EC RSH12

European Conference on Religion, Spirituality and Health

May 17-19, 2012
Bern, Switzerland

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EC RSH12

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Organization

Organizing Committee

- Dr. med. René Hefti (chair), Research Institute for Spirituality and Health and Psychosomatic Departement of the Clinic SGM Langenthal, Switzerland
- Dr. Stefan Rademacher, Research Institute for Spirituality and Health, Langenthal/Switzerland

Scientific Committee

Chair:

- Prof. Dr. med. Jean-Marc Burgunder, Department of Neurology, University Hospital, Berne/Switzerland

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- Riitta Bislimi, Nursing Expert, Klinik SGM Langenthal, Switzerland
- Doz. Dr. med. et scient. Raphael Bonelli, Sigmund Freud University, Vienna, Austria
- Prof. Dr. med. Arndt Büssing, Quality of Life, Spirituality and Coping; Witten/Herdecke University, Germany
- Dr. med. René Hefti, Research Institute for Spirituality and Health, Langenthal/Switzerland
- Prof. Dr. med. Peter Heusser, Chair for Theory of Medicine, Integrative and Anthroposophic Medicine, Witten/Herdecke University, Germany
- Ass. Prof. Dr. theol. Niels Christian Hvidt, University of Southern Denmark, Research Unit of Health, Man and Society, Denmark
- Ass. Prof. Kevin L. Ladd, PhD, Assoc. Department of Psychology, Indiana University South Bend, IN/USA
- Prof. Dr. med. Harold G. Koenig, Duke University Medical Center, Durham, NC/USA
- Peter La Cour, PhD, Psychologist, Researcher, Denmark
- Prof. Kenneth I. Pargament, Department of Psychology, Bowling Green State University, OH/USA
- Prof. Dr. John Swinton, School of Divinity, History and Philosophy, King's College, University of Aberdeen, UK
- Prof. Dr. Harald Walach, Institute for Transcultural Health Studies, University Viadrina Frankfurt a.d.O/ Germany
- Prof. Dr. phil. Dipl.-Psych. Karin Wilkening, Social Science, Fachhochschule Braunschweig/Wolfenbüttel, Germany

Conference Office

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Preface

Dear Conference Participants

On behalf of the Theological Faculty of the University of Bern I welcome you to the 3rd European Conference on Religion, Spirituality and Health. The particular focus of this conference is on "Spiritual Care". We're delighted to welcome experts from a range of disciplines including medicine and other health sciences, psychology and social sciences as well as theology. it is impressive to see the range of universities and countries beeing represented. There is a growing recognition that spiritual care is an important aspect of patient care and something that requires further collaboration between the disciplines. Thus, it is timely that we deepen our understanding of the connections between the various fields involved in the care of the human spirit. I trust that these days will be energizing and thought-provoking, offer some practical directions for the future and bring you an enjoyable time in our beautiful city of Bern.

Prof. Dr. Isabelle Noth
Theological Faculty of Bern

Dear Colleagues

The 3rd European Conference on Religion, Spirituality and Health will focus on Spiritual Care. The keynote-speakers approach the topic from their specific professional background, aiming to enhance the interdisciplinary dialogue between medicine, neuroscience and theology. The Bern Lecture is offered by Prof. Eckhard Frick, Professor for Spiritual Care at Ludwig-Maximilians-University in Munich. Symposia covering a broad range of topics invite discussion. Free communications allow research groups to present their research projects either orally or as posters. The best presentation given by a young researcher will be honoured by the Young Researchers Award. The conference aims to strengthen the network among researchers in the field and to promote scientific projects. A public lecture will be given by Prof. Traugott Roser.

Prof. Dr. med. Jean-Marc Burgunder
Chair Scientific Committee

Dr. med. René Hefti
Chair Organising Committee

Dr. Stefan Rademacher
Conference Office

Schedule

	Thursday May 17th	Friday May 18th	Saturday May 19th
9:00		Analysis of Reports questioning the Quality of Care for older People, *Wilfred McSherry*	Cognitive Processes & Religion: A Two-System Approach, *Fraser Watts*
		Discussion	Respondents
10:00		Coffee Break	Coffee Break
		CV Medicine and Spirituality – Consequences for Patient Care, *René Hefti*	Mental Health and the Sense of God as an Attachment Figure, *Pehr Granqvist*
11:00		Role of Religion in Patients undergoing Liver Transplantation, *Franco Bonaguidi*	Respondents
			Panel Discussion
12:00	Registration	Discussion	
		Lunch and Poster Presentation	Lunch and Poster Presentation
13:00			
		Meet the Expert	Meet the Expert
14:00	Welcome Introduction	Symposia F1 – F4 *(Kursraum 1 – 4)*	Symposia S1 – S4 *(Kursraum 1 – 4)*
	Spiritual Care in the United States – Understanding, Research and Practice, *Harold G. Koenig*		
15:00			
	Coffee Break	Coffee Break	Coffee Break
16:00	Impact and Significance of Religion & Belief in Social Work, *Sheila Furness*	Free Communication *(Kursraum 1 – 4)* 3 parallel Sessions: 1. Role of Religion & Spirituality in Care & Coping; 2. Comparing and Approaching different cultural Traditions; 3. Concepts of Spirituality in different Contexts	The Biopsychosocial Model and Spiritual Life, *Peter Verhagen*
	Discussion		Closing Session: Summary, Award, Goodbye
17:00	Disasters, Ritual and Mental Health, *Lars Danbolt*		
	Discussion		
18:00	Dinner		
		Public Lecture: Spiritual Care – Modewort, Trend oder echte Notwendigkeit? (in German) *Traugott Roser*	
19:00	Music Performance		
	Berne Lecture: Spiritual Care – How does it work? *Eckhard Frick*	Time for Questions	
20:00			
	Discussion/Respondents		
	Music Performance	Social Evening *(Restaurant Rosengarten)*	
21:00			

Keynote Speakers

Franco Bonaguidi
Dr. phil., Psychologist and tenured researcher,
Institute of Clinical Physiology, National Research Council NRC, Pisa, Italy,
www.ifc.cnr.it

Fields of Interest:
Cardiovascular disease and organ transplantation

Keynote Lecture:
Role of Religion in Patients undergoing Liver Transplantation

Lars Johan Danbolt
Adj. Prof, Dr. theol., Head of research, Center for Psychology of Religion,
Innlandet Hospital Trust, Hamar, Norway, www.religionspsykologi.no;
Norwegian School of Theology, Oslo, Norway

Fields of Interest:
Psychology of Religion, Practical Theology, memorial cultures and psychology, Ritual Studies.

Keynote Lecture:
Disasters, Ritual and Mental Health

Sheila Furness
Senior Lecturer/MA, Social Work Programme Director, Division of Social Work and Social Care, Social Sciences and Humanities, University of Bradford, UK

Fileds of interest: the impact of religion and belief on professional practice; preparing social work practitioners and students to develop cultural competence; regulation and inspection of care homes for older people and improving quality of life for older people living in care homes by involving friends and relatives

Keynote Lecture:
Impact and Significance of Religion & Belief in Social Work

Eckhard Frick
Prof., Dr. med., Professorship of Spiritual Care, Medical Faculty, University of Munich, Germany

Fields of Interest:
Psychoanalysis, Psychooncology, philosophical anthropology, psychoanalysis and palliative care

The Berne Lecture:
Spiritual Care - How Does It Work?

Traugott Roser
Prof. Dr. theol., Professur für Spiritual Care, Interdisziplinäres Zentrum für Palliativmedizin, Klinikum der Universität München, Germany, www.spiritualcare.de

Fields of Interest: SPIR: Taking a spiritual history in different health care settings, Health Care Chaplaincy, Spirituality and health care ethics, "Lebenssättigung": Conceptualizing a Theology of Spiritual Care, Spirituality and pediatric palliative medicine, Concepts of Jewish and Christian Spiritual Care, Integrating Spiritual Care in home care/outpatient Palliative Care, Sexuality and terminal illness, Health Care Ethics and Spirituality in Film, Religion in Film

Public Lecture: Spiritual Care: Modewort, Trend oder echte Notwendigkeit?

Peter J. Verhagen
psychiatrist (coordinator of the personality disorders programme group), psychotherapist, theologian; GGZ Centraal, Harderwijk, Netherlands; Chair of the World Psychiatric Association Section on Religion, Spirituality and Psychiatry; Dutch Foundation for Psychiatry and Religion; leading editor of the Dutch Journal 'Psyche & Geloof' (Psyche & Faith), www.religionandpsychiatry.com

Fields of Interest: treatments of personality disorders and the development of schema (group)therapy

Keynote Lecture:
The Biopsychosocial Model and Spiritual Life

Fraser Watts
Dr. theol, Reader in Theology and Science, Faculty of Divinity, University of Cambridge, UK

Fields of Interests:
Theology and psychology, cognitive and evolutionary theories of religion, relations and conflicts between science and religion

Keynote Lecture:
Cognitive Processes and Religion: A Two-Systems Approach

Partners and Sponsors

- Schweizerische Akademie für Psychosomatische Medizin (SAPPM)
- International Association of Psychology of Religion (IAPR)
- Klinikseelsorge Inselspital Bern
- Transdisziplinäre Arbeitsgruppe für Spiritualität und Krankheit (TASK)
- Palliativmedizin Inselspital Bern
- Departement für Integrative und Anthroposophische Medizin, Universität Witten-Herdecke
- Institut für Religiosität in Psychiatrie und Psychotherapie (RPP) Wien

- Merck-Serono

Pehr Granquist
Assoc. Prof., Department of Psychology, Stockholm University, Stockholm, Sweden

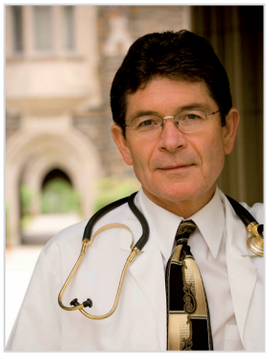
Fields of Interest:
attachment theory and research, developmental psychology, psychology of religion, evolution, aspects of health: Freedom from worry, reparation of working models, calm and confident exploration.

Keynote Lecture:
"I fear no evil for Thou art with me": Mental Health and the Sense of God as an Attachment Figure

René Hefti
Dr. med., Head of Psychosomatic Department, Clinic SGM Langenthal; Research Institute for Spirituality and Health, Langenthal/Switzerland; Lecturer, Medical Faculty, University of Bern, Switzerland

Fields of Interest: Impact of spirituality on cardiovascular diseases, mechanisms explaining beneficial effects, stress buffering and cardiovascular reactivity. Integrating religion and spirituality into psychosomatic therapy, spiritual history.

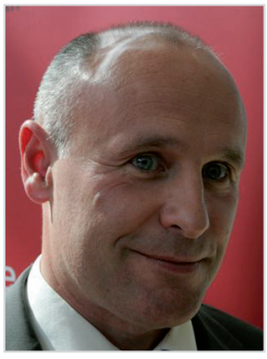
Keynote Lecture: Cardiovascular Medicine and Spirituality - State of the Art and Consequences for Care?



Harold G. Koenig
Prof. Dr. med., Duke University, Durham NC, USA; Distinguished Adjunct Professor King Abdulaziz University (KAU), Jeddah, Saudi Arabia

Board certified in general psychiatry, geriatric psychiatry and geriatric medicine and on the faculty at Duke University as professor of psychiatry and behavioral Sciences. 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.

Keynote Lecture:
Spiritual Care in the United States - Understanding, Research and Practice



Wilfred McSherry
Professor in Dignity of Care for Older People, Centre for Practice and Service Improvement, Staffordshire University/The Shrewsbury & Telford Hospital NHS, UK; Part-time Professor Haraldsplass Deaconess University College, Norway

Fields of interest: spirituality and spiritual care in nursing & health care practice; spiritual assessment in Health Care Practice; core and professional values in nursing and health care; dignity and older people; spirituality and end of life Care

Keynote Lecture: A Discursive Analysis of Reports Questioning the Quality of Care Provided to Older People in Acute National Health Service Hospitals in England: Implications for Dignity, Identity and Spirituality

Keynote Lectures
(in chronological order)

Spiritual Care in the United States - Understanding, Research and Practice

Prof. Harold G. Koenig, M.D.
Thursday May 17th, 14:30 - 15:30

After briefly reviewing the research and presenting a model to explain how spirituality affects health, Dr. Koenig will spend most of his time examining the integration of spirituality into the care of patients in the United States, and how well spiritual needs of patients are met during serious medical illness. He will explore reasons for addressing spirituality in medical care, and will report how often physicians take a spiritual history, pray with patients, support patients' religious beliefs, and discuss other ways of addressing spiritual issues in clinical practice. Finally, he will explore the boundaries across which health professionals should not cross.

Impact and Significance of Religion and Belief in Social Work

Sheila Furness, M.A.
Thursday May 17th, 16:00 - 16: 45

Religious and spiritual beliefs are of considerable significance to a large proportion of the population of people living in Britain and yet, both social work students and qualified practitioners report that such matters have largely been ignored in their professional training. This paper reports on some of the key findings of research carried out with social work practitioners and students over the past ten years. In particular, it explores the development, evaluation and ongoing revision of a framework to assist practitioners to develop a greater awareness and understanding of the importance and significance of religion and belief in the lives of service users. The framework consists of nine principles that could be applied and adapted for use by a range of health and social care professionals working in different settings and contexts. Real case examples will be used to illustrate how the framework can be applied in practice. In addition, early findings from interviews with service users will be shared about their beliefs and how and whether social workers and other care professionals were able to recognise and respond to their beliefs in the assessment and delivery of services.

Disasters, Ritual and Mental Health

Prof. Dr. theol. Lars Johan Danboldt
Thursday, May 17th, 17:00 - 17:45

During the last 25 years disaster ritualizing has emerged in Scandinavia and Northern Europe. Private ceremonies with candles, flowers, and letters on the site where a friend perished have been common, as well as public and more formal rituals like memorial services. These new public and private practices are interesting from the perspectives of ritual studies, clinical psychology of religion, and practical theology. The Scandinavian countries may be regarded as among the most secular in the world. In contrast to this view, it is interesting to observe that more people than ever before turn to the churches for ritual participation when something terrible has happened. Recent qualitative research including bereaved participants from four memorial services in Norway describes how people are searching for community, comfort and hope in ways related to the traditional sacred places. With reference to this study and the terror in Norway in the summer of 2011, I will describe and discuss ritual expressions and experiences, and the possible significance of disaster ritualizing with regard to mental health.

Berne Lecture: Spiritual Care – How Does It Work?

Prof. Dr. med. Eckhard Frick
Thursday, May 17th, 19:15 - 20:15

Spiritual Care does not "work" like most other interventions in health care that provide relief in suffering or eliminate pathologies. Much more than attaining goals, Spiritual Care means accompanying the patient's journey through presence, words, and humble acts of caring. The pivotal point of Spiritual Care is taking the patient's spiritual history, in order to put together a "diagnosis" and a strategy for therapy "outcomes" within the multiprofessional team. It is, however, not the history of an illness but a personal biography encompassing resources, needs, belongings, perhaps crisis and distress. Spirituality is a field between personal constructs and health care professionals' consensus. Part of the "diagnostic" process is understanding how the patient defines his/her spirituality. Is this spirituality part of the problem or part of the solution? Where are resources, where are individual or institutional obstacles opposed to the process of meaning making? Every team member needs basic competencies in screening for spiritual needs, in referral, and in accompanying. There are specific interventions, e.g., rituals and connecting with religious traditions. Nevertheless, even "material" surgical, medical, or nursing acts may be called "spiritual" if the caregiver is aware of the patient's spiritual quest and ready to accompany him or her. Research and evaluation in Spiritual Care should be patient-centred and take into account how and with whom the patient addresses spiritual issues. The most important "work" of Spiritual Care is discernment of spirits, accepting that spirituality remains a fragment, often far away from our ideals and in conflicts not yet resolved.

A Discursive Analysis of Reports Questioning the Quality of Care Provided to older People in Acute National Health Service Hospitals in England: Implications for Dignity, Identity and Spirituality

Prof. Dr. Wilfred McSherry
Friday, May 18th, 9:00 - 9:45

Over the last decade in England, there have been a number of reports, frameworks and strategies directed towards improving the care that older people receive within National Health Service (NHS) Acute Hospitals. Despite all this activity there are still emerging damming reports criticising the care that some older people receive while in hospital suggesting that this falls short of minimal national standards and best practice.
This paper presents the findings from a discursive analysis conducted on four reports published in England between 2009 – 2011. The findings from the analysis led to the identification of recurrent themes and concerns associated with the perceived erosion of core values in care such as compassion, dignity and empathy. Furthermore, the analysis suggests that a culture exists where individual and institutional attitudes do not recognise the humanity and individuality of many older people. The findings imply staff and organisations fail to respond with sensitivity and professionalism.
The implications of these findings are discussed within the context of preserving the dignity, identity, spiritual beliefs and values of older people while receiving acute hospital care. Some basic solutions for improving the current situation are provided and recommendations for ongoing dialogue and debate proposed.

Cardiovascular Medicine and Spirituality - State of the Art and Consequences for Patients Care?

Dr. med. René Hefti
Friday, May 18th, 10:30 - 11:15

Cardiovascular diseases are a main cause of total mortality. Religious involvement reduces mortality by 28% (HR 0.72) showing susceptibility to religious and spiritual influences. An overview is given

on epidemiological and clinical data. What are the underlying mechanisms? Behavioral aspects and psychophysiological concepts like cardiovascular reactivity reveal possible pathways. Some exciting studies support these hypotheses. Coping with heart disease and cardiac surgery is crucial in the course of illness and relies strongly on personal and social resources. Religion and spirituality can therefore be supportive in coping with cardiovascular diseases. Evidence from several studies will be presented and consequences for cardiac and spiritual care outlined.

The Role of Religion in Patients undergoing Liver Transplantation

Dr. Franco Bonaguidi
Friday, May 18th, 11:15 - 12:00

Waiting for liver transplantation is very stressful for patients. Since many of them have reported a profound return to God and spirituality, we have attempted to understand whether these religious manifestations might affect prognosis.
A group of 179 patients received a questionnaire on religiosity describing ways to face these difficulties by turning to God. After transplantation, during a follow-up period of 4 years, 18 patients died. To identify which variables predicted the survival of the patients, religious, demographic and clinical data (child-Pugh score, donor age, time of ischemia of the graft) and several variables related to surgery such as intra-operative bleeding, were tested using Cox analysis. Results show that the only variables able to predict survival after transplantation were religiosity and post-transplant length of stay in the intensive care unit. In particular, a factorial analysis of the answers to the questionnaire on religiosity showed that patients who presented an "active search for God" had a risk of death three times lower than those who did not report this experience. A passive attitude of waiting or an attitude characterized by generic trust in destiny were not associated with a prognostic advantage.
This study directly explored the relationship between the individual and God, regardless of religious creed (Christian, Muslim, or other) and church attendance. This religiosity is a personal encounter with God at a time when the patient, unable to bear painful reality, confronts his own existence.

Public Lecture: Spiritual Care – Modewort, Trend oder echte Notwendigkeit? (in German language)

Prof. Dr. theol. Traugott Roser
Friday, May 18th, 18:45 - 19:45

Spiritual Care findet – ausgehend von der Palliativmedizin – in Patientenversorgung, Forschung und Lehre im Gesundheitswesen seit einigen Jahren zunehmend Beachtung. Vieles bleibt dabei aber unklar: Worum geht es eigentlich? Was ist Spiritual Care - im Unterschied oder in Ergänzung zu Seelsorge - im herkömmlichen Sinn? Wer ist zuständig für Spiritual Care? Und wie lässt sich Spiritualität in einer pluralen Gesellschaft eigentlich bestimmen?
Der Vortrag wird in die aktuelle Literatur zu Spiritual Care einführen und anhand ausgewählter Fallbeispiele aufweisen, dass Spiritual Care nicht nur im Blick auf die Patientenversorgung in der Palliativmedizin, sondern auch in anderen Bereichen der Medizin von zentraler Bedeutung ist. Spiritual Care dient dem Schutz von Würde und Individualität des Einzelnen im Gesundheitssystem. Die immer wieder als Problem beschriebene Unschärfe des Begriffs „Spiritualität" erweist sich dabei als Vorteil.
Spiritual Care leistet aber über die Mikroebene der Begleitung des einzelnen Patienten hinaus einen wichtigen Beitrag auf der Mesoebene multiprofessioneller Teams und der Markoebene von Einrichtungen und ihren Trägern. Deshalb ist es wichtig, die Zuständigkeit für die Wahrnehmung spiritueller Bedürfnisse und Ressourcen von Patienten, Angehörigen und Betreuenden sowie die koordinierte Planung von Spiritual Care Interventionen als Aufgabe eines multiprofessionellen Teams zu begreifen und Kompetenz in Spiritual Care durch Bildungsmassnahmen zu fördern.

Cognitive Processes and Religion: A Two-Systems Approach

Prof. Dr. Fraser Watts
Saturday May 19th, 9:00 - 9:45

There is a growing consensus that humans (and only humans) have two distinct cognitive systems. That view is implicit in much psychodynamic theorising, as Wilma Bucci has made clear. From a neuroscience perspective, it has recently been popularised in Iain McGilchrist's magisterial The Mastery and his Emissary. One system is rational and analytic, the other is more holistic and intuitive. One of the most precise formulations of this distinction is that of Philip Barnard's Interacting Cognitive Subsystems. In this, there are two central subsystems concerned with meaning, a propositional subsystem that operates in a code capable of articulation and an implicational system that operates with more schematic, intuitive meanings.

There are various applications of this two-system theory to religion. It is likely that the capacity for religion was linked to the evolutionary development of these two separate meanings systems. In young children religion seems to be predominantly 'heart' religion, with 'head' religion developing later. Meditation involves switching off head-level cognition so that heart-level cognition can operate in purer form. Different forms of public worship lend themselves to being analysed in these terms, and is seen for example in the contrast between word-based Protestantism, and the non-verbal symbols of sacramental religion, and charismatic practices such as glossolalia (in which general meanings seem to give rise to articulation with little intervening propositional activity.)

"I fear no evil for Thou art with me": Mental Health and the Sense of God as an Attachment Figure

Prof. Dr. Pehr Granquist
Saturday May 19th, 10:30 - 11:15

Building on Bowlby's attachment theory, researchers have identified attachment relationships and security of attachment as important foundations for certain aspects of mental health. Drawing on a proposed link between attachment and believers' personal relationships with God, I propose that the perceived availability of God as a safe haven and secure base similarly provides a foundation for certain aspects of mental health. More specifically, I suggest that the perceived availability of God is particularly important under certain contextual conditions, such as during emotional turmoil, lack of social welfare and support, and when other attachment figures are unavailable or insufficient as security providers. I discuss four aspects of mental health that are particularly likely to be positively influenced by the sense of a personal, attachment-like relationship with God: freedom from worry, attenuation of grief, calmness and confidence in exploration, and reparation of internal working models (e.g., following loss through death and experiences of insensitive caregiving). Formal evidence is still largely absent in the empirical literature, but I marshal suggestive evidence from various sources, including cross-national surveys, questionnaire studies, and controlled subliminal experiments, to support these conjectures and help spur additional research. I conclude by suggesting that although an attachment-like relationship with God is typically a salubrious factor in relation to mental health considerations, it may also go in tandem with mental unhealth, especially for believers with an insecure attachment to God (e.g., who view God as frightening, aberrant, or inaccessible when needed the most).

The Biopsychosocial Model and Spiritual Life

Peter Verhagen
Saturday May 19th, 16:00 - 16:45

According to the WHO definition health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. In a sense the biopsychosocial model parallels this definition of health since in a biopsychosocial formulation the psychiatrist/therapist seeks the mental

health problems and their solutions in three dimensions of human experience. The WHO definition has never been changed although it has been criticized for several reasons. One theme of that criticism is the meaning of the word 'complete'. Experts tend to move from the present static formulation to a more dynamic one 'based on the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of wellbeing' (Huber et al, 2011). Such a dynamic view asks for a dynamic reformulation of the biopsychosocial model. In fact its lack of a dynamic foundation is one of the reasons of its incompleteness on a conceptual level. So we welcome a dynamic reformulation of the biopsychosocial model and would like to go a step forward. If we look at a systems theory approach we discern the three components of the biopsychosocial model as three levels of functioning and interaction between the individual and the environment. Each level has its own qualitative, sui generis causality. Causality on the biological level is different from that on the psychological level, and is different from that on the social level. At the same time there is hierarchical connection between these levels by which the special character of lower levels is preserved and opens up toward the higher levels. So, for instance, the functioning of the brain is not just localized on (or even restricted to) the biological level, but involved in a different way on the other levels of functioning and interaction as well. This saves the model from the idea that the higher levels are just products of the lower, so to say 'brain-level'.

However, even then, the model is still not complete. A spiritual component should be added. In the core the biopsychosocial model underscores the need of a holistic approach. Until now the spiritual or religious dimension has been included in the social dimension. Obviously spirituality and religiosity as practices have strong social components. However, there is more to them then just social practice. The same holds true if one would put up the spiritual dimension in (one of) the other two dimensions of the biopsychosocial model. In order to substantiate our claim we will show in what way the spiritual dimension has its own characteristics that makes it qualitatively different from the other dimensions. Research does suggest that spirituality/religiosity can be helpful for persons with physical and mental disorders and that the correlations found cannot be explained by or reduced to other psychosocial variables. So it is said, for instance, that fostering hope is helpful. Hope will be our keyword in demonstrating the qualitatively distinct, unique characteristics of the spiritual level in accordance with a new dynamic definition of health.

Symposia

F 1: Symposium for nursing professionals (in German language)

Chair: Urs Ellenberger, Friday, May 18th, 14:00 - 15:30

Grundlagen von Spiritualität in der Pflege aus der Sicht eines Pflegeexperten

Stephan Wolff, Diplom-Pflegewirt (FH),
Fachkrankenpfleger Psychiatrie, Trainer Aggressionsmanagement, Klinikum Hanau GmbH,
Geschäftsbereich Pflege- und Stationsmanagement in der Pflegeentwicklung, Deutschland

Das Thema Spiritualität ist gerade in den letzten Jahren wichtig für die Pflege geworden. Jedoch: Spiritualität wird sehr unterschiedlich definiert. Als kleinsten gemeinsamen Nenner aller Definitionen gilt die Verbundenheit zu anderen Menschen, zur Natur, zum Kosmos und zu einer höheren Macht. Der Begriff Spiritualität wird im Vortrag von den Begriffen Religion und Religiosität abgegrenzt.
Pflegende begegnen täglich Patienten, sie sich in existenziellen Lebenssituationen befinden. In diesen Situationen sollten sie sich den spirituellen Bedürfnissen ihrer Patienten zuwenden können. Wichtige theoretische Hintergründe für ein Verständnis von Spiritualität im Zusammenhang mit seelischem Leiden bieten:

- Die Psychotherapie Viktor E. Frankls (Logotherapie) beschäftigt sich damit, einen Sinn im Leben von Patienten zu beschreiben.
- Carl Gustav Jung beschreibt die Verbindung eines unbewussten übergeordneten Sinnes zu dem unbewussten Selbst, das tief in uns verborgen liegt und der Kern unseres Selbst ist. Transzendenz ist die Erweiterung des Bewusstseins von einem auf sich selbst zentrierten Ich zu einem Ich, das sich als Teil eines Ganzen versteht.
- Naturwissenschaftliche Strömungen greifen die Idee auf, dass der Kosmos als ein Ganzes betrachtet werden muss, in dem alles miteinander verbunden ist. Die Anhänger der New-Age-Bewegung behaupten, dass deshalb alles unter einem neuen Weltparadigma betrachtet werden müsse.
- Unsere moderne Welt ist durch Individualisierung, Pluralisierung und Globalisierung charakterisiert. Spiritualität ist auch ein Ausdruck für die Sehnsucht der Menschen nach Verbundenheit. Im Zusammenhang mit seelischer Not als Folge einer (schweren) Erkrankung wird dargelegt, wie Spiritualität hilft, Leiden zu bewältigen und welche Einflüsse auf die Gesundheit festgestellt wurden. Die Verbindungen von Spiritualität zu einigen Pflegetheorien werden beschrieben.

Das Thema beinhaltet aber auch Gefahren, die von spirituellen Führern oder Gruppen ausgehen, die aggressiv missionieren, fundamentale Wahrheitsansprüche vertreten oder sich einer Sprache bedienen, die extrem hohe Ansprüche formuliert. Andererseits kann man aber auch kritisieren, dass spirituelles Erleben von Gesundheitsprofis nicht ernst genommen oder gar pathologisch eingeordnet wird. Es werden ethische Grundprinzipien und Leitfragen erläutert, die dazu geeignet sind, eine eigene Haltung zum Thema Spiritualität zu formen und die Interaktion mit Patienten über das Thema Spiritualität zu gestalten.
Die spirituellen Bedürfnisse von Patienten können zu einem Teil des Pflegeprozesses werden. Ein strukturiertes Pflegeassessment untersucht die Bedürfnisse der Patienten. Es wird dargestellt wie der Pflegeprozess unter Anwendung von Pflegefachsprachen NANDA (Pflegediagnosen), NOC (Pflegeziele) und NIC (Pflegeinterventionen) dargestellt werden kann.

Ein Einblick in die Spiritualität der Pflege

Christoph von Dach
RN, MSc. Lukasklinik Arlesheim,
Switzerland

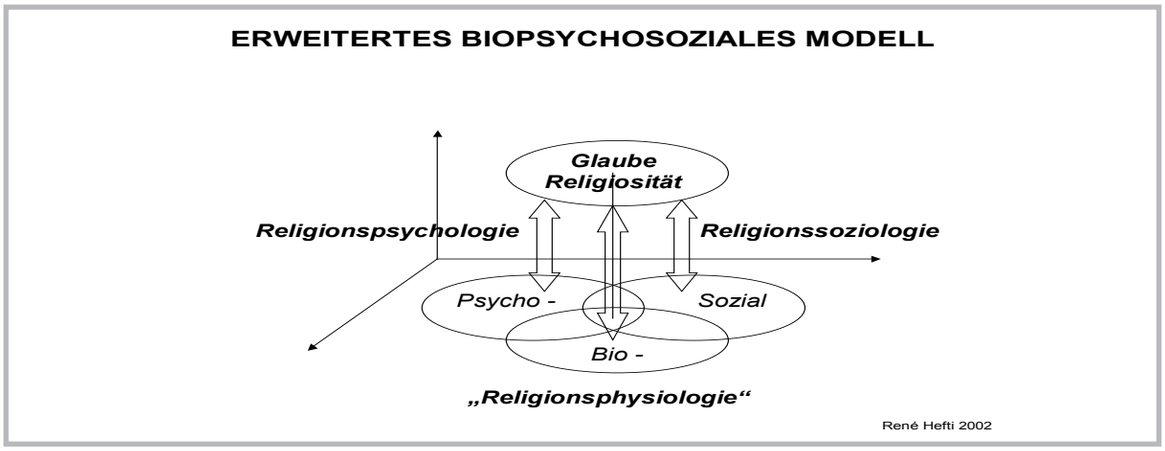
In dieser Forschungsarbeit wurden die spirituellen Vorstellungen von Pflegefachleuten der deutschen Schweiz untersucht. In einer ersten Phase wurden 13 Einzelinterviews in einem qualitativen Design durchgeführt. Die zweite Phase umfasste eine Onlinebefragung von 533 Pflegefachpersonen der deutschen Schweiz mit anschliessender quantitativer Analyse. Grundlage bildete eine Vorstudie mittels drei Gruppeninterviews in drei unterschiedlichen Institutionen (Bethesda Spital Basel, Kantonsspital Bruderholz Basel, Lukas Klinik Arlesheim) sowie eine umfangreiche Literaturanalyse. Die Ergebnisse weisen auf eine hohe Relevanz des Themas im Pflegealltag hin im Verhältnis zu sehr geringen Möglichkeiten, es im Alltag sin-

nvoll anzusprechen bzw. zu integrieren. Auch zeigt sich ein dringender Handlungsbedarf im Bereich Ausbildung und Gesundheitspolitik. Die Resultate weisen unter anderem darauf hin, dass der achtsame Umgang mit der eigenen Spiritualität eine Voraussetzung dafür ist, dass Pflegefachleute in ihrem Beruf zufrieden sind und im Beruf verweilen. Dafür müssen Bewusstsein und Räume im Pflegealltag geschaffen werden.

Spirituelle pflegerische Interventionen in einer christlichen Klinik für Psychosomatik und Psychiatrie: Praktische Darstellung der spirituellen Begleitung anhand einer Fallstudie

Riitta Bislimi
Nursing Expert, Klinik SGM Langenthal, Schweiz

In einer Fachklinik für Psychosomatik und Psychiatrie mit christlichem Leitbild, deren Therapiekonzept auf einem ganzheitlichen Menschenbild basiert, gehört die spirituelle Begleitung von Patientinnen und Patienten als fester Bestandteil zum pflegerischen Alltag. Bei gläubigen Patientinnen und Patienten stellt sich die Frage, wie eine solche Begleitung konkret gestaltet werden kann. Welche Interventionen haben sich wann und bei welchen Fragen als besonders hilfreich erwiesen?
Anhand eines Fallbeispiels einer 30-jährigen, allein erziehenden Mutter mit Erschöpfungsdepression und Hochsensibilität wird aufgezeigt, wie ihr Glaube durch pflegerische Interventionen unterstützt und als Ressource in die Pflege und Behandlung integriert werden konnte. Beim Klinikeintritt hatte sich die Patientin gerade von ihrem Partner getrennt. Sie hatte weder Wohnung noch Arbeit und war mit der Pflege ihrer dreijährigen Tochter überfordert. Im Laufe des zwölfwöchigen stationären Aufenthaltes durchlebte sie einen intensiven Prozess, der zur Vertiefung und Reifung ihres Glaubens beitrug und sie dazu befähigte, wichtige Entscheidungen für sich und ihre Tochter zu treffen. Auf diesem Weg wurde sie engmaschig durch das Pflegeteam begleitet.



F 2: Assessment of Competency in Spiritual Care Provision

Chair: Peter La Cour; Friday May 18th, 14:00 - 15:30

Spiritual Care in a Clinical Setting

Prof. Dr. Donia Baldacchino
Senior Lecturer, Coordinator of Research & M.Sc. Nursing Programme,
Faculty of Health Sciences, University of Malta, Malta

Spiritual care integrates the physical and psychosocial care to address client's needs holistically. Research suggests various definitions of spiritual care which include the "doing" and the "being" dimensions of care. Being refers to the personal spirituality of the care-givers which enables the therapeutic use of self in care by means of their active presence to clients. Thus, delivery of spiritual care incorporates

"being in doing". Illness may increase the individual's awareness of their own personal spirituality. The aim of spiritual care is to help clients to find meaning and purpose in life which may lead to spiritual well-being even in times of suffering. The care-giver's commitment towards providing active presence in care, may leave a positive impact on client's health. Research shows that when clinical experience is considered as a reflective journey, care-givers may acknowledge that while giving care to clients, they may also be on the receiving end. This paper presents research and the clinical model RESPECT of client's assessment of spiritual needs. Spiritual care may yield therapeutic and holistic effects on both the client and the care-giver.

A Framework of Competencies in Spiritual Care for Nurses and Midwives

Josephine Attard
Ass. Lecturer, Dep. of Midwifery, Faculty of Health Sciences, University of Malta
Malta

Spiritual care was identified by nursing and midwifery educational and professional bodies and research as an area that merits competence at point of registration. The discrepancy between the teaching of spiritual care and its delivery in clinical practice proposes the need for the development of a framework of competencies in spiritual care in order to equip nursing and midwifery students in meeting client's spiritual needs. The research study adopting a mixed method approach is conducted under the supervision of the University of Glamorgan and University of Malta. The study aims to develop a set of competencies drafted from a systematic literature review and focus groups utilizing case scenario approach in order to identify what nurses/midwives need to know, be able to do, or think, in order to meet the spiritual needs of the clients. The identified competencies in spiritual care will undergo expert scrutiny through a Modified Delphi Method approach. This will be followed by a consultation process with nursing and midwifery organizations in Europe to ascertain views, agreement or non-agreement on identified competency items and identify factors that facilitate or hinder the integration of the framework in nursing and midwifery education and clinical practice. It is hoped that this study will prevent assumptions regarding spiritual care, guide the education and professional sectors and equip the nurses and midwives with the necessary knowledge, skills and attitudes in spiritual care at point of registration.

F 3: Spiritual Needs

Chair: Arndt Büssing; Friday May 18th, 14:00 - 15:30

Spiritual Needs of Patients with Chronic Pain Diseases and Cancer

Prof. Dr. med. Arndt Büssing
Quality of Life, Spirituality and Coping; Witten/Herdecke University,
Germany

It is remarkable that spiritual needs are in most cases not regarded as an issue of the health care system. Not surprisingly, several patients report unmet spiritual needs. We intended to analyse which needs are of relevance for patients with chronic pain diseases and cancer, and which variables may predict them. In an anonymous cross-sectional study with standardized questionnaires (i.e., SpNQ, IIQ, BMLSS) we enrolled 285 patients (67.5% women; mean age 55 ± 14 years; 73% chronic pain, 20% cancer, 7% other). As measured with the Spiritual Needs Questionnaire (SpNQ), patient's needs for Inner Peace and Actively Giving/Generativity were expressed high, while their Religious Needs or Existential Needs were low. Regression models indicate that interpretation of diseases as "Value" and reduced life satisfaction were relevant predictors of these needs. However, patient's symptom score (VAS) or gender were not among the significant predictors. Apart from obvious needs to achieve states of inner peace and well-being, particularly Actively Giving/Generativity was of importance because it represents patient's intention to leave the role model of a 'passive sufferer' to become an active, self-actualizing giving individual. When these needs are identified, health care professionals and patient's relatives have the chance to react and support patients in their struggle with chronic illness.

Spiritual Needs of Patients in Psychiatry and Psychotherapy and their Utilization of Spirituality/Religiosity to Cope

Franz Reiser, Lic. psych.
Minister, Freiburg i. Bg., Germany

A clinical overview study at the University Clinic for Psychiatry and Psychotherapy at Freiburg/Germany has set out to survey psychiatric patient's spiritual and religious attitudes and practices, their spiritual needs and expectations towards the clinic and its personnel. For one and a half years, all new inpatients have received a questionnaire at the beginning and at the end of their clinical stay. Some first results will be presented. It seems that religion and spirituality are of importance for a significant part of patients, both generally and in relation to their disorder. A considerable amount of patients wishes that these dimensions are also addressed by the clinic staff. Further, spiritual needs as operationalized by the "Spiritual Needs Questionnaire" (Büssing) seem to represent an important distinguishable aspect of personality.

Spiritual Needs of Elderly in Retirement Homes and their Associations with Quality of Life

Nora-Beata Erichsen, MA
Kiel, Germany

Elderly who are not able to live in their familiar environment anymore, often suffer from the changes in their social surroundings and the loss of their previous role and self-determined way of life. It is already acknowledged that mostly self-realization and -identification, general questions on meaning of life as well as social membership and acceptance receive too little attention in everyday care and contact.
We intended to analyze the psychosocial and spiritual needs of elderly living in residential care homes, retirement and nursing homes, particularly. (1) Wherein do they find support, sense and meaning? (2) Are their needs recognized and satisfied? (3) Are there associations between these needs and their quality of life/life satisfaction? To address these questions, we started an anonymous survey using qualitative interviews/validated questionnaires among elderly living in those facilities and homes in Northern Germany. First results will be presented.

F 4: Spirituality: Definitions and Concepts in Historical and Philosophical Perspective

Chair: Kevin L. Ladd; Friday May 18th, 14:00 - 15:30

The History of the Concept of Spirituality

Dr. theol. Niels Christian Hvidt
Ass. Prof., University of Southern Denmark, Research Unit of Health, Man and Society, Denmark

In this presentation, I will focus on the history of the concept of spirituality. He will relate its roots in Western Theology, back to the Ancient Church were spirit as God-inhabited life contrasted carnal (sarx) as its opposite, leading to death. In the middle ages the dichotomy changed to signify the split between spiritual and material. Although the concept of spirituality thus has different historical roots it only emerged as a frequently used term in theology in 20th Century French Catholic Theology with the creation of the Dictionnaire de Spiritualité were it came to indicate a distinction between lived and dogmatic faith, before it became a fashionable concept in psychology of religion and, in particular, health-related literature. On the background of this historical presentation, I will problematize some studies on how the concepts of religiosity and spirituality are conceptualized in contemporary research literature on spirituality and

health often. In this overview it will become clear that there is a growing tendency of opposing religiosity and spirituality that was not found earlier in the historical development of the concept of spirituality. Furthermore, that the concept of spirituality has emerged as the overarching term proposed to contain both secular existential, spiritual and religious dimensions. Although such broadness may be beneficial for clinical practice where a concept apt for dialogue is warranted, its fuzziness make it less useful as a research term.

Spirituality in Cultural Historical Perspective

Dr. Herman Westerink
Department for Practical Theology and Psychology of Religion, Protestant Theological Faculty, University of Vienna, Austria

The emergence of the concept of spirituality in the psychology of religion is closely related to the decreasing importance of traditional religious institutions and religiosity as commitment to traditional contents of belief on the one hand, and the increase of the importance of individual spirituality in (post-) modern, secular societies on the other hand. The concept of spirituality is mostly defined in a broad and even vague way: it indicates a concern with personal life principles and ultimate questions about life's meaning in relation to the transcendent or (whatever one may consider) the sacred/divine. The apparent vagueness and broadness of the concept of spirituality is related to the different meanings of the concept in different intellectual and religious contexts, and subsequently, to different valuations of spirituality in relation to religion and lived religiosity – spirituality can be associated with what the theologians traditionally identified as fides qua (the mental act of believing), but also with a variety of non-Christian religious practices and experiences (yoga, meditation, etc.) in esotericism and New Age. The concept of spirituality includes and expresses both aspects of traditional faith as well as religion critique and post-religious, secular-existential beliefs, intuitions and practices.
In this paper the ambiguous, polyvalent and multidimensional concept of spirituality is described from a cultural-historic perspective, and related to the emergence and further development of the psychology of religion as scientific discipline. On the one hand, the growing interest in spirituality mirrors the on-going secularization process and the emancipation of the psychology of religion from theological discourse and theological institutions. On the other hand, the psychology of religion is still closely connected to a modern theological project of establishing true and healthy religious/spiritual worldviews in an era of strong decline of church authority and commitment to dogmas and creeds.

S 1: Spiritual Care in Psychiatry

Chair: Eckhard Frick; Saturday May 19th, 14:00 - 15:30

Mental Disorders, Religion and Spirituality 1990 to 2010: A Systematic Evidence-based Review

Prof. Dr. med. et scient. Raphael Bonelli
Univ.-Dozent, University of Salzburg/Vienna; Sigmund-Freud-University, Austria

Objective: Religion/spirituality has been increasingly examined in medical research during the past two decades. Despite the increasing number of published studies, a systematic evidence based review of the available data in the field of psychiatry has not been done during the last 20 years.
Method: The literature was searched using Pubmed (1990 –2010). We examined original research on religion, religiosity, spirituality, and related terms published in the top 25% of psychiatry and neurology journals according to the ISI journals citation index 2010. Most studies focused on religion or religiosity, and only 7% involved interventions.
Results: Among the 43 publications that met these criteria, thirty-one (72.1%) found a relationship between level of religious/spiritual involvement and less mental disorder (positive), eight (18.6%) found mixed results (positive and negative), and two (4.7%) reported more mental disorder (negative). All studies on dementia, suicide and stress-related disorders found a positive association, as well as 79% and 67% of the papers on depression and substance

abuse, respectively. In contrast, findings from the few studies in schizophrenia were mixed, and in bipolar disorder, indicated no association or a negative one.
Conclusions: There is good evidence that religious involvement is correlated with better mental health in the areas of depression, substance abuse, and suicide; some evidence in stress-related disorders and dementia; insufficient evidence in bipolar disorder and schizophrenia, and no data in many other mental disorders.

God's Image, Attachement's Figures and Psychosis

Dr. Philippe Huguelet,
Responsable du Secteur Eaux-Vives, University Hospital of Geneva and University of Geneva, Switzerland

In Bowlby's normative attachment conceptualization, the term "attachment relationship" does not refer to any type of close relationship but exclusively to those that meet four criteria: proximity maintenance, safe haven, secure base, and separation distress. The present study is based on the assumption that these four criteria are reasonably met as concerns the relationship of the believer with a spiritual object/figure. Two different modes of psychological coherence related to spiritual/religious coping have been described. The correspondence hypothesis suggests that there is a correspondence between early child-parents interactions on the one hand and a person's ability to cope in relation to a spiritual object/figure on the other. According to this hypothesis, a secure attachment history would enable a person to use a spiritual/religious object/figure as an attachment figure, which proximity would help regulate affects. The compensation hypothesis suggests that an insecure attachment history would lead to a strong religiousness/spirituality as a compensation of the lack of felt security.
Thirty patients with schizophrenia or schizo-affective disorder and 20 healthy controls were interviewed in order to measure their attachment style (AAI interview and coding method), and to explore their relation to a spiritual figure as a form of spiritual coping (semi-directive interview). Qualitative and quantitative results of this study will be presented in this conference.

Adressing the Spiritual Needs of Patients with Chronic Psychiatric Disorders

Sylvia Mohr, PhD
psycholgist, Adult Psychiatric Service of the Department of Mental Health and Psychiatry, University Hospital Geneva, Switzerland

The relevance of spirituality and religious coping practices (S/R) to people with severe mental disorders is even greater than the general population. S/R may be adaptive (a resource for recovery), or not (a source of despair and suffering). In a previous study, psychiatrists assessed S/R to their own patients. It elicits major spiritual themes which could be integrated into care. However, we didn't assess patients' wishes. This is the aim of the present study.
Method: The five psychiatrists of an outpatient psychiatric clinic in Geneva asked consecutively their patients about their wish to integrate S/R into their care; with who they share their spiritual concerns; and if they wish to discuss this issue with a psychologist leading the psycho-therapeutic group" spirituality and recovery" of the clinic.
Results: Among the 147 outpatients with severe mental disorders included in the study, less than half of them share their spiritual concerns with other people: chaplain (7%), a religious professional of their community faith (9%), psychiatrist (3%), or only relatives (24%). A quarter of patients wish the psychiatrist to address spiritual issues in their care, a third of them both with a religious professional, and 8% do not wish to address spiritual issues in their care, currently sharing this issue with a religious professional. 16% wish to meet the psychologist. The "spirituality and recovery" group was a psychotherapeutic indication for 11% of patients, other therapeutic objectives were more appropriate for 5%.
Discussion: The main result is that for one patient out of ten, S/R issues were of clinical significance to be integrated into treatment, such as supporting adaptive S/R, working on identity and value, disentangling psychotic symptoms from faith, linking the patient with a religious professional, addressing negative S/R. Integration of S/R into psychiatric care ranges from referral to chaplain, exploration of spirituality in individual and group psychotherapies, bringing in spiritual concepts and practices into psychotherapies, to holistic care programs. When the patient express spiritual needs and wants them to be addressed by a religious professional, the integration of spirituality requires collaboration with the chaplaincy service or

other relevant religious professional. Some patients wish to address spiritual issues with mental health professional only. Psychotherapies may be tailored to meet the special needs of patients.

S 2: Spirituality: Definitions and Concepts in Empirical Data

Chair: Niels Christian Hvidt; Saturday, May 19th, ATTENTION: 13:00 - 14:30

What is the Meaning of the Word "Spirituality"? Present Perception of Spirituality - an Empirical Danish Investigation

Peter La Cour, PhD
Health Psychologist, Rigshospitalet, Copenhagen, Denmark

Background: The word "spirituality" is a very frequently used concept in modern psychology of religion. However, it is quite clear that there is no common understanding of what this term stands for, and no common definition. It might even be the case that the term has different meanings in different countries and cultures. Thus, for example in the United States the concept can be opposed to the concept of religiosity (eg "I am spiritual but not religious") while in Catholic countries, the term is often understood as the "inner" side of the ordinary religious life. In Lutheran Denmark, the concept might mainly to be related to alternative environments and alternative medicine. We wanted to find the common understandings of the term spirituality in our country, Denmark.
Method and material: A broad and systematic collected list of known definitions of "spirituality" was formed, and 15 strategically selected informants were asked to freely express what they associated with the word spirituality. The resulting lists of 115 items were placed in alphabetical order (content-random order) in a final questionnaire. 415 Danes were asked to mark the meanings of the word spirituality for them as private persons (eg, mystery, holiness, alternative, harmony, etc).
Results: Answers to the questionnaire were processed with statistical cluster analysis. A four factor structure was evident, suggesting four distinct understandings of spirituality in Denmark: 1. Something very positive connected with attractive feelings and well-being, 2. New Age-ideology, 3. Non-religious, deep feelings, 4. Something negative and self-centered. Statistical analysis has not yet finished.
Follow-up: We are planning in similar ways to investigate the common meanings of the concepts of "religiosity" and "secular." We hopefully invite colleagues from other countries to make similar research for international comparison.

Spirituality and Religion – Convergences and Divergences in Beliefs, Practices, and Experiences. Analyses on the Basis of the worldwide Religion Monitor

Constantin Klein, Dipl.-Psych, Dipl.-Theol., (with Stefan Huber)
Center for interdisciplinary Research on Religion and Society, University of Bielefeld, Germany

In the social sciences changes in the religious sphere have traditionally been described in terms of secularization (e. g. Weber, 1917), privatization (e. g. Luckmann, 1967), and pluralization (e. g. Berger, 1980). In recent years, a growing number of scholars have also postulated a replacement of traditional religiosity by forms of personal spirituality (Knoblauch, 2009), a process which has been described, for instance, as "spiritual turn" (Houtman & Aupers, 2007) or as "spiritual revolution" (Heelas & Woodhead, 2005).
Research on subjective meanings and correlates of a self-attribution as being "spiritual", however, shows that the majority of people express their spirituality in continuity with their religiosity (e. g. Marler & Hadaway, 2002; Zinnbauer et al., 1997). Thus, the question arises whether being "spiritual" expresses anything else than being "religious" or whether spirituality is merely a synonym for religiosity. To answer this question it is necessary to investigate which experiences and behavior (beliefs, practices, emotions, affiliations etc.) relate to the self-attributions as spiritual or religious, respectively.
To shed some light on the diverse meanings of spirituality and religiosity, we have used the data of the worldwide Religion Monitor survey (Bertelsmann Foundation 2007, 2009) including representative datasets for 21 countries and have compared patterns of expressions of spirituality and religiosity. We found that in most countries a majority of people express their spirituality converging with their re-

ligiosity. The percentage of people without religious affiliation who call themselves spiritual (but not religious) differs strongly between cultures and seems to be a particular phenomenon of the western world. A comparison of people who can be classified either as exclusively spiritual, exclusively religious, both spiritual and religious or neither nor shows that the behavioral and experiential patterns of those considered as exclusively spiritual resemble strongly those who have been identified as neither religious nor spiritual, except that the former perform significant more meditation practices. The most intensive experiences and behavior, however, could be found among the group of the both spiritual and religious people.

S 3: Spiritual Care: Practical Aspects

Chair: Donia Baldacchino, Saturday, May 19th, 14:00 - 15:30

The Spiritual Ground of Gestalt Psychotherapy

Therese Bugeja, BSc (Hons)(Nurs.Stud.),P.G.Dip. (Educ.),MSc (Hlth.Educ.), P.G.Dip. Psychotherapy,S.R.N., Assistant Lecturer Nursing
Faculty of Health Sciences, Mater Dei Hospital, University of Malta, Malta

Some people may think that spirituality does not belong to psychotherapy and therapists may only deal with the emotional, behavioural, social, and cognitive aspects of life. While this may be true for some therapists, it is not true for all. Although some therapists know and value the spiritual dimension of life, they may wait for it to emerge from the client and may not initiate the discussion themselves, leaving the impression that it is not part of the process. Yet other therapists will not deal with it at all, or will deal with it insofar as it relates to the client's overall psychological and social functioning. By the same token, some clients will not bring it up unless the therapist does, thus leaving the impression that it is not part of their life. Nevertheless, spirituality is a valid dimension that needs to be considered by therapists since it may be intricately connected to client's issues and the reason they come to therapy. For all these reasons, this paper explores the connections between a Gestalt approach and spirituality. A number of concepts which make up this spiritual ground will be explained. I want to emphasize that these concepts are not separable and distinguishable from each other, but they are like faces of the same diamond - each and every one describes one aspect of the complex spiritual ground of Gestalt psychotherapy.

Prayer and Pain: The Mediating Role of Positive Re-Appraisals

Dr. Jessie Dezutter
Junior Researcher, University of Leuven
Belgium

Background: The present study explored the role of prayer as a possible individual factor in pain management. Framed in the transactional theory of stress and coping we tested first, whether prayer was related with pain severity and pain tolerance and second, whether cognitive positive re-appraisal was a mediating mechanism in the association between prayer and pain. We expected that prayer would be related to pain tolerance in reducing the impact of the pain on patient's daily life, but not necessarily to pain severity. Furthermore, we assume that positive re-appraisal can be an underlying mechanism in this association.
Methods: A cross-sectional questionnaire design was adopted in order to measure demographics, prayer, pain outcomes (i.e. pain severity and pain tolerance), and cognitive positive re-appraisal. Two hundred and two chronic pain (CP) patients, all members of a national patients association, completed the questionnaires.
Results: Correlational analyses showed that prayer was significantly related with pain tolerance, but not with pain severity. Furthermore, mediation analysis revealed that cognitive positive re-appraisal was indeed an underlying mechanism in the relationship between prayer and pain tolerance.
Conclusion: This study affirms the importance to distinguish between pain outcomes and indicates that prayer is especially important for pain tolerance. Further, the findings can be framed within the transactional theory of stress and coping and the results indicate that positive re-appraisal might be an important underlying mechanism in the association between prayer and pain.

Critical Thoughts on the Role of Prayer in Spiritual Care

Kevin L. Ladd, PhD, Ass. Prof. of Psychology,
Indiana University, South Bend, Indiana,
USA

The practice of prayer is central to the identity of theistic faith traditions. Its multiple dimensions span the wide range of faith-based experiences from the greatest joy to the deepest sorrow. It is natural, then, to think about incorporating prayer into moments of spiritual care. The challenge with this practice is that most spiritual care is unidimensional; it occurs during times of crisis. In other words, prayer is most often invoked as part of spiritual care when strong desires and expectations are coupled with weakened resources for critical thinking and preparation. Under these conditions, the nature of prayer is easily distorted by both caregiver and care receiver. For instance, prayer may be engaged as a "last resort" or as a "tool" for coping. This paper articulates these and other challenges, then offers potential correctives. Among the possibilities suggested for engaging the fullness of prayer include conceptualizing prayer as a visual and embodied state that is not a singular action but rather a lifestyle.

S 4: Spirituality and Coping with Disease

Chair: René Hefti; Saturday, May 19th, 14:00 - 15:30

Nature as the Most Important Coping Strategy with Cancer: A Swedish Survey

Prof. Dr. soc. Fereshteh Ahmadi
Department of Social Work and Psychology, Faculty of Health and Occupational Studies
University of Gävle, Sweden

Based on the findings of a qualitative study among cancer patients in Sweden (Ahmadi 2006), the authors have conducted a quantitative survey to examine to what extent the results are applicable to a wider population of cancer patients in Sweden. In addition to questions relating to the former qualitative study we have also used the RCOPE questionaire - designed by Kenneth I Pargament in the design of the new quantitative study. In this study, questionnaires are distributed among persons who are/were diagnosed with cancer in Sweden.

The study sample consisted of 2417 cancer patients (79 % women and 21 % men). Almost a third (29 %) of those who responded to the survey is 59 years old or younger; there are more (38 %) aged between 60 and 69 years. One third (33 %) are 70 years or older people.

The results show that nature has been the most important coping method among cancer patients.

The highest mean value (2.9) is the factor "that nature has been an important resource to you so that you could deal with your illness "; Two out of three of the respondents (68 %) respond that this method in a large or quite a large extent helped them feel better during or after illness.

The second highest mean value (2.8) is the factor "Listening to 'natural music '(birdsong and the wind) "; Two out of three of the respondents (66 %) answered that this coping method in a large or quite a large extent helped them feel better during illness.

In third place with the third highest mean value (2.7) is "To walk or engage in any activity outdoors gives you a spiritual sense."

The outcomes of the survey study concerning the role of the nature as the most important coping method with cancer confirms the result obtained from the previous qualitative studies.

The Role of Spirituality and Religion among People living with HIV/AIDS: Preliminary Results from Nigeria

Alex Asiktikpi, PhD
Lecturer, Department of Sociology, Covenant University, Nigeria

HIV/AIDS still poses a great health challenge in Africa and the burden of the disease is highest in sub-Saharan Africa where 25 million of the estimated 35 million infected people reside (UNAIDS/WHO, 2009).

In Nigeria, of the 3.8 million people infected only a fraction of that number have access to anti-retroviral drugs and other formal therapies while majority of people living with HIV/AIDS (PLWHA) are left to fend for themselves. The pervasive nature of religion in Nigeria and the social bonds it creates makes it a veritable platform on which PLWHAs may want to explore to cope with their new identity. Consequently, it is hypothesized in this study that PLWHAs who use SpR as a tool to adjust to their new identity would cope better with the disease and act more responsibly while those who do not use religion as an important source for coping will cope negatively. The study employed a triangulation methodology comprising focus group discussions, in-depth interviews and survey. Over two thousand PLWHAs drawn from the six geo-political zones of the country have been scheduled to participate in the study through their local networks, but so far less than 1000 have responded with more data being expected. However, preliminary analysis of data so far obtained suggests a complex relationship between religion, spirituality and health care, while univariate analysis also shows significant relationship with some key variables including age and sex.

Spiritual Care on the Edge

Ingrid Zürcher, supervisor and co-leader of the unit Spiritual Care, &
Patrick Mösli, pastoral minister, Berne University Hospital, Switzerland

Patients in a coma or similar condition experience unusual mental states which they can not communicate in a well-known way. How can physicians, nurses, pastors and other professionals get in contact with them? Are there forms of communication fitting and supportive for patients and their close ones which can even positively influence the chances of healing? The concept "Dreamland Intensive Care Unit" will be presented in this workshop and the pastoral experiences in work with patients, their close ones and coworkers in the university clinic will also be spoken of and discussed.

Pre-Conference Workshop

with Prof. Dr. med. Harold. G. Koenig, May 13-16, 2012

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

Many topics of this workshop are accessible in:
Koenig, HG (2011): Spirituality and Health Reserach: Methods, Measurements, Statistics, and Ressources.

Free Communications

All free communications will take place on Friday, May 18th, 16:00 - 17:30

Session 1: The Role of Religion and Spirituality in Hospice Work and End of Life Care

Spiritual Care at the End of Life: Meaning and Practice

Jaqueline Watts
Senion Lecturer, The Open University, London
UK

The spiritual welfare of dying people has in recent years moved from the domain of religion to become the concern of health care professionals, particularly as part of the ideal of holism that underpins palliative care. Professional delivery of spiritual care incorporates the features of assessment, control and treatment which may involve varying degrees of intrusion into the patient's deeply personal inner self. Using a case study approach, this paper explores meanings of spirituality and understandings of what is meant by the term "spiritual care". It argues that biographical and community approaches to spiritual care of dying people may be more congruent with the concept of the "whole person" because this support is rooted in an intimate contextual knowledge of the dying person by the caregiver. This challenges the dominant discourses of professional expertise to embrace informal personal and collective competence in this important aspect of end of life care. Biographical components of spiritual care may mean that, for some, this can only be successfully provided by those who have intimate and longstanding connections to the dying person. This essentially relational and ontologically based perception of spiritual care may present challenges to health care professionals whose relationship with their patients is inevitably instrumental and institutionally directed by virtue of the "sick predicament" of the patient, placing them, as professionals, in an only brief and transitory spiritual stakeholder role (Wright, 2004).

Making Life Rather than Making Sense: Integration of Spirituality into the Daily Practices in a Hospice

Wai Leng Tong
School of Health and Human Sciences, University of Essex, Colchester,
UK

Although the interest in spirituality research was growing in the field of healthcare, less was known about the particular practices of spirituality and how multi-disciplinary professionals of an interdisciplinary care team, volunteers and administrators integrate spirituality into the daily practices. This interpretive qualitative study was conducted in Hospice Benedict in the county of Essex in United Kingdom (UK), exploring the experience and understanding the insight about spirituality and spiritual care as seen through the eyes of the people who worked in Hospice Benedict, exploring the nature and problems they may have experienced in their daily practices, how they coped and most importantly, their contributions in the care for the terminally ill, dying and their families and friends. Most participants have had previous experiences of receiving care or of friends and families being cared for in a hospice. Most participants came from Christian faith traditions of varied denominations. I analysed the data by first looking at how the participants conceptualised their sense of spirituality and then examined how they incorporated those concepts which were central to them into their daily practices. I looked for common themes as well as differences in terms of what a person emphazised, the language each person used and how each person made sense of these phenomena. My research yielded three dominant concepts of spirituality. These participants experienced spirituality as journeying with, being connected and developing relationships through the gift of time. An understanding of the constructs of spirituality evolved from the data provide meaning to the daily practices of multi-disciplinary professionals of an interdisciplinary care team, volunteers and administrators and also was used to guide clinical, organizational changes and the development of the new educational program on spirituality and spiritual care in Hospice Benedict.

Perspectives on Religion and Spirituality in Hospice Palliative Care

Dr. Harold Coward
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Since the 1960s, the hospice movement, with its philosophy of dignity and compassionate care for the terminally ill, has gained widespread recognition as a model of choice for end-of-life care. Evolving out of the Christian roots of the British health care system, early hospice centres emphasized the importance of "spiritual care" of the dying. Over time however, in the technologically advanced and culturally diverse milieu of modern medical care, the religious and spiritual aspects of hospice care have frequently given way to more secularized concerns and approaches. This has resulted in a serious gap in scholarly literature in the field. To date, little has been written about the religious and spiritual dimensions of hospice care, even though this continues to be important in practice. Those who work in hospice palliative care and beyond are in need of better information on care for the dying for whom religion and spirituality are important aspects of their life. This presentation will focus on findings from two major studies: (1) how the major world religions understand a "good death" in hospice care; and (2) approaches needed for those who are "spiritual but not religious" or atheist/agnostic as they approach death. The results will allow hospice palliative care doctors, nurses, social workers, chaplains and volunteers to better meet the religious and spiritual needs of the dying person and his or her family.

Session 2: Theorizing the Field

What Does Spirituality Really Mean? A Historical and Etymological Review of the Word

Alireza Mohsenian Sisakht, Najmeh Karamzadeh Ziarati
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Iran

Nowadays spirit and its effects on physical health attract physicians and health researchers' attention. While analytical evaluation of published articles in this field shows diversity in the definition of the word "Spirit", an accurate historical and etymological survey of the meaning of this word determines that in religions like Islam, Christianity, Judaism, etc, and also ideologies like Eastern, Western and other ideologies, a common root with a unique and deep meaning exists, neglecting which may cause confusion in this field. We are trying to show this unity in this research paper.

Religiosity, Religiousness and Spirituality from a Cognitive Religious Science Perspective

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Results of research in evolutionary and cognitive religious science could reveal that religious belief (or, more exactly: spiritual belief) is an inevitable consequence of the development of the human brain. Successfully operating religious systems satisfy different needs of man, mediated by rituals, ideas of morality, metaphysics and social identity. The combination of affective and cognitive components seems to play a major role in religious and spiritual learning. The human brain ensures that man does believe. Unbelief and scepticism are symptoms of a stressful struggle against natural cognitive dispositions. On the grounds of a cognitive religious science with taking account of the evolutionary aspects of socio-psychological observations, psychology and results of latest brain research it should be possible to make a differentiation between religiosity, religiousness and spirituality. Contemporary concepts of spirituality are often vaguely or they are using religious axioms as a matrix, representing theoretical frameworks of specific religions, both not suitable for a scientific discourse. Without a clear definition of spirituality shared by the broader scholar community; a scientific discourse seems not to be successful. A new definition and conceptualization of spirituality has to encompass spirituality in a non-religious

context too, it should be acceptable for religious as well as non-religious but spiritual people; therefore reasonable for representatives of an agnostic and/or atheistic philosophical background. The article tries to elucidate the necessity for differentiation between a perhaps inherited general spirituality/religiosity and a may be individual spiritualness/religiousness. A preliminary model will be presented; nevertheless a conceptualization of spirituality at present time is still a "process in work".

The Role of Spirituality on Health: The Role of Spirituality in the Consonance between Cardiac Coherence and Brain Coherence

Prof. Dr. Viorica Ernest Ungureanu
President of the International Association of Medicine & Travel, Romania

The essence of humankind's spiritual adventure is related to comprehending the experience of global knowledge. The cosmic-religious level is a bio-psycho-social component. Oscilating between matter and spirit, between science and faith, the human being structurally reflects polarizing foci: sacred/profane, divine/human, spirit/matter, faith/reason, science/religion.
Science is close to consciensce, iots is a state of conscience when it acts – or ought to act – towards the welfare of humankind. When the truth of conceptual knowledge identifies itself with the transcendent truth, within the science-faith interrelatedness, reason consolidates faith and faith strengthens reason.
At present, the progress in medicine, physics, biology, genetics, astrophyics certifies the existence of that "possible reality", as Heisenberg would call it, the so-called invisible reality, as complex as the corporeal world, with which it is closely interrelated. The discoveries in the field of the physics of elementary particles and of genetic engineering bring forth the existence of an informational continuity which relates quantum physics to the morphogenetic fields. The possibilities offered by the stem cells, through genetic engineering, confirm this exitence of this informational continuity at all organizational levels of matter. It is now possible to state that stem cells testify to the existence of an eternally present, generating nucleus which has the power of turning potentiality into reality, actually being a matrix of becoming which demonstrates the infinite character of potentiality. Thus science consolidates philosophy and faith, and the human being, as Rabindranath Tagore put it, becomes aware of being related to the divine, to everything that exists in the universe, "which is the purpose and the fulfilment of humankind"
Our approach is an invitation to acknowledging that the perceivable and intagible interpenetrate, they harmonize the human being and give worth to life.

Session 3: Comparing and Approaching different Cultural Traditions

Spirituality and Religiousness as a Friend in Need? German-Chilean Intra- and Intercultural Comparisons in Depressive Symptomatology

Dr. Christina Hunger,
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Theoretical background: Studies from the USA have shown: spirituality/religiousness (SR) is negatively associated with depressive symptoms (Smith et al. 2003).
Aim: The intra- and cross-cultural examination of different SR aspects in Germany (Protestant by trend) and Chile (Catholic by trend) with depressive symptoms in non-clinical and clinical populations.
Methods: Depression: Structured Clinical Interview (SCID), Beck Depression Inventory (BDI); SR: Relationship with God Scale (Büssing 2010), Daily Spiritual Experience Scale (Underwood & Teresi 2002) and Religious Coping Scale (Winter et al. 2009).
Sample: 79 non-clinical individuals and 52 clinically depressed patients in Germany; 73 non-clinical individuals and 60 clinically depressed patients in Chile.
Results: Chileans showed higher levels of positive SR. No cross-cultural differences were demonstrated with respect to negative SR coping strategies. Positive SR was negatively associated with depressive symptoms in all samples. In contrast to clinically depressed patients in Germany, Chilean patients turned towards positive SR themes. However, when negative SR coping was taken into account, most of the variance in depression was explained by this SR dimension in both countries.

Discussion: The results lend support for the necessity of culture sensitive derivations and examinations of SR research hypotheses. Further investigations should also take the socio-historical context and conceptualization of SR into account, above all in secular countries. The results indicate the value of asking for negative SR themes, above all in clinical contexts.
Keywords: depression, religious coping, daily spiritual experiences, God images, cross-cultural psychology, Germany, Chile.

Positive Psychology and the Provision of Religiously-sensitive Mental Health Support Services to Cultural Minority Groups in the UK

Prof. Dr. Kate Miriam Loewenthal
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The provision of spiritual support and care has been developing in the UK, highlighted by the work of the National Spirituality and Mental Health Forum, the Spirituality Special Interest group of the Royal College of Psychiatrists, the Association for Pastoral and Spiritual Care and Counselling, academic initiatives such as the British Association for the Study of Spirituality, and the journal Mental Health, Religion and Culture, and training programmes such as the University of East London Certificate in Spiritual, Religious and Cultural Care. One of the problems in providing spiritual care is concern among minority groups about the one-approach-fits-all assumption: examples are offered from observations made in the frameworks listed above This paper describes some specific difficulties experienced in providing religiously-sensitive mental health support services to cultural minority groups in the UK. These included the dislike of examining negative states and feelings, the issue of stigma associated with mental illness, the need for anonymity and confidentiality, and the fear of misunderstanding of spirituality and of religious beliefs and practices. Examples of each are offered, with including some empirical support for the effects. Some of the difficulties can be resolved by using approaches related to positive psychology. Relevant features of positive psychology are outlined. Examples of services using this approach are described, together with research on their effectiveness.

Spiritual Definitions from New Zealand: a Map of the Terrain

Dr. Richard Egan
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A ubiquitous question about spirituality and health, in the literature and clinically, is “What do we mean by spirituality?”. There is very little data on what New Zealanders of any age think spirituality is - we presume all sorts of things - for instance, that people conflate religion and spirituality, but what is the evidence? This presentation reports on the spiritual definition issues of the first national study (2006-2008) of New Zealand’s spiritual care at end-of-life, primarily focused in hospices. The research employed mixed methods: Study One, using a generic qualitative approach for the process and analysis, involved 52 interviews (patients n=24, family members n=9, staff n=8, chaplains n=8, Maori experts n=3). Study Two surveyed 78% of New Zealand’s hospices (N=25, response rate 59%). As very secular county, with just 8-12% of the New Zealand population attending regular religious services, this study showed the majority view held that spirituality is a useful, important, inclusive and broadly defined concept. This presentation will discuss the range of definitions discovered from the research and offer a “map of the terrain” rather than a precise definition. These findings add weight to the international trend for spirituality to be further investigated and understood in healthcare.

Session 4: Spirituality & Religion in different Populations/Institutions

Religious Struggle in Swiss Patients Visited by Chaplains: Prevalence and Correlates

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Background: Patients with spiritual struggle feel abandoned or forsaken by God, and may believe that God is punishing them for their misconduct with disease or injury. Previous studies showed that spiritual struggle or negative religious coping are associated with inferior quality of life among patients. The studies also found spiritual struggle was significantly and positively related to emotional distress and depressive symptoms. This association has been demonstrated in cross-sectional as well as longitudinal studies.
Aim of the study: The study aims to investigate the prevalence and correlates of spiritual struggle in a Swiss patient sample visited by chaplains. Spiritual struggle was measured with two questions adapted from Pargament's Brief RCOPE. Correlates included demographic factors (age, gender, marital status), medical factors (length of stay, subjective health status, admission to hospital), religious factors (religious denomination, spiritual well-being with the subscales 'Faith', 'Meaning' and 'Peace') and psychological factors (depression and anxiety).
Results: A total of 540 patients (average age: M = 63.23 years, SD = 15.32 years, range = 18 – 94 years) participated in the investigation. Of these, 53% were women. Nearly half of the patients were Roman-Catholic, roughly 4 out of 10 were Protestant, and the remaining respondents did not belong to a religious denomination or were connected to another religion or denomination (primarily to evangelical free churches).
46% of the sample reported some evidence of spiritual struggle. In a logistic regression equation that modeled any spiritual struggle, vs none, spiritual struggle was significantly associated with non-expected admission to hospital (adjusted odds ratio [AOR] = 1.69; 95% CI, 1.16 to 2.48; p = .007) as well as 'Faith' (AOR = 1.27; 95% CI, 1.06 to 1.52; p = .011), Anxiety (AOR = 1.46; 95% CI, 1.12 to 1.91; p= .006) and Depression (AOR = 1.32; 95% CI, 1.02 to 1.71; p = .038).
Conclusion: Nearly half of the patients in this sample reported some spiritual struggle which was significantly associated with medical, religious and psychological factors. It is therefore important that patients who struggle spiritually are assessed quickly and efficiently, in order that spiritual care providers can intervene as soon as possible.

Christianity and Quality Indicators: a Hospital Perspective

Prof. Dr. med. Jürgen Stausberg
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Germany

In Germany, about one third of the hospitals are operated by catholic or evangelic funding bodies. Nevertheless, the common performance measures do not take into account the particular christian mandate of these hospitals, neither the measures legislatively obliged within the external quality assurance nor the quality indicators used by projects of private or governmental funding bodies. The project „Quality Indicators for Christian Hospitals" (QKK) covers about 40 hospitals. A benchmarking between the QKK-members started 2005 using common performance measures, e.g. the patient safety indicators of the US-national AHRQ. In 2009 a taskforce was set up to identify supplementary quality indicators that specifically address the christian mandate.
Bottom up, the members of the QKK steering committee contributed their ideas that had been already locally implemented. Top down, the task force made use of the concepts of a voluntary national certification program for christian hospital called proCum Cert. Within this program, specific requirements concerning christian hospitals had been mapped onto ISO 9001. Starting with this mapping, the steering committee members analyzed the possibilities to define one or several quality indicators for each requirement. In a second step, the proposed quality indicators were empirically assessed using routine data from about 450,000 inpatients treated by the member hospitals in 2010.
From 43 proposed quality indicators, 17 are selected for a test phase in 2012. Thirteen could be calculated from routine data already available in the hospitals. An additional data acquisition is necessary for 4 indicators. Additional 7 indicators suffer from an incomplete recording of the underlying data yet. The selected indicators cover for example the tracer

dementia, staff competencies concerning palliative care, and the frequencies of ethical and pastoral consultations. In terms of requirements, these indicators address the specific susceptibility of christian hospitals for patients suffering from dementia and the accountability of christian hospitals to appropriately consider the spiritual needs of the patients. As far as the authors know, QKK is the first project presenting a draft set of quality indicators specifically addressing the christian mandate of catholic and evangelic hospitals. With the publication of the draft set, QKK strives to foster the discussion of quality of care from a christian perspective and the differences between christian, governmental and private hospitals from a patients' perspective.

Implicit and Explicit Self-Regulation and Spirituality: A Comparative Study with Students and Elder Persons

Dr. Barbara Hanfstingl
Psychologist, Institute of Instructional and School Development, Klagenfurt, Austria

The presented paper deals with the relation between implicit and explicit self-regulation and spirituality and their differences between students and elder persons. Koole et al. (2010) define procedures underlying explicit self-regulation as analytical and future-oriented, like a planning system, whereas implicit self-regulation can be understood as a "systemical intelligence", feeling-oriented and focused on the congruence of one's own identity and self. Koole et al. postulate that implicit self-regulation tends to covary with spirituality, associated with "ego-transcendence" (Kuhl, 2005, p. 23). In a paper-pencil study we asked 135 students (aged 18 until 25; 80% female) and 72 elder (aged 56 until 87; 72% female) to fill out a questionnaire containing socio-demographic data, the German volitional component inventory (VCI; Kuhl & Fuhrmann, 2008), a German version of the Mystical Orientation Scale (MOS; Francis & Louden, 2000), and the German Centrality scale (Huber, 2003). First analyses show that people with higher religious and mystical levels have higher values in the implicit self-regulation scale self-access, but they have more everyday stress. Elder people show higher values in religious, students show higher values in mystical beliefs. Additionally, based on a cluster analysis we could identify three groups that differ with respect to the value of their spirituality: The mystical-oriented and religious group, the mystical-oriented and not-religious group, and the not-mystical-oriented and not-religious group. These and further findings will be discussed with respect to their meaning for the theoretical framework.

Spirituality in Children and their Parents Predicts Positive Mental Health

Andrew J.P. Francis, PhD
Assoc Professor, Behavioural Neuroscience, Divison of Psychology, RMIT University, Bundoora VIC, Australia

Our work is broadly framed within resilience theory, with the aim of identifying individual characteristics and experiences which will predict continued positive functioning and health in the face of potential life adversities. In particular, identification of childhood protectants and risks for the development of either psychological health or pathology is of particular importance. The positive impact of a sense of spirituality or life-meaning on mental health is reasonably well established in adults, although very little research has been conducted in children. The aim of our study was to determine predictive relationships between spirituality/meaning-making and mental health in children and their parents; and to examine relationships between parental and child functioning in these areas. In this ongoing study, 92 children and one each of their parents from rural and metropolitan communities completed self-report measures of mental health, temperament and social connectedness. Specific measures included the FACIT-Sp measure of spirituality/meaning-making, Beck Youth Inventories (BYI) of child mental health, Depression Anxiety Stress Scales (DASS) for adults, the UCLA Loneliness Scale and the Loneliness and Social Dissatisfaction Questionnaire (LSDQ). Significant correlative relationships indicate higher levels of self-reported spirituality in children are associated with better self-concept, lower anxiety, depression, anger and disruptiveness, and improved social connectedness. In adults, spirituality similarly predicted levels of depression, anxiety, stress and loneliness. Parental pathology was not generally predictive of child mental health, although there was a significant relationship between reported parental and child spirituality. In conclusion, our results indicate that some sense of spirituality or meaning-making is related to better mental health outcomes in both children and their parents, and suggests a positive avenue for improving resilience across developmental groups..

Posters

The posters will be exhibited in the entrance hall (see loaction plan) during the whole conference. The authors are present at lunchtime 12:15-13:30 on Friday, May 18th and on Saturday, May 19th.

On Meditation: A cross-cultural Comparison of the Motives behind the Practice of Meditation

Miriam Thye, Radboud Universiteit Nijmegen, The Netherlands / Osnabrück, Germany

Currently, research on meditation focuses mainly on its neuropsychological long-term effects. The present study further contributes to this understanding through a cross-cultural assessment of the motivational elements that lead people to practice meditation. Participants were recruited from a western, individualized, and secularized society (The Netherlands, N=17, aged 21-33), and from an eastern, collectivistic, and highly religious society (Bali, Indonesia, N=21, aged 18-38). A qualitative research paradigm was followed through the use of semi-structured interviews and content analysis. The results indicate motivational factors that are similar in both cultures: meditation seems to be a tool for achieving certain individual goals. The data suggests that meditation is looked upon as a mental technique rather than a spiritual activity even within the religious context. The main motivations to practice meditation in both cultures are: control, self-transformation, and recreation. The definition of these aims and their emphasis are culturally dependent and differ between the countries. In Indonesia the emphasis is on a collectivistic orientation (e.g. control of emotions) whereas in the Netherlands a more individualistic point of view (e.g. recreation) becomes obvious. In both cultures, meditation serves the same psychological function: as a relaxation method to enter deeper states of consciousness and to control their emotional states. Behind this self-centered motive, in the Indonesian as well as Dutch sample, there may also be a social motive, directed towards increased level of empathy.

Witchcraft, Deliverance and Health: A Case Study of Ghana

Rev. Daniel Kingsford Adomey, Global Grace Chapel International, Accra, Ghana

Some scholars have rightly observed that the centre of gravity of Christianity is shifting from the West to "the "two-thirds world", that is Asia, South America and Africa. The reasons for this shift are varied and complex. However, the reasons for the growth of Christianity in Africa significantly include the way the Africans have attempted to deal with their threatening fears, especially witchcraft. Witchcraft has been a prevailing belief in African cultures and has continually posed problems for the African people groups.

Religious intensity and Religious Crisis as Factors affecting Physician's Attitudes towards Patients

Jakub Pawlikowski, MD, PhD, Lublin, Poland

Background: Previous studies in medicine-religion area focused mostly on the relation between religiosity and patient's health and attitudes and the contemporary models of physician-patient relationship take into account cultural diversity of patients and fail to take into account the diversity of physician's beliefs and values. However, physicians are also active subjects of a physician-patient relationship and their beliefs may affect it. Religious accounts offer specific ontological, anthropological and axiological concepts when refer to many issues associated with medical practise (e.g. the problem of suffering, the attitude to a sick person and ethics of the beginning and the end of a human life), which may encourage to hypothesise that a religiously involved physician would apply such concepts in his or her professional practice. Many religions underline the value of merciful acts, especially the care of the sick. The aim of our survey was to verify the hypothesis that a religious intensity and religious crisis may affect physician's attitudes towards patients.
Method: The anonymous questionnaire consisted of standardized tools: Scale of Attitudes towards the Patient (SAtP) (4 dimensions: respect for autonomy, altruism, empathy and holistic approach to a patient), the Scale of Religious Attitudes (SReAt) evaluating the religiosity and Scale of Relious Crisis (both developed in Polish by Prezyna). The research was carried out on the group of 528 Polish physicians, 324 of them returned the questionnaire (turn = 61%); 51% women, 49% men; 93% Catholics; average work experience: 17.03 years; 52% of respondents work in surgical units and 48% of them in non-surgical units.
Results: Surgeons are significantly less religious (M=5.32; SD=1.06) than non-surgeons (M=5.61; SD=0.93); (t= -2.59, $p<0.05$). Religious intensity correlates positively with altruism (r=0.12; $p<0.05$), holistic approach (r=0.18; $p<0.01$) and empathy

(r=0.20; p<0.01) but not with a respect for autonomy. Religious crisis correlates negatively with above mentioned factors.
Conclusion: Physician's religiosity is an essential factor shaping their attitude to patients. The religiosity variable explains physician's moral attitude better than the denomination (religious affiliation) variable. Physician-patient relation frameworks should take into account not only patient's but also physician's cultural and religious beliefs.

The Psychological Outcomes of Religious Coping with Stressful Life Events

Yi-Yung Liu, University Teacher, Kaohsiung City, Taiwan

Koenig, McCullough and Larson (2001) have provided a theoretical model in their landmark volume Handbook of Religion and Health to illustrate how and why religious beliefs and rituals might influence mental health. However, there remains limited understanding of how Taiwan folk religion impacts on the believers' mental health, especially in difficult situations. The purpose of this study is to explore 1) What religious coping strategies are being used? 2) What is the impact on the mental health of women who practice these beliefs? 3) To determine if the process will be the same when we substitute Taiwan folk religion into the model provided in Koenig et al. A qualitative study utilizing face to face interviews with 15 women devoted to Taiwan folk religion. Snowball sampling of candidates who had experienced the helpfulness of religion in coping with stress in their lives guided the sampling strategy. Data was concurrently analyzed, using the content analysis method. Results suggest that the most effective and popular religious coping strategies are to first consult a spiritual medium and adopt his/her magical practices, and embrace the idea of Karma. Secondly, religious ideas and rituals made direct and indirect impacts on mental health such as self-satisfaction, self-confidence, self-worth, self-control, self-development and hope. Finally, we confirmed that the process of Taiwan folk religion on mental health is the same as stated in the model of Koenig et. al. However, informal religious groups and private religious rituals and practices may play more important role than religious beliefs in the cognitive appraisal and religious coping behaviors of individuals. Broader theoretical and empirical implications of these findings are discussed.

The Multidimensional Measure of Prayer Behaviour: Development and Location within Eysenck's Dimensional Model of Personality

Prof. Dr. Christopher Lewis, Division of Psychology, Glyndwr University, Wrexham, Wales, UK

The present study described the development of The Multidimensional Measure of Prayer Behaviour (MMPB) and location of the measure within Eysenck's dimensional model of personality (Psychoticism, Extraversion, and Neuroticism). The MMPB incorporates 5 subscales: "Colloquial", "Petitionary", "Ritual", "Meditative" and "Attunement". The MMPB was administered alongside The Revised Eysenck Personality Questionnaire. Abbreviated among a sample of 1,306 international respondents. Confirmatory factor analysis of the MMPB demonstrated that the hypothesised correlated five-factor model was found to be the best description of the data. Multiple regression showed that Psychoticism was negatively related to all prayer subscales, while Extraversion was positively related to the Coloquial subscale and Neuroticism was negatively related to the Attunement subscale. Suggestions for further research are provided.

Quality of Life of Men with Alcohol Dependence Syndrome

Indrek Linnuste, MSc in Health Sciences, Manager/Psychologist, SA Pärnu Hospital, Pärnu, Estonia

Background: Alcohol dependence is comprehensive disease that in addition to health problems, involves economic and social difficulties. The problems rise in individual and societal level. Men's health indicators, mortality, and health awareness are much lower comparing to women. Alcohol dependence is in society stigmatized phenomenon that is often considered as velleity, not disease. This attitude inhibits prevention, treatment, rehabilitation and development of support systems.
Aim: The study aims to describe and analyze quality of life of alcohol dependent men in Estonia.
Methods: Consecutive sample of men who participated in the study had been diagnosed with alcohol dependence and been on treatment in Pärnu Hospital, Estonia. The social-demographic indicators and exposure to alcohol were assessed using a questionnaire. General index of quality of life and six broader domains (physical health, psychological, level of independence, social relationships, environment, spir-

ituality/religion, personal beliefs) of quality of life were investigated using WHOQOL-100. The survey was carried out 2010-2011 in Pärnu Hospital. For data analysis statistical program STATA and Mann-Whitney test was used.
Results: In the final analysis answers of 57 men were used. The lowest average index of quality of life was for physical health (12.06), psychological wellbeing (11.88) and spirituality (11.86). Compared to European average, all domains for the study group had lower values. Men who were participating in self-help groups and/or were believers of some religion had higher estimation of their spirituality. Those men, who had had their longest period of non-drinking more than six and/or were in relationship, had higher estimations of social relationships.
Conclusions: In broader context, deeper cooperation of medical, scientific, political and non-governmental sphere is needed to gain success in the struggle against alcohol dependence. The practical work should start from better sharing of information about alcohol and co-morbid problems, more strict official alcohol policy, restructuring of treatment process to integrate medical and psychological methods.

Medical Students Perceptions on Religion/Spirituality and Spiritual Care: Results of an Austrian Pilot Study

Dr. med. Anahita Paula Rassoulian, University of Vienna, Austria

Introduction: Recent data demonstrated the importance of addressing spiritual issues in patient-doctor communication. Many U.S. Universities have included "Spiritual Care" in the curriculum either as a mandatory or an elective course. The introduction of an endowed professorship "Spiritual Care" at a German university has increased awareness for this topic in Europe. The aim of this study, conducted at the Medical University of Vienna, was to investigate medical students' attitudes towards "spiritual care", particularly to its relevance in their future profession.
Methods: Between June and December 2011, 350 students of the Medical University of Vienna (200 at their first, 150 at their sixth year) participated in a questionnaire assessing their own spirituality and religiosity, as well as the relevance of "Spiritual Care" in the communication with cancer patients.
Results: 88,5% of the first-years and 93,6% of the sixth-years agreed with the statement that religious conviction/spirituality might have an effect on cancer patients' coping. 94% (first-years) and 84,3% (sixth-years) consider talking with their patients about religious/spiritual issues, if patients wish to do so. 93,5% of the first-years consider assessment of religious/spiritual needs as the responsibility of chaplains, 42% as the responsibility of nurses, and 39,5% as the responsibility of doctors. 28% think it is in the responsibility of all three, 2,5% of none of the professions listed. 42,5% (first-years) and 22,1% (sixth-years) view religious beliefs as a part of medical history-taking. 96% (first-years) have never heard about the term "Spiritual Care". 36% consider religiosity/spirituality as a potentially relevant topic in their medical curriculum. 27,5% (first-years) and 69,3% (sixth-years) regard themselves as spiritual, 32,5% (first-years) and 67,9% (sixth-years) as religious individuals.
Discussion: Data presented here demonstrate that medical students consider religious conviction/spirituality as potential resource for coping, e.g. with cancer. At the same time, they do not consider "Spiritual Care" to be primarily part of a physician's responsibility. Most of the students are not familiar with the professional term "Spiritual Care", nor do they see the necessity of integrating it into clinical practice and medical education. Of interest, the percentage of students regarding themselves as religious and/or spiritual was significantly higher in last year students when compared with 1st year students.

Centrality of Religion and Health Behaviours among Medicine and Clerical Students

Dr. Marek Jarosz, Lublin, Poland

A person's health is one of major factors influencing on satisfaction and quality of life. It occupies one of the most important places in the hierarchy of values. Health may be treated as a psychophysical characteristic which ensures optimal functioning in various contexts. Pro-health behaviours involve actions which prevent diseases and improve health. Basic pro-health behaviours include balanced diet, physical activity, no smoking, no substances abuse and a regular lifestyle. Pro-health attitudes depend on many factors, such as sex, age, education, income or education. Numerous researches show that an important source of pro-health behaviours is religiousness as a major factor motivating to take different actions. This research tries to answer the question: what is the role of religiousness and medical knowledge in forming pro-health behaviours? To achieve this goal 143 students of medicine (M=21,34; SD=0,96) and 100 theology students preparing to priesthood (M=22,04; SD=1,66) have been examined. All of them were 3rd year students. To measure religiousness the scale of Huber C15 (five dimensions: Cognitive interest,

Ideology, Prayer, Experience, Worship and General score) was used while to measure different aspects of health behaviours were used the IZZ (Pro-health Behaviours Inventory), Quiz Fagerstrom's Scale (smoking). The results show that a higher centrality of religiousness significantly correlates with some aspects of pro-health behaviours such as non smoking, non alcohol abuse and so on.
Results: There are three statistical differences for BMI, daily meals and smoking in two groups. There are statistical differences in alcohol use in medicine and seminars students (U = 991,00***,U = 1233,50***). Correlations between religiousness and health behaviours are very low and few (Prophylactic behaviours r = 0,24*, Positive psychological attitude r = 0,17 *, Fagerstrom's scale r = -0,21*) in group of medical students. There is no significant statistical correlations between religiousness and health behaviours in group of students of seminars.
Conclusions: The relationship between religiousness and health behaviours has a different character among people with different centrality of religion. Medical students more frequently use stimulants such as alcohol and tobacco than seminar students do. This may indicate that the medical knowledge is insufficient in motivating health-seeking behaviours and that a more important role is played by religiosity and its centrality.

Perceived In-Group Density and Psychological Adjustment in a Sample of Northern Irish Catholics and Protestants

Prof. Dr. Christopher Lewis, Division of Psychology, Glyndwr University, Wrexham, Wales, UK

The contact hypothesis suggests that desegregation is good for minority group members, but this view has been challenged by studies describing a so-called "ethnic density effect". This term refers to the proposition that people who live in areas where the population reflects their particular ethnic, religious or social attributes tend to be afforded more psychological protection than those who live in areas where their attributes are atypical. This study examined the possibility of an "ethnic density effect" in the context of historical ethno-religious segregation in Northern Ireland. The authors hypothesised that the "ethnic density effect" is not simply the result of structural variables, such as ethnic population mix at local community level, but also on individual perceptions of area based ethno-religious group density, perceptions of their local group status and their levels of in-group identification or solidarity. Data from 1000 randomly selected participants were tested for ethno-religious group invariance in the prediction of psychological adjustment, as measured by the General Health Questionnaire (GHQ-12). Results indicated a small direct "ethnic density effect" based on perceptions of religious mix at local level ($p < .05$). Ethno-religious differences were observed in the relationships between perceived ethnic density and perceived discrimination ($p < .05$). The "ethnic density effect" reported in some cultural contexts was evident in Northern Ireland and this has implications for policy makers concerned with community relations.

Telehealth and the Medical Spiritual Dimension.

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Telehealth is a non-profit association that promotes the spiritual dimension of medicine. It operates through the Aid against the Suffering, the Development of the Compassion and Impermanence, the Promotion of Healing and Non-local Healing. The Aid against the Suffering is given through the teaching of spiritual practices such as mindfulness meditation directed to the Acceptance of the Present Moment. Other spiritual practices are also promoted, such as reciting the rosary as a prayer and the repetition of mantra. Specific issues for this purpose have been published by Telehealth, both in the form of books and in the form of iconographic publications (images of Friar Thomas from Olera and of St. Mary of Olive Trees). The Development of the Impermanence is a quality that comes after a suitable period of practice of mindfulness meditation that leads to a Non-Attachment. For this purpose the contemplative prayer of St. Teresa from Avila and St. John of the Cross is also proposed. As a consequence of the practice of mindfulness meditation, Compassion and Feeling of Sharing are spontaneously developed over time. Together with the Doctor Patient Education, they promote Healing. We intend for Healing a process which is fully internal within the patient and leads to optimize the care of his/her illness to the point of recovery or, if the illness is not curable, to accept it and live in a way as serene as possible. Non-local Healing is a research area for Telehealth: it includes the Distance Prayer as a practice favoring the Healing process. The most advanced research involves the Transcendental Consciousness for Healing. It is based on an distance evolution of Sat Nam Rasayan meditation: here the Doctor becomes Healer postulating the possibility of transcending time and space with the intention of healing during a particular meditative state.

The Relationship Between Psychiatric Staff´s own Spirituality and Their Attitudes Towards Religiosity/ Spirituality of Patients

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Objectives: In the context of a growing body of international research on questions related to "religions and health", though not in German-speaking countries, this study focused especially on psychiatric staff. It examines 1) spirituality of psychiatric staff (the main predictor variable), 2) staff's attitudes towards religiosity/spirituality of patients based on staff's own experiences (the main criterion variable) and 3) the relationship between the two variables.
Methods: An anonymous survey was distributed to the staff of psychiatry and psychotherapy departments of German university hospitals and confessional clinics (total 21 hospitals). In this study, staff is defined as medical, therapeutic and nursing staff working directly with patients during the period from October 2010 to February 2011. The survey's main instruments were DRI (Duke University Religion Index) for measuring intrinsic religiosity, taken as the indicator of spirituality in this study, and the questionnaire of Curlin et al. (2007), whose questions regarding attitudes towards religiosity/spirituality of patients were categorized into positive and negative influences.
Results: The response rate was 24.43% (n = 1654). In contrast to the assumption that psychiatric staff were less spiritual, results suggested that they have a moderate degree of spirituality (M = 7.0 (SD = 3.15) on a scale of 12.0). A significant difference of spirituality was shown between staff in university hospitals and confessional clinics tients.
Conclusions: Many studies emphasize the influence of staff's attitudes on the therapeutic process. This study verifies that staff's attitudes towards religiosity/ spirituality are related to how they interpret the experience of religiosity/spirituality of patients. In conclusion, staff's awareness about their own religious/ spiritual attitudes should be increased, so that religious/spiritual issues could be effectively and appropriately dealt with in treatments, which will result in an improvement of therapies for both patients and staff.

Addiction and Spirituality: The Role of Religion, Religiousness and Spirituality in the Process of Addiction and Recovery

Prof. Dr. Mary Rute Esperandio, Curitiba, Brazil

This investigation is one of the focuses of a research that has been developed on "Health, religion and contemporary subjectivity" in the Postgraduate Program in Theology at Universidade Catolica do Parana, Brazil. In this research, we sought to understand the role of religion and/or spirituality in the recovery process of addiction. Brazil is a very religious country and the initiatives in dealing with chemical dependency have emerged predominantly from religious denominations. However, there are few academic papers that discuss these issues. From a qualitative approach, the method used was the phenomenological one, as it is discussed by Merleau-Ponty, which emphasizes the sensitive-body's place in the production of knowledge and subjectivity, and seeks to reveal the meaning of the lived experiences by the subject. The data were collected through a semi-structured interview consisting of 21 questions designed to allow the respondents to relate their experience with addiction and recovery, and the role of religion and spirituality in this process. The respondents were selected by convenience in two locations: the first, a private Therapeutic Community, which has no religious confessions, the other one is the so called "Sobriety Pastoral", represented by an open group of self-help that cares of the treatment of family members and people with addiction in the space of a Catholic parish. The main emphasis in the Therapeutic Community is the study of the "Twelve Steps' of the Narcotics Anonymous. The Self-Help Group of the "Sobriety Pastoral" meets weekly to share and study the Sobriety Prayer: a religious adaptation of the Twelve Steps of Narcotics Anonymous. We interviewed a total of twenty-four people, 12 of each location. The data point that the uncompromising experience with different types of religion is a common thing during the active addiction. The treatment leads the recovering ones to value the engagement with a Higher Being as an important element in the development of spirituality, but this need is not necessarily linked to any particular religious group, and may even be syncretic. Spirituality is understood as a personal and independent religion. People with more time in recovery have deep involvement with religious activities and a daily search of spiritual development. For the respondents, religion is a source of strength, and the involvement in a religious community is a social, emotional and spiritual support that favors the maintenance of recovery.

General Information

Place of Conference
Inselspital (University Hospital Bern)
Auditorium Rossi
(Entrance 31B)

Conference Counter
The conference counter will be open during the whole confernce, i.e. during the following hours:
Thursday, May 17th, 12:00 – 20:30
Friday, May 18th, 08:30 – 18:00
Saturday, May 19th, 08:30 – 18:00

Conference Language
The conference language is English, except for the nursing symposium and the public lecture.

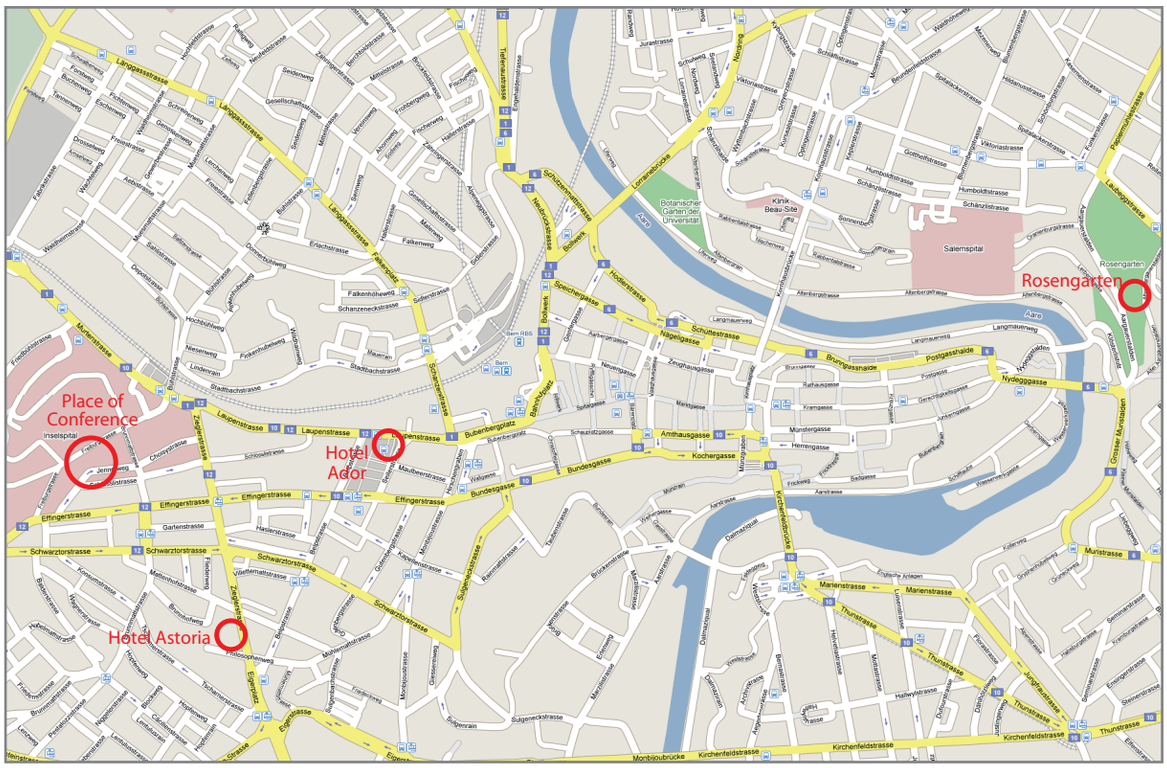
Conference Fee
The conference fee includes the costs for coffee breaks and the conference booklet. The conference badge qualifies to participate in the programme.

City Tour
To get an impression of the medieval cityscape of Bern and its time-honoured sandstone buildings we will make a guided tour through the historic city center.
The city tour will be on Friday evenig.
Meeting place and time will be announced.

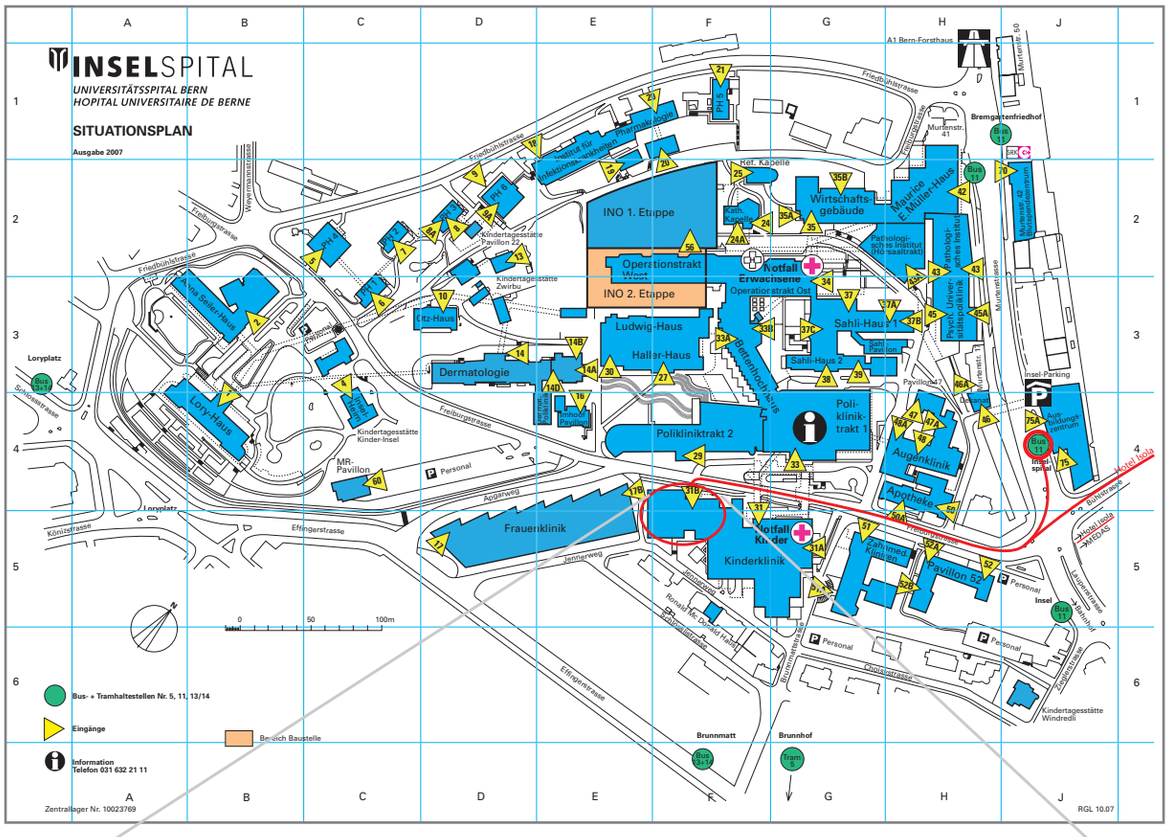
Social Evening
We will visit a restaurant with a splendid view over the roofs of Berne and enjoy a nice dinner in a convenient atmosphere. You are welcome to join us (EUR 45.-).
Place: Rosengarten
Time: Friday, May 18th, start 20:30

Maps

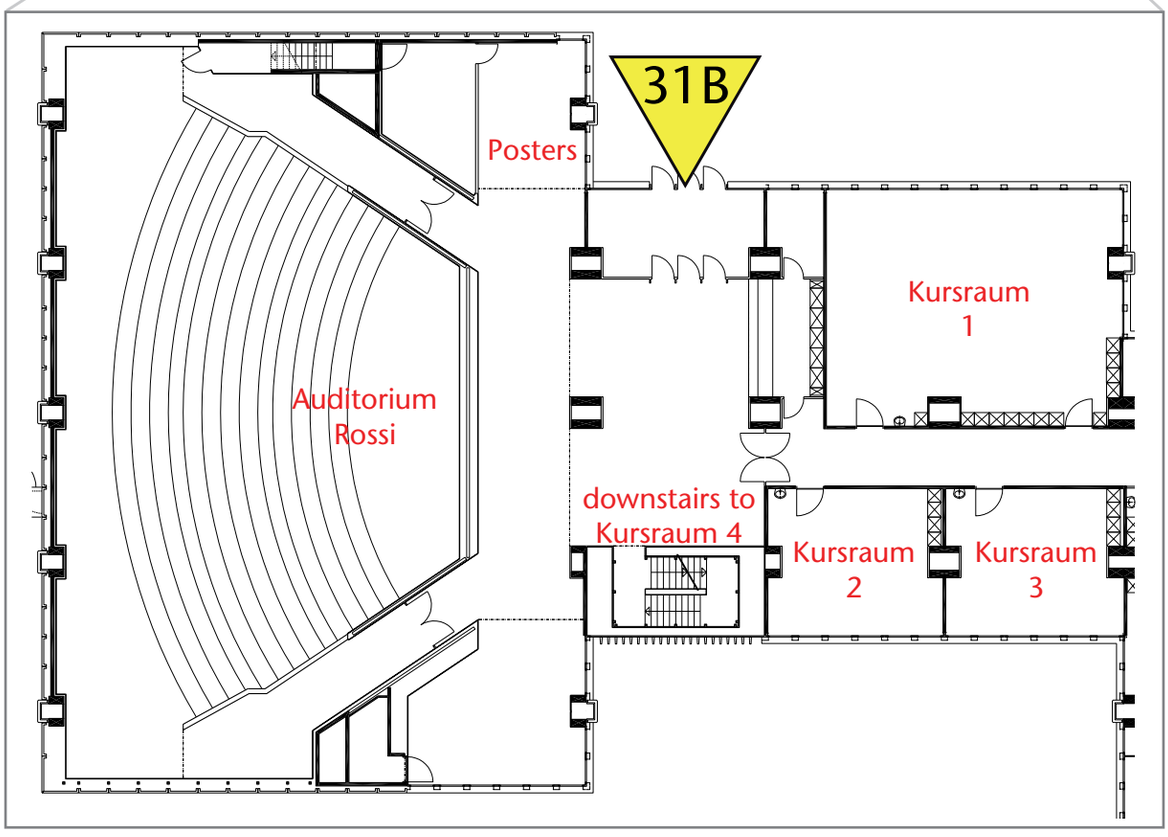
City of Bern



Insel Spital



Place of the Conference: Auditorium Rossi



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