instrumental, financial) provided by a network of people (family, friends, neighbours, broad public) in demanding situations39 . A significant correlation between the changes in self-perception and support from family, and the overall social support has been found. The more intensely the patients perceived the social support, the more intensely they perceived the changes in self-perception and in relationships with others[529]. Higher posttraumatic growth is associated with better health[530], mental quality of life and happiness[531].

No significant differences between the patients with shorter and longer period following the completion of treatment were found in relation to the level of posttraumatic growth and posttraumatic stress disorder symptoms. The comparative analyses were performed in cancer patients with respect to the length of the period following the completion of treatment, with 18 months being the criterial point in this regard. The correlation analysis was subsequently performed for both groups of cancer patients. More significant differences in the effect of confirmed relationships were mainly detected in patients 18 months from the completion of their treatment. In this group, moderately strong negative relationships of self-efficacy and optimism with posttraumatic stress disorder symptoms, as well as a weaker negative relationship with social support were found. At this stage, these variables might appear as more significant protective factors in relation to the development of posttraumatic stress disorder, while not necessarily leading to posttraumatic growth, which probably is a rather rare phenomenon. More than five years after a cancer diagnosis, 94.3 % of cancer patients reported "very strong" perception of at least one positive consequence after the stressful experience. Positive correlations between posttraumatic growth and fear of death and psychosocial support during the treatment, as well as with current depression symptoms have been found[532]. The findings suggest[37], that social support from family and

526 M. Pinquart et al., "Social support and survival in patients with acute myeloid leukaemia," *Support Care Cancer, 15*, no. 1 (January 2006): 81 – 87. doi: 10.1007/s00520-006-0114-x.

527 B. Mezuk A.V. Diez Roux and T. Seeman T, „Evaluating the buffering vs. direct effects hypotheses of emotional social support on inflammatory markers: the multi-ethnic study of atherosclerosis," *Brain Behaviour and Immunity. 24*, no. 8 (November 2010): 1294–300, doi: 10.1016/j.bbi.2010.06.006.

528 J. Shakespeare-Finch, J., B. Morris, "Posttraumatic growth in Australian populations." In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (2010): 157–172. John Wiley & Sons Inc.

529 Derya Tanriverd, Esen Savas and Ganime Can, "Posttraumatic growth and social support in Turkish patients with cancer." *Asian Pacific Journal of Cancer Prevention* 13, no. 9 (September 2012): 4311-4314. doi: 10.7314/apjcp.2012.13.9.4311.

530 M. Cohen, M. Numa, ."Posttraumatic growth in breast cancer survivors: A comparison of volunteers and non-volunteers,".*Psycho-Oncology*, *20*, no. 1 (2011): 69–76. https://doi.org/10.1002/pon.1709.

531 Sophie Lelorain, A. Bonnand-Antignac, and Agnés Florin, "Long Term Posttraumatic Growth After Breast Cancer: Prevalence, Predictors and Relationships with Psychological Health." *Journal of Clinical Psychology in Medical Settings,* 17, no. 1 (March 2010): 14-22. doi: 10.1007/s10880-009-9183-6.

532 Diana Christine Maria Gunst , Peter Kaatsch , and Lutz Goldbeck, "Seeing the good in the bad: which factors are associated with posttraumatic growth in long-term survivors of adolescent cancer?" *Support Care Cancer* 24, no. 11 (November 2016): 4607-15. doi: 10.1007/s00520-016-3303-2.

friends in the period following the diagnosing of cancer is an important source which might help with surviving the cancer and find a positive meaning in the cancer experience. Experiencing of emotional support after the cancer diagnosis has been proven to be important in the context of posttraumatic growth 8 years after the diagnosis.

Another analysis was focused on comparation of the selected psychosocial variables – self-efficacy, social support, dispositional optimism – in cancer patients and a control group of adults who were not cancer survivors and cancer patients. The cancer patients were divided into two groups: patients with short (0 – 18 months) versus longer (over 18 months) period following the completion of their treatment. Our findings suggest lower levels of optimism and self-efficacy in patients with shorter period following the completion of treatment as opposed to the control group. At the same time, higher levels of optimism and self-efficacy were reported in the control group in comparison to the group of cancer patients with over 18-month period following their treatment. The results suggest that the period shortly after the completion of treatment is particularly dangerous in terms of the development of psychopathological symptoms. According to Mishel [533], support from the social environment and, ideally, from the healthcare providers is necessary for the uncertainty in the situation of a chronic illness to become a source of growth experience. The author has also described a positive effect of spirituality and personal control factors. The affected individual needs time to focus on themselves and to reassess their own believes; otherwise (e.g. in case of evasive strategies), the process of integration of uncertainty into the new life with illness might stop. An extensive metanalysis of research studies showed general positive effect of self-efficacy on coping with the stressful situation and quality of life in cancer patients[534]. At the same time, a positive relationship with posttraumatic growth, which was mediated by the activation of problem-focused coping, was proven[535].

533 M.Mishel, M. "Reconceptualization of Uncertainty in Illness Theory, " *Journal of Nursing Scholarship, 22*, no. 4 (1990): 256 – 261.

534 A. Chirico et al., " Self-Efficacy for Coping with Cancer Enhances the Effect of Reiki Treatments During the Pre-Surgery Phase of Breast Cancer Patients," *Anticancer Research, 37*, no. 8 (August 2017): 3657-65. doi: 10.21873/anticanreS.11736

535 Z. Bellur, A. Aydýn, E. Alpay, „Mediating role of coping styles in personal, environmental and event related factors and posttraumatic growth relationships in women with breast cancer," *Turkish Journal of Clinical Psychiatry, 21*, no. 1 (2018): 38-51. doi: 10.5505/kpd.2018.65365

Conclusion

The results of the present study show positive correlations between posttraumatic growth and self-efficacy, social support and dispositional optimism. Moderately strong negative relationships of self-efficacy and optimism with posttraumatic stress disorder symptoms, as well as a weaker negative relationship with social support have been detected in patients over 18 months after the completion of cancer treatment. Our findings suggest lower levels of optimism and self-efficacy in patients with shorter period following the completion of treatment as opposed to the control group. There is a need to strengthen social support provided to cancer patients by families, friends, healthcare professionals and other significant persons. Strengthening of personality traits, self-efficacy and optimism when coping with cancer is definitely an important task, especially for patients immediately after the completion of the treatment.

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AUTHOR CONTRIBUTIONS

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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SPIRITUAL ACCOMPANIMENT OF PATIENTS IN PALLIATIVE CARE AFFECTED BY THE COVID-19 PANDEMIC

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Abstract

Introduction: The spiritual impact of COVID-19 on patients in palliative care is significant. Patients in palliative care are among the most vulnerable members of society; they are isolated and worried about their lives and the lives of their loved ones. Spiritual support and care provided by the hospice/palliative team can help to overcome fear and isolation. In the Concept of Health Care in the Field of Palliative Medicine Including Hospice Care, the Ministry of Health of the Slovak Republic listed the tasks of palliative care, including *the integration of psychological and spiritual aspects of patient care.* The members of the palliative team, priests, and clerics from the church or religious society to which the patient belongs can contribute to meeting the patient's needs.

The aim of the research was to find out in what form and how often a spiritual service was provided by the hospice/palliative team to patients during the COVID-19 pandemic.

Methods: In this research, we applied quantitative research strategies including descriptive statistics, and to respond to postulated research questions we used a non-parametric Spearman's correlation coefficient.

Results: The results of this research show that approximately 80 % of hospice workers and palliative care workers who participated in our research provided spiritual care to patients in the following rates: always, often sometimes.

Conclusion: The results of this research showed that hospice and palliative workers did not leave patients without spiritual care. Further and very relevant research in the field of palliative care could be aimed at the level of quality of provided spiritual care.

Keywords: Spiritual accompaniment **–** COVID-19 **–** Patient **–** Palliative care.

Introduction

The health status of patients in palliative and hospice care is very serious and their deep suffering manifests in various dimensions – physical, mental, emotional, social, and spiritual. During the COVID-19 pandemic, patient's fears and worries related to this disease and to isolation from their family members intensified. Mostly the first wave of the pandemic at the beginning of March 2020 was characteristic of misunderstanding and extreme worries about the negative impact of

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the hitherto unknown COVID-19 virus, and uncontrollable human behaviour.[537] In this context, there is an opening space for dialogue that could productively re-enter the game using direct connection to spiritual care in palliative and hospice areas. We should open space for dialogue with the ones with whom we share the same humanity, threats, fears and worries.[538] In addition to the fact that the dialogue may help to address the current value crisis,[539] it is also an important means of spiritual accompaniment, which forms an essential part of caring for palliative patients. A. Roulston points out that spiritual accompaniment complements the comprehensive care of palliative care professionals: Professionals need to establish a respectful relationship full of trust with patients, along with adequate communication skills, so that they can provide information suitable for the patient or family in a respectful way according to the patients' needs.[540]
In relation to the analyses of Roulston[541], Dobríková, Sedliaková,[542] on the importance of re-assessing one's life, recreating a coherent life narrative despite having a serious disease and being able to connect with something that transcends a specific individual,[543] we can state that, in addition to priests, also doctors, nurses, hospital attendants, social workers and volunteers can provide spiritual support or accompaniment to patients, respecting their comfort and wishes. Such spiritual accompaniment has an interpersonal character. For this reason, one of the most important purposes of this research is to address people who work in palliative wards and hospices in various positions. This purpose is followed by the aim of our research, which is to find out how often and in what form did the workers provide spiritual care to patients in hospice/ palliative care patients during the COVID-19 pandemic.

Hospice and palliative care

Hospice care is regulated under Article 7 par. 4 c) of Act No. 578/2004 Coll. on Healthcare providers, health workers and professional organizations in health, amending certain acts, a separate regulation of institutional health care. Under this Act, hospices guarantee patients that they will not suffer unbearable pain, that their human dignity will always be respected, and that they will not be left alone in the last moments of their lives.
Hospice care is palliative care provided to patients with incurable diseases and dying patients by hospices as separate medical facilities. It includes all elements of palliative care: palliative medicine, nursing, psychological, spiritual, respite and terminal care, and care for the bereaved. It can be provided in the form of institutional or outpatient care (the so-called mobile hospice).[544]

537 Lucia Ludvigh Cintulová, Jerzy Rottermund and Zuzana Budayová, "ANALYSIS OF MOTIVATION TO WEAR FACE MASKS IN THE SARS-COV-2 PANDEMIC RELEVANT ALSO FOR THE POST-COVID ERA," *Acta Missiologica* 15, no. 1, (2021): 119. https://www.actamissiologica.com/

538 Martin Dojčár, "Dialogue as a personal tool of integration of migrants," *Acta Missiologica* 14, no.1, (2020): 107. https://www.actamissiologica.com/

539 Dojčár, 107.

540 Audrey Roulston, "The impact of time and communication on professional decision-making regarding patients with advanced lung cancer: Interpretative phenomenological analysis of focus groups with specialist palliative care professionals ," *Acta Missiologica* 15, no. 1, (2021): 22. https://www.actamissiologica.com/

541 Roulston, 22.

542 Patricia Dobríková and Mariana Sedliaková, "Spirituality as a meaning in life facilitator in oncological patients," *Acta Missiologica* 15, no. 1, (2021): 47. https://www.actamissiologica.com/

543 Dobríková, Sedliaková, 47.

544 Koncepcia zdravotnej starostlivosti v odbore paliatívna medicína vrátane hospicovej starostlivosti, č. 17463/OZS, 2006.

Palliative care (WHO, 2002) is an approach that improves the quality of life of patients and their families facing the problems associated with a life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care involves health care provided by doctors (diagnosis and treatment), nursing care, rehabilitation, psychological care, medical-pedagogical care – for children, spiritual care, and social counselling.[545]
The role of palliative care is:

a) to improve the patient's quality of life until death,
b) to provide the patient with relief from pain and other serious symptoms of the disease,
c) to alleviate the patient's suffering and stabilize their state of health,
d) not accelerate or delay death,
e) provide the patient with comprehensive treatment and care by a team of healthcare professionals with professional competence,
f) to integrate psychological and spiritual aspects of patient care,
g) to provide a support system to ensure that the patient's life is as active as possible until death,
h) to provide help to the patient's relatives to cope with problems during the patient's illness and after the patient's death at the time of grieving.[546]

Hospice and palliative care and COVID-19

COVID-19 is an acute disease with clinical manifestations of pneumonia and accompanying respiratory diseases. Typical symptoms are dyspnoea (shortness of breath), cough, weakness, and fever. Other reported symptoms are anxiety, panic, restlessness, and delirium. Patients with rapidly worsening respiratory distress that do not receive intensive care will develop acute respiratory distress syndrome (ARDS) with severe dyspnoea, anxiety, and panic. With such symptoms, prompt intervention and control of the symptoms is required.[547]
Hospices provide healthcare to patients in the terminal stages of the disease. The aim of doctors, medical staff and social workers is to bring relief from pain and to accompany patients to the end with respect for the dignity of each of them. Like other medical facilities, hospices have not avoided the COVID-19 pandemic and its impact. They are struggling with a lack of hygiene supplies, finances, and personnel.[548]

According to the portal of the Archdiocesan Charity in Ko□ice, which is the founder of Mother Teresa Hospice in Bardejovská Nová Ves, this hospice was also affected by COVID-19. Strict quarantine was imposed that practically meant that patients were isolated without any visits from relatives. Quarantine also meant the prohibition of admitting new patients, which meant that the hospice could not lend a helping hand to families that had difficulty taking care of their relatives. This also influenced their funding. The portal optimistically notes that, despite multiple strict quarantine periods and positive patients, they did not stop the continuous accompaniment of the dying in their last moments.[549]

545 Koncepcia zdravotnej starostlivosti v odbore paliatívna medicína vrátane hospicovej starostlivosti, č. 17463/OZS, 2006.

546 Koncepcia zdravotnej starostlivosti v odbore paliatívna medicína vrátane hospicovej starostlivosti, č. 17463/OZS, 2006.

547 L., Chan, KS., Ali Z. Radbruch, *Recommendations for Symptom Control of Patients with COVID19.* In: De Lima L, Pettus K, Downing J, Connor S, Marston J (eds), Palliative Care and COVID19 Series – Briefing Notes Compilation (20-23). Houston (2020) IAHPC Press. Available in (link to eBook) Retrieved (date).

548 See: https://www.charita-ke.sk

549 See: https://www.charita-ke.sk/hospic/

Meeting the patient's spiritual needs

Comprehensive hospice care involves the patient's health, social, mental and spiritual spheres. Satisfying the patient's spiritual needs becomes an urgent and very important part of the entire patient care process. The main responsibility for meeting the patient's spiritual needs is held by the priest, but hospice staff and specially trained volunteers also have an irreplaceable role. Together, they meet the spiritual and mental needs and accompany the patient and his or her family in the last moments of life and support the family even after the patient's death.[550]

In hospices, where urgent clinical symptoms are a priority, COVID-19 caused a crisis of spiritual suffering. The spiritual distress of patients involves existential doubts, struggles with insecurity, despair, hopelessness, isolation, feelings of abandonment from God, or sorrow and need for reconciliation.[551]

Hospice care involves interprofessional spiritual care based on the general specialized model of care where the providers deal with spiritual problems and cooperate with specialists (priests, psychologists, volunteers) in spiritual care to treat spiritual suffering. The studies that support spiritual care show an association of spiritual suffering with the quality of life, endurance of physical pain, depression, and anxiety.[552] Patients often show apathy or aggression and refuse to cooperate with healthcare professionals in various ways.[553]

The spiritual aspect of a person

There is a whole spectrum of views of people, from an extremely materialistic understanding of people as highly developed animate beings to their idealization and spiritualization. Man is neither an animate being nor an angel.[554] Greek philosophy has analysed man as a microcosm which connects the visible world with the invisible. The understanding of man in the Bible is different: man is not understood as being composed of two parts, but as one whole manifested in different ways. His soul has the breath of life inside because man is a living being. Man is a body that indicates he is ephemeral and his internal Spirit means being open to God. In addition, his attitude is constantly changing. In the history of salvation, man is manifested in two basic categories: as a sinner and as a renewed man, as a terrestrial man and a heavenly man.[555]

Greek philosophy distinguished three components of man: *soma* (body), *psyche* (soul), and *nous* (reason), the so-called philosophical trichotomy. This distinction comes from Possidonia, but it was also adopted by Aristotle. We also know St. Paul's trichotomy: *"May the God of peace himself sanctify you completely. May your whole spirit, soul, and body be preserved blameless at the coming of our Lord Jesus Christ."* (1 Thess 5: 23). This is a different trichotomy than that was used by Greek philosophers, and we can see that Saint Paul does not consider *pneuma* to be only a part of the soul, as philosophers stated, but a connection to God. This specific term *pneuma* inspires the distinction between a man who is *psychikos* and one who is *pneumatikos*. According to Origenes, the soul becomes truly spiritual only when it is under the influence of the Holy Spirit. In his interpretation of St Paul's Epistle to the Romans, Zátvornik confirmed this idea and wrote: *"Everything will be completed through the Holy Spirit... A body without soul has no life, the spirit without the Holy Spirit has no spiritual life."*[556]

Spiritual fathers in early Christian times often referred to the following Gospel text: *"for it will not be you speaking, but the Spirit of your Father speaking through you.."* (Mat 10: 20). The word spiritual acquires a special meaning here and the spiritual father is the one in which the Holy Spirit is present because, according to St Paul *"the love of God has been poured forth in our hearts through the Holy Spirit that has been given to us."* (Rom 5:5).[557]

The spiritual life has a decisive influence on our relationship with other people but also towards irrational nature. Hence, the goal of man is spiritualization, which manifests in rational beings in a moral order. In trichotomy, as explained by St. Irenaeus, the Spirit unites with the soul and through the soul with the body to create the perfect man.[558]

Everyone has a spiritual side to their personality, although some people believe that only believers have spiritual needs. Everyone has to deal with feelings of guilt, the need for forgiveness and the meaningfulness of their life.[559] Once in a lifetime, everyone has to ask themselves the question: Who am I? Where do I come from? What is the meaning of my life and where is it going? Man is responsible for his actions.[560]

Spiritual accompaniment

Accompanying in a broader sense means being capable of "being with someone, walking with him, being close to him and not leaving him, giving the gift of own presence during a meeting with other people, being their guide.[561] Accompaniment is rather „a way of existence than a summary of techniques or prescribed instructions for accompaniment".[562] Sometimes the term spiritual guidance is also used. According to Špidlík, spiritual guidance is not a hierarchical, priestly or jurisdictional function. It is the availability of some people to take care of another person□s salvation.[563] In the apostolic exhortation *Evangelii Gaudium*, Pope Francis at several points outlines spiritual accompaniment and refers to it as the "*Art of Accompaniment*" – to remove our sandals before the sacred ground of the other. *"The Church must look more closely and sympathetically at others whenever necessary. In our world, ordained ministers and other pastoral workers can make present the fragrance of Christ's closeness and his personal gaze,"* writes the Holy Father. He notes that

> *"the pace of this accompaniment must be steady and reassuring, reflecting our closeness and our compassionate gaze which also heals, liberates, and encourages growth in the Christian life."* Spiritual accompaniment as such must always lead to God: *"To accompany them would be counterproductive if it became a sort of therapy supporting their self-absorption and ceased to be a pilgrimage with Christ to the Father." He defines a companion*

550 See : https://www.charita-ke.sk

551 Christina Puchalski et al. *Interprofessional Spiritual Care in the Time of COVID19.* In De Lima L, Pettus K, Downing J, Connor S, Marston J (Eds), Palliative Care and COVID19 Series – Briefing Notes Compilation (pp. 29-33). Houston: (2020). IAHPC Press. Available in (link to eBook) Retrieved (date)

552 Puchalski et al. *Interprofessional Spiritual Care,* 29-33.

553 Helena Novotná and Miroslav Kala "Spirituální potřeby a jejich diagnostika v nemoci," *Paliatívna medicína a liečba bolesti* 8(1e), (2015): 23-25.

554 Marián Mráz *Problém utrpenia a jeho riešenie v medicínskej etike,* (Dobrá kniha, Trnava 2000). 61.

555 According to St. Paul, the first Adam is the originator of bodily descendants. The last Adam, that is Christ, God and man, is the originator of spiritual descendants, because he gives people divine life. (Cf. Note to 1. Kor. 15, 45, p. 2414)

556 Špidlík, *Spiritualita křesťanského východu* (Řím – Křesťanská akademie Velehrad 1983), 112-115.

557 Špidlík, *Spiritualita,* 12.

558 Špidlík, *Spiritualita,* 44-45.

559 Mária Hardy, Emília Vranková and Daniela Bachyncová Giertliová, *Komunikácia a hodnota ľudskej dôstojnosti v paliatívnej starostlivosti,* In: HANOBIK, F. et al. (eds.): Zborník z medzinárodnej vedeckej konferencie Quo vadis hospic..., (Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety Bratislava, Bardejov 2012), 148-165.

560 Marián Mraz, *Problém utrpenia,* 61-62.

561 Krzysztof Trębski Counselling ako pomáhajúci vzťah a pastoračné sprevádzanie (Trnavská univerzita v Trnave, Teologická fakulta, 2016), 17.

562 Trębski, *Counselling,* 17.

563 Špidlík, *Spiritualita,* 332.

as a person who "has to realize that each person's situation before God and their life in grace are mysteries which no one can fully know from without." "The whole area of accompaniment – for the accompanied person and the guide – teaches us "to be patient and compassionate with others, and to find the right way to gain their trust, their openness and their readiness to grow."[564]

Accompanying persons in palliative care

In the Apostolic Exhortation *Evangelii Gaudium* – the Joy of the Gospel, Pope Francis characterizes accompanying persons, not only ordained ministers, but also other pastoral workers, as those who *can make present the fragrance of Christ's closeness and his personal gaze"*.[565] Accordingly, Jastrzab notes that the one who seeks help chooses a person of faith who, in spiritual guidance, becomes a companion on the paths of faith. This companion can be a priest, or any person endowed with the special charisma of spirit recognition, empathy, the ability to make a diagnosis, the gift of advice, etc. Spiritual guides are required to have experience in the intellectual-spiritual area. Spiritual guides may include educators, psychotherapists, social workers, and other people, who are able to help spiritually and mentally.[566]
According to Pope Francis, the art of accompaniment means that those who accompany should:

- *make present the fragrance of Christ's closeness,*
- *accompany at the pace reflecting our closeness and our compassionate gaze which also heals, liberates and encourages,*
- *guide to God,*
- *listen, because "listening helps us to find the right gesture and word, which shows that we are more than simply bystanders,"*
- *to realize that each person's situation before God and their life in grace are mysteries which no one can fully know from without,"*
- *not give in to forms of fatalism or cowardice.*[567]

Forms of spiritual care

Patients in palliative care who are aware of the seriousness of their disease primarily need a human being to assist them to cope with their situation. They need the interest of hospice or palliative care workers. In the spiritual service, communication is most important because it opens the way to dialogue. It does not have to be verbal. Even a handshake might be a great encouragement, especially for a person who feels abandoned.[568] Communication opens the way to prayer, which is or can become a great support for the client. As Pope Benedict XVI points out, what a person says in prayer is never lost. It is not a fiction to achieve mental performance or reassurance. Prayer is aimed at reality. If one prays, one transcends and opens up the space for God, where God will be able to act in a sick person and act through a sick person. Praying is an essential need. Through prayer, a dying person can overcome all tensions and gain inner peace.[569] Pastoral practice usually recommends simple prayers that the clients know, so that they can participate in the prayer themselves. One such appropriate prayer is the rosary to the mercy of God.

The sacraments are a very important form of spiritual service. The Catechism of the Catholic Church emphasizes that the sacraments apply to all stages and important moments of human life.[570] Patients in palliative care can receive the following sacraments: the Sacrament of Reconciliation, the Eucharist, and the Anointing of the Sick. An experienced believer whom the sick trusts can prepare the way to these sacraments for the priest. Especially in cases where the continuity of proceeding to the sacraments was interrupted and pastoral preparation (catechesis including basic lessons) is needed.[571] In the Sacrament of Reconciliation, the confessor can give the penitent the courage to have an active approach to the disease. Mental resignation, which manifests in hopelessness and helplessness, makes medical therapy very difficult. Penitents often have the false belief that there is no point in fighting for their lives.
They fall into fatalism that paralyses the will and acts destructively in an institutionalized environment. The confessor should strengthen the belief of the sick that life is God's gift, and that we should accept it and fight for it against the various adversities of fate.[572] The effectiveness of penance lies in restoring God's mercy and it unites the penitent with God in a perfect friendship. Those who receive the Sacrament of Penance with a contrite heart and with religiousness, usually find peace and satisfaction of conscience with strong spiritual consolation.[573]

The sick who are in sanctifying grace can receive the Eucharist that strengthens love inside the sick and unites them more closely with Christ. To those who are leaving this life, Church gives the Eucharist as a *Viaticum* (food for the journey). Receiving Christ's body and blood in this moment of passing to the Father has a special meaning and significance, and according to the Lord's words: *"Those who eat my flesh and drink my blood have eternal life, and I will raise them up on the last day"* (John 6:54).[574]

The sick feel extremely endangered in their disease. The sick often sought Jesus during his earthly life and tried to *"touch him, for there went virtue out of him, and healed them all"* (Luke 6:19). The Lord Jesus instituted the Sacrament of Anointing of the Sick to provide peace and strength to the sick and to give them strength for all the physical and mental struggles on their last journey. Most sick people who find themselves in danger of life intuitively feel that the most important thing for them is to associate with the one who has conquered death and who is the life – Jesus, the Saviour.[575] The celebration of this sacrament consists of anointing the sick with oil on the forehead and hands (in the Roman Rite) or on other parts of the body (in the Eastern Church). The anointing is accompanied by the liturgical prayer of the priest who asks for healing grace on the soul and body of the sick.[576]

Everyone has a spiritual side to their personality, although some people believe that only believers have spiritual needs. Everyone has to deal with feelings of guilt, the need for forgive-

564 POPE FRANCIS, Evangelii gaudium, https://www.vatican.va/content/francesco/de/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html
565 POPE FRANCIS, Evangelii gaudium, https://www.vatican.va/content/francesco/de/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html
566 Jastrzab, Darius. *Spoveď a duchovné vedenie*, In: AUGUSTYN, J.: Umenie spovedať Poradca pre kňazov a laikov, (Dobrá kniha Trnava, Spolok svätého Vojtecha Trnava 2010), 185.
567 POPE FRANCIS, Evangelii gaudium, https://www.vatican.va/content/francesco/de/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html
568 Aurel Štefko, *Dôstojnosť človeka v chorobe, starobe a zomieraní* (Dobrá kniha Trnava 2003), 118.
569 Štefko, *Dôstojnosť človeka,* 122.
570 *Katechizmus katolíckej cirkvi, 1999, Art. 1210.*
571 Štefko, *Dôstojnosť človeka,* 122-123.
572 Augustyn Józef. *Psychoterapia a spoveď*, In: AUGUSTYN, J.: *Umenie spovedať Poradca pre kňazov a laikov,* (Dobrá kniha Trnava, Spolok svätého Vojtecha Trnava 2010), 343.
573 *Katechizmus katolíckej cirkvi, 1999, Art. 1468.*
574 *Katechizmus katolíckej cirkvi, 1999, Art. 1394, 1396, 1524.*
575 *Youcat Katechizmus katolíckej cirkvi pre mladých 2011, Art. 140-142.*
576 Štefko, *Dôstojnosť človeka,* 128.

ness and the meaningfulness of their life.[577] Once in a lifetime, everyone has to ask themselves the question: Who am I? Where do I come from? What is the meaning of my life and where is it going? Man is responsible for his actions.[578]

- Novotná and Kala state that all sick patients that are worried about their lives may need spiritual care in varying degrees. Besides the sick, these questions can also be asked by family members and the personnel. Most people do not want to remain alone with their problems and issues. Potential candidates for spiritual care are often individuals that have mood swings, fear, depression, pessimism, loneliness, negatively evaluate their previous life, future prospects, etc.
- Spiritual care has various forms:
- Staying near the patient's bed – staying silent when the client is silent, contact based on the principle of basal stimulation.
- Giving information – informing about spiritual care and related topics.
- Supportive conversation – changing emotions in case of depression, anxiety and crying.
- Counselling conversation – the issue of relationships (partner, generational).
- Therapeutic conversation – involves existential topics.
- Sacramental service – prayer, reading of spiritual literature, the sacraments.
- Church service – in a dedicated space or directly on the ward.
- Professional contact – consultations with the personnel about the client and his or her spiritual needs.[579]

Research objective

The general objective of this research is to map spiritual service in hospices and palliative care wards during the COVID-19 pandemic.

The partial objectives of this research are to discover:

How often did hospice/palliative care workers provide spiritual care that involved:

1. staying near the patient's bed – staying silent when the client is silent,
2. having contact with the patient – on the basis of basal stimulation,
3. providing information to the patient on spirituality topics,
4. conducting supportive conversation with the patient with negative emotions – depression, anxiety and crying,
5. conducting counselling conversation with the patient – the issue of partner, family, and generational relationships,
6. conducting therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death,
7. providing spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments,
8. attending a church service with the patient – in a dedicated space or directly on the ward,

considering the **gender, age, job classification and the length of employment in the hospice/palliative ward.**

577 Hardy, Vranková and Bachyncová Giertliová, *Komunikácia a hodnota*, 150-151.

578 Mraz Marián. *Problém utrpenia,* 61-62.

579 Helena Novotná and Miroslav Kala "Spirituální potřeby a jejich diagnostika v nemoci," *Paliatívna medicína a liečba bolesti* 8(1e), (2015): 23-25.

Research questions

Research question No.1
How often did the hospice/palliative care workers provide spiritual care that involved staying near the patient's bed – staying silent when the client is silent, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 2
How often did the hospice/palliative care workers provide spiritual care that involved having contact with the patient – on the basis of basal stimulation, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 3
How often did the hospice/palliative care workers provide spiritual care that involved providing information to the patient on spirituality topics, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 4
How often did the hospice/palliative care workers provide spiritual care that involved conducting supportive conversation with the patient with negative emotions – depression, anxiety and crying, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 5
How often did the hospice/palliative care workers provide spiritual care that involved conducting counselling conversation with the patient – the issue of partner, family, and generational relationships, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 6
How often did the hospice/palliative care workers provide spiritual care that involved conducting therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 7
How often did the hospice/palliative care workers provide spiritual care that involved providing spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?
Research question No. 8
How often did the hospice/palliative care workers provide spiritual care that involved attending a church service with the patient – in a dedicated space or directly on the ward, considering their gender, age, job classification and the length of their employment in the hospice/palliative ward?

Research methods

To obtain the necessary information we used the existing available scientific literature and a non-standardized questionnaire. The questionnaire consisted of 12 questions. The first four questions were aimed at finding out information about the respondents regarding their age, gender, length of practical experience and their profession performed in the facility. The following 8 questions focused on the various forms of spiritual care that we monitored. The answers to these questions were designed in the form of the Likert scale: never – sometimes – often – always.

Characteristics of the sample

The research sample consisted of 75 employees of hospices and palliative wards. Their description related to the monitored aspects is given in the following table.

Table 1 Descriptive characteristics of respondents

		N	%
Gender	male	13	17.3
	female	62	82.7
Age category	20 – 25 years	8	10.7
	26 – 35 years	10	13.3
	36 – 45 years	26	34.7
	46 – 55 years	20	26.7
	56 – 65 years	11	14.7
Profession	hospital attendant	12	16.0
	nurse	47	62.7
	social worker	8	10.7
	doctor	7	9.3
	priest	1	1.3
Length of practical experience	up to 1 year	13	17.3
	1 – 3 years	18	24.0
	4 – 6 years	17	22.7
	7 – 10 years	17	22.7
	more than 10 years	10	13.3

Source: own elaboration

N – number

Statistical processing

For the purpose of our research, we used descriptive statistics and the non-parametric Spearman's correlation coefficient in SPSS 22.0.

Results

Table 2 Frequency of respondents' individual responses to aspects of spiritual care provided

Respondents' answers	Frequency/f	Number/N
5. I stay near the patient's bed, I stay silent when the patient is silent	never	9
	sometimes	33
	often	10
	always	23
6. I have contact with the patient – on the basis of basal stimulation	never	10
	sometimes	29
	often	18
	always	18
7. I provide information to the patient on spiritual topics	never	11
	sometimes	31
	often	14
	always	19
8. I conduct supportive conversation with the patient with negative emotions – depression, anxiety and crying	never	2
	sometimes	16
	often	25
	always	32
9. I conduct counselling conversation with the patient – the issue of partner, family, and generational relationships	never	10
	sometimes	33
	often	16
	always	16
10. I conduct therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death	never	11
	sometimes	28
	often	17
	always	19
11. I provide spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments	never	13
	sometimes	29
	often	13
	always	20
12. I attend a church service with the patient – in a dedicated space or directly on the ward	never	36
	sometimes	12
	often	17
	always	10

Source: own elaboration

The frequency of individual answers and the number of respondents to individual answers are given in Table 2. The answers, as noted in the questionnaire, are marked with the numbers 5 – 12. This marking will be used in the interpretation of the results.

Table 3 Significant correlations between the observed aspects found using the Spearman's correlation coefficient

	gender	age	5	6	7	8	9	10	11	12
gender	-									
age		-								
5			-							
6			0.297 sig. 0.010	-						
7		0.312 sig. 0.06	0.266 sig. 0.021		-					
8						-				
9		0.282 sig. 0.014			0.305 sig. 0.008	0.318 sig. 0.005	-			
10					0.385 sig. 0.001	0.355 sig. 0.002	0.599 sig. 0.000	-		
11		0.263 sig. 0.023	0.279 sig. 0.015	0.248 sig. 0.032	0.421 sig. 0.000	0.312 sig. 0.006		0.338 sig. 0.003	-	
12	0.266 sig. 0.021	0.230 sig. 0.047	0.321 sig. 0.005		0.388 sig. 0.001		0.240 sig. 0.038		0.533 sig. 0.000	-

Source: own elaboration

The values found using Spearman's correlation coefficient are given in **Table 3**. The rank correlation coefficient can range from -1 to +1. -1 represents the highest negative and +1 the highest positive correlation. 0 represents no correlation.

Interpretation of the results

We did not find any significant correlations between nominal variables (gender, age, employee status, length of practical experience), therefore we are not reporting their evaluation.

RQ No. 3 How often did the hospice/palliative care workers provide spiritual care that involved providing information to the patient on spiritual topics, considering their age?

Table 4 Providing spiritual care that involved providing information on spiritual topics, considering their age

		f	%		
Age category	20 – 25 years	8	10.7	**The tendency to provide information on spirituality increases with the age of the employee (answer No. 7)**	0.312 sig. 0.06
	26 – 35 years	10	13.3		
	36 – 45 years	26	34.7		
	46 – 55 years	20	26.7		
	56 – 65 years	11	14.7		

Source: own elaboration

In research question No. 3, we wanted to find out how often the hospice/palliative care workers provided spiritual care that involved providing information to the patient on spiritual topics, considering their **age.** The **significant correlation coefficient** 0.312 indicates that we found a positive relation in the sample – the tendency to provide information on spirituality increases with the age of employees.

RQ. No. 5 How often did the hospice/palliative care workers provide spiritual care that involved conducting counselling conversation with the patient – the issue of partner, family, and generational relationships, considering their **age**?

Table 5 Providing spiritual care – conducting counselling conversation – the issue of partner, family, and generational relationships, considering age

		f	%		
Age category	20 – 25 years	8	10.7	**The tendency to conduct counselling conversation increases with the age of the employee (answer No. 9)**	0.282 sig. 0.014
	26 – 35 years	10	13.3		
	36 – 45 years	26	34.7		
	46 – 55 years	20	26.7		
	56 – 65 years	11	14.7		

Source: own elaboration

In research **question No. 5**, we found that the frequency of counselling conversations with the patient increases with the age of employees, which indicates a correlation coefficient of 0.282.

RQ No. 7 How often did the hospice/palliative care workers provide spiritual care that involved providing spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments, considering their gender and age?

Table 6 Providing spiritual care – prayer, reading spiritual literature, mediation of the sacraments, considering gender and age.

		f	%		
Age category	20 – 25 years	8	10.7	**The tendency to provide spiritual service increases with the age of the employee (answer No. 11)**	0.263 sig. 0.023
	26 – 35 years	10	13.3		
	36 – 45 years	26	34.7		
	46 – 55 years	20	26.7		
	56 – 65 years	11	14.7		

Source: own elaboration

In research **question No. 7**, we wanted to find out the correlation between the provision of spiritual care to patients – prayer, reading spiritual literature and the age of employees**.** We found out that the tendency to provide spiritual care increases with the age of employees, which indicates a significant correlation coefficient of 0.263.

Research question No. 8

Is providing spiritual care that involves attending a church service with the patient – in a dedicated space or directly on the ward - related to **gender** and **age**?

Table 7 Providing spiritual care – attending a church service with the patient – in a dedicated space or directly in the department, considering age.

		f	%		
Age category	20 – 25 years	8	10.7	**The tendency to accompany the patient during a church service increases with the age of the employee (answer No. 12)**	0.230 sig. 0.047
	26 – 35 years	10	13.3		
	36 – 45 years	26	34.7		
	46 – 55 years	20	26.7		
	56 – 65 years	11	14.7		
		f	%		
Gender	male	13	17.3	**Women are more likely to accompany patients during a church service than men (answer No. 12)**	0.266 sig. 0.021
	female	62	82.7		

Source: own elaboration

In research question No. 8, we wanted to find out how often the hospice/palliative care workers provided spiritual care that involved attending a church service with the patient – in a dedicated space or directly on the ward, considering their age and gender. The correlation coefficient 0.230 indicates that we found a positive relationship in the sample – the tendency to **accompany the patient during a church service** increases with the age of the employee. Considering gender, we found that **women are more likely to accompany patients during a church service than men –** the **significant correlation coefficient** was 0.266

Table 9 Significant correlations between two ordinal variables found using Spearman's correlation coefficient

Correlation of respondents' answers		Value
5. I stay near the patient's bed, I stay silent when the patient is silent	6. increases when using basal stimulation	0.297 sig. 0.010
	7. increases with the tendency to provide information on spirituality	0.266 sig. 0.021
	11. increases with the tendency to provide spiritual service	0.279 sig. 0.015
	12. increases with the tendency to accompany the patient during a church service	0.321 sig. 0.005
6. I have contact with the patient – on the basis of basal stimulation	11. increases with the tendency to provide spiritual service	0.248 sig. 0.032
7. I provide information to the patient on spiritual topics	9. increases with the tendency to conduct a counselling conversation.	0.305 sig. 0.008
	10. increases in relation to the tendency to conduct therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death	0.385 sig. 0.001
	11. increases in relation to the tendency to provide spiritual service	0.421 sig. 0.000
	12. increases in relation to the tendency to accompany the patient during a church service	0.388 sig. 0.001
8.I conduct supportive conversation with the patient with negative emotions – depression, anxiety and crying	9. increases with the tendency to conduct counselling conversation	0.318 sig. 0.005
	10. increases with the tendency to conduct therapeutic conversation on existential topics about the meaning of life, suffering and death.	0.355 sig. 0.002
	11. increases with the tendency to provide spiritual service.	0.312 sig. 0.006
9. I conduct counselling conversation with the patient – on the issue of partner, family, and generational relationships	10. increases in relation to the tendency to conduct therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death.	0.599 sig. 0.000
	12. increases in relation to the tendency to accompany the patient during a church service	0.240 sig. 0.038
10. I conduct therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death.	11. increases with the willingness to provide spiritual service	0.338 sig. 0.003
11. I provide spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments	12. is associated with the tendency to accompany the patient during a church service.	0.533 sig. 0.000

Source: own elaboration

Table 9 shows significant correlations between the two ordinal variables found using Spearman's correlation coefficient. In employees who state that:

1. They stay near the patient's bed and stay silent when the patient is silent – the tendency to provide basal stimulation (0.297), to provide information about spirituality (0.266), to provide spiritual service (0.248), and to accompany the patient during a church service (0.321) increases with the frequency (sometimes, often, always).

2. They have contact with the patient on the basis of basal stimulation – the tendency to provide spiritual service increases with the frequency (sometimes, often, always) (0.248).

3. They provide information to the patient on spiritual topics – the tendency to conduct counselling conversation (0.308), to conduct therapeutic conversation with the patient on existential topics about the meaning of life, suffering and death (0.385), to provide spiritual service (0.421), and to accompany the patient during a church service (0.388) increases with the frequency (sometimes, often, always).

4. They conduct supportive conversation with the patient with negative emotions – depression, anxiety and crying – the tendency to conduct counselling conversation (0.318), to conduct therapeutic conversation with the patient on existential topics about the meaning of life, suffering and death (0.355), and to provide spiritual service (0.312) increases.

5. They conduct counselling conversation with the patient – the issue of partner, family, and generational relationships – the tendency to conduct therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death (0.599), and to accompany the patient during a church service (0.240) increases.

6. They conduct therapeutic conversation with the patient on existential topics about the meaning of life, suffering and death – the tendency to provide spiritual service (0.338) increases.

7. They provide spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments – the tendency to accompany the patient during a church service (0.533) increases.

Discussion

In our research, we focused on the spiritual accompaniment of patients/clients in palliative care during the COVID-19 pandemic (two waves of the pandemic have been recorded thus far and we are currently facing the third wave).

Every person has spiritual needs. Novotná and Kala (2015) emphasize that it is not easy to recognize the spiritual needs of a sick person. They are often masked by different behaviours. Moreover, the spiritual needs of patients who stand outside the religious system of the church and religious organizations are hardly recognizable whilst in general contact with the patient.[580] For this reason, we aimed at spiritual care in a broader sense. We also had in mind the personnel

580 Helena Novotná and Miroslav Kala "Spirituální potřeby a jejich diagnostika v nemoci," *Paliatívna medicína a liečba bolesti* 8(1e), (2015): 23-25.

who can carry out spiritual accompaniment. According to Jastrzab, spiritual guides can be educators, psychotherapists, social workers, or nurses[581]. Our research sample consisted of people who come into direct contact with palliative patients (hospital attendants – 12, nurses – 47, social workers – 8, doctors – 7, priest – 1).

Our research was aimed at finding out how frequently spiritual care was provided in hospices and palliative wards. Since we aimed at the spiritual ministry more broadly, we asked the respondents how often they: stayed near the patient's bed – staying silent when the client was silent; have contact with the patient on the basis of basal stimulation; provide information to the patient on spiritual topics; conducted supportive conversation with the patient with negative emotions – depression, anxiety and crying; conducted counselling conversation with the patient – the issue of partner, family, and generational relationships; conduct therapeutic conversation with the patient on existential topics about the meaning of life, suffering and death; provide spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments; and, attend a church service with the patient – in a dedicated space or directly on the ward.

Based on the research findings we can state that in the frequency always, often, sometimes, from the research sample of 75 respondents:

1. 19 – 66 respondents (88%) stayed near the patient's bed (staying silent when the client was silent) during the COVID-19 pandemic. According to Galbadage Thusara et al., COVID-19 causes social distancing and makes it impossible for the family members to visit patients in hospices or palliative wards. Hence, the presence of personnel near the patient's bed is extremely important.[582]

2. 19 – 65 (87%) respondents had contact with the patient – on the basis of basal stimulation during the COVID-19 pandemic. Basal stimulation in the spiritual area is important, because it stimulates verbal and non-verbal communication to induce pleasant feelings and experiences on a sensory level (basal stimulation may involve, for example, favourite religious songs, photos, etc.)

3. 19 – 64 (85.4%) respondents provided information to the patient on spiritual topics during the COVID-19 pandemic. In their study, Novotná and Kala (2015) state that the assessment of spiritual needs should be performed after first establishing a relationship with the patient. For the assessment, we need to master the art of conducting conversation, having a personal interest in the patient and his or her life, and being aware that we cannot press on the patient and assume that we are entitled to such information. Anxiety, sadness, lack of hope, peace, love and forgiveness, losing the meaning of life in sickness, anger or unwillingness to cooperate are among the guiding elements for determining the problem in the spiritual area. In practice, however, the assessment of spiritual needs is neglected and considered a completely personal matter involving only the believing patients.[583] In their study, Puchalski Christina et al. noted that appropriately trained staff can provide qualified spiritual support to patients and families. They recommend

581 Jastrzab, Dariusz. Spoveď a duchovné vedenie, 185.

582 Thushara Galbadage, Brent M. Peterson, David C. Wang, Jeffrey S. Wang and Richard S. Gunasekera. (2020). Biopsychosocial and Spiritual Implications of Patients With COVID-19 Dying in Isolation. Front. Psychol. 11:588623. doi: 10.3389/fpsyg.2020.588623

583 Helena Novotná and Miroslav Kala "Spirituální potřeby a jejich diagnostika v nemoci," *Paliatívna medicína a liečba bolesti* 8(1e), (2015): 23-25.

that staff complete training aimed at spirituality, active listening, sympathetic presence, prayer and sharing the sacred moment.[584] This topic relates to **RQ No. 3**, where we found that the tendency to provide information on spirituality increases with increasing age. The veracity of this finding lies in the fact that with increasing age more experience is gained in the spiritual field.

4. 65 respondents (87%) **conducted supportive conversation with the patient with negative emotions – depression, anxiety and crying** during the COVID-19 pandemic. In their study, Riahi Somayeh et al. state that the development of spiritual care provided by nurses and other personnel had positive results, i.e. increased patient satisfaction with care, decreased anxiety and depressive symptoms during hospitalization and generally improved quality of life.[585]

5. 73 respondents (97,4%) conducted counselling conversation with the patient – the issue of partner, family, and generational relationships during the COVID-19 pandemic. According to Downing Julia et al., counselling conversation is one of the non-pharmacological measures. The result of this conversation is better pain control, and positive thinking despite the pain and disease.[586] This topic is associated with **RQ No. 5**, where we found that the frequency of the counselling conversation with the patient increases with the age of the employee, which indicates a correlation coefficient of 0.014.

6. 64 respondents (85,4%) conducted therapeutic conversation with the patient – on existential topics about the meaning of life, suffering and death during the COVID-19 pandemic. In their study, the authors Novotná and Kala point out that the most important aid in the spiritual area is talking to the patient. The sick often remain alone with their worries and fears, and most healthcare workers and relatives do not have the courage to start conversations about existential questions with them.[587] In this case, it is very good if the conversation on existential topics is taken over by a priest who performs the Good Shepherd's service or the Good Samaritan service[588]

7. 62 respondents (82.7%) provided spiritual service to the patient – prayer, reading spiritual literature, mediation of the sacraments during the COVID-19 pandemic. The faith of the sick goes through a test period but also a period of extraordinary grace. Faith allows Christians to draw deep into the well of consolation and hope in a very specific way. The sick have the opportunity to satisfy their spiritual needs by assuming the sacraments. Vertical communication and belief in something beyond them fill patients with spiritual content and it helps to manage their situation. On the one hand, the sick long for healing; on the other hand, their faith helps them to accept the situation, it helps to give it meaning. Physical and internal healing is not reserved just for a few lucky ones. A person sincerely rooted in God and one who pushes God out of their life, can also intensify the inner monologue during the disease, communicate through prayers and ask for healing. The answer to prayer is a mystery. They may think that God does not answer them but the answer can be found in God's apparent silence. Only after some time will they realize that the silence is the answer.[589]

The above question that we asked the respondents is related to **RQ No. 7**, in which we examined the relationship of providing spiritual care to patients – prayer, reading spiritual literature - with the age of the employee. We found out that the tendency to provide spiritual service increases with the age of the employee, which indicates a correlation coefficient of 0.023.

8. 39 respondents (52%) accompanied the patient during a church service – in a dedicated space or directly on the ward during the COVID-19 pandemic. We are aware that if patients have the opportunity to visit the chapel and be able to physically attend church services, it is beneficial for their spiritual life. The research showed a relatively low number of hospice and palliative workers who accompanied patients during a church service, but this has a logical explanation because church services during the first and second wave of COVID-19 were limited and at some point prohibited. Patients had the opportunity to watch services through the media. The topic of accompanying the patient during a church service relates to **RQ No. 8.** We wanted to find out how often the hospice/palliative care workers provided spiritual care that involved attending a church service with the patient – in a dedicated space or directly on the ward, considering their gender and age. We found that the increasing tendency to **accompany the patient during a church service** was associated with age and, considering gender, we discovered that the tendency **to accompany a patient during a church service was higher in women than in men.**

Our research suggests the following recommendations for practice:

We want to emphasize that it is very important to stay near the patient's bed and stay silent when the patient is silent. When applying this approach, personnel show interest in the patient. The Apostle Paul described a similar approach: "Rejoice with those who rejoice, weep with those who weep!" (Rom 12:15).

Regarding the provision of information on spirituality, it is important that the workers are true and speak simply. On topics to which we don't know the answer, we should honestly say that we don't know, and we can recommend another person who we assume will be able to respond to the patient's question.

Regarding negative emotions, we found that 87% of personnel (always, often, sometimes) conducted supportive conversation. During the COVID-19 pandemic, patients needed to overcome the feeling of isolation. Supportive conversation as a strategy for managing loneliness and fear is extremely important. The authors of the study entitled *Spiritual care in critically ill patients during the COVID-19 pandemic*, De Diego-cordero, Lopez-Gómez, Lucchetti, Badanta (2021) state that in Spain nurses were responsible for providing spiritual care to their patients. Although

584 Christina Puchalski et al, *Interprofessional Spiritual Care in the Time of COVID19*. In De Lima L, Pettus K, Downing J, Connor S, Marston J (eds), Palliative Care and COVID19 Series – Briefing Notes Compilation (pp. 29-33). Houston: (2020). IAHPC Press. Available in (link to eBook) Retrieved (date).

585 Riahi Somayeh, Fateme Goudarzi, Shirin Hasanvand, Hasan Abdollahzadeh, Farzad Ebrahimzadeh, Zahra Dadvari. Assessing the Effect of Spiritual Intelligence Training on Spiritual Care Competency in Critical Care Nurses. Journal of Medicine and Life, 11(4), 346–354. https://doi.org/10.25122/jml-2018-0056.

586 Downing Julia, et all. Symptom Control at the End of Life in Children with COVID19 Infection. In De Lima L, Pettus K, Downing J, Connor S, Marston J (Eds), Palliative Care and COVID19 Series – Briefing Notes Compilation (pp. 39-43). Houston: (2020). IAHPC Press. Available in (link to eBook) Retrieved (date).

587 Helena Novotná and Miroslav Kala "Spirituální potřeby a jejich diagnostika v nemoci," *Paliatívna medicína a liečba bolesti* 8(1e), (2015): 23-25.

588 Peter Vansač, "Duchovné sprevádzanie osôb s psychickými poruchami," *Theologos* 17, No. 1/2015: 187-197.

589 Peter Vansač Duchovná služba v paliatívnej a hospicovej starostlivosti, In Laca, S., Dancák, P., Laca, P. (ed.): "Spolupráca pomáhajúcich profesií v paliatívnej a hospicovej starostlivosti ," in: Zborník z medzinárodnej vedeckej konferencie, (Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety Bratislava, Detašované pracovisko Kráľovnej Pokoja z Medžugoria Bardejov 2011), 317-326.

they generally believe that spirituality is important for treatment and helps patients to cope with the disease, they stated that they were not trained to handle this type of care. They also described work overload, a lack of time and training as the reasons for limited spiritual care.[590] We recommend that employers organize courses regarding the topic of spiritual care for patients in palliative care.

Conclusion

Spirituality has always been considered a basic dimension of hospice patient care, especially during the COVID-19 pandemic. The results of our research support the role of spirituality in hospices and palliative wards. We studied how often employees in the positions of nurse, hospital attendant, social worker, doctor and priest provide spiritual care to their patients. The results of the research showed that approximately 80% of employees provided spiritual care during the first and second wave of the COVID-19 pandemic. The quality of the provided spiritual care was not one of the objectives of this research. This field should be studied in other research studies, since palliative care is a very important and popular topic.

Author Contributions

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

Conflict of interest

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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CASTE-BASED PREJUDICE AMONG THE STUDENTS IN A MISSIONARY COLLEGE IN NEPAL

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Abstract

Background: Caste-based prejudice and discrimination are entrenched in all spheres of life in Nepal with pernicious consequences. Education has an important role in eradicating prejudices of all kinds. This study investigates if a Jesuit college in Nepal has been successful in removing caste-based prejudice from its students. It is important to engage in conversations regarding caste-based prejudice, analyze it and find ways to end it because caste-based prejudice and discrimination not only add distress to those who experience them but also negatively impact the education, occupation, economic and health outcomes of a society at large.

Methods: Using a 24-itme scale this study measured the level of caste-based prejudice prevalent among the students in a Jesuit college in Nepal. The scale was administered in the form of a survey questionnaire that was sent via email to the students in their college-designated personal emails. Using the Likert scale, each item was set to measure disagreement or agreement with seven choices available to the respondents ("strongly disagree", "disagree", "somewhat disagree", "neither agree nor disagree", "somewhat agree", "agree" and "strongly agree"). These responses were then assigned numerical values from 1 to 7, with a high score of 7 corresponding to the strongest agreement to a prejudiced attitude. The total score of each respondent was computed by summing up the individual scores for each of the 24 items. Statements to measure non-prejudiced attitudes were reverse coded so that the strongest acceptance of such a statement produced the lowest numerical value in the total prejudice score. SPSS version 21 was used for statistical analysis of the data.

Results: The overall prejudice level was found to be low (M = 58.46, SD = 12.73, N =950). There were no significant variances in the prejudice scores with respect to the gender, caste, religion, family, region and school of the respondents. Moreover, the education level of the parents made little difference as far as the variances in the mean scores of the prejudice level of the respondents were concerned.

Conclusion: The results suggest that the goal of Jesuit education in removing caste-based prejudices among the students is being met in Nepal and that caste-based prejudice and discrimination are on the decline in Nepali society at large. However, further research needs to be undertaken to confirm that the reported low score is indeed due to the impact of activities specifically geared to reduce the caste-based prejudice among its students by the college. Additional investigations are necessary to ascertain that the low level of caste-based prejudice reported does indeed translate into non-casteist behaviors.

Keywords: Caste-based prejudice **–** Jesuit college **–** Nepal.

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Introduction

Nepal is a landlocked country wedged between China and India with a population of 26.5 million in 2011. Till 2007, Nepal was the only constitutionally declared Hindu nation in the world. The interim Constitution (2007-2015) repealed the tag of the Hindu nation; and a new Constitution in 2015 declared Nepal as a secular, inclusive, democratic, socialism oriented, federal democratic republican state. Despite the change in the nature of the Constitution, in all aspects Nepal is still a Hindu state with over 81.4 % of the population practicing Hinduism and 9.04% practicing Buddhism; Muslims account for 4.38%, Animistic religious practitioners 3.04% and Christians 1.41 % of the total population.[593]

One of the defining features of Hinduism is the caste system.[594] A caste is a hierarchized and ascribed social category which is "exclusive - no one belongs to more than one group - and exhaustive - everyone belongs to some group."[595] Caste membership is hereditary and caste relationships are characterized by endogamy, separation/repulsion and the division of labor based on hereditary specialization.[596]

Perhaps the most ubiquitous feature of the caste system is the "group-based" ranking of people which ascribes them with "superior" and "inferior", "upper" and "lower", "pure" and "impure" and "pollutable" and "non-pollutable" status.[597] In Nepal, at the top of the caste hierarchy are the Brahmin groups followed by the Chhetri (known as Kshatriyas in India) groups who together consist of 32% (31.2% in the Hills and 0.8% in the Plains known as the Madhes) of the total population.[598] At the bottom of the caste hierarchy lie the Dalits, who were historically known as the "untouchables", who constitute 12.6% (8.1% in the Hills and 4.5% in the Madhes) of the total population.[599] In between these two opposite ends of the caste hierarchy lie the Janjati/Adivasi groups (ethnic/indigenous nationalities) who were appropriated to the caste system and were graded through legal promulgations.[600] They constitute 35% (27.7% in the Hills and 7.7% in the Madhes).[601] Alongside the ethnic/indigenous nationalities in the caste hierarchy are placed a con-

593 Dilli Dahal, "Social Composition of the Population: Caste/Ethnicity and Religion in Nepal," in *Population Monograph of Nepal, Vol.2: Social Demography*, (Kathmandu: Central Bureau of Statistics, 2014), d, https://nepal.unfpa.org/sites/default/files/pub-pdf/Population%20Monograph%20V02.pdf

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598 Dahal, "Social Composition," 4.

599 Dahal, "Social Composition," 4.

600 Höfer, *The Caste Hierarchy*,7-10.

601 Dahal, "Social Composition," 4.

glomeration of groups referred to as the Vaisya in the conventional *Varna* division of caste.[602] In Nepal, these groups form 14.5% of the total population and are concentrated in the Madhes.[603]

In caste-based societies, occupational mobility, inter-caste marriages, and inter-dining are generally seen as the strongest predictors of the prevalence of caste-based prejudices and discrimination or their enfeeblement.[604] Available scholarship related to these three predictors in Nepal attest to the persisting tenacity of caste-based prejudices.[605]

The Society of Jesus, also known as the Jesuits, has been involved in education apostolate in Nepal since 1952. While proselytization has never been an objective of Jesuit mission in Nepal, the Jesuits have tenaciously worked towards forming their students as men and women of conscience, compassion and commitment besides making them competent[606]. Unsurprisingly, a morally upright conscience, empathy for one's neighbor and self-less commitment to build up one's society are diametrically opposed to the nature of the caste system.

Using a reworked version of the Blatant and Subtle Prejudice Scale developed by Pettigrew and Meertens,[607] this study measures the level of caste-based prejudice prevalent among the students in a Jesuit college in Nepal. This study is relevant for three main reasons. First, the level of prejudice present in a Jesuit college is an indicator of the level of its success in forming men and women of conscience, compassion and commitment. Second, the level of prejudice prevalent in college-going students is an indicator also of the level of prejudice existing in society at large; and this knowledge is crucial because prejudice is the most visible expression of intolerance and discrimination. Studies done in caste-based societies have testified that caste-based prejudices and discrimination not only add distress to those who experience them but also negatively impact

602 MN Srinivas, "Some Reflections on the Nature of Caste Hierarchy," *Contributions to Indian Sociology* 18, no.2 (1984): 153–154, https://doi.org/10.1177/006996678401800201; McKim Mariott, "Varṇa and Jāti," in *The Hindu World*, eds. Sushil Mittal and Gene Thursby (New York: Routledge, 2005), 359-360.

603 Dahal, *Social Composition*, 4.

604 André Béteille, "The Peculiar Tenacity of Caste," *Economic and Political Weekly* 47, no.13 (March, 2012): 42, https://www.jstor.org/stable/23214709

605 Ivan Deschenaux, "The Resilience of Caste: Dalits, Psychological Essentialism and Intercaste Marriage in the Himalayan Foothills of Eastern Nepal" (PhD diss., London School of Economics, 2019); Anne Parker, *Multi-ethnic Interface in Eastern Nepal: Culture Change in Siddha Pokhari* (Kathmandu: Himal Books, 2013); Mom Bishwakarma, "Democratic Politics in Nepal: Dalit Political Inequality and Representation," *Asian Journal of Comparative Politics* 1, no.12 (2016): 1-12, https://doi.org/ 10.1177/2057891116660633; Steven Folmar, "Problems of Identity for Hill Dalits and Nepal's Nationalist Project," in *Nationalism and Ethnic Conflict in Nepal: Identities and Mobilization after 1990*, eds. Mahendra Lawoti and Susan Hangen (London: Routledge, 2013), 85-101; David Gellner and Krishna Adhikari, "Introduction: Nepal's Dalits in transition," *Contributions to Nepalese studies* (December 2019): 1-9, https://www.researchgate.net/publication/344659216; Amar BK, *The Stigma of the Name: Making and Remaking of Dalit Identity in Nepal* (Kathmandu: Social Science Baha, 2013); Espen Villanger, "Caste Discrimination and Barriers to Microenterprise Growth in Nepal," *Chr. Michelsen Institute WP* no.9 (November 2012):1-29, https://www.cmi.no/publications/file/4606-caste-discrimination-and-barriers-to.pdf; Ram Mainali, Saqib Jafarey, and Gabriel Monte-Rojas, "Earnings and Caste: An Evaluation of Caste Wage Differentials in the Nepalese Labor Market," *The Journal of Development Studies* 53, no.3 (March 2016): 396-421, https://doi.org 10.1080/00220388.2016.1189535

606 Society of Jesus, *Ignatian Pedagogy: A Practical Approach*, https://www.sjweb.info/documents/education/pedagogy_en.pdf.

607 Thomas Pettigrew and Roel Meertens, "Subtle and Blatant Prejudice in Western Europe," *European Journal of Social Psychology* 25 (1995): 57-75, https://doi.org/10.1002/ejsp.2420250106

the education, occupation, economic and health outcomes of a society at large.[608] Therefore, self-reflecting societies must continually look for interventions to decrease prejudices so that social cohesion and well-being of all may prevail.[609] Third, there is a dearth of comprehensive quantitative studies that measure the extent of caste-based prejudice in Nepal. This study hopes to take a few steps in filling this lacuna in scholarship on caste in Nepal.

The rest of this article begins with a summary of the literature review which includes a brief description of the nature of prejudice in the tradition of Gordon Allport[610] and the nature of caste and caste-based prejudice in Nepal. The purpose of the study and its methodology follow. The penultimate section reports the results of the data analysis. The article concludes with a discussion of the findings and suggestions for future research.

Literature Review

Gap in Literature

Various studies point to an extensive prevalence of caste-based prejudices and discrimination in Nepal. These include ethnographic studies,[611] interviews,[612] historical reviews,[613] analysis of national surveys,[614] focus group discussions,[615] and personal narratives.[616] However, there is a lack of empirical quantitative studies measuring the level of caste-based prejudice in Nepali society.[617] Besides, most of the studies on caste-based prejudice and discrimination have been

608 Amit Thorat and Omkar Joshi, "The Continuing Practice of Untouchability in India: Patterns and Mitigating Influences" (Paper, Population Association of America Annual Meeting, 2015), 1-24, https://paa2015.princeton.edu/papers/153481#:~:text=Art.,punishable%20in%20accordance%20with%20law; Sukhadeo Thorat, Paul Attewell, and Firdaus Rizvi, "Urban Labour Market Discrimination," *Indian Institute of Dalit Studies: Working Paper Series* 3, no.1 (2009): 1-25. http://www.dalitstudies.org.in/download/wp/0901.pdf; Amit Thorat, Reeve Vanneman, Sonalde Desai, and Amaresh Dubey, "Escaping and Falling into Poverty in India Today," *World Development* 93 (2017): 413-426. https://doi.org/10.1016/j.worlddev.2017.01.004 dx.doi.org/10.1016/j.worlddev.2017.01.004; Ashwini Deshpande, "Caste Discrimination in Contemporary India," in *Inequality and Growth: Patterns and Policy, Volume 2: Regions and Regularities*, eds. Kaushik Basu and Joseph Stiglitz (London: Palgrave Macmillan, 2016), 248-273; Amit Thorat, Diane Coffey, Payal Hathi, and Nidhi Khurana, "Explicit Prejudice: Evidence from a New Survey," *Economic and Political Weekly* 53, no.1 (2018): 46-54.

609 Andreas Zick, Beate Küpper, and Andreas Hövermann, " Intolerance, Prejudice and Discrimination: A European Report" (Berlin: Friedrich-Ebert-Stiftung, 2011), 34-35, https://library.fes.de/pdf-files/do/07908-20110311.pdf

610 Gordon Allport, *The Nature of Prejudice* (Cambridge: Addison-Wesley, 1954).

611 Deschenaux, "The Resilience of Caste," 2019; Parker, *Multi-ethnic Interface*, 2013.

612 Damodar Khanal, "The Quest for Educational Inclusion in Nepal: A Study of Factors Limiting the Schooling of Dalit Children" (PhD diss., University of Manchester, 2015, http://103.69.125.248:8080/jspui/bitstream/123456789/127/1/Damodar%20Khanal%20Phd%20thesis.pdf.

613 Bishwakarma, "Democratic Politics in Nepal," 2016.

614 Mainali, Jafarey, and Monte-Rojas, "Earnings and Caste," 2016.

615 Bhawan Chalaune, "Dalit Student's Perceptions and Experiences of Caste-based Discrimination in Nepalese Schools," *International Journal of Research-Granthaalayah* 8, no.8 (August 2020): 147-154, https://doi.org/10.29121/granthaalayah.v8.i8.2020.977

616 Lila Bishwakarma, "Caste-based Discrimination in Schooling: A Narrative Inquiry," *Nepalese Journal of Development and Rural Studies* 14, no.1-2 (2017): 56–62, https://doi.org/10.3126/njdrs.v14i1-2.19648

617 United Nations, *Literature Review on Harmful Practices in Nepal* (Kathmandu: UN, 2020), 6, https://nepal.unfpa.org/sites/default/files/pub-pdf/Literature%20Review%20on%20Harmful%20Practices%20in%20Nepal.pdf

done from the perspective of the Dalits. Moreover, no standardized study has been done to measure the level of caste-based prejudice prevalent in the college-going youth in Nepal.

The Nature of Prejudice

The Allport-ian tradition of prejudice research describes prejudice and discrimination as negative, unjustified, and exclusionary attitudes and behaviors towards groups and individuals based on their membership in a group.[618]According to this line of scholarship, in matters of prejudice, the most significant factor is the prejudiced person's categorization of someone as belonging to a particular outgroup. Prejudices, thus, are "group-based" and "group-focused"[619] social attitudes and, as such, have cognitive, affective and behavior-related dimensions.

According to Pettigrew and Meertens, prejudices towards outgroups can be both blatant or explicit and subtle or implicit.[620] While blatant prejudice is markedly visible through one's words and actions and "as a rule express clearly negative generalized attitude,"[621]subtle prejudice is less visible and "often involve attributions of blame, where groups are told that their own behaviour is responsible for prejudices,"[622] and violence against them. Both blatant and subtle prejudices share similar negative attributions towards the outgroups, such as, stupidity, laziness, uncleanliness, physical weakness and psychological instability, criminality, deviousness and slyness; and both have significant and detrimental negative consequences for their targets.[623]

Blatant prejudice is often found in the belief in the inherent inferiority of the outgroup.[624] Such beliefs act as legitimizing ideologies[625] that aid the superior groups to "explain away any outgroup disadvantage in the society and thus denies that discrimination exists."[626] Another component of blatant prejudice is an opposition to intimate contact with the outgroup.[627] Opposition to intimate contact also reflects a power relation between the two groups, resulting generally, with the members of "superior groups" refusing to work under the supervision of a "lower group" member or denying the "lower groups" access to social, political and economic opportunities. Subtle prejudices operate more covertly.[628] Pettigrew and Meertens list three components of subtle prejudice:

618 Allport, *The Nature of Prejudice*, 1954; Frances Aboud, "The Developmental Psychology of Racial Prejudice," *Transcultural Psychiatric Research Review* 30, no.3 (1993):229-242, https://doi.org/10.1177/136346159303000303

619 Zick, Küpper, and Hövermann, "Intolerance, Prejudice and Discrimination," 29.

620 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 58.

621 Zick, Küpper, and Hövermann, "Intolerance, Prejudice and Discrimination," 31.

622 Zick, Küpper, and Hövermann, "Intolerance, Prejudice and Discrimination," 31.

623 John Dovidio , Adam Pearson, and Samuel Gaertner, "The Nature of Contemporary Prejudice: Insights from Aversive Racism," *Social and Personality Psychology Compass* 3 (2009): 3-8, https://doi.org/ 10.1111/j.1751-9004.2009.00183.x; Zick, Küpper, and Hövermann, "Intolerance, Prejudice and Discrimination," 36.

624 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 58.

625 Sarah Cotterill, James Sidanius, Arjun Bhardwaj, and Vivek Kumar, "Ideological Support for the Indian Caste System: Social Dominance Orientation, Right-Wing Authoritarianism and Karma," *Journal of Social and Political Psychology* 2, no.1 (June 2014):99, https://doi.org/ 10.5964/jspp.v2i1.171.

626 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 58.

627 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 58.

628 John Dovidio and Samuel Gaertner, "Aversive Racism," *Advances in Experimental Social Psychology* 36 (2004): 1-52, https://doi.org/10.1016/s0065-2601(04)36001-6; Calvin Lai, Kelly Hoffman, and Brian Nosek, "Reducing Implicit Prejudice," *Social and Personality Psychology Compass* 7, no.5 (2013): 315-330,https://doi.org/ 10.1111/spc3.12023

the defense of traditional values by the "superior groups", the exaggeration of cultural differences by them and the denial of positive emotions towards "lower groups."[629]

The Nature of Caste-based Prejudice in Nepal

In its most explicit form, caste-based prejudice is manifested through the practice of untouchability, directed in varying degrees towards those on the lower rungs of the caste hierarchy.[630] In Nepal, the Dalits who are on the lowest rung of caste hierarchy are the worst sufferers of untouchability.[631] Untouchability means, firstly, that as "untouchables," the Dalits "should not be looked at (un-seeable); secondly, that they should not be approached (unapproachable); and thirdly, that they should not be touched (untouchable)."[632] Over 200 forms of caste-based prejudice and discriminatory practices against the Dalits have been documented in Nepal.[633] Some of these practices include denial of entry to the common places of worship, eating and work and into the houses of the "higher castes"; residential segregation of the Dalits' living quarters outside the main part of the villages; denial of access to common resources like drinking water sources, community forests, public health services and crematory sites; physical segregation and humiliation during festivals, marriage processions and funerals; and threat, violence and murder when the Dalits attempt to have inter-caste marriage relationships, especially with the "upper castes." Studies on caste in Nepal have recorded these and other blatant caste-based discriminatory practices against the Dalits in large measure.[634]

Another common way caste-based prejudices find expression is through derogatory name calling and group stigmatizing. This type of prejudice is directed at all caste groups and is largely related to the cultural traits of certain groups or their occupation. For example, the Brahmins are "crafty" and "spongers" and the Magars (an ethnic group) are "dangerous people" and "prone to violence."[635] The Gurungs (an ethnic group) are "sheep"[636] and the Dalits are "dirty", "water polluting", "untouchable" and "low caste,"[637] "naturally dishonest", and "incorrigible."[638]

629 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 58-59.

630 Thorat et al., "Explicit Prejudice," 46-54; Suraj Yengde, *Caste Matters* (Haryana: Penguin Random House, 2019).

631 Krishna Bhattachan, Tej Sunar, and Yasso Bhattachan, "Caste-based Discrimination in Nepal," *Indian Institute of Dalit Studies: Working Paper Series* 3 (2009): 1-50, https://idsn.org/wp-content/uploads/user_folder/pdf/New_files/Nepal/Caste-based_Discrimination_in_Nepal.pdf; Surinder Jodhka and Ghanshyam Shah, "Comparative Contexts of Discrimination: Caste and Untouchability in South Asia," *Economic and Political Weekly* 45, no.48 (2010): 102-103.

632 Kurmana Chalam, *Caste-based Reservations and Human Development in India* (Los Angeles: Sage Publications, 2007), 75.

633 Bhattachan, Sunar, and Bhattachan, "Caste-based Discrimination in Nepal," 11-13.

634 Deschenaux, "The Resilience of Caste"; Parker, *Multi-ethnic Interface*, 69-74; Bishwakarma, "Democratic Politics in Nepal"; Folmar, "Problems of Identity," 85-117; United Nations, "Literature Review on Harmful Practices," 13-16.

635 Casper Miller, *Decision-Making in Village Nepal* (Varanasi: Pilgrims, 2000), 101.

636 Yuji Yamamto, "The Sukumbasi Transformation from Communitas to Community: The Birth and Death of 'Proto-Charisma' among Squatters in Pokhara, Nepal," in *Social Dynamics in Northern South Asia, Volume 1: Nepalis Inside and Outside Nepal*, eds., Hiroshi Ishii, David Gellner, and Katsuo Nawa (New Delhi: Manohar), 135.

637 Jodhka and Shah, "Comparative Contexts of Discrimination," 4-7.

638 Yamamoto, "The Sukumbasi Transformation," 135; Deschenaux, "The Resilience of Caste," 164-165.

Subtle caste-based prejudices also take various forms, such as, blaming the "lower caste" for their own plight, the perception of "lower caste" groups as acting in unacceptable ways and not working hard enough to succeed, the perception that the "lower caste" groups have no cultural values and practices, exaggerating "upper castes" perceived cultural superiority and forming gross stereotypes about the "lower castes", and a denial to express positive emotional responses towards the "lower caste" groups.

Purpose of the Study

Using a modified version of the Blatant and Subtle Prejudice Scale developed by Pettigrew and Meertens,[639] the present study aims to investigate the level of caste-based prejudice among the students in a Jesuit college in Nepal.

Methodology

Operationalization of the Terms

In the present study, the terms caste-based prejudice and discrimination are used to describe prejudices and discrimination carried, expressed and perpetuated by a member of a particular caste in regard to the member(s) of another caste, on the basis of that person's belonging to another caste, which lead to unfair or unequal treatment of that person and other members of that person's caste, their oppression and exploitation.

Blatant and Subtle Caste-based Prejudice (BSCP) Scale

The Pettigrew and Meertens Scale to measure blatant and subtle prejudices have been modified and used in a variety of contexts.[640] Like other modified versions of the same, the BSCP scale also was created based on similar assumptions: (1) caste-based prejudice can have two forms, blatant and subtle; (2) both types of prejudice can be distinguished and measured; and (3) both forms of prejudice are correlated.

The BSCP scale was evaluated by a four-member panel of scholars on an adequacy scale ranging from "absolutely inadequate", "inadequate", "slightly inadequate", "neutral", "slightly adequate", "adequate" to "absolutely adequate". Among the four evaluators, two rated the scale as "slightly adequate" and two others rated it as "adequate". Following suggestions from the evaluators several questions were reworded and reconsidered to make them equivalent and comparable across caste/ethnic groups. Personal interviews were conducted with four students of different caste/ethnic groups for equivalence checking to ensure that the meanings of the questions were understood similarly across different caste cohorts. A subsequent pre-test (N=146) recorded a healthy reliability (Cronbach's alpha, $\alpha = 0.88$).

The finalized BSCP scale included 24 items of which four items were used to measure the components "threat and rejection" (e.g. *In general, people belonging to the "lower-castes" cannot be trusted*) and five items were used to measure the "intimacy" component (e.g. *I would not mind*

639 Pettigrew and Meertens, "Subtle and Blatant Prejudice," 61-63.

640 Hector Martini, Amalio Blanco, Miguel Ruiz, and Manuel Castro, "RIVEC (Rejection, Intimacy, Values, Emotions and Culture) Prejudice Scale: An Adaptation to the Chilean Context of the Blatant and Subtle Prejudice Scale," *Journal of Pacific Rim Psychology* 10, no.6 (2016): 1-12, https://doi.org/10.1017/prp.2016.3

if someone from my family married a person from a caste „lower" or „higher" than mine). The components "traditional value", (e.g. *In general, people from the "lower-caste" groups are lazy*) "exaggeration of cultural differences" (e.g. *The cultural practices of the "upper-caste" groups are better than those of the "lower-caste" groups*), and "positive emotions" (e.g. *I believe that people from "lower-caste" groups have every right to come up in life*) components were measured using seven, five and three items, respectively. Using the Likert scale, each item was set to measure disagreement or agreement with seven choices available to the respondents ("strongly disagree", "disagree", "somewhat disagree", "neither agree nor disagree", "somewhat agree", "agree" and "strongly agree"). These responses were then assigned numerical values from 1 to 7, with a high score of 7 corresponding to the strongest agreement to a prejudiced attitude. Statements to measure non-prejudiced attitudes (items 2, 5, 10, 13, 16, 20, 21 and 22 in the BSCP scale) were reverse coded so that the strongest acceptance of such a statement produced the lowest numerical value in the total prejudice score.

Independent and Dependent Variables

The total prejudice score of each respondent was computed to form the dependent variable. Independent variables used to check the differences in the level of prejudice between various cohorts included age, gender, faculty of study, caste/ethnicity, religion, place of secondary education, i.e. Grade 1-10, type of school, academic qualification of parents, and type of family. The various categories within the cohorts included, among others, male and female, undergraduate and postgraduate students, caste groups like Brahmins, Chhetris, Newars and Ethnic/Adivasi groups and major religious groups. The family types were grouped under two cohorts: nuclear family (parents and siblings) and joint family (grandparents, parents, uncles and/or aunts, cousins and siblings).

Participants and Process

A Jesuit college in Nepal was selected for the study. At the time of the data collection in January 2021, the college had 2573 registered students across 12 faculties. The BSCP scale was set in the form of a survey questionnaire in Google Form which was sent via email to all the students in their college-designated personal emails. The form was set in one person per response mode and was un-editable once the form was submitted. Students were given two weeks to respond. The responses were automatically recorded in the Google data sheet.

Standard ethical principles of survey research methods were adhered to in collecting the final data. Informed consent was sought from the respondent at the beginning of the questionnaire. The nature of the questionnaire, the purpose of the study and its voluntary nature were explained. The confidentiality and anonymity of the respondents were ensured by not collecting their names and emails. Gathering the data through Google Forms meant that the interviewer and bystander effects were neutralized. The inclusion of both positive and negative statements was deemed to have minimized the risk of response bias. Similarly, the questionnaire was inclusive in nature with variables like gender, caste/ethnicity and religion having the options of "no", "other" and "prefer not to mention." The above procedures sought to decrease response biases, especially social desirability bias.[641]

641 Ivar Krumpal, "Determinants of Social Desirability Bias in Sensitive Surveys: A Literature Review." *Qual Quant* 47 (2011): 2025-2047, https://doi.org/ 10.1007/s11135-011-9640-9

Description of the Respondents

Of the total respondents (*N* = 950) 57.1% were female (*N* = 542). The age of the respondents ranged from 15 to 30. There were responses from all the 12 faculties in the college; 50.5% of the respondents were from Plus Two (*N*=480); 11.1% were from A-Level (*N*=105);[642] students from Bachelors (*N*= 312) consisted of 32.8% of the respondents. The smallest cohort was from Masters (*N*=53) with only 5.6% of the total respondents.

The biggest caste/ethnic group was the Brahmins with 286 respondents (30.1%) followed by Newars (*N*=258), Chhetris (*N*=173) and Indigenous/Ethnic groups (*N*=121). There were only 25 Dalit respondents (2.6%). 40 respondents (4.2%) chose not to mention their caste/ethnic identity. Most of the respondents were Hindus (81.5%). Buddhists (8.7%), Christians (2.8%) and Kirati/ Indigenous religious practitioners (1.5%) were also part of the response group. 65.8% of the respondents had completed their secondary education from within the Kathmandu Valley. 89.1% of the respondents completed their schooling in private schools. Most of the respondents were from nuclear families (*N*=816; 85.8%).

Reliability of the Scale and Data Normality

The data was computed to form a total score, summing up the individual scores for each of the 24 items. The reliability test showed Cronbach's alpha, α = 0.74. The Boxplot spotted 10 outliers (*N*=952). Two cases were removed because they had the same response for all items. Others were retained because the outlier scores were considered to be genuine. The descriptive data showed that the trimmed mean (*N*= 952; *M* = 58.03) and the mean (*N*= 952, *M* = 58.46) values were very similar. Given this and the fact that the values were not too different from the remaining distribution, the other outlier cases were retained in the data file. The Shapiro-Wilk test Sig. value was *p*<.001, suggesting a violation of the assumption of normality which is quite common in large samples. However, the Histogram pointed to an approximately normal distribution. This was also supported by the Normal Q-Q Plot which showed a reasonably straight line. The overall conclusion was that the distribution of scores was reasonably normal and so, for statistical analysis, parametric tests could be safely conducted. Moreover, parametric tests have been the most common statistical tools used in similar studies conducted elsewhere.[643]

Data Presentation and Analysis

SPSS version 21 was used for the data analysis. Descriptive analysis showed that the mean score for the prejudice level was 58.46 (*N*=950) with an overall minimum of 36 and a maximum of 100. Standard Deviation was 12.73. A summary of the mean scores and standard deviation scores of selected cohorts is presented in Figure 1.

642 Plus Two and A-Level are two-year pre-degree courses, completion of which will qualify a student to apply to the universities to pursue undergraduate degrees. For a description of the education system in Nepal, see: Ministry of Eduction, Science and Technology, *Education in Figures, 2017* (Kathmandu, 2020), 5, https://www.moe.gov.np/assets/uploads/files/Education_in_Figures_2017.pdf

643 Martini et al., "RIVEC (Rejection, Intimacy, Values, Emotions and Culture) Prejudice Scale."

Figure 1: Descriptive Statistics: Total Prejudice Score

Cohorts	N	Minimum	Maximum	Mean	Std. Deviation
GENDER					
Male	401	32.00	100.00	60.07	12.90
Female	542	32.00	95.00	57.07	11.98
ACADMIC LEVEL					
Plus Two	480	32.00	96.00	57.07	11.88
A Levels	105	32.00	100.00	56.49	11.97
Bachelors	312	36.00	96.00	60.51	13.55
Masters	53	36.00	96.00	62.90	13.72
RELIGIOUS AFFILIATIONS					
No religion	25	38.00	75.00	53.60	10.01
Buddhism	83	36.00	94.00	59.42	11.83
Christianity	27	37.00	87.00	63.33	12.95
Hinduism	774	32.00	100.00	58.28	12.65
CASTE GROUPS					
Adivasi	47	36.00	88.00	61.68	11.25
Dalit	25	38.00	81.00	56.08	11.10
Indigenous/ethnic group	121	34.00	88.00	59.47	12.15
Brahmin	286	32.00	100.00	57.66	13.33
Chhetri	173	33.00	96.00	58.74	12.79
Newar	258	32.00	96.00	58.74	12.79
Prefer not to mention	40	37.00	96.00	60.32	14.66
GEOGRAPHICAL GROUPS					
Madhes	185	33.00	87.00	59.01	11.92
Hill, including Newars	765	32.00	100.00	58.33	12.88
TYPE OF SCHOOL (Grade 1-10)					
Government-run schools	104	37.00	100.00	62.42	12.01
Privately-run schools	846	32.00	100.00	57.98	12.70

Independent samples t-tests were conducted to compare the prejudice scores for different cohorts. There was no statistically significant difference in the scores for males (*M* = 60.07; *SD* = 12.90) and females (*M* = 57.07; *SD* = 11.98; *t* (941) = 3.68, *p* = .000 (2-tailed). The mean difference was 3.0 (95% *CI*: 1.38 to 4.62). Similar independent t-tests were conducted also for the following groups: the respondents who had completed their secondary education inside (*N* = 625; *M* = 57.92; *SD* = 12.77) and outside (*N* = 325; *M* = 59.52; *SD* = 12.51) the Kathmandu Valley; the practitioners of Hinduism (*N* = 774; *M* = 58.28; *SD* = 12.65) and other religions (*N* = 176; *M* = 59.28; *SD* = 12.90); Brahmins and Chhetris combined (*N* = 459; *M* = 57.68; *SD* = 12.79 and other caste groups combined (*N* = 491; *M* = 59.19; *SD* = 12.58); the respondents who identified themselves as from the Hills (*N* = 765; *M* = 58.33; *SD* = 12.88) and the Madhes, (*N* = 185; *M* = 59. 01; *SD* = 11.92); the respondents who were in Plus Two (*N* = 585; *M* = 56.97; *SD* = 11.88) and the respondents in other faculties combined (*N* = 365; *M* = 60.86; *SD* = 13.58); the respondents from nuclear families (*N* = 816; *M* = 58.39; *SD* = 12.52) and joint families (*N* = 134; *M* = 58.8; *SD* = 13.7); the respondents whose fathers had a minimum higher secondary education (*N* = 430; *M* = 59.59; *SD* = 12.89) and with Bachelors and above (*N* = 520; *M* = 57.53;

SD = 12.47); the respondents whose mothers had a minimum higher secondary education (*N* = 611; *M* = 59; *SD* = 12.56) and Bachelors and above (*N* = 339; *M* = 56.63; *SD* = 12.76); the respondents who studied Grade 1-10 in private schools (*N* = 848; *M* = 57.98; *SD* = 12.70) and in government schools (*N* = 104; *M* = 62.42; *SD* = 12.01).

Statistically significant results, with small effect sizes (*eta squared* < .06), were found for the following: the respondents who were in Plus Two and the respondents in other faculties combined, *t* (948) = -4.63, *p*= .000 (2-tailed), *mean difference* = -3.88, 95% *CI*: -5.53 to -2.24, *eta squared* = .02; the respondents whose fathers had a minimum higher secondary education and with an education level of Bachelors and above, *t* (948) = 2.49, *p* = .013 (2-tailed), *mean difference* = 2.06, 95% *CI*: 0.44 to 3.68, *eta squared* = .006; the respondents whose mothers had a minimum higher secondary education and with an education level of Bachelors and above, *t* (948) = 3.07, *p*= .002 (2-tailed), *mean difference* = 2.59, 95% *CI*: .94 to 4.25, *eta squared* = .01; and the respondents who completed their schooling (grade 1-10) from government schools and private schools, *t* (948) = 3.38, *p* = .001 (2-tailed), *mean difference* = 4.44, 95% *CI*: 1.86 to 7.0, *eta squared* = .01.

One-way between-groups ANOVA was conducted to explore the impact of age on the prejudice score. The respondents were divided into three groups according to their age (group 1: yrs 15-19; group 2: yrs 20-24; group 3: yrs 25-30). There was a statistically significant difference at the *p* <.05 level in the prejudice scores for the three age groups *F* (2, 947) = 14.87, *p* <.001. Despite reaching statistical significance, the actual difference in the mean scores between the groups was quite small. The effect size, calculated using *eta squared* was = .03. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for Group 1 (*M* = 56.93; *SD* = 11.98) significantly differed from Group 2 (*M* = 61.51; *SD* = 13.53) and Group 3 (*M* = 62.80; *SD* = 14.00); the mean difference (-4.58) between Group 1 and Group 3 (- 5.86) was larger than for Groups 1 and 2.

Similar tests were conducted for the combination of caste groups, religious affiliations the respondents' fathers' and mothers' education levels, the respondents' families and the level of education of the respondents. Statistically significant mean scores were found only with regard to the education level of the respondents which was grouped under four categories (1 = Plus Two; 2 = A Level; 3 = Bachelors; 4 = Masters). There was a statistically significant difference at the *p* <.05 level in the prejudice scores for the four academic levels *F* (2, 946) = 14.87, *p* <.001. Despite reaching statistical significance, the actual difference in the mean scores between the groups was quite small. The effect size, calculated using *eta squared,* was = .02. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for Group 1 (*M* = 57.07; *SD* = 11.88) and Group 2 (*M* = 56.49; *SD* = 11.97) significantly differed from Group 3 (*M* = 60.51; *SD* = 13.55) and Group 4 (*M* = 62.90; *SD* = 13.72).

The strength of the relationship between prejudice and age, prejudice and education level of the respondents, and prejudice and education level of the respondents' parents was investigated using Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no serious violation of the assumptions of normality, linearity and homoscedasticity. There was a statistically significant positive correlation at the 0.01 level (2-tailed) between age and prejudice with high levels of the prejudice score associated with older population, *r* = .173, *N*=950, *p*<.001. However, the effect was small as only 3% of the variance was explained by age. The education levels of the respondents were categorized into three cohorts with a score of 1 to 4 (1 = Plus Two and A-Level; 2 = Bachelors; 3 = Masters).

Once again there was a positive correlation between the academic level of the respondents and the prejudice score and the correlation, although flagged as significant, was of small effect, *r*=.154, *N* = 950, *p*<.001. Further, the education levels of the parents were assigned values to form a continuous variable. The prejudice level of the respondents decreased as the education level of the father increased, but there was no statistical significance to it. Similarly, there was a negative relationship between the prejudice score and the education level of the mother; i.e., the higher the education level of the mother, the lower the prejudice level of the respondent. Although statistically significant, the effect size was small, 1.08%. Similarly, when the parents' education was combined to form a continuous scale, the total scores showed a statistically significant negative relationship; however, only a negligible percent (0.84) of the variance was shown.

Since the age and prejudice score showed a statistically significant correlation, tests were conducted to see if the correlation significance level persisted between the male and female groups. The correlation between age and prejudice for the males was significant at 0.05 level (2-tailed), *r* = .110; *N* = 401, *p*=.027. Similarly, the correlation between the age and the prejudice score for the females was also statistically significant at the 0.01 level (2-tailed), with the older respondents having a higher prejudice level, *r* = .220; *N* = 542, *p* = .000. In order to check if the difference in the correlation coefficient between the males and females is statistically significant, *r* values were converted to *z* values and the following equation was used to calculate the observed value of *z* (*Zobs value): Zobs* = $\frac{z1-z2}{\sqrt{\frac{1}{N1-3}+\frac{1}{N2-3}}}$. In this case, *Zobs* value was -1.78 which was within the specified bounds (-1.96 to 1.96), indicating no statistically significant difference in the strength of the correlation between age and prejudice score for males and females.

Similar tests were also undertaken to investigate the strength of the correlation between the educational level of the parents and the prejudice score among males and females. While for the males the correlation was not statistically significant (*r* = -.080, *N* = 401, *p* = .109) for the females, a statistically significant negative correlation at the 0.01 level (2-tailed) was flagged (*r* = -.136; *N* = 542, *p* = .001). The *Zobs* value was 0.47, indicating that the two correlation coefficients were not statistically significant.

Similarly, the correlation between the educational level of the parents and the prejudice score for the Hindu respondents was significant at the 0.01 level (2-tailed), (*r* = -.111; *N* = 774; *p* = .002), comparing it with all the other religious groups combined (*r* = -.011, *N* = 176; *p* = .889). However, the *Zobs* value = 1.21 indicated no statistically significant difference in the strength of the correlation between the parents' education level and the prejudice score for respondents belonging to the Hindu religion and others religions combined.

The correlation between the education level of the parents and the prejudice score for the respondents who studied inside and outside the Valley till Grade 10 was examined. There was a statistically significant correlation at the 0.01 level for the respondents who studied inside the Valley, *r* = -.113, *N* = 625, *p* = .005; the respondents who studied outside the Valley recorded a statistically non-significant correlation, *r* = -.024, *N* = 325, *p* = .668. However, the *Zobs* value = 1.63 indicated no statistically significant difference in the strength of the correlation.

Lastly, the correlation between the education level of the parents and prejudice score for the respondents according to their caste was examined. The caste cohort was split into two groups; Group 1: Brahmin and Chhetri; Group 2: other caste groups. There was a statistically significant correlation at the 0.05 level for the first group, r = -.112; N = 459, p = .017; a statistical significance was not found for the second group, r = -.055, N = 491, p = .223. However, the *Zobs* value = 1.73 indicated no statistically significant difference in the strength of the correlation.

Findings and Discussion

The data analysis shows the level of caste-based prejudice among the students in the Jesuit college under study is low (M = 58.46, SD = 12.73, N=950). Given that all measures to mitigate the effect of social desirability bias were undertaken and that 75% of the respondents belonged to the "upper caste" (Brahmins, Chhetris) and Newars who are commonly associated with higher levels of prejudice in erstwhile studies in caste-based societies,[644] such a low mean score augurs well for the creditability of the college in reducing caste-based prejudices among its students.

Moreover, the mean scores for caste-based prejudice were uniform across most of the cohorts, namely, gender, caste/ethnic groups, religion, region, type of family, place of secondary education and across the various categories within them. This suggests that the low score was not because of methodological or statistical errors. Moreover, statistically significant differences in the mean scores were not found in most of the cohorts. The cohorts that reported statistically significant differences in the mean scores, namely, age, education level, and the type of schools of the respondents, also reported small levels of impact.

The low score is dissimilar to the results reported in various studies from Nepal on caste-based attitudes and discrimination, and untouchability. Taken together, the comparison between the mean scores of the variables under study suggests an incompatible point of view in one of the commonly held conclusions in caste studies which says that in the practice of caste "there are regional differences, rural-urban differences, differences due to religion, caste and community; differences based on wealth, occupation and education."[645]Empirical evidences with respect to untouchability recorded in India show differences according to caste and rural-urban settings. Brahmins were reported to have the most practices of untouchability compared to other caste groups, and the urban areas reported significantly lower levels of the practice of untouchability compared to the rural areas.[646] Similar disparities in caste-based explicit prejudice were found among the rural-urban population, caste groups and gender in India in another study.[647] In Nepal too, the historical perception is that Brahmins and Chhetris are more prejudiced than all others, that the practice of caste-based prejudice and discrimination is less in urban centers compared to the rural areas and that caste-based prejudice and

644 Thorat et al., "Explicit Prejudice"; Thorat and Joshi, "The Continuing Practice of Untouchability"; Ashwin Rajadesingan, Ramaswami Mahalingam and David Jurgens,"Smart, Responsible, and Upper Caste Only: Measuring Caste Attitudes through Large-Scale Analysis of Matrimonial Profiles." *Proceedings of the International AAAI Conference on Web and Social Media* 13, no.1(2019): 393-404, https://ojs.aaai.org/index.php/ICWSM/article/view/3239

645 Béteille,"The Peculiar Tenacity of Caste," 43.

646 Thorat and Joshi, "The Continuing Practice of Untouchability,"18.

647 Thorat et al., "Explicit Prejudice."

discrimination is deeper among the Madhes communities than the people in the Hills.[648] The present study, however, suggests that, as far as the level of caste prejudice is concerned none of the categories, whether it was caste, religion or region, had a significant impact. This result significantly point to the existence of prejudice free inter-caste relationships and interactions among the students in the college.

Another result that indicates a healthy relationship among different caste groups in the Jesuit college is that differing education levels of the respondents' parents had little impact on the prejudice level of the respondents. Moreover and rather surprisingly, the respondents whose parents had no or little formal education reported lower or the same level of caste-based prejudice as the respondents whose parents had Masters or Ph. D.

All in all, the results suggest that the college's efforts to eradicate caste-based prejudice among its students are bearing fruits. However, there are several caveats to this conclusion. Firstly, the Jesuit college is a self-financed private educational institute and thus presumably has students from the upper half of the economic spectrum in the country who have been seen to display "caste-neutral" attitudes.[649] Moreover, further research has to be done to establish that the low score is not the result of educated young people yielding "an education-related acquiescence response-bias that has very little to do with the respondent's true attitudes."[650] Similarly, further studies are needed to establish if the low level of prejudice reported does indeed translate into non-casteist behaviors, which is not often the case as studies on prejudice have shown elsewhere.[651] Such a research is crucial especially because the incongruity in reported attitudes and actual practice regarding caste-based prejudices and actions seems to be prevalent in Nepal. For example, in a study in the Western districts of Nepal, to the question if non-Dalit teachers and students behave the same at school and at home, 97.4% respondents (N=235) answered no,[652] indicating that there clearly is an incongruence in attitudes expressed publicly and practices upheld privately.[653]

Limitations of the Study

This study has several limitations. Firstly, although one of the implicit goals of the Jesuit college under consideration is to form men and women who are free of caste-based prejudices, this study fails to analyze the specific activities conducted by the college in order to reduce caste-based prejudice among its students. Further enquiry is necessary to confirm that the reported low prejudice level among the students is indeed the result of the explicit and targeted efforts of the college in eradicating caste-based prejudice among its students. Secondly, the BSCP scale used in the study lacked explicit statements on the practice of untouchability.

648 Dahal, "Social Composition," 4-7

649 Ritwik Banerjee and Nabanita Gupta, "Awareness Programs and Change in Taste-based Caste Prejudice," *PLoS One* 10, no.4 (2015): 7, https://doi.org/10.1371/journal.pone.0118546

650 Mary Jackman, "Education and Prejudice or Education and Response-Set?" *American Sociological Review* 38, no.3 (1973): 327, https://doi.org/10.2307/2094356

651 Mary Jackman, "General and Applied Tolerances: Does Education Increase Commitment to Racial Integration?" *American Journal of Political Science* 22, no.2 (1978): 302-324, https://doi.org/10.2307/2110618; Mary Jackman and Michael Muha, "Education and Intergroup Attitudes: Moral Enlightenment, Superficial Democratic Commitment, or Ideological Refinement?" *American Sociological Review* 49, no.6 (1984): 751-769, https://doi.org/ 10.2307/2095528

652 Chaluane, "Dalit Student's Perceptions," 149.

653 Khanal, "The Quest for Educational Inclusion," 108-111.

The scale could have achieved more accurate results if more explicit statements regarding caste-based prejudice were included. Thirdly, most of the respondents were "upper caste" Hindus studying in a self-financed urban educational institute and hence, the generalizability of the results are restricted.

Conclusion

Using the Blatant and Subtle Caste-based Prejudice Scale, a reconstructed version of the scale to measure blatant and subtle prejudice developed by Pettigrew and Meertens, this study measured the level of caste-based prejudice among the college-going students in a Jesuit educational institution in Nepal. The data showed that the overall level of caste-based prejudice among the students is low. Contrary to the usual assumptions in caste-based attitudinal and behavioral studies, the present study showed that the prejudice level did not significantly vary according to the gender of the respondents, their caste, the religion they practice, the type of family they belong to and the region from which they come. Similarly, the education level of the parents had little impact as far as the differences in the mean scores of the prejudice level of the respondents were concerned.

AUTHOR CONTRIBUTIONS

All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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THE SECULARIZATION OF YOGA AS A SIGN OF THE TIMES

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Abstract

Background: In his study, the author addresses the hot topic of the secularization of yoga, which appears to be one of the signs of our times on a global scale. The phenomenon of the secularization of yoga is approached from the philosophical point of view in relation to the classical Yoga Darśana – one of the six normative philosophical systems of India.

Conclusion: The main objective of the study is to argue in favour of the thesis that the popularity of postural yoga without a spiritual basis is a sign of our times and represents an aberration from the traditional concept of yoga.

Keywords: Classical Yoga Darśana – Secularization of yoga.

Introduction

Yoga has been known in the Central European cultural area for many decades. In the former Czechoslovakia, it has been spreading from the beginning of the 20th century. Mass interest in yoga has been noted since the 1980s, when yoga sport units were established in Slovakia and the Czech Republic, e.g., TJ Slávia VŠT Košice (1975–1990), which was later, after the fall of socialism, transformed into a civil association: *Association for the Advancement of Yoga* (in Slovak *Spoločnosť priateľov jogy*) (1990 – present). André Van Lysebeth, a Belgian disciple of Swami Sivananda, one of India's most prominent promoters of *hatha yoga* and *rāja yoga* during that period, hugely contributed to the popularization of both these yoga traditions in the former Czechoslovakia. Van Lysebeth visited the Czechoslovak Socialist Republic multiple times and his book *Yoga* (in Czech *Jóga*), the first in his extensive monograph series on yoga, was initially published by the state publishing house Olympia in 1972, shortly after its original French edition.

In a broader Euro-Atlantic context, yoga is usually associated with an effort to improve the quality of life, especially in terms of health. It is not surprising that the first attempts to apply yoga in rehabilitation and physical education in Slovakia date back to the 1950s. In recent decades, yoga has become synonymous with a specific form of sports activity based on bodily postures and thus has established itself in the mainstream of Western pop-culture under the name *postural yoga*. The contemporary hegemony of this interpretation has pushed other interpretations of yoga out of the game – not only in those parts of the world where yoga represents a form of cultural import (in Europe and North America), but also in that part of the world where yoga originated – on the Indian subcontinent. Interpretations of yoga as a sports activity (*postural yoga*) have prevailed over more traditional interpretations among the general public – both those

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transmitted orally through ancient Indian *śramanas* shrouded in legends (alternatively from the pre-Aryan period of Indian history, the Harappan civilization), and those captured in the textual traditions of the original traditions of yoga dating back to the origins of Indian writing (the *Vedas* and the *Upanishads*), or later to the golden age of great eposes of Hinduism and to the predominantly modern textual tradition of *hatha yoga*.

The main objective of the study is to argue in favour of the thesis that the popularity of postural yoga without a spiritual basis is a sign of our times and represents an aberration from the traditional concept of yoga. For the purpose of this study, hermeneutical and comparative methods are employed: The classical Yoga Darśana, traditionally considered normative with regard to yoga throughout the long history of Indian civilization, is introduced as a reference model of yoga in its comprehensive and authentic form; as such it is interpreted and further confronted with some non-classical views of secularized postural yoga.

The Classical Yoga Darśana

The concept of yoga covers an infinite number of spiritual and psycho-mental methods and techniques. There is no one single yoga, and no two yoga systems are alike. "As the concept of yoga refers to each ascetic technique and each meditation method, we can find yoga practices almost all over India, in Brahmaṇ circles, among Buddhists and Jains,"[655] notes Mircea Eliade, a recognized historian of religions.

Yoga in its traditional sense as Yoga Darśana is one of the six philosophical systems of India, literally "views" or "sights" (from the Sanskrit *darśan*), authorized by the religious authorities of Brahmans as being orthodox.[656] Its primary textual source is *The Yoga Sutras* by Patañjali and "its influence has been widespread among many other schools of Indian thought".[657]

However, the classical Yoga Darśana is not a kind of speculative philosophy as developed in Europe after the end of antiquity; in fact, it is a practical and experiential "educational program" (1) associated with the vision of its transcendental goal, (2) the methodology that should lead to this transcendental goal, and with the relevant (3) educational style. What is of greatest importance in this regard is that the program of classical yoga is developed in relation to the Sacred, it is shaped by this relation, and manifests this relation in various ways. As such it is a clear example of *spirituality* as defined by Zdeněk Vojtíšek, Pavel Dušek and Jiří Motl within the context of the phenomenology of religion.[658] In short, *the classical yoga described in The Yoga Sutras of Patañjali is a kind of spirituality – the personal relationship of man to the numinous transcendence: it is neither a religion, nor a physical exercise*. Let's have a closer look at this claim and provide a sketch of its hermeneutics in order to establish the reference point for our further investigation of the matter.

The spiritual character of classical yoga is indicated by the very etymology of the word *yoga*: The Sanskrit root *yuj* has two basic meanings – "to join or bind together" and "to yoke". In the first case, the goal of yoga comes into play (even though it is defined differently in different traditions and schools of yoga); in the second case, the emphasis is laid down on the process leading to

655 Mircea Eliade, *Dejiny náboženských predstáv a ideí II*, 55.

656 Namely: Nyāya, Vaiśesika, Sāmkya, Yoga, Mīmāmsā, Vedānta.

657 *Encyclopedia Britannica*, "entry Yoga". http://www.britannica.com/eb/article-9077981/Yoga.

658 Zdeněk Vojtíšek, Pavel Dušek and Jiří Motl, *Spiritualita v pomáhajících profesích*, 19.

this union, which is associated with disciplining personality. The normative definitions of both are provided by *The Yoga Sutras* – *The Yoga Aphorisms* – a writing establishing the textual tradition of Yoga Darśana.

The Yoga Sutras occupy an exceptional place in Indian literature and neither the fact that their author remains unknown can change it. Although the authorship of the authoritative text on yoga is attributed to Patañjali, we do not know much about this legendary sage; the dating itself is also uncertain (between the 2nd century BCE and the 4th century ACE). It is not known whether he was the grammarian from the 2nd century BCE or someone else. Quite certainly, this man, known as the "father of yoga", was not the inventor or creator of yoga, but its systemiser: He himself admitted that he only systematized various teachings of yoga.[659]

The final text is a synthesis of several doctrines and practical methods originating from the period of transition from Brahmanism to Hinduism (from the 3rd century BCE to the 3rd century ACE). It is even possible that the text was created by combining several older texts. Mircea Eliade presupposes that Patañjali "merely rehandles the Sāmkya philosophy in its broad outlines, adapting it to a rather superficial theism in which he exalts the practical value of meditation."[660]

Patañjali's definition of the goal of yoga went down in history. "Yoga is the inhibition of the fluctuations of the mind/consciousness," he writes in his *Yoga Sutras* (1:2; "yogaś-citta-vrtti-nirodhah"), and adds to it with one breath, "Then the Seer is recognized as such." (*Yoga Sutras* 1:3; "tadā-draṣṭuḥ-svarūpe-'vasthānam").

The Transcendent Goal of Yoga Darśana

According to these framing definitions, the ultimate goal of yoga consists in *stilling* (Sa. *nirodhah*) *of the movements of the mind* or *consciousness* (Sa. *citta vrtti* – "thought-waves" or "mental fluctuations", also "fluctuations of consciousness") so that the *witnessing consciousness* (Sa. *drastuh* – "the Seer"; also, *ātman*, *sāksin* or *purusa*) is clearly *recognized* as such (Sa. *avasthānam*), that is as detached from all mental or consciousness activities. When the process of the "yoking" of yoga is done, *consciousness* (Sa. *drastuh*, *ātman*, *sāksin*, *purusa*) *rests* (Sa. *avasthānam*) *in itself* (Sa. *svarūpe* – "essential or natural state"). When the state of abidance in "pure" (i.e., purified of content) consciousness is established, "liberation" (Sa. *moksa*) occurs.

In other words, "the inhibition of the fluctuations of the mind/consciousness", which Patañjali speaks about, is not self-serving, but has a specific meaning, essential for understanding of yoga – it is a means enabling entry behind the curtain of phenomenal reality, or rather its psycho-mental representations, to the background of personality, manifesting itself in *enstasis* (Sa. *dhyāna*) as the sacred, the all-pervading and pervasive "basis" of reality – the only *Being* founding the plurality of *beings*. This transcendent aim of yoga, which found manifold conceptualization throughout the long history of Indian thought – *sāksin* in Yoga Darśana, *purusa* in Sāmkya Darśana, *ātman* in Vedānta Darśana – is ultimately revealed in the transcendent "experience" of *samādhi*.

The Method of Yoga Darśana

In four chapters (Sa. *pāda*) of his *Yoga Sutras*, Patañjali provides an explanation of the method aiming at this transcendent goal by structuring it – probably according to the pattern of the

659 *Yoga Sutras* 1:1

660 Mircea Eliade, *Yoga: Immortality and Freedom*, 7.

Eightfold Path of Buddha – into the eight limbs. Out of these eight limbs comes the designation of the whole system: *astānga yoga* – "the yoga of eight limbs".

The eight "limbs" (Sa. *anga*) consist of: *yama* (self-control regulations), *niyama* (rules of proper conduct), *āsana* (bodily posture), *prānāyāma* (control of the life force or energy – *prāna*), *pratyahara* (withdrawal of consciousness from the sensual perceptions), *dhāranā* (concentration), *dhyāna* (enstasis), and *samādhi* (union).
The individual "limbs" of yoga should be considered as the stages of the spiritual path leading to ultimate liberation. Even though each of the eight degrees of Patañjali's system has its own specific content, each is at the service of the same goal. They are designed to enable *single-pointed concentration* or *one-pointedness* (Sa. *ekāgratā*) because at the end it is *one-pointedness* that only leads to liberation (Sa. *moksa*, also *mukti*, *kaivalya*).

Based on their subject, the individual stages of classical yoga can be divided into three thematic units. The first two degrees or "limbs" consist of moral foundations of yoga and include values and attitudes. The next three degrees consist of discipline at the level of psychosomatics, and the final three represent the modalities of contemplation. While on the one hand the individual "limbs" of *astānga yoga* need not be interpreted in a strictly causal sense, because perfection in yoga is not the sum of individual perfections, but a new, *transcendent state* – transcending and completing the *human state*, on the other hand, the first five stages of classical yoga are establishing preconditions for *single-pointed concentration* or *one-pointedness* (Sa. *ekāgratā*), which is expected to end up in uncovering the sacred Being (Sa. *ātman*, *sāksin*, *purusa* – the Self) in *samādhi* and through it further reaching the final freedom from the contingency of profane existence (Sa. *samsāra*) – "abolishing the human condition" as Eliade puts it.[661]

From the point of view of phenomenology of religion, in particular the one of Mircea Eliade, *ekāgratā* is an exemplary example of a "break" in between two qualitatively distinct levels of human existence – the profane and the sacred. Through the "breakthrough" of the Sacred into the world (Lat. *hierophany*), a "rift" is created in the homogenous expanse of profane time, space, and existence (Ger. *Dasein*) – "a fixed point", "a centre", or "a central axis" (Lat. *axis mundi*), "where" the Sacred vibrates with the fullness of its *being*, and "where" only the fully human existence is possible.

The change of perspective, evoked *by ekāgratā* and conditioned by moral and psychosomatic qualifications, matures in the symbolic understanding of the world. For a yogi, the world is no longer a world of "things" – a conglomerate of beings distributed in space and time in a mechanistic sense; instead, it becomes a world of symbols. A symbol refers outside of itself – to the meaning it simultaneously points to and hides. The world, human body, and human psyche have a symbolic meaning for a yogi – *yogic cosmology* reveals the dimensions of existence that are unknown in Newtonian physics; *yogic anatomy* reveals the symbolism of the human body and discovers finer layers associated with energy channels (Sa. *nādī*) and vital energy centres (Sa. *cakras*); *yogic psychology* points to the symbolic meaning of psychic structures, contents, and processes.

661 Mircea Eliade, *Yoga: Immortality and Freedom*, 66.

Desacralization of Yoga

On the contrary, symbolic perception disappears or becomes less important once yoga is secularized. For "desacralized forms of yoga", the world is "only" a conglomerate of beings distributed in space and time, the human body is "only" a biological organism, and the psyche is "only" the sum of psychic processes. No wonder that such a view may result in the interpretation of yoga as a sports activity, sometimes associated with the initiatives to include yoga in the list of Olympic sports.[662]

It was probably Tirumalai Krishnamacharya (1888–1989), who unintentionally stood at the beginning of the current trend of the secularization of yoga – paradoxically, the same man, who vastly contributed to the mass popularization of *hatha yoga*. Nor did his emphasis on the bodily aspects of yoga practice led him to resign to specific yoga aspects (as we have already demonstrated on the example of classical Yoga Darśana) as can be documented by the following quote from his book *Yoga Makaranda*, a classical contemporary text on *hatha yoga*: "*pranayama* must only be practised along with *asana* and while observing the *yama* and *niyama*. (...) One who is not skilled in the *yama*, *niyama* and *asana* will not receive any benefits."[663] In this, Krishnamacharya differs from the present-day proponents of desacralized yoga, regardless of whether they follow his legacy or not.

The mainstream branch of desacralized yoga is represented by yoga as a form of physical exercise – no matter whether its promotors make occasional references to the tradition of classical yoga or include opening chants at the beginning of their yoga classes or not – they intentionally aberrate from the traditional concept of yoga. This is true of Pattabhi Jois (1915–2009) with his *ashtanga vinyasa yoga*, B. K. S. Iyengar (1918–2014) with his *Iyengar yoga*, or Bikram Choudhury (1944–) and his *hot yoga* with a fixed series of 26 postures, just to name the most influential representatives of this popular trend depicting yoga as a physical exercise. The school of Pattabhi Jois explicitly admits that "The Astanga Yoga method taught by Shri K. Pattabhi Jois focuses first on the practice of asanas in order to establish health, to correct imbalances, and to strengthen the system, thus stabilizing the body and mind, without which we are unable to control our sense organs"[664]. However, their focus on postures remains unchanged even during the further levels of practice.

The first two mentioned above learned yoga directly from Tirumalai Krishnamacharya and they share multiple similarities in between themselves. They both had been focusing on sequencing yoga poses (Sa. *āsanas*) into series, which were presented as the original works of their authors and linking them by smooth transitions or movements (Sa. *vinyasas*), what is the main feature of the so called *vinyasa style of yoga* so typical for the postural yoga approach in recent decades.

At the same time, the two also differed in their approaches to execute these exercises – while the approach of Pattabhi Jois can be described as energetic and disciplined,[665] for the approach of Iyengar was typical his emphasis on the alignment in the performance of yoga postures by using various props and princely developed techniques.[666]

The subject, nevertheless, opens almost endless opportunities for further investigation, as already conducted, for instance by Andrea Jain at the intersection of premodern, modern, and contemporary yoga traditions and schools.[667] There is also definitely no doubt that such enterprise should not be aimed at establishing some kind of censorship or "yoga police" as Daniel Simson reminds us.[668]

Several-thousand years of development have led to the fragmentation of yoga into countless forms and this process certainly continues to the present time. Side-by-side the classical Patañjali Yoga Darśana and traditional branches of yoga such as *bhakti*, *karma* or *jnana yoga*, and the various traditions of Buddhist, Taoist, and Jain yoga, a wide range of non-traditional branches of yoga had been established over the centuries. In recent years, multiple sports variants of "yoga" have also appeared. These variants of yoga often lack a spiritual dimension absolutely crutial and substantial for authentic yoga. In this sense, they represent the new trend of the desacralization of yoga, which appears to be one of the signs of our times.

The current dynamics of differentiation of yoga is also the dynamics of its secularization – the lost of the essential contact with the Sacred that is the source of absolute meaning – the case both in the theory and practice of "secularized yoga". The secularization of yoga is a deep alienation from the foundations of yoga in their relation to the Sacred. Only on this foundation the ultimate goal of yoga can be determined and conditions for practical implementation of yoga on moral grounds can be created and further extended by specific methods and techniques designed to model (and transform) the whole existence of a practitioner who takes on the "yoke" of yoga (Sa. *yuj*).

The phenomenon of secularization of yoga has to be placed into broader, ontological context. We can reasonably assume that it is, to some extent, conditioned by it in a similar way as contemporary man is conditioned, or rather determined, by one's alienation in relation to Being (Lat. *esse*) that establishes one's very existence (Lat. *ens*). The psychological consequence of "forgetting of being", as Martin Heidegger puts it ontologically, is a consumer mentality exemplary manifesting this alienated being trapped in objectification.

The "forgetting of being" is the loss of "authenticity" (Lat. *aut–ens*) and the restrain of "autonomy" (Gr. *auto–nomos*), or the capacity of self-disposal – the ability to establish a moral law. All surrogate attempts to imitate authenticity and autonomy in the exciting manifestations of distinct individualism characteristic of our times, however, remain illusory.

Conclusion

Yoga in the form of different schools of spirituality appears to be a specific kind of relationship to the Sacred. The absence of institutional elements does not allow the classification of traditional yogic traditions as religious systems; however, these yogic traditions are not immune to succumb to secularisation.

662 Gejza M. Timčák, "Yoga as a Part of Sanātana Dharma", *Spirituality Studies*, 2019, 5 No. 1, 30.

663 Tirumalai Krishnamacharya, *Yoga Makaranda*, 13.

664 *Aṣṭāṅga Yoga*, 8.

665 See Pattabhi Jois, *Yoga Mala*.

666 See B. K. S. Iyengar, *Light on Yoga*.

667 Andrea R. Jain, *Selling Yoga*, 2015.

668 Daniel Simson. "Restraining the Yoga Police." *Spirituality Studies* 6, no. 2, (2020): 60–63.

The phenomenon of the secularization of yoga is most apparently manifested in the form of the so-called *postural yoga*. Postural yoga is the most obvious example of the tendencies of desacralization in the area of yoga. The topic itself raises a near infinite number of further questions to be subjected to additional research. In this regard it is crucial that any such endeavours refrain from any kind of censorship or "yoga police".

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THE MYSTAGOGY OF LITERARY WORK BY KAROL WOJTYLA

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Abstract
Backround: Wojtyle's literary work through a mystical abstraction that is not opposition to universally valid concepts or reality seeks to answer the question after shaping concrete answers to the most difficult questions of the meaning of human existence. Wojtyla is based on the belief that these answers are able to fully and most strongly reveal the lived reality perceived as a space in which God is hiding. This is related to another constant of his work which is the search for a relationship of faith and intellect. In this context it studies the dual nature of existence or its passive and active dimension. In the passive dimension of existence in which he also encounters the capacity for contemplation he finds an active dimension that is the subject's adequate response to the acting God or the mystical act of exposure to grace. The passivity thus experienced becomes an active act through love.
Conclusion: Further important and interesting research and studies in this area could focus, for example, on the inspiration found in Karol Wojtyla's poetry.
Keywords: Karol Wojtyla – Mystagogy – Poetry – Literary work – Personalism.

Introduction

Wojtyla's literary work is a specific form of mysticizing abstraction that does not stand in the opposition to universally valid concepts or towards living reality. His work strives for an answer to the question on what is touching the meaning of human existence. Wojtyla comes out of persuasion that living reality perceived as space in which God is hiding is most fully and strongly able to reveal these answers. This is connected with another constant of his work which is searching for relation of belief and intellect. In this context he examines the dual character of existence or more precisely its passive and active dimension. He finds in the passive dimension, in which he meets also the ability of contemplation, an active dimension that is an adequate answer of the subject towards the acting God, more precisely a mystic act of exposure to the grace. The passivity experienced this way transforms itself through love into an active deed.

Wojtyla and theatre

Karol Wojtyla since an early age showed tendencies towards study, sport and knowledge but he was also aware of his special talent for perceiving fundamental values of artistic manifestations as a way how to express the deepest reality. It was the playwright Mieczyslaw Kotlarczyk, whom Wojtyla met in Wadowice during his engagement in amateur theatre companies, who noticed his talent. Since his early age Wojtyla was a passionate admirer of theatre and his

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passion grew a lot. Already in 1934 he visited local theatres and acted in them and since 1936 he cooperated with avant-garde theatre personality of Mieczyslaw Kotlarczyk.[670] Twelve years older Kotlarczyk took sixteen years old Wojtyla under his wings.[671] Already at the age of eight he took part on the functioning of an amateur theatre group as a prompter. He showed his own first theatre performance in hospital in Bielsko-Biała, where he used to go visiting his dying brother.

Wojtyla fell in love with theatre passionately. He went probably through all jobs that are connected to theatre. He worked there as a prompter, actor, director and theatre critic, he translated some dramas, as, for example, Sophocles' Oedipus. Wojtyla was always persuaded that theatre is a powerful ethical force.[672]

In years 1934-1938 he played main roles or directed altogether ten comedies. Further he played in the drama *Antigone*, co-directed distinctive conception of the New Testament text *Apocalypse*, *A Non-Divine Comedy* by Krasiński, *Kordian* by Slowacki, *Sulkowski* by Żeromski, *Sigismund II Augustus* by Wyspiański, a modern drama in verse *Judas of Kerioth* by Rostworowski and others.

Kotlarczyk, who was a professor at a certain girls school,[673] introduced to Wojtyla his unique theory of theatre, the so called *rhapsodic theatre*, which Wojtyla later shared with him and co-created it with him. The events and their succession are not primary here but grasping the issue and development of it which is happening mostly in an abstract, thus philosophical way.

According to Kotlarczyk, an actor, artist has a similar assignment as a priest: an artist is, through sources of this world, to open the realm of the transcendent truth. Theatre needs to be created as if from the inside of reality. "The theatre of the inner world should have carried to the surface universal truths and universal moral values that direct our world and offer to it the possibility of pure transformation." (Weigel, 2005, 43) Wojtyla adds to it: "The rhapsodic theatre lays a problem directly, in its abstract form, not under a veil of theatrical action which is present only as by the way, as illustration of the problem. The rhapsodic theatre could be characterized as intellectualistic since the intellect is a realm of abstraction, it is a conceptual area." (Wojtyla 2005, 969)[674]

In 1939, after Wojtyla passed the first exams at the Jagiellonian University, he finished his first collection of poetry *The Renaissance Psalter.*[675]

Under a strong influence of Kotlarczyk he decided to apply himself to the theatre also as an author.[676] In autumn 1938 Wojtyla moved to Krakow, started attending the Jagiellonian University

670 Cf. Bettetini, Massimo, Introduzione, in: Wojtyla, *La dottrina della fede in San Giovanni della Croce*, (Bompiani, Milano 2003), 5.

671 Cf. Weigel, George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 43.

672 Cf. Reale Giovanni, Presentazione, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Milano 2005), XV.

673 Cf. Buttiglione, Rocco, .*Il pensiero dell´uomo che divenne Giovanni Paolo II*, (Milano 1998), 34.

674 Wojtyla Karol, Sul teatro della parola, in: *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro*, (Bompiani, Milano 2005), 969.

675 Cf. Bettetini, Massimo, Introduzione, in: Wojtyla, *La dottrina della fede in San Giovanni della Croce*, (Bompiani, Milano 2003), 6.

676 Wojtyla' dramatic work is composed of: *Giobbe* (*Hiob /Job/*, written in 1940, first published in: *Poezje i dramaty*, Znak, Krakow 1980), *Geremia* (*Jeremiasz/Jeremiah/*, written in 1940, first published in: *Poezje i dramaty*, Znak, Krakow 1980), *Fratello del nostro Dio* (*Brat naszego Boga / Brother of Our God/, written in* 1949, first published in: Tygodnik Powszechny 51-52/1979, Krakow), *La bottega dell´orefice* (*Przed sklepem jubilera / The Jeweler's Shop/*, Znak 12/1960, Krakow), *Raggi di paternitá* (*Promieniowanie ojcostwa /Radiation of Fatherhood – a Mystery. /,* written in 1964, first published in: Znak 11/1979, Krakow), *Considerazioni sulla paternitá* (*Rozważania o ojcostwie / Meditation on Fatherhood/. /*, Znak 5/1964, Krakow). Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Bompiani, Milano 2005), XXXVII.

as a student of Polish philology, wrote poetry and keenly visited theatre. In that time he joined the *Studio 39* theatre group. After the German invasion the group went on with its activity illegally. When the university got closed, Wojtyla worked in a quarry and in the evenings attended rehearsals. In that time he was writing his drama *David*. The date was 1939 and Wojtyla was nineteen years old. Unfortunately this piece of work was not published and got lost.[677] At Easter 1940 he writes a drama *Job*[678] and in summer a drama *Jeremiah*, a drama on motives of the national history, in three acts.[679]

Job is written in verses that are partly in free form. Unlike his following dramas, its verse is short. The play reacts on the historical situation of Poland, when the nation is plagued by a bloody and merciless burden of the Nazi occupation. The theme coincided with the long tradition of Polish messianism. For Polish patriots of the nineteenth century was Poland, being divided into three parts, an image of Christ sufferings. In the play *Jeremiah* Wojtyla thinks at length about the reasons that conditioned the fall of his homeland in the past times and at the present. He perceives the sufferings of the Polish nation as a catalyst of the national life. This opus already foreshadows Wojtyla's future "inner theatre". Yet, the idealistic vision of the Polish history, which is present at Polish romanticists, sounds still strongly in his thought.

Wojtyla's first theatrical experiments have not retained up. Since the early texts it is obvious that the author succumbed to the romanticizing epicity that contained in itself the influence of the Polish literary romanticism. However, he always strived to imprint into the sujet a deeper question and make it the main axis of the narrative. In *Job* it is an archetypal issue of human suffering seen in the New Testament light. In *Jeremiah*, the strong patriotism is already evident, in the sense of a parable Jeremiah – Skarga, Poland – Jerusalem.

At the beginning of the year 1941 Wojtyla persuaded Kotlarczyk to move to Krakow with his whole family. When Mieczyslaw Kotlarczyk founded the Rhapsodic Theatre on 22nd August 1941, Wojtyla became its active part[680] from the very beginning. The curtain, the traditional stage disappear from the scene, the script, costumes, make-up vanish. It is the word what enters fully into the centre of events. The first performance of the Rhapsodic Theatre was staging of the play King Spirit by Slowacki that was, quite along the lines of the Polish romanticism, to encourage the heavily tormented people to hope.[681] Works as *Balladyna, Samuel Zborowski, King Spirit* by Slowacki, *Master Taddeus* by Mickiewicz, *Promethidion, Pure Love at Sea-side Bathing* by Norwid, *The Wedding, Liberation* and *Return of Odysseus* by Wyspiański, *Miguel Manara* by Milosz[682] belong to the repertory of the Rhapsodic Theatre. Wojtyla acted in all seven war plays that the Rhapsodic Theatre performed. In that time Wojtyla entered into the secret seminary in Krakow.

The exclusive position of works by Slowacki in the repertory was not accidental. The poet who desired to revive Poland by the power of word coincides with Kotlarczyk's belief that it is the force of word that gives the theatre its weight and ethical earnestness. He sees theatre as an adequate means for passing on hopes. It is what fascinates Wojtyla. His literary instincts that got matured during the studies of philology brought him by that time to the opinion that word is capable to

677 Cf. Reale Giovanni, Presentazione, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Bompiani, Milano 2005), XIV.

678 In 1940 Wojtyla writes to Kotlarczyk: *I myself wrote a new drama with Greek form, Christian spirit.... A drama about suffering: "Job"*. Taborski Boleslaw, Introduzione, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Bompiani, Milano 2005), 269.

679 Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.* (Práh, Praha 2005) 52.

680 Weigel, *Svědek naděje,* 52.

681 Weigel, *Svědek naděje,* 70.

682 Cf. Buttiglione Rocco. *Il pensiero dell´uomo che divenne Giovanni Paolo II*, (Milano 1998), 37.

change what the world of force assumes to be unchangeable, if such word is pronounced clearly, truly and with sufficient emphasis and vigor.

Wojtyla was also strongly affected by Krasiński's Non-Divine Comedy that "is an apologia of the end of the Western world, which disintegrated itself in a merciless social and wordly fight. The main characters are Count Henry who defends spiritual values that are innate to the romantic tradition and Pancras who is a head of rationalistic and modernizing revolution. Pancras wins politically but loses spiritually. The sufferings and cases of injustice that piled up during the social transformation cannot be redeemed by any construction of future society." (Jawień, 1966, 142-143)

The second plane of Krasiński's poem-play, which would strongly influence Wojtyla's future focusing, is that fundamental spiritual forces of civilization have their fullest expression in family. Family is thus getting into the centre of his attention.[683]

The Rhapsodic Theatre reflected the New Testament image of the world created by the Word, that Logos which was with God and which itself was God. The word *rhapsodic* could in a certain sense mean also *Christian*. Kotlarczyk understood theatre as a sacral platform, as an idiosyncratic form of ritual.[684] He was considerably affected by Rudolf Otto's book *The Idea of the Holy.*[685] His theatrical theory that was built on centrality of word was not a pointless form but reflected Otto's influence. Kotlarczyk raises the liturgical, sacral character of a theatrical gesture and the fact that through it universal values are revealed to the audience. On the basis of such concept the profession of actor is only a step from the profession of priest.[686] Under his influence Wojtyla writes in one of his theoretical works on theatre: "A word is ripening into a gesture...Everything is happening in the rhythm of words and ideas, in the inner tension." (Wojtyla, 2005, 967)[687]

The Rhapsodic Theatre does not strive for the opposition of universally applying concepts and facts but quite in contrary: it seeks, with the help of abstraction, what the reality is capable as fully and strongly as possible reveal, thus what creates particular answers to the most difficult questions about the sense of human existence.

The Rhapsodic Theatre soon fuses with an illegal group *Union* – a cultural branch of the military resistance movement with a strong emphasis on Christian thought. It has an active support of the archbishop Sapieha who helps at underground operations. The Union was created by the well-known poet and dramatist Jerzy Baum who represented the tradition of Polish national messianism. Wojtyla felt vitally bonded to this tradition. Together with others he joined the Union and took the fidelity oath of "connection of a person with a person, a nation with a nation and the community of all people with Christ." (Szulc, 1995, 90) Thoughts of the Union reflected traditional Polish reservations towards capitalism – though not in the Marxist spirit.[688]

Wojtyla cooperated with the Rhapsodic Theatre. He wrote theoretical essays and supported it until it was banned by communist power in 1967. The last article about the Rhapsodic Theatre, *Przedmowa do ksiazki Mieczyslawa Kotlarczyka, Sztuka zywego slowa*[689]

683 Buttiglione, *Il pensiero,* 37.

684 Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 71.

685 Otto Rudolf, *Posvátno* (Praha 1998).

686 Cf. Buttiglione Rocco, *.Il pensiero dell´uomo che divenne Giovanni Paolo II*, Milano 1998, p. 35.

687 Wojtyla Karol, Sul teatro della parola, in: *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro*, (Bompiani, Milano 2005), 967.

688 Cf. Wojtyla, *Sul teatro della parola,* 90

689 Wojtyla Karol, Prefazione a „L´arte della parola viva" di Mieczyslaw Kotlarczyk, in: *Tutte...* , pp. 933-934.

(*The forvard to Mieczyslaw Kotlarczyk's book The Art of the Living Word)*, he wrote already as a cardinal.[690]

Wojtyla and poetry

On the contrary from dramas, Wojtyla wrote poetry for his whole lifetime.[691] According to themes, his poetry blends with his philosophical and theological work or with the practical aiming of his spiritual service. The interesting fact is that Wojtyla, in spite of the prevailing majority of the so-called spiritual poetry that in that time was written in the traditional bound verse, used the free verse, which was close to modern poetic sensibility, from the very beginning. Using of free verse was connected to the turn of the modern art towards subject. He used the poetic language as well as the form of free verse also while writing dramas.

At the end of nineteen-thirties Wojtyla immersed into reading work by Saint John of The Cross. Wojtyla is also interested in his poetry. He borrows it from the library Bibliotheca Carmelitana.[692] In the same time he starts writing his own poetry.[693] He dedicated the first poem *Over This Your White Grave* to his mother.

Only after the war Wojtyla starts devoting himself to his own artistic activity more intensively. At the time of his return from studies in Rome, he renews contacts with the Rhapsodic Theatre and founds a theatrical group at the Saint Florian's Church where he is incardinated as a chaplain.[694]

Wojtyla writes his first collections in parallel with the drama David. Writing of several other poems, for example the poem *The Word – Logos (Rhapsody),* follows. The loss of his father and his aiming to priesthood affects and deepens essentially also his poetry. The worriless and joyful

690 Cf. Taborski Boleslaw, Introduzione, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Bompiani, Milano 2005), 262ff

691 All biographical data where it is not stated otherwise are drawn from: Gramatowski Wiktor - Wilińska Zofia, *Karol Wojtyla negli scritti. Bibliografia* (Cittá del Vaticano 1980).

692 Cf. Szulc Tad, Jan *Pavel II. Životopis* (Tok, Praha 1995), 94.

693 Wojtyla's poetic creation consists of opuses: *Sulla tua bianca tomba* (*Nad Twoja biala mogila / Over This Your White Grave,* written in 1939, first published in: *Poezje i dramaty*, Znak, Krakow 1980), *Magnificat* (written 1939, first published in: *Poezje i dramaty*, Znak, Krakow 1980), both collections are a part of the manuscript *Salmo rinascimentale/Libro slavo* (*Renaissance Psalter/ The Slav Book,* first in: *Poezje i dramaty*, Znak, Krakow 1980), *Canto del Dio nascosto* (Jawień, Andrzej, *Pieśń o Bogu ukrytym / Song of the Hidden God /*, *Glos Karmelu* in numbers 1/1946, 3/1946, 3/1947, 5/1947, Krakow), *Canto dello splendore dell´aqua* (Jawień Andrzej, *Pieśń o blasku wody /Song on the Splendor of Water/*, Tygodnik Powszechny 19/1950, Krakow), *La madre* (Jawień Andrzej, *Mother,* Tygodnik Powszechny 50/1950, Krakow), *Pensiero-Strano spazio* (Jawień Andrzej, *Myśl jest przestrzenia dziwna /Thought Is a StrangeSpace/*, Tygodnik Powszechny 49/1952, Krakow), L*a cava di pietra* (Jawień Andrzej, *Kamieniolom /Quarry,* Znak 6/1956, Krakow), *Profili di Cireneo* (Jawień Andrzej, *Profile Cyrenejczyka /Profiles of a Cyrenean/*, Tygodnik Powszechny 13/1958, Krakow), *Nascita dei confesori* (Jawień Andrzej, *Narodziny wyznawcow /Birth of Followers/*, Znak 11/1963, Krakow), *Chiesa* (Jawień Andrzej, *Kościól /The Church/*, Znak 11/1963, Krakow), *Pellegrinaggio ai luoghi santi* (Jawień Andrzej, *Wendrówka do miejsc świetych /Journey to the Holy Places/*, Znak 4/1966, Krakow), *Veglia pasquale 1966* (Jawień Andrzej, *Wigilia wielkanocova /Easter Eve/*, Znak 4/1966, Krakow), *Pensando patria*... (Gruda Stanislaw Andrzej, *Myślac Oiczyzna... /Thiking homeland.../*, written in: 1974, first published in: Znak 1-2/1979, Krakow), *Meditazioni sulla morte* (Gruda, Stanislaw Andrzej, *Rozwazanie o śmierci /Thoughts on Death/*, Znak 3/1975, Krakow), *La redenzione cerca le tue forme per entrare nell´inquietudine di* ogni uomo (Gruda Stanislaw Andrzej, Odkupienie szuka Twego ksztaltu, by wejść w niepokój wszystkich ludzi */ Redemption is looking for your shape, to enter the concern of all people/",* Znak 10/1979, Krakow), *Snanislao* (Gruda Stanislaw Andrzej, *Stanislaw*, Znak 7-8/1979, Krakow). Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro*,Bompiani, Milano 2005, s. XXXV-XXXVII. However, the list is inaccurate, because we could also include most of his plays in his poetry; we have not included his last collection, which he had already written as a pope.

694 Cf. Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 103.

pre-war period is replaced by themes more solemn; they more and more focus on his spiritual course. Also his form purged of useless ornaments starts gaining distinctive features. Wojtyla chose the form of free verse purposefully also because it provided him with space for a meditative ground of expression.

Afterwards a poetic cycle *Song about Hidden God* followed.[695] It was a sort of contemplative poetry; it coincided with his interest in work by the Spain mystic Saint John of the Cross. Here Wojtyla's work finds itself on the very frontier of poetry and dialogue, of prayer.

Besides religious themes also patriotic themes profile themselves in Wojtyla's poetry, as it is e.g. in the poem *Beggars* or social themes as in the poem *Proletariat*. All these three topics are interconnected and they, being thought over in a new way, occur in other poems.

In years 1949 – 1950 Wojtyla completed the drama *Brother of Our God*.[696] He in this drama postulates the conception of a Christian social revolution.[697] In this work the important role plays the issue of revolution. *The stranger* with whom the main character of this play, Adam, communicates is probably Lenin, who lived in years 1912-1914 near Krakow.[698] Wojtyla was writing his work in the time when Poland was flooded by the left-wing revolutionary image of post-war organization of the world. Wojtyla insisted on the necessity of social justice but at the same time he proclaimed that economic and political liberation which is limited only on the material sphere is insufficient.

The stranger sees the growing social anger, he is close to people labouring in unjust working conditions in mines, factories; and he does not undervalue the social mood. "And this force grows. What will it bring? Sir, I appreciate this maturing collective consciousness." (Wojtyla, 2005, 635)[699] The answer is absolutely unavoidable; it is about identity of person. "Sir, this anger is of an objective value. It is not possible to disappoint it." (Wojtyla, 2005, 637)[700] Though Wojtyla respects legitimacy of the social anger at which he is pointing e.g. in the collection *The Quarry*, he does not see the solution in the social revolution but in the revolution of love, in accepting the poor as brothers.[701] Here he connects the theme of love with the social theme. Neither solipsism nor egoism is a way out of the situation. Adam's friend Max sees the solution of the social issue

695 Wojtyla Karol, Canto del Dio nascosto, in: ibidem. It is published unsigned for the first time in the magazine *Glos Karmelu* in numbers 1/1946, 3/1946, 3/1947 a 5/1947. It is entirely published in Wojtyla's collected literary work *Poezje i dramaty* (*Básně a dramata*), Znak, Krakow 1980.

696 Wojtyla Karol, Fratello del nostro Dio, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro*,Bompiani (Milano 2005). In the play *Brother of Our God* the main character is Adam Chmielowski, the expressive figure of Polish history. Chmielowski participates actively in the revolt against Russia in 1863. He lives long years in Russian incarceration where his leg is amputated. Then he studies fine art in Warsaw, Paris and later in Munich. In 1870 he exhibits his first works; he is considered a distinguished artist. In 1880 he enters the Society of Jesus but after six months he leaves the noviciate from the reason of nervous exhaustion. Afterwards he lives in the country with his brother and as a Franciscan tertiary devotes himself to the poor. Then he comes back to Krakow, puts on a monk's robe, puts his vows into the bishop's hands and accepts the name Albert. This way the congregation of Albertine brothers emerges, followed soon by a woman branch, Albertine sisters; both branches of the order devote themselves to the care about the poor and homeless. Brother Albert dies on Christmas Eve 1916.

697 Cf. Szulc Tad, Jan *Pavel II. Životopis*, (Tok, Praha 1995), 124.

698 Cf. Taborski Boleslaw, Introduzione, in: Wojtyla Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro*, (Bompiani, Milano 2005), 581.

699 Wojtyla Karol, Fratello del nostro Dio (Jawień Andrzej, *Brat naszego Boga*,Tygodnik Powszechny 12/1979, Krakow), in. *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 635.

700 Wojtyla, Fratello del nostro Dio, 637

701 Cf. Wojtyla, Fratello del nostro Dio, 677.

in hermeneutic closing in oneself of everyone who wants to accomplish his assignment fully, (Wojtyla, 2005, 621)[702], while Adam chooses the path of openness.[703]

In 1950 the cycle of poems *Song on the Splendor of Water* was also published. Wojtyla, however, publishes both his poetic texts and dramas under the pseudonym Andrzej Jawień or Stanislaw Andrzej Gruda.[704]

All the experience Wojtyla is coming through is sooner or later reflected in his creation. Especially it is experience of labour in a quarry that gets engraved in his mind forever. In 1956 he described this experience in a poem consisting of four parts in free verse, *The Quarry*[705] that was published in *Tygodnik powszechny*.[706] In 1957 the publishing house Znak published a collection of poetry under the same title. *The Quarry* reacts on Marxist reducing and misusing the theme of human work. Hands are, according to Wojtyla, a landscape of heart: "Hands belong to the heart" (Wojtyla, 2005, 199)[707]

A year later the same publishing house publishes his collection *Profiles of a Cyrenean*[708] that comes out of Wojtyla's personal spirituality. In the function of The Way of the Cross Wojtyla contemplates intensively his whole spiritual life. He is deeply persuaded that everyone is in a certain sense a Simon of Cyrene.[709]

In 1960 his play *The Jeweler's Shop* followed.[710] He uses here not only realia as, for example, wedding rings but also positioning of characters. The interaction of two is always complemented with the third. Two are spouses, the third is a jeweller,[711] the unknown (God). Matrimony is not only reciprocal being in itself. Love that widens existence is at the same time participation on the absolute Being and on the absolute Love.[712] "Love is of a taste of a whole person...It cannot be

702 Wojtyla, Fratello del nostro Dio, 621.

703 Cf. Wojtyla, Fratello del nostro Dio, 619.

704 Cf. Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 117.

705 Wojtyla Karol, La cava di pietra (JAWIEŃ, Andrzej, *Kamienielom*, Znak 6/1957, Krakow), *in*: *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005).

706 Cf. Szulc, Tad, Jan *Pavel II. Životopis*, Tok, Praha 1995, p. 89. It is published under the pseudonym Andrzej Jawień in *Znaku*, č. 6 in 1957.

707 Wojtyla Karol, La cava di pietra (Jawień, Andrzej, *Kamienielom*, Znak 6/1957, Krakow), *in*: *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 199.

708 Wojtyla Karol, Profili di Cireneo, in: Ibidem. I tis written in 1957 under the pseudonym Andrzej Jawień and it is published in 1958 in *Tygodnik Powszechnym* no 13.

709 Cf. Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 96.
The jeweler's shop

710 Wojtyla Karol, Bottega dell´Orefice (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro*, Bompiani, Milano 2005. In the play in the first act Andrew gets engaged with Teresa, he later marries her. The second act shows the marriage of Stephane and Anna that is stricken by a lengthy crisis. Here also the character of Father Adam appears who is a family friend and strives to help them. Adam is probably an impersonation of the author's posture that stands against the hedonic concept of love which is focused only on itself. Anna wants to sell her wedding ring. But the jeweller refuses her with words: "*One has no weight in itself, only both have their weight together.*" Wojtyla, *La Bottega...*, p. 811. Everything essential takes place in front of the jeweler's shop, in one space of mind, consciousness, spirit. Stances and inner dramas of characters are connected by ceaseless aiming to the essential or its opposite. The main theme and the axis of the narrative is the issue of love.

711 The jeweller, for his moral authority, represents God. His jeweler's scales do not weigh objects but the whole human being and its destiny. Cf. Wojtyla Karol, Bottega dell´Orefice (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro*, (Bompiani, Milano 2005), 811.

712 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 867.

for a while. The eternity of man comes through it. Because it finds itself in God's dimension. Only God is eternity." (Wojtyla, 2005, 825)[713] In God is the future of man. "It is love what determines the future." (Wojtyla, 2005, 799)[714]

Love is felt in various ways. Perhaps as a challenge for man to take his destiny into his own hands. "Love is a constant challenge. God himself may challenge us so that we challenge destiny by ourselves." (Wojtyla, 2005, 849)[715] God himself is a challenge to man to take destiny into his own hands. Love is of a unifying character. "Love is a synthesis of two existencies that meet in one point and from two become just one." (Wojtyla, 2005, 817)[716] It is also a specific form of burden. "The weight of these gold rings is not the weight of metal but the proper weight of man." (Wojtyla, 2005, 789)[717] The real love bears in itself a relationship to God and to eternity.

Wojtyla links to this drama another play-poem *Radiation of Fatherhood.*[718] According to the philosopher Josef Tischner, the heart of the work is "creative interactivity of characters. We can express this idea in words: Thanks to you, I become myself and thanks to me, you become yourself. The experience of creative interaction is mysterious...We know that every human "I" is bearing inside a hint of "you"...It is important to say that all worldwide dramas describe the course of the interaction – either creative or destructive." (Tischner, 2005, 879)[719]

By this play Wojtyla crowned his unbound dramatic trilogy[720] It is the supreme artistic work. He does not give up the epic yet, especially in the first of the plays, but the texts are carried on in an utterly masterful way of continuity of thought that dominates the form and portrays of characters. Historical events and surroundings are transformed into their timeless dimension and only on this platform they communicate with the spectator or reader.

713 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 825.

714 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 799.

715 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 849.

716 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 817.

717 Wojtyla, Bottega dell´Orefice, (Jawień Andrzej, *Przed sklepem jubilera*, Znak 12/1960, Krakow), in: *Tuttel le opera,* 789.

718 Wojtyla Karol, Raggi di paternitá (Gruda, Stanislaw Andrzej, Promieniowanie ojcostwa, */ Radiation of fatherhood/* Znak 11/1979, Krakow), in: Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro (Poezje i dramaty, Znak, Krakow 1980), (Bompiani, Milano 2005). In the play *Radiation* of *fatherhood* the author links to what he began in the drama *The Jeweler's Shop*. Both works coincide with Wojtyla's study *Love and Responsibility*. The author deepens here various adumbrations, parables of the inner world. The outer situations, the outer world, the outer space is just an image of what is going on inside. The number of actors is minimized: Adam, the mother, Monika. Adam is an image of every man, he is a synonym of humanity, of common fate. All the figures are of a symbolical character. Monologues prevail and even dialogues have the nature of a monologue. The whole second and the third part are written in prose. Monologues between Monika and Adam, the child and the father are of an archetypal character.

719 *„If I love, I must always choose you in me, so I must always give you birth and always be born in you."* Wojtyla Karol, *Raggi di paternitá* (Gruda, Stanislaw Andrzej, *Promieniowanie ojcostwa*, Znak 11/1979, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 933.

720 The trilogy consists of dramas *Our God's Brother* written in 1944-1949 but first published 22th December 1979 in *Tygodnik Powszechny,* then *The Jeweler's Shop* written in 1960, first published in *Znak* no. 12 in 1960 under the pseudonym Andrzej Jawień and *Radiation of Fatherhood* written in 1964 and published in *Znak* no 11 in 1979 under the pseudonym Stanislaw Andrzej Gruda. The unbound part of this play is its independent continuation *Meditations on Fatherhood* which he writes in 1964 and the same year publishes in *Znak* no. 5 under the pseudonym *Andrzej Jawień*.

Wojtyla is still interested in literature. Examining of human experience attracts him. He strives to bring his students to literature, he even spurs his colleague Stefan Sawicki to study and read modern "*dark literature*" as *The Plague* by Camus.[721] Rocco Buttiglione is persuaded that Wojtyla perceives literature as a *locus theologicus* in which the idea of sainthood of man meets with the idea of estrangement: "Wojtyla tries to show in his work that the only one choice in front of which modern man finds himself is to choose between the sainthood and the loss of humanity." (Buttiglione, 1998, 242)

In 1963 his poetic cycle *The Church* is published.[722] His poetry always corresponds thematically with his philosophical and theological way of thinking. In the time of council it focused on the essential issues of the mystic character of the church. In 1965 another cycle of poetry *Journey to the Holy Places* was published.[723]

The next year the poem in prose *Meditation on Fatherhood*[724] is published. In 1966 Poland celebrated the thousandth anniversary of acceptance of Christianity. The same year Wojtyla's poem *Easter Eve 1966* is published. It is written at the occasion of a thousand years from Mieszko's accepting of baptism. In Polish history is this event perceived as the baptism of Poland. Its plane, similarly as that of the poem *Stanislaus*, is not carried by the spirit of Polish messianism as it is presented by the Polish romantic tradition; it is rather inspired by philosophy of history, in which the poet walks through his nation's history and strives to find a deeper sense of being of man and history outside history, in God.

Karol started getting acquainted with his nation's history very early.[725] He searches here the meaning and encouraging for the present time. One of the key characters that would influence him strongly is a bishop – martyr, Saint Stanislaus. Wojtyla's relationship to St. Stanislaus does not weaken even later. It rather grew, especially at the time when he was shortly after war ordained a priest. Afterwards he in 1954 joined the faculty at the Catholic University in Lublin as a professor of Christian philosophy, he gathered around him the best historians to discuss the circumstances of Saint Stanislaus' death.[726]

The meditative plane that in his work intersperses with patriotism and philosophy of history is present also in the poem *Thinking Homeland...*from the year 1974. In the fourth part of the poem Wojtyla's thoughts, on the background of the homeland's history, turn to the misuse of liberty that arouses the need to fight for it. The poem opens itself to all nations, the whole universe becomes the homeland. The poetic cycle *Thoughts on Death* is published in 1975 and three years later a long poem *Stanislaus* is published, still under the pseudonym. In 1967 the Polish communist regime shuts down the Rhapsodic Theatre.[727]

However we must not miss out the fact that Wojtyla's literary work is accompanied in a symbiotic relation also with his scientific-theoretical work. His poems try to capture certain facts of his theoretical thought and spiritual essence on the base of metaphoric meanings and make out

721 Cf. Weigel George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 122.

722 Cf. Weigel, George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 151.

723 *Wedrówka do miejsc świetych* originated around the year 1965 as an authentic record of his visit in Israel, published in *Znak*, no. 4 in 1966 under the pseudonym Andrzej Jawień.

724 Wojtyla, Karol, Karol, Considerazioni sulla paternitá (Jawień, Andrzej, *Rozważania o ojcostwie*, Znak 5/1964, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005).

725 Cf. Weigel, George, *Svědek naděje. Životopis papeže Jana Pavla II.*, (Práh, Praha 2005), 35.

726 Cf. Szulc, Tad, Jan *Pavel II. Životopis* (Tok, Praha 1995), 25.

727 Cf. Szulc, Jan *Pavel II.,* 214.

of them the object of metaphysics.[728] For example in the poem The Samaritan Woman the well becomes a body, an eye, the eye becomes Christ, Christ's heart into which the Samaritan woman is accepted. Christ's heart becomes a hug of eternal love and conversion. It seems as if we were reading, again and in new way, *Song of Songs*.

At Wojtyla, the written word strives to copy reality. And this experience of reality in his work refers towards the Entirely Other. The name Adam appears in his poems very often. It is an emblematic metaphor of man. The poetic subject is identical with Adam. Wojtyla thus refers to the relation of a person to God, a personal relation. The person is born from the interaction of "I" and "you". The ground of this relational structure "I" and "you" is the relationship of both to the personal "You", to their personal God. Nevertheless, this Adam got lost to himself and walks through the process of seeking. In *Reflection of Fatherhood* the author puts following words into Adam's mouth: "For many years I have lived like a man exiled from my deeper personality yet condemned to probe it." (Wojtyla, 2005, 955)[729]

Conclusion

Wojtyla's world of thought contained in his literary work is markedly anthropocentric. It is shown in his dramas or poetry and it is so also in his theoretical work that is strikingly unique and paramount form of Christian personalism. "Yet can the current unbind their full strength? It is he who carries that strength in his hands: the worker." (Wojtyla, 2005, 195)[730] Wojtyla's poetry gives the impression of a compact amalgam of form and contain that is entirely oriented to universal values of man. It would be very difficult to find in the modern poetry a similar expression that would concern with man, his nature, his relation to history and his final fate lying in God that intensively.

A study dedicated to inspiration in Karol Wojtyla's poetry would certainly be very interesting. We have no space for it here. Just as a sidelight we note that Wojtyla is not a poet of wide intrinsic inspiration. His writing carries remarkable traces of intellectualism and time to time also a didactic-pedagogic purpose which does often to his poems harm.[731] This of course does not change anything on the fact that he, in his best poetic manifestations, reaches the qualities of a genuine poet. Some authors compare his style with that of the great modern poet T. S. Eliot or Charles Peguy.[732]

The most distinctive plane of Wojtyla's both poetic and dramatic work is meditation that is mostly a monologue of a poetic subject and is of a strikingly philosophizing setting. "Who said that on the balance of the world man outweighs?" (Wojtyla, 2005, 173)[733] The one who pronounces the word is perceived as the one who raises a question, an issue, who carries an idea, who calls to the struggle for truth. About the intimate, meditative nature of his poems[734] testifies the fact that Wojtyla never recited his poetry in public and that it was never published under his own name until 1978, when the secret of his pseudonyms was revealed.[735] The only one exception is perhaps his last collection of poetry *Roman Triptych*[736] that summarizes themes noted above, in which the experience of papacy becomes a lived experience and from which the poetry of the collection is coming out, from which it is drawing. Even here it is possible to speak about an author pseudonym since it is published under his pontifical name John Paul II.

AUTHOR CONTRIBUTIONS The mentioned author significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST The author declares that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, the author declares that there is no conflict of interest related to this article or its review.

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728 Cf. Bettetini, Massimo, Introduzione, in: Wojtyla, *La dottrina della fede in San Giovanni della Croce*, (Bompiani, Milano 2003), 17.

729 Wojtyla, Karol, Considerazioni sulla paternitá (Jawień, Andrzej, *Rozważania o ojcostwie*, Znak 5/1964, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 955.

730 Wojtyla, La cava di pietra (Jawień, Andrzej, *Kamienielom*, Znak 6/1957, Krakow), *in*: *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 195.

731 "The axis of Wojtyla's poetic work coincides with theology and philosophy; this axis lies in the dynamic concept of man, not only in his earthly dimension but most of all in his metaphysical ground and in his eschatological determination. The concept constructed by this way puts necessarily a question if it is possible to compose the poetic work on the basis of philosophical and theological plans. Wojtyla does not use philosophical terms and conceptions as a theme of a discourse but as a topic for reflection and meditation." Reale Giovanni, Karol Wojtyla pellegrino sulle tre vie che portano alla veritá: Arte, Filosofia, Religione, in: Wojtyla Karol, Metafysica della persona. Tutte le opere filosofiche e saggi integrativi (Milano 2005), XXIII.

732 Cf. Taborski Boleslaw, Introduzione, in: Wojtyla Karol, Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro (Bompiani, Milano 2005), 755.

733 Wojtyla, Karol, Profili di Cireneo (Jawień Andrzej, *Profile Cyrenejczyka*, Tygodnik Powszechny 13/1958, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), (Bompiani, Milano 2005), 173.

734 Cf. Karol Dybciak, Poetycka fenomenologia czlowieka religijnego. O literackiej tworczości Karola Wojtyly, in: *Sacrum v literaturze* (Lublin 1983), 148-165.

735 Cf. Taborski Boleslaw, Introduzione, in: Wojtyla, Karol, *Tutte le opere letterarie. Poesie, Drammi e Scritti sul teatro* (Bompiani, Milano 2005), 4.

736 Jan Pavel II., *Římský triptych* (Kostelní Vydří), 2003.

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Wojtyla, Karol. *Raggi di paternitá* (Gruda, Stanislaw Andrzej, *Promieniowanie ojcostwa*, Znak 11/1979, Krakow), in: *Tuttel le opere letterarie. Poesie, Drammi e Scritti sul teatro* (*Poezje i dramaty*, Znak, Krakow 1980), Bompiani, Milano 2005.

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PROPOSAL FOR A CHRISTIAN ICONOGRAPHY AMONG THE BAMILEKES OF WEST CAMEROON: THE EXAMPLE OF THE „STATIONS OF THE CROSS"

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Abstract
Meditating on the „Stations of the Cross" in the Roman Catholic Church is a prominent congregational prayer. It is a fourteen-station liturgy that follows the „passion of Christ," often illustrated using paintings in Christian churches like those in the Bamileke region. These tables are on the fringes of the local community due to their representational style. Hence, there is a problem of image accessibility socially, as well as the valorization of endogenous cultivation elements; thus, our goal is to translate scenes from the „Stations of the Cross" into a visual image inspired by Bamileke cultural elements; which is the primary goal of this study. The creative process revolves around the following points: representation of local culture's symbolic patterns, graphic research, and compositions on the theme of the „Way of the Cross" adaptation of these compositions to the Bamileke sculpture's characteristics and fusion of the obtained motives and cultural elements. Our results are paintings with a variety of shapes and colours that are better suited to the cultural expression of the territory. We illustrate with the Bamileke tribe to demonstrate that a peoples' cultural values are similar to the majority of the evangelical message on multiple levels. At the end of this study, we would like to discuss the stakes of the representation of the black race character in Christian iconography in the Western Middle Ages.
Keywords: Iconography –"Stations of the Cross" – Painting – Bamileke people – Local culture.

Introduction

Iconography is a methodical study of plastic representations (for example, paintings, sculptures, engravings) of a given subject, such as a person, time, theme, symbol, place, civilization, or religion, including their sources, meanings, and classification. The central theme of Christian iconography is the character of Christ. According to the Catholic Church, the „Stations of the Cross" (via Crucis).[738] is the subject of a reasonably varied repertoire of artistic representations.

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✉ **Wang Ai Hong Professor of Products Design Department, Jingdezhen Ceramic Institute, Jingdezhen**
✉ **Elena Enanga Esembe MSc. Student of Public Administration Department, Shanghai University of Finance and Economics**

738 Timothy Matovina and Gary Riebe-Estrella, *Horizons of the Sacred: Mexican Traditions in U.S. Catholicism, Cushwa Center Studies of Catholicism in Twentieth-Century America* (Cornell University Press, 2018).

It is designated to commemorate the „Passion of Christ“ by evoking 14 particular moments (some from tradition and not reported in biblical writings). These ceremonies occur during Lent, especially on Good Friday. The ceremony sometimes includes a procession of activities comprising of sermons, meditations, and prayers; then Catholic Christians proceed to carryout obeisance in front of 14 paintings[739], crucifixes and other symbols arranged either around the Church or an adjoining place (usually a path reproducing the ascent at Calvary), within the church premises.

By extension, the „way of the cross“ designates all the tangible symbols (paintings, statues, plaques, crucifixes) marking the various stations of the ceremony. After visiting many Catholic churches within the Bamileke community, the researcher observed the following; firstly, most of the iconographies found there are on the fringes of the local cultural context. This finding highlights a significant problem of accessibility to all social strata and valuing local culture elements.

Consequently, this research focuses on the icons retracing the passion of Christ, also quoted as the „way of the cross.“ The icons mentioned include the environmental setting, the characters‘ representation, attire, and many other elements omitted from the paintings found. This observation leads us to wonder about the creative process of translating the scenes of the „Stations of the Cross“ into a striking image based on Bamileke cultural elements and making a fragment of the liturgical texts more accessible while enhancing the local culture.

The primary question generates several others that permit an in-depth examination of the problem. This study addresses the problem using the following research questions; What masterpieces materialize the „way of the cross“ amongst the Bamileke community, especially in Cameroon? How do these masterpieces in the Roman Catholic church influence the behaviour in the context of the Bamileke‘s? What is the iconological meaning of the symbols of the Bamileke people?[740] How to use them within the framework of the pictorial creation of the „way of the cross“? What plastic analysis results from these pictorial achievements?

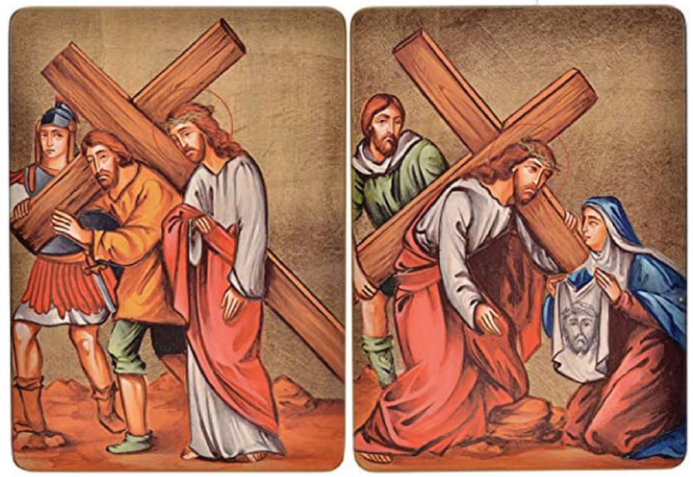
Some Masterpieces Which Materialize The „Stations of The Cross“ In the Roman Catholic Church in Europe and Cameroon

According to Franciscans in the 14th and 15th centuries, the stations depicting the „way of the cross“ highlight the various stages of Jesus‘ journey to Calvary. The number of stations varied from fourteen to fifteen stations until the end of the 17th century, when it upgraded at fourteen. It was Popes Clement XII and Benedict XIV who fixed the form of this devotion.

739 Claude Louis-Combet, Via Crucis: the „way of the cross“ by Gabriel Saury, the Workshop of the capercaillie 2012.

740 Benoît Thery, *Intercultural Management in Africa: Renaissance* (EMS Editions, 2020).

Representations in Europe



Painting 1: « Imprimerie Chemin de croix 15 stations », (Holyart Tableaux Chemin de Croix 15 Stations Bois : Amazon.fr: Cuisine et Maison amazon.f).

Painting 2 : « Holyart Chemin de Croix 15 Stations 50x38 cm Impression sur Bois », (*https://www.amazon.fr/Chemin-Croix-stations-50x38*impression/dp/B01CK8RDMM)

The pictorial achievements above are closer to those made during the classical period. At first glance, the term „classic“ appears in the Renaissance and denotes, as opposed to Gothic art, an aesthetic defined after the ancient Greco-Roman model. At the end of the 19th century, the art historians gave its current meaning to the notion of „classicism“ to define this current,

which developed from the end of the Fifth Century in the plastic arts, architecture, literature, and philosophy.[741]

The classical art of the 17th century is a continuation of that of the Renaissance. Its keywords are always the search for mathematical harmony, the antique style, the observation of nature, the art of perspective, modeling, and anatomy. The artists put order and symmetry at the forefront of their ideal of beauty. The paintings encompass aspects of drawing, the sharpness of the contours while highlighting the sequence forms and privileged treatment of the materials. In other words, the paintings show the effects of colours, lighting, and the play of crucial characteristics of baroque art, something that the artist prefers to erase with a smooth invoice. Such specificity is a characteristic of classical painting.

For more or less valid reasons, we can say that in Cameroon, the representation of the „way of the cross" does not have the same echo as in Europe.

Some representations in Cameroon and Bamileke territory

Through his many creations, the Reverend Father Engelbert MVENG continues to contribute to Christian art worldwide and Cameroon in particular. The eminent Man of God further describes African traditional art as the creative work of the Negro-African genius; through this work, man expresses his vision of the world, his vision of man, and his conception of God.[742] Art is lived and expressed in music, dance, and poetry. Therefore, art is a cosmological, anthropological, and liturgical language.

Painting 3: R.P.E Mveng, (https://www.pinterest.com/eliamdedieu/chemin-de-croix-mveng/)

741 Martin Galinier, François Baratte, *Roman funerary iconography and society: Ancient Corpus, new approaches?* History of Art (University Press of Perpignan, 2019).

742 R.P. E, MVENG, B*lack African art, cosmic liturgy, and religious language* (Editions) mame, POINT OMEGA, Paris, 1964. p 120.

The first Christian paintings were traced to the Yaoundé region (Nyon-et-So department, Bicop parish) in the 1935s with the artist and catechist Max Mintsa.[743] The themes he developed in his works are the „Stations of the Cross" and Hell.[744]

Painting 4: Jesus carrying the cross (Max Mintsa), Nyon-et-So department, Bicop parish, centre- Cameroon, picture by V, ABOUNA ABOUNA

Painting 5: Holy Trinity Church of Bafoussam/ west Cameroon,
4th station: Jesus meets his mother (picture by Majolie Carine Djoukwo Tsanetse)

Ultimately, African art is limited to arrangements of shapes and colours that no longer even have sign values referring to the sensitive world. It is a „surrealist" art whose proponents attach significant importance to thematic elements, often unusual in themselves or their connection, and the irrational meaning they can take on.

743 V, ABOUNA ABOUNA, 2006. Contribution to the study of religious iconography in Cameroonian art from 1935 to 2004: The case of Catholic Christianity in painting in Yaoundé, Master's Thesis in Art History, University of Yaoundé I, Yaoundé.

744 V, ABOUNA ABOUNA, 2007. Studies of the „Way of the Cross" in Cameroonian religious art of the twentieth century: The case of painting and sculpture in the center province, D.E.A.A. thesis in Art History, University of Yaoundé I, Yaoundé.

General Information on The Bamileke People and Their Symbols

This point briefly discusses the history of the Bamileke people.

Picture 1: The sizeable Bamileke hut (case Badjounaise), http://armelletouko.canalblog.com/albums/connais_tu_mon_beau_pays__region_de_l_ouest_cameroun/photos/74645315-cage_badjoun.html

Historical overview

The Bamileke are a people of Central Africa, living in the West region of Cameroon.[745] They are denizens of the „Bamileke Country," a vast region of the savannah in the volcanic highlands of the Grassland, making them the largest ethnic group in the country.[746]

According to D. Toukam[747] the Bamileke originates from the Baladis of Sudan. The current Feelahins / Copts[748] are recognized as Baladi's who got assimilated though retaining significant aspects of their ancestral culture. After exiting Upper Egypt in the 9th-century A.D.D., the Baladi-Bamileke arrived in the Tikar region in the 12th century.[749]

745 J-P, NOTUE, and L, PERROIS, Contribution of ethnological research to the history of Civilizations in Cameroon (CNRS, Paris, 1973).

746 J-P, NOTUE, *Study of the plastic arts: iconographic inventory and analysis of the artistic heritage of western and north-western Cameroon,* research mission report in Cameroon MINREST / ORSTOM, Paris, 1994.

747 Dieudonne Toukam, *History and anthropology of the Bamileke people* (New edition, revised and augmented), (Éditions L'Harmattan, 2016).

748 Collective, editors Lisa Chauvet, Flore Gubert, Thibault Jaulin, Sandrine Mesplé-Somps*, Migrants actors of political change in Africa? sociological overtures* (De Boeck Supérieur, 2018).

749 J-P, NOTUE, *Place du Kè et du sacré in the arts of Western Cameroon* (MESIRES-ISH / ORSTOM, Yaoundé, 1990).

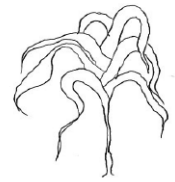
Presentation of Bamileke symbols that will be used in the design of the works

a) Symbolic motives

Drawing 1: the Bamileke stool (Majolie Carine Djoukwo Tsanetse)

Drawing 2: Architecture bamiléké (Majolie Carine Djoukwo Tsanetse)

Drawing 3: The Palm tree (Majolie Carine Djoukwo Tsanetse)



Drawing 4: The tree of peace (Majolie Carine Djoukwo Tsanetse)

Their meanings[750]

- The stool: It symbolizes royal power.
- The conical roof of architecture: It is the most characteristic type of habitat of the Bamileke people
- The Palm tree; The palm tree is unique in that it produces a drink that is very popular in the region called white wine. Its ribs contribute to the manufacture of habitats, stools, and many other everyday objects in traditional society. The palm nuts it offers to contribute to making the nutritionally highly prized red oil.
- The tree of peace; From its scientific name, dracaena is present in most Bamileke concessions in western Cameroon. As its name suggests, it symbolizes peace.

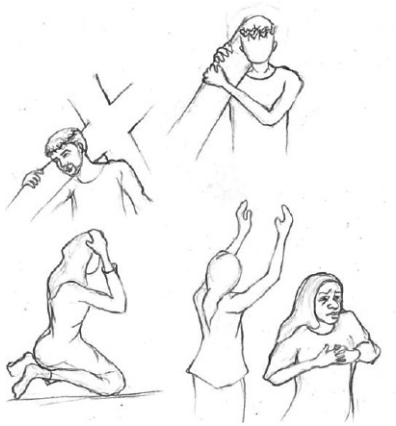
Design and Production

By way of illustration, we have chosen the fourth station of the Stations of the Cross: „Jesus meets his mother."

750 Jean Paul NOTUE, 1988, the symbolism of the arts Bamileke (West Cameroon): historical and anthropological approach, Thesis for the Doctorate of the University of Paris I, under the direction of Jean Devisse, available on the website: http://www.theses.fr/1988PA010669

Conception

- **Graphic research and compositions**



Drawing 5: Graphical search for the fourth station (Majolie Carine Djoukwo Tsanetse)

Drawing 6: First composition (Majolie Carine Djoukwo Tsanetse)

Drawing 7: Second composition (Majolie Carine Djoukwo Tsanetse)

Drawing 8: Third composition (Majolie Carine Djoukwo Tsanetse)

Drawing 9: Fourth composition (Majolie Carine Djoukwo Tsanetse)

- **Graphic adaptation of the Compositions to the Bamileke sculpture characteristics.**

According to Lecoq[751] this sculpture is characterized in the old formula by an extraordinary plenitude of forms starting with the head, moving to full cheeks and a rounded forehead, the strong shoulders clinging to a mighty bust prominent belly on short, folded legs[752] It evolves in the current style towards a more geometric representation of volumes and lines.[753] We illustrate this in pictures 2 and 3 below.

751 Raymond Lecoq, 1958, digitized (2008), the Bamilekes, African Presence, An African civilization.

752 R.P. E, MVENG, *African Art and Handicrafts* (Editions CLE, 1980).

753 J-P. NOTUE, *Batcham sculptures du Cameroun*, Musée de Marseille, Réunion des Museums Nationaux, Marseille, diffusion Threshold, 1993.

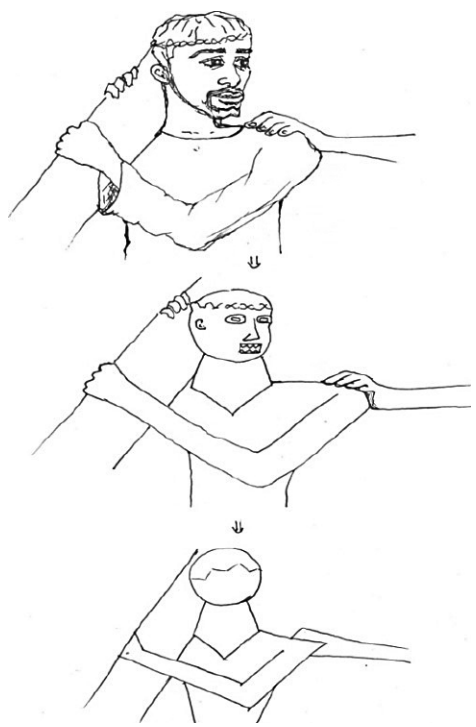
Picture 2: Princesse Bangwa, Man Ray, https://detoursdesmondes.typepad.com/dtours_des_mondes/2007/04/princesse_bangw.html

Picture 3: Couple bamiléké cérémoniel, by Anne Doridou-Heim, (https://www.gazette-drouot.com/article/couple-bamileke-ceremoniel/26203)

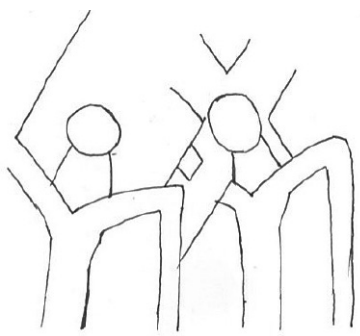
Drawing 10: Adaptation of the compositions, case of the 1st composition (Majolie Carine Djoukwo Tsanetse)

Drawing 11: Adaptation of the compositions, case of the 2nd composition (Majolie Carine Djoukwo Tsanetse)

Drawing 12: Adaptation of the compositions, case of the 3rd composition (Majolie Carine Djoukwo Tsanetse)

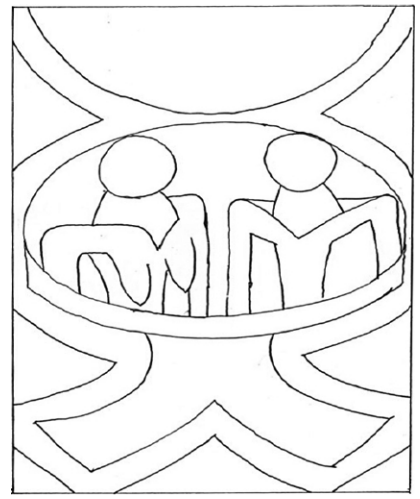


Drawing 14: Adaptation of the compositions, case of the 4th composition (Majolie Carine Djoukwo Tsanetse)

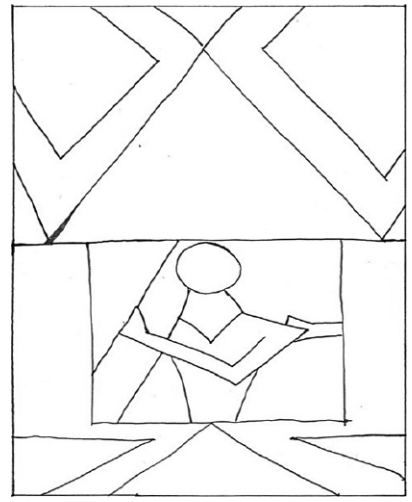


Drawing 13: Adaptation of the compositions, case of the 3rd composition (Majolie Carine Djoukwo Tsanetse)

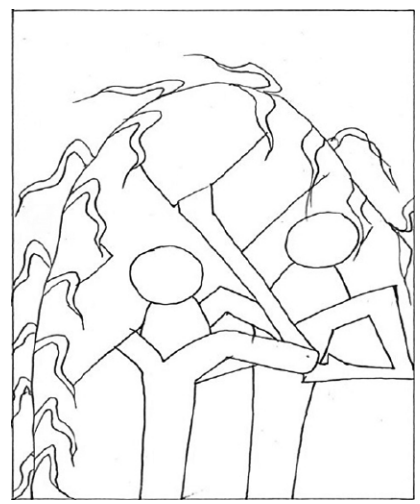
- ***Fusion of motifs and cultural elements***



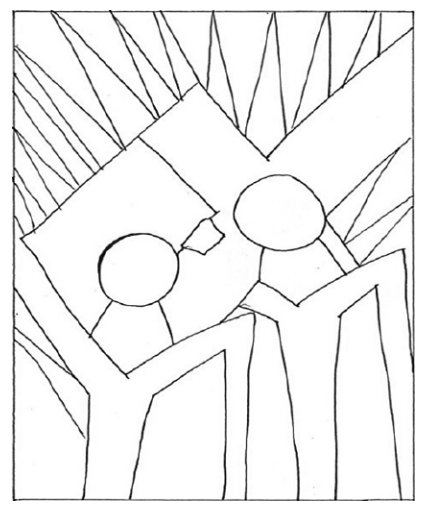
Drawing 15: merger 1 (Majolie Carine Djoukwo Tsanetse)



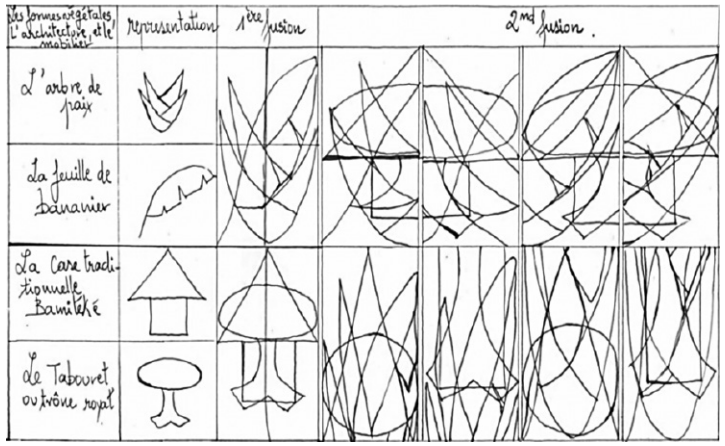
Drawing 16: merger 2 (Majolie Carine Djoukwo Tsanetse)



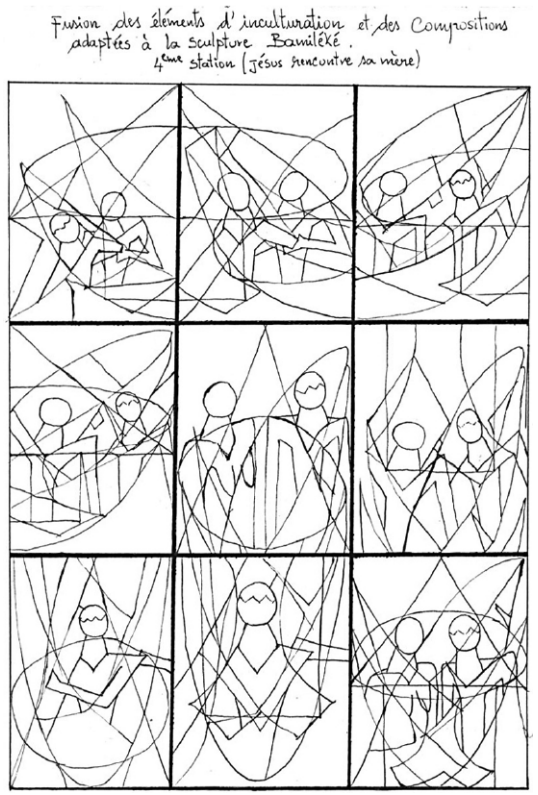
Drawing 17: merger 3 (Majolie Carine Djoukwo Tsanetse)



Drawing 18: merger 4 (Majolie Carine DjoukwoTsanetse)



Drawing 19: study sheet designed by Cameroonian artist Pascal KENFACK [17], drawing by Majolie Carine Djoukwo Tsanetse



Drawing 20: other compositions (Majolie Carine Djoukwo Tsanetse)

Realization

- Realizations on paper

Painting 6: preparatory study 1, Majolie Carine

Painting 7: Preparatory study 2, Majolie Carine Djoukwo Tsanetse. Djoukwo Tsanetse.

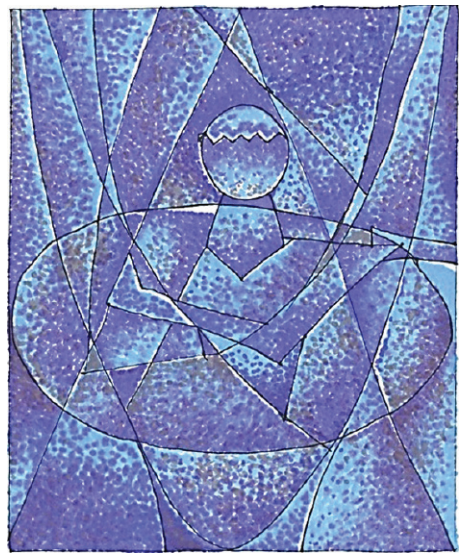
Painting 8 : Preparatory study 3, Majolie Carine

Painting 9: Preparatory study 4, Majolie Carine Djoukwo Tsanetse. Djoukwo Tsanetse.

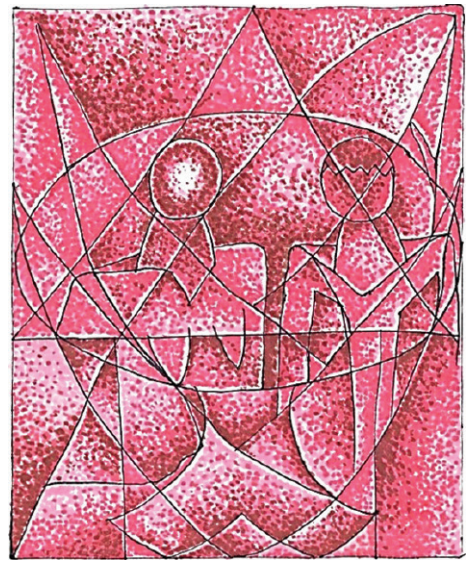
Painting 10: Preparatory study 5, Majolie Carine

Painting 11: Preparatory study 6, Majolie Carine Djoukwo Tsanetse. Djoukwo Tsanetse.

Painting 12: Preparatory study 7, Majolie Carine

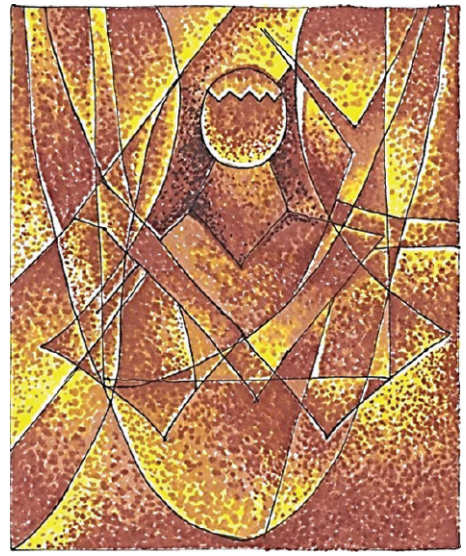


Painting 13:Preparatory study 8, Majolie Carine Djoukwo Tsanetse. Djoukwo Tsanetse.



Painting 14: Preparatory study 9, Majolie Carine

Painting 15: Preparatory study 10, Majolie Carine Djoukwo Tsanetse. Djoukwo Tsanetse.



Painting 16: Preparatory study 11, Majolie Carine

Painting 17: Preparatory study 12, Majolie Carine Djoukwo Tsanetse Djoukwo Tsanetse

- A work on canvas

Painting 18: Fourth station of the „Stations of the Cross": Jesus meets his mother, Mixed technique (acrylic + calabash on canvas)70x100cm (Majolie Carine Djoukwo Tsanetse).

Analysis of the work

Following the iconographic/iconological analysis method established by Panofsky[754], the result discussion follows thus; In measuring 70 x 100 cm, the painting presents two characters in contact. One carries a cross, presumably Jesus, while the other raises his left hand to the sky in prayer to Providence, thus showing his discontent at the injustice of which his Son is the victim. According to biblical accounts, it is about Mary, the mother of Jesus. The coming together of these two characters reflects the communion of spirit between them, which is why they share the same suffering.

754 Erwin Panofsky, *Studies in Iconology: Humanistic Themes in the Art of the Renaissance* (New York: Oxford University Press, 1939).

The palm tree, which is part of the composition of this work, symbolizes life in Christianity.[755] It refers to divine Providence because it indicates a water point. Its fruits which produce palm oil (highly nutritious), support life. Moreover, it is the hallmark of the martyrs. The presents of palm trees in an area signify waterholes for many pilgrims mentioned in the Bible. In the West region of Cameroon, the palm tree sells at high prices for a variety of reasons, including the use of its veins in architecture, the raffia wine it produces, and the red oil that emanates from its nuts.[756] Simply put, the palm tree is of particular interest to the average Bamileke.

Therefore, its use in the representation of this scene reflects the great interest in copying the example of Mary, mother of Jesus. She accompanies her Son with great sorrow and affection. She is, all the same, aware that the outcome of this passion will be victorious for her Son. The relationship between pilgrims who seemed marveled upon gazing at the palm tree signifies a water point. The dominant tone here is green. Its symbolism is associated with that of plants.[757]

Christian iconography is a premonitory color of rebirth or regeneration, as the heart of a renewed hope.[758] In general, Bamileke art gives green the identity of growth by using examples of plants. Plants capture the natural forces of the earth and receive solar energy. They accumulate this power, hence their property.

Issues and study perspectives

- ***Functionality***

Cultural function

The study constitutes a kind of language whose reading is accessible to all men of the earth, beyond the differences of culture, languages, and borders. Indeed, the paintings that we have made contain everything: the past, the traditions, the philosophy of the people concerned. On this subject, Madeleine Ochsé affirms: „the meeting of cultures: Africa / West is inevitable for a society in perpetual change. From this fusion, a great unsuspected art, the artists of the Christianized countries will be the creators. „[759]

Utility function

Because of the iconological study on the painting, we can note that it presages a factor in improving human behavior. We have explored the rather vast field of Bamileke cultural elements, thanks to which works have been conceived and produced. This exercise leads us to say that Christianity, like the local traditional religion, promotes solid moral values to facilitate social cohesion. To this end, Reverend Father Engelbert Mveng.[760] asserts that African art is essentially religious. It carries a single message: the call of man to seek his salvation, the victory of life over death.

755 Eugene Muntz, *Studies in the History of Christian Painting and Iconographer* (Good Press, 2021).

756 J-P, NOTUE, *Secret societies among the Bamileke of western Cameroon* (ISH / ORSTOM, 1984).

757 Manuel Gutierrez, Michèle Ballinger, Manuel Valentin, Mathilde Buratti, Collective, 2016. *Colors in the arts of Africa. From Prehistory to the present day,* Contemporary Archives, 119 pages; J-P, NOTUE, 1978, *Contribution to knowledge of the arts Bamileke (west Cameroon)* thesis by D.E.S, Department of History, University of Yaoundé, Mimeo.

758 Christophe Stener, Anti-Semitic Iconography of the Life of Judas Iscariot: Christian Art, BoD - Books on Demand, 2020.

759 Ochsé, M, *A sacred art for our time, I know I believe* (Paris, 1959), 132.

760 R, P, E, MVENG, *Africa in the Church: Word of a Believer* (Harmattan Publishing, Paris, 1985), 54.

- ***Religious issues***

The present achievements advantages are favourable to the materialization of the concept of inculturation in the Church. It is a notion developed by the Catholic Church at the end of the 1970s to denote the consideration by the clergy of local cultural specificities.[761] It is a two-way adaptation: of the Gospel message from the point of view of a specific culture (African or Chinese, for example); of the cultural milieu affected by evangelization, who discovers in Christianity a way to enrich and deepen their vision of the world.

Saint John Paul II, notably having approached the subject in several encyclicals and during numerous speeches, defines inculturation as «The incarnation of the Gospel in indigenous cultures, and at the same time the introduction of these cultures. in the life of the Church. «[762] It» signifies an intimate transformation of authentic cultural values by their integration into Christianity and the rooting of Christianity in the various human cultures.»[763]

It is a theological term that has been defined in *Redemptoris Missio* 52[764] as the continual dialogue between faith and culture. By this, we mean introducing the Gospel to the culture, the act of the African. It is a process by which the African tradition is recognized, accepted, and affirmed as welcoming and conveying biblical texts like all other so-called Christian beliefs.[765] Behind the challenge of liturgical inculturation in an African context is searching for African habits and practices.[766] In this sense, this process becomes a gradual or brutal lifting of the ban on African culture and its liberation from the Western culture.[767]

In short, with the Second Vatican Council (1962-1965), a new dynamic was set in motion, pushing the young Churches of Africa to explore avenues of evangelization suited to their environment. The publication of the Apostolic Exhortation *Evangelii Nutiandi* after the 1974 synod calls for a greater reconciliation of Africanity with Catholicism and lays the sure foundations for evangelization.[768] The pastoral visits of Pope John Paul II to Cameroon in 1985[769] and especially in 1995 with the publication of the post-Synodal Apostolic Exhortation will consolidate the churches of Africa on the path to the incarnation of Christ.

761 Dominique KAMGA SOFO, *Church and Culture of Africa, the Djo of West Cameroon* Harmattan, 2010.

762 L, Santedi Kinkupu, *Dogma and inculturation in Africa: perspective of a theology of invention* (Éditions Karthala, 2003). 139.

763 R, Luneau, *Words and Silences of the African Synod* (1989-1995) (Éditions Karthala, 1997), 48.

764 Francois Dussaubat, Jean-Paul II: *Texts chosen by François Dussaubat, Spirituality in pocket* (Artège Editions, 2017).

765 JOSEPH NDI OKALLA, *Inculturation and conversion: Africans and Europeans facing the synod of churches in Africa, Christians in freedom, Christians in freedom: disputed questions, Collection Christians in freedom* (Karthala, 1994).

766 Celestine Colette Fouellefak Kana wife DONGMO, Religious values and sustainable development: an approach to analyzing the institutions of the Bamilekes of Cameroon (African Collective Books, 2010).

767 Celestine Colette Fouellefak Kana wife DONGMO, 2005, *Western Christianity has the test of African religious values: the case of Catholicism in Bamileke country in Cameroon (1906-1995),* Doctoral thesis in history, under the direction of Claude Prudhomme, Lyon 2, available on the site: theses.fr/2005LYO20086

768 J-P, MESSINA, Christianity and the Quest for Identity in Africa (Clé, Yaoundé, 1999).

769 J. EKASSI NYEBELE, 2008-2009, Reception of the Vatican Council II in Cameroon by Mgr Jean ZOA and the National Episcopal Conference of Cameroon (CENC): 1965-1998, Thesis of DOTORAT PH. D in History, Yaoundé-Cameroon.

- ***Issues related to artistic creation***

Our achievements highlight the purification of forms, which calls into question representations according to Western aesthetic canons. In artistic creation, the production promotes recovered objects (gourds, sawdust, fine sand, among others). Art must be so unconcerned with the means of expression. Beauty can arise from the union of the most unexpected materials, provided that the hand which assembles them is that of an artist.[770] The main thing is the inspiration, not the technique; the authentic artist can with any means translate his inspiration.

Conclusion

Many scholars have approached themes dealing with Christian iconography differently, including the representation of the «Stations of the Cross.» They did so in painting, sculpture, ceramics, and other more or less tangible means.[771] Often, such paintings can be found on the walls of our religious buildings, whether in Europe, Africa, or Cameroon.[772] We can observe there is a disparity in style and the criteria of their design. An illustration in the West region is in the various works presented for the «Stations of the Cross.» Either in paintings or sculpture, each art follows the principles of classicism. In the case of painting, the representations are linear, favouring the drawing, and therefore the sharpness of the outlines. Great importance is attached to the construction of space in successive planes.

In Africa, R.P. Engelbert Mveng is one of the most expressive artists in Christian art. He stands out from others by the originality of his works. The «Stations of the Cross» that he designed and produced considers the Negro-African aesthetic through the shapes and colours used. Léopold Sédar Senghor[773] theorized it in seven main characteristics: Negro-African art is inseparable from personal work, it is an art engaged in daily life, based on collective practices, the different art forms are correlated, the schematism and the stylization of the forms pass by the image and the rhythm, African art is not descriptive but explanatory, it is an engaged art and always topical.[774]

In Cameroon and more in Bamileke country, images of the «Stations of the Cross» have come under the influence of Western standards of representation. The present study made it possible to design representations more adapted to the local Bamileke cultural context.

The cultural elements gave rise to the motifs that use a pictorial creation. From these elements, we set up a process of creation whose purpose was to design and produce paintings on the theme of the «Way of the Cross.» The creation focuses on several points: Graphic research and the compositions, the adaptation of the compositions to the criteria of Bamileke sculpture, the fusion of Bamileke motifs and cultural elements.

As for the realization, the author used coloured pencils on paper and canvases using a mixed technique. She combines acrylic and the collage of salvaged objects such as calabashes, fine

770 Jean-Luc Chalumeau, *Contemporary art, Upp. Hors Collec* (UPPR Éditions 2016).

771 Jean– Marie BODO, Music, a privileged instrument of the liturgy for the second evangelization of Cameroon (Edition arm, Paris, 1991).

772 R.P. Engelbert MVENG, *Centenary Album : 1890-1990 ; (Catholic Church in Cameroon , 100 Years of Evangelization*) (National Episcopal Conference of Cameroon, 1990).

773 COURTEILLE, *Sophie, interview with Abdou Sylla*, „Senghor has created his own aesthetic of negro art and contemporary art", *Afrik'arts*, 1, (2005): 40.

774 J – M. ELLA, *My African Faith* (Karthala, Paris, 1985).

sand, sawdust. Through the iconological analysis put together by the art historian Erwin Panofsky, we have given ourselves to the introspection of the painting produced. We have thus illustrated a scene of the «Stations of the Cross» more suited to the cultural context of the Bamileke people.

Thus, parallel with the study carried out by Dieumeme Noelliste and Mirlenda Noelliste[775] on Afro-Caribbean religions, we can say that our pictorial production contributes to enhancing the habits and customs of the Bamileke people on one side and the other. Part of facilitating the dialogue between the traditional religion and the Christian religion (the Gospel of Jesus Christ). Religion has always been an essential element in understanding human life, aspirations, history, community, culture, and destiny throughout the ages. In order to facilitate this understanding of the other, it is helpful to observe their cultural modalities and question the foundations of their beliefs. All of this helps to establish a dialogue.

It is also worth noting that the teachings of Christianity are not unfamiliar to Africans in general and the Bamileke in particular. The evangelical message has only seemed weird to him because of what he has been taught in the context of colonisation, and hence by Westerners. In truth, the cultural values of such a group support life, fraternity, neighbourly love, and the fear of God, among other virtues mentioned in the Bible. As a result, we would like to point out that Christianity and the local Bamileke culture share many similarities and that no one should «demonise» the culture of the other, especially if they do not know it well. It is with this in mind that we have exploited some Bamileke signs and symbols in artistic creation. The idea being to valorize them, to present them as tangible instruments whose Christianity could use in its evangelizing mission.

When God talks to us, R.P. Engelbert Mveng states that he wants us to comprehend him in our language. On the Day of Pentecost, the Holy Spirit spoke to every pilgrim from Jerusalem in their native tongues. For millennia, the interaction between Christ and Africa will not disregard the fundamental patterns of its language because this language connects the believing soul in its first drive towards the God of his salvation.

Moreover, this study offers the possibility of questioning the symbolism of the subjects represented in Christian iconography in the Middle Ages, on the real motives which animated the creators of Western sacred art. B. Ambassa and JC Abada Medjo[776] observe that most of the works of art produced during this historical period had something in common: the character referring to the angel or the saint was white, while the one referring to the demon was black.

Thus, the authors speak of colonialism and its representations of Africa and Africans. According to them, colonial ideology will develop the negative imagery of the African conveyed since Antiquity and the Middle Ages. This imagery of the dark relates to sin, temptation, and the devil. Unlike God, who is white, we depict the demon or devil in black colour. Therefore, the second half of the eighteenth century and the beginning of the nineteenth century were significant in the mythical representation of the negro. This chronology corresponds to the beginning of the first European exploratory missions in the African continent. Thus, in the various works of fiction reporting on these colonizing missions, Africa was presented as a hostile continent, with a harsh and murderous climate supported only by the savage negroes who inhabit it.

However, one is entitled to wonder if such an approach corresponds to the intrinsic values contained in the Gospel message, including equality of the human race, love of neighbor, inter-individual respect, to name a few.

AUTHOR CONTRIBUTIONS The mentioned author significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST The author declares that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, the author declares that there is no conflict of interest related to this article or its review.

775 Dieumeme Noëlliste, Mirlenda Noëlliste, *Afro-Caribbean religions in the light of the Christian faith: Similarities and differences* (Langham Publishing, 2019).

776 Bernard Ambassa Fils, Jean Claude Abada Medjo, *Africa in discourse: literatures, media and contemporary arts:* Volume 1, scénarisations littéraires des alérités africaines, (Editions Publibook, 2019).

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PROSOCIALITY AS AN EXTROVERTIVE MODALITY OF SELF-TRANSCENDENCE

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Abstract
Backround: The study proposes a philosophical interpretation of the phenomenon of prosociality developed around the thesis that prosociality is the extrovertive modality of self-transcendence.
Conclusion: Its main argument is construed on philosophical reasoning based on the inherited human experience of intencionality in the sense of human capacity to know that demonstrates itself as unlimited and manifests itself in various acts of self-transcendence – a universal human ability to cross the limitations of one's individual psychosomatic structure.
Keywords: Prosociality – Altruism – Self-transcendence – Consciousness – intencionality.

Introduction

When Abraham Maslow introduced the notion of self-transcendence into his *hierarchy of needs* in 1967, self-transcendence is considered the keystone of his *psychology of motivation* since that time. Maslow describes the concept of transcendence in his theory referring "to the very highest and most inclusive or holistic levels of human consciousness, behaving and relating, as ends rather than means, to oneself, to significant others, to human beings in general, to other species, to nature, and to the cosmos."[778] At this level of motivation toward self-transcendence, it is possible to search for justification of altruism and prosocial behavior as Henry Venter attempted among others. Venter[779] characterizes transcended individuals as those who "typically seek a benefit beyond the mere personal, identifying with something greater than the purely individual self, often engaging in selfless service to others."

In this regard, Louis Roy notes that this kind of moral autonomy is closely related to self-transcendence and is possible due to "a central element in human nature", which Maslow calls "intrinsic conscience."[780] It is this "intrinsic conscience", which Maslow considered the source of autonomy, that is the human ability to follow interior motives, the presence of which differentiates an autonomous morality from the heteronomous one.

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778 Abraham Maslow, *The Farther Reaches of Human Nature* (New York: Penguin, 1971), 269.

779 Henry J. Venter, "Maslow's Self-Transcendence: How It Can Enrich Organization Culture and Leadership," *International Journal of Business, Humanities and Technology* 2, no. 7, (2012): 69.

780 Louis Roy, *Self-Actualization and the Radical Gospel* (Collegeville: MGB, The Liturgical Press, 2002), 20; Abraham Maslow, *Toward a Psychology of Being* (New York: Van Nostrand, 1968), 6–7.

Conscience refers to *consciousness* – the human ability to be aware and self-present. The role of conscious activity is fundamental for both self-transcendence and prosociality.

Since we presuppose that the topic of self-transcendence cannot be comprehensively explained on the empirical basis, we have made a methodological decision to employ a philosophical approach to it that, as Louis Roy puts it, "begins with self-knowledge", i.e., "the direct self-acquaintance."[781] In accordance with this presumption, we approach self-transcendence through consciousness, more precisely through human *intentionality* – a fundamental inner dynamism of human consciousness to reach objects, whether material or mental.

The Phenomenon of Self-Transcendence: An Outline

We begin our reasoning with the proposition: Intentionality is the only modality of consciousness we are familiar with. Following this proposition, *we understand intentionality as an act of consciousness that points beyond itself*. In other words, to us intentionality is the "ability to tend toward", as the Latin etymology of the *in-tendere* suggests: It is "intending directedness towards objects"[782], an intrinsic human capacity to be aware (of something).

We use the term capacity partly with regard to the meaning that Robert Forman gives it, i.e., "something inherent or prelinguistic within us"[783], in contrary to something acquired from outside or derived from culture.

The meaning above is in accordance with the one proposed by Franz Brentano. By introducing the notion of intentionality to contemporary philosophy, Brentano points out to exactly this common feature of all human mental activity as referring to an object, i.e., "direction toward an object."[784] The object-directed character of intentionality is simultaneously expressed by the very term of *intention* in the same manner as its meaning in the Scholastic philosophy.[785]

Philosophical analysis based on observation of our ordinary, everyday experience shows that there must be a constituent common to all intentional acts, which is consciousness. In other words, an intentional act is possible due to the presence of consciousness. Consciousness is co-present in every intentional act as its intrinsic condition. Intentionality as an act of consciousness pointing beyond itself is possible only due to the co-presence of consciousness in an intentional act.

Thus, there are two modalities of consciousness that appear to constitute the structure of an intentional act: An extrovertive modality of consciousness directed to an object of consciousness, and an introvertive modality of consciousness accompanying every intending act and pointing to the subjectivity of consciousness. We denote the two constituent modalities of an intentional consciousness *object-consciousness* and *subject-consciousness*.

781 Louis Roy, *Mystical Consciousness: Western Perspectives and Dialogue with Japanese Thinkers* (Albany: State University of New York Press, 2003), xv.

782 Roy, *Mystical Consciousness,* 8.

783 Robert K. C. Forman, ed. *The Innate Capacity: Mysticism, Psychology, and Philosophy* (New York: Oxford University Press, 1997), 11.

784 Franz Brentano, *Psychology from an Empirical Standpoint* (Translated by A. C. Rancurello, D. B. Terrell, and L. McAlister. London: Routledge, 1995), 88.

785 Brentano, *Psychology,* 88.

Since human experience comprises simultaneously objects that appear exterior to our awareness (*object-consciousness*), along with our observing awareness (*subject-consciousness*) intentionality implies a twofold transcendence of self, which we might call extrovertive and introvertive. By *introvertive self-transcendence* we understand a movement of consciousness to the reality introvertive to an individual psychosomatic structure and manifesting in transindividual identity. By *extrovertive self-transcendence* we understand a movement of consciousness to the reality extrovertive to an individual psychosomatic structure and manifesting in prosocial behavior.

The Phenomenon of Prosociality: An Outline

The concept of prosocial behavior had been shaped in relation to psychological research of socially positive or prosocial behavior since its development in the second half of the 20th century mainly in the context of social psychology and in reaction to the preceding research interest in asocial and antisocial behavior. The very notion of prosocial behavior was introduced to psychology by David L. Rosenhan and G. H. White independently on one another in 1967. Several authors place prosociality in the space of antinomic dynamics of prosocial behavior as an opposite or alternative of antisocial behavior (E. Staub, R. Roche Olivar, J. Reykovský, J. Křivohlavý, etc.). Prosocial behavior is thus usually characterized as "helping act" intended to benefit another[786], or as "behavior meant to be of benefit of another person, group of people or social goal without a pre-expected reward."[787]

In a more complex way, prosocial behavior is interpreted as behavior that benefits the other, brings profit to the other and thus, it is socially desirable in contrast to socially undesirable behavior (asocial and antisocial behavior). Moreover, we prefer to specify prosociality through the notion of altruism, when the term was pre-defined as behavior that brings benefit to the other and is motivated by selfless concern for the welfare of the other, that is, without claiming a reward or expecting a reward.

However, not even this definition can be considered thoroughly unquestionable. At present, not only the very possibility of altruistic behavior, but also the relationship between prosocial and moral behavior is considered disputable. Let us have a closer look at the issue. The term altruism has its origin in positivist philosophy of August Comte (1798 – 1857). When Comte defines the term altruism as "love for humanity", more precisely, for "great being" (Grand Être) of humanity, as a subject of his cult of "religion of humanity", he does so in contradiction to the term of egoism.[788] The aim of the "positive philosophy" of August Comte, that is, a reasonable social order freed from "religion" and "metaphysics", presupposes behavior in favor of the whole (altruism) in contradiction to behavior in favor of an individual (egoism).[789]

Unlike Comte, ethology and sociobiology of the 20th century find manifestations of altruism also in the world of animals of the same species. When ethologists characterize altruism as behavior in which "an individual is willing to perform sacrifice for the sake of another individual to the extent that they endanger their own survival."[790], they put the "issue of altruistic behavior" in contrast to the traditional evolutionistic principle of the struggle for survival as formulated by Charles Darwin (a living organism strives to maximize the length of their own survival).

If the etymology of the word *altruism* refers to others in their difference (Lat. *alter*, "other", "different"), then the selfless concern for the welfare or benefit of another, or the sacrifice of one's own interests to interests of the other, becomes a characteristic feature of altruistic behavior. An unselfish relationship to the other, as an opposite of egoism, however, does not exclude the interest to care for one's own welfare. The weakest point of the positivist image of altruism as unconditioned behavior in favor of the whole of humanity lies in the categorical submission of one's own welfare to welfare of the other, because it is essentially a denial of inner value of an altruistically behaving individual (dignity of a person), which cannot be questioned, but requires an unconditioned acceptance and recognition.

Similarly to the notion of altruism, the notion of prosociality is not unambiguous either. The contents of both notions are sometimes identified, sometimes more or less distinguished. When altruism is associated with prosocial behavior, it is usually interpreted in two ways – either as motivation of prosocial behavior, or as a form of prosocial behavior.

The term *prosociality* is derived from the Latin words: *pro* – "for", "focus on", and *socius* – "companion", broadly "community". Its etymology indicates that "[p]rosociality is different from altruism understood only at individual or interpersonal level, precisely through its social goal, that is the focus on society"[791], but not in its nature.

Obviously, the calculation of a reward, or profit, both in a material and non-material form (praise, or for example, a feeling of satisfaction resulting from the performed action that can implicitly, in a hidden and non-thematized manner motivate to repeat the action), that is, both in the form of an "external" and "internal" reward, is excluded from prosocial behavior. Is, however, altruistic motivation possible at all?

Critics of altruism question mostly the possibility of resignation on the "internal reward" (positive self-evaluation, self-esteem, etc.), even though they usually admit the possibility of resignation on the "external reward" (financial or material profit, social recognition, etc.). Undoubtedly, the presence of "internal reward", however uncalculated, is a serious argument against the possibility of authentic altruism.[792] The same is true for the areas of interfaith dialogue and mission strategies.[793]

However, from the educational point of view, the objection to authentic altruism questioning the very possibility of selfless behavior does not have to be an obstacle to educational process aimed at development of prosocial behavior and authentically altruistic motivation[794], as it has

786 Grahame Hill, *Moderní psychologie: Hlavní oblasti současného studia lidské psychiky* (Praha: Portál, 2004), 84.

787 Roberto Roche Olivar, *Etická výchova* (Bratislava: Orbis Pictus Istropolitana, 1992), 149.

788 Peter Kunzmann, Franz-Peter Burkard and Franz Wiedmann, *Encyklopedický atlas filosofie* (Praha: NLN, 2001), 165.

789 Hans Joachim Störig, *Malé dějiny filozofie* (Praha: Zvon, 1991), 341 – 345.

790 Nicola Ubaldo, *Obrazové dějiny filozofie* (Praha: Universum, 2006), 514.

791 Roche Olivar, *Etická výchova,* 102.

792 Ivan Podmanický and Andrej Rajský et al., *Prosociálnosť a etická výchova: Skúsenosti a perspektívy* (Trnava: Typi Universitatis Tyrnaviensis, 2014), 55.

793 Ladislav Bučko, Elena Rauschová, and Jana Tretiaková-Adamcová, "A Search for a Current Mission Model in Cambolia," *International Review of Mission* 109, no. 1, (2020): 34 – 39. DOI: 10.1111/irom.12307

794 Roche Olivar, *Etická výchova,* 152.

been proved by several years of experience of implementation of the course Ethical Education in the school system of the Slovak republic.[795]

To sum up, we understand the term prosocial behavior as a complex phenomenon, that is as such behavior or action that *brings benefit* (good) to another individual or a group of individuals, while it is *not motivated by duty* (deontological ethics) *or by desirability* as an end to be achieved (teleological ethics), but by *selfless concern for the welfare* (benefit or good) of the other (altruism). Beside the moments of *selflessness*, *personal initiative* (activity), and basal focus on the *good or benefit of the other*, we may consider the *unity of action and intention* to be also constitutive for prosociality. Thus, prosocial action can be characterized not only by a selfless activity aimed at the good (benefit) of the other, but also by the intention to act for the benefit of the other selflessly, that is without claiming or expecting either external or internal reward. These are its four distinctive features. They can be identified trans-culturally and trans-religiously in the notions of, for instance, *caritas* (Christianity), *sadaqah* as well as *zakat* (Islam), *ahimsā* (Hinduism), and *mettā* (Buddhism).

Self-Transcendence and Prosociality

Now the question is, how can be these two concepts comprehensively interconnected? And how does the above-mentioned clarification of the concept of prosociality rely to our explanatory proposal – the thesis that prosociality is the extrovertive modality of self-transcendence?

We have distinguished two aspects of self-transcendence – an introvertive aspect and an extrovertive aspect of self-transcendence. In doing so, we based our distinction on the universal human experience of intencionality. Observation confirms its inherited and unlimited character as human capacity to know and to transcend – to cross the limitations of a psychosomatic structure of an individual. Despite the real of ordinary human experience, transcending process of this kind are well documented in multiple reports going through religious and spiritual spectrum that include the so-called *mystical death* and similar phenomena (for more on *mystical death* see, e.g.[796]).

Self-transcendence might appear an unusual phenomenon, but the opposite is true. It seems to be a part of human life we all may come in touch with. On the other hand, it does not always enter the field of our experiencing. In order it happened, a stimulus is needed. An existential crisis can be such a stimulus that evokes self-transcendence. When facing serious crises, humans may sometimes find in themselves a capacity to somehow move beyond one's own limitations. Here the concepts of "through" and "beyond" seem to define the "movement", which is otherwise hardly definable. The literal meaning of the term "transcendence" points at the same direction. "'Ascending' means moving upward, while 'trans' means both 'through' and 'beyond'," as Louis Roy reminds us.[797] Thus, there are two elements that preliminarily characterize self-transcendence – a *movement*, which goes *through* or *beyond* ordinary human experience.

795 Andrej Rajský and Ivan Podmanický, et al., *Človek človeku: K prameňom etickej výchovy* (Trnava: Typi Universitatis Tyrnaviensis, 2016), 79 – 136.

796 Slavomír Gálik, "St. Teresa of Ávila & Rōshi Jiyu-Kennett: A Comparative Study," *Spirituality Studies* 7, no. 1, (2021): 2–17.

797 Louis Roy, *Transcendent Experiences: Phenomenology and Critique* (Toronto: University of Toronto Press, 2001),151.

We have provided a closer look at the phenomenon of self-transcendence and a more differentiated understanding of it both in terms of its structure and meaning in our recent monograph Self-Transcendence and Prosociality[798], where we propose further reasoning based on case studies from the history of spirituality.

Further research based on this article that can be profiled into the production of similar relevant studies or contributions to expert debates can be carried out, for example, in the area of enhancing the perception of meaningfulness and the phenomenon of self-transcendence in different spheres of life and in different global contexts. It is known that spirituality is also an important coping mechanism and, as such, it allows reflection on as well as reassessment of negative experiences. This contributes to a transformation of the individual's personality in a positive direction.[799]

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798 Martin Dojčár, *Self-Transcendence and Prosociality* (Frankfurt am Main: Peter Lang, 2017).

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POPE FRANCIS AND THE JEWS
THE PROPOSED POSSIBILITIES OF JEWISH-CHRISTIAN DIALOGUE

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Abstract
Background: The Slovak project *Otvárame dvere* (Opening the Door), aimed at fostering Jewish-Christian dialogue, has existed for several years. In this study, members of the project's working team focus on the personality and thinking of Pope Francis in relation to the Jewish community. His views are presented in context in order to analyse his recent visit to Slovakia and the speech he gave at Rybné Square in Bratislava.
Conclusion: Jewish-Christian dialogue is currently developing strongly across the globe, including in Slovakia. The recent visit of Pope Francis highlighted this initiative, including the project *Otvárame dvere* – Opening the Door – to promote Jewish-Christian dialogue. The project involves preparing other breakthrough initiatives aimed at providing deep support for Jewish-Christian dialogue that will be accessible to the academic world and the general public.
Keywords: Pope Francis – Jews – Dialogue – Chagall – Holocaust.

Introduction

The recent visit of the head of the Catholic Church to Budapest at the end of the Eucharistic Congress, and his subsequent, multi-day visit to Slovakia, provided grounds to scientifically elaborate on the topic of possibilities for developing Jewish-Christian dialogue.

Historically, papal visits abroad were not common. Until the 20th century, popes seldom left Rome and the Vatican. When they did, it was often into exile on the order of emperors, and because of their beliefs, as occurred in the first three centuries after Christ's birth. If we disregard the Avignon captivity of the popes, papal apostolic visits started only in the 20th century with Pope Paul VI and continue with the current Pope Francis.[801]

Pope Francis came to Slovakia at the invitation of President Zuzana Čaputová and the Conference of Bishops of Slovakia. He came in a dual role – as the representative of the Vatican City State and as the head of the Catholic Church. Each such visit is thoroughly prepared by Vatican diplomats. However, popes sometimes improvise and their words and gestures have to be thoroughly analysed.

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801 Cf. John W. O'Malley, *A History of the Popes from Peter to the Present* (A Sheed and Ward Book, 2010).

Pope Francis in the context of open tradition and art

The current Pope was born Jorge Mario Bergoglio on 17 December 1936 in Buenos Aires, Argentina. He had four siblings. After graduating from Secondary Industrial Chemical School, he decided to become a priest at the age of twenty-one and, on 11 March 1958, he joined the Jesuit order. He then continued with classical studies in philosophy and theology. In addition to Spanish, he also speaks Italian and German.

He was ordained a priest on 13 December 1969. After a short period of teaching, he was elected the Provincial of the Jesuits in Argentina (1973-1979). Between 1980 and 1986, he was employed as rector of the Colegio Máximo de San Miguel and at the local Faculty of Philosophy and Theology.[802] This is where he met Rabbi Abraham Skorka and they became very close friends.[803]

He was ordained a bishop in 1992 and a cardinal in 2001. He held several important positions in the Vatican and ultimately became a member of the Congregation for Divine Worship and the Discipline of the Sacraments, for Institutes, and, in 2005 he was elected President of the Argentine Bishops' Conference (and re-elected in 2008).

At the conclave of 13 March 2013, he was elected Pope. Pope Francis is the 266th pope, the first from the Jesuit order and the first pope from the southern hemisphere. He selected his name after Francis of Assisi, because he identified himself with the well-known vision where Christ appeared to Francis of Assisi and appealed to him: *"repair my house".* (The Italian word *chiesa,* and the Latin word *ecclesia,* have two meanings. They refer to a stone house and the Church as a community.[804])

Various critics of Pope Francis tend to stress his Argentinian origin to decrease the significance of his ideas. We would like to note that Pope Francis is influenced by German and especially French Catholic theology from the period prior to the second Vatican Council.[805] In this context we emphasize the role of German theologian Roman Guardini,[806] especially his principle *coincidentie oppositorum*, the constructive tension between two opposites, and the search for agreement between them. Bergoglio wrote his doctoral thesis on Guardini's philosophy: *The opposite as a structure of everyday thinking and the Christian message*. However, he did not complete this thesis. We note that Guardini distinguishes between the opposite and contradiction, e.g. good and evil are contradictory, but dynamics and statics are opposite.

Romano Guardini uses the ideas of the Franciscan theologian Bonaventure (early 13th century), whose thinking influenced also Pope Emeritus Benedict XVI.

To elaborate on Bergoglio's origins[807] we would like to emphasize the Pope's complex roots in the Christian tradition and his openness to thought. This means that his words and deeds, however new they may seem to us, are based on authentic Christian tradition,[808] in terms of social commitment, migration[809] and ecumenical, Jewish-Christian or interreligious dialogue.

These are included in Francis' ongoing reform of the Church[810]. Bergoglio rejects Messianic populism, and, like his predecessor Joseph Ratzinger, rejects the right-wing and left-wing political theologies in the imperial theology of early historian and bishop Eusebius of Caesarea, leaning more towards the theology of history.

Reconciliation and the search for harmony between opposites form the basis for his thinking of the appropriate reform of the Church and in dialogue aimed at other religions, in this case Judaism.[811]

The artistic influence of Chagall

Another of his major influences was the oil painting *White Crucifixion* by Marc Chagall (born Moshe Zacharovich Shagal), a surrealist painter of Jewish origin. The painting was created in 1938, two weeks after the tragic Kristallnacht. Today we can see this canvas at the Art Institute of Chicago.

In his biography from 2013 entitled *"Pope Francis: Conversations with Jorge Bergoglio: His Life in His Own Words"*, he describes it as one of his favourite paintings. Pope Francis said:

> *"The White Crucifixion by Marc Chagall, who was a religious Jew, is not cruel, but hopeful... Pain is depicted there with serenity. To my mind, it's one of the most beautiful things he painted."*

The individual scenes and characters from Chagall's time are related to the scene of crucifixion in terms of the Jewish nation and its suffering. In an atmosphere full of contemporary violence (against the Jews), Chagall emphasizes that the suffering Christ was a Jew. Instead of a loincloth, he painted a *tallit* – a Jewish prayer shawl. On his head he placed a scarf instead of a traditional crown of thorns. Above his head, he placed an inscription in Aramaic, which was spoken by Jews in Judea.

The Latin words *Iesus Nazarenus Rex Iudaeorum* translate as *Jesus of Nazareth, King of the Jews.* They form the acronym INRI above the T-shaped cross. In Aramaic: *Yeshu HaNotzri Malcha D'Yehudai.* The text *Jeshua HaNotzri* in Hebrew may have two meanings: first: Jesus of Nazareth; second: Jesus the Christian.

Who is this Nazarene or Christian "Man of sorrow"? Why does Chagall emphasize his Jewish identity? What kind of thinking does he invite both Jews and non-Jews to?

For centuries, Christians have largely ignored the fact that Jesus of Nazareth, considered the Son of God in Christian tradition, was a Jew. People have forgotten this and the Christians persecuted the Jews for centuries. They refused to see them as fellow men related to Jesus Christ, who was a Jew until his crucifixion. Jews were accused of killing him as if some Christians forgot that Jesus, his Mother and his disciples, were actually Jews.

802 Peter Hünermann, *Uomini secondo Cristo oggi. L'antropologia di papa Francesco* (Citta del Vaticano: Libreria Editrice Vaticana, 2017).

803 Massimo Borghesi, *The Mind of Pope Francis. Jorge Mario Bergoglio's Intellectual Journey* (Collegeville, Minnesota: Liturgical Press Academic, 2017), 11-32; Jorge Mario Bergoglio and Abraham Skorka, *On Heaven and earth* (Randon House Mondadori, 2010).

804 Cf. Yves Congar, *Vraie et fausse réforme dans l'Église* (Paris: Les Éditions du Cerf, 1969).

805 Borghesi, *The Mind of Pope Francis,* 33-57; Sergio Rubin and Francesca Ambrogetti, *El Jesuita. Conversaciones con el cardenal Jorge Bergoglio, sj.* (Argentina S.A.: Ediciones B, 2010).

806 See: Pavel Frývaldský, "Protiklady života a katolická jednota. Romano Guardini v myšlení papeže Františka a Benedikta XVI.," *Communio* 89/4, (2018): 63-82; Borghesi, *The Mind of Pope Francis,* 58-78.

807 See also: Martin Dojčár, "Hugo Makibi Enomiya-lassalle, SJ: A pioneer of the dialogue of spiritual experience," *Acta Missiologica* 13, no. 2, (2019): 36-50. https://www.actamissiologica.com/

808 Cf. Juan Carlos Scannone, "El papa Francisco y la teología del pueblo," *Razón y Fe* (2014, t. 271, n. 1395): 31-50; POPE FRANCIS: *Life after the Pandemic* (Libreria editrice Vaticana, 2020).

809 Cf. Martin Dojčár, "Dialogue as a personal tool of integration of migrants," *Acta Missiologica* 14, no.1, (2020): 102-108. https://www.actamissiologica.com/

810 Cf. POPE FRANCIS: *The Church of Mercy. A vision for the Church* (Chicago: Loyola Press, 2014).

811 Austen Ivereigh, *Let us dream. The path to a better future. Pope Francis in conversation with Austen Ivereigh* (New York: Simon and Schuster, 2020); Austen Ivereigh, *Wounded Shepherd: Pope Francis and His Struggle to Convert the Catholic Church* (New York: Henry Holt, 2019).

Returning to the ideas of Pope Francis and Chagall's canvas: Jesus crucified is displayed as a symbol of suffering of the chosen people in a historical context. He suffered along with Jews as one of them. This also sheds new light on the suffering of Jews in history.

When we look at the canvas again, the crucified Jesus is surrounded by scenes full of horror and destruction. Four figures are grieving in pain above the cross. On the top right, fire blazes from a burning synagogue. On the left, a man is running with a Torah scroll, and on the right, we see a (disrespectfully) unfolded scroll in flames. A man in green is running with a pack on his shoulder while distraught mother beneath him clasps a child and tries to protect him from danger – an image reminiscent of refugees fleeing the brutality of immediate conflict.

On the left, we see a boat probably full of refugees, while above them there is a ruined village burning and its inhabitants and their belongings are scattered in the chaos of a pogrom, with soldiers approaching from above.

In this darkness of destruction, a six-branched candelabra shines as a symbol of hope. It is not a traditional menorah, but it is reminiscent of one. It seems damaged, its seventh arm missing. One of the candles is not lit. They may yet set it on fire. The circle around the candelabra has a more perfect shape than the crooked halo around Jesus' head. It is hard to say what Chagall meant. It is possible that, in the midst of pain over his own nation, he sympathized with the crucified Jesus and perceived him as a member of this suffering community, and at the same time appealed to the non-Jewish world that worships Jesus as the Son of God. We assume that, for Chagall, Jesus represents the embodiment of injustice and wrongs that many Jews through all time have innocently suffered...

Darkness could overwhelm us if we did not understand that power that is greater than injustice. In the painting, the power is depicted as a wide stream of light from above. It does not come from Jesus or his cross; it seems like from another world. It is a rich glow that peacefully penetrates to the centre of suffering and brings answers to the question of its meaning. Light in darkness, peace in confusion, the only certainty in the chaos of violence and the uncertainty of destruction. Hope. Pope Francis considers this painting, with its scenes full of persecution and misery, to be full of hope. The reason is that Christ is depicted here "in peace". With his peaceful face, Jesus expresses "the peace of God, which surpasses all understanding" (cf. Phil. 4:7).

The basic aspects of the Pope's thinking

We mentioned Chagall's painting because through this painting we can perceive the painful relationships between Christians and the Jewish community over the last 2,000 years.

A few hours after he was elected pope, Francis sent a letter to Rome's Chief Rabbi, Riccardo di Segni, stating that he hoped to *contribute to the deepening of relations between Jews and Catholics*, which was recorded from the period 1962-1965. In response, Rabbi di Segni stated that the background of the new pope *"gives him confidence and hope"* that relations would continue to improve. Francis' predecessors, John Paul II and Benedict XVI, also sought reconciliation between Catholics and Jews during their papal terms.

Ronald Lauder, the president of the World Jewish Congress,[812] has stated that the new pope *"always has his ears open for our worries":*

> *"By choosing such an experienced man, someone who is known for his open-mindedness, the cardinals have sent an important signal to the world,"* said Lauder. *"I am sure that Pope Francis will continue to be a man of dialogue, a man who is able to build bridges (...)"*

812 See also: Harold Kasimow and Alan Race, ed., *Pope Francis and Interreligious Dialogue. Religious Thinkers Engage with recent Papal Initiatives* (Palgrave: Macmillan, 2018), 101-112.

Lauder stated that Francis

> *"will speak out against all forms of anti-Semitism both within and without the Catholic Church, he will take action against clerics who deny or belittle the Holocaust, and he will strengthen the Vatican's relationship with Israel."*

In 2015, the Pope paid tribute to everyone who contributed to building friendship between Jews and Catholics, and named especially Saints John XXIII and John Paul II. As he said, he longs to follow in their footsteps.

The Joy of the Gospel

The basic ideas of the Pope's relationship with the Jews are present in the apostolic exhortation *Evangelii gaudium* (*The Joy of the Gospel*) *Proclaiming the Gospel in Today's World* 247-249 from 24 November 2013, a few months after Bergoglio was elected pope. The text is interestingly inserted between *ecumenical dialogue* and *interfaith dialogue*, which indicates the specific relationship of Christians. In this context, we recall an important idea that is still waiting for theological deepening.[813] The point is that relationships with Jews do not form a part of the *Pontifical Council for Interreligious Dialogue*, but the Holy See's Commission for Religious Relations with Jews forms part of *the Pontifical Council for Promoting Christian Unity*. Christianity's Jewish roots are clearly represented here. The exhortation (cf. *EG* 247) quotes Romans 11:29 and emphasizes the continuation of God's covenant with the Jewish people, recalls the common heritage of Jewish sacred writings that Christians call the Old Testament, clearly reminds us of the rootedness of Christianity in Judaism, the common faith in one God, and clearly refuses to consider Judaism as a false, misguided religion that would lose its significance in the wake of Christianity.

In the following paragraph (248), the Pope speaks about two matters: the importance of friendship, and regretting the persecutions that involve or have involved Christians. In the last of the three relevant paragraphs (249) he reiterates God's blessing for Israel and the need to realize the values that the Church can derive from Judaism, but also clearly mentions the differences between Christians and Jews, which are personified in Christ, while noting that this does not prevent mutual cooperation.

We cannot change the past, but we can change the future

From the Pope's text (*EG*) it is clear that he is aware that the attitudes of some Christians were and often are incorrect and contradict the spirit of the Gospel. He wishes that we would not only be able to identify such wrong attitudes, but reveal them in a way that people learn from them and do not repeat them.

We would like to mention that Christians in the early Church were accused by the imperial state authorities of atheism, the abduction of young children, of drinking blood and being outrageous, and experienced persecution and attacks associated with plundering and lynching. Matthew 7:12 offers a golden rule: *In everything, do to others what you would have them do to you, for this sums up the Law and the Prophets.* We can find it in a negative form in the Book of Tobias and in Rabbinic literature: *do not do to others what you do not want them to do to you.* Unfortunately, history shows that some Christians did not learn from this recommendation and later accused Jews of the same things that they themselves had been accused of, even adding the accusation of deicide. For centuries this has been considered by Christians as the main "fault" of

813 Lucia Hidvéghyová, *Od Seelisbergu po Jeruzalem a Rím. Dokumenty židovsko-kresťanského dialógu* (Trnava: Spolok Svätého Vojtecha, 2018).

Jews. It is necessary to recall and take into consideration the problem of generalization of faults and searching for a scapegoat, which Rene Girard in his famous work *le Bouc emissaire* clearly described as an unfortunate mechanism for finding a victim, always leading to a dead end.[814]

According to Pope Francis, an important stimulus for changing the relationships between Christians and Jews is the Second Vatican Council, mostly point 4 of the declaration *Nostra Aetate*, from 1965. The Pope notes that Christians and Jews have lived together in Rome for almost two thousand years, but there has been tension between them throughout history.[815] As Pope Francis said, *"a true fraternal dialogue"* between Christians and Jews "could develop after the Second Vatican Council, following the declaration of *Nostra aetate"*, which *"represents a definite 'yes' to the Jewish roots of Christianity and an irreversible 'no' to anti-Semitism."*[816] Nevertheless, the roots of this dialogue are present in the history of Christianity, although sometimes they are barely seen under a pile of ash.

According to Pope Francis, the Second Vatican Council took into account the *Ten Points of Seelisberg* (Switzerland, 1947) to correct the negative image of Jews among Christians. This closely relates to the establishment of the International Council of Christians and Jews. The idea of the Council's cooperation with the Catholic Church was first presented at the Seelisberg Conference (1947), and officially began after the establishment of the Vatican Commission for Religious Relations with the Jews in 1974.

Dialogue and roots

Pope Francis often speaks about the common ground of Christian and Jewish traditions derived from One God of the Covenant, and states:

> *"Both faith traditions find their foundation in the One God, the God of the Covenant, who reveals himself through his Word. In seeking a right attitude towards God, Christians turn to Christ as the fount of new life, and Jews to the teaching of the Torah. This pattern of theological reflection on the relationship between Judaism and Christianity arises precisely from Nostra aetate* (cf. *NA*, 4), *and upon this a solid basis can be and must be developed even further."*[817]

The Pope emphasizes the word dialogue in the first place.[818] There are always two members in a dialogue, who listen to one another. The first task of the dialogue is not to convince the partner of one's own truth, but to understand what he says and find out if one understands him correctly. Here Pope Francis and Abraham Skorka refer to Thomas Aquinas and Maimonides, who always begin by recalling their opponent's opinion. They do not automatically agree with the opponent, but they want to discover if they understand him correctly.

Dialogue is an essential companion to the doctrine, teaching, because it shows teaching with a human face.

814 Eric Fuchs, "René Girard et le bouc émissaire," *Revue de Théologie et de Philosophie* 115, no. 3, (1983): 285-92.

815 Cf. Edward Kessler, "I am Joseph, your brother: A Jewish perspective on Christian-Jewish relations since Nostra Aetate No. 4," *Theological Studies* 74, no. 1, (2013): 48-72. https://doi.org/10.1177/004056391307400103

816 Michael L. Fitzgerald, "Nostra Aetate, a Key to Interreligious Dialogue," *Gregorianum* 87, no. 4 (2006): 699–713. http://www.jstor.org/stable/23581614

817 Cf. https://www.tkkbs.sk/view.php?cisloclanku=20150630015

818 Kasimow and Race, *Pope Francis and Interreligious Dialogue,* 85-100.

The Pope further emphasizes the meeting and often recalls Jesus' conversation with the Samaritan woman in John's Gospel. Jesus is patient, respecting the other person and gradually reveals their common way.

Another important concept is walking: it is often used as a metaphor for dialogue, where it involves walking together with another person. The Pope mentioned this topic of walking together in 2017 and expressed joy that Christians and Jews are going through a period of dialogue.

The Pope later speaks of "reconciled diversity". It is a concept first offered by the Protestant theologian Oscar Cullman,[819] who was a friend of Paul VI and an observer at the Second Vatican Council.[820] This concept is suitable for relations with other Christian denominations and with Jews.

After all, it is not by coincidence that the events of the 20th century invited us to rediscover the value of the "dialogical principle" and to embrace the anthropological significance of revelation from thinkers who developed Jewish heritage, such as Martin Buber and Franz Rosenzweig. Buber's work as a philosophy of meeting and dialogue develops a dialogical concept of *self*, which says that it is the dialogue, the relationship with others, where the *self* realizes to become a person. According to Buber, each personal dialogue moves in the area of relationship (*das Zwischen*), where something remains unsaid – and not fully said[821], and this understanding of dialogue as an ability to listen retains its appeal even today. The common pursuit of justice and peace goes beyond the limits of and finds support in spiritual attitudes. It means that free people are cooperating with God based on the following approach: *Letaken olam bemalchut Shaddai.* "Dialogue always and primarily remains a characteristic of love, hope and selflessness."[822]

Cooperation

Among the advances in mutual relations over the last half century, Pope Francis has specifically mentioned the development of mutual trust and recognition. He notes that there are several areas where Jews and Christians can cooperate for the good of humanity:

> *"Respect for life and creation, human dignity, justice and solidarity can be involved in our unification for the benefit of the development of society, and to secure a future full of hope for future generations. In a special way we are called to pray for peace and work together for its benefit."*

Pope Francis is aware of the contrast between Jewish-Christian anthropology and anthropologies based on the premise of the denial of God or the latest rise in xenophobic fundamentalism, and strongly rejects the instrumentalization of religion, which is the misuse of religion for political and religious purposes. He addressed the following words to the Conference of European Rabbis:

> *"Today, in Europe, it is more important than ever to emphasise the spiritual and religious dimension of human life. In a society increasingly marked by secularism and threatened by atheism, we run the risk of living as if God did not exist. People are often tempted to take the place of God, to consider themselves the criterion of all things, to control them, to use*

819 Oscar Cullmann, *Unity through Diversity* (Minneapolis: Fortress Press, 1988), 9.

820 Cf. David Gibson, "Excerpts: Pope Francis on ecumenism, secularism, terrorism and gossip," Religion News Service, 28 October 2016.

821 Cf. Maurice S. Friedman, *Martin Buber The life of Dialogue* (Chicago: University of Chicago Press, 1956), 57.

822 Brunetto Salvarani, *Carlo Maria Martini FRATELLI E SORELLE Ebrei, cristiani, musulmani* (Milano: Bompiani 2020), 60.

everything according to their own will. It is so important to remember, however, that our life is a gift from God, and that we must depend on Him, confide in Him, and turn towards Him always. Jews and Christians have the blessing but also the responsibility to help preserve the religious sense of the men and women of today, and that of our society, by our witness to the sanctity of God and human life: God is holy, and the life He has given is holy and inviolable."

Unequivocal condemnation of every form of hatred

Pope Francis touched on the topic of hatred and anti-Semitism,[823] recalling the aforementioned declaration of the Second Vatican Council. He addressed the following words to the delegation of the Conference of European Rabbis:

"Anti-Semitic trends in Europe these days are troubling, as are certain acts of hatred and violence. Every Christian must be firm in deploring all forms of anti-Semitism, and in showing their solidarity with the Jewish people (cf. *Nostra aetate*, 4). *Recently we marked the seventieth anniversary of the liberation of Auschwitz, the concentration camp which has come to be synonymous with the great tragedy of the Shoah. The memory of what took place there, in the heart of Europe, is a warning to present and future generations. Acts of hatred and violence against Christians and the faithful of other religions must likewise be condemned everywhere."*

Pope Francis' address to the Jewish community at Rybné Square in Bratislava

Pope Francis' address during his meeting with Slovakia's Jewish community was short and comprehensive (it consists of approximately two-and-a-half standard pages). In the beginning, the Pope mentions Rabbi Chatam Sofer who lived and worked in Bratislava in the 19th century (died in 1839). He also mentions the Neolog Synagogue that was located right next to the cathedral, but which was destroyed during the Communist period – basically the entire Jewish quarter was demolished. If you want revenge on someone, you want to cast the memory of him into oblivion. This is why historical chronicles must be analysed critically, because they were often commissioned by the victor.

Pope paraphrases the Book of Exodus, which describes Moses' encounter with God at the foot of Horeb, in a burning bush. Moses is supposed to take off his sandals at God's command (cf. Exod. 3). The same need was perceived by the Pope, because he visited a place marked by God's presence. Some rabbis interpret the bush as a thorn bush. When we get pricked, it hurts. When God reveals himself in a thorn bush, with thorns that cause pain, he shows his own, so to speak, suffering.[824]

The rabbinic commentary refers to Israel's slavery in Egypt. The reason why the Pope mentions this biblical event can be understood from the subsequent reflection, where he mentions the Second World War and reminds us of the horrific tragedy of the murdering of more than 100,000 Slovak Jews. He quotes "You shall not misuse the name of the LORD your God!" (Exod. 20:7) and returns to the important topic of rejecting the instrumentalization of religion, and its misuse for political, economic and other purposes. He recalls that, historically, there were people who claimed that God is with them, but they were not with God. This clearly means that those who murdered Jews during the war and declared that they acted in the name of God in fact acted against God, and that God suffered as suggested in the rabbinic exegesis of a thorn bush.

823 Cf. Donald J. Dietrich, "Antisemitism and the Institutional Catholic Church," *Holocaust and Genocide Studies* V16, N2, (Winter 2002): 415-426.

824 Peter Dubovský et al., *Exodus* (Trnava, Dobrá kniha, 2013), 105.

In the next section, the Pope mentions the important Hebrew word "*zachor*": "Remember!", which is important not only for Jews but also for Christians: to remember God's work in life but also the terrifying events, in order to prevent them from ever happening again. When thinking of this tragedy, the Pope mentions the first lamp on the Chanukkiah, which is lit annually by the local Jewish community in the square. Here we can return to Chagall's painting: we see that destruction and death do not have the last word, but the light of the candelabra that resembles the menorah and the stream of light that seems to carry the whole cross illuminate the painting – darkness does not have the last word.

In the following part of his speech, the Pope returns to the aforementioned meeting in Rome and the subsequent steps that have been taken. At the end of the address he refers to the symbolism of a *door opening* from both sides. This is very encouraging, because the educational programme successfully conducted by the Faculty of Theology of Trnava University with the Jewish Cultural Institute has a similar name.

Conclusion

To conclude our study we would like to draw attention to a fact that is often overlooked: Rybné Square witnessed not only a meeting between Pope Francis with the Slovak Jewish community. There were 50 guests from the Jewish community and 50 guests from the Catholic Church, including bishops. It was the meeting between the Pope and representatives of both these two communities.

The Pope came as a pilgrim to meet the Jews, gathered side-by side with Christians. His goal was not only to remind them of old wrongs, or to encourage their mutual reconciliation. He entered a very symbolic and meaningful place, at that moment shared by the two living communities that have a common future full of possibilities to cooperate, remember, discover each other and keep *the door open*, or, to echo Chagall's painting, keep the last candle burning.

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THE IMPACT OF THE FIRST TWO WAVES OF THE SARS-CoV-2 PANDEMIC ON SENIORS IN SOCIAL SERVICES FACILITIES

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Abstract

Background: The most vulnerable group in this pandemic in the population are the elderly. In terms of their age and health, they are most exposed to the consequences of a pandemic. Social services facilities, where seniors live in communities where SARS-CoV 2 is very easy to spread, are facing a difficult test of how best to protect their residents.

Methods: The research deals with the effects of the pandemic situation on seniors, on the work of employees and directors in facilities for seniors**.** For data collection, we used qualitative research, which was carried out in the form of individual interviews with three target groups, which consisted of recipients of social services, workers in social service facilities and directors as representatives of non-public providers of social services. As part of the research methodology, we used situation analysis with the open coding method. Research was done at senior home Samaritan in Tekovske Luzany, Slovakia.

Results: We transformed the data obtained from interviews with 60 participants into codes and categories that emerged from the research questions. The results are shown in the text tables. **Conclusion:** The pandemic had a significant impact on the lives of seniors in the mental, physical and social spheres. The organization of social care in the facilities had to adapt very quickly and flexibly to the critical situation, although the management did not have any financial resources for the increased costs of hygiene and health care.

Keywords:Pandemic. SARS-Cov-2. Eldery. Social Service Facilities. Crisis Management.

Introduction

The COVID-19 pandemic has hit the lives of people around the world. The spread of SARS-CoV-2 and subsequent diseases have had enormous health, but also social, psychological, economic and environmental consequences.

As a result of this pandemic, every country in the world faces its own possibilities, capabilities and economic conditions. Slovakia also faced this situation in the given conditions. Whether the solutions adopted were the most appropriate in the given situation will become clear in the future.

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The most vulnerable group in this pandemic in the population are the elderly[826]. In terms of their age and health, they are most exposed to the consequences of a pandemic. Social services facilities, where seniors live in communities where SARS-CoV 2 is very easy to spread, are facing a difficult test of how best to protect their residents.

The non-profit organization Diakonia of the Evangelical Church of the Augsburg Confession, as a socially oriented organization, operates in 42 social services facilities for the elderly in Slovakia. We summarized the experience of these facilities during the first wave of the pandemic in our article, and in the research we focused specifically on one of these facilities. We examined the experiences of the residents and employees and the measures introduced during the first wave of the pandemic in the Samaritan - facility for the elderly in Tekovské Lužany, Slovakia.

Problems during pandemic

During the process of introducing emergency arrangements to stop the spread of SARS-CoV-2, many obstacles arose, some of which were foreseeable, some were difficult to implement in practice, and some of which led to a fundamental or slight change in the functioning of social services facilities. which affected the organizational, management and spatial capabilities of providers. Problems have also arisen in staffing due to the lack of carers in the normal situation, the coronavirus emergency revealing weaknesses in the provision of social services and the lack of preparedness to protect the health of seniors and other beneficiaries from a pandemic.

One of the biggest problems associated with the pandemic was **the lack of staff** involved in the preparation and implementation of all arrangements, the workers themselves and the recipients of social services were at risk, and no one could predict whether and for how long the coronavirus would be kept behind the gates.

In the process of implementing the measures, which took place in March 2020, we encountered **problems in understanding the importance of arrangements** such as wearing towels, increased hygiene requirements, social isolation and setting new rules, in some cases violations and low cooperation between workers and users. Later, restrictive actions were tightened, which meant the **creation of a contingency plan** in the fight against coronavirus, and especially in the of COVID-19 cases in social services facilities, it was necessary to introduce a process of mapping, monitoring and evaluation. Obstacles also appeared on the part of the clients of community, many of whom were **misinformed, feared the spread of the unknown virus and feared death**[827]**.**

Similar feelings were shared by the staff of the facility, who on the other hand were also worried about family members, they did not have contact with them, as the staff in the examined facility alternated in weekly to biweekly shifts according to need and the current pandemic situation.

The problems also concerned the dissemination of various **information and misinformation**, believing that this was a violation of the rights of seniors and other recipients of social services, the **ban on visits** and social isolation caused negative reactions from the family as well. The facilities were forced to adapt communication with families to new conditions, workers spent time explaining the reasons why they had to do so and tried to create conditions for users to communicate with the outside environment online. For this purpose, they used **digital tools**, taught the recipients to use computers and mobile phones for online video calls, through which they could communicate with their own family. Some facilities set up **music concerts in the courtyard** of the facility during the emergency measures for the coronavirus, where social service recipients watched the concert from the windows at a sufficient distance and were able to experience positive feelings for a while and remove fear of the future. Such public initiatives also reinforced **feelings of public solidarity with social service facilities**, which were going through a difficult period and needed material and financial assistance to combat the pandemic.

The SARS-CoV-2 coronavirus pandemic affected facilities **unprepared financialy and personnaly**. Social service providers did not have extra financial resources to ensure increased costs for hygiene needs, hygienic-epidemiological measures in connection with disinfection, face and hand protection, etc. The provider had to provide increased material and technical equipment and changes in the management and provision of social services, which had an impact on the staff composition of employees, their work performance, schedule of work services and shifts had to be adjusted and extended as needed. Workers were called into the service regardless of the conditions in the family environment, they had to adapt to the situation. There was fear and apprehension of coronavirus infection on both sides.

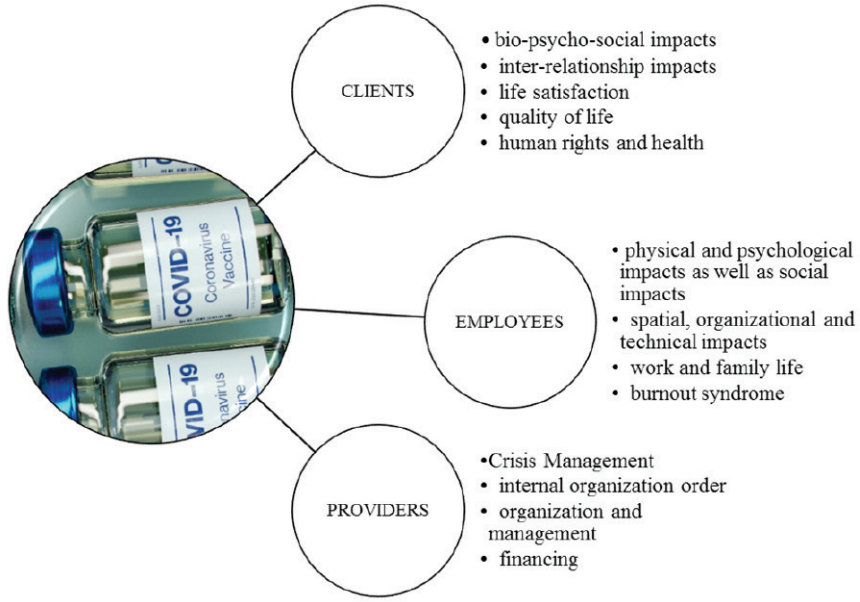
The rules also changed when **accepting new clients for residential or outpatient service**, where the provider can request from the client a certificate of infectivity from the attending physician or a negative test for COVID-19 or preventively separate this client from other clients for up to 14 days.

The transition of clients from social facilities to hospital in the case of hospitalizations and back, when incorrect procedures often occurred, became problematic. The client left the facility properly tested as negative and came from the hospital to the facility without prior testing at COVID-19 (usually after a few days with symptoms and suspected coronavirus), the discharge report stated that the patient had been tested for coronavirus with negative result whereas the patient was not aware that he or she was physically tested.

826 Krcmery, et al. "COHORTATION AND TESTING OF ELDERLY HOMELESS WITHIN COVID PADEMICS IN AN URBAN ENVIRONMENT – EXAMPLE OF A LIFE ISLAND MISSION MODEL," *Acta Missiologica* 14, no 1, (2020): 78. https://www.actamissiologica.com/

827 Costa, et al. "SOME SPECIFICITIES OF LONG-TERM CARE WITHIN THE EU IN THE CONTEXT OF THE CONSEQUENCES OF COVID-19," *Acta Missiologica* 14, no 1, (2020): 80. https://www.actamissiologica.com/

Figure 1. Groups affected by the coronavirus SARS-CoV-2 in social services



Source: own processing

Methods

We have used method of **qualitative research**, which was carried out in the form of individual interviews with three target groups, which consisted of recipients of social services, workers in social service facilities and directors as representatives of non-public providers of social services. Within the research methodology, we used **open coding and situational analysis,** which the author Kalenda describes as a set of all narrated aspects that form the researched phenomenon, which can be supported by empirical data[828].

Data were collected at the turn of 2020-2021 from November 2020 to early March 2021

In the analysis of qualitative data, an **interview** was chosen for research purposes and we used open and axial data coding based on an inductive-deductive approach, which focuses on the relationships between individual codes and the authors refer to what they were specifically concerned. In the initial classification, different codes with different ranges of meaning are created.[829]

828 Kalenda, "Prozatím nevyužitá šance: situační analýza v pedagogickém výzkumu," *Pedagogická orientace* 26, no. 3, (2016): 460.

829 Maguire, Delahunt, "Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars," AISHE-J: *The All Ireland Journal of Teaching and Learning in Higher Education* 9, no. 3, (2017): 27.

Research objectives

The main goal of the research was to analyze the specific effects of the coronavirus pandemic and government measures in the provision of social services for dependents, and what changes the pandemic caused, what measures non-public social service providers, workers and clients in the social services had to adapt to.

Sub-objectives:

- Identify the survival of actors in social services facilities,
- Define the readiness of social services facilities for a pandemic situation and analyze changes in the functioning and management of social services at a selected non-public provider,
- To determine the impacts caused by the coronavirus SARS-CoV-2 on various spheres of life from the point of view of the recipient, the non-public senior homes provider and the employees in senior homes,
- Characterize the specific measures implemented within the Pandemic Plan.

Research questions

Within the research, we determined the following research questions, which we used to fulfill the subject of research:

RQ1: How were social service facilities for eldery prepared for the crisis situation in the form of a coronavirus pandemic?
RQ2: What measures have facilities taken in relation to the SARS-CoV-2 pandemic?
RQ3: Was the facility staff able to adapt to the new operating conditions that have changed as a result of the measures taken to stop the spread of coronavirus?
RQ4: Which principles of facility operation had to change?
RQ5: What areas of social services were affected by the coronavirus SARS-CoV-2?
RQ6: How did the pandemic situation caused by the SARS-CoV-2 affects the lives of social service recipients?
RQ7: How did the pandemic situation caused by the SARS-CoV-2 and the measures associated with it affect the workers in t?he facility?
RQ8: What effects did the pandemic situation caused by the SARS-CoV-2 have on the provision of social services from the point of view of a non-public SS provider?

Research sample

The research sample consisted of 60 participants, of which 30 were recipients of social services in the facility Samaritán and 27 employees in social services facilities, and we also involved 3 non-public social service providers on behalf of directors or statutory representatives.

TABLE 1: Research sample and its characteristics

Recipients (30)	Employees (27)	Providers (3)
Senior age 70-85 years Facility Samaritan Dependence IV.-VI. Residential social service Stay during the pandemic of the first and second wave	Permanent employment Practice at least 1 year Job classification at the time of the pandemic Age 30-55 years	Private provider Facility Samaritan in Tekovské Lužany Children‘s center in Levice Help center in Šárovce

Source: Authors

The tables show the most frequent answers of the participants, processed from the records of interviews, which numerically prevailed over others. From a statistical point of view, it is a **modus value**. These answers were processed by open coding in the form of codes and categories within the research questions RQ1 to RQ8.

TABLE 2 RQ1: How were social services facilities prepared for a coronavirus crisis? (in the first wave)

Readiness	1	2	3	4
Hygienic and protective equipment		X		
Material equipment for anti - epidemiological measures				X
Spatial equipment			X	
Staff training and recruitment of workforce		X		
Biological waste				X
Crisis plan and anti - pandemic measures			X	

Note. 1-very good, 2-sufficient, 3-average 4-insufficient
Source: Authors

We analyzed the results of the research by open coding, we identified the preparedness for the pandemic situation caused by the coronavirus SARS-CoV-2 on the basis of 6 areas, while the results showed that the lowest level of **readiness for biowaste handling** (used cloth and surgical drapes, gloves, protective suits , respirators, antigen tests, etc.) and **material equipment** was insufficient to implement preventive measures.

TABLE 3: RQ2: What measures have facilities taken in relation to SARS-CoV-2?

Basic measures	1	2	3	4
drape-distance-hands	X			
Temperature measuring	X			
Visitation ban and social isolation		X		
Testing			X	
Turnus shift rotation		X		
Beginning of alternation of changes working in isolation		X		
Reprofiling of beds			X	
Restriction of group activities		X		
Surface disinfection and ventilation	X			
Food preparation and boarding	X			

Note. 1-very good, 2-sufficient, 3-average, 4-insufficient
Source: Authors

TABLE 4 RQ3: Was the facility staff able to adapt operationally to the new conditions that have changed as a result of the anti - pandemic measures taken to stop the spread of coronavirus?

Ability to adapt to altered working conditions for SARS-CoV-2	1	2	3	4
Hope and motivation	X			
Valuation			X	
Competences		X		
Trust and respect		X		
Individual attitudes			X	

Note. 1-very good, 2-sufficient, 3-average, 4-insufficient
Source: Authors

TABLE 5: RQ4: Which principles of facility operation had to change?
Based on the answers of employees and clients, we identified changes in the following areas:

Areas of change
1. Hygiene, eating and dining
2. Movement in the premises of the device
3. Testing
4. Social and group activities
5. Visits to the facility
6. Admission of new clients dependent on residential social service

Source: Authors

TABLE 6
RQ5: Which areas of social services were affected by the SARS-CoV-2?
RQ6: Summary of basic changes in the functioning of facility before and during the pandemic

Internal rules of the facility Activities and activities	Before pandemic	During pandemic
Educational and development activities	Yes	No
Interest activities	Yes	No
Therapeutic activities	Yes	No
Spiritual activity	Yes	No
Visit of the doctor at the facility	Yes	Yes
Pocket money for recipients	Yes	Yes
Walks outside the facility	Yes	No
Client parties and celebrations	Yes	No
Visits to family, relatives and acquaintances in the facility	Yes	No
Crisis management and reprofiling of beds	No	Yes
Regular anamnestic meetings	Yes	No
Spacing	No	Yes
Adherence to hygiene measures and disinfection at repeated intervals	No	Yes
Fulfillment of individual client development plans	Yes	No
Higher number of deaths and provision of related actions	No	Yes
The need to wear a mask for employees	No	Yes
The need to wear masks for clients	No	No
Certificate of infectivity	No	Yes
Testing of employees regularly	No	Yes
Testing of clients on the transition to and from the device	No	Yes
Testing of new users of social services	No	Yes
Adjustment of employees‘ vacations	No	Yes
Adjust of movement outside the device	No	Yes
Organization of working time	Yes	Yes
Workers in shifts for an epidemic	No	Yes
Disinfection of premises	Yes	Yes
Cover of spiritual needs	Yes	Yes
Stream of Holy Mass	No	Yes
Accompanying clients when dying with family members in the facility	Yes	No
Video calls with family	No	Yes

Source: Authors

TABLE 7: RQ6 How has the SARS-CoV-2 pandemic affected clients‘ lives?

Impacts of coronavirus on clients	1	2	3	4
Fear and feelings of hopelessness	X			
Mental burden			X	
Physical burden			X	
Social isolation	X			
Restrictions on activities		X		
Death			X	

Note. 1-very high, 2-high, 3-average, 4-low load rate
Source: Authors

TABLE 6: RQ7: How has the pandemic situation and the associated measures affected the staff in the facility ?

Impacts of coronavirus on facility staff	1	2	3	4
Restrictions on communication and information			X	
Shift rotation and working conditions	X			
Interpersonal relationships			X	
Physical and mental stress	X			
Social isolation and separation from the family		X		
Restrictions and limitations for SARS-CoV-2	X			

Note. 1-very high, 2-high, 3-average, 4-low load rate
Source: Authors

TABLE 7: RQ8: What were the effects of the coronavirus pandemic on the provision of social services from the perspective of a non - public social service provider?

Impacts on social service providers	1	2	3	4
Accepting new clients			X	
Disinfection costs				X
Financial burden	X			
Legislative changes and regulations	X			
Internal order and human resources	X			
Activity mode restriction		X		
Other restrictions and regulations		X		

Note. 1-very high, 2-high, 3-average, 4-low load rate
Source: Authors

Discussion

The SARS-Cov-2 pandemic poses the greatest threat to the elderly in the population[830]. It has very strong negative effects in the field of health, mental and social. The facilities for seniors themselves face new and serious challenges. They had to reorganize their work to meet the most demanding hygiene standards, which they did not have the finances for, and it was also very difficult to provide hygiene aids at the beginning of the pandemic. These shortcomings were compensated in particular by the extraordinary commitment of their employees, who worked on two-week continuous shifts of departments from their families, as it was not possible to provide enough tests for daily testing. Everyday activities and social contacts of seniors were limited and social isolation is very hard on seniors. In addition, the health effects of COVID- 19 have been catastrophic for seniors. Despite increased efforts, the spread of the virus could not be stopped in many facilities, which had fatal consequences for clients. They died separated from their loved ones, who could only connect with them through digital networks. Even those who survived COVID-19 often bear the severe health consequences of the disease.

Facilities for the elderly had to involve crisis management in resolving the pandemic. The lack of resources, as well as financial, material but especially personnel, was compensated only by the extraordinary dedication and efforts of all employees[831]. The government and the ministries tried to issue regulations in an often unknown and confusing situation, which were often incomprehensible and did not correspond to the dynamic development of the situation[832]. On the contrary, the immediate involvement and assistance of local communities helped a lot.

We analyzed the effects of COVID-19 in the area of social services on the basis of the categorization of participants' statements. Recipients of social services - clients stated that their pandemic affected the most in the following areas:

Psychological area: clients reported that they suffered to a greater extent from feelings of anxiety, depression, negative thinking associated with a pandemic, feelings of mental exhaustion and helplessness, which led to a loss of motivation and hopelessness. The greatest impact was reported by the fear, which appeared in the recipients in various forms, it was mainly the fear of losing life, fear of losing contact with the outside world and fear of a pandemic entering the facility[833].

Physical area: for many clients, the introduction of restrictions and anti-epidemiological measures was a physical burden, as they required, in particular, increased hygiene requirements, disinfection of premises and restrictions on activities.

Social area: social impacts included, in particular, the restriction of activities in the facility, the ban on visits and social isolation, the elimination of leisure activities and the restriction or suspension of social activities, cultural and musical events that were part of normal life in the facility, as well as or other joint actions in the orange and red SARS-CoV-2 coronavirus spread. The impacts also mentioned tense relations and a hostile atmosphere in the facility, which stemmed from a negative perception of pandemic measures.

830 Subramanian et al. "THE COVID-19 PERSPECTIVE FROM BOTH SIDES OF THE GLOBE – SOUTH EAST ASIA VERSUS EUROPE. "THE CORONAVIRUS DISEASE MAY BE CONTROLLED WITHINLATE SPRING AND EARLY SUMMER, 2020" PRACTICAL EXPERIENCE GAINED DURINGEPIDEMICS SIMILAR TO THE CORONAVIRUS PANDEMIC " *Acta Missiologica* 14, no 1, (2020): 164. https://www.actamissiologica.com/

831 Beno et al. "ANALYSIS OF THE POVERTY RISK IN EUROPEAN COUNTRIES," *Acta Missiologica* 14, no 1, (2020): 99-100. https://www.actamissiologica.com/

832 Costa et al. "SOME SPECIFICITIES OF LONG-TERM CARE," 80.

833 Varghese, Kubacki, Caban et al. "CERTAIN NEGATIVE CONSEQUENCES RELATED TO THE CORONAVIRUS PANDEMICAND RELEVANT POSSIBLE SOLUTIONS," *Acta Missiologica* 14, no 1, (2020): 83. https://www.actamissiologica.com/

- Death: Clients reported that they had increased negative thoughts of death and anxiety about the pandemic threat in connection with the SARS-CoV-2 coronavirus.

New coronavirus deaths in social care homes account for 30% to 60% of all COVID-19 deaths in several Member States. The deaths of citizens receiving long-term care have reached 50% in some countries, such as Belgium, Spain, France and Germany, and the number of deaths of seniors in facilities has exceeded 37%[834].. The team of authors Brichtová et al. developed a Plan for Minimizing Mortality and Protecting the Quality of Life with an Emphasis on Solutions for Vulnerable Groups, which offers recommendations and proposals for measures based on the WHO, such as: introduction of infolines for seniors, monitoring of staff failure in facilities. Creation of quarantine rooms in facilities, testing and distribution of protective equipment, change of operation or creation and distribution of food and non-food support packages for the needy[835].

There is an increased risk of death in single and socially isolated people, which has been confirmed in several studies, argue that social isolation and loneliness increase the risk of death by up to 26-29%, which can be compared to smoking 15 cigarettes a day[836].

Other research that social isolation increases the risk of cardiovascular disease, obesity and stroke, while having a direct effect on feelings of anxiety, depression and cognitive decline. As a result of these measures, this group of people enters a vicious circle from which they are unable to get out of their own accord, mainly because the state of emergency is constantly prolonged and the release of measures is carried out according to the current epidemiological situation, which no one can predict. The longer the social isolation lasts, the deeper its effects on the psychological experience of the recipients[837].

SWOT analysis

Based on the results of the research, we can use SWOT analysis to specify the impacts of the epidemic caused by the SARS-CoV-2 on the management, organization and functioning of social service providers, as well as suggest opportunities to address it:

A. Strenght (positive aspects):

- Created strategic documents and pandemic plans, which were not previously part of the management of social services management, which are divided into residential, field and outpatient forms, as well as low-threshold social services and crisis intervention services.
- Creation of own internal regime on the basis of recommendations and measures of the chief hygienist of ÚVZ SR.
- Ensuring one's own diet without the need to bring food from outside ofsocial services facilities.

834 EUROPARL.. COVID-19: Zmiernenie dopadov pandémie na domovy sociálnych služieb. 3. https://www.europarl.europa.eu/news/sk/agenda/briefing/2020-10-05/5/covid-19-zmiernenie-dopadov-pandemie-na-domovy-socialnych-sluzieb

835 Brichtová et al. Plán na minimalizáciu mortality a ochranu kvality života s dôrazom na riešenie pre zraniteľné skupiny. (Verzia 24. 4. 2019): 1.

836 Holt-Lunstad et al. "Loneliness and social isolation as risk factors for mortality: a meta-analytic review," 10, no. 2, (2015 Mar): 229. DOI: 10.1177/1745691614568352

837 Chu, Donato-Woodger, Dainton, " Competing crises: COVID-19 countermeasures and social isolation among older adults in long-term care," *J Adv Nurs* 76, no. 10, (2020): 2457. doi: 10.1111/jan.14467

- Social solidarity, increased motivation and activity of staff in the facility, as well as volunteers in providing assistance in the fight against coronavirus, local initiatives for the elderly and infirm, such as sewing towels, delivery, hygiene items, music, cooking for staff on duty and people in the front line.
- Strengthen crisis management in social services, introduce new measures to protect the lives and health of beneficiaries that have not been previously considered (for example, in influenza epidemics).
- Creation of a nationwide vaccination system against coronavirus with preference for vaccination doses for the elderly, chronically ill and disabled, social services facilities in some districts (Levice, Nové Zámky, Trnava) were preferentially vaccinated.
- Development of digital skills of recipients in an effort to ensure online communication with the outside world (online streams of masses) and family (video calls).
- Creation of the Mutual Assistance Fund, which in cooperation with the donor portal ludialudom.sk is financed by the Office of the Government of the Slovak Republic, in order to eliminate the negative effects of coronavirus and the creation of SOS subsidies for the business sector.
- Positive examples of solidarity mediated in the media with a focus on increasing assistance in the field of social services, such as food collections, imports of aids, etc.

B. Weaknesses (negative aspects):

- Unpreparedness of providers for sudden changes, change of operation and management of the facility, change of internal order, change of staff, change of working hours, change of financing, legislative changes.
- Increased physical and mental burden on recipients and employees, increased risk of burnout, worsened working climate and tense interpersonal relationships[838].
- Introduction of hygienic-epidemiological measures in connection with temporal, organizational, technical, spatial and financial problems for which the facilities were not prepared and which lasted for too long a period (more than a year).
- Social isolation and ban on visits, as well as ban on movement outside the SS facility as well as ban on visits for families and known recipients.
- Inability to participate in development programs, limited or stopped group activities, in-facility therapies or other routine activities that were part of the beneficiaries‘ lives and enriched their lives, including spiritual activities.
- Leisure time spent mostly passively, activation of recipients at a minimum level, watching news and information about coronavirus from television caused more depression, fear and frustration in clients, feelings of insecurity increased.
- Impossibility to participate in hobby activities carried out outside the facility, impossibility to spend Christmas or Easter with the family outside the facility, suspension of celebrations in the facility or occasional events such as Seniors‘ Day or International Women s Day.
- The need to motivate recipients to a higher level of hygiene, the need to overcome misinformation, the need for psychological support and intervention, the need to resolve a number of conflicting situations.

838 Varghese, Kubacki, Caban et al. “CERTAIN NEGATIVE CONSEQUENCES RELATED TO THE CORONAVIRUS PANDEMIC,” 84.

C. Opportunities:

- Introduction of information campaigns to eliminate the spread of misinformation and safe lines for the elderly.
- Implementation of information and awareness campaigns in the prevention and fight against the pandemic, as well as support for general awareness in the implementation of emergency measures and prolongation of emergencies, as well as raising awareness of the importance and significance of individual measures (completely absent in the first wave).
- Adaptation of the regime of functioning of facilities and creation of conditions of the provider so that individual measures have the least possible negative impact on social services as well as on their recipients.
- -Creating cooperation, partnership and support between SS providers, founders, local governments and individual ministries in developing action plans, strategies and anti-pandemic measures to prevent the spread of the epidemic and mitigate its effects on various spheres of social life and functioning, especially at-risk groups, among which we also include individuals with a dependence on social services.
- Creating financial reserves (public and private) in the event of emergencies and emergencies in the spread of epidemiological diseases or other events with a widespread impact on the health of citizens.
- Creating innovative start-ups to increase and improve conditions in the field of education, research and science, entrepreneurship and fulfillment of the Strategy of Successful and Modern Slovakia, which also includes improving social services and promoting mental health.
- Creating a network of close cooperation between social service providers, founders, care agencies at the level of cities and municipalities in consolidating support for the dependent (not only in times of pandemic).

D. Threaths

- Lack of preventive tools to eliminate the emergence and spread of epidemiological diseases in the future,
- Financial unsustainability of social services and lack of human and social capital.
- Proposal of measures and methodological and legislative procedures in an effort to eliminate threats that can reach a wide range of objective and subjective dimensions of the quality of life of citizens and increase resources in society towards independence and sustainability.
- Lack of resources and support in the field of science and research as well as low creation of conditions for education and development of laboratory centers.
- Promoting digitalisation can lead to even greater social isolation of some groups, as well as job losses, which can be a threat to post-communist countries to a greater extent than the benefits they themselves bring.
- Failure to implement measures for rapid societal change, to respond flexibly to global trends and the effects of pandemic threats in connection with economic and economic crises.

Conclusion

In the fight against epidemiological situations that could jeopardize the provision of services in social services facilities, we have proposed the following recommendations:

1. It is necessary for several entities to cooperate in resolving the crisis situation in the social services facility in connection with the epidemic, for example, the local community can provide some needed material equipment for the social services so that they can provide basic protective work aids to employees during the epidemic. It is necessary to build a relationship between entities at the local and regional level, which will enable active cooperation in the implementation of the crisis and pandemic plan in social services, as well as assistance in the distribution of OPP and food.

2. Creating a space for temporary low-capacity provision of services for those deprived citizens who cannot be cared for by a quarantined family, for example with the help of housing assistance, to which field carers are temporarily relocated as part of the community services model for citizens.

3. Merging of facilities in the same district during the collapse of the workforce in the facility, or the creation of isolated parts in the facility, where it is possible to reprofile beds for Covid-19 patients.

4. Involvement of force or medical support staff in the event of the collapse of social services facilities, which would help ensure long-term institutional care for dependent citizens in the event of a loss of more than half of the staff in the facilities who are in quarantine.

5. Creation of isolation rooms directly in social service facilities, or in cooperation with another social services provider, if the facility does not have suitable spatial and material capacities. In the case of closing existing services, the city assists with the provision of spare capacities.

6. Implementation of epidemiological procedures, including testing, which has proven to be a suitable preventive tool in facilities.

7. Re-evaluation of created crisis plans and protocols in social services facilities based on monitoring and evaluation of the previous epidemic, ie analysis of its impacts and subsequent setting of anti-epidemiological procedures (discussions - round tables - what the pandemic gave us and what it took from us).

8. Introduction of a system of early identification of cases of citizens infected with an infectious disease and establishment of temporary quarantine measures in the social service facilities, including psychological support during social isolation.

9. Information and awareness campaigns to support vaccination of the population and to prevent the spread of anti-vaccination campaigns.

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QUALITATIVE RESEARCH FOCUSED ON THE APPLICATION OF COUNSELLING IN SLOVAKIA ON SELECTED HELPING PROFESSIONS

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Abstract

Background: The issue at hand deals with the concept of counselling as a supportive method that can be used by helping professions and may prompt the client to become aware of their own personal resources and abilities. The qualitative research was carried out to determine ways in which counselling may be used by two selected helping professions in Slovakia (pastoral care carried out by churches and social work).

Conclusion: The experts who actively participated in focus groups saw great potential in counselling, as there is a demand for this method among churchgoers and priests alike. The results obtained demonstrated that there is a need for counselling as a support method for the sacrament of reconciliation and human formation, as well as proper long-term spiritual guidance in the field of pastoral work. The results showed that, in the field of social work, counselling is needed when working with individuals, carrying out social counselling, individual planning, or individual accompaniment in various difficult social situations. The method of counselling should be defined in terms of quantity and quality by carrying out studies and performing analyses on the needs and possibilities of the application of counselling in Slovakia and on the creation of specific proposals for a model of pastoral counselling in Slovakia.

Keywords: Counselling – Pastoral counselling – Helping professions – Communication skills – Client.

Introduction: Theoretical background of the research

The present qualitative research is based on the KEGA project entitled *Creation of a distance learning module in pastoral counselling for selected helping professions – social work and pastoral theology*, which aimed to apply the method of pastoral counselling to the Slovak environment. The theoretical background of the present research will contain well-known information that is not shared for the purpose of its mechanical reproduction but because a similar research focus, both theory- and content-wise, has not been carried out in Slovakia thus far. Therefore, the theoretical background of the present research contains selected relevant theoretical outputs, which are directly intertwined with the practical research carried out directly in the Slovak environment. This background is divided into the following key areas: *Counselling as a method and professional activity benefiting the client; Conditions for the professional training and practical work of counsellors globally; Helping professions in Slovakia (selected helping professions: pastoral care and social work).* These sections are followed by the definition of the research with a detailed description of its individual parts and phases.

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Counselling as a method and professional activity benefiting the client

"***Counselling is an interactive client-beneficial relationship*** *set up to approach clients' issues. These issues can be social, cultural and/or emotional, and the Counsellor will approach them holistically. A client can be a person, or a family group, or even an institution. The overall aim of counselling is to help clients recognise opportunities to help them live in more satisfying ways as individuals and as members of society.*"[840] This was the definition of the term counselling provided by the European Association for Counselling in 1995.

Counselling is a collaboration between counsellors and clients. Professional counsellors help clients identify their life goals and potential solutions to problems that are causing them emotional turmoil. They strive to improve the clients' communication skills, enhance their self-esteem, and promote changes in their behaviour while taking into account their optimal mental health.

Counselling is a tool, a **method** that prompts the client to become aware of their own personal resources and abilities. The aim of the cooperation between the counsellor and the counsellee is to develop social skills in such a way that the client can move forward independently in a positive direction in terms of their personal growth and formation. Counselling, in very simple terms, can be defined as helping people help themselves. Counselling has important theoretical roots in Rogerian theory. In modern times, however, counselling employs various techniques from other psychological schools of thought, educational sciences, and social work, depending on the field in which the counsellor works.[841]

Counselling as a **specialised professional activity** began to develop at the beginning of the 20th Century, primarily in the field of career counselling. Nowadays, there are many different forms of counselling (family counselling, family planning counselling, health counselling, school and educational counselling, career counselling, job counselling, experiential counselling, gerontological counselling, behavioural health counselling, domestic violence counselling, addiction counselling, community counselling, housing counselling, credit counselling, debt counselling, divorce and marriage counselling, pastoral counselling in church settings, etc.).

The accompanying person – i.e. the counsellor – must be professionally trained to perform this activity. The study of counselling is aimed at acquiring theoretical knowledge in the field of counselling psychology, pedagogy and social work, law, or sociology. An essential part is undergoing practical training in different types of institutions or carrying out individual sessions with clients. In practice, it is necessary to recognise, distinguish, and apply various techniques of working with the client, depending on the nature of the target group, the depth of the client's problem, or the possibility of applying such a technique in a particular stressful situation. That is why it is necessary for the counsellor to undergo professional training.

840 European Association for Counselling: How the EAC defines Counselling. http://eac.eu.com/definition-counselling/

841 Mária Šmidová and Katarína Slezáková, *Counseling v pomoci rodinám. Nová metóda v sociálnej práci – counseling – v pomoci rodinám so špecifickými potrebami* (Trnava, 2016).

Conditions for the professional training and practice of counsellors globally

In the United States, the professional training of counsellors is, in most cases, included in academic studies. In this regard, *a licensed professional counsellor* is protected by a professional degree and requires an academic Master's degree, clinical experience as well as experience in supervision. The final examination or the granting of the license is governed by federal and state laws. In the United States, the discipline of counselling is clearly differentiated from the discipline of psychotherapy by several professional associations (American Counseling Association – ACA, National Board for Certified Counselors – NBCC, Inc., Council for Accreditation of Counseling and Related Educational Programs – CACREP, Chi Sigma Iota – CSI). These associations, societies, and international associations also ensure compliance with the Code of Ethics for counselling professionals.

In the United Kingdom, the professional practice of counselling is closer to psychotherapy in terms of counsellors' competence, whereas in Germany clinical counsellors are active in many professions.

Europe, Asia and Latin America, and more recently parts of Africa apply the American model of counselling in various ways. The reason behind the successful adoption of counselling as a new method is related to the various levels of competition from other professional organisations, associations, and international societies. For instance, NBCC, Inc., with its registered office in Greensboro in North Carolina, has branches all around the world. The way the individual branches are tied to the American counselling tradition has at times led to accusations that the discipline's methodology is culturally biased and it is not possible to apply it to Asia or other countries.[842] Therefore, the transcultural application of methods developed in the United States and Europe poses an enormous challenge to the discipline. This, however, does not detract from its increasing importance, particularly in Asia.

In most European countries, counselling is a free profession and counsellors are members of counselling associations to guarantee professional quality. In response to the demands of the education system, many European universities include counselling courses in the curricula of Master's degree programmes or specialisations, especially in the faculties of psychology and education. Countries of Eastern Europe are less aware of or less likely to turn to counselling. This leaves room for the use of other forms of help, such as psychological, psychiatric, social, etc. [843]

Helping professions in Slovakia (selected helping professions: pastoral care and social work)

From the experience of foreign countries, it is clear that the counselling method can be employed in several helping professions and may be implemented in several models. In the present contribution, we will focus on two models, i.e. counselling in social work and pastoral counselling.

Social work as a practical profession and a scientific discipline promotes social change, social cohesion, people's rights and freedom. It is based on the principles of social justice, respect for human rights, collective responsibility and honouring people's differences. Social work employs people and various structures in solving life problems and enhancing social well-being with the help of social work theories, social sciences, humanities, and traditional (original) knowledge.[844] In practical terms, social work is about helping, supporting, serving and guiding the client, be it an individual, a group, or a community. Accompanying a social work client (counselling) is not yet a sufficiently developed and implemented part of the work of social workers in the Slovak environment. As shown by the examples from abroad, counselling could be applied in the Slovak context, for example in social services, in all its forms, i.e. outpatient, residential or field counselling. The target group that social work focuses on most often includes seniors, unemployed citizens, marginalised groups, persons with disabilities and their families, victims of domestic violence, homeless people, people raised in children's homes, families with children, or other social work clients.

Pastoral care is a multifaceted set of activities used by the Catholic Church and Christian denominations in carrying out their mission. This mission consists of various activities and spiritual care for people with or without a Christian or other faith in their particular living conditions. Pastoral care may be dedicated to a particular group of persons (e.g. youth pastoral care, vocational pastoral care, pastoral care for the sick, soldiers, the unemployed, families) or particular life situations (e.g. pastoral care in hospitals). The objective of pastoral care is to serve people. This service may consist of helping them find or strengthen their faith and to deal with various life situations, as well as the administration of the sacraments. The theological discipline known as pastoral theology deals with the issue of pastoral care. Pastoral care focuses on parishes. In order to help support it, pastoral centres were established in the Catholic Church after 1990 in various dioceses throughout Slovakia.[845]

Pastoral accompaniment combines – in the broad sense of the term – spiritual care for a person and methods of effective psychological help (counselling). It contributes not only to spiritual growth but also to a person's general development. It wants to help people around the world find their inner balance and regain spiritual integrity. It gives them the opportunity to discover and explore ways to live life as usefully as possible, and thus move closer to the highest level of overall well-being.

In a broader sense, it could be said that pastoral care and social work have a common goal, i.e. the integral goodness of man. Each of these disciplines, however, approaches the realisation of this goal in a different way. Counselling as a method can be a useful tool for both social work clients and persons interested in spiritual/pastoral accompaniment.

Definition of research

The intention of the helping professions is to provide a personalised and effective form of assistance to people in their particular spiritual (pastoral) or social (social work) activity. The current situation in Slovakia in this field is marked by a lack of communication skills necessary for more effective work of helping professions in their individual professional activities. The main research problem of the present qualitative research is the creation of a space for the improvement of professional skills in relation to communication skills, conversation, and building trusting relationships within professional activities in the case of selected helping professions.

842 For more detailed information on this fact see, for example: Allen E. Ivey, Mary Bradford Ivey, and Carlos P. Zalaquett, *Intentional Interviewing and Counseling: Facilitating Client Development in a Multicultural Society* (Cengage Learning, 9th Edition 2018).

843 For more detailed information see, for example: Mária Šmidová and Katarína Slezáková, *Counseling v pomoci rodinám. Nová metóda v sociálnej práci – counseling – v pomoci rodinám so špecifickými potrebami* (Trnava, 2016).

844 International Federation of Social Workers. Global definition of social work. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

845 For more detailed information see, for example: Marián Mráz. *Základná praktická teológia, Dejiny, koncepcie, perspektívy* (Bratislava: Aloisianum, 1997).

Research problem and objectives

The research problem, as outlined above, consists of the *knowledge related to counselling, practical experience with this method, the interest of the professional public in the application of counselling in the Slovak environment, and the related challenges of implementing counselling in the field of selected helping professions in Slovakia*.

The research objective was to determine ways to effectively apply the counselling method to the system of selected helping professions in Slovakia.

The examined factors have not yet been looked into in similar research conducted in the territory of Slovakia. Therefore, we decided to use the following open-ended **research questions** to achieve the objectives:

A What is the participants' understanding of the word counselling?

B What is the participants' practical experience with the counselling method both in Slovakia and abroad?

C Where do participants see the need/usefulness of counselling within the selected professions in Slovakia?

D What risks/challenges do participants perceive in the implementation of counselling in the Slovak professional environment?

Description

The present research was part of the KEGA project entitled *Creation of a distance learning module in pastoral counselling for selected helping professions – social work and pastoral theology.* The practical aim of this research was to update the already-developed working version of the training programme responding to the needs and actual working situation of the selected helping professions.

The qualitative research used a descriptive method with an exploratory approach since the examined factors have not yet been looked into in a similar study in the field of professional research in Slovakia. For this reason, the objectives were achieved using open-ended research questions. To answer them, the method of focus groups was chosen, which allows researchers to reach a consensus on relevant issues.[846] In view of this fact, focus groups set out to explore the opinion of the professional public on the presented topic. Their intention was not to look for background information but to find qualitative content data on the selected topics.

Research factors and variables

In light of the research objective, the main factor of the research was the **method of counselling in Slovakia** in relation to the demand for it. Thus, it was looked into using the following variables:

a. Theoretical knowledge of counselling as a method (connotation and denotation)

b. Practical experience with counselling in Slovakia and abroad

c. The need for counselling (skills, content-related goals and clientèle) in the helping professions

d. Challenges/risks associated with the implementation of counselling in the Slovak environment

Characteristics of the research sample

The sample of respondents was determined using purposive sampling[847] within the territory of Slovakia. Probands had to meet two basic criteria: first of all, to have long-term experience in the field of helping professions with direct contact with clients; the second condition was experience in long-term management or leadership of an organisation, institution or even activity in the field of helping professions in Slovakia.

Participants were approached individually, based on them meeting the aforementioned criteria. The reason for this was to guarantee professionally valuable, up-to-date, and practical answers to the research questions on the selected topic. The participants represented two selected helping professions – pastoral care and social work. In total, the present research involved 17 adults, 5 women and 12 men, who have been professionally active in the field of helping professions for a long time.

Methodology

A qualitative research strategy was chosen to carry out the research. The research was conducted in person through focus groups. The focus groups were 90 minutes in length.

The collected data were subjected to a practical-application qualitative analysis, in which the level of knowledge of the counselling method by the participants and their previous experience with its use, need or shortcomings in the selected professional activities were examined. This examination set out to determine to what extent counselling is needed, well-known, and applicable in Slovak practice. It also intended to find out in what ways counselling should be applied to the target group in regard to its content and optimal professional requirements. **In other words, the demand of the helping professions for the counselling method was described in relation to its adaptation to the Slovak environment.**

Ethical aspects of the research

Prior to the research, the organisations represented in the research, in which the respondents have been working professionally for a long time, as well as the respondents themselves, provided written consent to the processing of their personal data for the purposes of the research, and also consented to the inclusion of their names as well as the names of the respective organisations. This information is included in the research report as being confirmation of the relevance of the research. The data results are anonymised, so the respondents' answers are not linked to their names and personal details.

846 Audrey Roulston, "The impact of time and communication on professional decision-making regarding patients with advanced lung cancer: Interpretative phenomenological analysis of focus groups with specialist palliative care professionals ," *Acta Missiologica* 15, no. 1, (2021): 12. https://www.actamissiologica.com/

847 For more detailed information see, for example: David Silverman, *Qualitative Research* (SAGE Publications Ltd; Fourth edition 2016).

Subsequently, research participants were provided with background information about the research, its objectives and possible applications in practice, as well as ethical lessons. This information was also processed in the form of documents that were presented to the respondents for them to sign. Since the research was conducted in person in the midst of the COVID-19 pandemic, the respondents were asked to sign a declaration of the absence of symptoms of viral infectious diseases in addition to the aforementioned documents.

After complying with the ethical aspects of the research, the specific characteristics of the focus group method were presented to the participants.

The research consisted of a brief introduction to the topic and active participation of the respondents in the focus groups. Participants were informed that the focus groups would be recorded in audio format starting from the administrator's announcement, and later transcribed verbatim for research purposes. Participants were also assured that they were free to suspend their participation at any time and that they could ask for the administrator's assistance. All participants provided written consent to the aforementioned terms and conditions of the research and participated in the focus groups for the entire duration.

Data analysis

The consensual qualitative research method for simple qualitative data (CQR-m)[848] was selected for data analysis. It was a bottom-up method focusing on data exploration. In this method, the categories were derived from the data by creating categories, a coding system, and the subsequent categorisation of responses.

The first part of this analysis was prepared separately by three researchers who then sought to reach a consensus in their claims. Subsequently, an auditor examined their work and resolved disagreements in the consensus of the three researchers. The categories created were then supported by examples from the statements.

Results

The reason for conducting the present research within the framework of the aforementioned KEGA project was to carry out basic research on which the project will be subsequently built.

In order to achieve the main objective of the research, four sub-objectives were chosen. These were used to examine specific variables, thus drawing a picture of the researched issue at hand: knowledge and awareness of the counselling method, practical experience with this method, the need for the counselling method within the selected helping professions, and potential challenges/risks associated with its possible implementation. Based on these variables, research questions were formulated. The researchers received responses through focus groups and analysed them using consensual qualitative analysis. Based on this analysis, the researchers managed to successfully answer all four research questions.

848 For more detailed information see, for example: Patricia T. Spangler, Jingqing Liu, and Clara E. Hill. Consensual qualitative research for simple qualitative data: An introduction to CQR-M. In C. E. Hill, ed., Consensual qualitative research: A practical resource for investigating social science phenomena (pp. 269–283). (American Psychological Association, 1st ed. 2012).

Research objective A: Theoretical knowledge of counselling as a method (connotation and denotation)

The first research question focused on determining the knowledge and understanding of the counselling method by the professional public. The reason for asking this question was to determine to what extent the counselling method is known and properly understood throughout Slovakia. This was perceived as being crucial for the proper expectations on the part of the professional public and for avoiding inconsistencies in its implementation among the already existing methods and techniques in Slovakia. The results showed that, although the counselling method is known by the public, there is a thin line leading to it being partly mistaken for similar methods or related therapies. The following table shows the specific categories of responses:

Participants **defined the method** of counselling as:

Method of guiding the client in a personal search for inner coping resources	Helping a person find the inner strength to cope with a difficult situation in which they find themselves Resolving inner conflicts and difficulties by finding the inner resources of the client The method of discovering the resources within the client to figure out the next steps
Method of preventive assistance in stressful situations	Method of preventive assistance in stressful situations as prevention of the development of a more severe pathology Method aimed at helping people cope with a stressful situation – in search of integrity
Method for development and personal growth	Developing young people into healthy individuals using proper and unforced communication Method aimed at developing the marital or parental mission A path to personal growth The method of human accompaniment – a simple aid in changing one's attitude towards a personal situation

Participants also mentioned the **skills that they felt were characteristic of the counselling method**:

Non-directiveness	Conducting the conversation in a non-directive way The ability to actively listen and lead a conversation Seeking resources, not answers
Personal predisposition	Willingness to help
Focusing on specific aspects	Ability to start with something specific Conducting a meeting practically, not academically
Value neutrality	Maintaining a non-professional character Having a spiritual foundation but being able to integrate it into daily life

Research objective B: Practical experience with counselling in Slovakia and abroad

The intention of the second research question was to find out whether the participants had personal experience with some form of counselling. We wanted to know what form of counselling it was and what it was called. The participants mentioned several types and names, two

of which came up most frequently. The first type was **pastoral accompaniment** encountered by the participants in Italy and England, for example. Its intention was to accompany a person in their spiritual growth – not to guide them but to give them space to talk about their spiritual journey. The second most frequently mentioned form of counselling was **life accompaniment** (or human accompaniment). Its main goal was to help people cope with their day-to-day life during a stressful period. The participants encountered this form of accompaniment in Austria and Hungary, for example.

One respondent who studied the counselling method in the United Stated stated that counselling as a field of study has a solid clinical as well as practical basis there, similarly to the United Kingdom. The emphasis is on practical teaching, practice and supervision that is provided in the organisations in which the students acquire practical experience. Supervision is seen as a standard part of counselling education in the United States and is provided at a number of levels. The aforementioned factors are due to the fact that, in the United States, the professional services of a counsellor are in high demand. Therefore, facilities and organisations are open to working with students studying counselling and are willing to provide them with practical experience and supervision to further their academic and personal growth.

Pastoral accompaniment	Counselling – pastoral accompaniment Pastoral counselling (Italy) Pastoral accompaniment (England)
Life accompaniment/counselling	Life counselling (Germany) Life counsellor (Hungary) Life guide Life assistant Human accompaniment
Other	Mental health specialist (Austria) Professional counselling Clinical counselling (United States)

Research objective C: The need for counselling (skills, content-related goals and clientèle) in the helping professions

The third research question set out to find out the extent of the demand for the counselling method that can be expected in Slovakia and towards what to direct this demand. The content of the counselling method is evident, but its practical application was the main goal of the research.

The participants' answers to the third research question provided an ample variety of solutions that are helpful for the following steps of the KEGA project.

First of all, we focused on the usability of the counselling method in the activities or services that are part of pastoral theology: We categorised the responses into four groups. Professionals pointed out that counselling is necessary for the proper accompaniment of a person by a priest but *especially by a non-professional person* in longer conversations **in support of the sacrament of confession**. Participants highlighted the importance of taking time to talk and have discussions with people that would help make a change in their life or to find the source of their suffering, hurt, or sinful actions. The need for conversations is confirmed by the people who go to confession or meetings related to pastoral activities. The respondents who were priests drew attention to the lack of time in confessionals and would welcome the possibility of qualified non-professionals working with people coming to the confession. However, some expressed concern about whether churchgoers would be willing to go talk to such a professional, as they know from experience that people find it difficult to approach similar professions, such as psychologists.

The second identified category was a professional activity – **the skill of human formation**, helping priests and non-professionals create healthy relationships in the parish by improving their work with individuals.

The third category was filled with responses related to **a supportive method for proper spiritual direction**. For example, one participant highlighted the method of St. Ignatius, who tried to guide people to find the answers for their own life (cf. The Spiritual Exercises of Ignatius of Loyola). The final use of the counselling method was in the **continuous formation of priests and monks**. Counselling skills could be helpful, for example, to seminarians or other professionals and practitioners who have responsibility for this area of formation.

In regard to social work, participants stated they felt there was room for improvement in their work in specific social services. These were specifically **working with individuals, social counselling, and individual planning in a variety of challenging social situations**. In particular, they felt the need to be able to better establish a trusting relationship, which would lead to more effective assistance.

In addition to other professions, the participants listed mitigation workers in large companies or life guides helping students overcome difficult situations at school or as part of early prevention as much-needed professions.

The respondents indicated a potential target group for counselling based on whether pastoral accompaniment or social work accompaniment would be applied. Most often they would welcome accompaniment of families in specific stressful situations or accompaniment of Roma families who are often disadvantaged by segregation. The second group would consist of clients who have problems with finding employment. This group includes, for example, the long-term unemployed who have lost their work ethic that could be regained through accompaniment. However, the need for employee accompaniment is also often declared by employers of foreign workers who assist employees in their assimilation to ensure their better performance and well-being in the working environment. In a pastoral context, respondents see opportunities to accompany people who are experiencing crises of different types, depending on their age, whether they be teenagers, middle-aged people, or seniors. The last target group could consist of consecrated persons who would use counselling as a complementary tool to spiritual accompaniment.

Usability within pastoral theology	- Encouragement of spiritual growth, providing space to discuss changes in one's life in between confessions - A form of human formation – a tool for priests or within parish charities for building relationships within the parish or in working with individuals - In the context of spiritual accompaniment – an important skill for having a proper authentic conversation (e.g. as a seminarian) - Continuous formation of priests – personal
Usability within social work	- The need to form relationships with clients in the context of individual client work - In the context of social counselling – as an appropriate method for effective help-seeking - A method useful in individual planning with the client - Applicable in various social situations - A method suitable for graduates to be able to make first contact with a client and establish a trusting relationship
Usability of counselling per se	- As a conciliator within a company trying to avoid a crisis - A teacher's assistant who accompanies a child through some difficulties at school – helping the child find solutions to problems at school - In parishes or day centres as an alternative to psychologists or priests to simply talk things out - As part of early intervention
Target group	- Roma community – proper communication - Accompanying families in a stressful situation - Foreign workers – assimilating them into their new environment to help them perform better and improve their well-being at work - Young people – in a critical situation/at a crossroads when making a decision - Mid-life crisis – asking the right questions - Consecrated persons – a complementary tool to spiritual accompaniment - Long-term unemployed people – regaining a work ethic

Research objective D: Challenges/risks associated with the implementation of counselling in the Slovak environment

The last research objective is a vision for the future, i.e. the challenges and risks that may be associated with the implementation of counselling in Slovakia. The first category concerns the risk as well as the fact that counselling is currently not established in the Slovak environment nor is there a job position in which a counsellor could perform this activity full-time. In Slovakia, counselling does not exist as an independent field of study nor as a standard job position. There is currently no denying this fact but, as we can see, there are efforts to establish counselling in both the academic and professional fields.

The second risk that may be associated with the establishment of counselling in Slovakia is the respondents' opinion that "people generally avoid going to professionals (psychologists or psychiatrists) to help them solve their problems or deal with stressful situations". According to the respondents, there may be several reasons for this. For example, one of the most serious

reasons concerns the mistrust, fear or other negative reactions or prejudices that are often associated with visiting this type of professional. As the respondents go on to say in their answers, in most cases confiding their problems to family members or close friends or acquaintances is preferable to visiting a psychologist or psychiatrist. Alternatively, problems are briefly talked about with their spiritual advisor, confessor, etc. According to the respondents, people struggling with a problem visit a specialist (psychologist, therapist, psychiatrist) only when such a problem turns into a pathology. In this context, the question arises whether people would perceive "other" professionals working in the field of mental health support, i.e. counsellors, with less prejudice and would be willing to visit them in situations when they are no longer able to solve their problems on their own.

The last category is also a statement of the risk that counselling is not well-known in the Slovak environment, seeing as though, according to the respondents, "only a few people know what this method is about and what the parameters of such help are." Moreover, people expect specific advice rather than "just" accompaniment, which is more challenging due to the fact that clients are considered partners who take full responsibility for their problems.

Lack of systematised positions for counsellors	There is no systematised position that would comprise exclusively of the provision of counselling
Unwillingness to visit a professional with personal problems	Slovaks are not used to visiting a therapist to discuss personal problems unless they deal with a pathology People are not used to talking about their problems ("bringing them up") outside their circle of family and friends
Ignorance about the method of accompaniment	We are used to counselling, not accompaniment – people expect advice and guidance instead of accompaniment Counselling is not perceived by the public as an alternative, they scarcely know what it actually entails

Discussion

The present research set out to look into methods of applying the counselling method to the environment of selected helping professions in Slovakia, particularly in two key areas – pastoral care and social work.

In addition to its main objective, the research defined the following sub-objectives.

The first sub-objective set out to determine whether the respondents had any theoretical knowledge about counselling and, if so, whether their understanding was correct, and how they viewed counselling content-wise. The respondents were also asked what kind of skills counsellors should have in order to properly implement this method. They drew on their own experience; some had personal experience with counselling abroad, while others had heard about this method from other people's experience or merely knew about it on a theoretical level. With the exception of one respondent who had studied counselling in the United States, respondents stated that they had received incomplete, some rather fragmentary, knowledge and had formed incorrect ideas about counselling. There was a desire among the respondents to have counselling be clearly defined in the Slovak environment so that this method could be employed by competent professionals. Counselling should also be clearly distinguished from other scientific disciplines and their working methods. We agree with this proposal, seeing as though the only way to help establish counselling in Slovakia is to clearly define this discipline and distinguish it

from other methods of helping clients. As opposed to psychotherapy, for example, counselling is not long-term cooperation with the client. The clients are not persons dealing with a social pathology. That means that the counsellor focuses on prevention so that the pathology does not become part of the client's problem.

The second sub-objective set out to determine participants' experiences with counselling both in Slovakia and abroad. The theoretical part of the article already mentioned that education and professional training in counselling takes several forms in foreign countries. These forms differ in scope, clientèle, content, and names, depending on the different level of their definition, the scope of their professional activities, and the cultural context of a particular country.

That is why it is important to provide a clear definition of the counselling method, determine its field of application and form in order to implement it in Slovakia in a proper and non-confusing way. These three tasks constitute the basis for the implementation of further qualitative research that will build on the content of the research findings.

The third sub-objective focused on the need for counselling in the selected helping professions in the field of social work and pastoral care carried out by the church. In the field of social work, counselling could be helpful particularly in establishing a relationship between clients and social workers and as a support method for individual development. The participants pointed out that there is often a lack of customisation of a solution to the client's problems as, during collaboration with social workers, the client's experience, attitude, and personal preferences are often overlooked or not understood properly. The counselling method would be able to help establish a proper collaboration between clients and the various helping professions.

All priests who took part in the research agreed that counselling has enormous potential in the field of pastoral care, seeing as though churchgoers who come to a confession or other activities often expect to have the time and space to have a wider discussion or conversation with the priest about their problems. Practical experience has shown that churchgoers are eager to be heard but priests often lack the time or space to meet their needs. Due to the fact that priests would like to accommodate such needs, they are open to offering the churchgoers the option to use the services provided by accompanying professionals outside the ranks of the church. The problem lies in the fact that accompaniment does not have an established professional framework, which is why counselling could satisfy these needs instead.

The fourth sub-objective focused on the challenges and risks arising in connection with the implementation of counselling in the Slovak environment. Seeing as though people generally tend to avoid visiting professionals in the field of mental health support, experts who participated in the conducted focus groups considered it a major challenge to help explain the meaning, purpose and content of counselling to potential clients. People merely seek out mental health professionals when their problem suddenly gets too big to handle. Therefore, it is necessary to ensure proper and patient promotion and effective dialogue with professionals working with different methods or in different fields.

Conclusion

The present research examined the application of the counselling method in the environment of two selected helping professions (pastoral care carried out by churches and social work) in the territory of Slovakia. The experts who actively participated in the focus groups all concluded that counselling had great potential because there is a demand for such a method, for example in the field of pastoral care, both among churchgoers and priests. However, there remains a number of tasks to be fulfilled. First of all, there is a need to define counselling in the Slovak environment. Moreover, an explanation and proper interpretation of the content and potential of counselling should be provided to the general professional as well as non-professional public. Finally, it would then remain to establish the counselling method through the proper channels.

As indicated above, the data obtained from the present research will serve as the basis for further quantitative and qualitative research. It will also be used to carry out studies and analyses concerning the needs and possibilities of the application of counselling in Slovakia and to create specific proposals for an effective model of pastoral counselling that would be suitable for the Slovak environment.

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AUTHOR CONTRIBUTIONS
All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST
All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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USING ARTIFICIAL INTELLIGENCE IN PATIENT CARE: THE RESPONSIBILITY OF THE CLINICIAN (SHORT COMMUNICATION)

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Abstract
Artificial Intelligence (AI) has become a significant contributor to technological advancement in society. AI is now being used in medicine and healthcare for many purposes, including patient diagnosis. But non-invasive diagnostic AI systems remain a tool for clinicians use in providing patient care. Such systems do not relieve the engaged clinician from the ultimate responsibility of making the diagnosis
Keywords: Artificial intelligence **–**AL/ML technologies **–** Patient Care **–** Chronic Post-COVID-19 syndrome.

Introduction

The rapid development of artificial intelligence (AI) has led to a hurried search for appropriate applications. Data scientists and other technology experts have often led the effort to employ artificial intelligence in a wide range of human endeavors.

The European Commission published a proposal on April 21, 2021 "to address the variety of risks associated with societal adoption of AI." Concerned with the legal ramifications of AI development, Schaake (2021)[850] cited the FY2019 US National Defense Authorization Act's five part definition of AI "that ranges from [a] ny artificial intelligence system that performs tasks under varying and unpredictable circumstances without significant human oversight to '[a] set of techniques, including machine learning that is designed to approximate a cognitive task, 'and even to' [a]n artificial system designed to act rationally.'

The European Commission proposal, which contains the Artificial Intelligence Act, defines an AI system as 'software that is developed with one or more of the techniques and approaches listed in Annex I and can, for a given set of human-defined objectives, generate outputs such as content, predictions, recommendations, or decisions influencing the environments they interact with [-].'[851] The author continues by citing the Annex I techniques and approaches as follows:

a) Machine learning approaches, including supervised, unsupervised and reinforcement learning, using a wide variety of methods, including deep learning;

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850 Marietje Schaake, "The European Commission's Artificial Intelligence Act." HAI: Stanford University Human-Centered Artificial Intelligence, June 4, 2021, https://hai.stanford.edu/sites/default/files/2021-06/HAI_Issue-Brief_The-European-Commissions-Artificial-Intelligence-Act.pdf

851 Eve Gaumond, "Artificial Intelligence Act: What Is the European Approach for AI?" Law fare. accessed June 4, 2021, https://www.lawfareblog.com/artificial-intelligence-act-what-european-approach-ai

b) Logic and knowledge-based approaches, including knowledge representation, inductive (logic) programming, knowledge bases, inference and deductive engines, (symbolic) reasoning and expert systems;

c) Statistical approaches, Bayesian estimation, search and optimization methods.'[852]

AI in medicine

Many promising applications of AI are in the field of medicine. The work of scientifically-educated clinicians has pushed the boundaries of AI to include significant diagnostic applications. Buch et al (2018)[853] write:

> "Informing clinical decision making through insights from past data is the essence of evidence-based medicine. Traditionally, statistical methods have approached this task by characterizing patterns within data as mathematical equations, for example, linear regression suggests a 'line of best fit.' Through 'machine learning' (ML), AI provides techniques that uncover complex associations which cannot easily be reduced to an equation….This allows ML systems to approach complex problem solving just as a clinician might by carefully weighing evidence to reach reasoned conclusions."

In their book "Noise: A Flaw in Human Judgement, Kahneman, Sibony and Sunstein (2021)[854] write of variations in human decisions that are not caused by bias. They write: "Algorithins offer an especially promising avenue, and doctors are now using deep-learning algorithmics and artificial intelligence to reduce noise (p. 280).

By way of further explanation, they write:

> "Medicine is noisy. Faced with the same patient, different doctors make different judgements about whether patients have skin cancer, breast cancer, heart disease, tuberculosis, pneumonia, depression, and a host of other conditions…However, considerable noise is also found in areas where it might not be expected, such as in the reading of X-rays."

Buch et al (2018)[855] wrote of the applicability of AI in general medical practice: "AI has shown potential in interpreting many different types of image data including retinal scans, radiographs and ultrasound," noting that these images can be captured with relatively "inexpensive and widely available equipment."

Gaumond (2021)[856] cited the European Commission's High-Level Expert Group an Artificial Intelligence Guidelines which spelled out key requirements for AI systems including "human agency and oversight" implying that AI systems must be subject to human supervision. Schaake (2021)[857] spells out the steps providers can use to be compliant with Articles 9 through 15 of the AI to include:

852 Gaumond, "Artificial Intelligence,"

853 Varun H Buch, Irfan Ahmed and Mahiben Maruthappu, "Artificial intelligence in medicine: Current trends and future possibilities," *British Journal of General Practice* 2018; 68 (668): 143-144. DOI: https://doi.org/10.3399/bjgp18X695213

854 Daniel Kahneman, Olivier Sibony and Cass R. Sunstein, *Noise: A Flaw in Human Judgement* (New York: Little, Brown Spark, 2021).

855 Buch, Irfan Ahmed and Mahiben Maruthappu, "Artificial intelligence,"

856 Gaumond, "Artificial Intelligence,"

857 Schaake,"The European Commission's,"

"Put(ting) in place measures to guarantee human oversight and ensure high-risk AI systems can be overseen by natural persons during the period in which they are in use."

In further support of the idea that AI systems support clinicians as opposed to replacing them, Buch et al (2018)[858] writes:

"Machines lack human qualities such as empathy and compassion, and therefore patients must perceive that consultations are being led by human doctors…therefore, AI commonly handles tasks that are essential, but limited enough in their scope so as to leave the primary responsibility of patient management with a human doctor. There is an ongoing clinical trial using AI to calculate target zones for head and neck radiotherapy more accurately and far more quickly than a human being. An interventional radiologist is still ultimately responsible for delivering the therapy but AI has a significant background role in protecting the patient from harmful radiation."[859]

Conclusion

When AI is employed in individual patient care settings, a question may arise as to who is making a diagnosis. An important underlying consideration is that the patient chose to engage the clinician in his or her case and should be able to reasonably assume that the clinician is responsible for making that diagnosis. The AI system is one of a number of tools which the clinician can use in making a diagnosis.

If the clinician decides to utilize a non-invasive AI system, that physician should be ultimately responsible for the care of the patient to include making an appropriate diagnosis based upon all available clinical information.

In this context, it is also important to note a number of key aspects:

1) A clinician is not ethically obligated to obtain the informed consent of the patient before utilizing non-invasive AI in making a diagnosis since the clinician is merely employing AI as a tool to be used in making the diagnosis and the clinician is ultimately responsible in making the diagnosis.

2) The clinician can explain to the patient the role of the AI system in assisting the clinician in making a diagnosis. This explanation should be at the discretion of the clinician.

3) If the patient objects to the use of AI in his or her care, the clinician should be free to withdraw from the care of the patient and refer the patient to anther provider.

There is a need to perform research and studies that will address the diverse use of AI technologies in order to assist in the assessment, diagnosis and treatment of acute as well as chronic diseases, and diseases that are related to the COVID-19 pandemic. In the event of a continuation of the COVID-19 pandemic, as well as other similar pandemics, it is also important to highlight how AL/ML technologies can be deployed to provide new insights into a patient's health status, pre-existing medical history data, or new data captured during remote healthcare delivery.

858 Buch, Ahmed and Maruthappu, "Artificial intelligence,"

859 See also: Mu-ming Poo, "Brain science and AI technology in the post-COVID era," *National Science Review*, 8, no. 3, 2021, https://doi.org/10.1093/nsr/nwab040 ; Almeida, Fernando, José Duarte Santos and José Augusto Monteiro. "The Challenges and Opportunities in the Digitalization of Companies in a Post-COVID-19 World," *IEEE Engineering Management Review* 48, no. 3, Third Quarter 2020. 97-103. DOI: 10.1109/EMR.2020.3013206 ; Jiang, Fei et al., "Artificial intelligence in healthcare: past, present and future," *Stroke and Vascular Neurology* 2, (2017): 230–243. doi:10.1136/svn-2017-000101

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CHRONIC POST-COVID-19 SYNDROME. NEW JOINT MISSION OF MEDICINE, SPIRITUAL SERVICES AND PSYCHOTHERAPY FOR 2022 (SHORT COMMUNICATION)

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Abstract
The acute COVID-19 consequences include apart of 4 million deaths more than 150 million severe ad 100 million regular cases of the acute viral disease. However, with increasing experience we have to delete the word acute and replace about 10 percent of those suffering on severe disease with the new diagnosis - chronic postcovid syndrome (CPS). To manage that new entity, medicine or social work alone is useless. Treatment of CPS is a mission or joint venture of psychologists, infectious diseases physicians, neurologists, spiritual assistance incl priests and religious healthcare orders and other auxiliary disciplines.
Keywords: Chronic Post-COVID-19 syndrome **–** Spiritual services **–** Psychotherapy.

Introduction – origin and burden of the disease

CPS appears in about 10 percent of all those who survived severe course of covis sars mers and other coronavirus diseases. Is similar to chronic fatigue syndrome, known as late consequences of Infectious mononucleosis, CMV and other chronic diseases in normal host. Eg 15 percent of those who survived severe EBV disease are treated for months and years for chronic fatigue syndrome (CFS) which is the best pathological pendant or ,,cousin,, of chronic Post-COVID-19 syndrome.

Current estimates from UK and US recor more than 15 percent of all survivors as candidates and 10 percent as proven of chronic postcovid syndrome. The burden of this syndrome therefore is huge, has unpredictable economic consequences since thepatients are unable to work or stopping regular work just after returning bac from convalescence.[861]

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Need for interdisciplinary approach-mission of experts

Concerning symptoms, 90 percent of those who suffer after covid PCS within one to 4 weeks (acute phase) suffer on headache and fatigue, another 50 percent of musculosceletal pain and disorders, 456 percent on acute fatigue, 40 percent of insomnia, 30-60 percent have severe depression.

Therefore joint mission-combined approach of a group of specialists should be organized to so called PCS centers. There are about 10 such cventzers in Slovakia, 25 in Hungary 42 in Czech republic, and thousands in the Us and hundreds in UK. Commonest members of this group are specialist offering neurologic services (neurologists, pneumologists), psychiatrists, psychologists, spiritual worker, social workers. Physiotherapy specialized for lund rehabilitation is more than welcome.

Conclusion

More than 75 percent of those with chronic fatigue syndrome, may be cured fefor its beibng really ,,chronic,, that is one month.Several countries has Health maintenance organisations offering spa and other physiotherapy and most patients are able to go back to their original work at least for part time. Unfortunately one quarter of PCS patients stay really in the chronic phase, which may least 6-12 months and is called by neurologists psychiatrists and other experts as ,,crux medicorum,,. Exactly like the old chronic fatigue syndrome.[862]

Economical and psychosocial consequences of COVID-19 pandemics - may convert to a chronic maybe lifetime disease. Bad news that we see therefore currently only the top of the iceberg of covid, good news is, that the portfolio of immunostimulatory drugs, antidepressants, analgetics, multivitamins, hormones and other remedials combined with spiritual help and psychotherapy are usually successful and the number of those who suffer realy chronically on CFS is not (yet) increasing event in countries with huge extend of the first two waves.

AUTHOR CONTRIBUTIONS All the mentioned authors significantly, directly, and intellectually contributed to the work and approved its publication.

CONFLICT OF INTEREST All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

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CHALLENGES OF PALLIATIVE CARE

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The 9th Annual International Conference on Hospice and Palliative Care provided many stimuli to workers in practice and also at the level of development and support of palliative and hospice care in Slovakia. It was seen as a source of inspiration and raised questions on how to apply and develop in Slovakia those aspects that are very helpful in some other countries and are not yet available there. This conference is very important and the Faculty of Health Sciences and Social Work at the University of Trnava and the University of Scranton have been working on it for many years.

We can see very important challenges for palliative care in the following areas:

The hospital model under home conditions, which was presented by prof. Daniel J. West in his conference contribution. In this model of care, the patient is discharged from the hospital and maintained at home as part of the treatment process. Significant benefits: reduction in the treatment duration; significantly different re-hospitalization rates for the same health problem; reduction of treatment costs; lower infectiveness compared to the hospital. It is currently used mainly for people over 65 years of age. Its application requires a multidisciplinary team composed of nurses, social workers, workers providing psychosocial support, hospice workers, and other collaborating health professionals such as physiotherapists, speech therapists and audiologists. Most importantly, it is of great benefit if it includes a team providing palliative care. In this model, it is also important to ensure consistent monitoring so that the patient has an accurate diagnosis and is able to receive the prescribed drugs at the right time, adequate for his or her health. It is a health-care process that is more complex when compared to the hospital. Therefore, it is important that the team described in this model is as efficient as possible. However, there are significant complications that are unfavourable to this model and we have to face them. Among the most serious ones, there are, for example, the threat of neglect and related difficulties; an unsuitable environment and living conditions for a patient where, for example, there is a high risk of falling; excessive patient isolation and, thus, it is not possible to apply the model of a hospital under home conditions; restricted or no access to food for a patient; the inability of a patient to understand what the hospital at home involves and what should be expected from it; and, last but not least, to set up a system of payment for the medical care provided. So far, the following levels are taking place in practice: partial reimbursement covered by health insurance (the example of North America) and specific health care pricing strategies, which apply mainly to

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countries with national health care systems. The model of a hospital at home has the potential to be applied worldwide. The model is a response to the demand for increasingly strong support of the concept: *„what is most comfortable for the patient?“*. For this purpose, it is still necessary to carry out extensive research and strategies that would allow this medical care model to be of the highest quality and affordable for patients. This can significantly support the concept of telehealth and related technologies that will be part of the treatment process for patients treated at home or who will be receiving outpatient care in the near future.

In addition to Professor West's contribution, for example, the discussion raised the question of what the difference is between the provision of post-acute care in the hospital and at home where a patient is visited by a team of health professionals and other specialists in terms of financial costs. Professor West replied that these costs are reduced by 25-30% in favour of medical care at home, which is, in his opinion, a very significant finding.

possibilities for applying the principles of mindfulness in the medical care of cancer patients

Mindfulness refers to the practices of meditation that cultivates the consciousness of the present moment. As Dr. Steve Szydlowsky said in his conference contribution, this method has great benefits for both physical and mental health by reducing anxiety and stress levels, especially when it comes to managing serious and deadly diseases that can be a trigger for patients. Practising mindfulness can help them reduce the degree of being overwhelmed by the negative emotions due to illness, and improve their concentration and attention; it can prevent stress, lead to better sleep habits, or help cope with past experiences. Therefore, when applying the method of mindfulness into the medical care of cancer patients, it is necessary to consider possible mechanisms of mindfulness, to investigate clinical applications and to identify challenges in the field of mindfulness.

cannabis for therapeutic use in patients with end-stage diseases / in patients with chronic pain / in patients with neurological difficulties was presented by MUDr. Ondřej Sláma, PhD. in his contribution.

The Czech Republic is one of the countries where cannabis has been officially recognized as „cannabis for medical use", i.e. cannabis used in medical practice. The State Agency for Medical Cannabis (SAKL) in the Czech Republic considers dried female flowers of Cannabis sativa L. (cannabis) or Cannabis indica L. (Indian hemp) suitable for medicinal use. The main active substances are cannabinoids, among which Δ-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) stand out due to their action. The substances also consist of essential oils, terpenes, flavonoids and alkaloids. The first Czech cannabis was delivered to the market by the State Institute for Drug Control (SÚKL) in March 2016. It is used as supportive care for serious medical conditions such as chronic pain, neuropathic pain, neurological diseases, multiple sclerosis, nausea, vomiting and loss of appetite in connection with cancer treatment and treatment of HIV infection, rheumatoid arthritis, and other diseases. The cultivation of medical cannabis and other related activities are very strictly subject to legal regulations. This cannabis always contains a precisely defined amount of medicinal substances and is delivered to pharmacies in the appropriate quality stipulated by legal regulations. The conditions for the use of cannabis are regulated by Decree No. 236/2015 Coll., stipulating the conditions for prescription, preparation, distribution, dispensing, and use of magistral formulas containing medical cannabis.

Patients in the Czech Republic can obtain cannabis for medical purposes from two sources: cannabis grown in the Czech Republic (provided by SÚKL through a selected grower) or imported from abroad (permitted by the Ministry of Health of the Czech Republic) and distributed subsequently by private distributors of medicinal substances. The price of cultivated cannabis is legally defined (it consists of the grower's offer, distribution costs, pharmacy surcharge and VAT). In the case of imported cannabis, the price is not regulated and fully depends on the supplier and the pharmacy. Both sources of medical cannabis do not yet have a specified reimbursement covered by health insurance funds.

The specific and appropriate ratio of THC and CBD for each individual patient always depends on the type and signs and symptoms of the disease. The maximum possible amount of cannabis dispensed per patient for a period of one month is 180g. Cannabis for medical use can only be prescribed to a patient by a doctor specializing in: clinical oncology, radiotherapy, neurology, palliative medicine, pain treatment, rheumatology, orthopaedics, infectious medicine, internal medicine, psychiatry, ophthalmology, dermato-venereology, and geriatrics. Cannabis can only be written out in the form of an electronic prescription with restrictions. This is a special form of electronic prescription, thanks to which the pharmacy can verify whether the maximum amount of cannabis dispensed for a particular patient has not been exceeded in a given period (one month).

The prescribing physician should decide on the most appropriate form of cannabis treatment for each individual patient. The basic forms are inhalation and oral administration. The advantage of inhaled administration is the relatively rapid onset of action, the effective transfer into the blood and the subsequent spread throughout the whole organism. A disadvantage of this form of administration may be the problematic dosing, especially for patients in need of small doses. In the case of oral administration, it is an advantage that, in consultation with a specialist/physician, it is possible to prepare very precise doses based on the patient's state of health. The disadvantage can be considered a delayed onset of action, where the patient believes that the treatment is „ineffective" and thus can take a higher dose which can subsequently cause an overdose and also health complications. For these reasons, the dosage prescribed by the physician must always be adhered to.

Even in the case of cannabis for therapeutic use, side effects may occur. The cause can be either a higher dose or, for example, its combination with alcohol. In most cases, the side effects are mild and usually go away within a few days. The most well-known side effects include, for example, a state of euphoria, a feeling of relaxation, a fast heartbeat, uncontrollable bursts of laughter, changes in the perception of the environment, a dry mouth and red eyes. There may also be conditions of nausea or a deterioration of health, such as vomiting when a certain THC limit has been reached, which is individual for each patient. If, for example, significant changes in mental status occur during use, the patient should inform his or her attending physician immediately. It is important to realize that cannabis for medical use is a medicine. Therefore, any patient taking cannabis should adhere to established treatment parameters such as dosage or route of administration. This is very important when starting or taking larger doses of cannabis. During this period, it is also appropriate for the patient to be under the supervision of e.g. a family member who may be helpful in dealing with side effects or unpleasant conditions caused by use.

In order to apply cannabis for therapeutic use of the highest quality and provide effective treatment, it is still very important to carry out detailed clinical studies on the treatment of cannabis. However, it does not always have a therapeutic effect, nor cure every disease or every patient, nor does it cure every stage of a disease. In order to make progress in cannabis treatment research, it is important to gather relevant information and evidence on successful and unsuccessful treatment. In this context, one should be aware that the success of the treatment depends, to a large extent, on the patient's genetic information as well as his or her mental state, the individually selected variety of cannabis, the amount of cannabis, and the form of cannabis administration. For the field of palliative care, the treatment by cannabis for therapeutic use has undoubtedly yet to reach its full potential. However, it needs to be approached without overestimation in the light of credible surveys or statistics.

legislative regulation on the provision of palliative care in Slovakia

MUDr. Andrea Škripeková, PhD., in her conference contribution focused on the forthcoming legislation on the provision of palliative care in Slovakia also shows that the area of palliative care has made some progress in the last decade. Nevertheless, its application shows that most patients and their families are mostly dissatisfied because a humane approach is still absent. In practice, we encounter the process of dying which is accompanied by pain, loneliness, loss of dignity, dissatisfaction, and other forms of suffering. Practice also points towards insufficiently handled physical, psychosocial and spiritual distress. Patient care is fragmented and non-complex, communication between healthcare professionals, patients and families is ineffective, and there is still an enormous burden on the patient's health care support system, etc. It follows from the above that, in the forthcoming legislation on the provision of palliative care, it is necessary in particular: to support legislative enshrining, which would include, for example, an effective system of reimbursement for multidisciplinary palliative care in inpatient medical facilities as well as social service facilities; define long-term medical care; to promote the teaching of palliative care in the undergraduate and postgraduate education of all staff involved in the provision of palliative care; define the availability, systematic approach and quality of care on the part of palliative care providers; prepare subsidy programs that support the capacities of current and potential providers of specialized palliative care; sensitively mediate and de-taboo the topic of dying and end-of-life care.

paediatric palliative care

MUDr. Mária Jasenková in her conference contribution discussed how palliative care works in Slovakia and what kind of medical care is provided by the non-profit organization Plamienok. All children's home hospices are part of the non-profit sector, not the state healthcare system. Slovakia is no exception in this respect; the same applies to foreign countries. Paediatric palliative care is still developing in Slovakia. The last two decades have been marked by positive developments and shifts in this field; nevertheless, it is still not sufficiently developed. For example, such medical care is still not available to everyone. In this context, special attention needs to be given to adjusting legislation and standards in the field of paediatric palliative care, as well as to the staff dedicated to this topic, and, last but not least, to increasing funding in this area. Serious shortcomings in paediatric palliative care also include, for example, the lack of doctors, nurses, health professionals, carers, social workers, and psychologists who are trained in paediatric palliative care and have enough experience to provide quality assistance to the child and his or her relatives. For the time being, society perceives the topic of paediatric palliative care as being marginal. Ssociety itself is more inclined to talk, for example, about euthanasia than about life in its final stages and related palliative care.

Plamienok also includes a home care department that employs doctors, nurses and social workers. They take care of terminally ill children who can be among their loved ones thanks to the team that visits them at home. In 2011, the Center for Mourning Therapy was established within the non-profit organization Plamienok. This type of therapy was intended for families who were in Plamienok's home care, but practice has shown that more families who were not in this care need help. The centre also deals with children who have lost a loved one. It organizes group therapies in which surviving children and adults meet individually. For example, children or adolescents of a similar age meet once or twice a month under the guidance of centre therapists. The purpose of these meetings is to help children and adults to transform the loss of their loved ones into something that will give them strength as time goes on. To make their lives more joyful and less painful. Plamienok's vision is to contribute to such a change in the lives of surviving families and children. Working in the non-profit organization Plamienok requires the personal and professional growth of employees; for example, by undergoing a specialized training program for employees. This increases the quality of assistance provided to children and families at the required level. Plamienok is also involved in the education of students of medical faculties, students of nursing, social work, special and medical pedagogy, and psychology. It also organizes lectures on the loss of loved ones and palliative care, open to the general public.

In their conference contribution, RNDr. Mgr. Jaroslava Brňová, PhD., MPH. and PhDr. Jana Prnová, PhD., focused on the epidemiological aspects of SARS-CoV-2 spreading in health care facilities. As part of their contribution, they prepared and presented valuable statistics to map several specific impacts of COVID-19 on the functioning of health facilities that are important for staff and patients. Subsequently, they supplemented them with recommendations for practice which were appropriate and helpful for the work and protection of all experts who had participated in the conference.

Given the challenges and benefits that these complex areas can bring, we can undoubtedly expect further significant and inspiring professional enrichment for palliative care at the upcoming 10th International Conference on Hospice and Palliative Care, its anniversary year.**WE HAVE BEEN LOOKING FOR ANSWERS TOGET**

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