European Conference on Religion, Spirituality and Health 2012

Cardiovascular Medicine and Spirituality

State of the Art and Consequences for Care?

René Hefti, M.D.

Head of Psychosomatic Department, Clinc SGM Langenthal
Lecturer for Psychosocial Medicine, University of Bern
Director of the Research Institute for Spirituality and Health

EC RSH12

Cardiovascular Medicine

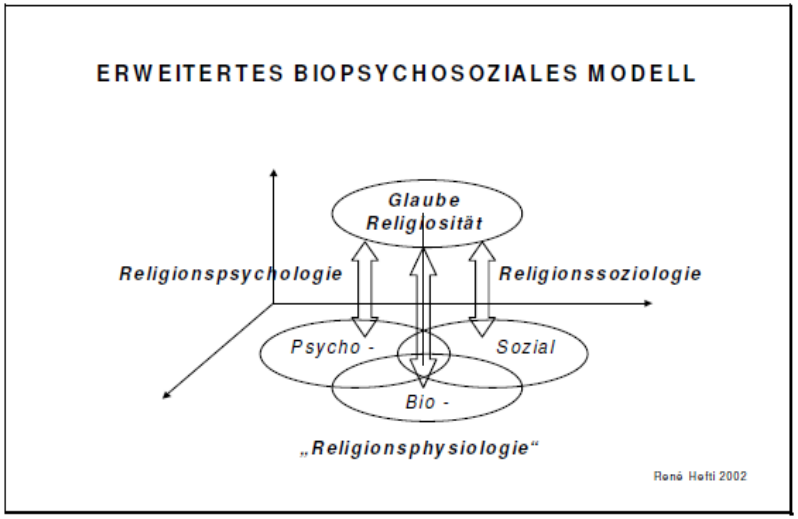


TABLE OF CONTENT

① Introduction: history, concepts

② Epidemiology: cv mortality

③ Mechanisms: riskfactors

④ CV Reactivity: one studies

⑤ Coping with heart disease: brief

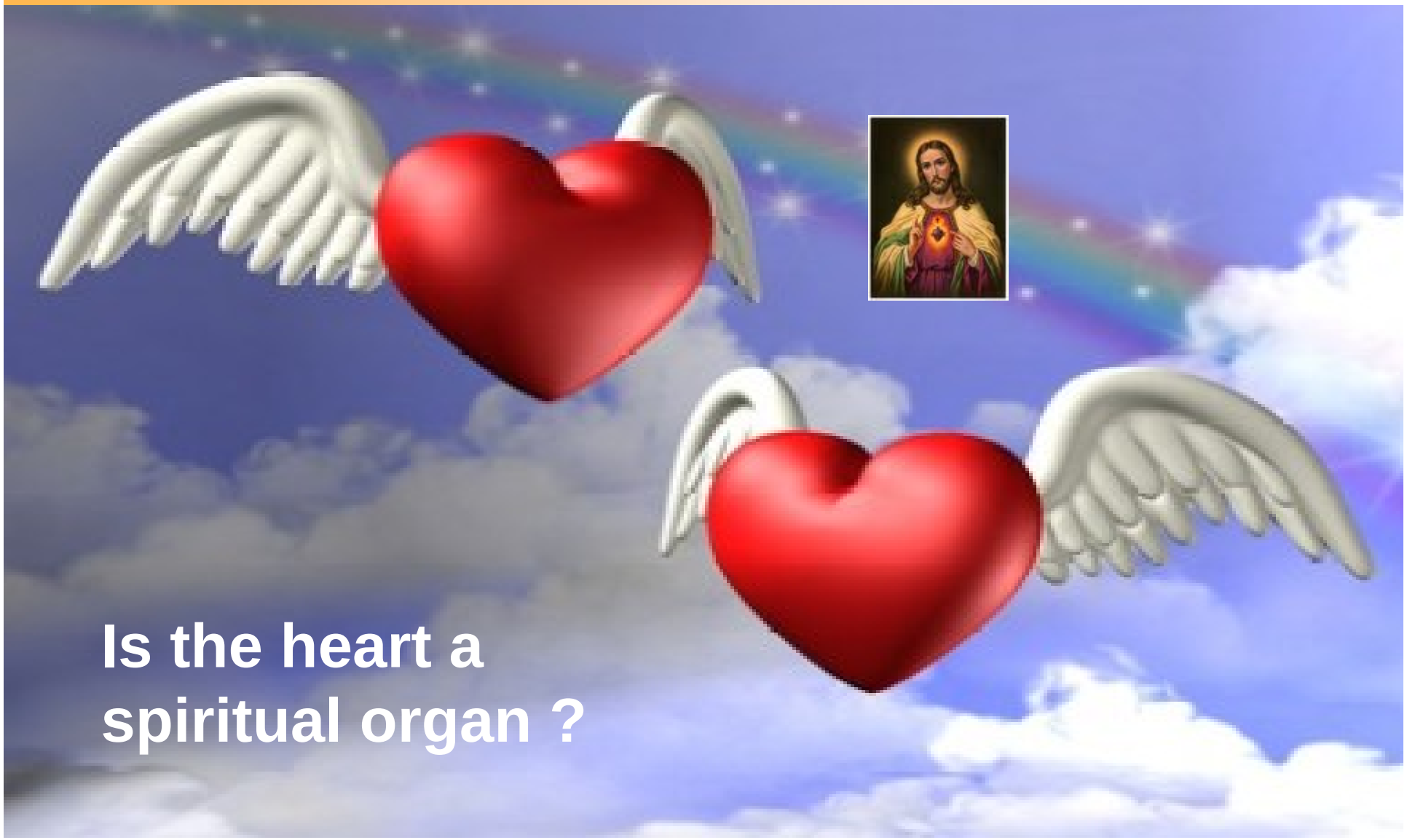
⑥ Consequences for care

EC RSH12

INTRODUCTION

CV Medicine and Spirituality

KLINIK SGM LANGENTHAL
Psychosomatik
Psychiatrie
Psychotherapie



Historical Aspects – 2000 b.C.

Proverbs

„Above all else, guard your heart, for everything you do flows from it“ Proverbs 4.23

„A heart at peace gives life to the body, but envy rots the bones “

Proveerbs 14.30

„A cheerful heart is good medicine, but a crushed spirit dries up the bones “

Proverbs 17.22

Historical Aspects – 1640 a.C.

Blaise Pascal
1623 – 1662

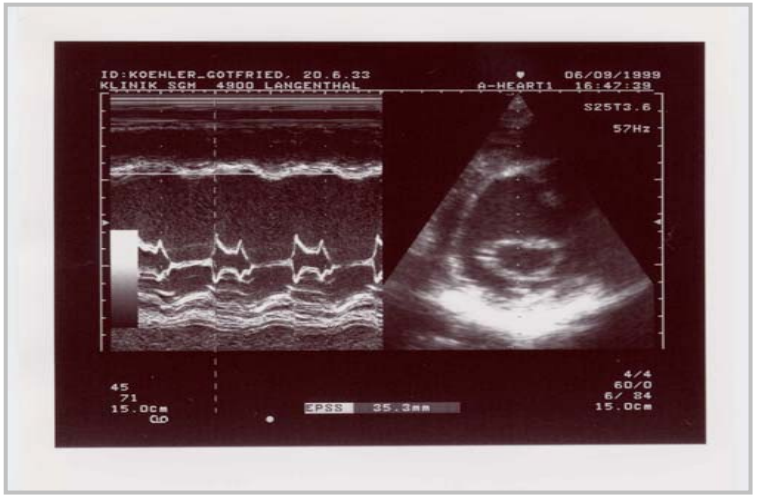
Mathematician and Philosoph

„La Coeur a ses raisons gue la raison no connait point“

Heart as a place of „deeper“ Knowledge

G.K., 66 years, IHD/3VD

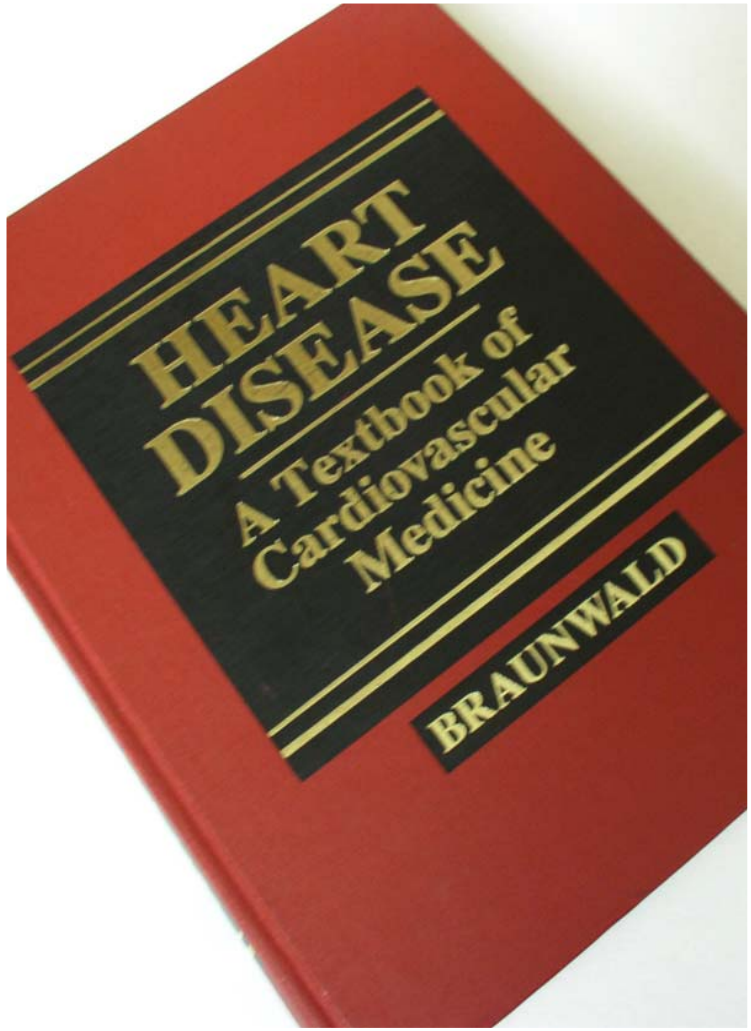
KLINIK SGM FÜR PSYCHOSOMATIK
Stiftung für ganzheitliche Medizin



No classical riskfactors

- No family history
- No smoking
- No hypercholesterimia
- No diabetes mellitus
- No hypertension

Psychokardiology – 1980 a.C



Braunwald, Edition 1980

Chapter 55: Emotion, Psychiatric Disorders, and the Heart

„Substantial evidence exists to indicate associations between psychosocial stresses and CAD, hypertension, arrhythmia and SD“

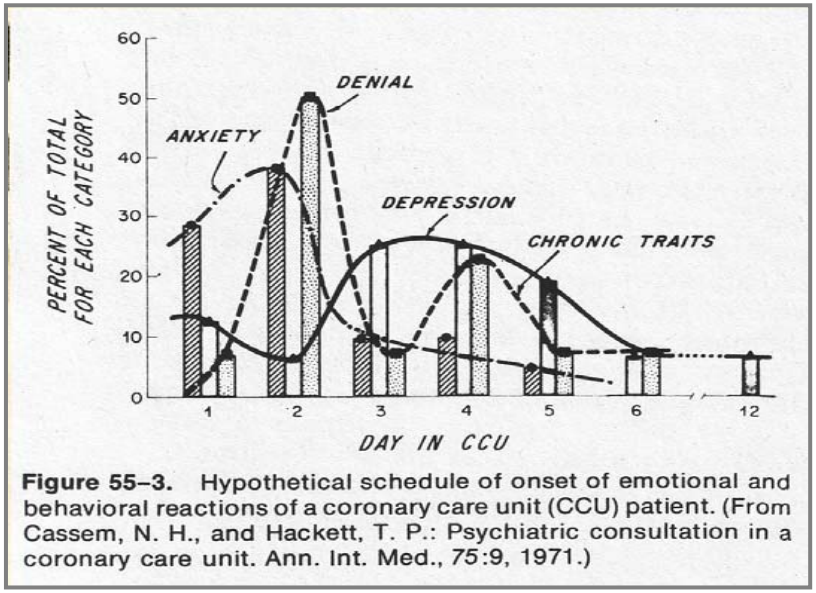
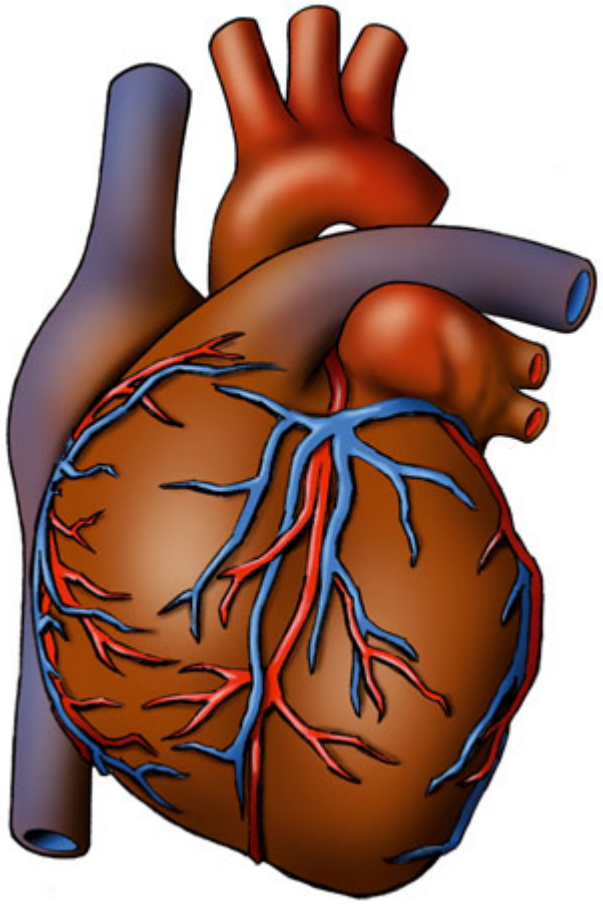


Figure 55–3. Hypothetical schedule of onset of emotional and behavioral reactions of a coronary care unit (CCU) patient. (From Cassem, N. H., and Hackett, T. P.: Psychiatric consultation in a coronary care unit. Ann. Int. Med., 75:9, 1971.)

CV Medicine and Spirituality



Evolution of Concepts

- Biomedical model: heart as a pump, hydraulic system
- Bio-psycho-social model: emotional influences, stress
- Extended bio-psycho-social model: spiritual influences

⇨ **More holistic view of the cardiovascular system**

EPIDEMIOLOGY

Special Article

Psychotherapy and Psychosomatics

Psychother Psychosom 2009;78:81–90
DOI: 10.1159/000190791

Received: March 26, 2008
Accepted after revision: April 3, 2008
Published online: January 14, 2009

Religiosity/Spirituality and Mortality

A Systematic Quantitative Review

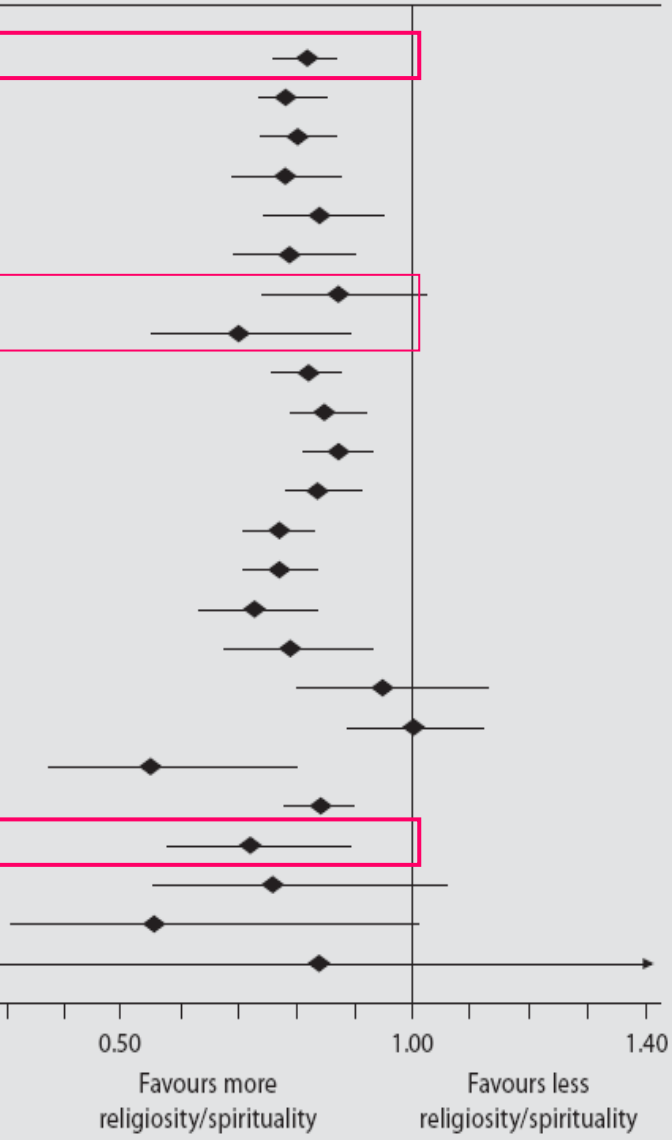
Yoichi Chida[a] Andrew Steptoe[a] Lynda H. Powell[b]

[a]Psychobiology Group, Department of Epidemiology and Public Health, University College London, London, UK;
[b]Department of Preventive Medicine, Rush University Medical Center, Chicago, Ill., USA

Key Words
Body-mind-spirit interaction · Meditation, prayer · Meta-analysis · Positive psychology · Preventive medicine · Religious coping · Well-being

havioral factors (smoking, drinking, exercising, and socioeconomic status), negative affect, and social support. We divided studies according to the aspects of religiosity/spirituality measure examined, and found that organizational activity (e.g. church attendance) was associated with greater

Type of analysis	Studies n (%)	Combined effect size		p value for heterogeneity
		HR (95% CI)	p value	
Overall analysis[1,2]	44 (100.0)	0.82 (0.76–0.87)	<0.001	<0.001
Sample size ≥500[1,2]	27 (61.4)	0.78 (0.73–0.85)	<0.001	<0.001
Sample size ≥1,500[2]	21 (47.7)	0.80 (0.74–0.87)	<0.001	<0.001
Follow-up ≥10 years[1,2]	32 (72.7)	0.78 (0.69–0.88)	<0.001	<0.001
Follow-up ≥20 years[1,2]	11 (25.0)	0.84 (0.74–0.95)	<0.001	0.023
Old population ≥60 years old[2]	22 (50.0)	0.79 (0.69–0.90)	<0.001	<0.001
Male population	19 (43.2)	0.87 (0.74–1.02)	0.085	0.007
Female population[1,2]	9 (20.5)	0.70 (0.55–0.89)	0.004	0.012
Study quality score ≥3[2]	30 (68.2)	0.82 (0.76–0.88)	<0.001	<0.001
Fully controlled covariates[1,2]	21 (47.7)	0.85 (0.79–0.92)	<0.001	<0.001
Controlled negative affect[1,2]	25 (56.8)	0.87 (0.81–0.93)	<0.001	<0.001
Controlled social support[2]	26 (59.1)	0.84 (0.78–0.91)	<0.001	<0.001
Organizational activity[1,2]	33 (75.0)	0.77 (0.71–0.83)	<0.001	<0.001
Religious attendance (overall)[1,2]	25 (56.8)	0.77 (0.71–0.84)	<0.001	<0.001
Religious attendance (≥weekly)[1,2]	14 (31.8)	0.73 (0.63–0.84)	<0.001	<0.001
Church activity or attendance[2]	7 (15.9)	0.79 (0.67–0.93)	0.004	0.076
Non-organizational activity	4 (9.1)	0.95 (0.80–1.13)	0.58	0.027
Intrinsic aspects	4 (9.1)	1.00 (0.89–1.12)	0.99	0.23
Multi-dimensional aspects[2]	3 (6.8)	0.55 (0.38–0.80)	0.002	0.63
All-cause mortality[2]	27 (61.4)	0.84 (0.78–0.90)	<0.001	<0.001
Cardiovascular mortality[2]	6 (13.6)	0.72 (0.58–0.89)	0.003	0.091
Cancer	5 (11.4)	0.76 (0.55–1.06)	0.10	0.17
Respiratory disease	3 (6.8)	0.56 (0.31–1.01)	0.055	0.77
Digestive disease	3 (6.8)	0.84 (0.28–2.80)	0.84	0.10



Healthy Population

Ischemic Heart Disease Study

1: Cardiology. 1993;82(2-3):100-21. Related Articles,

UniBasel S·F·X

Factors predictive of long-term coronary heart disease morta among 10,059 male Israeli civil servants and municipal employees. A 23-year mortality follow-up in the Israeli Ischei Heart Disease Study.

Goldbourt U, Yaari S, Medalie JH.

Department of Epidemiology and Preventive Medicine, Sackler School o Medicine, Tel Aviv University, Israel.

Over 10,000 male civil servants and municipal employees in Israel, aged years and above, underwent an extensive clinical, biochemical, anthropometric, sociodemographic and psychosocial evaluation in 1963, and 1968. Follow-up for mortality was continued through 1986. Over 23 years, a number of previously established risk factors for coronary heart disease (CHD) incidence were found to predict mortality. The long-term follow-up assisted in illustrating temporal patterns. A single causal assessment of blood pressure retained high prediction for long-term mort Blood lipids, while significantly associated with both coronary and all-ca mortality, exhibited a small contribution to the latter, when compared to hypertension, cigarette smoking habits and diabetes. Weak associations o long-term coronary mortality with the dietary intake patterns of fatty acid reported at baseline, were probably fully mediated by the effect of the die serum cholesterol. Religious orthodoxy appeared to provide a degree of immunity, part of which was independent of life-style correlates. A numb of now well-established associations in cardiovascular epidemiology wer first demonstrated, or amplified, in the study. Patterns of ethnic diversity the risk factor and prevalence rates of CHD persisted, as viewed from the angle of mortality rates, over nearly a quarter of a decade, highlighting th enigma of a migrant country as a cardiovascular melting pot.

PMID: 8324774 [PubMed - indexed for MEDLINE]

Table 4. CHD and total mortality by smoking habits, diabetes and religious orthodoxy, 1963–1986

Smoking status	Cases	Mortality	
		CHD	all causes
Never smoked	3,158	40	129
Quit smoking	1,677	51	151
Current smokers			
1–10 cigs/day	1,498	47	153
11–20 cigs/day	1,634	60	193
>20 cigs/day	1,944	70	237
Cigar and pipe	141	72	164
Diabetics	479	149	357
Nondiabetics	9,580	50	162
Religious orthodoxy			
Most orthodox	2,103	38	135
Orthodox	1,528	51	162
'Traditional'	1,782	51	162
Secular	2,085	54	166
'Nonbelievers'	1,747	61	168

Rates are age-adjusted per 10,000 person-years of follow-up.

20% Risikoreduktion für Koronartod

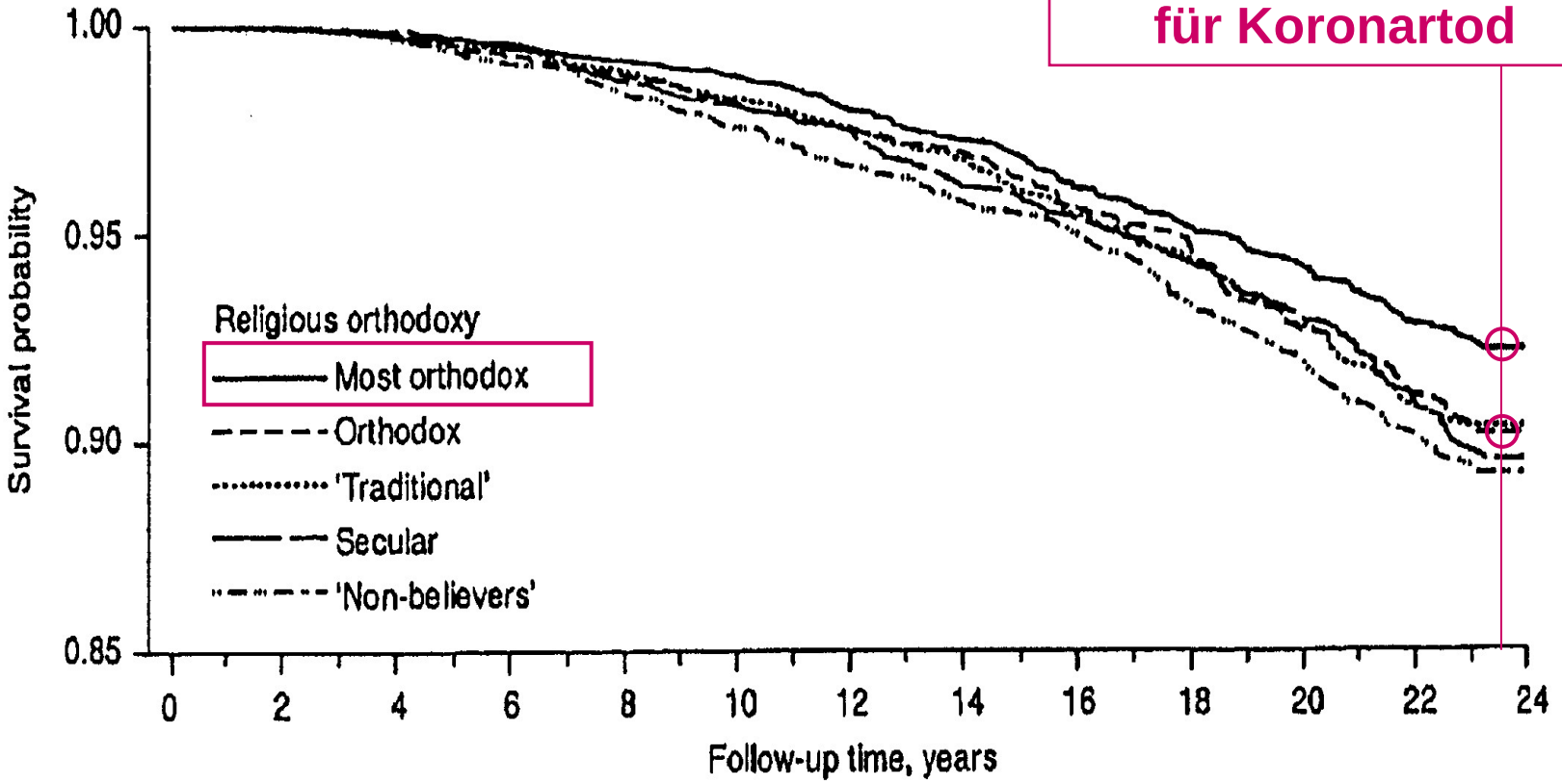


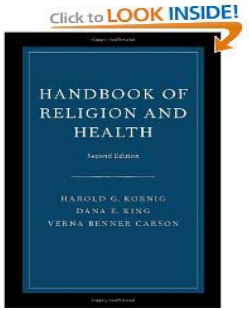
Fig. 7. Kaplan-Meier (above) and adjusted (below) life table curves by degree of religious orthodoxy: 23-year CHD mortality adjusted by age, SBP, total cholesterol, cigarette smoking, diabetes, QI and presence of CHD at baseline.

MECHANISM

Mechanisms ?

Religion and Spirituality moderate

- **Lifestyle/health behaviors**
  - Less smoking (121 of 137 studies, 90%)
  - Lower cholesterol (12 of 21 studies, 52%)
  - Better blood pressure (36 of 63 studies, 57%)
  - More exercise (25 of 37 studies, 68%)
- **Psychosocial factors/stress level**
  - Less hostility (23 of 35 studies, 66%)
  - More optimism and hope (55 of 72 studies, 76%)
  - Less Anxiety (147 of 299 studies, 49 %)
  - Less depression (272 of 444 studies, 61%)
  - Better social support (61 of 74 studies, 82%)
- **Coping with Stress (stress buffering)**



FORSCHUNG UND PRAXIS
Das aktuelle Medizin-Journal
Jahrgang 15 - Nr. 8 Oktober 2006

Messe in der St. Augustine Kirche in New Orleans. Steckt darin ein antihypertensives Potential? Quelle: imago/UPI Photo

Geht von Religiosität eine antihypertensive Wirkung aus?

In der Frage, wie sich Religiosität auf die Gesundheit auswirkt, gehen die Meinungen auseinander. Sigmund Freud etwa wetterte gegen die Religion als „universelle Zwangsneurose", die sich aus verdrängter Sexualität, plagenden Schuldgefühlen und unterdrückten Emotionen speise. Rudolf Steiner hielt umgekehrt den Atheismus für eine krankmachende Gesinnung. Die Leugnung des Göttlichen war für ihn zugleich die Ablehnung einer Kraft, die ein „gesundes Gefühl des Leibes eingibt". Naturwissenschaftlich geprägte Forscher, die Objektivität stets mit messbaren Befunden begründet sehen möchten, werden beiden Thesen wohl kaum etwas abgewinnen können.

Je eifriger gebetet wurde, um so niedriger war der Blutdruck

Vor allem in den USA, wo die Wissenschaft der Religiosität mit deutlich weniger Distanz als in Europa begegnet, haben Forscher zunehmend die gesundheitlichen Auswirkungen religiöser Aktivität ins Visier genommen. Ihre Ergebnisse sprechen eher gegen die These, dass Religion dem seelischen Wohlbefinden der Gläubigen abträglich ist. Je eifriger die Befragten ihrem religiösen Glauben in der Praxis Ausdruck verliehen, um so stärker waren sie etwa gegen den Missbrauch von Alkohol und Drogen gefeit. Kirchliche Gebundenheit war mit einer niedrigeren Scheidungsrate und einer höheren Zufriedenheit in der Ehe assoziiert, was wiederum die Rate psychiatrischer Behandlungen reduzierte.

Religiöse Betätigung in einer Religions- oder Kirchengemeinschaft, von denen es in den USA bekanntlich unzählige gibt, scheint auch eine entspannende Wirkung auf die Blutgefässe zu haben. Schon 1998 haben Wissenschaftler der Duke University in Durham in einer Studie eine quasi antihypertensive Wirkung von regelmässigem Kirchgang, Beten und Bibelstudium beobachtet. Sie hatten sich in dieser Studie bei knapp 4000 älteren Einwohnern von North Carolina per Befragung ein genaues Bild von der Intensität der religiösen Betätigung verschafft und diese in Beziehung zum Blutdruck gesetzt.

Das Ergebnis: Je häufiger die Kirche besucht, daheim gebetet oder das Buch der Bücher studiert wurde, um so niedriger war der Blutdruck. In der Gruppe der Gläubigen, die ihre Religiosität am eifrigsten praktizierten, war die Prävalenz hypertoner Blutdruckwerte um 40 Prozent niedriger als bei Mitmenschen, die nur hin und wieder das Bedürfnis nach Kirchgang oder privatem Gespräch mit Gott im Gebet verspürten. Allerdings schien der Blutdruckeffekt sehr davon abhängig zu sein, welches Medium für die Glaubensvermittlung gewählt wurde: Wer sich nämlich vornehmlich auf dem häuslichen Sofa an der per Fernseher ausgestrahlten Predigt erbaute oder der Heilsbotschaft am Radio lauschte, hatte sogar höhere Blutdruckwerte als Vergleichspersonen.

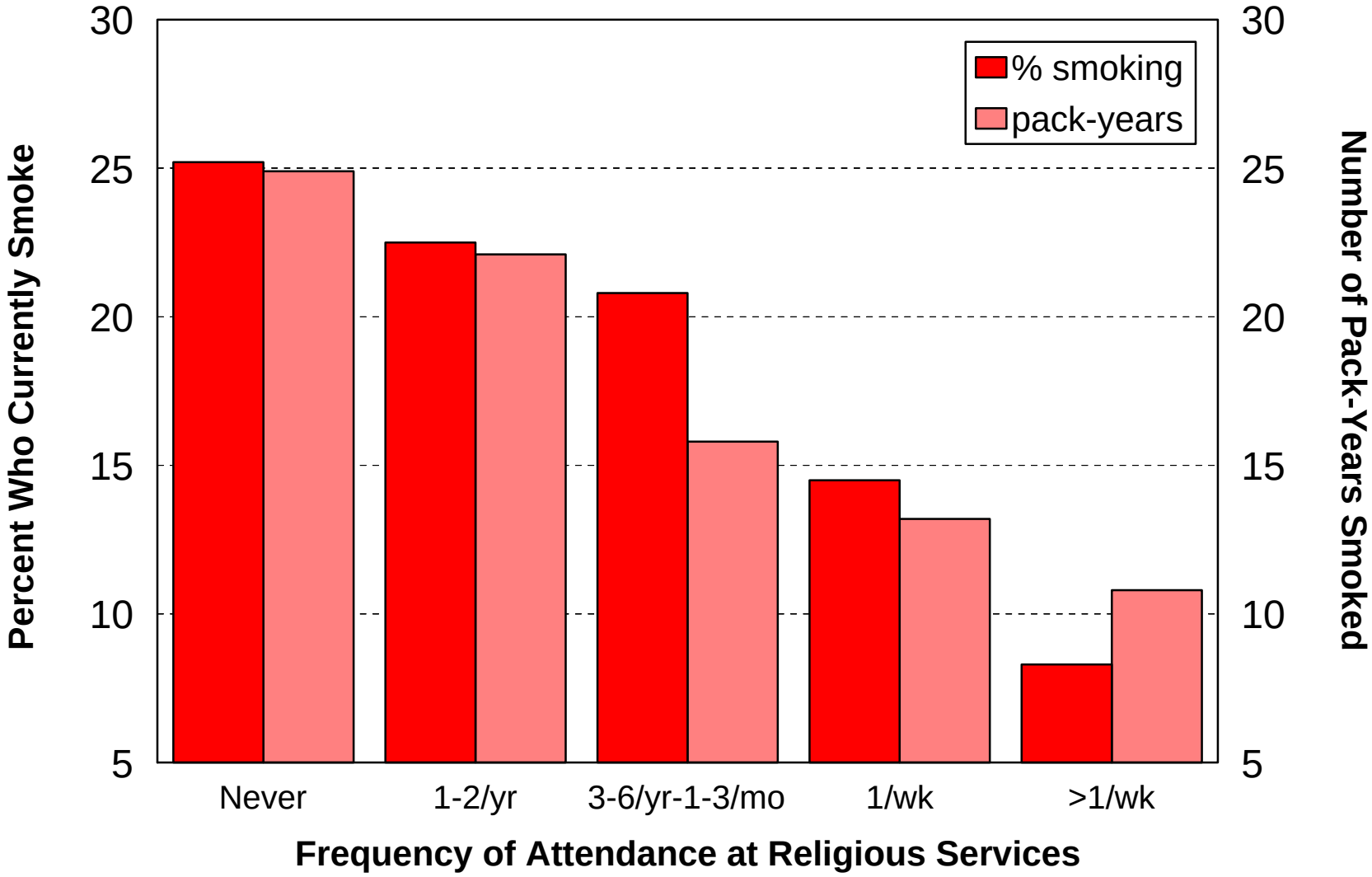
In einer neuen Studie, deren Ergebnisse Dr. Sharon B. Wyatt beim ASH-Kongress vorgestellt hat, sind die Forscher nun auf einen ähnlichen Zusammenhang zwischen praktizierter Religiosität und Blutdrucksenkung gestossen. In dieser Studie (Jackson Heart Study) sind 5302 Afro-Amerikaner – in der Mehrzahl Frauen – ausführlich nach ihren kirchlich organisierten wie auch privaten religiösen Aktivitäten befragt worden.

Religiosität möglicherweise ein „Puffer" gegen Stress

Auch in dieser Studie zeigte sich, dass Frauen, deren Aktivitäten und Lebenseinstellungen in hohem Masse religiös geprägt waren, niedrigere Blutdruckwerte hatten als die übrigen Studienteilnehmerinnen – und dies, obwohl bei ihnen der Body Mass-Index überdurchschnittlich hoch und die Compliance bei der Einnahme ihrer antihypertensiven Medikation relativ schlecht war. Wyatt vermutet, dass Religiosität wie ein „Puffer" die Auswirkungen von Stressbelastung unter anderem auf die Blutgefässe abmildern kann. Dafür spricht auch die in der Studie gemachte Beobachtung, dass ein hoher Grad an religiöser Betätigung mit einem relativ niedrigen Plasmaspiegel des Stresshormons Cortisol assoziiert war. *(ob)*

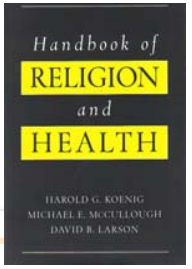
Religious Attendance and Cigarette Smoking

3968 Persons aged 65 or Older in North Carolina



Outcome/Investigators	Type	Method	N	Population	Location	Religious Variable	Findings	Controls	Rating
Hypertension (Ch 17)									
Armstrong (1977)	CC	C	418 vs. Cs	CDA	Australia	#1 (SDA vs. non-SDA)	non-SDA > SDA	MC	7
Alexander (1996)	CT (analysis by gender for Schneider et al (1995) study below)					#1 Transcendental Med	P	—	10
Benson H (1977)	R	reviews effects of Relaxation Response on blood pressure							
*Beutler (1988)	CT	C	120 (40 each group)	CDA	Netherlands	laying hands, thought projection	NA	—	9
Blackwell (1976)	CT	C	7	MP	—	#1 Transcendental Med	(P)	—	—
*Brown D (1994)	CS	S	597	CDA,B,M	Norfolk, VA	#12 relig scale, ORA,D	NA	MC	8
Caudill (1987)	R	reviews effects of relaxation therapy (4 studies) & relaxation response (2 studies) on blood pressure							
*Fonnebo (1992b)	CS	C	222 vs. Cs	CDA	Norway	#1 D (SDA vs. non-SDA)	non-SDA > SDA	SC	6
Graham (1978)	CS	R	355	CDA,W,M	Georgia	#1 ORA	P	MC	7
Hafner (1982)	CT	C	21	MP	—	#1 meditation	NA	—	—
Hixson (1998)	CS	C	112	CDA,F	North Carolina	#3+ RC,RF,IR	P	SC	6
Hutchinson (1986)	CS	R	357	CDA	West Indies	#1 ORA	P	SC	6
*Koenig (1988)[f]	CS	S	106	MP,E	Illinois	#15+ ORA,NORA,IR	(P)	SC-sex	6
Koenig (1998a)[g]	PC	R	4000	CDA, E	North Carolina	#4 D, ORA, NORA	P	MC	9
Kong (1982)	D	describes experience of creating high blood pressure control centers in churches							
Kumanyika (1992)	D/CT	C	188	CM, 100%B,F	Baltimore	church-based wt loss	P	—	7
Lapane (1997)	CS	R	5145	CDA	Rhode Island	#1 church membership	P	MC	8
Larson DB (1989)*	CS	S	401	CDA,M	Georgia	#2 ORA, SR	P	MC	7
*Leserman (1989)	CT	C	27 cardiac surgery patients		Boston	#1 relaxation response	NA	—	7
*Levin (1985)	CS	R	1125	CDA-Mex-Am	Texas	#2 ORA,SR	NG (with SR)	NONE	6
Levin (1989)	R	reviews seven blood pressure studies conducted between 1960 and 1987 that relate to religion							
Livingston (1991)	CS	R	1420	CDA,B	Maryland	#1 church affiliation	P	MC	8
McCullagh (1960)	D	S	44	monks	KY, MA	cholesterol (low) & hypertension (high)		—	2
Merritt (2000)	Exp	C	74	CDA,B,young	Durham, NC	#5 ORA,NORA,IR	P	SC	8
Miller RN (1982)	CT	C	96	MP	—	#1 healing prayers-distant	P	—	6
Patel (1975)	CT	C	34	MP	England	#1 Yoga	P	—	8
Patel 1976)	CT	C	27	MP	England	#1 Yoga (Shavasan)	P	—	7
Pollack (1977)	CT	C	20	MP	New York City	#1 Transcendental Meditation	NA	—	7
*Ross (1965)	CS	S	1272	Parents/medical students	Baltimore, MD	#1 D	J = Ca = P	NONE	6
Rouse (1982)	CS	C	293	CDA	West Australia	#1 D (Mormons vs. SDA)	Morm > SDA	SC	6
Saunders (1988)	D	describes experience of creating high blood pressure control centers in Black churches and why effective							
Schneider (1995)	CT	C	111	CDA,B,E	Oakland, CA	#1 Transcendental Meditation	P	—	10
Scotch (1963)	CS	R	1059	CDA	South Africa	#2 ORA, CM	P	SC	
Stavig (1984)	CS	R	1757	CDA-Asians	California	#1 (affiliation vs. none)	P	MC	
Steffen (2000)	CS	—	—	CDA	North Carolina	#1+ RC (from COPE)	P	MC	
Sudsuang (1991)	CT	C	52	M (ages 20–25)	Thailand	#1 Buddhist meditation	P	—	
Timio (1988)	PC/CC	S	144 vs. Cs	R (Ca nuns)	Italy	#1 Ca nuns vs. other	P	MC	
Walsh (1980)	CS	C	75	immigrants	Ohio	#1 ORA	(P)	MC	
Walsh (1998)	CS	C	137	immigrants	Toledo, OH	#2 ORA,SR	P	MC	
*Webster (1979)	CC	C	779 vs. Cs	CDA	Australia	#1 SDA vs. non-SDA	non-SDA > SDA	SC-age	
Wenneberg (1997)	CT	C	39	CDA,M	Iowa City, IA	#1 Transcendental Meditation	P	—	

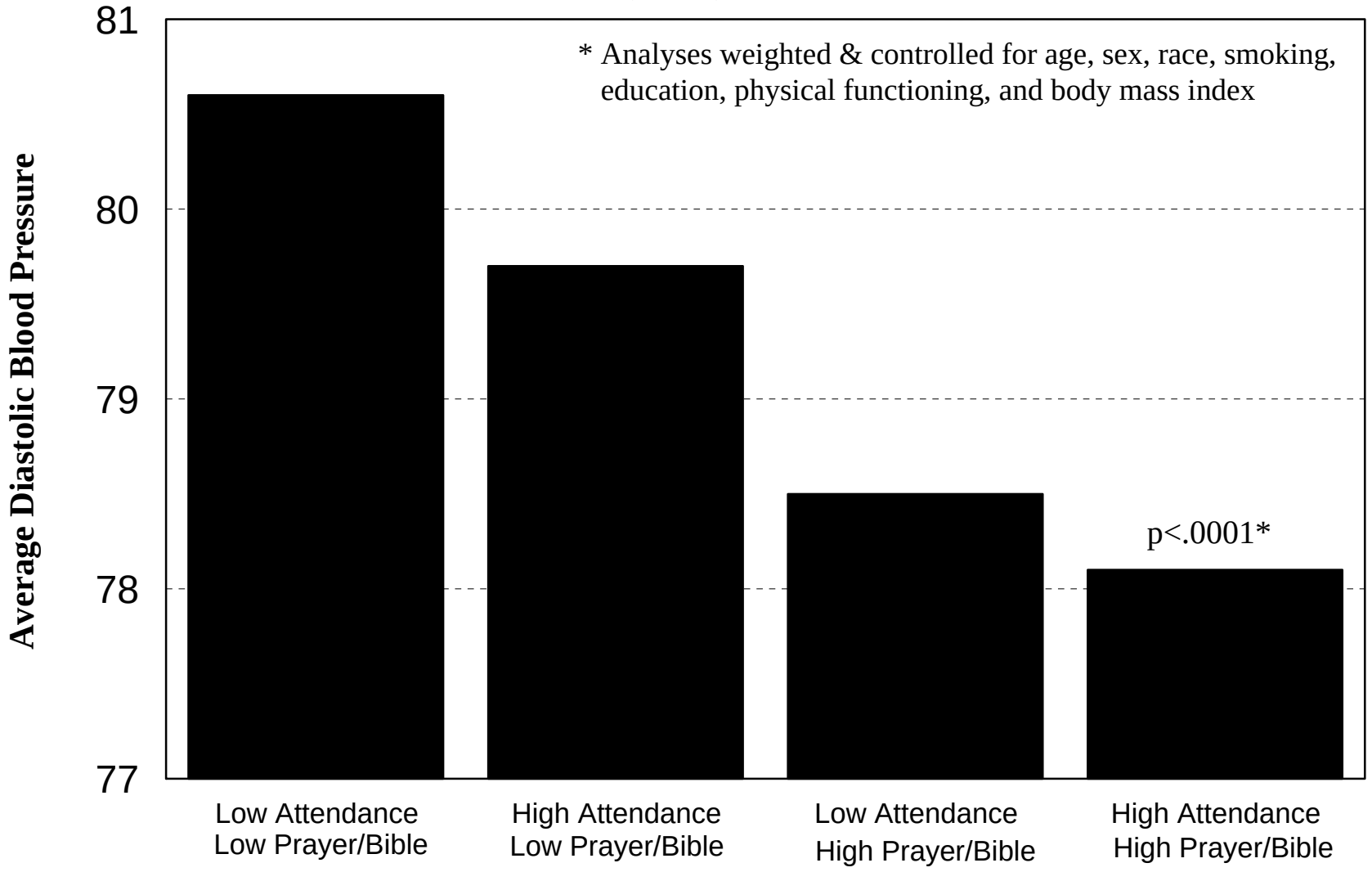
30 Studies



Religious Activity and Diastolic Blood Pressure

(n=3,632 persons aged 65 or over)

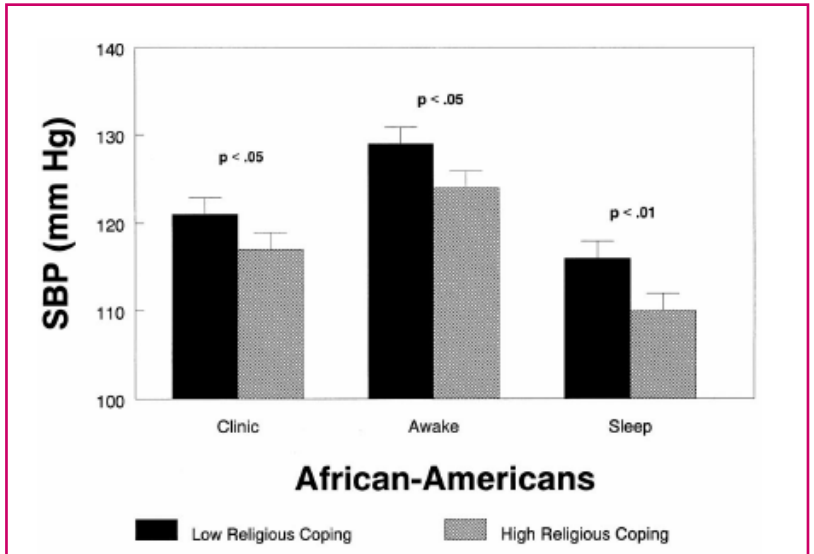
Citation: International Journal of Psychiatry in Medicine 1998; 28:189-213

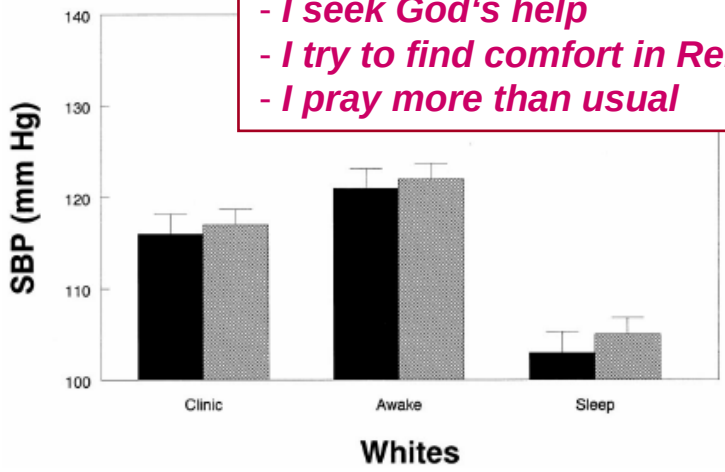


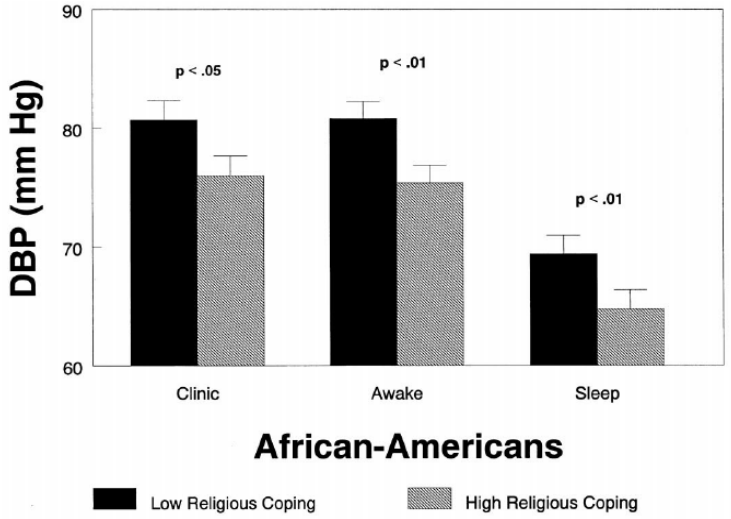
High = weekly or more for attendance; daily or more for prayer
Low= less than weekly for attendance; less than once/day for prayer

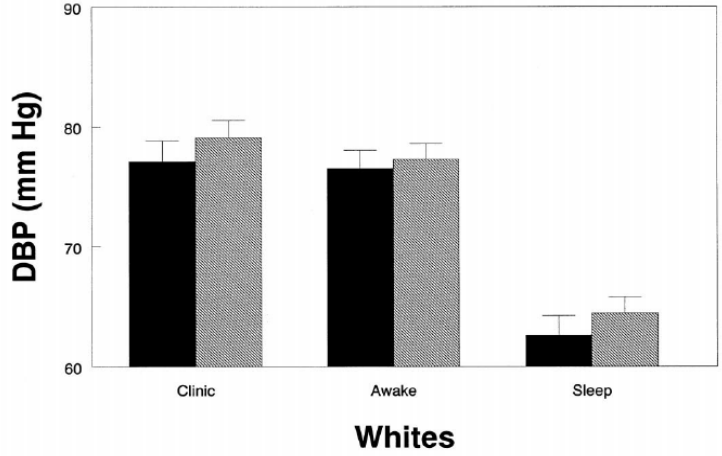
Religious Coping

- *I put my trust in God*
- *I seek God‘s help*
- *I try to find comfort in Religion*
- *I pray more than usual*









P. R. STEFFEN et al. Psychosomatic Medicine 63:523–530 (2001)

Age and Blood Pressure Changes

A 20-Year Follow-up Study in Nuns in a Secluded Order

MARIO TIMIO, PAOLO VERDECCHIA, SANDRO VENANZI,
SIMONETTA GENTILI, MAURIZIO RONCONI, BIANCA FRANCUCCI,
MAURO MONTANARI, AND ETTORE BICHISAO

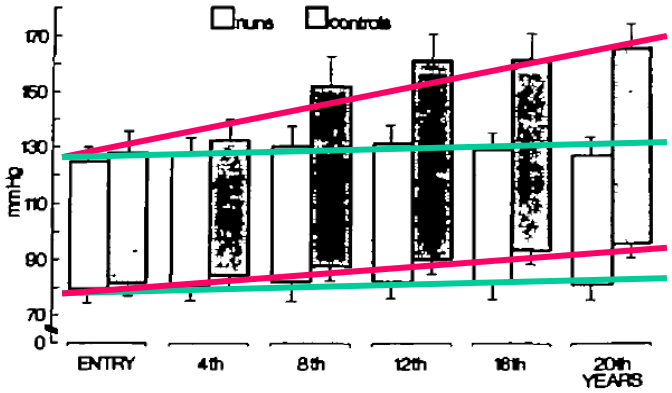


FIGURE 1. *Mean values (± SD) of systolic and diastolic blood pressure obtained every 4 years to the end of the study.*

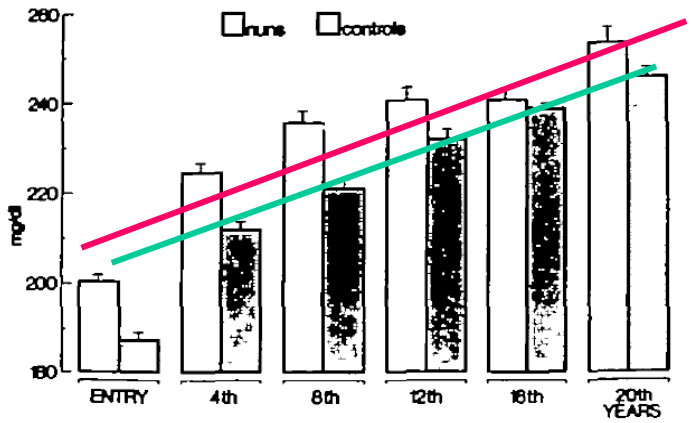


FIGURE 2. *Mean values (± SD) of total serum cholesterol obtained every 4 years to the end of the study.*

BP-Change by a Religious Intervention (*Manikonda*)

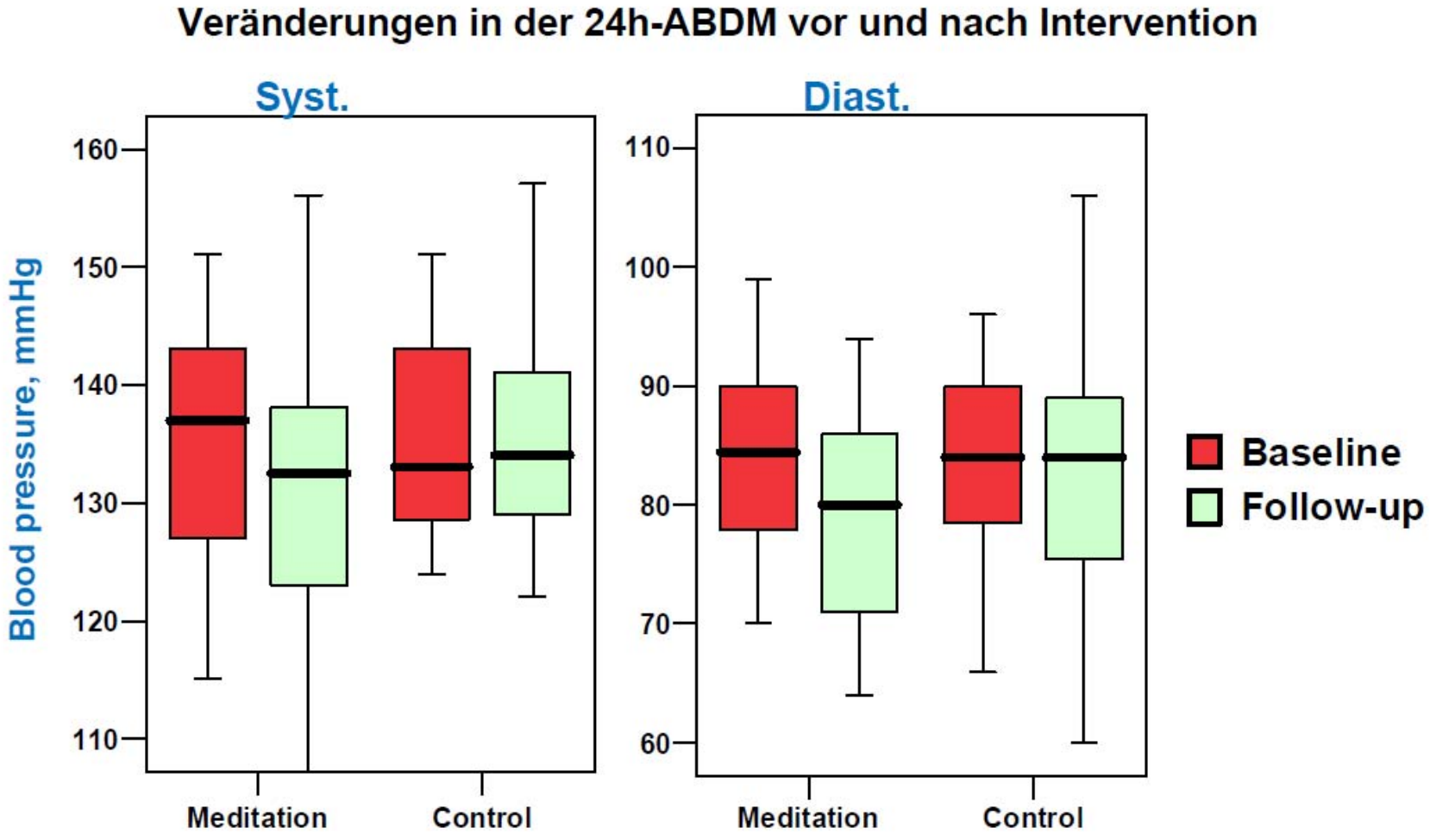


Abb.11 SBP und DBP bei Baseline-und Follow-up in der 24h-ABDM

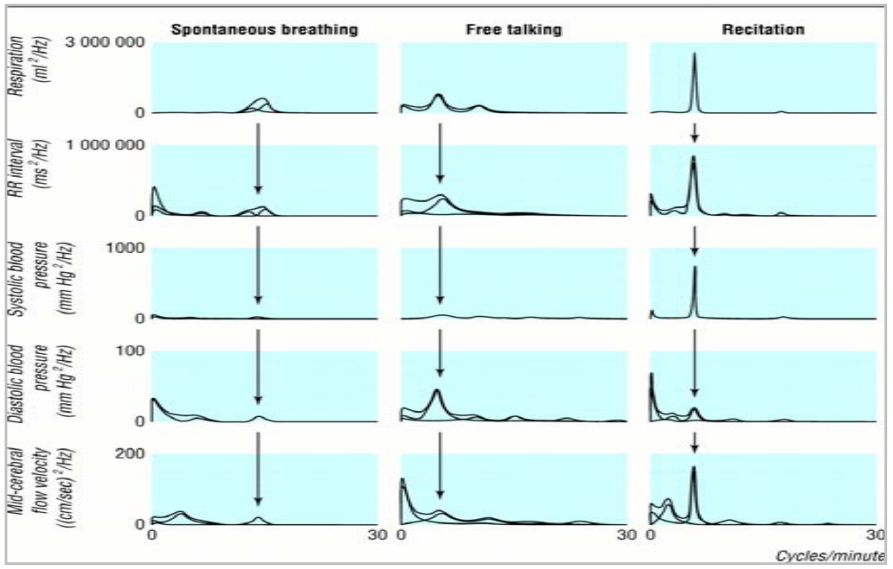
Rosary Prayer and Religious Music

Rosary Prayer

Regulating effect of rhythmic prayer on respiration, heart rate, blood pressure and cerebral blood flow

British Medical Journal 2001

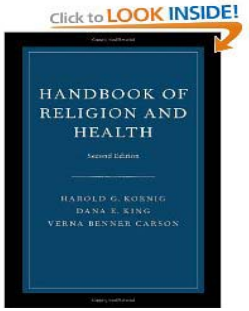
Prof. L. Bernardi, Cardiologist, Pavia

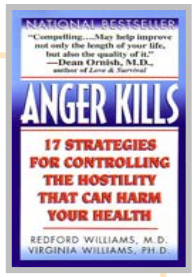


Mechanisms ?

Religion and Spirituality moderate

- **Lifestyle/health behaviors**
  - Less smoking (121 of 137 studies, 90%)
  - Lower cholesterol (12 of 21 studies, 52%)
  - Better blood pressure (36 of 63 studies, 57%)
  - More exercise (25 of 37 studies, 68%)
- **Psychosocial factors/stress level**
  - Less hostility (23 of 35 studies, 66%)
  - More optimism and hope (55 of 72 studies, 76%)
  - Less Anxiety (147 of 299 studies, 49 %)
  - Less depression (272 of 444 studies, 61%)
  - Better social support (61 of 74 studies, 82%)
- **Coping with Stress (stress buffering)**





Journal of Behavioral Medicine
26 (5): 373-393, October 2003
Copyright © 2003 Plenum Publishing Corporation
All rights reserved

A Change of Heart: *Cardiovascular* Correlates of Forgiveness in *Response* to Interpersonal Conflict

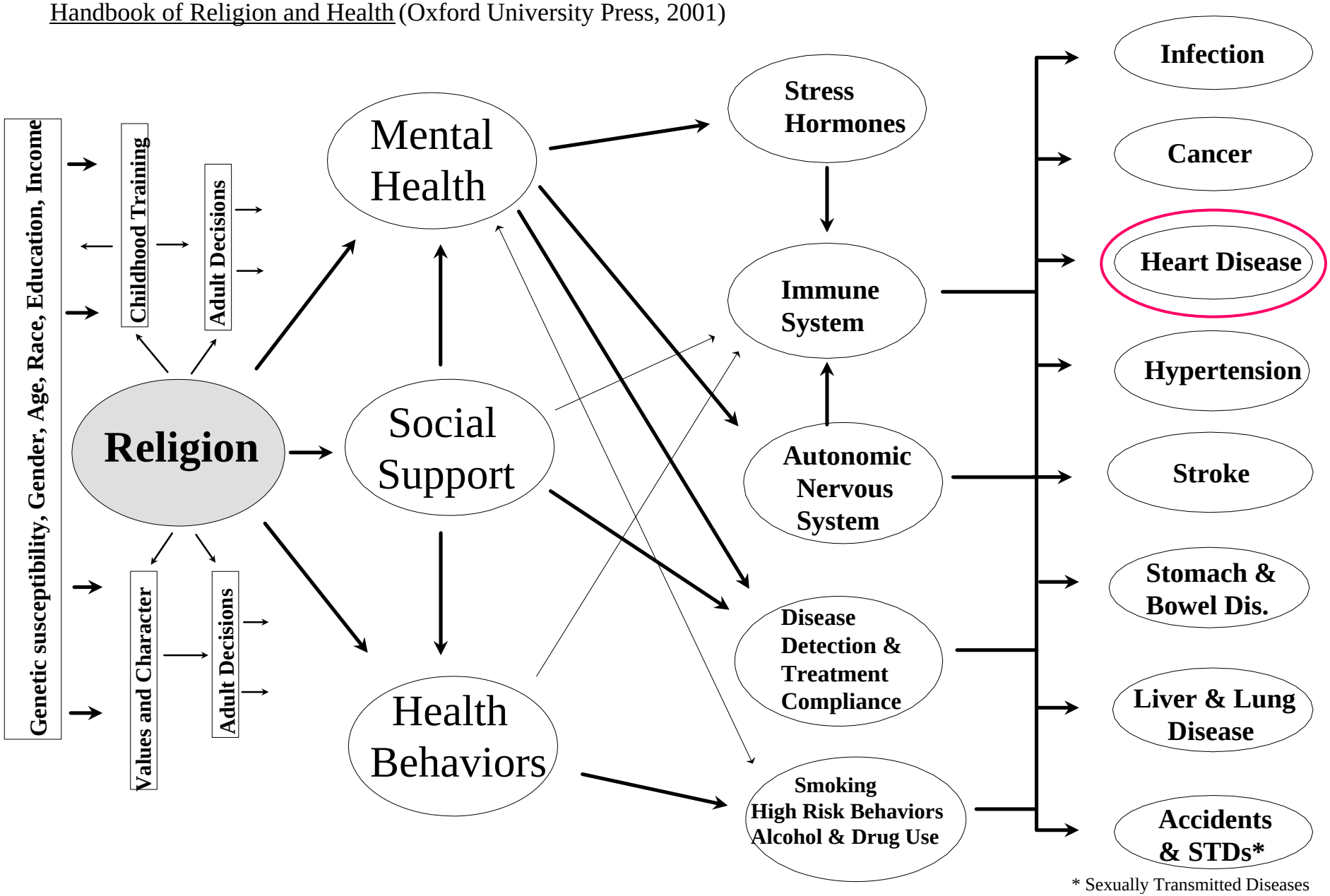
Kathleen A. *Lawler*
*Department of Psychology, **University** of **Tennessee**, Knoxville, **Tennessee** 37996-0900;*
klawler@utk.edu

Abstract

This study sought to examine the psychophysiological correlates of forgiveness in ***response*** to interpersonal conflict. One hundred eight college students (44 males and 64 females) participated in two interviews about times of interpersonal betrayal, one about a parent and one about a friend/partner. Measures of forgiving personality and state forgiveness were collected, as well as ***stress***, hostility, empathy, and self-reported ***illness*** symptoms. During baseline, interviews and recovery periods, repeated measures were taken of blood ***pressure***, heart rate, frontalis EMG, and skin conductance. Trait forgiveness was associated with lower levels of blood ***pressure***. State forgiveness was associated with lower blood ***pressure*** levels, heart rate, and rate ***pressure*** product. Acute, ***stress***-induced reactivity was also linked to forgiveness: state forgiveness was associated with diastolic and ***mean*** arterial ***pressure*** and rate ***pressure*** product reactivity during the parent interview. Increased blood ***pressure*** recovery after ***stress*** was also linked to trait forgiveness. Forgiveness may produce beneficial effects directly by reducing allostatic load associated with betrayal and conflict, and indirectly through reductions in perceived ***stress***.

Model of Religion's Effects on Health

Handbook of Religion and Health (Oxford University Press, 2001)



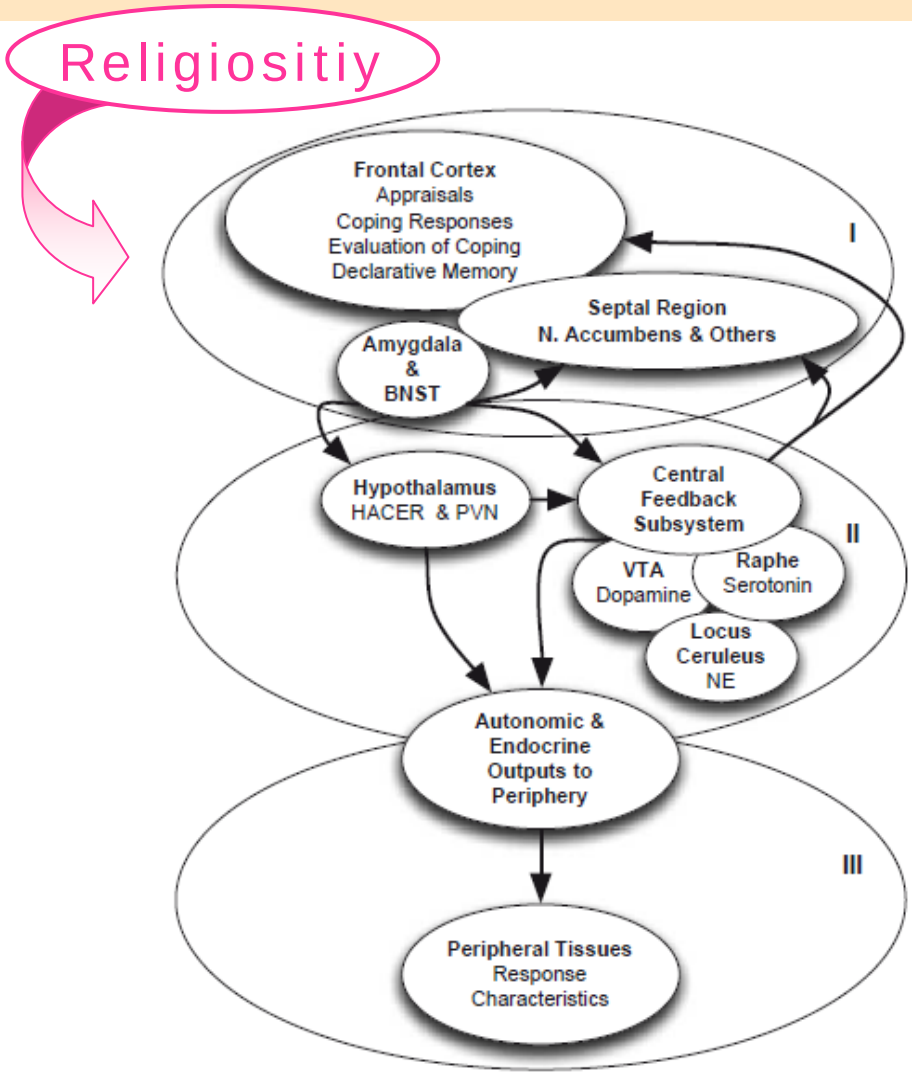
* Sexually Transmitted Diseases

CV REACTIVITY

Cardiovascular Reactivity

- Important concept in psychosomatic medicine
- **Cardiovascular response** to mental (Stroop), social (TSST) and physical challenges
- Typical measures:
  - Heart Rate (HR) and Heart Rate Variability (HRV)
  - Blood Pressure (BP), Blood Pressure Variability (BPV)
  - Cardiac output (CO) and pre-ejection period (PEP)
- **Psychophysiological risk factor** for cardio-vascular disease (Hypertension, CAD)
- **Individual differences** in cv reactivity are determined by complex mechanisms (Lovallo)

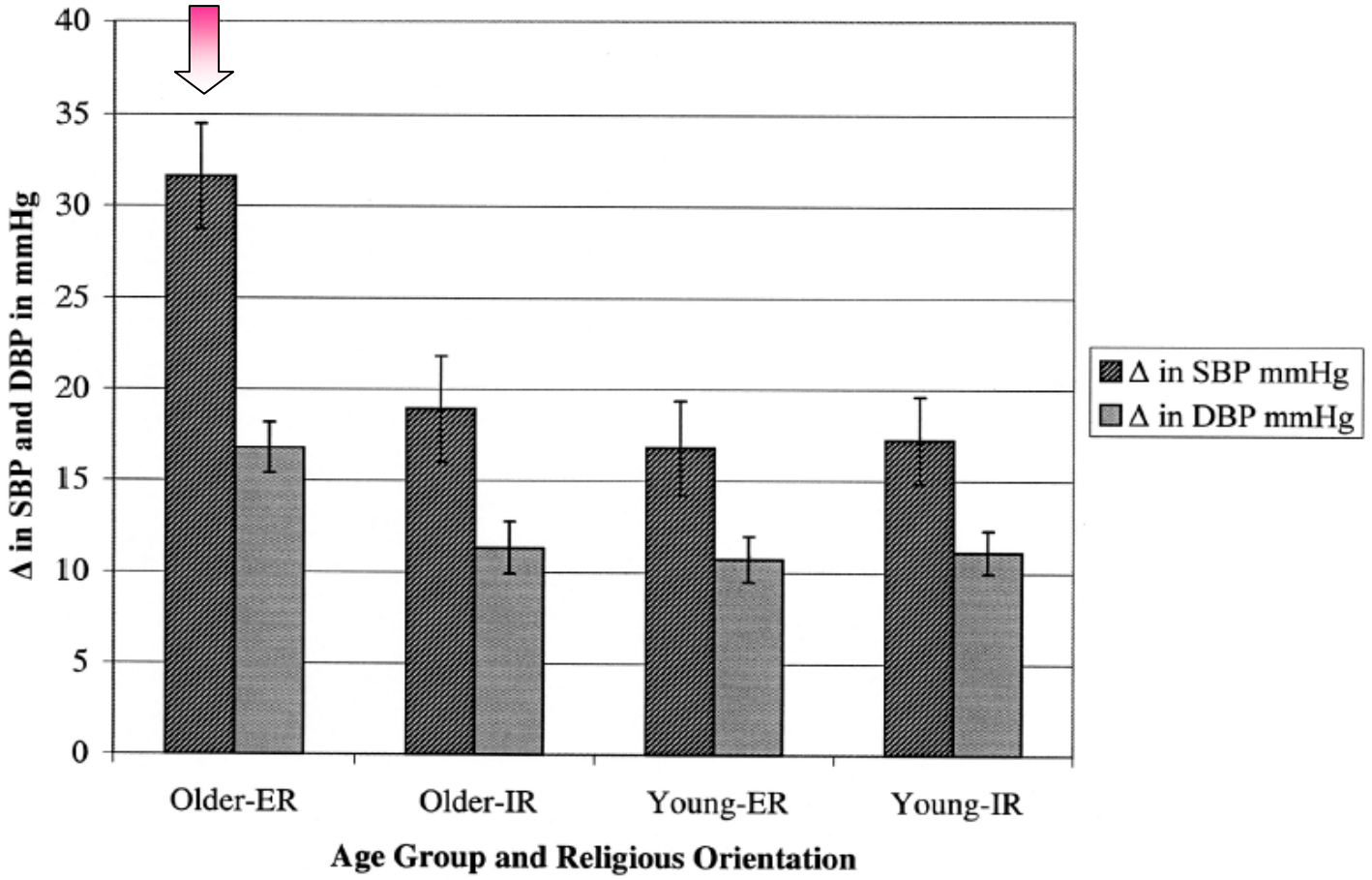
Cardiovascular Reactivity



Three level model

- The fronto-limbic system (cognitions and emotions)
- Hypothalamus and brainstem (regulatory centers, configure outputs to the body)
- Peripheral Organs (different response characteristic)
- Lovallo 2005

CVR and Religiosity



Masters et al. 2004

CV REACTIVITY PROJECT

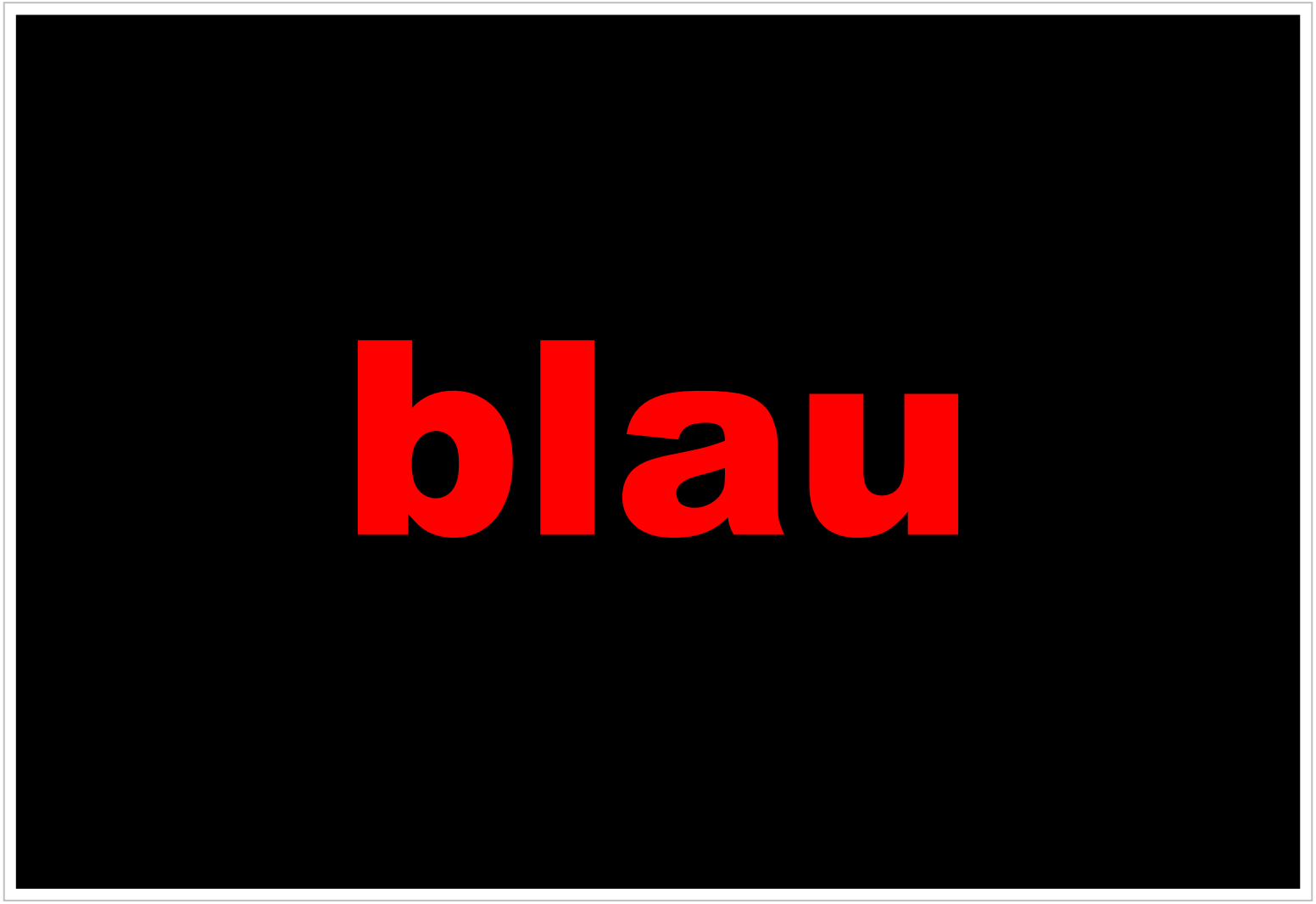
CV REACTIVITY PROJECT-1

- Master thesis of Sibylle Probst & Robert Pfandl, psychology students at the University of Bern

- 40 patients with mild to severe depression
- Assessment of medical history and medications (cardiovascular. psychiatric)
- Assessment of BDI, SCL, S-R-T (centrality, emotions towards God) and RCOPE
- **Mental stress testing = Color-Stroop**

NIKE
SONY
VAIO

COLOR STROOP



KLINIK SGM FÜR PSYCHOSOMATIK
Stiftung für ganzheitliche Medizin

Structure of Religiosity Test

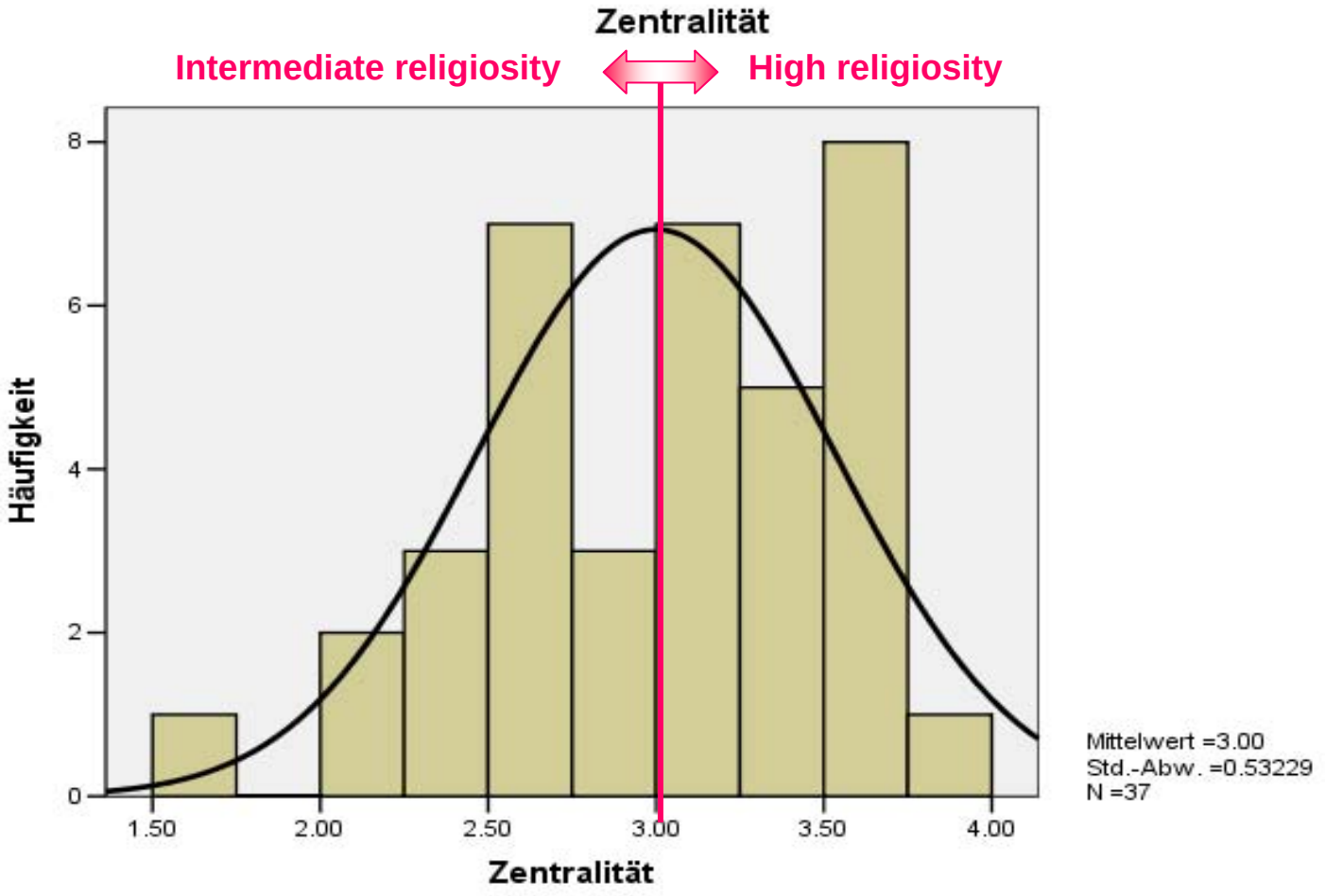
Huber: Synthese der Messmodelle von Allport und Glock

Dimensionen:

- kognitives Interesse
- Religiöse Ideologie
- Gebet
- Religiöse Erfahrung
- Gottesdienst

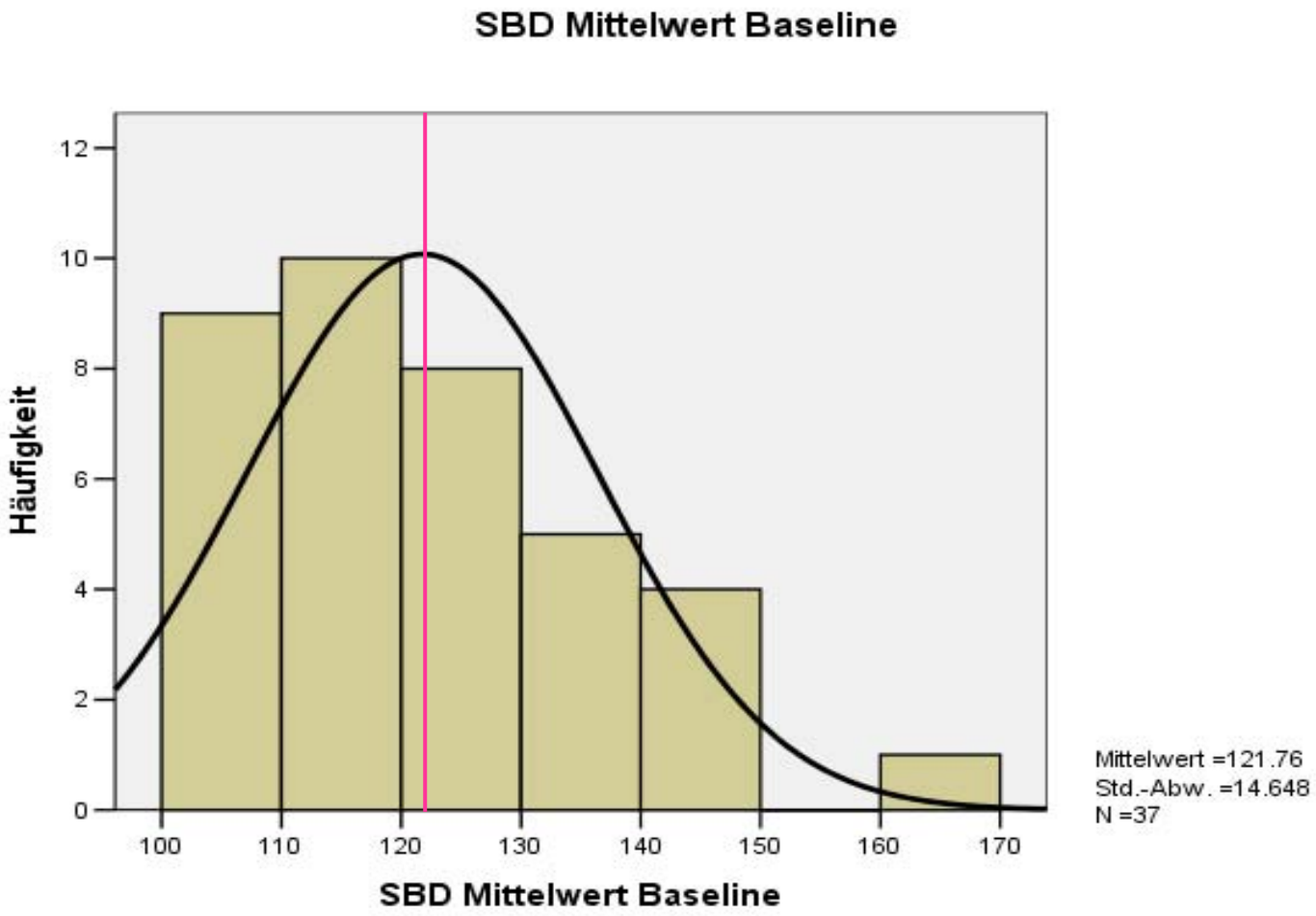
- **Religiosität als persönliches Konstruktsystem mit den Hauptkomponenten Zentralität (bestimmt Stärke) und Inhalt (bestimmt Richtung).**

Sample Characteristics

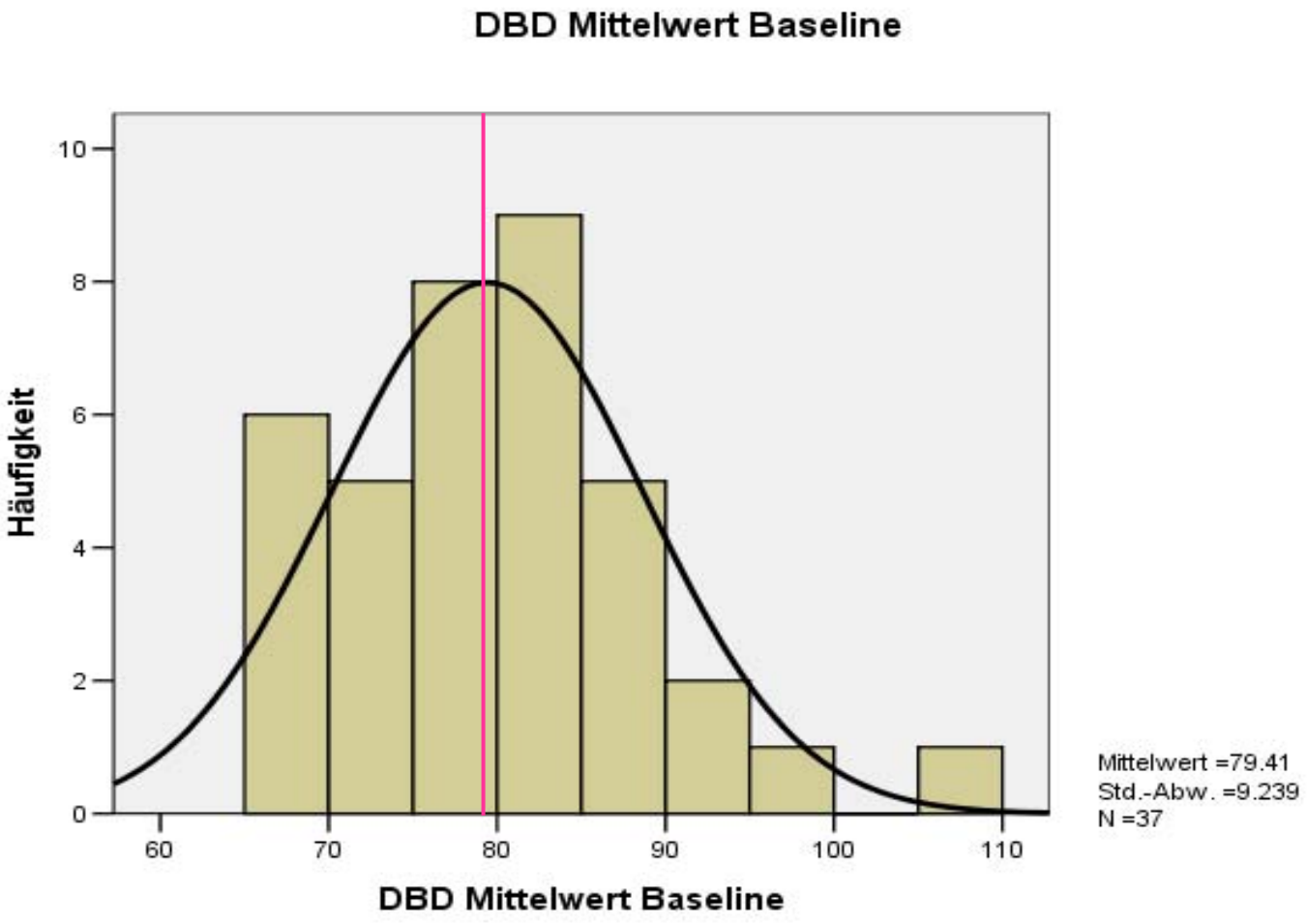


Mittelwert =3.00
Std.-Abw. =0.53229
N =37

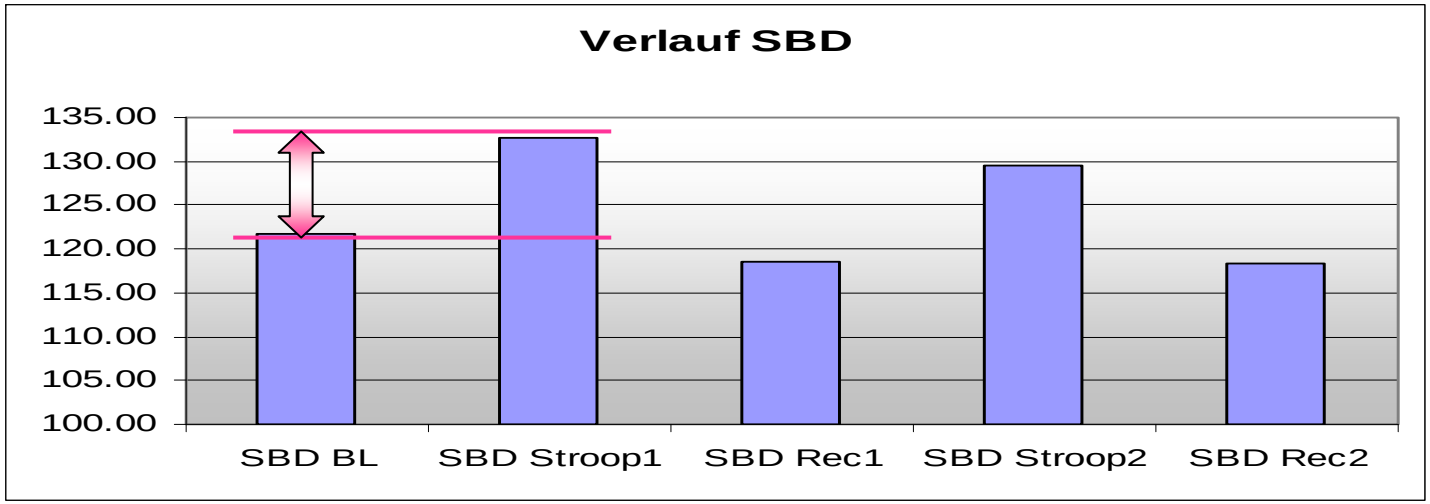
Physiological Parameters

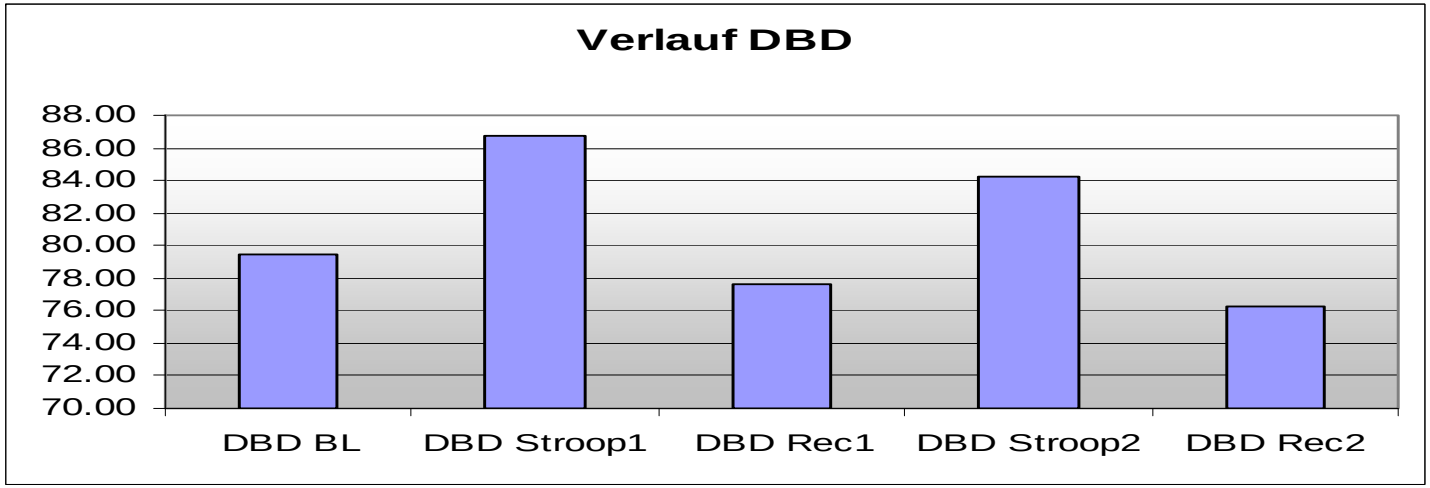


Physiological Parameters



BP-Reactivity during Stroop





Linear Regression Model

Aufgenommene/Entfernte Variablen[b]

Modell	Aufgenommene Variablen	Entfernte Variablen	Methode
1	sex Geschlecht, age Alter[a]	.	Eingeben
2	BDIeS1 BDI-Wert[a]	.	Eingeben
3	RSTeS10 Zentralität[a]	.	Eingeben

a. Alle gewünschten Variablen wurden aufgenommen.

b. Abhängige Variable: DSt1SBD Reaktivität SBD Stroop1-BL

Results:

- **Religiosity explained 20% of the variance**
- **Age, sex and BDI less than 10%**

Modellzusammenfassung

Modell	R	R-Quadrat	Korrigiertes R-Quadrat	Standardfehler des Schätzers	Änderungsstatistiken				
					Änderung in R-Quadrat	Änderung in F	df1	df2	Änderung in Signifikanz von F
1	.282[a]	.079	.025	11.01234	.079	1.466	2	34	.245
2	.282[b]	.080	-.004	11.17704	.000	.005	1	33	.942
3	.503[c]	.253	.159	10.22686	.173	7.417	1	32	.010

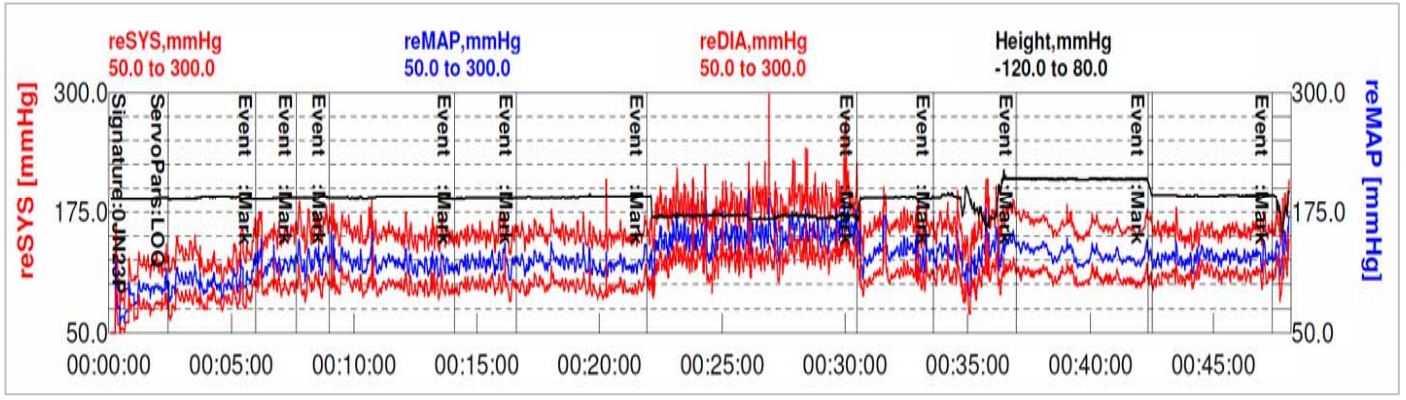
a. Einflußvariablen : (Konstante), sex Geschlecht, age Alter

b. Einflußvariablen : (Konstante), sex Geschlecht, age Alter, BDIeS1 BDI-Wert

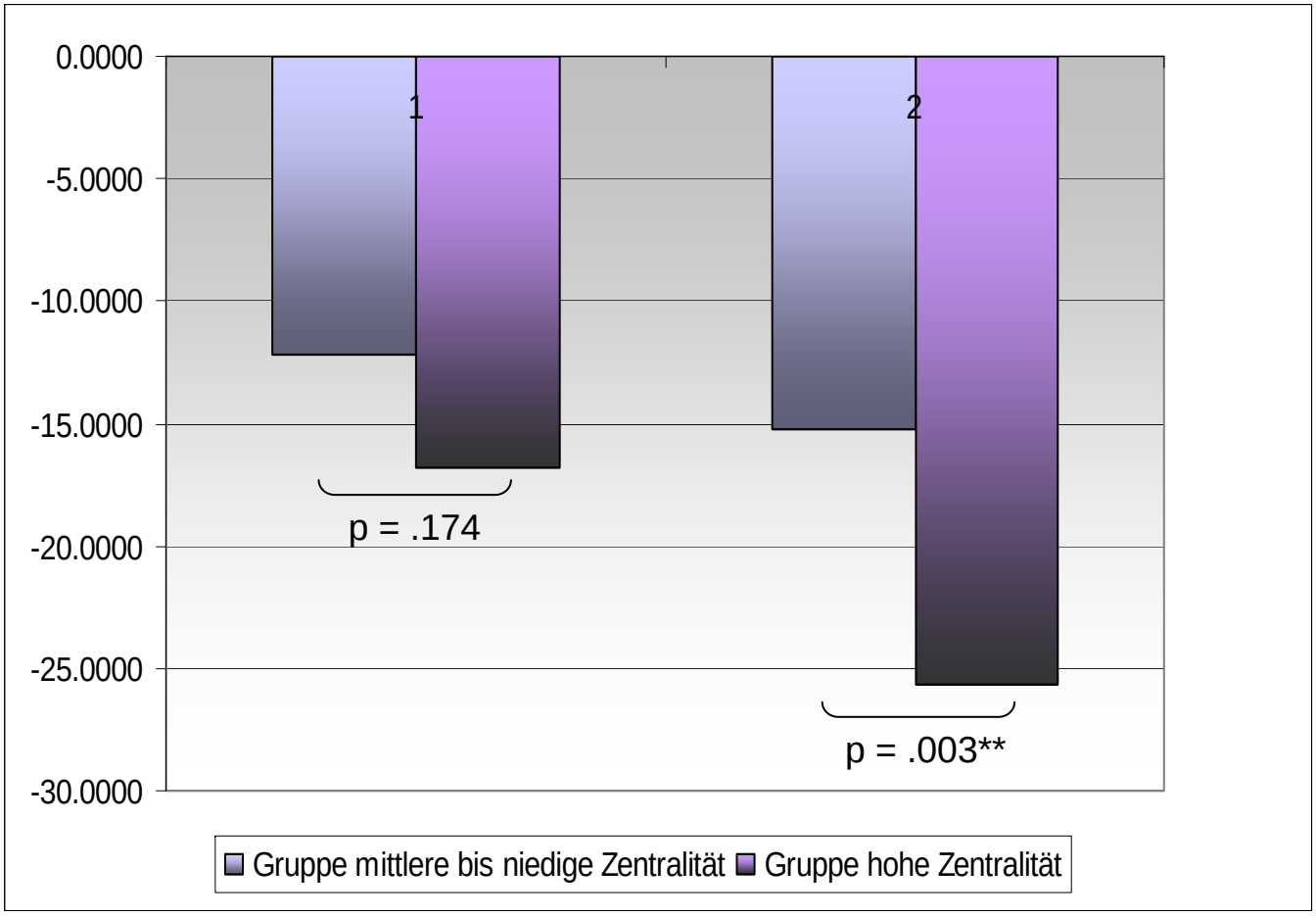
c. Einflußvariablen : (Konstante), sex Geschlecht, age Alter, BDIeS1 BDI-Wert, RSTeS10 Zentralität

CV REACTIVITY PROJECT-2

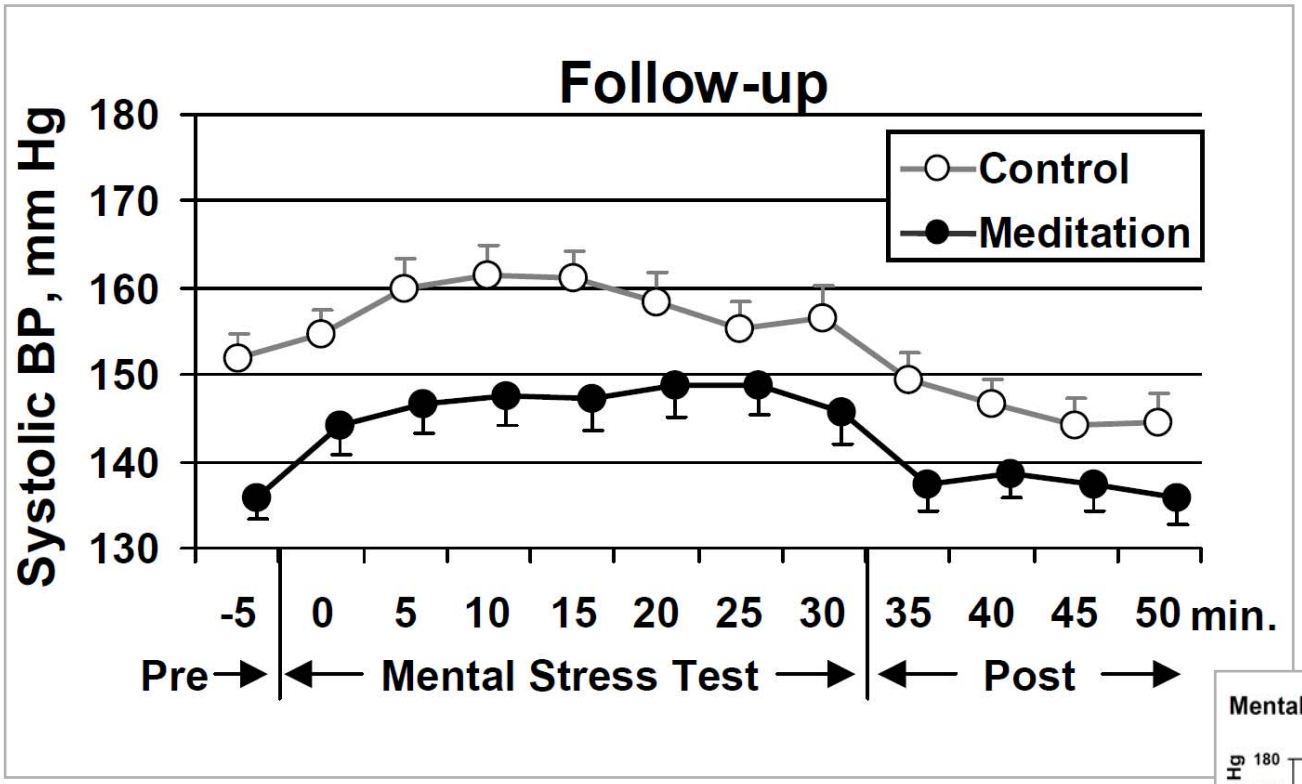
- Doctoral thesis of Lars Kägi (medical)
- 32 healthy young adults, male/female
- Assessment of BDI, SCL, Anger Scale, S-R-T (centrality, emotions towards God)
- Stress protocol (Stroop, TSST, Tilt)

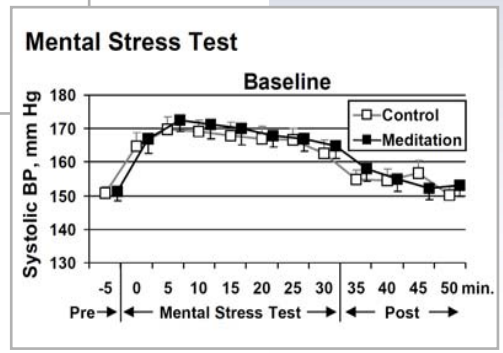


CV REACTIVITY PROJECT-2



Meditation instead of Medcation

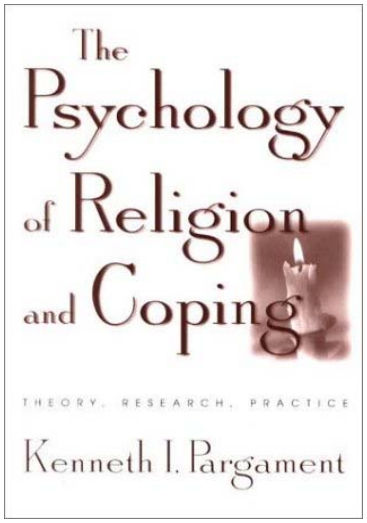




Manikonda et al., 2006

COPING WITH HD

RELIGIOUS COPING



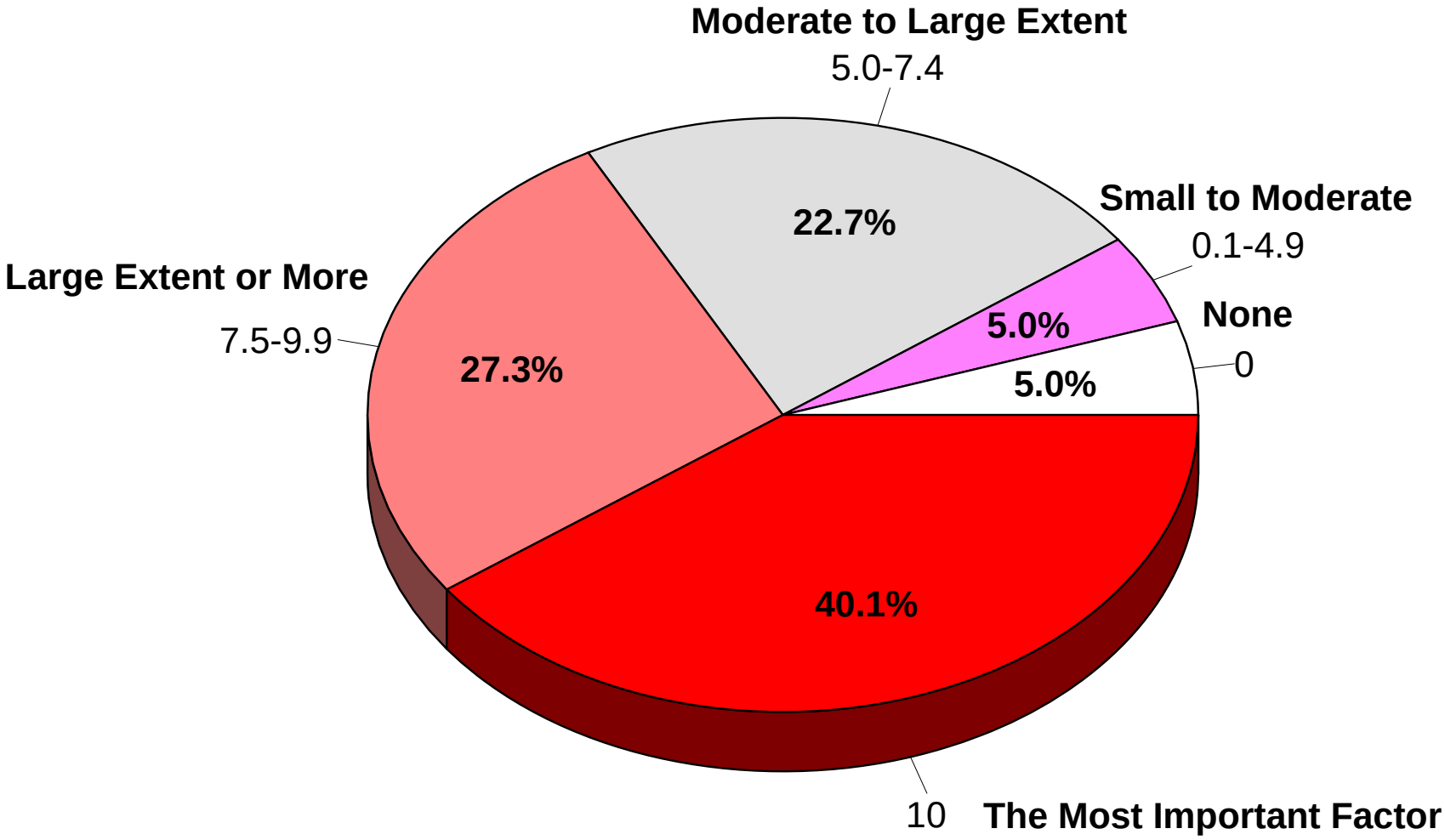
Positive „functions“ of belief:

- ***Meaning/Significance/identity***
  - *Auch im Kranksein, im Leiden, im Sterben*
  - *Ist eine identitätsbildende Kraft (Hell)*
- ***Control***
  - *Schafft ein Gefühl von Kontrolle (Paradoxon)*
  - *Zentrale Dimension in Krankheit/-bewältigung*
- ***Wellbeing***
  - *Stärkt die positiven Emotionen (Freude, Dankbarkeit)*
  - *Fördert das loslassen negativer Gefühle durch Vergebung*
- ***Connectidness***
  - *Fördert Beziehungen, Verbundenheit, Ich-Du (Buber)*
  - *Ist eine gemeinschaftsbildende Kraft (Durkheim, Hell)*
- ***Transformation***
  - *Fördert Veränderungsprozesse, Neuorientierung*

Alle oben genannten Aspekte können sich bei ungesunden Glaubensformen genau ins Gegenteil wenden

Self-Rated Religious Coping

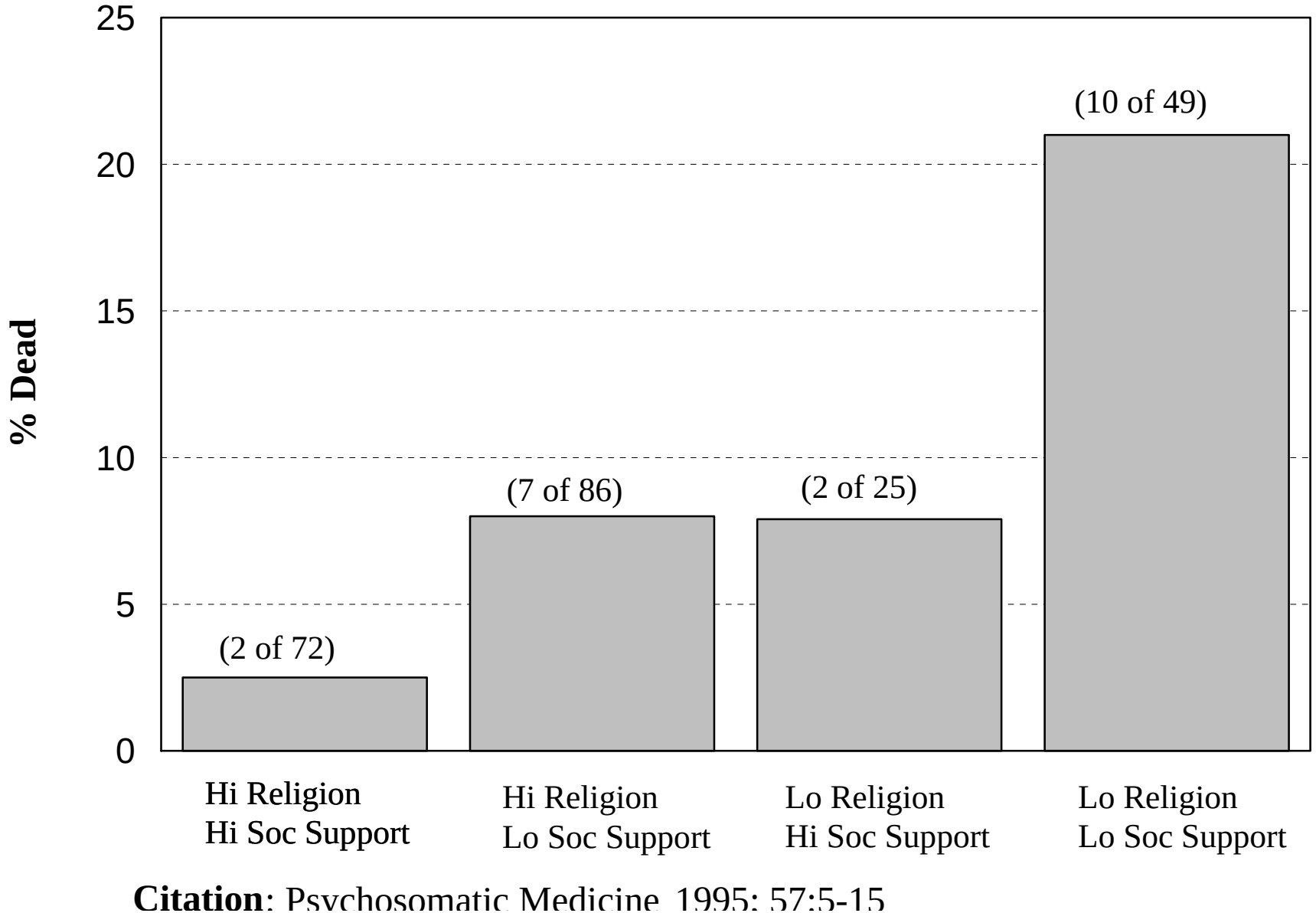
(On a 0-10 scale, how much do you use religion to cope?)



Responses by 337 consecutively admitted patients to Duke Hospital (Koenig 1998)

Six-Month Mortality After Open Heart Surgery

(232 patients at Dartmouth Medical Center, Lebanon, New Hampshire)



Citation: Psychosomatic Medicine, 1995; 57:5-15

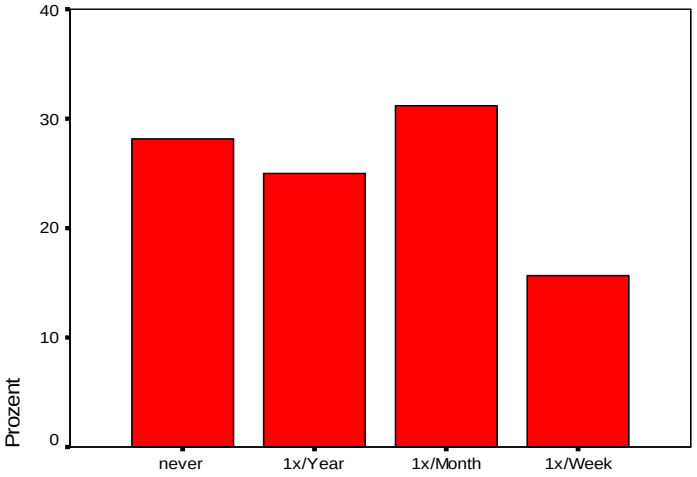
Coping with Heart Surgery

Influence of religious factors on the outcome of bypass surgery

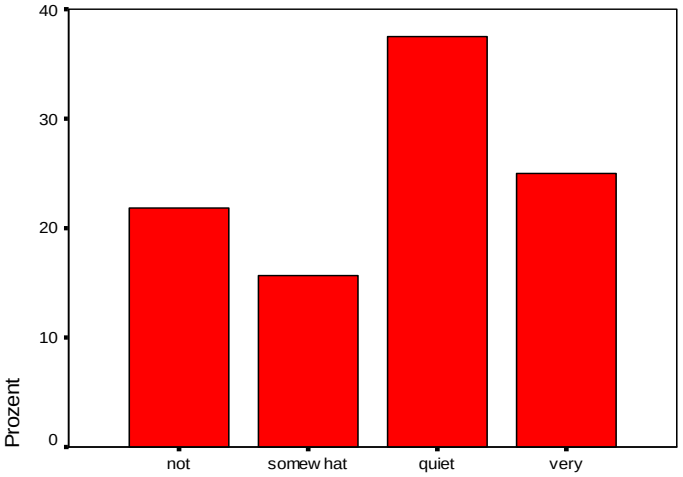
René Hefti, MD, Rehazentrum Hochegg (A), 1997

- *32 patients post coronary bypass surgery*
- *Questionnaire assessing post operative course, health condition and religiosity (church attendance, salience of religion)*
- *Medical records, op results*
- *Patients with higher religiosity had better outcome (CSS, LVF), better health condition and less po complications*

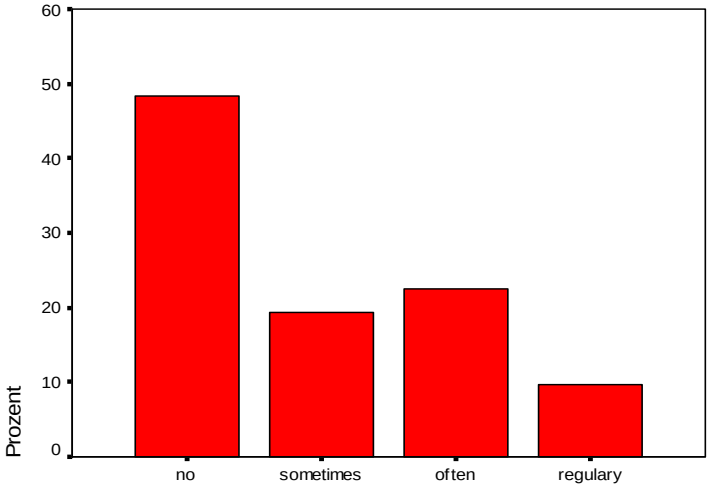
How often are you attending religious sevices?



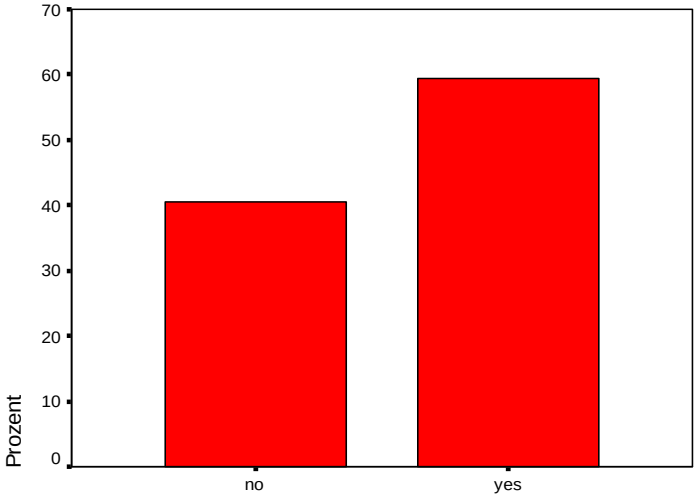
How important is religion/faith for you?



Did you pray (by) yourself ....



... did somebody pray fo you?



René Hefti 1997 , 32 Patienten

CONSEQUENCES FOR CARE

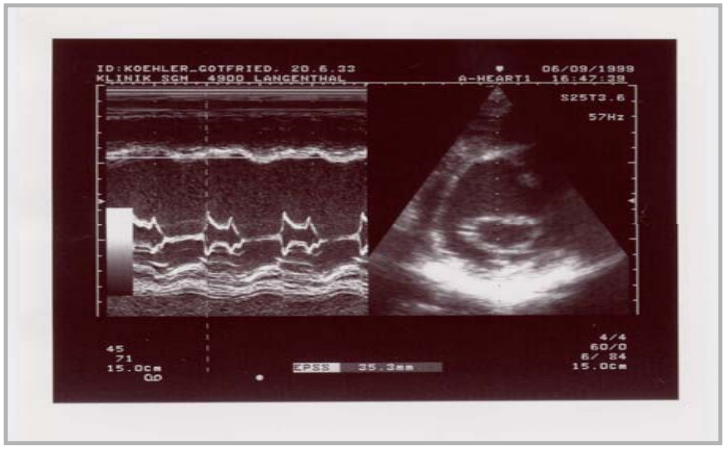
Consequences for Care

- Patient centered psychosocial approach
- Taking a short spiritual history
- Assessing spiritual needs and struggles
- Supporting patients beliefs
- Refering to pastoral/spiritual counselers

⇨ **Interdisciplinary spiritual care model**

Spiritual Care in CV Medicine

KLINIK SGM FÜR PSYCHOSOMATIK
Stiftung für ganzheitliche Medizin



Forschungsinstitut für Spiritualität und Gesundheit

Research Institute for Spirituality and Health

- Home
- Events
- Newsletter
- Shop
- Downloads
- Support
- Links
- Institut
- Kontakt

Newsletter

Abonnieren Sie unseren Newsletter und bleiben Sie aktuell informiert!

▶ mehr

Europäische Konferenz

Forschungsinstitut für Spiritualität und Gesundheit · Research Institute for Spirituality and Health

European Network of Research on Religion, Spirituality and Health

Newsletter July 2009 — Volume 4 • No. 3

Editorial

Dear colleagues, dear friends

First of all I want to thank Erminia Colucci for her brilliant contribution to this newsletter on „Spirituality and Suicidology" which brings up a very relevant topic in mental health care. I want to encourage you to read the full article that can be freely downloaded (see reference).

Second I invite you to use the newsletter as a platform to share your research projects and promote your publications. The European Network is growing constantly and „transcending" European borders, as Erminia Colucci's contribution shows.

Thirdly I am happy to announce our 2nd European Conference on Religion, Spirituality and Health, which is going to take place in May 13-15, 2010 in Bern/Switzerland. The overall topic will be religious and spiritual coping, the international keynote speaker Prof. Ken Pargament. As a pre-conference there will again be the opportunity to participate in a 4-day research workshop with Prof. Harold Koenig. I warmly invite you to take part in both events and to submit your abstracts for the European Conference where we plan to launch a Young Researcher Award (further information see our webpage www.ecrsh.eu)

René Hefti, MD

Topic

Recognizing Spirituality in the Assessment and Prevention of Suicidal Behaviour

Introduction

In pre-modern times, concerns related to illness and healing were often encompassed within the wider domain of a religious worldview and, in many cultures, healing was a sacred art (Bathgate, 2003). Today, (Western) Medicine, including Psychiatry, and in general Psychology, are secular disciplines. But, as observed by D'Souza (2002), in many parts of the world a holistic view of human being has survived. This is seen, for instance, in Chinese and Indian Medicine, in the healing arts of American Indians and among Indigenous Australian peoples. However, as Swinton (2001) points out in his *Spirituality and mental health care. Rediscovering a „forgotten" dimension*, even though the idea of spirituality appears to belong to a surpassed era, in fact the latter part of the twentieth century has seen a noticeable rise in interest in spirituality within the Western world. But, as Swinton (2001) clarifies later, this does not refer to institutionalized religions which are becoming less popular.

The distinction between religion and spirituality has gained greater prominence since the 1960s (Dein, 2005) and, nowadays, there seems to be general agreement (e.g. Birnbaum & Birnbaum, 2004; Fetzer Institute, 1999; Oldmall, 1996) about the necessity to differentiate between these two concepts: religion and spirituality do not necessarily overlap for everyone and individuals may be spiritual without being religious (unreligious spirituality) and religious without being spiritual (unspiritual religiosity). Consequently, religion - defined more narrowly as a formal, ritualized and institutionalized system of beliefs - should not be treated as synonymous of spirituality but, eventually, as one form of spirituality (or the most common cultural representation of spirituality, in Eckersley's -2007- words).

After a brief discussion on the definition of spirituality, the article presents evidence from the literature that, in spite of the importance spirituality might have for mental health patients and suicidal people, it is still an overlooked area in Suicidology. Attention is also given to a central aspect of spirituality that has, with few exceptions, been neglected in suicide research, i.e. meaning and purpose in life. Suggestions for future research are offered in the closing section.

What Should Not Go Neglected and How: Future Direction

The *Mental Health Foundation report* (2006) points out that, whilst there is recognition that there are differences between religion and spirituality, much of the research uses measures of religious practice as a proxy. But, as Swinton (2001) affirms, the significant thing to bear in mind is that spirituality may well be significant to many people with mental health problems, even though they may not express an interest in or adherence to an established religious tradition. For instance, Webb (2003) admits that a faith-based religious spirituality was not going to work for someone with a rational-istic and atheistic upbringing like his but that this form of sacred relationship with a religious God has been the key to the recovery of other suicidal patients. Therefore, research should attempt to discover those aspects of life that give meaning to individuals that are beyond the traditional parameters of religion (Mental Health Foundation, 2006). Consequently, the first suggestion for future direction in research is to focalize on the broader concept of spirituality, on the feeling of transcendence, on the personal and cultural ways of experiencing and expressing spirituality, and do so by increasing the use of qualitative methodology. Swinton (2001) is very critical of the use of quantitative methods to study religion and spirituality. One of the limits shown by quantitative studies of religion is that usually they are reductionistic, simplistic and treat religion and spirituality as if they are unidimensional constructs, often assuming that these can be adequately measured by a single variable. In fact, in the cross-cultural journals reviewed by Tarakeshwar, Stanton and Pargament (2003), the authors criticized that religious dimension was assessed through a few global indicators (such as church affiliation, church attendance and prayer) which do not reflect the multidimensional nature of religion[1]. Burkhardt (1989) supports the idea that spirituality

EC RSH10

First Announcement

2nd European Conference on Religion, Spirituality and Health

May 13-15, 2010 • Bern, Switzerland • www.ecrsh.eu

General Information

The 2nd European Conference on Religion, Spirituality and Health puts an special emphasis on religious and spiritual coping in health and disease. The keynote speakers approach the topic from their specific professional background, aiming to enhance the interdisciplinary dialogue between medicine, neuroscience and theology. The newly established Bern Lecture will be offered by Prof. Kenneth Pargament, an internationally recognised expert on religious coping. Symposia invite discussion and 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.
Another focus is to strengthen the network among researchers in the field and to promote scientific projects. A public lecture will be given by Prof. Thierry Carrel.

Keynote Speakers & Main Topics

- PD Dr. med. et scient. Raphael Bonelli
  Medical Faculty, University of Salzburg, Austria
  Research in Forgiveness Therapy
- Prof. Dr. med. Jean-Marc Burgunder
  Department of Neurology, University of Bern, Switzerland
  The Neurobiology of Coping
- Prof. Dr. med. et. M.M.E. Peter Heusser
  Chair for Theory of Medicine, Integrative and Anthroposophic Medicine, University of Witten/Herdecke, Germany
  Spirituality in Medical Anthropology. Why? And how?
- Ass. Prof. Dr. theol. Niels Christian Hvidt
  Research Unit of Health, Man and Society, University of Southern Denmark, Denmark
  Theological Perspectives on Religious Coping
- Prof. Dr. Mary Kalfoss
  Nursing Research, Diakonova University College, Norway
  Spirituality, Love and Quality of Life
- Prof. Dr. med. Maria Kopp
  Institute of Behavioral Sciences, Semmelweis University, Hungary
  Meaning in Life, Religion and Health in a Changing Society
- Prof. Dr. Kenneth I. Pargament
  Dep. of Psychology, Bowling Green State University, USA
  Wrestling with the Angels: Spiritual Struggles and their Implications for Health & Well-Being
- Prof. Dr. John Swinton
  School of Divinity, History and Philosophy, King's College, University of Aberdeen, UK
  Religion and Mental Health
- Prof. Dr. Harald Walach
  School of Social Sciences, University of Northampton, UK
  Mindfullness Spirituality and Coping

Public Lecture

- Prof. Dr. med. Thierry Carrel
  Department of Cardiovascular Surgery, University of Bern
  Hat Spiritualität überhaupt noch einen Platz in der hochspezialisierten Medizin ? (German)

Call for Abstracts

We invite the submission for presentations until Decembe
www.ecrsh.eu (see abstract

www.fisg.ch oder www.rish.ch