RSH08

# European Conference on Religion, Spirituality and Health

May 1-3, 2008
Bern, Switzerland

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# Preface

## Dear Colleagues

Dieser Text ist noch ein Entwurf ..... This Conference aims to enhance the interdisciplinary dialogue between medicine, neuroscience, psychiatry, psychology, spiritual science and theology. Experts will give comprehensive overviews on the topic, covering physical as well as mental health issues. Symposia invite discussion and free communication allows research groups to present their research projects either orally or as posters. Methodological support can be sought from research experts in their specific fields. Another emphasis is to strengthen networking among researchers in the field and to promote scientific projects. Prof. Harold Koenig will inform us about new developments in the United States. Dieser Text ist noch eine Entwurf .....

Dr. med. et M.M.E. Peter Heusser

Dr. med. René Hefti

Prof. Dr. med. Jean-Marc Burgunder

# Programme

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| 10:00 | | Coffee Break | Coffee Break | 10:00 |
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| 16:00 | Europe and the Birth of Science in Spirituality<br>Dr. med. et M.M.E. Peter Heusser | Competencies for Spiritual Care<br>Dr. Donia Baldacchino | Future Perspectives, Closing | 16:00 |
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# Keynote Speakers

### Dr. Donia Rita Baldacchino (Malta, Malta)

Senior lecturer and coordinator of M.Sc. health science (nursing/ midwifery) at the Department of Nursing and Midwifery studies at the Institute of Health Care at the University of Malta. Member of the Institute of Health Care Research Ethics Board. 2002 doctor of philosophy Ph.D. (nursing). Certificate in adult education. Renal nurse.

**Keynote Lecture: Competencies for Spiritual Care**
**Free Communication: The Search for Meaning in Acute Illness**

### Dr. med Arjan Braam (Utrecht, The Netherlands)

Consultant psychiatrist in Altrecht Mental Health Care, Department of Emergency Psychiatry, Utrecht, the Netherlands, and senior researcher in the Institute of Extramural Medicine (EMGO-Institute) at the VU University Medical Center in Amsterdam. Since 1992 researcher in the Longitudinal Aging Study Amsterdam (LASA), a gerontological and epidemiological prospective research initiative.

**Keynote Lecture: Religious Resources and Depression - Results from the Netherlands**

### Prof. Dr. med. Jean-Marc Burgunder (Bern, Switzerland)

Graduation at the Faculty of Medicine in Berne and training at the National Institute of Mental Health, in Bethesda, USA. He developed a programme on research and management of patients with movement and muscle disorders with a special emphasis on neurogenetics in Bern and Singapore. Professor in experimental neurology at the Departement of Neurology, University of Bern, Switzerland, visiting professor at the Faculty of Medicine of the National University of Singapore and at the Sichuan University in Chengdu, PR China.

**Keynote Lecture: Religion, Spirituality and Neuroscience**

### Prof. Dr. med. Arndt Büssing (Witten-Herdecke, Germany)

Head of the working group "Spirituality and Medicine" at the Chair of Medical Theory and Complementary Medicine of the medical faculty of the University Witten/ Herdecke, Germany. Co-editor of the German Journal of Oncology, editorial board of the journal Transpersonale Psychologie und Psychotherapie, advisory board of the journal Research in Complementary Medicine and Journal of Spirituality and Health International, advisory board of the "Canadian Research Institute on Spirituality and Healing ", and executive board of the "Society for Meditation and Meditation Research".

**Keynote Lecture:** Role of Religion and Spirituality in Medical Patients

### Dr. med. et M.M.E. Peter Heusser (Bern, Switzerland)

Doctor for General Medicine. Member of staff at the Ita Wegman Clinic, Arlesheim, Switzerland, (anthroposophically oriented hospital). Lecturer for anthroposophic medicine at the Institute for Complementary Medicine KIKOM , University of Bern, Switzerland. Lecturer at the Seminars for Anthroposophic Medicine Arlesheim, Dornach (Switzerland) and Filderstadt (Germany). ). Advisory board of the Integrated Curriculum for Anthroposophic Medicine, Medical School of the University of Witten/Herdecke, Germany. Master of Medical Education, University of Bern.

**Keynote Lecture: Europe and the Birth of Science in Spirituality**

### Dr. phil. Stefan Huber (Schlieren, Switzerland)

Psychologist and Theologian. Ph. D. in Psychology of Religion. Senior researcher at the Center for Religious Studies, Ruhr-University Bochum, Germany. Since 2007 "Religion Monitor" of the Bertelsmann Stiftung.

**Keynote Lecture: The Multidimensional Structure of Religiosity**
**Symposium: Centrality and Content of Religiosity: S-R-T**

### PD Dr. med. Philippe Huguelet (Geneva, Switzerland)

Psychiatrist in charge of the "Secteur Eaux-Vives" of the Adult Psychiatric Service, Geneva Department of Psychiatry, Switzerland. As a clinician, he practices behavioural cognitive therapy. Research on neurocognitive and psychosocial aspects of schizophrenia.

**Keynote Lecture: Integrating Spirituality into Schizophrenia Care**

### Ass. Prof. Dr. theol. Niels Christian Hvidt (Odense, Denmark)

Theologian and associate professor at the Research Unit of Health, Man and Society, Institute of Public Health, Health Sciences, University of Southern Denmark. Research on belief in divine action and interaction with humans.

**Keynote Lecture: Theological Perspectives in Religion and Health Research**

### Prof. Dr. med. Harold G. Koenig (Durham, NC/USA)

Board certified in general psychiatry, geriatric psychiatry and geriatric medicine, and on the faculty at Duke University, USA, as professor of psychiatry and behavioral Sciences, and associate professor of medicine. He is co-director of the Centre for Spirituality, Theology and Health at Duke University Medical Centre. Editor of the International Journal of Psychiatry in Medicine, founder and editor-in-chief of Science and Theology News.

**Public Lecture: Recent Overview on Religion, Spirituality and Health Research**

### PD Dr. phil. Sebastian Murken (Trier, Germany)

Clinical psychotherapist and director of the Psychology of Religion Research Group, University of Trier and director of several research projects. Since 2006 private lecturer at the Institute for the Study of Religions, University of Leipzig. Holds doctorate in psychology and in religious studies. Since 1995 development and realization of a treatment concept for the treatment of patients with spiritual and religious problems.

**Keynote Lecture: Religion and Coping in Cancer Patients**

### Dr. phil. Christian Zwingmann (Trier, Germany)

Christian Zwingmann is a Senior Project Manager at Prognos AG, Düsseldorf, Germany, in consultancy on healthcare and social issues. He received his Diploma (1991) from Frankfurt University, Germany, and his Ph.D. (2002) from Freiburg University, Germany, both in Psychology. He has 15 years of experience in health services research, especially rehabilitation research. Furthermore, he conducted several studies in the field of psychology of religion. In 2005 he was a visiting scientist at the Psychology of Religion Research Group, Bad Kreuznach, Germany.

**Keynote Lecture: Religion and Coping in Cancer Patients**

# 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.

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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.

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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.

# 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 ein 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 Lebesqualität 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 Lebensqualitäts-dimensionen, 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 Lebens-qualität 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 dele-giert 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 Wohl-befinden 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 Gren-zen 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, see-lische und physische Ebene auswirken. Die Patienten bedienen sich unterschiedli-chen 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 Pfle-gefachmann 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 Religi-on als hilfreiche und schnell verfügbare Ressource angesehen werden, welche posi-tive 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.

### Literature


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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. René Hefti; 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

The Pre-Conference Workshop is will take place in 2010. For further questions contact:
**rene.hefti@klinik-sgm.ch**.

# Free Communication

## Spirituality in Medicine

Chair: Dr. med. René Hefti; Location: Kursraum 1

### Experience with a Whole Person Assessment Clinic in Primary Care

Dr. med. Michael Graham Sheldon
London School of Medicine, London, United Kingdom
Friday, May 2nd, 13:30-13:45

**Introduction:** As part of an ordinary General Practice in east London we have completed a pilot study of a whole-person assessment process using a physician, counsellor and pastor to complete a physical, psychological and spiritual assessment of patients with chronic and multi-factorial healthproblems. Following referral from local General Practitioners an initial consultation was held to determine suitability for the clinic. Around half of the patient's referred were not considered suitable because of ongoing serious mental health problems and an inability to participate in a reflective process of health assessment. Each patient who was entered into the pilot study was seen by all three therapists over a two month period, with consultations booked for at least an hour each. The care was integrated as all three therapists met to discuss each patient and produce with the patient an action plan for future management.

**Methods of assessment:** We have experimented with conducting physical assessments by the doctor, psychological assessments by the counsellor and spritiual assessments by the pastor. The suggested model of conducting these assessments and how to integrate the final assessment in agreement with the patient will be discussed.

**Process:** The number of consultations needed, the time taken, and the ability of patients to cooperate in the process will be discussed.

**Results:** Over a one year period, 20 patients were included in the study and representative cases will be presented illustrating the integration of physical, psychological and spiritual factors in the disease process and in its management.

**Discussion:** Suggestions as to future methods of completing whole person assessments in a variety of primary care settings will be discussed. Issues of patient selection, time required, patient participation, qualifications of therapists and different models of conducting these assessments will be covered.

### Mindfulness Based Stress Reduction in Patients with Fibromyalgia – a Randomized Controlled Trial

Dr. Stefan Schmidt; Coauthors: Paul Grossman, S. Jena, B. Schwarzer, J. Naumann, Harald Walach
Center for Meditation, Mindfulness and Neuroscience Research in Complementary Medicine, Department of Environmental Health Sciences, University Medical Center Freiburg, Germany
Friday, May 2nd, 13:45-14:00

Mindfulness-based stress reduction (MBSR) is a structured eight-week group program teaching several types of mindfulness meditation techniques as well as yoga. MBSR aims at developing nonjudgmental awareness of moment-to-moment experience with an orientation toward cultivating kindness, tolerance, and acceptance toward life's vagaries. The program is distilled from ancient Buddhist techniques but is practical, non-religious, and non-esoteric. Health benefits of this intervention have been shown in a number of pilot studies, uncontrolled observational studies and randomized investigations of chronic pain disorders. Fibromyalgia is a clinical syndrome with chronic pain, fatigue, and sleep disorders as major symptoms. The effectiveness of MBSR for fibromyalgia patients was investigated in a large randomized three-armed trial. The trial was limited to women only because fibromyalgia is very predominantly a female disorder. Overall 168 patients were randomized to either (1) MBSR, (2) an active control procedure employed to account for nonspecific effects of MBSR, or (3) a wait list. The main outcome criterion was self-reported general quality of life at four months post-treatment. Secondary outcome variables were fibromyalgia-specific quality of life, depression, pain quality, anxiety, mindfulness, compliance, number of tender-points, and concomitant therapeutic treatments. In addition, data for a Biobehavioral Fibromyalgia Index composed of a variety of physiological and behavioral variables are currently under analysis. This index will be generated from an ambulatory physiological monitoring and electronic-diary system that concurrently measures 24-hour cardiorespiratory function and physical activity, as well as intermittent standardized self-reports of mood, fatigue, and type of activity during awake hours. Primary and secondary outcomes are assessed at the beginning and end of the training, as well as at 4- and 12-month post-treatment. Eighty-two percent of the patients completed the study per protocol. All results are reported using intention-to-treat. With respect to the primary outcome of general quality of life, patients improved significantly at the four-month fol-

low-up (p=.004). While the comparison of the groups showed no significant difference, the mindfulness group was the only one to show a significant pre-post improvement (p=.02). Other variables show a similar picture. Of eight outcome variables, seven showed a significant improvement. In six cases, MBSR demonstrated a significant pre-to-post difference, whereas the active control showed two and the wait list only one significant difference. Regarding group effects, only anxiety manifested a significant effect of MBSR compared to the wait-list (p=.02). We conclude that patients in the MBSR arm benefited most in all measured variables. The comparison between the groups often failed to reach significance because patients in the control groups improved as well. Thus the effect sizes were too small for the overall sample. We were surprised by the relatively small effect sizes for the group comparisons, as a similar pilot study yielded much clearer results. Several methodological issues will be discussed that may explain these differences.

## The Search for Meaning in Acute Illness

Dr. Donia Baldacchino
Institute of Health Care, University of Malta, Malta
Friday, May 2nd, 14:00-14:15

The sudden onset of a life threatening illness such as, acute myocardial infarction appears to trigger the search of causal meaning, in an attempt to find an answer to why me?

This cross sectional exploratory research study is part of a longitudinal study which was conducted in the main general teaching hospital in Malta in 2001. The aim of this study was to explore patients' search for causal meaning of their acute illness. A systematic sample of 70 Roman Catholic patients with first myocardial infarction, aged between 40 –89 years (Mean=61.9 years) were recruited at the Coronary Care Unit (CCU). Data were collected by face to face interview on transfer to the medical ward from CCU.

The theory of Logotherapy and Existential analysis (Frankl 1962) guided the study. The qualitative findings revealed that the specific causal meaning of illness was oriented towards their past and future purpose in life. Finding meaning rendered patients to turn to their God for coping and helped them to prioritize their values in life, such as appreciating more their health, family and friends.

These findings corroborated with Frankl's Theory whereby individuals' beliefs can give meaning to their illness and life. Meaning may enable individuals to change their attitude to life, including their unavoidable suffering.

This paper presents a set of recommendations for further research, education and management of patient care in order to increase awareness of the health care professionals so as to bridge the gaps in the current clinical practice

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## Hagiotherapy, Depression and the Life Values Scale

Dr. med. Sanea Nađ; Coauthors: Marina Marinovic, Lucija Murgic
Department for Psychiatry, University Clinic Zagreb, Zagreb, Croatia
Friday, May 2nd, 14:15-14:30

Abstract Hagiotherapy is a Croatian method, developed by PhD. Tomislav Ivančić, and applied worldwide in centres for spiritual help. It is an autonomous and competent therapy method for healing man's spiritual domain. Hagiotherapy explores the anatomy of the spiritual soul, as well as its physiology and pathophysiology. Its basis are philosophical-theological studies of man, so that it deals with the onthological level of man. Many authors like H. Urs von Balthasar, K. Rahner, M. Beck, A. Jores and D. Amen emphasize how important the spiritual domain is in healing man. In hagiotherapy an appropriate questionnaire is used to establish the cause of spiritual problems, after which the spiritual diagnosis is made. For healing spiritual illnesses, including existential, basic and actual ones, the therapy on the cognitive, axiological and anthropological level is carried out. Since body, psyche and spirit represent an inseparable unity, spiritual illnesses often convert into psychic or physical ones. At the Centre for Spiritual Help in Zagreb cases of long-lasting migraine were researched, which had been treated only symptomatically by physicians, because no medical cause could be found. Through removing the causes in the spiritual domain the migraines were completely healed. Thus it was proved that in healing man an integral approach is necessary, and the treatment should be pneumatic-psycho-somatic.

# Spirituality in Psychiatry

Chair: Ursula Wolf, lic. phil.; Location: Kursraum 2

## Religious Coping among Outpatients suffering from Chronic Schizophrenia: A Cross-National Comparison

Dr. phil. Sylvia Mohr; Coauthors: Laurence Borras, Judith Czellar, Christiane Gillieron, Symine Kramer, Isabelle Rieben, Pierre-Yves Brandt, Huguelet Philippe
University Hospitals of Geneva, Department of Psychiatry, Geneva, Switzerland
Friday, May 2nd, 13:30-13:42

**Objectives:** To assess country-specific religious affiliations and practices in patients suffering from chronic schizophrenia and to explore if religious coping varies by different social and cultural contexts.

**Method:** 115 outpatients from Geneva (Switzerland) and 121 from Trois-Rivières (Quebec), aged 18-65, with a DSM-IV diagnosis of schizophrenia were randomly selected for a semi-structured interview.

**Results:** Despite of different socio-cultural and religious contexts, religion plays an important role in the daily life of 2/3 of the patients in the two sample (62% vs 68%) and half of them use it to cope with their illness (42% vs 62%). Moreover, both populations reproduce to some extent the same patterns of religious coping: positive sense of self, meaning to their illness and life, comfort, control and support. Principal Component Analysis made on religious variables highlights a very similar factorial structure in both of them.

**Conclusion:** The clinical implications of religious coping are an important resource in both living contexts. It should be systematically explored for each patient in clinical practice to improve the outcome of schizophrenia.

## Awareness of Action and the Attribution of Agency are Key Issues in the Neuroscientific Study of Consciousness

Jose Raul Naranjo Muradas; Coauthor: Stefan Schmidt
Center for Meditation, Mindfulness and Neuroscience Research in Complementary Medicine, Department of Environmental Health Sciences, University Medical Center Freiburg, Germany
Friday, May 2nd, 13:42-13:54

Attribution of agency involves the ability to distinguish our own actions and their sensory consequences which are self-generated from those generated by external agents. Although we are normally aware of our motor intentions and goals, we do not have conscious access to all our motor commands and every fine motor adjustment. Certain components of these internal representations may become available to awareness when the discrepancy between the predicted and the actual sensory consequences of an action is large. The exact threshold above which this perceptual-motor conflict becomes available to awareness is currently a focus of intensive research. Healthy subjects may be poorly aware of their motor performance. In patients with prefrontal lesions, deafferentation and schizophrenia, perceptual-motor awareness is severely impaired. We hypothesize that if there are pathologies with a detrimental effect on the sense of self-agency, then meditation, known to improve self-awareness, might influence the cognitive processes related to the implicit and conscious monitoring of actions. In fact, brain areas linked to meditation-related alterations in self-awareness are also known to be associated to the experience of self-agency. This connection offers a pathway for behavioral measurements of spirituality. Mindfulness, the continuous non-judgmental awareness of moment to moment experience, is often used as a spiritually-based clinical intervention for a large set of conditions. But the degree of mindfulness which is important to measure in clinical trials is so far only accessible indirectly via questionnaires. Few studies have shown a positive correlation between visuomotor performance and bodily self-awareness with meditation practice. Nevertheless, a direct assessment of meditation-related cortical processes during a sensorimotor integration task remained largely unexplored. We investigate the impact of mindfulness meditation on EEG activity, visuomotor performance and perceptual-motor awareness in meditators during a conflicting sensorimotor task, where the congruency between actions and their sensory consequences is altered. The experimental device consists of a digitizing tablet connected to a video projector via a computer and a "projection tablet". When tracing a line on the digitizing tablet, the subjects see in the "projection tablet" a projected line coming from the video projector. In order to provide a false feedback, a simple algorithm for introducing an angular bias is used. The task is to draw a straight line between the starting point and the target. Subjects are instructed to move mindfully with moment to moment awareness their hand at a moderate speed. After each trial participants are asked to report their perception of the bias-induced movement distortion. This task is presented to novices in meditation before and after an intensive 8 weeks mindfulness programme (MBSR: mindfulness based stress reduction) which requires daily home practice of meditation. The data of this sample is compared to a group of long-term meditators and a group of healthy non-meditators. In this oral presentation the analysis of visuomotor performance and sense of self-agency in short-term meditators before and after the MBSR course will be reported.

## Religiosity in Evidence-Based Psychiatry

Univ.-Doz. Dr. med. et scient. Raphael M. Bonelli
Department of Psychiatry, University of Graz, Austria
Friday, May 2nd, 13:54-14:06

In comparison to its social inpact, religiosity is widely underrepresented in scientific papers. We try to analyze the possible connection between religiosity and mental health. As result we present three groups of evidence: 1) psychiatric disorders widely lacking scientific evidence in this area (like dementia, schizophrenia, mania, eating disorders, and personality disorders); 2) psychiatric disorders, where reliable evidence can be concluded from the published material (i.e. substance addiction, depression, and suicide); and 3) psychiatric disorders with conflicting evidence (e.g. anxiety disorders and obsessive-compulsive disorder). Actually, religiosity seems to be a protective factor for substance addiction, depression, and suicide. Carefully including this dimension into the psychotherapeutic setting seems to be advisable.

## Religious Supervision with Psychiatrists

Prof. Dr. Pierre-Yves Brandt
University of Lausanne, Faculty of Theology and Religious Studies, Lausanne, Switzerland
Friday, May 2nd, 14:06-14:18

An interdisciplinary group (Adult Psychiatric Service, Geneva) is conducting a research on spiritual and religious coping by patients with schizophrenia. First results of a program of religious supervision for the psychiatrists will be presented. Special attention will be given on the interpretation of cultural meaning of religious behaviors (i.e. religious duties or the meaning of individual prayer for patients with muslim background). The central purpose of this supervision is to modify the representation of what is spiritual or religious and what is not. Propositions for achieving this purpose will be discussed.

## Are Structure and Centrality of the Religious-Spiritual Construct System associated to Personality Dimensions and Psychopathological Symptoms?

Dr. phil. Human F. Unterrainer; Coauthors: Karl Heinz Ladenhauf, Sandra Wallner, Peter Liebmann
Institut for Pastoraltheology and Pastoralpsychology, University of Graz, Austria
Friday, May 2nd, 14:18-14:30

**Method:** In total 420 persons of both sexes were examined: Religiosity and spirituality were investigated in clinically well characterized detoxified addicts (N=120), depressive in-patients (N=100), and persons with no psychiatric diagnosis/treatment in their biography (N=200) using a Multidimensional Inventory for Religious-Spiritual Well-Being (MI-RSWB 48) in combination with the Centrality Scale (C-Scale) and the Structure of Religiosity Test (RST). Personality dimensions were investigated using the Six Factors of Personality Test (6F Test). In psychiatric patients the psychopathological dimensions were assessed using the Brief Symptom Inventory (BSI), the Beck Depression Inventory (BDI), the Brief Psychiatric Rating Scale (BPRS), and the Montgomery Asberg Depression Rating Scale (MADR-S). Data were evaluated with $\chi^2$ Test and Correlation/Regression analysis. General Linear Model multivariate (parametric) and Kruskal-Wallis H Test (non parametric) were conducted for multiple group comparisons.

**Results:** Women showed to be more religious-spiritual than men and there was a positive association between religiosity/spirituality and age. Depressive patients turned out to be the most religious-spiritual, addicts the least. The personality dimensions Piety, Extraversion and Openness showed to be positive predictors of religiosity/spirituality, Neuroticism and Aggressiveness were found to be respective negative predictors. Psychopathological symptoms were the strongest negative predictors of Hope and Forgiveness as religious-spiritual dimensions. The more central the individual religious-spiritual construct system is, the more powerful are its effects.

**Conclusions:** There is a relevant mutual association between religiosity/spirituality, personality, and psychopathological symptoms, in dependence of the centrality of the individual religious-spiritual construct system. Thus integrating of religious-spiritual issues might open up new strategies in diagnosis, prevention, and therapy of psychiatric diseases.

# Sociomedical Aspects of Spirituality

Chair: Dr. med. et M.M.E. Peter Heusser; Location: Kursraum 3

## Effects of Mindfulness-Based Coping with University Life (MBCUL): A Pilot Study

Dr. med. Marie-Louise Gander; Coauthors: Siobhan Lynch, Harald Walach
School of Social Sciences, University of Northampton, United Kingdom
Friday, May 2nd, 13:30-13:50

University life is accompanied by an array of potential stressors, such as changing relationships, new living environments and academic pressure. Additionally, the mental health of students appears to be on the decline. An 8-week course of mindfulness-based coping with university life (MBCUL) has been developed to help students cope with the stressors of university life, based on Kabat-Zinn's mindfulness-based stress reduction program. The primary objectives were to test the feasibility of this study and whether MBCUL improves mindfulness. Secondary we investigated its impact on mental health and on the stress system via the hypothalamus-pituitary-adrenal (HPA) and the sympathic-adrenal-system (SNS). The study is a pre/post-intervention design. Psychological and physiological measurements were taken: mindfulness (FMI), mood (HADS), stress (PSS), s-cortisol for HPA and s-alpha-amylase for SNS. We were interested in the change of the cortisol awakening response (CAR) as well as the change of the diurnal profile of the s-cortisol and s-alpha-amylase. Additionally we conducted post-intervention interviews to explore participants' experience of the programme and its impact on their lives, which we analysed qualitatively using interpretative phenomenological analysis. Data was collected from 11 MBCUL and from 8 wait-list-control participants. The saliva from 8 MBCUL and 6 control-group participants was used in our analysis. There was a sig. change of FMI ($z = -2.437$, $p < .015$), HADS ($z = -2.243$, $p < .025$) and PSS ($z = -2.374$, $p < .018$). We observed a sig. negative correlation between the change of FMI and the change in PSS ($rho = -.744$, $n = 10$, $p < .014$) and HADS ($rho = -.861$, $n = 9$, $p < .003$). A trend towards lower overall cortisol and alpha-amylase levels were also observed. But due to the small number of participants we did not observe any sig. effects. Participants reported finding MBCUL an enjoyable experience, which they felt, provided them with a 'coping toolkit'. MBCUL increased mindfulness and improved the stress-levels and mental health of students in this pilot study. It had a personal beneficial impact on the student's life. At present we are replicating the study with a larger sample size in order to get more reliable result on the physiological level.

## The Resonance Phenomenon – about the Spiritual Dimension of Homeopathy

Dr. med. André Thurneysen
Institute for Complementary Medicine (KIKOM), University of Bern, Switzerland
Friday, May 2nd, 13:50-14:10

In the course of homeopathic case taking one can observe an intensive dynamic interaction, during which the patient will mostly experience a feeling of being eventually perceived and taken seriously. Therefore, he will start to tell further unasked details. The associative link through materia medica knowledge enables the homeopath to approach even indirectly yet uncovered fields. The more the interview is spontaneous, the greater the chance arises that central key points of the patient can be freed. In such situations a specific sensation can happen, which the author calls resonance phenomenon; it is hard to put into words, but it's very clearly felt - in the authors case in the region of the solar plexus. At this moment, the patient as well as the homeopath realize immediately that a very important point of the patients history is reached. The idea, essence, problem or character of this key point has absolutely to be covered by the later prescribed remedy. As this phenomenon is not measurable, there remains the unanswered question whether the conditions which allow its happening are of spiritual dimension. Starting from this experience and based on the daily homeopathic practice this question is further developed to a model which tries to show the potential of homeopathy as a spiritual dimension and link between human collective and individual as well as between nature (materia medica) and symptomatology to provide human awareness.

## Spirituality – the Fourth Dimension of Health. A new Public Health Perspective

Dr. phil. MAS Ralph M. Steinmann
Swiss Health Promotion, Bern, Switzerland
Friday, May 2nd, 14:10-14:30

**Background:** In Public Health only the physical, mental and social dimension are acknowledged as dimensions of health. Various Research has, however, yielded good evidence for the existence of a spiritual dimension of man and therefore of health. Despite innumerable attempts there is still no unanimously approved definition of spirituality and spiritual health.

**Aims and Methods:** On the basis of research in different fields of science a new definition of spirituality is presented. It aims at compatibility with as many value systems, sciences and socio-cultural backgrounds as possible. The main focus is, however, on defining „spiritual health" from the point of view of Public health, particularly health promotion and illness prevention.

The definitions of spirituality and spiritual health are based on a broad interdisciplinary literature research. The definition of spiritual health includes a systematic research of the evidence-based public health literature.

**Results:** Spirituality is defined in terms of eight core dimensions which are supplemented with five dimensions to define spiritual health. Due to the usage of universally acknowledged values and simple wording both definitions attempt to qualify for acceptance and use beyond differences in socio-cultural and religious backgrounds, gender and age.

On the other hand the definitions mark-off spirituality from theoretical or pathological interpretations and from shallow phenomena in the esoteric and wellness market.

Spirituality is also marked-off from institutionalized, normative religiousness or religion. Furthermore spirituality is established as the fourth dimension of health clearly distinguishable from the physical, mental and social dimensions.

**Conclusions:** Spirituality is a human dimension in its own right. Spiritual interventions have proved to have various positive effects on morbidity and mortality. Therefore the three classical dimensions of health are to be complemented by spirituality. The acknowledgement and integration of spirituality in Public Health has the potential of far reaching and manifold impacts on the future self-conception, orientation and success of this science. Consequences are the extension of Engel's biopsychosocial model, a strengthening effect on basic values of health promotion, and the need for the development of spiritual (health) literacy apart from mental health and religious literacy.

# Theological Aspects of Spirituality

Chair: Prof. Dr. med. Jean-Marc Burgunder; Location: Kursraum 4

## Religion as a Health Resource in Migration?

MA Silvia Büchi, PhD-Student; Coauthor: Brigit Obrist
Institute of Social Anthropology, University of Basel, Switzerland
Friday, May 2nd, 13:30-13:45

Most research in migration and health is dealing with the interaction in the medical system, for example how access to the health services could be improved for migrant people. Such studies are mostly characterized by a pathology-oriented research perspective. Despite a growing demand for changing research perspectives since the 1992 WHO-Conference „Migration and Health", only few researchers studied health and wellbeing of migrant people instead of disease and illness. Inspired by Antonovsky´s salutogenic approach, we carried out a qualitative research project in 2004/05, aimed at knowing more about the experience of health and daily health activities, as well as resources mobilised by migrant people. A mixed African-Swiss research team explored the health concepts and daily health activities of Sub-Saharan Africans living in Switzerland, who consider themselves and/or are considered by others as mastering problems affecting their health. The data showed that these migrants understand health as dynamic and multidimensional. For most of them a religious dimension constitutes an integral part of their health concepts. Health problems in Switzerland are brought in relation to „stress" and the men and women have developed different daily strategies in order to stay healthy in migration. Various personal, soical and material resources are mobilised in response to the demands of difficult life conditions. Among others, belief and religious activities are considered as important health resources. In their effort to stay healthy or to recover from illness, migrants don`t blindly follow a cultural pattern fixed by their origine. Health and illness are experienced in interaction with a multifaceted and changing environment and this influences their daily health practices. Health resources may therefore also be experienced as a source of problems. (This project was supported by the Swiss Federal Office of Public Health in the context of the strategy „Migration and Health 2002-2007", which aims for a better understanding of migrant health and illness and for a better access to the Swiss health services for all migrants.)

## Faith in God in a Danish Hospital - Difference between Questionnaire and Pastoral Care

Nadja Ausker and Lotte Mørk; Coauthors: Christian Busch, Peter la Cour, Henning Nabe-Nielsen
Rigshospitalet, København, Denmark
Friday, May 2nd, 13:45-14:00

**Method:** 480 patient-handled questionnaires about health, belief and religious activities during illness and hospital admittance compared to a hospital chaplain's experience in her daily work.

**Results:** Questionnaire: To the question addressing which factors have an influence on healing and recovery, the patients responded that family and friends, in addition to inner resources, are of great significance. God's influence and alternative treatment were relatively highly regarded. When asked about their perceptions of God, 34.5 percent responded that they perceive God as loving, whereas only five percent perceive God as punishing. When comparing the two questions it becomes evident that there is a correlation between one's perception of God and what one believes influences recovery. It seems that there is a relationship between the image one has of God and one's perspective on life. Pastoral Care: The image of God that the Chaplain meets is different from the one revealed in the survey results; it is typically a more negative image than what people truly wish to believe in. When people are in crisis it can be challenging to maintain a positive image of God. During these trying times, people often feel that God is above this world and above caring for them, because why else would they feel this sick? An image of a punishing God is often what comes to mind when a patient is searching for an explanation to and meaning behind their illness and suffering. Nevertheless, the Chaplain experiences that a patient's image of God can change depending on which stage of the illness the patient is in.

**Conclusion:** There is a difference between how patients respond in a questionnaire and how they respond to a Chaplain in person. We believe that this is due to the existence of two coexisting realities, since there appear to be a difference between patients' ideal and general perceptions of God versus their images of God while in crisis.

## God's Representation and Word Use

Dr. phil. Judith Czellar; Coauthors: Sylvia Mohr, Laurence Borras, Simyne Kramer, Pierre-Yves Brandt, Christiane Gillièron Paléologue, Philippe Hugelet
Hôpitaux Universitaires de Genève, Service de Psychiatrie Adulte, Geneva, Switzerland
Friday, May 2nd, 14:00-14:15

Our study is related to research measuring the impact of the religiosity of people suffering from Schizophrenia. In this study the religiosity of patients was estimated through semi-structured interviews which were audio-recorded and transcribed. In each interview the clinician asked the subject "What is your idea of God?" and "What are God's qualities?" We were interested in analyzing the answers to these two open-ended questions. Our goal was to see if there was a link between the type of religiosity of the patients and the vocabulary used by the patient. The practices, the religious faith and the means of facing illness of 70 patients were estimated through a battery of 12 variables. On these last ones Multiple Correspondence Analysis and cluster analysis were the methods of analyzing the responses. In order to categorize the individuals in the most homogenous groups possible based on their religiosities three classes were retained: a first class where there is an absence of religiosity (n=24), a second class where the religiosity is average (n=34) and a third class where religiosity reveals itself to be essential at an individual as well as a collective level (n=12). When we study the vocabulary of these three classes, we find differences. Words that refer to a rather cognitive and ideological approach appear in the first two classes. In the third class, for which religiosity is essential the vocabulary used to describe this religiosity refers to emotional and affective domains. Our results are illustrated through examples of answers typical of each class.

## The Bahá'í Faith and Medicine: A Theoretical and Historical Approach to the Relationship of Religion and Healing

Dr. med. Stephan Anis Towfigh
Potsdam, Germany
Friday, May 2nd, 14:15-14:30

In many cultures religion has played an unsurpassed role for both medical theory and philosophy, as well as for understanding and curing illness, and coping with it. The anthropology given in the scriptures of the World religions have helped the learned and the physicians to shape scientific and medical concepts. However, this religious influence has gradually lost its impact due to the deliberate separation of science and religion. One of the main criticisms expressed against Western medicine today is that whereas medical approaches are scientific, they are not holistic and do not consider the subtle connection of body, mind, spirit and soul. The present study explores the Bahá'í Faith and its scriptures on the relationship of religion and science, belief and medicine. In addition to an analysis of the relationship between physician and patient, concepts such as prayer and nutrition in the context of healing are presented. The study has been carried out in the field of history of medicine.

# Posters

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**References:** 1. WHO Definition of Health. Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, 1946
2. McCord, G. et al., 2004. Discussing spirituality with patients: a rational and ethical approach. Annals of Family Medicine 2(4), 356-361.

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

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

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

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

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

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

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

**References**


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## Chronic Pain and Religiosity (Nr. 5)

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

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

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

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

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

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

**Literature**


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


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


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

## VROID-MHAP-Study (Nr. 7)


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


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

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

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

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

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

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

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

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

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

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

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

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

Georg Saltzwedel
Paracelsus-Hospital Richterswil, Switzerland

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

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

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

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

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

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

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

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

Marco Martinuz, Theologian
Centre Hospitalier Universitaire Vaudois, Switzerland

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

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

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

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

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

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

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

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

Daniel Moyinihan
Trafford General Hospital, Manchester, United Kingdom

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

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

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

**Aims & Objectives**:

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

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

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

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

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

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

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

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

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

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

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

# General Information

## Place of Conference

Auditorium Rossi (Entrance 31B)
Inselspital
University Hospital Bern
Switzerland

## Conference Counter

The conference counter will be open during the whole confernce, i.e. during the following hours:

Thursday, May1st, 2008 13:00 – 19:00
Friday, May 2nd, 2008 08:30 – 19:00
Saturday, May 3rd, 2008 08:30 – 17:00

## Conference Fee

The conference fee includes the costs for lunch, coffee breaks and the conference booklet. The conference badge qualifies to participate in the programme.

## Conference Language

The conference language is English.

## Organ Recital

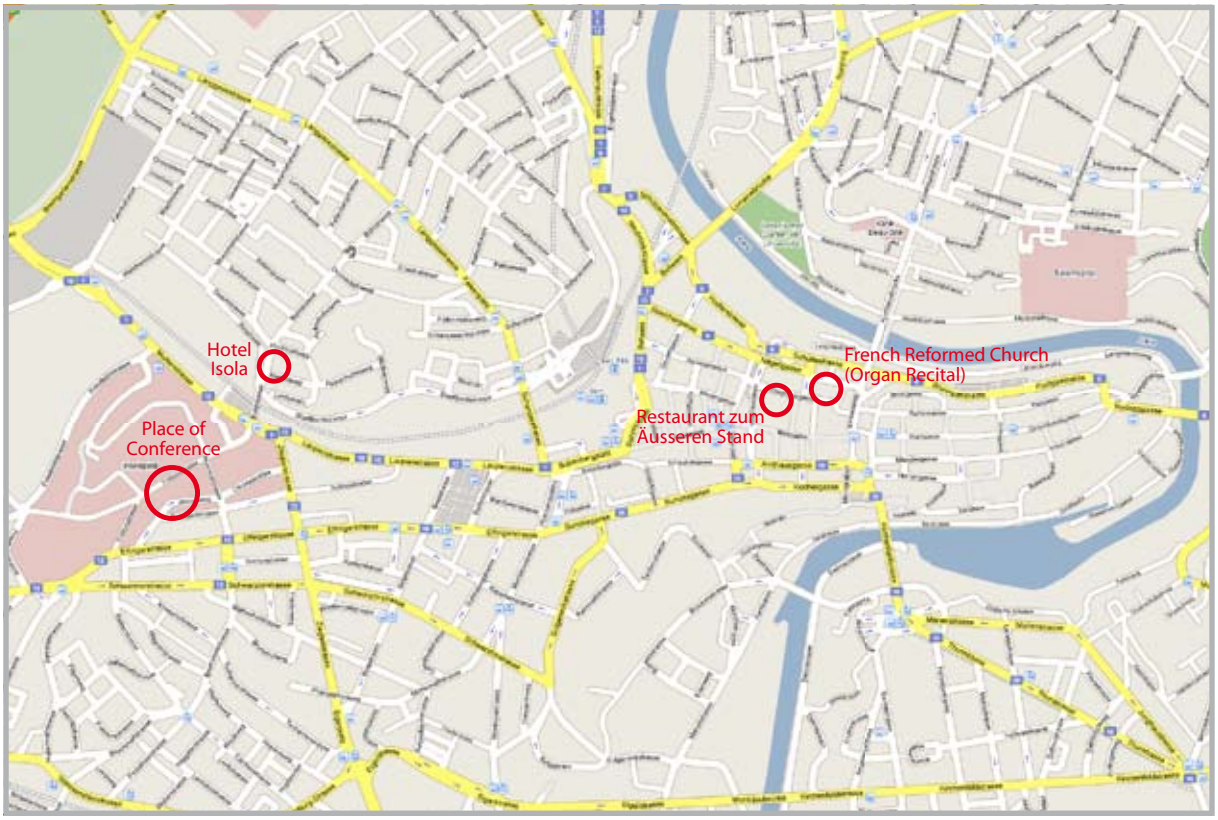
On Thursday evening, we have the opportunity to attend an Organ concert at the French Reformed Church downtown Bern. This is the oldest Church building in the city, first built in the second part of the thirteenth century, and is widely renowned for its excellent acoustics. Nina Wirz, an established keyboard instrument teacher and soloist, has prepared a varied program of spiritual organ music specifically for our Congress. Works will be offered from four century of Organ music, including composers from Francisco Correa de Arauxo to Olivier Messiean and John Cage.

## Social Evening

To get an impression of the medieval cityscape of Bern and its time-honoured sandstone buildings we will make a walk through the old City of Bern and climb up the tower of the Cathedral. After this fitness-program we visit a traditional bernese restaurant and enjoy a nice dinner in a beautiful ambiente. You are

## Maps

### City of Bern



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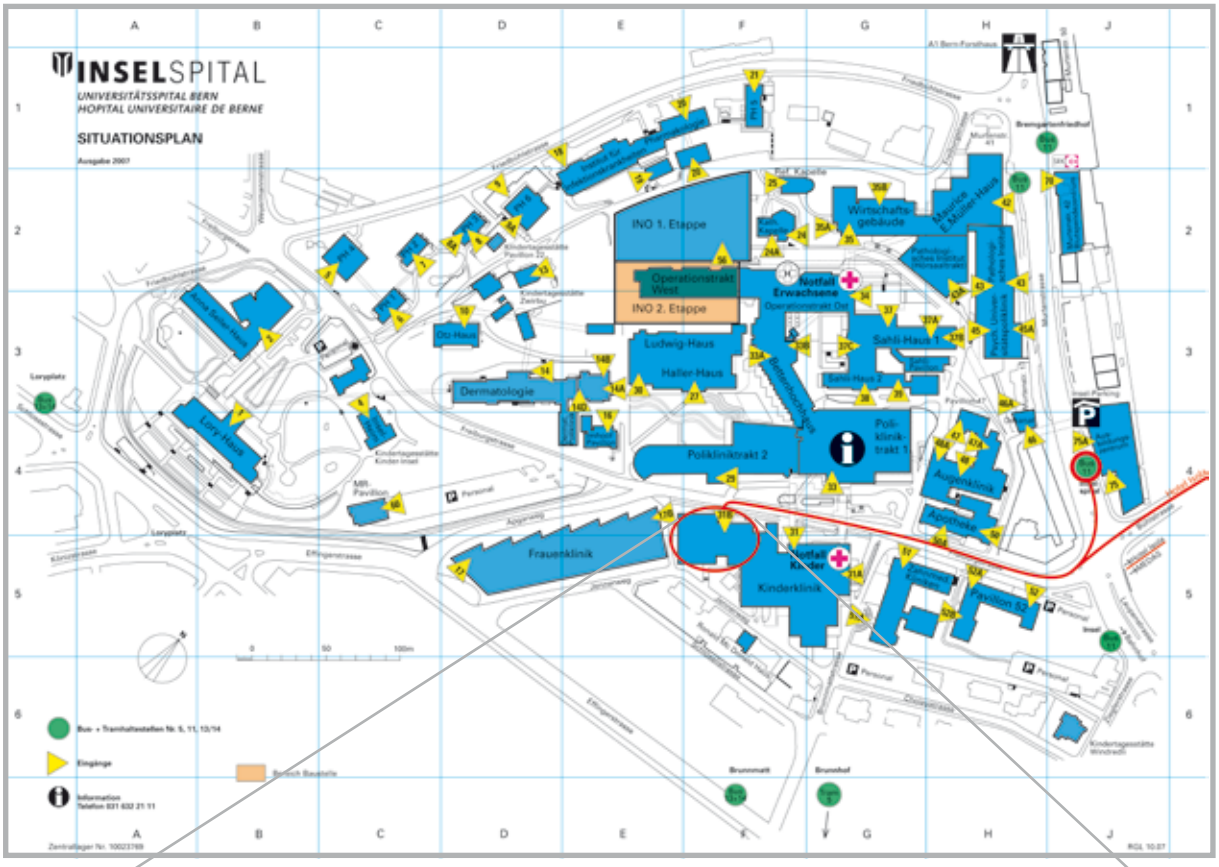
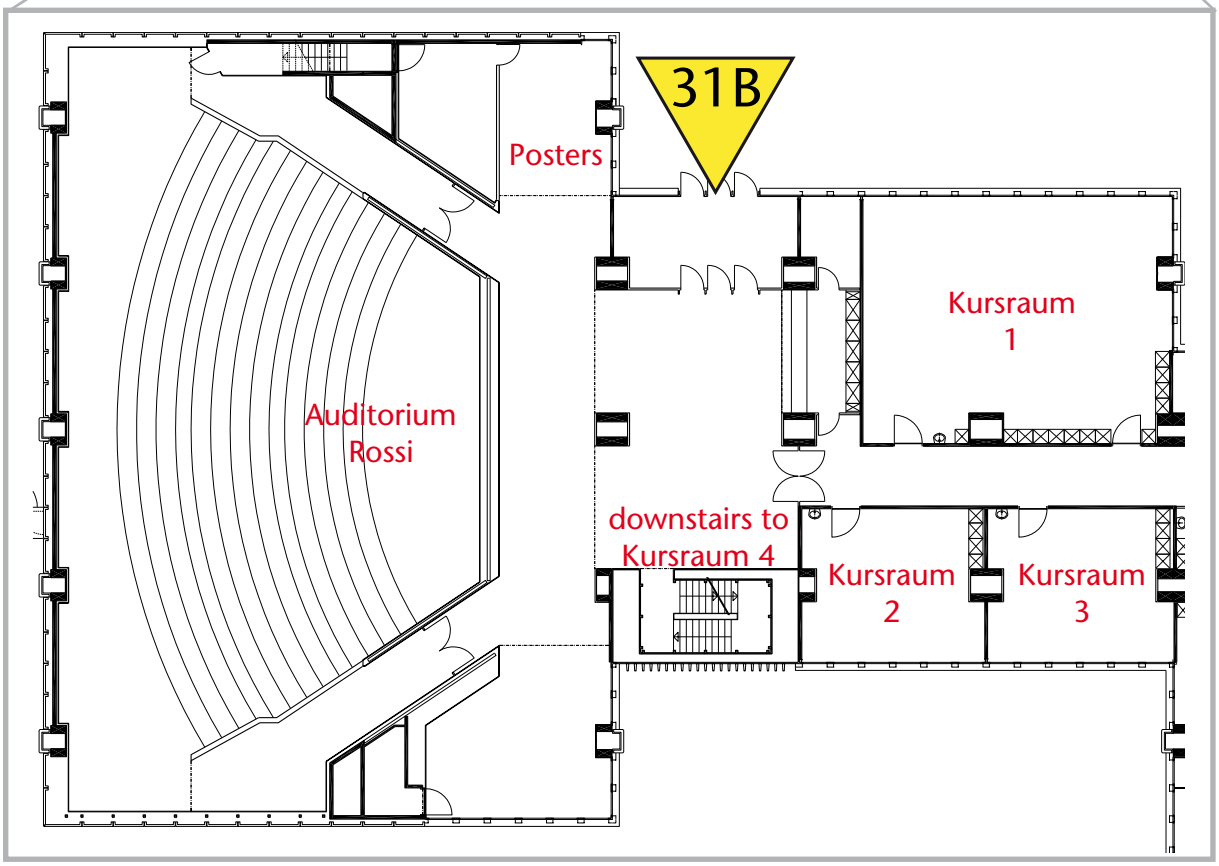



## Place of the Conference: Auditorium Rossi



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