Symposia

Spirituality and Health: Historical, Cultural and Ethical Aspects (F1)

Chair: Roland Hauri-Bill, lic. phil.; Location: Kursraum 2

Health in the Perspective of Early Christian Monastic Texts

Prof. Dr. theol. Martin George
Department of Historical Theology, University of Bern, Switzerland
Friday, May 2nd, 10:30-10:55

Spirituality and Science in the 21st Century – An Approach towards bridging the Gap

Dr. med. Ursula Wolf
Institute of Complementary Medicine, University of Bern, Switzerland
Friday, May 2nd, 10:55-11:20

Modern science is based on physical laws and mathematical equations. Thus, only quantifiable objects and processes, i.e. which can be measured and expressed by a number. Qualitative properties can not be included. Moreover, science reduces all phenomena including spirituality and the mind exclusively to material processes and mechanisms, e.g. neuronal activity. Spirituality is based on faith, inspiration and deity, i.e. immaterial entities and reaches beyond both time and the material world. Although the laws in science and spirituality seem to be contradictory, science and spirituality extend at least in part into the same areas of life, nature and the universe. Men are related to both, science and spirituality and therefore often feel to be in a dilemma. The question arises whether it is possible to overcome this problem. One approach to surmount this problem can be found in Rudolf Steiner's Anthroposophy. Anthroposophy enables to broaden one's perception that is often limited to sense perception and the material world to a perception that comprises supersensible realities and immaterial forces and their action in man, nature and the universe. This results in a spiritual science that applies logical reasoning analogously as in natural science. This approach will be presented in more detail and discussed.

Ethics in Health Care Chaplaincy

Dr. theol. Katrin Bentele
Johann-Wolfgang Goethe University Frankfurt, Germany
Friday, May 2nd, 11:20-11:45

The ethical challenges of modern medicine have not only influenced the development of medical ethics, bioethics or care ethics by decisively changing the everyday work of physicians and nurses, but have also changed the role and working fields of hospital chaplains. Nevertheless a professional ethics in health care chaplaincy has not been developed right now. This is relevant since health care chaplains seem to be the natural partners for patients, doctors, nurses or relatives to deal with questions concerning ethical problems. Also more and more often they are working in hospital ethics committees or even provide leadership of such institutions. This means, that health care chaplains need to have a sophisticated ethical education because of the radical changes of their role and working fields during the last decades.

Besides the ethical challenges which go along with new achievements in modern medicine also ethical questions are to be addressed with regard to the specific professional role of health care chaplains. For instance we have to ask, if or how the professional profile of health care chaplaincy is changing because of the ethical work; how the role can be defined, that can be taken over by health care chaplains working on an ethics committee; do we have to face conflicts induced by the double role as chaplains and ethicists; are there ethical questions concerning the relationship between chaplains and patients in analogy to the doctor-patient-relationship for example with regard to asymmetric structures; how is the relation between religious belief and ethical conviction; and so on. These questions are even more relevant in a more and more pluralistic, multi-cultural and multi-religious context.

Religion und Spiritualität in der Pflegepraxis (F2)
Religion and Spirituality in Nursing Practice (F2 - in German)

Chair: Ursa Neuhaus, lic. phil.; Location: Kursraum 3

Die Rolle der Spiritualität in der Pflege

Dr. Hildegard Holenstein, Pflegefachfrau
Inselspital, Bern, Switzerland
Friday, May 2nd, 10:30-10:55

Wo immer wir in der Geschichte der Pflege nachforschen, stossen wir auf eindrückliche Hinweise, dass die Pflege von Kranken, die Sorge um Kranke, mit Spiritualität in enge Verbindung gebracht wird, ja sogar, dass die ursprünglichen Wurzeln von Helfen, Sorgen und Heilen darin gründen. Die christliche Tradition macht den Gottesbezug der religiös motivierten Krankenpflege zur heiligen Pflicht. Die barmherzigen Schwestern von Ingenbohl schreiben in ihrer Geschichte, dass die „aufopfernde Hingebung, die wohlwollende Liebe, die Geduld, der ächte Muth, die Festigkeit und die unbegrenzte Treue, die aus einem lebendigen Glauben kommen, die Haupteigenschaften einer Pflegerin sind". Auch wenn Pflege heute mit anderen Worten, mit anderen Begriffen definiert wird, behalten diese Aussagen hohe Aktualität.

Werden Menschen in schwierigen Lebenssituationen im Pflegealltag begleitet, erhalten spirituelle Grundfragen besondere Bedeutung. Kranke Menschen und sehr oft auch ihre Angehörigen fragen nach dem Lebenssinn, nach dem Warum. Sie werden in Notfallsituationen plötzlich und in der Langzeitpflege kontinuirlich mit der Endlichkeit menschlichen Daseins konfrontiert. Die Tatsache, dass das Leben eine oft unwiderrufliche Wendung nimmt, es nie mehr sein wird, wie es war, ist ebenso belastend, wie medizinische Eingriffe. Solche Schicksalsschläge machen betroffen und verlangen von Pflegenden viel Feingefühl und innere Bereitschaft, nebst der medizinisch/pflegerischen Versorgung auch spirituelle Bedürfnisse der Patienten und ihrer Angehörigen wahrzunehmen.

Die klinische Praxis bestätigt, dass trotz der rückläufigen Bedeutung der Religion in unserer Gesellschaft, viele Fragen, Entscheidungen und Reaktionen von Menschen – Patienten, Angehörigen und Pflegenden, wie gar oft auch vom gesamten medizinisch-therapeutischen Team – nicht verstanden werden können, ohne die Anerkennung individueller Spiritualität. Die Grenzen der vermeintlichen Allmacht der hochspezialisierten Medizin sind belastend und wecken Momente grosser Angst oder gar Verzweiflung. Die ausgesprochenen oder unausgesprochenen Fragen nach dem „warum gerade ich?" der Schrei „mein Gott, warum hast du uns verlassen?" die zugeschürte Kehle beim Anblick des Schwerverletzten, die tiefe Betroffenheit, die Angst, das Bangen, werden für Betreiligte zum bedeutsamen Lebensinhalt und stellen hohe Ansprüche an Pflegende.

Pflegewissenschafterinnen weisen dem Wahrnehmen des subjektiven Erlebens und der Sinnhaftigkeit von Kranksein hohe Bedeutung zu. Pflegenden wird der Auftrag zugeordnet, sich in ihrem Handeln dem therapeutischen und zwischenmenschlichen Beziehungsprozess bewusst zu sein. Der Bearbeitung von Hindernissen, sei es im Heilungs- und Genesungs-, oder im Sterbeprozess und der Bedeutung des In-Beziehung-Tretens, des aktiven Hinhörens auf spirituelle Bedürfnisse in solchen Belastungen, bei Frustrationen, Angst und Konflikten, muss Raum geschaffen werden. Das „integrierte Pflegemodell" der Pflegewissenschafterin Dr.Dr. Silvia Käppeli weist sehr deutlich auf spirituelle Anteile der Pflege hin. Sie stellt das Leiden in den Mittelpunkt des pflegerischen Interesses und bezeichnet das Leiden bzw. dessen Prävention oder Linderung als wesentlichen Inhalt der Pflege.

Anthroposophische Pflege und Spiritualität

Christoph von Dach, Pflegefachmann und Pflegedienstleitung
Lukasklinik, Arlesheim, Switzerland
Friday, May 2nd, 10:55-11:20

Die Wurzeln der Anthroposophischen Pflege reichen weit zurück. Schon bald nach der Gründung der ersten anthroposophischen Klinik (Ita Wegman Klinik, gegründet 1921) begann die Ärztin Ita Wegman (1876-1943) systematisch, eine Pflege aufzubauen, die nach den Grundsätzen der Anthroposophischen Medizin arbeitete. Die Pflege war eine Grundvoraussetzung, um Anthroposophische Medizin im stationären Bereich durchführen zu können. Im Laufe der Jahrzehnte entwickelte sich die Anthroposophische Pflege weiter zu einem eigenständigen Konzept. Nebst der Ita Wegman Klinik entstanden

weitere Kliniken im In- und Ausland. 1963 wurde die Lukas Klinik gegründet. Sie entstand zur Behandlung von onkologischen Erkrankungen auf der Basis der Anthroposophischen Medizin.

Anthroposophische Pflege und Medizin basieren auf der Schulmedizin. Sie verfolgen einen integrativen Ansatz. Es werden also im schulmedizinischen Setting Methoden und Konzepte der Anthroposophischen Pflege umgesetzt. Diese Verbindung ist eine einzigartige Situation, da im Rahmen der Komplementärmedizin in der Regel kein Entweder-oder angestrebt wird.

Grundlagen der Anthroposophischen Pflege bilden die Erkenntnisse der Anthroposophie. Diese wurde begründet durch Rudolf Steiner (1861 – 1925) und als Geisteswissenschaft konzipiert. Anthroposophie ist keine Religion und somit konfessionell unabhängig.

Grundlagen der spirituellen Ausrichtung der Anthroposophischen Pflege bilden:

- die Basierung auf einem geistigen Welt- und Menschenbild
- das ganzheitliche Verständnis von Gesundheit und Krankheit
- die innere Haltung in der täglichen Arbeit
- die Anerkennung einer nichtstofflichen, geistigen Wirksamkeit

Im Rahmen einer Nationalfondsstudie (NFP 34) konnte nachgewiesen werden, „dass die stationäre Behandlung in einem anthroposophischen Spital (Lukas Klinik) zu signifikanten Verbesserungen der Lebensqualität führen kann. Das betrifft emotionale, aber auch globale, körperliche, kognitiv-spirituelle und soziale Aspekte. Ein Nutzen der Anthroposophischen Medizin wurde auf der körperlichen, seelischen, kognitiv-spirituellen und der Beziehungsebene empfunden.“ (Heusser P. et al, Forschende Komplementärmedizin, Band 13, Heft 3, Juni 2006). In der genannten Studie ist zu sehen, dass nebst einer siginifikanten Verbesserung von 12 der 20 gemessenen Lebensqualitätsdimensionen, die koginitv-spirituelle Dimension deutlich verbessert wurde und zwar auch noch 6 Monate nach dem Spitalaufenthalt. In einer weiteren Studie wurde nachgewiesen, dass das ‚spirituelle Wohlbefinden‘ für die Lebensqualität im Endstadium der Krebserkrankung der wichtigste Prädiktor ist (Brady et al., Mc Clain et al. 2003).

Die genannte Studie belegt eine Stärke der Anthroposophischen Pflege. Durch den speziellen Hintergrund, die Art und Weise und die zur Verfügung stehenden Methoden (z.B. die äusseren Anwendungen wie Wickel, Kompressen und Rhythmische Einreibungen) wird sie zur spirituellen Pflege, die im speziellen auch spirituelle Bedürfnisse der Patientinnen und Patienten abdecken kann, so dass diese nicht von vornherein an die Seelsorgerin bzw. den Seelsorger delegiert werden müssen. So fördert Anthroposophische Pflege – als Teil eines grösseren Behandlungskonzepts (mit Ärzten, künstlerischen Therapien, Ernährung etc.) – das positive Erleben der spirituellen Ebene und damit die Verbesserung der Lebensqualität des an Krebs erkrankten Menschen. Wenn die Aussage von Levine und Tarq dazugestellt wird, wonach „eine signifikante Korrelation zwischen ‚spirituellem Wohlbefinden‘ und funktionellem Wohlbefinden besteht“ (Levine und Tarq 2002), kann gesagt werden, dass Anthroposophische Pflege auch auf das spirituelle Wohlbefinden wirkt und damit das funktionelle Wohlbefinden deutlich positiv beeinflusst.

Einfluss der Religion auf die Krankheitsbewältigung bei Patienten mit chronischen Erkrankungen

Martin Filipponi
Fachhochschule Visp, Steg, Switzerland
Friday, May 2nd, 11:20-11:45

Bei chronisch erkrankten Patienten werden verschiedene Ebenen des Menschen betroffen. Die Patienten müssen zur Kenntnis nehmen, dass die Medizin ihre Grenzen hat und nur noch die Symptome gelindert werden können. Die kurative Behand-lung rückt in den Hintergrund. Ein chronisches Leiden kann sich auf die geistige, seelische und physische Ebene auswirken. Die Patienten bedienen sich unterschiedlichen persönlichen Ressourcen, um mit ihrem Leiden umzugehen. Eine mögliche Ressource bei der Krankheitsbewältigung kann die Religion bilden. Die Pflege kann jedoch nur auf einen geringen Wissensfundus zurückgreifen, welcher nachweislich den Einfluss der Religion auf die Krankheitsbewältigung darstellt. Dabei besteht die Gefahr, dass die Religion als Ressource, in den Hintergrund tritt. Die vorliegende systematische Literaturübersichtsarbeit wurde im Rahmen der Ausbildung zum Pflegefachmann an der Fachhochschule Wallis erarbeitet und ging der Frage nach, wie der Einfluss der Religion auf die Krankheitsbewältigung bei Patienten mit chronischen Erkrankungen in der wissenschaftlichen Literatur beschrieben wird. Um eine Antwort auf diese Frage zu erhalten, wurde in den pflegerelevanten Datenbanken Medline und Cinahl nach passender Forschungsliteratur gesucht. In die Arbeit wurden 9 Studien mit unterschiedlichem Evidenzgrad miteinbezogen. Sechs Studien stammen aus den Vereinigten Staaten, zwei Studien aus Grossbritannien und eine Studie aus der Schweiz. Bei der Suche wurde der Fokus bewusst nicht auf eine bestimmte Religion oder Konfession ausgerichtet, da ansonsten zuwenig Datenmaterial zur Verfügung geständen hätte. Aus den Datenmaterial wurde ersichtlich, dass sich die

Religion positiv auf die Hoffnung, das soziale Leben, das Kontrollgefühl, auf die Psyche und die Physis auswirken kann und einen angst- und stressdämpfenden Effekt haben kann. Über den Einfluss der Religion auf das Schmerzerleben und die Compliance, sowie über den Effekt des Gebetes auf die Krankheitsbewältigung herrscht Unklarheit. Betrachtet man die gesammelten Informationen, kann die Religion als hilfreiche und schnell verfügbare Ressource angesehen werden, welche positive Effekte auf die Krankheitsbewältigung haben kann. Dies setzt jedoch voraus, dass die Patienten keine Schuldgefühle oder ein verfälschtes, negatives Gottesbild aufweisen. Ansonsten besteht die Gefahr, dass die Religion mehr Schaden zufügen, als Hilfe leisten kann.

Integration of Spirituality in the Patient-Physician Relationship (F3)

Chair: Dr. med. et M.M.E. Peter Heusser; Location: Kursraum 1

The Spiritual Path as an Inner Development of Health Professionals

Dr. med. Marion Debus
Gemeinschaftskrankenhaus Havelhöhe, Charité Teaching Hospital, Berlin, Germany
Friday, May 2nd, 10:30-10:55

Integration of Physical and Spiritual Factors in Diagnosis and Treatment

Dr. med. Reinhard Jeserschek
Department of Orthopedic Surgery, University of Graz, Austria
Friday, May 2nd, 10:55-11:20

Nowadays, living and working in the field of orthopaedic surgery may lead to the feeling, that human beings can be “repaired” by titanium, vanadium, chrome and so on. More and more computers, navigation systems and automatically supervised controlling mechanisms overlay the work of a doctor with his patients.

But surprisingly a lot of doctors seek for solutions to extend the field of diagnosis and treatments in terms of a new access. How can they look at health and illness from a more philosophical point of view?

One approach is the anthroposophic medicine which is widespread especially in german speaking countries.

Not to omit the physical body of human beings but to integrate spiritual and physical layers is the intention leading to a diagnosis more comprehensive than usually seen. This may lead to therapies referring to the different layers.

The aim of this contribution to the Conference is to show that it is justified to use different points of view to treat an orthopaedic patient as an entire being more successfully than in a solely conventional way.

Some commonly occurring disorders may serve as examples.

Disease as Doorway to Initiation

PD Dr. med. Dr. dent. Gerold Eyrich
Department of Cranio-Maxillofacial Surgery, University of Zurich
lic. phil. Laura von Tscharner
Institute of Psychology, University of Zurich
Friday, May 2nd, 11:20-11:45

Initiation has been played a significant role in spiritual and religious experience ever since. In general, initiation also aims at a beneficial behaviour under critical mostly life threatening conditions. Taking a close look into several initiation ceremonies a basic structure of the practice is revealed resembling the course of disease. However, the patient and the treating individual are consciously and subconsciously connected and are interacting. Recent studies have emphasized the importance of beliefs and attitudes

in healing, focusing on the patient only. Hence, the role of the treating individual also deserves a closer look to understand the influence on the healing process. In initiation specific beneficial thoughts or images have been transferred to alter the set of beliefs as well as the behaviour through modelling or experience. New findings of neurobiology as well as some theories of personal interaction do supply us with a possible understanding of the transfer. Initiation may serve as a basic model to understand and use personal interaction as a beneficial and healing relationship. It is the purpose of this oral communication to further depict this model of interaction.

Religion, Spirituality and Cardiovascular Disease (F4)

Chair: Prof. Dr. med. Roland von Känel and Dr. med. René Hefti; Location: Kursraum 4

Regular religious practice and cardiovascular risk factors

András Székely; Coauthors. Árpád Skrabski, Mária Kopp
Institute of Behavioral Sciences, Semmelweis University, Hungary
Friday, May 2nd, 10:30-10:55

In the Hungarostudy 2002 12.668 people were interviewed in their homes, they represented the Hungarian population above 18 years according to age, gender and subregions. In the population above 18 years 25 % are non-believers, 18 % do not practice their religion, 27 % are religious in their own way, 17 % rarely and 13 % regularly practice their religion. Since 1995 the percentage of non-believers decreased by 6 %, and there was a considerable increase in the rate of people who regard themselves religious in their own way. The religion is not at all important for 35 %, it is slightly important for 39 % and it is very important for 26 %. Both the religious involvement and the importance of religion was most closely connected to age, gender, income and education, therefore we had to correct the data according to these parameters to analyse the interactions between religion and health. Religious practice was in each case closely connected with better mental and physical health (in those cases where there was a significant connection). Those people who practice religion regularly smoke less cigarettes per day with 43 %, had 42% less sickness days ill in the last year and their working ability is significantly higher. They showed higher well-being according to the WHO wellbeing score, they are less depressive, less hostile and more cooperative, they can be characterized with less emotional ways of coping and more problem-focused coping and they have more social support from parents and co-workers. The subjective importance of religion was connected with less smoking, less spirit consumption, with higher cooperativity and tolerance and with more adaptive ways of coping. On the other hand among those who regarded religion as very important depression and working disability was higher. This connection might be related to the fact that religion was more important for chronically ill people. The importance of religion seems to be more closely connected to spirituality while practising religion with being a member of a community.

Religion, Blood Pressure and Cardiovascular Disease – Is there a Relationship?

Dr. med. René Hefti
Research Institute for Spirituality and Health, Langenthal, Switzerland
Friday, May 2nd, 10:55-11:20

The interplay of spiritual, emotional and behavioural factors with cardiovascular functioning and disease was well known in ancient/religious traditions (e.g. torah). Empirical findings from the last 30 years support this hypothesis. At least 40 studies have been performed investigating the influence of religion on blood pressure. The majority of them showed beneficial effects.

A recent survey in the United States including more than 14000 participants confirmed that attendance at religious services weekly or more than weekly was associated with lower hypertension prevalence and blood pressure (Gillum 2006). Another investigation measured 24-hour ambulatory blood pressure in African-Americans and whites (Steffen 2002). In African-Americans there was a significant influence of

religious coping on systolic and diastolic blood pressure ($p < .05$, $p < .01$). Cardiovascular reactivity to physical as well as psychosocial stressors is an important measure to assess the functional status of the cardiovascular system. Neuroendocrine regulation is one of the underlying mechanisms. In a sample of healthy students cortisol response to a computer task was measured (Tartaro 2005). Students rating themselves as "not at all religious" had a significantly higher cortisol response relative to those endorsing any degree of religiosity. Another moderating factor on blood pressure is forgiveness. College students participated in two interviews about times of interpersonal betrayal (Lawler 2003). Trait and state forgiveness were associated with lower blood pressure levels.

Religion and spirituality have been shown to reduce the incidence of coronary artery disease (CAD) by influencing cardiovascular risk factors. A greater sense of spirituality was associated with lower cholesterol risk ratios (total cholesterol/HDL) and triglyceride levels (Doster 2002). An amazing prospective study on over 10,000 Israeli men followed up for 23 years aimed to assess factors predictive for long-term coronary heart disease mortality (Goldbourt 1993). The study included religious orthodoxy. The most orthodox had a significant survival benefit of 20%. Religious orthodoxy appears to provide a degree of immunity against CAD, part of which was independent of life-style factors. Finally a theoretical model (adapted from Koenig 1999) describes how religion affects physical health.

Heart Rate Variability as a Tool for Assessing Functional Integration of Body, Soul and Spirit in Diagnosis and Therapy

M.M.E. Dietrich von Bonin
Institute of Complementary Medicine (KIKOM), University of Bern, Switzerland
Friday, May 2nd, 11:20-11:45

Heart rate variability HRV is influenced by many factors such as age, respiration, cardiovascular and neurological diseases, medication, as well as physical and mental conditions. It is controlled by the antagonistic action of vagal and sympathetic influences. The autonomic activity is supposed to be generated by oscillators in the brain stem. Since the autonomic modulation of HRV is proportional to sympathetic or vagal tone, it provides information about the sympathicovagal balance of the whole body.

In other words, HRV consists of complex rhythmical fluctuations of the heart's own steady beat, which is crucial for its ability to adapt to external demands, to serve the quickly changing needs for blood supply to the organs and muscles of the body.

A second level of response comes into view by looking at emotions which directly alter the state of the autonomic system and thus influence HRV. These sympathical or vagal reactions are caused by psychic excitation or relaxation.

Furthermore, our own research has demonstrated the occurrence of reproducible individual patterns in HRV during recitation of speech-exercises, hexameter verse and alliterative verse.

Therapeutic application of such verses has been shown to enhance cardiorespiratory coordination, to transmit the rhythmical contents of such verses via respiration to the heart's rhythms.

The old Greek and Nordic poetry of hexameter and alliterative verse belongs to the spiritual heritage of humanity. Hence, the rhythmic action of the human heart is capable of reflecting and integrating information of body, soul and spirit.

This integrative capability is a typical feature of the rhythmic system in the concept of a threefold organisation of the body used in Anthroposophic Medicine. According to this idea, spiritual and emotional entities not only reflect or belong to neuronal activity, but encompass all three systems of nerves and senses, rhythmical and metabolic processes. Therapeutic recitation is performed by understanding poetic content, walking and breathing all in one action that is organized by the brain, but has its main effects in the field of rhythms, in particular breathing and heart rate modulations, thus enhancing physical, emotional and mental integration.

HRV may serve as a tool for detecting and understanding disintegration problems among body, soul and spirit and evaluating therapeutic means in future.

Integration of Spirituality in Health Care Practice (S1)

Chair: Prof. Dr. Dr. Dipl. Psych. Harald Walach; Location: Kursraum 2

Mindfulness Based Therapy

Prof. Dr. Dr. Dipl. Psych. Harald Walach
University of Northampton School of Social Sciences & Samueli Institute, Northampton, United Kingdom
Saturday, May 3rd, 10:30-10:50

Mindfulness is a concept originally derived from the Buddhist tradition, although a point can be made that any serious spiritual practice enhances mindfulness. In recent years, several ways have been proposed to integrate mindfulness into therapeutic interventions. The most popular one is Mindfulness Based Stress Reduction, developed by Jon Kabat-Zinn. Other methods include Mindfulness Based Cognitive Therapy for Depression Relapse Prevention, or Dialectic Behavior Therapy for borderline patients. We have recently started a Mindfulness Based Coping with University Life program.

Although it is not entirely clear whether mindfulness itself is the decisive therapeutic component, mindfulness based interventions seem to produce beneficial health outcomes. A meta-analysis of MBSR intervention studies has shown a mean effect size of d = 0.53 across interventions and designs. MBCT has been proven effective by a series of trials, as has DBT.

In this presentation I will briefly review the literature critically and ask the question which component of the programs might be the decisive elements of beneficial therapeutic change.

Spiritual Issues in Life or Death Decisions and End of Life Care

Rolf Heine, Director of Nursing
Filderklinik, Filderstadt-Stuttgart, Germany
Saturday, May 3rd, 10:50-11:10

In end of life care and in life threatening situations like Near Death Experiences we experience that religious and cultural patterns vanish and at the same time common human and individual human patterns emerge. Spirituality and believes removes from traditions and come to a more individual expression.

Near Death Experiences can be regarded as indications for the possibility of consciousness which is independent from the body. (Pit van Lommel) Assuming such an independent consciousness and assuming the immortal nature of the human individual essence influences the everyday care, the mental and spiritual accompaniment as well as fundamental therapeutic decisions in end of life care.

The universal patterns of Near Death Experiences can provide a model for end of life care which is based on humanity and spirituality.

Teaching forgiveness - a novel therapeutic intervention to promote health?

Dr. med. Rudolf H. Brodbeck
Practising Physician, Alchenflüh, Switzerland
Saturday, May 3rd, 11:10-11:30

Forgiveness is a learned skill. Scientific research shows that learning to forgive is good for one's health and well-being – good for mental, relational and spiritual health and according to recent data good for physical health as well. Forgiveness training may take place in a single or group setting. In this presentation a forgiveness training program will be introduced and three years of clinical experience with application of the program are discussed.

Illness and Changes in Woldview: Taking the Needs of the Patients seriously

Peter La Cour, Post Doc
Center for Research in Existence and Society, University of Copenhagen, Denmark
Saturday, May 3rd, 11:30-11:50

The link between illness and religious coping has been taken for granted in the American psychological literature, based on research made in the very religious American culture. But is the link of illness and

religious coping also the case in secular societies like in Scandinavia, where very low levels of religious belief are shown in surveys? Or would less religiousness and less existential thoughts be found as the usual, normal and understandable reactions - and as such, should existential and religious denial be supported by the clinician and hospital staff? Religious struggle has shown to be dangerous to health in several studies, and we really do not know much of religious coping in very secular surroundings, where religion is seen as a very private affair.

In a recent hospital-based study we have demonstrated changes in the patients' meaning system during illness, also in a very secular hospital in urban Denmark. But we found the areas of existential concern and of spiritual/religious practice to show more change than the area of religiosity, and we found some very complex patterns of change with gender and age specific differences opposite to what may be expected. Opposite to the general population and assumptions, the youngest generation was the most religious active and we found the women to lose religious faith during serious illness.

Also the clinical psychology assumption of "the more ill, the more psychological pressure" was challenged in our study. The need for existential/religious/practice coping seemed to peak at the duration of 3 month of illness, and there were no clear patterns of more coping, when illness had changed to the worse within the last month, as should be presumed. For the women the pattern was the opposite: the reported more religiousness, when the illness changed to the better, not the worse.

It is possible that religious coping may show to be very different in religious and secular societies and the standard equipment of clinical knowledge when meeting physically ill patients could need some rethinking and refinement.

How do we understand and meet the patients' changing worldviews in a non-patronizing way? The symposium addresses our understandings of personal crisis and change during illness, religious and secular meaning-making and development of adequate clinical/professional attitudes.

Tools for Assessing Religiosity and Spirituality (S2)

Chair: Dipl.-Theol., Dipl. Psych. Franz Fischer; Location: Kursraum 4

Centrality and Content of Religiosity: S-R-T

Dr. phil. Stefan Huber
Center for Religious Studies, University of Bochum, Germany
Saturday, May 3rd, 10:30-10:50

The "Structure-of-Religiosity-Test" (S-R-T; see Huber, 2006, forthcoming) is a comprehen-sive test designed for multidimensional and comparative inter-religious research in the field of religion as well as for practical use in psychotherapy. The backbone of the S-R-T is defined by six core dimensions of religion: intellect, ideology (belief), public practice, private practice, experience and consequences for everyday life (Glock, 1962; Stark & Glock, 1968; Huber, 1996). The measurement of these dimensions differentiates systematically between centrality and content of religiosity (Huber, 2003). The concept of centrality is related to the efficacy of religion in personality. The more central religion is, the greater is its impact on the experience and behaviour of a person, and the greater is the relevance of religion for psychotherapy. Because of this function, the measurement of the concept of centrality is most important within the S-R-T. The Centrality Scale is constructed by equally weighting the measurements of general intensity for the first five core dimensions (Huber, 2004, 2007). The concept of content is related to the direction of religion. Religious contents can be regarded as beliefs, attitudes, schemas, styles, and orientations. They are always related to a certain direction that religion leads a person into. For instance, it can be assumed that the belief in a merciful and forgiving God leads a person into another direction as the belief in a wrathful and punishing God. The current version S-R-T comprises 127 items. In the paper, I mainly discuss application strategies of the S-R-T in psychotherapy.

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Religious Coping: R-Cope – German Version

Dr. Dirk Lehr
Department of Medical Psychology, University of Maarburg, Germany
Saturday, May 3rd, 10:50-11:10

As Folkman and Moskowitz (2004) stated, religious coping recently has become one of the most fertile areas for theoretical consideration and empirical research. In the late 1990s, Pargament, Koenig and Perez (2000) developed the RCOPE and Brief-RCOPE (Pargament, Smith, Koenig, Perez, 1998). This multidimensional questionnaire is regarded as an important contribution to the measurement of religious coping. Although some German coping questionnaires consider religion as a way of coping, it is assessed only one-dimensional, not differentiating functional and dysfunctional aspects. Therefore the aim of the studies was to evaluate a German version of RCOPE scales.

Method: According to theoretical, empirical and economic considerations several RCOPE scales were selected for adaptation. Four samples were examined: 210 subjects experienced a life event; 102 subjects were suffering from cancer, 117 subjects were suffering from chronic somatic conditions; 112 inpatients were diagnosed with mental disorders. Dimensionality of Brief-RCOPE was investigated by exploratory and confirmatory factor analyses. According to the procedure described by Pargament et al. (2000) dimensionality of selected RCOPE scales was examined by exploratory factor analyses.

Results: Brief-RCOPE: Alpha of positive and negative scales were .91 and .84 respectively. Velicers MAP-Test and exploratory factor analyses confirmed the two-dimensional structure of the Brief-RCOPE. However, the model fit in confirmatory factor analyses failed to reach acceptable values. A shorter version of the Brief-RCOPE demonstrated satisfying fit indices.

Selected RCOPE scales: Reliabilities of all scales were satisfying. With regard to dimensionality, results differed from Pargament et al (2000). In general, fewer dimensions of religious coping were found. Some scales displayed expected factor loadings (i.e. seeking support from clergy or members) while others (i.e. religious focus) tend to demonstrate unsystematic loadings. Some positive coping scales formed one single factor (i.e. seeking spiritual support, collaborative religious coping).

Results of stability or retest reliability suggest that religious coping strategies are rather stable personal characteristics. Medium to strong associations with posttraumatic personal growth could be replicated. Correlations with depression and anxiety were clearly weaker, occasionally failed to be significant.

Conclusion: Despite their limited number of items, the adapted RCOPE sales demonstrated a considerable reliability. Correlations with personal growth and depression (external validity) were comparable to Pargaments results. Higher associations with anxiety suggest religious coping to be more efficient to reduce anxiety than depressed mood. Typically, dimensionality increases as experiences in the field of interest increase. The decrease of dimensions compared to American samples could reflect a more secular culture in Germany.

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Spirituality: SpREUK

Prof. Dr. med. Arnd Büssing
Chair of Medical Therory and Complementary Medicine, University of Witten/ Herdecke, Germany
Saturday, May 3rd, 11:10-11:30

The SpREUK questionnaires as tools to measure spiritual/religious attitudes of patients dealing will chronic diseases Several patients have turned away from institutional religiosity, but still may have an interest in a more individual spiritual approach – or they have no interest at all in these issues. Thus, to assess a patient´s interest in spiritual concerns, we have developed the SpREUK questionnaire (acronym of the German translation of „Spiritual and Religious Attitudes in Dealing with Illness") which is not biased for or against a particular religious commitment, and consequently avoids exclusive terms such as God, Jesus, praying, church etc., and has already proven to be a good choice in the context of chronic disease. Out tool relies on essential motifs found in counselling interviews with chronic disease patients (i.e. trust/faith, source/hold, message/change), and was so far tested in 1.119 Christians, Muslims, and Atheists/Agnostics. The shortened version SF-24 differentiates three factors (Cronbach's alpha = 0.931): Search for Meaningful Support; Trust in Higher Source; Positive Interpretation of Disease (re/appraisal); and holds an additional 9-item factor to address Support of Life through Spirituality/Religiosity (alpha = 0.963). To avoid an intermix of attitudes, convictions and practices, the engagement in distinct spiritual, religious, existentialistic and philosophical forms of practice was measured with an additional manual, the SpREUK-P questionnaire. The SpREUK-P version SF-25 (alpha = 0.916) differentiates four factors: Conventional Religious Practice / Gratitude; Existentialistic (insight and development) Practice (with an orientation to nature); Spiritual Body-Mind Practices; and Humanistic Practice. Both instruments were extensively tested and optimized in patients with different chronic diseases, i.e. cancer, multiple sclerosis, chronic pain, and others. A more general and comprehensive approach can be found in the 30-item ASP questionnaire (alpha = 0.942) which differentiates: Prayer, Trust (in God), and Shelter; Insight, Awareness, and Wisdom; Conscious interactions; and Transcendence Convictions.

Quality of Life and Spirituality: SELT-M

Dr. phil. Brigitte van Wegberg, Clinical Psychologist
Hirslanden Clinic, Zurich, Switzerland
Saturday, May 3rd, 11:30-11:50

As spirituality was not traditionally included in QoL assessment until recently, the SELT (Scales for the Assessment of Quality of Life in Tumor Patients), a QoL instrument developed by German Oncologists, was modified. This modification, the SELT-M, was psychometrically tested and added to the pool of instruments used to determine QoL of metastatic cancer patient in a project carried out between 1993 and 1998 and sponsored by the Swiss National Foundation.

Methods: Anthroposophic experts on spirituality and cancer treatment were invited to draft questions capturing the essence of spiritual QoL. Eight questions on the meaning of life, on death and dying, life orientation, valuable new experiences due to illness, being oneself and new interests, new hopes and goals in life were included. Comprehension and face-validity were tested in 89 patients with advanced breast and gastro-intestinal cancer. The answers to the SELT-M in an institution practising conventional (Institute of Medical Oncology, Berne) and one practising non-conventional (anthroposophic) medicine (Lucas Clinic, Arlesheim) were analysed and compared. Construct validity was tested by multitrait scaling analysis. Discriminant and convergent validity were also tested. The EORTC QLQ-C30 was used as a standard for validation.

Results showed the SELT-M feasible in administration. The questions were well understood and readily answered. Four of the five SELT-M subscales were internally consistent. The subscale on spiritual QoL showed higher within than outside subscale correlations for six of its eight items. Association of the SELT-M with the EORTC QLQ-C30 was good for the items and subscales covering the same aspects of QoL in both questionnaires, namely emotional and physical functioning as well as fatigue. In accordance with expectations, there was no association between spiritual QoL with any EORTC QLQ-C30 subscales. Self-assessed spiritual QoL in the SELT-M corresponded well with interviewer assessments.

Conclusion: Overall there is confirming evidence for the hypothesised structure of the SELT-M, especially for the newly developed module on spiritual QoL. The new subscale on spirituality covers an aspect of QoL which is distinct from other aspects. This module may be used as part of a comprehensive assessment of quality of life in severely ill cancer patients.

Issues Related to Spirituality in Neuropsychiatric Care (S3)

Chair: Prof. Dr. med. Jean-Marc Burgunder; Location: Kursraum 1

Religious Aspects in Psychotherapy

Dipl. Psych. Dipl.-Theol. Constantin Klein
Carl Gustav Carus Dresden University Hospital, Technical University, Dresden, Germany
Saturday, May 3rd, 10:30-10:50

The paper will address two main topics. First, in order to answer the question why religiosity should additionally be integrated into common psychotherapy, the most important psychosocial mechanisms of religiosity that cause beneficial effects on mental (and physical) health will be described: social support of religious groups; attachment to God or other religious figures; alternative religious value orientations; a religious sense of coherence; religiously motivated healthy behaviors; and religious coping. It will be illustrated that all these factors can make religiosity an important resource for a better mental health, although they can be harmful under specific circumstances, too. Secondly, opportunities to consider religiosity within diagnostics and psychotherapeutic treatment will be proposed. Examples for an exploration of religious issues and for an integration of religious interventions in the treatment will be given. Main emphasis will be laid on some important conditions that therapists should regard when integrating religiosity in psychotherapy. Keeping these conditions will help to address religiosity in a careful and respectful way and to decide concretely in which cases religiosity should reasonably be considered and in which cases it should not be integrated.

The Influence of Religiosity on Huntingtons's Disease and Dementia

Univ.-Doz. Dr. med. et scient. Raphael M. Bonelli
Department of Psychiatry, University of Graz, Austria
Saturday, May 3rd, 10:50-11:10

In my presentation I will summarize the attempts to assess effects of quality of life (QOL), spirituality, and religiosity on rate of progression of cognitive decline in Alzheimer disease (AD) and other dementias. In detail, I describe the paper of Kaufman et al (Neurology, 2007). In this longitudinal study, the authors recruited 70 patients with probable AD. The Mini-Mental State Examination was used to monitor the rate of cognitive decline. Religiosity and spirituality were measured using standardized scales that assess spirituality, religiosity, and organizational and private religious practices. After controlling for baseline level of cognition, age, sex, and education, a slower rate of cognitive decline was associated with higher levels of spirituality ($p < 0.05$) and private religious practices ($p < 0.005$). These variables accounted for 17% of the total variance [$F(11,58) = 2.24$, $p < 0.05$]. There was no correlation between rate of cognitive decline and QOL. In conclusion, higher levels of spirituality and private religious practices, but not quality of life, seem to be associated with slower progression of Alzheimer disease.

Religious Coping with Schizophrenia

Dr. phil. Sylvia Mohr
Department of Psychiatry, University of Geneva, Switzerland
Saturday, May 3rd, 11:10-11:30

Background: Spirituality and religiousness were highly prevalent in a 115 psychiatric outpatient cohort. For 71% of patients, religion was helpful in giving them a positive sense of self (in terms of hope, comfort, meaning of life, enjoyment of life, love, compassion, self-respect, self-confidence, etc), in decreasing the severity of positive symptoms (either by lessening the emotional or behavioral reactions to delusions and hallucinations and/or by reducing aggressive behavior), as well as on negative and general symptoms like depression and anxiety. At the social level, religion provided guidelines for interpersonal behavior, which led to reduced aggression and improved social relationships. In spite of the subjective importance of religion, only one-third of the patients received social support from a religious community. However, for 14% of patients,

religion was a source of despair and suffering. Some felt despair after failure of the spiritual healing they had sought. Others used religion to cope, but with a negative outcome, i.e. increased delusions, depression, suicide risk and substance misuse. Religion may play positive and negative roles in the frequent comorbidity associated with schizophrenia (suicide attempts and substance misuse). Religion may also play a role in decreasing or increasing adherence to psychiatric treatment.

Objectives: to assess the predictive value of religious coping and the evolution of religion among those patients at 3-years.

Results: 80% of the cohort participated to the follow-up study. The salience of positive religious coping at baseline was predictive of a better outcome (fewer symptoms, better social functioning and a better quality of life and self-esteem). Partial correlations for controlling for baseline status ranged from .24 to .32. The salience of negative religious coping at baseline (n=13 patients) was correlated with increased symptoms, lower social functioning, lower quality of life and lower self-esteem at follow-up. Religion was stable for 71% patients. For 22%, the salience of religion increased (9%) or decreased (13%) drastically. For 7%, positive and negative religious coping reversed.

Conclusions: Religion is a predictive factor of clinical outcome. Mostly, it facilitates recovery by instilling hope, purpose and meaning in life, and provides an effective resource to cope with symptoms, even psychotic ones. However, positive religious coping may vanish over time, or evolve to spiritual struggles. Therefore, positive religious coping has not to be taken as granted and need to be supported in integrated psychiatric care. Negative religious coping predicts increased suffering and psychopathology. In consequence, it has to be a target of clinical care, all the more that such patients were seldom supported by a religious community. Therefore, it is of relevance to assess systematically religious coping in psychiatric care and to address spiritual issues.

Psychiatric Disorders and the Pathology of Body-Spirit Interactions

Dr. med. Marjolein Schulthess-Roozen,
Department of Psychiatry, Ita Wegman Hospital, Arlesheim, Switzerland
Saturday, May 3rd, 11:30-11:50

The field of psychiatry is a dynamic part of science nowadays, not only because of its subject. The so called “biological psychiatry” finds out astonishing and remarkable news about the nerve substances and the nerve interactions. Also in the field of psychotherapy there is more research than ever, and philosophical and theological themes are increasingly integrated.

All over the world there are different views on psychiatric illness; cultural anthropology describes how this is for instance in parts of Africa, Southern America, Asia. The DSM and ICD code system try to integrate this world wide view in their new conceptions of classification of psychiatric and psychosomatic diseases.

Still there are many questions to be answered like ”what brings about a healthy development through out life: in child, grown ups and in old age”. In my work as a psychiatrist the spiritual science called Anthroposophy is extremely helpful to understand and treat people with psychiatric diseases and questions upon life. Anthroposophy is based on the spiritual research of Rudolf Steiner. For this symposium I want to speak about his discoveries about the relations of the soul to the physical body. This relationship has a threefold character. Everything that has to do with perception and cognitive functions as a part of activity of the soul corresponds with the nerve activity. In the same way our feelings are related to all rhythmical functions in the organism and our willing is specifically bound to all metabolic processes. Every kind of disorder of these 3 physiological principles evokes disease. Based on this threefold relationship I will focus on psychiatric disorders, especially depression and its treatment.

Religion and Spirituality in Oncology (S4)

Chair: Dr. med. Ursula Wolf; Location: Kursraum 3

The Role of Spirituality in Oncological Care

Dr. med. Günther Spahn
University of Zurich and Klinik Öschelbronn, Germany
Saturday, May 3rd, 10:30-10:50

The diagnosis of cancer causes a crisis in any person affected by this disease. Decisions have to be made not only concerning treatment pathways, but also to define one`s own understanding of life quality, the way of palliation, resolution or acceptance of symptoms associated with cancer.

Spirituality holds a salutogenetic quality which may influence the various changes cancer induces on the level of body image, emotions and social functioning.

Spiritual experiences either in a religious or a non-religious context can increase the feeling of confidence and are essential components of the "meaningfulness" a human being strives for in a life-changing situation.

In the area of cancer care the therapist-patient relation is characterized by the need for a reliable and confidential relationship in order to decrease anxieties, insecurities and all the "pain" this disease may cause. The enhancement of a feeling of confidence and meaningfulness within the given situation may therefore be a goal for therapists working with cancer patients. Consequently, we should ask the question whether cancer care teams should provide a space for spiritual experiences? How should they look like ? Mindfulness as a basic tool in the care of patients, but also as a formal exercise for patients and therapists alike may provide a possibility to open the space for spiritual experiences shared by patients, doctors and nurses and other health care providers. Education in the concept of salutogenesis and in techniques such as mindfulness meditation may greatly enhance the satisfaction of patients and therapists working in the field of cancer care.

Walking a Narrow Ridge: The Spirituality of Questions in Living and Dying with Cancer

Rev. Christine Marti
Spiritual Care Provider, University Hospital of Zurich, Switzerland
Saturday, May 3rd, 10:50-11:10

A cancer diagnosis brings about many kinds of questions and many layers of questioning in its sufferers. The content and colour of such questions often change as the illness and its treatment unfold. Inasmuch as even the initial questions tend to circle around issues of prognosis and survival and are thereby highly open-ended, it is for numerous sufferers often the case that their nexus of questions and questioning undergo a marked shifts in which poignantly existential themes, both concrete and abstract, become evident, at times even predominant.

Such shifts can bring about diverging reactions in cancer patients, ranging a broad spectrum from acute anxiety, to profound regression, to newfound hope, to a gentle inwardness, acceptance and letting go. Accordingly, as patterns of questions reach new and deeper levels, it is possible for the inner worlds of some sufferers to embrace new spiritual paradigms as well, paradigms in which images of self and those of God emerge anew, showing themselves to be markedly interrelated. Questions of one's existence and theological and/or spiritual questions become often entwined. As such, many sufferers finding themselves walking a narrow ridge amidst all the questions of life, death, self and God which continue to unfold.

The focus of this presentation is to explore the kinds of spiritual paradigms which emerge for cancer sufferers in the context of living and dying with their illness.

Biography Work and Spirituality in Oncological Treatment

Dr. med. Walter Legnani
Artemedica, Milano, Italy
Saturday, May 3rd, 11:10-11:30

The term spirituality may be led to three main meanings:

- religious (the opposite of "carnalitas")
- philosophical (the opposite of corporality or materiality)

- a meaning that we could call juridical ("spiritualia" opposite to "temporalia").

Spirituality, real adhesion to our own spirit, may be defined just the constitutive level of human being, that makes him exclusive, unrepeatable, unmistakably himself as much as corresponding to his own destiny.

In neoplastic patients a so meant spirituality lives a critical moment.

Oncology today is like a war, often unavoidable, because it is almost always too late, it is too urgent to treat; the patient appears exhausted for diagnostic and therapeutic course he has undergone. Frequently his past is distorted, idealized or on the contrary seen through distorting filters. And in painful present future dissolves in an absolute lack of project capability and creativeness. The patient finds no more a role, a meaning, and therefore a reason to recover.

R. Steiner describes man not like a sum of apparatuses but like a whole, consisting of different constitutive parts. There is a harmonic connection linked to man's specificity, where thinking, feeling and will coexist.

Biography work means to make a biography an "art" (making it story, or poetry), to give again a sense of art to a life perceived bad, negative. Biography work means to help to go beyond a block, to find the thread of a destiny again, to get the strengths of ego working again, so that it may take again the command.

Narration by septenniums is an useful interpretive way of work, every septennium as a stage of physical and spiritual growth, eventually summarized in an image; facing this picture the patient sees himself again from a point of view out of him, recognizes a part of his own ego in objective and historicized way, he find again something lost, he regains possession of it.

Another important investigating method consists in looking at the recurrences: here life is not seen as a line-route but, we could say, as a circular or sinusoidal one. There are moments in life which refer, with a closing connection, to past times; there are events so important, traumas so conditioning which wait you in a cyclical recurrence, like a large roundabout. Enigmatical, cyclic returns like that of seasons and of the whole universe.

It is not a matter of thinking spirituality only as a practice to console, to tolerate better. Biography work is a concrete, real factor within oncological care. It is an indispensable factor, possible in different extent according to circumstances, if we want not only to destroy sick cells, but also to treat causing process. Namely we want to fortify the strengths of the Ego, so they can repossess harmoniously physical and metabolic man, instead of trying desperately to subdue it by an organic invasion neurosensorial-type.

We can consider artistic therapies as synergic (a new door opened to the soul), an so eurithmia (word that becomes movement), rhythmical massage (vital contact, the hands of therapist as resumption of a positive perception of one's self).

Pre-Conference Workshop

with Prof. Dr. med. Harold. G. Koenig, April 27-30, 2008

Preceding the conference there was a 4-day Pre-Conference Research Workshop with Prof. Dr. Harold Koenig. The workshop was open to all interested in doing research on religion, spirituality and health (accepting participants of any educational level or degree, including theologians, chaplains, physicians, nurses, psychologists, pastoral counselors, public health specialists, epidemiologists, or other potential researchers). Professor Harold Koenig is known as senior author of the "Handbook of Religion and Health". He holds a university teaching position as full professor at Duke University Medical Center (Internal Medicine, Psychiatry, and Behavioral Sciences). Furthermore he is co-director of the Center for Spirituality, Theology and Health. This center offers – amongst others – a 2-year post-doc program in religion and health, which Dr. Koenig has compressed into 4-day workshops. Mentorship meetings with Prof. Koenig allowed participants to discuss individual research projects.

The following topics have been discussed:

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

Preceding our next conference 2010 there will again be the opportunity to paricipate in a research workshop. Further information: **rene.hefti@klinik-sgm.ch**.