Keynote Lectures

Theological Perspectives in Religion and Health Research - Origins and Impact of Healthy and Unhealthy Representations of God

Ass. Prof. Dr. theol. Niels Christian Hvidt
Thursday May 1st, 14:30-15:30

In recent years we have seen an important increase in psychosocial and medical research in religious coping. There is now substantial evidence that healthy representations of God lead to positive health outcomes in terms of coping with disease, quality of life, and probably even longevity. There is similar evidence that unhealthy representations of God and the ensuing spiritual struggles have the opposite health outcomes. While there is rich data regarding the effects of different representations of God, there are only few articles in the spirituality-health literature that present the theological origins of these religious representations. This lack of **theological** input in the faith-health literature may be caused by the concern of some theologians that a spirituality that is centered on the subjective needs of humans leads to a consumerist spirituality that has man in the center instead of God.

The purpose of Dr. Hvidt's presentation is thus to present a brief theology of Divine providence that is challenged by the problem of human suffering, also known as theodicy, while addressing the said theological critique.

Conference questions

- How do different representations of God affect patients' illness concepts, especially their reflections on the origin and cause of their disease?
- How do these different representations of God impact the way patients cope with disease?
- What characterizes a healthy versus an unhealthy spirituality from a theological point of view.

Europe and the Birth of Science in Spirituality

Dr. med. et M.M.E. Peter Heusser
Thursday May 1st, 16:00-17:00

Earlier, medicine always included religion and spirituality. This changed since the 19th century when the natural sciences became the most important basis of medicine.

The birth of science took place in Europe when with Greek philosophy and medicine (e.g. Aristotle and Hippocrates) human knowledge began to detach itself from the ancient temple mysteries of Greece, Egypt, Mesopotamia and other cultures. External observation and thinking led to first scientific discoveries in the Hellenistic and Arabic periods of medicine. In the Middle Ages, Aristotelian Scholasticism brought about a thorough training in logical reasoning, the application of which to the empirical facts of physical observation led to the development of natural sciences and technical inventions as sparked by Galileo Galilei, Leonardo da Vinci and others.

So European science started out as natural science. The spiritual however, by its very nature not being accessible to sense perception, was often not considered as a matter of science but instead of mere belief or philosophical speculations.

However, Europe has also brought forth spiritual science. Plato, Aristotle, Thomas Aquinas, Spinoza, Schelling, Hegel, Steiner, Hartmann, Hösle, Wandschneider, and the physicists Heisenberg and Heitler showed that the laws of nature are spiritual, but objective and real entities that constitute nature and can be detected by human thinking, a view known as Realism of Universals or Objective Ontological Idealism. It is opposed to the presently dominating Nominalism (of Kant, Popper and others) which holds that the laws of nature are only subjective principles of the human mind without objective significance for nature itself. Fichte and Troxler pointed to the activity of thinking as a clear spiritual perception of the human mind; Steiner showed how this perception can be expanded by systematic training to an exact perception of immaterial forces and their interactions in the human being, nature and the cosmos (life, soul and spirit), and how a modern spiritual science can be developed by subjecting these spiritual perceptions to the same logical reasoning as is done in natural science with physical perceptions. Steiner called this science "Anthroposophy" (1902), a term already used for the same purpose by Troxler, MD and professor of philosophy at the University of Bern, in 1835.

Since the 20th century, Anthroposophy has already widely been used in medicine and other professional fields to expand and complement knowledge from natural science by spiritual science to arrive at a modern holistic understanding and practice of human affairs.

Religion, Spirituality and Neuroscience

Prof. Dr. med. Jean-Marc Burgunder
Thursday May 1st, 17:00-18:00

Investigations on the interaction between spiritual experiences and brain function have a long history, with time honoured theoretical considerations and, more recently, with experimental studies from psychology, neurophysiology, brain imaging and even neurogenetics.

In this lecture, two aspects of the neuroscience of spirituality will be examined in the context of recent data discussed in the scientific literature and even more so in the lay press, neurogenetics and functional brain studies of events involved in spiritual and religion experiences.

Classical genetic studies have provided quite strong evidence for a hereditary component of spirituality. Twin studies have shown that measures of intrinsic spirituality or of self-transcendence are highly correlated between monozytotic twins, who share the same genetic background, as compared to dizygotic twins, living in the same environment but with dissimilar genetic make up. This is in contrast to other studies with measures related more to extrinsic religiosity, like church attendance, showing similar results between both groups. Genetic background of a given trait may be examined by searching for an association of that trait with small variations in particular genes. One such study, which has not been replicated, has been performed and a statistically slightly significant association of self-transcendence measures with a variation of a gene encoding a protein involved in the transport and accumulation of the neurotransmitter, dopamine, has been found.

Different techniques may be used to perform imaging in order to gain information about which areas of the brain are active during a specific task. Such studies in people from varied religious background have demonstrated involvement of several distributed areas of the brain, including areas not related to emotion.

These studies clearly show an involvement of brain biology in spiritual experiences, which is quite intuitive considering the common narrative of meditating people about their self conscious participation in the meditating process. This consideration certainly is also well in line with the traditional concept of human as a creature bearing the mark of the creator, and they do not by themselves prove the invalidity of the idea of an external spiritual entity. Future investigations along similar lines might well be able to demonstrate the physiological events at an even more detailed level, however, they will not be able to shed light upon the actual semantic contents involved in, emerged from, or projected into religious and spiritual experiences. These contents cannot be reduced to brain events and will ever need to be approached by other means of investigation.

Role of Religion and Spirituality in Medical Patients

Prof. Dr. med. Arndt Büssing; Coauthors: Thomas Ostermann, Peter F. Matthiessen
Friday May 2nd, 9:00-10:00

Patients with chronic diseases use adaptive coping styles which conceptually refer to external and internal loci of disease control, i.e. Trust in Medical Help and Conscious Way of Living / Positive Attitudes, while Trust in God´s Help (TGH), which is a measure of intrinsic religiosity, was rated lower. In 6,944 elderly individuals, TGH correlated marginally with Physical and Mental Health related quality of life (SF-12). In cancer patients, TGH correlated weakly with Physical Health, while in female cancer patients, TGH correlated negatively with Mental Health. When controlled for age, these correlations disappeared.

In 396 female cancer patients, neither Life Satisfaction (BMSLS) nor Depression or Anxiety (HADS) correlated with TGH; only depressive ESCAPE from illness (AKU) correlated negatively, but to some small extend. Also in 115 patients with depressive disorders, TGH did not correlate with depression (BDI), but with life Satisfaction, and again negatively with ESCAPE. In 589 chronic patients, appraisals such as challenge and values, and life satisfaction aspects myself and future perspectives were associated with TGH. Moreover, Life satisfaction correlated with Conscious Living / Positive Attitudes. Thus, we confirm interconnections between adaptive coping, positive appraisal, and spirituality/religiosity.

Because several patients have turned away from institutional religiosity, but may have an interest in a more individualized spirituality, we analysed patients with the conceptually more open SpREUK questionnaire. In 821 patients with chronic diseases, patients with higher age and cancer were significantly more in Search for Meaningful Support because of illness (spiritual quest orientation), had Trust in Higher Guidance (intrinsic religiosity), had a Positive Interpretation of Disease (hint to change life because of illness), and ascribed beneficial effects of their spirituality/religiosity with respect to life concerns. In patients with chronic pain diseases, just the BENEFIT scale correlated with life satisfaction aspects such as future perspectives, myself and overall life. Neither ESCAPE nor Physical Health correlated with spiritu-

al/religious issues, while Mental Health correlated negatively with the spiritual quest dimension. Thus, spirituality/religiosity has to be regarded as distinctive concepts which nevertheless may be related to quality of life.

In conclusion, even though chronic patients may rely on medical resources of help, they intend to frame their life by themselves, and this behavior was associated with greater satisfaction in life. Patients´ spiritual/religious concerns may enhance their self-esteem, give emotional comfort and can provide meaning and hope - and thus life-satisfaction. The results corroborate the claim for a comprehensive approach in the treatment of chronic patients.

Religion and Coping in Cancer Patient

PD Dr. phil. Sebastian Murken and Dr. phil. Chrisitan Zwingmann
Friday May 2nd, 14:30-15:30

The diagnosis and treatment of cancer is a life-altering experience of crisis. Strenuous therapies, reduced functioning, fear of recurrence or progression, and uncertainty about survival are among the burdens patients have to face. Due to severe stress which involves elements of personal threat, adjustment to illness often is an existential struggle for maintaining hope, control, and a sense of meaning and purpose in life. In this process, many patients seem to rely on their religious beliefs. Across several studies of participants with diverse types of cancer, the majority reported, often spontaneously, religious faith to be an important source of support in dealing with their illness.

Since the 1990s, there has been increasing interest in the role that religious faith and – somewhat broader and loosely defined – spiritual beliefs might play in patients' responses to cancer. A considerable number of quantitative studies so far found religiosity/spirituality of cancer patients modestly but meaningfully associated with psychosocial adjustment (e.g. less emotional distress, less anxiety and depression), various dimensions of health-related quality of life, or beneficial coping strategies. However, research results are not entirely consistent. Null findings and even negative associations were shown as well, at least for some target variables. Thus, evidence appears to be mixed in sum.

In our presentation we will first outline some major findings in regard to the religion/spirituality–coping with cancer connection. Several aspects will be highlighted: religiosity in cancer patients ("epidemiology"), religiosity in dealing with cancer patients ("psychooncology/nursing"), and religious coping ("psychology").

In a second part we will report an own study investigating the role of religious variables in a sample of German breast cancer patients. In this study, participants were assessed upon admission to an inpatient rehabilitation program. In addition to positive and negative religious coping, two basic nonreligious coping styles (depressive coping, active problem-focused coping) and psychosocial adjustment (anxiety, depression) were measured. Research questions concerning the mediating role of nonreligious coping and the relative predictive power of positive and negative religious coping were addressed through structural equation modeling. Results indicated that the relationship between religious coping and psychosocial outcomes was completely mediated by nonreligious coping, whereby only depressive coping and not active problem-focused coping proved to be a mediating variable. Positive and negative religious coping were somewhat positively related to each other; their (indirect) predictive power on psychosocial adjustment was identical though in an opposite direction. Results will be discussed in regard to previous Anglo-American and European research.

Competencies for Spiritual Care

Dr. Donina Rita Baldacchino
Friday May 2nd, 16:00-17:00

Literature defines Spiritual care as being rather than doing with the aim of assisting the clients/patients to find meaning in their illness and purpose in life. Apart from the specific intervention of spiritual care, it is well documented that therapeutic use of self is of utmost importance in holistic care. Although the health care professionals claim to deliver holistic care, literature criticized the interdisciplinary team for giving minimal attention to the spiritual dimension in patient care. This may be due to lack of time, work overload, secularisation of the contemporary society, feelings of incompetence to deliver spiritual care and lack of education.

Research demonstrates that personal spirituality and life experiences of the health care professionals, supported by education on the spiritual dimension in

care, may ameliorate delivery of spiritual care. Education reinforced by role-modelling may eventually promote reflection in and on care and may enhance learning on spiritual care.

Learning and delivery of spiritual care may be guided by generic and specific competencies based on research. This paper presents a set of generic competences derived from international research which is currently on the increase, supported by research in Malta conducted by the speaker in Malta and Australia, on patients/clients, chaplains, qualified nurses and students. These findings give light on spiritual care and the impact of education on health care professionals. The findings demonstrate that spiritual care is not an 'optional extra' (Ross 1997) or simply the role of the hospital chaplain. Spiritual care is the responsibility of each member of the interdisciplinary team in order to implement holistic care collaboratively (Baldacchino 2003).

While taking into consideration the factors which may inhibit and enhance the delivery of spiritual care, recommendations address further research, education of the interdisciplinary team and the management of patient care.

References

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Public Lecture and Podiums Discussion
Recent Overview on Religion, Spirituality and Health Rese

Prof Dr. med. Harold G. Koenig
Friday May 2nd, 15:00-16:00

Dr. Koenig will speak about the latest research findings on religion and health from around the world, including research conducted in the United Kingdom, Europe, and the Middle East. He will also talk about some of the key research studies conducted in the past, particularly those conducted by himself and his team at Duke University, and discuss how these studies inform the practice of medicine and the importance of integrating spirituality into patient care. He will especially focus on the role of religion in coping with stress, and how religious beliefs and practices can help patients deal with illness, pain, suffering and traumatic stress. He will tell us about how physicians in the U.S. are responding to this research, to what extent they are integrating it into their care of patients, and the changes in medical education that have occurred in the past 10-15 years as a result of this research. Finally, he will discuss the latest activities now going on at that Duke University's Center for Spirituality, Theology and Health, including the latest research they are doing there, and discussing the new Society for Spirituality, Theology and Health that they are helping to establish in the United States and seeking to broaden to include researchers in other countries around the world.

The Multidimensional Structure of Religiosity

Dr. phil. Stefan Huber
Saturday May 3rd, 9:00-10:00

In my keynote lecture I discuss a model of the multidimensional structure of religiosity. The model integrates theoretical concepts and operational constructs from various disciplines that study religion empirically (sociology of religion, psychology of religion, religious studies, theology). The common denominator of these categories is that they have empirically proven to be of high value, and that they are well known – at least within their own disciplinary discourses. Given this state of affairs, the main thing that makes the model special is that it systematically cross-references and interconnects these categories.

The taxonomy of the model is constructed on the basis of three principles (Huber, 2003, 2004, 2007, forthcoming):

1. From the sociology of religion comes the question of what general social form religiosity takes. Corresponding to this, the first principle of construction is the distinction between six core dimensions of religion, namely intellect, ideology (belief), public practice, private practice, experience and consequences for everyday life.
2. From the psychology of religion comes the question of how relevant religiosity is to the human personality's cognitive and emotional system. Corresponding to this, the second principle of construction is the distinction between three

qualitatively distinguishable levels of centrality, namely non-religious, religious, and highly religious.
3. From theology and religious studies comes the question of material religious "Gestalten"; and the inner logics at work within them. Corresponding to this, the third principle of construction is the distinction between the general and specific contents of religiosity. Concerning the general content the model differentiates between two foundational religious semantics, namely theistic, and pantheistic.

In the second part of my lecture I illustrate the model presenting some international and cross-cultural results of the Bertelsmann Stiftung's Religion Monitor (BRM), which refers directly to the discussed model of religiosity. The data are drawn from representative surveys conducted in 21 countries (N>21.000) in 2007 (Bertelsmann-Stiftung, 2007). They encompass five major religious groups: Judaism (Israel), Christianity (13 nations: Australia, Austria, Brazil, France, Germany, Guatemala, Italy, Poland, Russia, Spain, Switzerland, UK, and USA), Islam (3 nations: Indonesia, Morocco and Turkey), Hinduism (India), and Buddhism (Thailand). They also includes two nations, namely Nigeria and South Korea, with more than one major religious culture.

References

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Integrating Spirituality into Schizophrenia Care

PD Dr. med. Philippe Huguelet
Saturday May 3rd, 13:30-14:30

Recovery is a important goal in the care of patients with severe mental disorders such as schizophrenia. Being a process rather than a goal, recovery involves taking into account patients' preferences in terms of values and life goals. Data showing that religion and spirituality can be an important part of recovery begin to arise. Indeed, religious coping appears to be important for patients with schizophrenia, as a way of coping with their disorder and other life issues, but also in terms of one's identity and setting important life goals. By contrast, the deleterious influence of religion on positive symptoms may have been overestimated, as there is no evidence toward this hypothesis. Even if a minority of patients features delusion with religious content, this does not appear to constitute a fortiori a negative issue, as qualitative research shows that this does not hinder patients from gaining some help from religion or spirituality. This talk will describe the clinical implications of these findings, as well as preliminary results from a study on the effect of a spiritual intervention in Geneva Switzerland. Psychiatrists should consider religion when treating patients with schizophrenia, first by a spiritual assessment. This leads to various issues such as mobilization (in a social and existential perspective), working on one's identity, considering spiritual crisis and others. Also, illness and treatment representation may be influenced by religion in various cultural backgrounds, that having to be discussed with patients in order to improve patients' adherence and thus fostering a recovery oriented care.

Religious Ressources and Depression - Results from the Netherlands

Dr. med. Arjan Braam
Saturday May 3rd, 15:00-17:00

Affective or emotional aspects of religiousness are considered to be crucial in the association between religiousness and well-being, especially in later life. The emotional aspects of religiousness, can be un-

derstood as pertaining to the God image, or better defined as the God-object-relationship, corresponding to feelings of trust towards God or to religious discontent. In the current contribution, empirical findings are discussed about associations between God image, depressive symptoms, feelings of guilt, and personality characteristics, such as defined by the Five Factor Model of Personality.

As part of a pilot study of the Longitudinal Aging Study Amsterdam (LASA), a small sample of older church-members (n = 60), aged 68-93, filled out a questionnaire, including the Questionnaire God Image on feelings to God and perceptions of God, and items on hopelessness, depressive symptoms, and feelings of guilt, and the 120-item version of the NEO-PI-R.

Feelings of discontent towards God correlated positively with hopelessness, depressive symptoms, feelings of guilt, and also with depressive symptoms assessed 13 years earlier; these findings pertained to Protestant participants in particular. Most facets of God image, positive, critical, and about punishment reappraisals, were associated with more feelings of guilt. A possible explanation for the most pervasive finding, that feelings of discontent towards God are related to depressive symptoms, is that both, throughout life, remain rooted in insecure attachment styles.

Neuroticism was associated to feelings of anxiety towards God as well as discontent towards God. Agreeableness was associated to perceiving God as supportive and to prayer. These findings persisted after adjustment for depressive symptoms. For the other three personality factors (Extraversion, Openness, and Concientiousness), no clear patterns emerged. As in studies about God image and Five Factor Model of personality among younger people, some of the current results were prominent.

In the main LASA study, the Questionnaire God Image was administered in 2005 to 304 respondents: 190 of these had high levels of depressive symptoms at one or more of the four previous LASA assessments in the previous 12 years (1992-2003), and 114 represented the control group, without high levels of depressive symptoms before. The distribution of scores on the Questionnaire God Image scales completely parallelled those as were found in Sassenheim. Positive and supportive facets of the God Image received higher scores than the critical facets. Cross-sectionally, feelings of anxiety towards God and feelings of discontent towards God had pronounced positive associations with depressive symptoms. These results were most pronounced for the non-affiliated. Positive feelings towards God and perceiving God as supportive had modest, negative associations with depressive symptoms. Adjustment for Neuroticism only slightly reduced the strength of the results. High levels of depressive symptoms in the previous assessments were similarly associated with anxiety towards God and feelings of discontent, as well as with negative religious coping.

It is concluded that affective aspects of religiousness seem to maintain a strong relationship with vulnerability to depression. Neuroticism plays an important, although not entirely exclusive role in the understanding of the relevance of critical facets of the God image for depression. That findings also pertain to the non-affiliated suggests that the clinical exploration of religiousness should not be restricted to those members of religious organisations.