COMPASSION FATIGUE: EMBRACING SPIRITUALITY

Gayatri Naraine
Representative of the Brahmakumaris at the United Nations, Brahma Kumaris World Spiritual University, New York, USA

Compassion Fatigue is described in a variety of ways, depending on the experience of the person speaking about it. Some examples include: 1) a state of being experienced by those helping others in distress; 2) an extreme state of tension, stress, and preoccupation with the suffering of those being helped, which can create stress for "the helper"; or 3) taking on the suffering and pain of others and making it one's own. Compassion Fatigue results in emptying the self of reserves, losing flexibility, and no longer fun to be around.

Causes of Compassion Fatigue include lack of strong personal boundaries, unresolved past pain, overdeveloped sense of responsibility, and an impulse to rescue anyone in need.

Symptoms of Compassion Fatigue include a feeling of being depleted, emotional ailment, sadness and apathy, and "them" vs. "us" mentality.

This presentation makes a case for embracing spirituality that is transcendent in nature. In embracing spirituality, the process involves moving from Compassion Fatigue to Compassion Inquiry to Compassion Satisfaction. It is a road to healing that calls for authentic self-care, subtle discernment, strengthened resilience, balanced life, being grateful, and the helper asking for help. It also looks at the essential element of empathy.

Embracing spirituality is about the integrative person taking into consideration the quadrants of physical, emotional, social, and spiritual aspects when looking at self-care.

PSYCHIATRISTS AND COMMUNITY PARTNERS EXAMINE RELIGION AND SPIRITUALITY

Helen Herrman[1,2,3]

[1]Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia, [2]Orygen, National Centre of Excellence in Youth Mental Health, Melbourne, Australia, [3]President, World Psychiatric Association, Geneva, Switzerland

The WPA Position Statement on Spirituality and Religion in Psychiatry, created by the leaders of the WPA Section on Religion, Spirituality and Psychiatry and endorsed by the WPA General Assembly in 2017, reviews the significance of spirituality and religion to the health and quality of life of people worldwide. It notes the relevance of spirituality and religion in various ways to the origins, understanding and treatment of mental health problems and makes several recommendations for the practice and development of psychiatry. Others have reflected on the relevance of spirituality to positive emotions and social connections and to wellbeing and health across the lifespan.

Achieving consensus and developing this Position Statement represent a historic development in psychiatry (Verhagen 2017). In this presentation I will comment on a number of implications for the practice of psychiatry, focusing on the importance of working in partnership with other groups and organisations - including people with lived experience and family carers, and leaders and members of faith communities.

The WPA was established in 1950 with the vision of: “A world in which people live in conditions that promote mental health and have access to mental health treatment and care that meet appropriate professional and ethical standards, integrate public health principles and respect human rights”. A current focus for WPA is expanding the contribution of psychiatry to improved mental health worldwide by reaching people who face adversity and disadvantage. This is based on two things: working with psychiatrists to use their expertise in a range of community settings; and collaborating successfully with other groups and organisations. Working with the WPA member societies and community partnerst to develop practical resources and support the widespread use of the Position Paper’s recommendations represents an important component of this work.

WPA POSITION STATEMENT IN RELIGION, SPIRITUALITY AND PSYCHIATRY: PRACTICAL IMPLICATIONS

Alexander Moreira-Almeida
School of Medicine, Universidade Federal De Juiz De Fora (Ufjf), Juiz De Fora, Brazil

Recently WPA approved a Position Statement on Spirituality and Religion in Psychiatry, that was a consequence of the increasing public and academic awareness of the relevance of religion/spirituality (R/S) to health issues. It is an important step towards improving clinical practice in psychiatry and ensuring that the spiritual, as well as biopsychosocial, needs of mental health service users are met during the course of their treatment. A large number of empirical studies have been shown that values, beliefs and practices related to R/S remain relevant to most of the world population and they have significant implications for prevalence, diagnosis, treatment, outcomes and prevention, as well as for quality of life and wellbeing. This talk will present the Position Statement and its practical implications for research, education and clinical practice. Areas for consideration of R/S include: inclusion in history taking, diagnosis, treatment, clinical research, ethical considerations, cooperation with faith communities, and recognition of its potential benefits and harms.

Moreira-Almeida A, Sharma A, van Rensburg BJ, Verhagen PJ, Cook CC. WPA Position Statement on Spirituality and Religion in Psychiatry. World Psychiatry, 15:87-8, 2016.

PSYCHIATRY AND RELIGION. CONTROVERSIES AND CONSENSUS: A MATTER OF ATTITUDE

Peter J. Verhagen
Psychiatry, G Gz Centraal Mental Health Institution, Harderwijk, The Netherlands

Although empirical findings on religion, spirituality and psychiatry are indisputable important and abundantly available, and yet are often ignored in main stream psychiatry, the meaning of religion and spirituality in psychiatry goes beyond the outcomes-based clinical studies. There is much more to ask and to know than just about practical concerns in clinical practice.

I see four attitudinal, problematic issues: 1) although empirical evidence is available it is not regularly used in clinical practice. How to explain that in a medical discipline that attaches great importance to evidence? This is a clinical practice question. 2) Is a connection investigated between the patient's daily (religious or spiritual) experience, the clinical findings and the evidence, and if so, how? This is the issue of applying clinical and research findings to the patient's situation and experiences. 3) The opposite way from point 2): In what way is the daily experience of the patient 'translated' in clincial language and operationalized in research constructs? This is the issue of abstraction (as 'artificial pulling out') from daily (religious or spiritual) experience to clinical language and to research approaches. 4) The interactions between levels of abstraction implied in 1), 2) and 3) ask for a stance of meta-theoretical reflection. Reflection upon this complex structure of levels of assessment and inter-level interactions will necessarily require and will simultaneously lead to an interdisciplinary and interreligious dialogue.

So we find not just one (empirical) but four levels of understanding and analysis: (a) daily (religious or spiritual) experience, (b) clinical practice, (c) scientific practice, and (d) meta-theoretical reflection. The professional attitude I want to recommend is a stance of critical reflection based on epistemic virtue.

Reference: Verhagen, P.J. (2019). *Psychiatry and Religion. Controversies and Consensus: A Matter of Atiitude.* Düren: Shaker Verlag.

FROM PSYCHO-ANALYSIS TO CULTURE-ANALYSIS: APPLYING RELIGIOUS BELIEFS IN THERAPY

Marwan Dwairy
Educational Counseling, Oranim Academic College, Oranim, Israel

This lecture re-examines the application of psychodynamic approach in collective cultures and suggests culture-analysis as an alternative and/or to pave the road for psycho-analysis. Culture-analysis is based on the fact that each cultural value system includes many opposites and contradictions. In culture-analysis therapist identifies subtle contradictions within the belief system of the client and employ cultural aspects that may facilitate change. Similarly to how a psychoanalyst analyses the psychological domain and brings conflicting aspects to the consciousness (e.g. aggression and guilt) in order to mobilize change, a culture-analyst analyses the client's belief system and brings contradicting aspects to the consciousness in order to mobilize revision in attitudes and behavior. Unlike the unconscious drives which are revealed through psychoanalysis, these intra-culture conflicts are not supposed to be threatening because all aspects revealed are culturally and morally legitimized. In order to conduct a "within-culture therapy," therapists need to be open and incorporate several aspects of the culture in the therapy in order to create a new dynamic within the client's belief-system. Beside empathy, a thorough inquiry into the client's culture is needed in order to identify the cultural aspects that could be employed in therapy. Some examples of within culture-analysis will be presented.

INTEGRATING PRINCIPLES OF RAJYOGA IN PSYCHOTHERAPY

Sujatha Devanathan Sharma
Psychoogy, Mindspecialists, New Delhi, India

Living as we are in highly stressful times with rising consumerism, competition, conflict, strife, catastrophes and climate change, it is not surprising individuals and societies are not only facing psychological distress but also a crisis of existence. More and more people are seeking out spiritual solutions to mental health issues, besides the mainstream psychiatric and psycho therapeutic treatments. This paper will discuss some of the core principles of Rajyoga meditative lifestyle, as practiced by the Brahmakumaris, a secular, non-religious spiritual organization, with about 8500 centers around the world. The attempt is to present a framework for integrating the concepts, principles and practice of Rajyoga with psychotherapy practice, based on a holistic mind-body-spirit (soul) approach to mental well-being. It highlights the role of the mind, intellect and 'sanskars' (deeply embedded habit patterns) that can determine mental wellness or illness. The practice of Rajyoga is aimed at self-transformation through self-awareness, inoculation of specific Meta cognitive states through meditative processes and value based living through imbibing universal core values. Key concepts of Soul consciousness, Connection with the Supreme, the World drama, Cycle of time, Karma and the Powers of Soul are briefly discussed. These spiritual underpinnings emphasize their applicability in developing inner strength and stability to cope with crisis and psychological distress. They have many parallels with CBT processes which provide an ideal platform for complementary, integrative applications to bring about transformation and change in attitudes, beliefs and thoughts and behaviors in the clients.

Rajyoga Meditative Lifestyle is a holistic approach that can promote well-being and prevent mental health issues, and achieve a healthy balance between the inner and outer, intrapersonal and interpersonal, self and the Highers self/Supreme, paving the way for an empowered, quality of life and harmonious living.

LETTING GO: SPIRITUAL EXPERIENCE IN PSYCHEDELICS, MEDITATION AND DEPTH PSYCHOLOGY

Paul Summergrad[1,2]

[1]Psychiatry, Tufts University, Boston, USA, [2]Department of Psychiatry, Tufts University, Boston, USA

In this talk, I will discuss several related but distinct forms of spiritual experience which are in part linked by changes in consciousness, conscious attention and encounter with what has been called numinous experiences. Drawing on recent research, and personal experiences, I will discuss the impact of psychedelics on persons with mood and anxiety states, including end of life situations, common findings associated with response to psychedelics including correlation with spiritual experiences, and neuroimaging findings. Meditative and prayer traditions will be discussed, both as a form of practice including its underpinnings in ethical daily behavior. Finally I will talk about the confrontation with the numinous and the unconscious in depth psychology traditions and dreams. All of these states are associated with letting go of preconceptions, in many cases refocusing or forcing changes in self-perception, organization and perceptions of the world. Implications for clinical care and both depth and cognitive psychotherapies will be addressed

PSYCHOTHERAPY WITH A HASSIDIC CLIENT SUFFERING FROM "SPIRITUAL DISSONANCE" AND RELIGIOUS EMPTINESS

Gabriel Strenger
Counseling and Human Developme, University of Haifa, Haifa, Israel

Some orthodox and ultra-orthodox Jewish patients suffer from what I've called "spiritual dissonance" – coined on the basis of Leon Festinger's classic term "Cognitive Dissonance" (1957). Spiritual dissonance is a condition in which a person experiences, on varying levels of consciousness, a growing discrepancy between everyday religious practice and inner spiritual experiences. In these cases the religious tools provided by the Halacha (Jewish law) aren't experienced as vessels or instruments in the service of the person's spirituality or attachment to God (as they're supposed to be), while in more severe cases the religious practice actually become a hindrance to the person's spiritual development. As a rule, the more orthoprax the person, the vaster the potential of Spiritual Dissonance and the deeper the agony of the resulting feelings of guilt, shame and existential emptiness.

Psychotherapeutic exploration of these conditions often leads to the uncovering of the client's pathological object relations and/or unresolved loyalty issues with early parental figures, preventing the maturing of the patient's religious identity.

This case presentation will give an account of some processes that took place in a psychotherapy conducted with a Haredi (ultra-orthodox) Chassidic man, exemplifying the aforementioned dynamics and the psychotherapeutic strategies used for unblocking spiritual and religious maturation.

THE ESSENCE OF JEWISH INTEGRATIVE PSYCHOTHERAPY- A CASE STUDY

Michael Binyamin Aboulafia
Faculty of Education, University of Haifa, Haifa, Israel

Jewish integrative psychotherapy presents some very unique characteristics that turn every treatment into a different kind of therapy. Here are some examples of these characteristics - in Jewish integrative psychotherapy there is a very precise map of the forces of the soul; There is significance to every crisis; Any decline is for the purpose of immigration; There is a very optimistic and positive perception of who the person is. There is also the possibility that the therapist will be idle to the patient, similar to him to find a key to healing Another characteristic of many of the special principles described in the book "Shovi Nafshi" is devotion and a very high moral level of caring.

In this lecture, I will focus on a typical principle of Jewish integrative psychotherapy, which is a verse in the Book of Ecclesiastes, which teaches that one can recognize the virtue of man.

The case study will show treatment with a 14-year-old girl who has been dealing with anorexia, post-traumatic stress disorder, very high sexual arousal and severe suicidal impulses. After repeated attempts to treat her in the community, she was hospitalized. The treatment lasted for about a year, and was characterized by the use of trauma treatment tools such as SE, along with the use of tools of Jewish integrative psychotherapy, such as connecting the self-destruction movement to Kabbalah concepts; Or like the use of verse Ecclesiastes, which helps us understand what positive trait lies behind the crisis. According to this understanding, there is no mental illness, but rather a passing crisis.

Gradually the optimistic spirit penetrated the girl's heart, and she learned to believe in herself. The therapeutic process became part of the girl's quest for independence, self-sufficiency, and empowerment, at the end of which the girl was without medication, thanksgiving for this difficult crisis.

THE QUIET REVOLUTION OF BIBLE THERAPY – CONSCIOUSNESS, SOUL AND INTENTION

Yael Shafir Garibi
Psychotherapy, Haifa University, Zichron Yakkov, Israel

The lecture will describe the means by which Bible Therapy enables therapeutic practice based on bible stories in the realm between the **consciousness** of our subjective stories and the **soul** which is governed by these stories, and turns our attentive awareness to the positive **intention** behind preservation of these stories and recreating them through the shifts in biblical stories.
This lecture is based on 12 years of study and research of biblical stories that provided the basis for the creation of a unique treatment method – the **"Bibletherapy"**.
This method uses the foundations of healing the soul found in the stories of the Bible and the encounter between the story and the different aspects of the human soul.
The Jewish spiritual path is man's journey from "I" the ego to the "self" and from there to the divine dimension or what C.G. Jung calls "the Collective Unconscious". The Bible is full of travel stories that describe this path, interspersed with the therapeutic quality of the power of faith.
In the lecture I will present a clinical example of a Bibletherapy process that is based on the proposed transformation in the biblical story of Sarah. An original therapeutic model will be presented, that combines the forces of change in the story that enables the transition between the ego and the ego forces that operate in it to the "self", that is the deeper dimension of consciousness in the wish to bear a child.
Through this clinical example, I will discuss the influence of the story on the creation of a transformation within the "I" space toward the "Self" by recruiting the power of belief, or the Placebo Effect. i.e., how the use of the power of faith can create restructuring of ego powers that enables a change in the depth of consciousness and a connection to the divine dimension and the fulfillment of the wish to become a mother and bring life into the world.

"UNITY OF OPPOSITES"– HOPE IN THE SPIRITUAL JEWISH-HASSIDIC APPROACH REVIVED IN A NEW THERAPEUTIC MODEL

Ziva Bracha Gidron
Psychotherapy, Indipendent, Jerusalem, Israel

This lecture will describe how can the theraputic space help to creat hope in psychodrama psychotherapy group, based on a jewish hassidic spiritual terms called:" Holding opposites" and "Unity of Opposites".
This psycho Spiritual approach is based on the kabbalistic & Hassidic approach of Rabbi Israel HBa'al Shem Tov (1700-1760), founder of the Hassidut movement, and Rabbi Shneor Zalman from Liady (1745-1813), who created the idea known as the "Unity of Opposites."
Those concepts that developed in the 18th century can be compared to the dialectical experience that appears in psychotherapy as split between the "multiplied selfs" (Mitchel 2003), but also as opposites in mental situations in which an integration must be processed; specifically, integration through creative dialog between opposites.
A new research in psychodrama psychotherapy group describes how can a therapeutic process can expand the therapeutic space for hope, and creates an opportunity to "hold opposites. This idea emerged Michael Eigen's therapeutic psychospiritual approach about "the Self as unity of all the fragments" (Eigen 2012), based on Jewish mysticism the KABBALA (13th century) In helping to make an emotional movement (Eigen 1988) from despair to hope and from crisis to reparation (Rotenberg 1990).

CHRISTIAN RELIGION/ SPIRITUALITY IN A MENTALIZATION-BASED TREATMENT GROUP: EXPERIENCES AND PRELIMINARY RESULTS FROM THE NETHERLANDS

Nathan van der Velde[1], Arthur Hegger[2]
[1]Kennisinstituut Christelijke Ggz, Eleos Mental Healthcare, Ede/ Bosch en Duin, The Netherlands,
[2]Ambulante Behandeling, Eleos Mental Healthcare, Ede/ Amersfoort, The Netherlands

In this presentation we report on our experience with integrating religion/ spirituality of patients into group psychotherapy in a Christian mental healthcare institution in the Netherlands (Eleos). Personality disorder patients in our weekly mentalization-based treatment (MBT; Bateman & Fonagy, 2016) group show both parallels and divergences in their attachment relationships with significant others and God (correspondence and compensation religious attachment representations; e.g. Granqvist & Kirkpatrick, 2016; Hall & Fujikawa, 2013). MBT is aimed at increasing reflective functioning in interpersonal relationships (Fonagy & Alison, 2014) and as such is promising for integrating religion into psychotherapy. However, this potential has only scarcely been discussed in the literature (e.g. Schaap-Jonker & Corveleyn, 2014; van der Velde, Schaap-Jonker, Eurelings-Bontekoe & Corveleyn, submitted). Peter Fonagy (personal communication, September 30, 2017), one of the founders of MBT, has drawn attention to the normal and abnormal developmental roots and possible 'benefits' of religion. He suggests that experienced closeness to God activates the attachment system, as such R/ S has the potential to increase social cognition and mentalizing (not just in the religious realm). All patients in our group show limits in attachment security and feeling close in interpersonal relationships. However, some patients do report closeness and/ or safety in an enduring relationship with God. In the course of the group, this seemed for some to be a form explicit compensation (pretend mode, a mode of nonmentalizing adressed in MBT, Bateman & Fonagy, 2016), and their experience was more distant and unsafe (i.e. wrathful God). God was not so available as an emotional attachment figure as would seem. The value of the group is that patients can share their different experiences of God. We saw a proces of increased mentalizing: attention to emotional (implicit) God representations increased, and there was less theological discussion about cognitive (explicit) God representations.

CORRELATES OF RELIGIOSITY AMONG SUBSTANCE USERS: RESULTS FROM A LARGE-SCALE NATIONALLY REPRESENTATIVE STUDY.

Ofir Livne[1,2], Jürgen Rehm[3,4], Deborah Hasin[5,6], Shaul Lev-Ran[7,1,3]

[1]Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel, [2]Department of Psychiatry, Lev Hasharon Medical Center, Netanya, Israel, [3]Institute for Mental Health Policy Research, Centre for Addiction and Mental Health, Toronto, Ontario, Canada, [4]Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada, [5]Mailman School of Public Health, Columbia University, New York, USA, [6]New York State Psychiatric Institute, New York State Psychiatric Institute, New York, USA, [7]Addiction Psychiatry, Lev Hasharon Medical Center, Netanya, Israel

Background: Considering the negative outcomes (e.g.: physical and mental health problems) associated with substance use and substance use disorders (SUD), numerous studies have focused on identifying risk factors as well as protective factors for SUD. A growing number of studies show that religiosity is a protective factor against mental health problems, including SUD. Nevertheless, there is a lack in studies exploring the association between the various indices of religiosity (internal and external) and SUD; furthermore, previous reports on the protective role of religiosity on SUD have methodological limitations, such as: use of small non-representative samples of the general population, non-adherence to DSM-5 SUD diagnostic criteria, and lack in models controlling for confounders. To-date, no study has examined the moderation effect of religiosity on the relationship between substance use risk factors and SUD.

Methods: Drawing on data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III; N=36,309) we examined the relationship of public religiosity (frequency of service attendance, religious social group size), and intrinsic religiosity (importance of religious/spiritual beliefs) to 12-month substance use and SUD, including: alcohol, tobacco, cannabis and other drugs. Furthermore, we evaluated the moderating effects of religiosity on the relationships between substance use predictors and 12-month SUD. A series of sensitivity analyses controlled for numerous confounders.

Preliminary Results: Internal religiosity and frequency of service attendance, but not religious social group size, moderate the association between numerous risk factors of alcohol, tobacco and cannabis use, and AUD, TUD and CUD; however, these effects are less pronounced for associations with other DUD. These moderating effects remain significant in numerous sensitivity analyses.

Study Implications: This study provides findings from a nationally representative large-scale study on the association between different religiosity indices and SUD, including numerous substances, while controlling for a wide range of confounders. To our knowledge this is the first study that examines the moderation effect of religiosity on the associations between substance use risk factors and SUD. Findings may clarify whether religiosity is an independent protective factor of SUD and indicate which populations may benefit from its protective characteristics.

BRINGING SPIRITUALITY INTO PRACTICE: MEETING THE WIDER SELF IN THE CLINIC

Ifat Eckstein[1,2,3,4]

[1]Senior Coordinator, International Focusing Association, New York, USA, [2]Ceo/founder, Widefulness Multidimensional Psychotherapy, Moshav Bait Hananya, Israel, [3]Academic Coordinator & Lecturer, Shiluv Institute, Kiryat Tiveon, Israel, [4]Senior Member, Israeli Association of Family & Couple Therapists, Tel Aviv, Israel

More and more therapists and patients are seeking a broader approach to conventional psychotherapy, an approach that encompasses and acknowledges the wider self within the wider whole. This shift corresponds with the works of some of the great forefathers of modern psychology, such as Jung's 'collective unconsciousness' (1969) and Maslow's 'peak experience' (1964). These pioneers understood the significance of the spiritual to emotional health and development, yet most contemporary approaches to psychotherapy do not embrace this aspect. To bring spirituality into practice, psychotherapists need a wider perspective of human consciousness and a more expansive toolbox. On a practical level, this involves working from and within experiential process which Gendlin (1967) describes "as a direct feel of the complexity of situations, a concrete experiential feeling process".

Spirituality may be expressed in diverse ways during the therapeutic process, occurring either naturally and/or as part of intervention. By holding the notion that spirituality is not 'over there' but rather an inherent part of therapy, psychotherapists can experientially work with it in the 'here and now' in the clinic.

In this lecture, the model of Levels of Consciousness will be presented as a bridge for bringing spirituality into practice. Through it, the process of therapy becomes deeper, creating new integration and meaning. From physical to universal consciousness, the model moves through seven levels, exploring and understanding the many layers of knowledge, experience, memory and connection held in each. By integrating levels of consciousness into practice, new avenues of intervention become apparent, creating possible shifts and positive outcomes.

INSIGHTS FROM THREE CORE YOGA TEXTS FOR MENTAL HEALTH PROMOTION

Jyotsna Agrawal
Clinical Psychology, National Institute of Mental Health and Neuro Sciences (Nimhans), Bangalore, India

Good mental health is not just an absence of mental illness, but also includes high well-being (WHO, 2001). This requires attention to mental health promotion, which would be beneficial for people anywhere on the mental health continuum (Keys & Lopez, 2002; WHO 2004). Although globally such interventions have increased over last one decade, they have often neglected spiritual aspects of human life. Yoga is an applied psycho-spiritual pathway to finding the highest good in life, which also has a physical component to it. However in research the physical aspect of yoga has overshadowed its psycho-spiritual aspect. Therefore the current study was conducted to qualitatively analyze three core yoga texts to gain insights for development of a mental health promotion program. The texts selected were *Bhagwad Gita, Patanjali Yoga Sutra* and *Yoga Vasistha*, which are considered to be the most influential texts for generations of spiritual seekers. These texts integrate ideas from multiple Vedic philosophical schools (e.g. *Sankhya/ Vedanta*) to propose a practical approach for overcoming suffering and finding oneness with the supreme reality. In the analysis it was found that two out of these three texts are based on dialogue between a 'hero' and a mentor (*guru*) figure. The narrative begins with the 'hero' having a psychological crisis, whereby the description matches modern criteria for anxiety/ depression. He is then helped by the mentor in terms of finding a meaningful spiritual framework for the existence and one's place in it. He is further taught a variety of applied techniques, in terms of breath control (*pranayama*), meditation as well as cultivation of specific virtues and skills. The third text is briefer, without a narrative; however has similar themes for spiritual growth. Details of these themes will be presented along with their implications for development of a mental health promotion program.

MINDFULLY MUSLIM – THE CREATION OF AN ISLAMIC MINDFULNESS GROUP THERAPY PROGRAM

Yusra Naifa Ahmad[1], Kenneth Fung[2], Ahmed Hassan[3], Alan Fung[4], Susan Abbey[1]
[1]Psychiatry, University Health Network, Toronto, Canada, [2]Psychiatry, Toronto Western Hospital, Toronto, Canada, [3]Addiction Psychiatry, Centre for Addiction and Mental Health, Toronto, Canada, [4]Psychiatry, North York General Hospital, Toronto, Canada

There are 1.8 billion Muslims, comprising 24.1% of the global population. This population can be further sub-divided into the following groups based on geography: (1) Muslims who have resided in the Western world for quite some time, (2) newcomers to the West including recent immigrants & refugees & (3) Muslims living in Muslim-majority countries. There is a clear mental health need in these various populations that is largely unmet due to various factors including stigma & a paucity of culturally & spiritually appropriate services. Mindfully Muslim is a novel group therapy intervention designed to address this need & has the potential to be adapted to each sub-population. The goals of the program include building bridges & cultivating peace through disciplined self-awareness & contacting the present moment. Mindfully Muslim is compassionate, culturally aware, inherently anti-oppressive & trauma-informed.

Inspired by principles drawn from MBSR (Mindfulness Based Stress Reduction) & MBCT (Mindfulness Based Cognitive Therapy) & grounded in the Islamic tradition, it is currently being delivered in Canada to women who are struggling with mood & anxiety disorders. Because of the impact of the program, Mindfully Muslim has received national media coverage & been granted an award. It is unique for being one of the few group therapy programs that has been spiritually adapted for the Muslim community by a female Muslim psychiatrist. This latter point is important because of the depth of knowledge about Islamic teachings and culture that someone "from the inside" can provide while simultaneously operating within a rigorous clinical framework.

Given the growing size of the Muslim population in Canada, the United States and Europe and the intensity of current geopolitical divides with rising waves of anti-immigrant sentiment, xenophobia, anti-Semitism & Islamophobia, the need for a program like this is not only great, but also pressing.

(Presentation will be 10 minutes, but if organizers permit 20 minutes, data about the impact of the program in Canada can be shared.)

PREVENTING RELIGIOUS DELUSIONS FROM BECOMING DEADLY

Paul Thomas Amble
Yale University, Department of Psychiatry, New Haven, USA

A single woman, separated from her husband and estranged from three of her older children, retained custody of her two children ages 5 and 8. Despite working two jobs, buying a home, and taking good care of her two children she slowly developed the idea that god wanted her to join him in heaven. As these thoughts became more prominent, she incorporated her children into this belief as well and eventually ceramonally drugged and drowned the two in a bathtub in the context of babtizing them.

This talk will briefly outline the case, discuss the topic of matricide conducted in the context of a religious delusion, and outline the pathogenesis of this delusion from the first thought to where the idea of her death and the deaths of her children became formost in her mind.

The talk will conclude by outlining interventions that the public mental health system should consider to reach out to persons with similar afflictions in order to possibly intervene in such cases.

INTEGRATING PSYCHIATRIC SERVICES INTO THE ULTRA-ORTHODOX SCHOOL SYSTEM

Ayol Samuels, **Harvey Kranzler**
Psychiatry, Albert Einstein College of Medicine, New York, USA

This paper will present a model for the delivery of psychiatric services for children and adolescents within an ultra-orthodox chassidic school system. Dr. Kranzler, a Yiddish speaking Child Psychiatrist, will discuss his experience working as a consultant to a New York State funded special needs school in Kiryas Joel for children in this Satmar community with developmental, psychiatric and other disabilities. Dr. Samuels will discuss his experience doing psychiatric consultations within a Chabbad yeshiva in Tsfat. Both will present a brief introduction to the respective Hassidic sects that they serve, the model of psychiatric care delivery, the specific sensitivities and needs in these communities, and some of the challenges of practicing psychiatry within an ultra-orthodox religious institution.

MARTIN BUBER AND THE POSSIBILITY OF HEALING MIND

Gottfried Maria Barth
Department of Child and Adolescent Psychiatry, University Hospital and Faculty of Medicine
Eberhard Karls University, Tübingen, Germany

The Philosophy of dialogue is a valuable basis for psychotherapeutic and psychiatric work. Martin Buber indicates in "Ich und Du" (1923) the importance of I-Thou for human existence. "I-Thou" is an holistic encounter beyond all psychological knowledge. He emphasizes the importance for Psychotherapy in many writings but also points out the difference to usual psychotherapeutic work, which mainly works in the I-It relationship. In the Dialogue with Carl Rogers sharing a person-centered approach Buber illustrates the difference of his philosophy of human existence. Only in the I-Thou dialogue there is real encounter between individuals. In the work with serious mentally affected young patients they frequently reject therapeutic approaches. Undergoing true personal encounter can lead them to the experience of serious assistance. This opens the possibility of therapeutic interventions in a mutual and respectful relationship. The practical knowledge of the work in the intensive care unit of a child and adolescence psychiatric hospital shows the I-Thou as the most important key to facilitate therapeutic progress. The trans-therapeutic approach of Martin Buber offers the opportunity of therapeutic work with patients, which are not able to affiliate usual Psychotherapy or Psychoanalysis. Therefore Martin Buber ist the most important teacher for daily psychiatric work and opens the possibility of healing a serious affected mind.

CLINICAL USE OF MORAL DEVELOPMENT WITH FAMILIES AND PATIENTS WITH RELIGIOUS STRUGGLES

Richard F Camino-Gaztambide
Psychiatry and Health Behavior, Medical College of Georgia, Augusta University, Augusta, USA

The therapist often encounters patients with diverse spiritual struggles, for example, conflicts within families due to differing religious worldviews, parents confronting the dilemma of how to approach and relate to their LGBTQ child, or marrying outside their religion.1 Most of these patients probably will state that the basis of their conflict is related to a moral clash or conflict.2 Therefore, could theories on morality or moral development be a tool to help solve or ease their moral struggles? Initially, pioneers in the field of moral development and moral psychology like Piaget and Kohlberg emphasized that morality occurred within the context of cognitive development and rational processes that were the main drivers of moral thought and action.3 In the last 20 years, research on moral theory and development has been influenced by new discoveries in ethology, evolutionary biology, neurosciences, epigenetics, and the role of culture and religion.3 Specifically, the integration of cognition and emotions as part of the new moral paradigm. The Moral Foundation Theory (MFT) provides a set of five binary foundations of "right/wrong" they believe are innate. These foundations are a. Care/harm b. Fairness/cheating, c. Loyalty/betrayal, d. Authority/subversion, and e. Sanctity/degradation.4 Although, everyone possesses some degree of each foundation, the way that each of these items influence religious worldviews can vary, with white conservatives to be influenced by all five foundations to more or less the same degree, meanwhile, liberal or non-white religious worldviews tend to be more influenced less by the sanctity/degradation or authority/subversion dyads.56 The Moral Foundations Questionnaire (MFQ) have been used in numerous research studies with accumulating N> 100,000, including cross-cultural samples over 30 plus countries.78 As such, the use of the MFQ can be a valuable tool for clinicians to understand how patients and family's values are influencing their moral outlook.9,10 The MFQ provides clinicians an instrument that examines their tenets and ideals, therefore, opening opportunities for alternatives and ponder solutions to bridge/solve their moral conundrum.10,11 The aim of this presentation is to present practical applications of MFQ in the therapeutic process.

THE DIAGNOSTIC CATEGORY OF "RELIGIOUS OR SPIRITUAL PROBLEM" IN DSM-IV: CELEBRATING A 25TH YEAR ANNIVERSARY

Francis G. Lu
Psychiatry, Uc Davis, Sacramento, Ca, USA

In 1994, the DSM-IV included the new diagnostic category of "Religious or Spiritual Problem" (V-code 62.89) in the V-code section of conditions that may be a focus of clinical attention which are by definition not mental disorders: "This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." Both the diagnostic category and its definition were retained in the 2013 DSM-5. In 1992, David Lukoff, Francis Lu, and Robert Turner had submitted a proposal to the DSM-IV Task Force for this new diagnostic category to provide a non-pathological diagnosis for distressing experiences involving religion or spirituality. The goal was to reduce mis-diagnosis of such experiences as psychopathological phenomena consistent with and diagnostic of mental disorders by enlarging the differential diagnosis to include this non-pathological one. By utilizing this diagnostic category, clinicians can provide appropriate religious/spiritual assessment, diagnosis, and treatment planning including possible religious/spiritual interventions consistent with the individual's and family's cultural background and identity. John McIntyre, MD, past APA President, and Harold Pincus, then Director of the APA's Office of Research and Co-Chair of the DSM-IV Task Force, observed that this new entry in DSM-IV was "a sign of the profession's growing sensitivity not only to religion but to cultural diversity generally." A 2019 PubMed search of "Religious or Spiritual Problem" resulted in 8 citations, which will be briefly reviewed, and future possible developments discussed.

SPIRITUALITY/RELIGION IN ETHICAL CLINICAL PRACTICE: THE ICING OR THE CAKE?

John Raymond Peteet
Psychiatry, Harvard Medical School, Boston, USA

Ethical and other concerns surround the role of spirituality/religion (S/R) in clinical practice. These have their roots in boundary violations, Freud's atheism, secular culture's "immanent frame", the "religiosity gap", psychiatrists' exposure to problem cases and the marginal position of S/R within medicine and bioethics.

To address these concerns, it can be helpful to consider the relationship of S/R to three fundamental questions of ethics: "What is the good?","What stategies exist to learn and do the right thing?", and "How does the context matter?"

Human good or flourishing is increasingly recognized to include not only mental and physical health, but financial and material security, happiness and life satisfaction, meaning and purpose, character and virtue and close social relationships. S/R offers a vision of the good, guidance and practices that support living well, and differing, contextualized perspectives on values and preferred virtues.

This relationship of S/R to ethics has a number of clinical implications: First, S/R is basic to how people justify their lives. Second, psychiatrists encourage transcendent strategies in approaching challenges in areas such as depression, moral injury, mistrust and sociopathy. Third, clinicians have available a range of ways to ethically engage patients' S/R in the service of their flourishing. Fourth, differing clinical settings and world views illuminate the relevance of context in helping patients become their best selves. Finally, an inner life is important to clinician resilience. Rather than simply cultural icing, S/R is integral to the cake of whole person ethical practice, which encompasses positive psychiatry and professionalism. Failing to engage S/R is a lost opportunity to help patients envision and achieve lives worth living.

SPIRITUAL PSYCHOTHERAPY FOR INPATIENT, RESIDENTIAL AND INTENSIVE TREATMENT (SPIRIT)

David H. Rosmarin
Department of Psychiatry, Mclean Hospital/ Harvard Medical School, Brighton, USA

Recent research suggests that more than half of acute psychiatric patients profess interest in addressing spirituality as part of their treatment (Rosmarin, Forester, Shassian, Webb, & Bjorgvinsson, 2015). However, very few spiritually-integrated interventions are available to accommodate high levels of acuity and heterogenous diagnostic profiles among patients with diverse levels of spiritual/religious involvement. Twenty-two clinicians of diverse disciplines and diverse spiritual/religious affiliations were trained in how to deliver a flexible, spiritually-integrated, cognitive behavioral therapy protocol dubbed "Spiritual Psychotherapy for Inpatient, Residential & Intensive Treatment (SPIRIT)." Over a one-year period, clinicians were deployed to 14 clinical units (8 inpatient, 2 residential, 2 day treatment), and delivered treatment to 1,443 patients presenting with primary diagnoses of depressive disorders, bipolar and related disorders, personality disorders, psychotic disorders, substance use disorders, eating/feeding disorders, anxiety-related disorders, and other disorders. Patients completed surveys at the end of each treatment session. The vast majority of patients reported that the group clarified how spirituality can be integrated into treatment (81.2%), helped identify spiritual resources that can be utilized to reduce distress (73.2%), and helped identify spiritual struggles that were contributing to distress (62.2%). Statistical analyses found that patient response to treatment was not predicted by patient demographic factors or clinical characteristics (e.g., levels of symptom severity, levels of care, clinical units, diagnostic profiles). While religiously affiliated patients reported more benefit from treatment, non-religious patients endorsed SPIRIT positively overall. Interestingly, patient response was more favorable to non-religiously affiliated clinicians than to clinicians with a religious identity. These findings suggest that spiritually-integrated psychotherapy can be delivered by diverse staff to acute psychiatric patients with heterogeneous diagnostic profiles across multiple levels of care, within the context of a large psychiatric medical center.

TRAINING SPIRITUAL AND RELIGIOUS ORGANIZATIONS IN MENTAL HEALTH & ILLNESSES

Avdesh Kumar Sharma
Director, Mind Specialists, New Delhi, India

This presentation is about mutual learning, sharing, building bridges and being in harmony for mental health, and distress as well as emotional well-being of self and others around. Mental Illnesses – It would be arrogant to suggest that modern medicine has all the answers for all mental illnesses, whether through medicines (which are less than a century old at best) or devices which have recently come on the horizon. The psychotherapeutic component (which for various reasons is not utilized to the extent it should be) has components of cultural/spiritual/religious beliefs of the community which must be utilized for health and overcoming disease.

Mental Health including preventive and promotive mental and emotional well-being should be the goal rather than management once an illness has arisen. Preventive and promotive mental health and emotional well-being is based on view of self and the world in cultural context which the basic tenets of all religious texts and spiritual belief systems.

India recognizes and has official treatment modalities of Ayurveda, Yoga, Unani, Sidha and Homoepathy (AYUSH), which has components of thought from various traditions and spiritual/religious practices. India has more then 100 television channels devoted to Spiritual content and many modern 'Gurus' who handle group therapy/way of living for improving mental health and emotional well-being for the masses.

Specific Interface/training of mental health professionals and spiritualists – Interface of Spirituality and mental health and illness have been carried out by us (Dr. Avdesh Sharma & Dr. Sujatha Sharma) in last about twenty years, specially with Raj Yoga as practiced by the Brahmakumaris, a spiritual organizing having presence in about 130 countries including Israel near Tel Aviv through 8000 centers. Here are some of the programs – Mindmatters – Workshop module training program for major mental illnesses for the spiritual heads of centers.

Television and web series in three languages – English, Hindi and Punjabi.

Lecture tours and workshops for General public (interested in spirituality), Senior teachers of Spiritual centers and health professionals in eleven countries and about twenty cities in India.

Medical conferences – Mind Body Medicine conferences at Mount Abu, Rajasthan, other part of India – typically thrice/year, residential for about 3-5 days, attended by Doctors (Senior specialists) and spiritualists from India and also internationally (typically 500-3000 attendees).

Psychiatric conferences at Spiritual Headquarters in Mount Abu.

Studies of mainstream psychiatry that have looked at psycho-spiritual components and tools – mainly addictions to tobacco, alcohol or drugs.

Book (physical & electronic) on 'Spirituality and Mental Health' – official publication of Indian Psychiatric Society and Rajyoga Education and Research Foundation.

Use of traditional games with mental health messages as part of campaign for Mental Health (C4MH) for working with community (details on www.mindspecialists.com) by the spiritual organization centers.

Utilizing the principles of Information and formal spiritual life style for self by mental health professionals and clients (who are inclined and have shared cultural and spiritual values. The services are provided without any charges.

BOUNDARY VIOLATIONS AT THE INTERFACE OF SPIRITUALITY, RELIGION AND MENTAL HEALTH CARE: MAKE A FENCE FOR THYSELF

Rael Strous
Maayenei Hayeshua Medical Center and Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Spiritual leaders exercise great influence on those around them. Often in a mere short time, the spiritual leader can inspire and impact lives in a manner that a mental health worker is incapable of doing. While this idealized power can be of special assistance to the congregant, student or spiritual follower it can be associated with dangers. The risk inherent in such a dominant and influential relationship may be due to inconsistent attention to boundaries, an often-overlooked aspect in spiritual leadership training. This has become critical given the changing role of the spiritual leader in many contexts whereby he or she is called to attend to many issues over and above the traditionally religious or spiritual consultation role. This role has become for many more of a counselling function. Boundaries ensure that professional and private identities remain separate. Boundaries are not an impediment – rather they allow safe interaction and ensure security for both parties. Boundary violations thus reflect damage to the safety of the interaction between the spiritual leader and the religious follower during the counselling process and can be significantly detrimental. Often boundary violations begin inoffensively with a genuine desire to assist the congregant or student in distress, however the aftermath may be significantly destructive to both sides as well as respective families. The phenomenon of boundary violations may be associated with a distinctive personality profile in the spiritual leader and follower. Boundary violations may easily be prevented with education, training and maintaining various safety mechanisms thus preventing any damage.

DEVELOPING A SCALE OF SPIRITUALITY FOR THE USE IN A HETEROGENEOUS SOUTH AFRICAN CLINICAL ENVIRONMENT LICATE

Bernard Janse van Rensburg[1], Marie Poggenpoel[2], Chris Myburgh[3]
[1]Psychiatry, University of the Witwatersrand, Johannesburg, South Africa, [2]Nursing, University of Johannesburg, Johannesburg, South Africa, [3]Educational Psychology, University of Johannesburg, Johannesburg, South Africa

Introduction: A South African definition of spirituality was identified in an earlier explorateive inquiry, which documented the views and experience of local psychiatrists on the role of spirituality in South African specialist psychiatric practice and training (University of the Witwatersrand, 2010). Comparing this with other definitions by e.g. the WPA and the Royal College of Psychiatrists (Cook, 2010), confirmed similar and overlapping components. These components were included in a proposed scale for measuring spirituality in a local context, requiring for its psychometric validity to be established. For this, criteria identified by De Jager Meezenbroek et al. (2012) were considered.
Objectives: To measure spirituality of identified groups in a local clinical setting and to evaluate the reliability, validity and factor structure of this scale.
Method: As a first phase, participants were recruited from local health science students of the University of the Witwatersrand. Factor Analysis with promax (oblique) rotation was used to determine underlying dimensions in the data. The eigenvalue criterion, scree plot, and proportion of the total variance explained, were considered in determining the number of factors to be extracted. Sub-scales were scored by taking the mean of the constituent items. The reliability of derived sub-scales was determined by Cronbach's alpha. The correlation between sub-scales was determined by Spearman's correlation coefficient. Data analysis was carried out using SAS v9.4 for Windows
Results: A total of 445 graduate medical students participated, with median age of 23 years, while 66.5% were female and 84% single. Most (67.7%) indicated that they were monotheist believers with the second and third largest groups agnostic (10.6%) and atheist (8.8%). Of the monotheist believers, 58.7% were Christian (n=257), 12.1% Muslim (n=35) and 4.1% Jewish (n=18). Only eight (1.8%) indicated their religion/faith tradition as traditional African. The majority (39.3%; n=132) indicated that they attended a religious event at least once a week, while most (43.2%; n=186) considered themselves as "moderately" religious and 21.1% (n=91), as "very" religious. Regarding the scale, the factorability of all 35 items was initially examined. Several well-recognised criteria for the factorability of a correlation were used, confirming that each item shared some common variance with other items. Given these overall indicators, initial factor analysis was deemed to be suitable with all 35 items. A total of three items (items 6, 25 and 12) were successively eliminated. In the final stage, a factor analysis of the remaining 32 items was conducted, with six factors explaining 61% of the variance. Internal consistency for each of the scales, examined using Cronbach's alpha, was adequate with all alphas >0.7. All the subscales were significantly correlated with $p<0.0001$, with only the positive correlation between "Beyond" and "Meaning" ($r=0.63$) found to be of note. Overall, these analyses indicated that six distinct factors were underlying the responses to the spirituality scale items, and that these factors were reasonably internally consistent. These factors were: "Beyond", "Awareness". "Meaning", "Others", "Journey" and "Connection".
Conclusion: Six distinct, internally consistent factors underlying the responses to the spirituality scale items, were identified.

PEAK SPIRITUALITY: EXPLORING SPIRITUAL EXPERIENCES OF AWE, WONDER AND TRANSCENDENCE IN NATURE WITH PEOPLE LIVING WITH MENTAL ILLNESS.

Simon Jones, Anton Isaacs, Keith Sutton
Department of Rural and Indigenous Health, Monash University, Melbourne, Australia

Background: There is an increasing awareness of the important role religion and spirituality plays in recovery for people living with mental illness. However, a 'spirituality gap' exists between service users and mental health clinicians in how religion and spirituality is viewed and utilised in mental health care. This paper explores the experience and benefit of spirituality by itself and in nature for people living with mental illness.

Method: This study used a qualitative, grounded theory approach involving adults living with mental illness. Participants received a spirituality intervention in a program promoting mental health and wellbeing through contact with nature and outdoor adventure activities. The program was conducted by Out Doors Inc., a Melbourne based NGO.

Findings: The study found that religion and spirituality is generally significant, providing meaning, purpose and hope in crisis, and enables participants to manage and cope with their mental illness. Nature provides an optimal therapeutic environment to connect with personal spirituality through peak experiences of awe, wonder and the transcendent strengthening mental health, wellbeing and recovery.

Conclusion: The study illustrates one way of introducing religion and spirituality into mental health practice, harnessing the strengths of personal spirituality, and contact with nature to promote recovery. The intentional use of spirituality in mental health practice promotes mental health, meaning, strength and resilience necessary for recovery. Supporting personal spirituality in nature with people living with mental illness is a holistic treatment approach translating knowledge into practice.

RELIGION AND ITS EFFECT ON ATTITUDES OF MENTAL HEALTH PROFESSIONALS TOWARD LGBTQ PATIENTS

Julian Lagoy, M.D.[1,2], Adam Childers, Ph.D.[3], Anita Kablinger, M.D.[2], Anjali Varma, M.D.[4]
[1]Adult Mental Health, Community Psychiatry, San Jose, USA, [2]Department of Psychiatry, Virginia Tech Carilion School of Medicine, Roanoke, USA, [3]Department of Mathematics, Roanoke College, Roanoke, USA, [4]Mental Health Service, Salem Veterans Affairs Medical Center, Salem, USA

Objective: To identify providers' religion, areas of bias, comfort levels, and the need for provider education regarding LGBTQ patient care.
Methods: An anonymous 20 question survey (modified LGBT-DOCSS) was emailed to psychologists and psychiatrists, including trainees in each of these disciplines, in the Veterans Affairs (VA) healthcare system in Virginia, North Carolina and West Virginia. The survey included questions about religion, educational background, level of training, and challenges faced while caring for LGBTQ patients.
Results: This data set is composed of 118 responses from VA mental health professionals. Two primary areas were evaluated: do respondents believe the LGBTQ lifestyle is immoral and do respondents feel prepared to professionally care for LGBTQ patients. 10% (12 of 118) of the respondents indicated that they believed the LGBTQ lifestyle is immoral but none of the demographic or professional descriptors were predictive for indicating this belief. It was interesting to see that none of those who identified as atheist or non-affiliated (n=46) and only a small minority of those who identified as Muslim, Jewish, Christian, Hindu, or other (12 of 72) reported this belief. Just under 39% (46 of 118, CI: .3898+- .0888) responded feeling unprepared in some capacity to care for LGBTQ patients. While none of the predictors were statistically significant, it was interesting to see that 50% (10 of 20) of the under 30 age group felt unprepared which was higher than the other age groups (Chi-Square test for independence, p-val = 0.2841). Among the professional groups, the psychiatry residents felt the most unprepared with 61% (16 of 26) indicating so (Chi-Square test for independence, p-val = 0.07169).
Conclusion: Mental health professionals, including those who identify as religious, generally have positive views toward LGBTQ patients but have mixed responses about feeling prepared to care for them.

SPIRITUAL/RELIGIOUS REPRESENTATIONS IN TRANSCULTURAL PSYCHIATRIC CONSULTATION

George Eric Jarvis[1], Marie-Nathalie Leblanc[2]

[1]Psychiatry, Mc Gill University, Montreal, Canada, [2]Sociology, Université De Québec à Montréal, Montreal, Canada

Background: Hall (1997) discussed how cultural representations and signifying practices are fundamental to understanding concepts, ideas and feelings in the other. While cultural representations have been explored in mental health settings, spiritual/religious (S/R) representations remain neglected.

Aims: The current exploratory study reports on S/R representations in patients referred to a Cultural Consultation Service (CCS) in Montreal to 1) determine the proportion of patients evaluated over the time period in which S/R representations are clinically important, 2) suggest categories of S/R representations to guide clinicians working with culturally diverse clientele, and 3) highlight how S/R representations may inform psychiatric treatment.

Method: All CCS charts from 2015 were reviewed and assessed for preliminary descriptive and thematic findings relating to the study aims (N=41). The first author thematically categorized the data gathered from these patient charts by generating an initial list of themes, searching and reviewing the themes, defining and naming them, and producing a preliminary report.

Results: Spiritual and religious (S/R) representations were related to the presenting problem in the majority of referrals (25/41). In these cases, S/R representations were grouped into the following themes: (i) direct *cause* of the presenting problem in 3/25 cases, (ii) direct *cure* of the problem in 1/25 case, (iii) source of *comfort* or support in 6/25 cases, and (iv) source of social *predicament* in 6/25 cases. 9/25 cases had more than one theme. The treatment plan was influenced by S/R representations in all cases.

Conclusion: Spiritual and religious (S/R) representations were clinically important in the majority of referrals to the CCS in 2015. S/R representations were grouped into themes of cause, cure, comfort and predicament and wove their way through the histories of patients from diverse backgrounds. Awareness of S/R representations opened the way to culturally appropriate treatments and interventions.

RELIGION, SPIRITUALITY AND PSYCHOSIS- A CASE SERIES

Rupinder Kaler[1], Nadia Saleem[2]

[1]Early Intervention Team in Psychosis, Coventry and Warwickshire Partnership Trust, Coventry, UK, [2]Camhs, Coventry and Warwickshire Partnership Trust, Coventry, UK

Background: Religion and spiritual belief seem to be important for mental health service users; while some find it useful, a source of comfort, for others it is a source of distress. Mystical or religious experiences are common in UK or USA, a third reporting mystical experience at some stage in their life (Hay 1987). In Great Britain and Europe, 21-24% of patients with schizophrenia have religious delusions (Koenig 2007).

Grover *et al* 2014 summarise that the common themes in studies which have evaluated the delusional themes of various religious/spiritual delusions are that of persecution (by malevolent spiritual entities), influence (being controlled by spiritual entities), and self-significance (delusions of sin/guilt or grandiose delusions).

Differentiating psychotic states from religious beliefs, can be complicated and their management challenging to professionals. Religion and spirituality can serve as an effective method of coping with the illness but also influence treatment compliance and outcome in patients.

Objective: We would like to discuss a series of patient cases presenting with religious beliefs in psychosis and issues within their management.

Method: Using case studies, we draw on issues involved in working with patients with psychosis who hold religious beliefs: problems of differential diagnosis, in engagement, treatment and their outcomes.

Conclusions: Patients with chronic and severe mental illness often present for treatment with religious delusions. Psychotic vs. non-psychotic beliefs and experiences may be difficult to distinguish from one another.

Our case series confirms that religious delusions can influence help seeking, treatment, and illness outcome. Given the importance of religion and spirituality for many patients, biopsychosocial model of assessment should integrate the same, in order to achieve a whole-person approach to their management. There is a clear need to involve religious professionals and develop collaborative patterns of working together with mental health professionals.

RELIGIOUS HEALTH INTERVENTIONS IN BEHAVIOURAL SCIENCES (RHIBS): A SCIENTIFIC CLASSIFICATION OF RELIGIOUS PRACTICES IN HEALTH TO RIGOURISE THE DESIGN AND EVALUATION OF INTERVENTIONS.

Riya Patel, Nazanin Khasteganan, Jonathan Jong, Deborah Lycett
Centre for Advances in Behavioural Sciences, Coventry University, Coventry, UK

Background: Increasing development of religiously integrated interventions for health in a wide variety of physical and emotional conditions call for a clear classification of the effective religious components. To date no such taxonomy for religious health interventions has been developed and consequently specific religious components, their meanings and plausible mechanisms by which they affect health are often unclear. Additionally, overlapping components within health interventions make it difficult to differentiate what is an emotional or spiritual practice from what is an act of religious faith or belief in a higher power. We have developed an empirically-derived taxonomy that clearly defines the religious practice, the rationale for use with specific health condition, the context in which it is used or delivered, and the meaning it holds for participants who engage with this religious practice through healthcare interventions.
Aim: To reach international consensus on the first version of an empirically-derived taxonomy of religious practices in health interventions.
Methods: *Taxonomy development:* Three rapid, scoping reviews of systematic reviews, intervention studies and their associated qualitative explorations to identify studies of religiously-integrated-health-interventions. We coded intervention descriptions to develop the empirically-derived prototype taxonomy. The taxonomy clearly defines a religious practice, the rationale for its use in relation to specific health conditions, the context in which it can be used or delivered, the religions such practices have been affiliated with and the meaning it holds for participants who engage with this religious practice through healthcare interventions. Within the taxonomy we also provide examples of how the practices have been used. *Delphi exercise:* An international panel of experts will review the taxonomy and reach consensus on its content.
Results: Work is not yet complete, but we expect to present the findings of the Delphi exercise by the time of conference.
Implications: A taxonomy that identifies active ingredients within religiously integrated health interventions will advance the fields of psychology of religion and health by supporting the development of future religious health interventions, facilitating evidence synthesis, determining the importance of religious components and understanding mechanisms of action.
Funding acknowledgment: John Templeton Foundation ID #61188

TRAUMA AND THERAPY: THE LOSS AND RECOVERY OF FAITH

Kate Miriam Loewenthal[1,2,3,4,5]

[1]Psychology, New York University in London, London, UK, [2]Psychology Professor Emeritus, Royal Holloway University of London, London, UK, [3]Psychology, Glyndwr University, Wales, UK, [4]Psychology, Royal Holloway University of London, Egham, UK, [5]Psychology, Glyndwr University, Wrexham, UK

This paper outlines the practice of EMDR (Eye Movement Desensitisation and Reprocessing) used in trauma therapy. The paper will describe an unexpected observation: after therapy, religiously-affiliated clients often described difficulty with their religious faith following trauma and prior to therapy. They spontaneously reported the recovery of their faith as EMDR progressed. Reports and experiences during therapy, and interviews following therapy are described. These observations are discussed in the context of the literature on loss of faith and post-traumatic spiritual growth. It is noted that the EMDR literature contains negligible reference to this phenomenon, which deserves more attention.

YOGA AND PSYCHIATRY

Prasad Rao Gundugurthi[1], Kishan Porandla[3], **Pavan Kumar Kulkarni[2]**

[1]Department of Psychiatry, Director, Asha Schizophrenia Clinic, Hyderabad, India, [2]Psychiatry, Chalmeda Ananda Rao Institute of Medical Sciences, Karimnagar, Telanagana, India, [3]Professor and Head, Department of Psychiatry, Prathima Institute of Medical Sciences, Karimnagar, India

Yoga And Psychiatry: The south east asia region has a long history and rich heritage in traditional medicines and practices which contributes to health and wellness of their people. Yoga is one such traditional therapeutic system. Yoga is believed to offer means for actualization of human potential to perfection through its three dimensional approach to health- physical, psychological and spiritual. Psychiatric illness have been described as the most devastating disorders of mankind because of their worldwide prevalence and the impact these disorders have on mankind making them incapable of leading a harmonious life. In this context, Yoga is not only a cure but also a prophylactic way of tackling the unforeseen. That is to say, not only Yoga addresses the issues in illness, but also the wellness. WHO report 2015 Oct, states Schizophrenia affecting around 21 million people across the globe. Psychopharmacology is going through changes at rapid pace but still the effectiveness is an issue of concern. The outcomes are variable and relapses are common. Yoga, as add on treatment, can be of help. Reasons for such implications shall be discussed.

Yoga and Depression: There are lot of unmet needs in the treatment aspects of psychiatric patients and their attenders. In this we are exploring Yogaas an add on intervention in the treatment of psychiatric patients. Recent work has shown that schizophrenia patients who regularly do Yoga have increased Serum Levels of BDNF which co-relates with antidepressant efficacy of Yoga in the above patients. The caregivers of the patients with longterm psychiatric illness experience a great deal of stress and burn out which was found to be significantly reduced in patients' attenders who regularly practice Yoga. The current understanding of Yoga and how it neurobiologically brings about a change in the outcome measures of psychiatric illness is being highlighted in this symposium.

Yoga and addiction: There are many theories as to why people use substances, but perhaps one of the most widely accepted is the self-medication hypothesis. This hypothesis suggests that drug use is an attempt to relieve symptoms of an underlying disorder or condition, such as stress, depression, or anxiety. Applying yoga in clinical settings is one way of teaching patients to monitor their psychological changes in response to day to day stress, understand oneself better and thus helping maintain the abstinence. A regular yoga practice also helps people develop the discipline needed to succeed in 12-step programs, which often are used as the primary method of treatment for many substance users. The mindfulness practices taught in yoga and the slow, controlled breathing are tools to help curb impulse control and thereby preventing relapse. Literature and outcomes shall be discussed.

AN IPA STUDY OF SPIRITUALITY IN EPILEPSY

Louise Natalie Spiers[1], Chris A. Roe[1], Melinda Spencer[2]
[1]Psychology, University of Northampton, Northampton, UK, [2]Sport, Excercise & Life Sciences, University of Northampton, Northampton, UK

This study forms the second part of a mixed methods PhD, exploring spirituality in epilepsy. Since the beginning of modern epileptology in the 19th century, case studies have been published about individuals with epilepsy who report non-shared, spiritual experiences that include: conversation with spirits, religious conversion, understanding the meaning of the cosmic order, conversations with God, out of body and near-death experiences. The attribution of such experiences in Temporal Lobe Epilepsy (TLE) is discussed extensively in neuropsychiatric contexts; the DSM V lists such experiences as symptomatic of pre, inter and post-ictal psychosis. Case studies on epilepsy offer limited qualitative information about the phenomenology of the experience, as they are primarily concerned with differential diagnosis and appropriate medical interventions. In this second study, we focus on the phenomenological elements of spirituality in TLE from the perspective of the meaning that they have for experients.

Interpretative Phenomenological Analysis (IPA), a qualitative methodology focusing on the phenomenology and meaning of experiences, was employed. Nine individuals were interviewed using face-to-face interviews. Analysis involved listening to the audio recording multiple times, reading and re-reading the transcripts and developing interpretative codes in an iterative manner. An idiographic approach was employed by considering each participant individually and developing emergent themes and subthemes in the first instance. For IPA, the reason for doing this is to engage deeply in the participant's experience and ensure that their individual voice is understood and represented in the resulting study. Final, superordinate themes and subthemes that demonstrate convergence of experience was then undertaken.

The participants' experiences in this IPA study are qualitatively very like spiritual experiences in the literature in non-epileptic populations. The value and status of these preliminary findings are at variance with the neuropsychiatric literature, which regards such experiences as problematic seizure-related events requiring medication. The medical model assumes that persons with TLE wish for these experiences to stop and recommended practices are focused toward achieving this; where persons do not wish for this outcome, this may be seen as indicative of psychosis. Accounts from participants in this study are contrary to this view.

Findings include the insight that participants with TLE and spiritual experiences do not share the nature of their experiences with medical professionals for fear of stigma and being pathologized. Most participants stated that they would rather keep their epilepsy and the perceived gifts these spiritual experiences afford, than lose their epilepsy and the resulting spiritual experiences. This would suggest that the participants do not view their condition as an affliction by something they value highly. Participants' interviews suggest a divergence between how the medical model diagnoses and responds to these spiritual experiences and the subjective experience and understanding of their meaning. Medical professionals should find TLE and the nature of the experience of participants of this IPA study of interest, particularly because of the implication for approaches towards patient engagement.

A UNIFIED THEORY OF RELIGIOUS EXPERIENCE

John Calvin Chatlos
Addiction Psychiatry, Rutgers University/ Rwj Medical School, Piscataway, New Jersey, USA

Discussions of religion/spirituality often include such wide-ranging ideas as beliefs, values, worth, dignity, connectedness, serenity, purpose, wisdom, compassion, courage, love, faith, truth, science, creativity, God/divine, mystical, supernatural, transcendence, immanence, joy, ethics, guilt, shame, forgiveness, and even intimacy and sexuality. Additionally, spirituality and spiritual experience have been elusive partly because of characteristics described by William James as ineffable, noetic, transient, and passive. This paper describes a process grounded in Cognitive Behavioral Theory that leads to identifying a "Framework of Spirituality" that is proposed as the result of an ancient evolutionary experience common to all humanity. This "Unified Theory of Religious Experience" provides an explanation for how all of these ideas are integrated with spiritual experience and is proposed as related to the mystical core of possibly all religions.

This Paper presents a new understanding of an immanent "Spiritual Core" that can become open using specific CBT processes that grounds spiritual experience solidly in a scientific understanding. An experiential process guides participants through an exploration that demonstrates the role of experiences of "self-worth" (as self-confidence, self-esteem, self-competence) and "dignity" (as reason/wisdom, empathy/compassion, honesty/courage) as the key to promote a personal opening to spiritual experience as part of a well-defined "Framework of Spirituality". Characteristics of this spiritual experience including transcendence, immanence, connectedness, aliveness, wholeness, peace/joy, and purpose will be highlighted. Key actions of open-mindedness, open-heartedness, and open-handedness practiced through mindfulness meditation skills are linked with the role of "intuition" that is required to open creativity, often associated with this mystical type of experience. Implications of this specific process will be related to addiction and mental health treatment, especially with healing of trauma, personal growth and happiness, ethics, with opportunity for further research, including neuroimaging, and professional development. This is also a neutral framework for global Interspiritual / Interfaith dialog toward developing global unity of purpose.

DECODING 21ST CENTURY GODS- A COMPARATIVE STUDY OF SELF HELP GURUS AND MENTORS

Prashant Sunil Chaudhari[1], **Amol Tayade[2]**, Krishnapriya Murlimanohar[1], Prashant Chaudhari[1]
[1]Psychiatry, Ltmmc and Sion Hospital, Mumbai, India, [2]Psychiatry, Seth Gs Medical College and Kem Hospital, Mumbai, India

With the advent of individualised living as opposed to community and family, parameters of success and happiness have changed. This shift has heralded dependency on individuals and agencies specialized in problem solving and performance coaching. The usual problems leading to mental stress working as psychodynamic factors in triggering various psychiatric diseases. These stressors then lead to decline in socio-occupational functioning or performance. Hence the individuals and agencies claiming to be specialized in problem solving and performance coaching become the epicenter of people and then life slowly assuming significance as that of God. Religion is the way of life and it's pursuit is followed with great devotion all over the world. We find reference of Messianic figures cross-culturally who helps people in this pursuit of happiness. Similarly these contemporary counterparts of messiahs, who are also known as self help gurus assumes godliness and their followers often have a belief system taking the form of a religion. We have observed through social media that these people have followers more than some small religions existing since centuries. This article assumes relevance and significance as individuals today do not shy away from seeking help from these gurus as much as they have apprehension about going to back psychiatrist due to stigma. It is not uncommon to have seminars of these people to attract tens of thousands of people many of whom could be in prodrome of many of neurotic spectrum of illnesses in psychiatry. Testimonies of individuals studied revealed report of improvement after confrontation in front of crowd in such sessions where it probably helps like group therapy. This idea of religious following of non-religious entities if employed as a measure in preventive psychiatry has great potential to deal with increasing burden of mental illnesses and eventually achieving mental health for all.

THE ROLE OF SPIRITUALITY IN PHYSICIAN RECOVERY FROM ALCOHOLISM

John A. Fromson[1], Riva Shah[2]

[1]Department of Psychiatry, Harvard Medical School/Brigham and Women's Hospital, Boston, Ma, USA, [2]Department of Psychiatry, Oregon Health & Science University School of Medicine, Portland, Or, USA

Spirituality is a key component of healing. Physicians in the United States have incorporated mind, body, and spiritual connections into their practice, but around the world it has had varying levels of acceptance and utilization by the medical community. When physicians become patients, they also find support and comfort through spirituality, especially those with alcohol use disorders. Physicians who participate in Alcoholics Anonymous (AA) or 12- Step Facilitation (TSF) therapy and experience a spiritual awakening are likely to have a sustained long-term recovery. Those who participate in physician health programs with mandatory AA meeting attendance have high rates of total abstinence.

THE HOLISTIC TREATMENT PLAN: A SYNERGISM OF THE LEFT AND THE RIGHT COLUMN.

Gurmeet Kour[1,2]

[1]Incharge, Drug De Addiction Centre, Psychiatry Diseases Hospital, Government Medical College Jammu, Jammu, India, [2]Consultant in Mental Health, Dr Gurmeet's 'Cmcc' (Counseling and Mind Care Centre), Jammu, India

India, with all its multitudes of diversity, one of the fastest growing economies in the world, and yet one cannot dismiss the deep impact that religion and spirituality have on the Indian psyche of the 21st century. Like any other fast evolving population in flux, the Indian people are facing a lot of stress and related disorders, substance use disorders and other mental illness. In this scenario, a holistic treatment approach that involves synergism of pharmacological, psychological and psycho-social interventions with support from religious and spiritual practices in tandem is the way forward to successfully treat and rehabilitate patients back into their normal routines.

I've been using this approach in my clinical practice for a decade now where along with the prescribed medication on *the right column* of the prescription, *the left column* is reserved for activity scheduling of the patient. Activity scheduling entails mind consciousness where one wakes up with a bed tea of positive thoughts about one's own soul of being empowered, pure, pious, truthful, happy, and compassionate; practicing gratitude to the almighty creator or mother nature, however one practices their faith ; physical activity for one to two hours a day including yoga and pranayama (deep breathing exercises) ; meditation and relaxation exercises that induce soul consciousness by means of Isha Kriya; religious practice of chanting mantras, shlokas or verses that are specific to the faith system of the patient to uplift their spiritual morale in dealing with their illness/disorders/adversaries; and one activity which was pleasurable to the patient in his/her pre-morbid state specially in their high school days; one group activity with the family/friends/religious community is advised per day. In the end the patient is advised to maintain a journal which is then used in planning appropriate CBT for the patient for the next session.

MINDFULNESS, MEANING AND INFLAMMATION IN YOUTH WITH INFLAMMATORY BOWEL DISEASE

Tatjana Ewais[1,2], Jakob Begun[1,2]

[1]Mater Young Adult Health Centre, Mater Health Ltd, Brisbane, Australia, [2]School of Medicine, University of Queensland, Brisbane, Australia

Background: Adolescents and young adults with IBD have triple the rate of mental disorders than that of general population and higher rates of depression than youth with any other chronic illness (Fuller-Thomson and Sulman. 2006). Mindfulness-based programs are evidence-based group programs for treatment of depression, anxiety and stress which also hold promise in reducing systemic inflammation, normalizing gut microbiome and modulating brain neuronal connectivity (Neilson, Ftanou, Monshat, Salzberg, Bell, Kamm, Connell ,Knowles ,Sevar, Mancuso and Castle.2016).

Objectives: To present an evidence-based review of mindfulness intervetions in IBD. With reference to the literature and findings from a IBDmindfulness randomised controlled trial (RCT), we will outline controversies in conceptualization of mindfulness and the rationale for inclusion of the Viktor Frankl's model of meaning (Frankl.1964), in the standard Mindfulness based cognitive therapy (MBCT) curriculum. We will present preliminary findings of the RCT of MBCT in youth with IBD and depression, including improvements in participants' depression, anxiety levels and quality of life, as well as their biological markers of IBD activity and markers of inflammation (Ewais, Begun, Kenny,Chuang, Barclay, Hay and Kisely. 2019).

Methods: Systematic review of review of the mindfulness intervention in IBD (Ewais, Begun, Kenny, Rickett, Hay, Ajilchi and Kisely. 2019), followed by the summary and analysis of the pre and post measures of psychosocial and inflammatory markers of IBD in the RCT of MBCT in Youth with IBD and depression.We will also present a qualitative analysis of the experiences and views of the adolescents and young adults who completed the IBDmindfulness RCT (Ewais, Begun, Kenny, Headey and Kisely. 2019).

Findings: We found statistically significant improvements in depression, anxiety and quality of life as a result of mindfulness training as well as a trend in improvement of inflammation and disease activity which did not reach statistical significance. Young people who participated in the IBD Mindfulness program rated their experiences as highly positive with particular emphasis on developing connections with their peers, sense of agency and meaning and learning mindfulness skills.

Conclusion: Mindfulness is currently a hot topic in the area of the integrated treatment of IBD and our findings shed light on the feasibility and efficacy of an adapted, IBD-tailored and developmentaly informed mindfulness program with spiritual component from Viktor Frankl's conceptualisation of meaning and sources of meaning.

THE LORD IS MY SHEPHERD, DO I STILL NEED SOCIAL SUPPORT?

Aaron D. Cherniak[1,2], David H. Rosmarin[3], Steven Pirutinsky[4]

[1]Department of Psychology, Stockholm University, Stockholm, Sweden, [2]Mental Health Department, Mayanei Hayeshua Medical Center, Bnei Brak, Israel, [3]Department of Psychiatry, Mc Lean Hospital/harvard Medical School, Belmont, USA, [4]Graduate School of Social Work, Touro College, New York, USA

Loneliness is an increasing public health concern (Beutel et al., 2017). Spirituality/religion (S/R) effects mental health via social support and coping beliefs and behaviors (Paloutzian & Park, 2013). While studies have investigated whether social support mediates the relationship between S/R and health outcomes, research has not explored whether social support moderates this link. This study will examine how S/R, conceptualized as attachment to God (ATG), predicts levels of depression and anxiety based on differences in social support including longitudinal patterns. Granqvist and Kirkpatrick (2016) propose that secure ATG develops through a) a compensation pathway, in which ATG emerges in an insufficiently supportive environment, and b) a correspondence pathway in which ATG develops among other secure relationships. Since secure ATG predicts favorable outcomes and vice versa, we suggest that the adverse effects of loneliness on coping are buffered by secure ATG as an internalized representation of a safe have and secure base. Further, due to the influence of social support on coping, we expect the adverse effects of insecure ATG on coping will be buffered by social support. Therefore, we expect secure ATG to predict better outcomes regardless of social support, and insecure ATG to predict worse outcomes except when accompanied by greater social support. As part of a larger longitudinal study of a diverse Jewish sample, approved by the McLean Hospital/Harvard Medical School IRB, 586 participants were assessed at 6-month intervals for 3 years – a total of six waves from March 2014 to January 2017. Demographic information including religious affiliation and diagnostic information was collected at Wave 1. ATG, social support, and depression and anxiety were assessed at each wave. Results will be analyzed with moderation analysis and multilevel modeling. If supported, our results will indicate that loneliness may make ATG of greater consequence for well-being.

HEARING VOICES DEMONIC & DIVINE

Christopher Charles Holland Cook
Theology & Religion, Durham University, Durham, UK

Auditory Verbal Hallucinations – voices heard in the absence of any visible speaker – may be experienced as of religious significance in the context of normal spiritual practices and in psychiatric disorders. Similar phenomenal are attested to in the scriptures of the worlds major religious traditions, and in historical accounts drawn from those traditions, as well as in research into contemporary religious experiences. Examples will be considered, primarily from the Judeo-Christian tradition, and conclusions drawn for the guidance of clinical and pastoral practice.

ENHANCING MENTAL HEALTH CARE THROUGH PARTNERSHIPS WITH FAITH COMMUNITIES; TRAINING ON SPIRITUALITY-/RELIGIOSITY-RELATED COMPETENCIES IN PSYCHIATRIC RESIDENCY; AND SPIRITUALLY INTEGRATED PSYCHOTHERAPY - AN ASIAN CANADIAN PERSPECTIVE

Alan Fung
Dept of Psychiatry and Neuroscience Program, Tyndale University College, Toronto, Canada

Evidence of the influences of spirituality and religion (S/R) on mental health is increasingly recognized. The World Psychiatric Association (WPA) has recently published a Position Statement on Spirituality and Religion in Psychiatry (Moreira-Almeida et al, 2016), which has emphasized the importance of addressing the S/R dimension in the provision of psychiatric care; the relationship of S/R to diagnosis, etiology and treatment of mental disorders as essential components of psychiatric training; and that psychiatrists should be willing to collaborate with leaders and members of faith communities in support of the well-being of their patients. These would also form the 3 major topics of my presentation.

First, I will discuss about partnerships between mental health and faith communities in enhancing mental health – utilizing examples from North America, including specific Asian Canadian communities of various faith traditions. Second, I will present on the major findings from a recently-conducted systematic review on the teaching of spirituality- & religiosity-related competencies to psychiatry residents globally. Third, I will discuss about spiritually-integrated psychotherapy as an example of the integration of S/R in mental health treatments, and will present on a recent study on Christian-based spiritually-integrated psychotherapy in East Asian Canadians (as part of the Templeton Foundation-funded Bridges Consortium). Through these different examples, this presentation aims at illustrating the diverse opportunities in addressing the S/R dimension of mental health – as a pathway for achieving high quality, person-centred mental health care – including for Asian Canadians. Potential barriers and challenges will also be discussed.

RELIGIOSITY AND SPIRITUALITY IN PSYCHIATRIC RESIDENCY: WHY, WHAT AND HOW TO TEACH?

Fabrício Henrique Alves Oliveira e Oliveira[1], John Peteet[2], Alexander Moreira-Almeida[1]
[1]Medicina, Universidade Federal De Juiz De Fora (Ufjf), Juiz De Fora, Brazil, [2]Medicine, Harvard Medical School, Boston, USA

Abstract Objective: To propose a practical core curriculum for R/S in clinical practice for psychiatric residency programs (PRPs) based on the available evidence.
Methods: Review of studies describing the implementation of R/S curricula in PRPs and identification of the most commonly taught topics and teaching methods. The proposed R/S curriculum was defined based the on most prevalent and effective strategies and recommendations from psychiatric associations to create a fairly comprehensive R/S curriculum that is simple enough to be easily implemented in PRPs around the globe, even where there is a shortage of time and of faculty expertise in R/S.
Results: The curriculum is a twelve-hour course divided into six 2-hour sessions.
Topics: concepts and evidence regarding R/S and mental health relationships, taking a spiritual history/case formulation, historical aspects and research, main local R/S traditions, differential diagnosis between spiritual experiences and mental disorders, and R/S integration in the approach to treatment.
Teaching methods: didactic classes, group discussion, study of guidelines, taking a spiritual history, panels, field visits, case presentations, and clinical supervision.
Resident evaluation: taking a spiritual history and making an R/S case formulation.
Program evaluation: quantitative and qualitative written feedback (from residents and preceptors).
Conclusions: A brief and feasible core R/S curriculum for psychiatric residency programs is proposed; investigation of the impact of this educational intervention is needed.
Keywords: curriculum, religiosity, spirituality, residency, psychiatry.

DOES GENETICS EXPLAIN SPIRITUALITY?

Homero Vallada[1,2]

[1]Psychiatry, Universidade De Sao Paulo, Sao Paulo, Brazil, [2]Center for Molecular Medicine, Karolinska Institutet, Stockholm, Sweden

The presentation will initially show some historical aspects of the genetic investigation of human behavior, including normal and pathological behaviours. We will then look at how genetic components may contribute to a person's religiosity/spirituality.

NEW STUDIES OF PSYCHEDELIC DRUGS IN PSYCHIATRY AND THEIR RELATIONSHIP TO SPIRITUALITY

Richard Doblin
Psychedelic Psychotherapy, Maps, Belmont, USA

Rick Doblin, Ph.D., Founder and Executive Director of the non-profit research and educational organization, the Multidisciplinary Association for Psychedelic Studies (MAPS), will review the range of psychedelic drug research underway today, discuss the psychedelic mystical experience and its role in psychotherapy, explain the role of MDMA-Assisted Psychotherapy in the treatment of PTSD, outline likely post-approval regulations, and mention the role of the psychedelic spiritual experience in conflict resolution between Israelis and Palestinians.

RELIGIOUS BELIEF AT THE LEVEL OF THE BRAIN: NEURAL CORRELATES AND INFLUENCE OF CULTURE

Albert Gaw[1,2]

[1]Psychiatry, Ucsf, San Francisco, USA, [2]Psychiatry, Asian Community Mental Health Services, Oakland, California, USA

This powerpoint presentation summarizes key functional magnetic resonance (fMRI) studies that correlate the neural substrate of religious belief and the influence of culture. Belief, whether religious or nonreligious, is associated with greater signal in the ventromedial prefrontal cortex (vMPFC), a brain region important for self-representation, emotional associations, reward, and goal-driven behavior. However, religious belief, compared with nonreligious belief, registers greater signal in the precuneus, anterior insula, ventral striatum, anterior cingulate cortex, and posterior medial cortex—areas associated with governance of emotion, self-representation, and cognitive conflict. In contrast, nonreligious belief registers more signal in the left hemisphere memory networks (Harris et al. PLoS One 2009;4:e0007272).

Moreover, cultural studies revealed self-judgment tasks in nonbelievers involved more the vMPFC, whereas Christians had significantly increased activation in the dorsomedial prefrontal cortex (Han et al. Soc Neurosci 2008;3:1–15).

Consequently, the Christian belief of “surrendering to Christ” seemed to weaken neural coding of stimulus self-relatedness but enhanced neural activity underlying evaluative processes of self-referential stimuli. The findings suggest a transformation of the semantic autobiographical self to Christ's conceptual self.

Reference:

Gaw AC: Religious belief at the level of the brain: neural correlates and influence of culture. The Journal of Nervous and Mental Disease. 207; July 2019,604-610.

MISTRANSLATIONS AND CULTURAL TENSIONS BETWEEN ENGLISH AND MANDARIN CHINESE PSYCHOTHERAPISTS AND PSYCHIATRISTS

Nathan Szajnberg[2], Yikun Wu[1]
[1]Wuhan Mental Health Center, Wuhan Medical School, Wuhan, USA, [2]Israel Psychoanalytic Society, San Francisco Center for Psychoanalysis, Palo Alto, USA

We give an overview of both mistranslations from German/French/English psychiatric terms into Mandarin and miscommunications about Western psychiatric concepts. Miscommunications are due to both a tension within Chinese culture (Taoism vs. Confucianism) and between Western and Chinese value systems of the individual and family/society.

Mistranslations. We review the contemporary literature on the challenges of translations: some translators believe that there are no inaccurate translations; others argue (our position) that some translations are more accurate. Here is an example of intentionally inaccurate translation. A foreign lecturer in China insisted on the importance of the concept of "phallus/penis" to understand psychoanalysis. One author/translator (YW) was told by her Chinese professor that she should translate phallus as"ancient stone icon." When she asked to use common Mandarin terms for penis, the professor/department head insisted these were unacceptable words for a Chinese audience. Ironically, at the end of the lecture, one Chinese attendee asked what was a "phallus"? This is an example of conscious mistranslation," similar to Strachey's decision to translate Freud's Seele (soul) as "mind," for the British audience.

A troubling mistranslation is for "psychoanalysis." The Mandarin contraction for"psychoanalysis" is the same as the contraction for "schizophrenia." Hence, the first author (YW) identifies herself as a psychodynamic therapist (not psychoanalyst) to Mandarin audiences.

Another mistranslation is Freud's term "Es" ("it"), which was translated into the Latin "id." "Id" is further distorted into the Mandarin, 本我 ben3 wo3, meaning "origin-I" or "instinct-I"[1] By definition, the id cannot contain the concept of "I" or ego. (Cf. footnote for Confucian and contemporary Chinese attitudes about inborn negative impulses.)

The second half of our presentation focuses on the millennia-long tension within Chinese culture between belief systems of Taoism vs. Confucianism. We summarize both sets of belief systems, then point out correspondences between these and contemporary Chinese "communism," in which, for instance, the concept of "confidentiality" may not be plausible for patients.

We close with the profound tension between the traditional Chinese commitment to family/society (like Japanese amae), versus the Western commitment to individual autonomy at the expense of dedication/responsibility to the family. We discuss these implications.

[1] Id is more problematic in Chinese cultural history. Confucian belief is that people are born "good" (closer to Rousseau's concept). One opposing thinker in Confucian times, Xun Zi, disputed Confucius, arguing that people are born evil (perhaps closer to Catholic original sin). But, the Confucian belief, promoted by Mencius, is the prevalent belief in contemporary China. An idea such as Id, to the degree that it represents negative or destructive impulses, would be not as well received. That is, the translation of the concepts into words is complicated by the fundamental cultural belief systems into which foreign concepts are introduced.

Young Chinese children learning their first reading in Chinese, often start with a book written by 13th Century Mencius, that begins with three words, ren zhi chu, xing ben shan, "People At birth, are naturally good."

A SURVEY OF THE PHENOMENOLOGY AND PSYCHOLOGICAL IMPACTS OF PERCEIVED SPONTANEOUS AFTER-DEATH COMMUNICATIONS

Evelyn Elsaesser[1], **Chris A Roe**[2], Callum Cooper[2], Alejandr Parra[3], David Lorimer[4]
[1]N/a, University of Geneva, Geneva, Switzerland, [2]Psychology, University of Northampton, Northampton, UK, [3]N/a, Instituto De Psicología Paranormal, Buenos Aires, Argentina, [4]N/a, Scientific and Medical Network, London, UK

A spontaneous After-Death Communication (ADC) occurs when a bereaved person unexpectedly perceives the deceased person in a manner that is interpreted as indicative of the continued survival of some aspect of that person. This may be experienced through the senses of sight, hearing, smell, or touch, but commonly recipients might simply "feel the presence" of the deceased person or have a subjective impression of having received a contact or a communication, for example during sleep. ADCs occur frequently, with an estimated 25-50% of the bereaved having experienced one or more (Cooper et al., 2015), and have been reported in different cultures and time periods (Haraldsson, 2012; Sidgwick et al., 1894).

Despite their widespread occurrence, ADCs have been little researched and are absent from scientific and medical discourse. As a consequence, persons who experience an ADC usually have no frame of reference in terms of which to understand, integrate and benefit psychologically and emotionally from their experiences. Additionally, they typically fear that disclosure will cause them to be labelled as credulous, or even as suffering from some pathology or psychiatric disorder (Evenden et al., 2013; Roxburgh & Roe, 2014). For many participants, involvement in a research study can be the first time they have spoken openly about such experiences; for example, Rees (1975) reported that only 27.7% of his participants had previously discussed their exceptional experiences (EEs) with anyone, and just 14.6% had told more than one person. This reticence acts as a hindrance to research into the effects of anomalous experiences upon the bereavement process.

Whatever the ontological status of ADCs, they are perceived as real by a great number of persons and therefore deserve to be taken seriously by researchers interested in how people negotiate the bereavement process. When ADCs are acknowledged and engaged with they have been found to aid the bereaved person in coming to terms with their loss (Cooper et al., 2015). Counterintuitively, it seems that participants who felt a continued bond with the deceased as a result of their ADC felt more able to accept the death of their loved one, 'let go' of them, and re-engage with the wider world around them.

This presentation will introduce a survey project that is the most extensive interrogation of the phenomenology and impacts of spontaneous ADCs attempted to date. Using an online survey platform that included English, Spanish and French versions of the questionnaire, over 1,000 respondents who had experienced an ADC answered a sequence of up to 200 questions relating to their ADC (follow up questions were presented following affirmative answers and were omitted following negative answers). The primary research questions include: What type of person reports an ADC? In what form (type) are ADCs reported? Under what circumstances do they occur? What attributions do people make to their ADCs? What is the impact on experients? How does it influence their individual grieving process? How does it influence personal beliefs about life and death?

SPIRITUALITY, SUICIDALITY AND COGNITIVE FUNCTION IN PATIENTS WITH SCHIZOPHRENIA: A CROSS SECTIONAL STUDY FROM NIGERIA.

Oluyomi Esan[1], Arinola Esan[2]

[1]Department of Psychiatry, University of Ibadan, Nigeria, University of Ibadan, Nigeria, Ibadan, Nigeria, [2]Department of Medicine, University College Hospital, Ibadan, Nigeria, Ibadan, Nigeria

Background: There is increasing evidence that spirituality has an important effect on the outcome of patients with schizophrenia. However, very few studies have explored spirituality and outcomes in the context of cognitive functioning and suicidality among patients with schizophrenia.

Methods: The Daily Spiritual Experience Scale (DSES), Screen for Cognitive Impairment in Psychiatry (SCIP) were applied in this cross-sectional study, to all consecutive and consenting stable outpatients with schizophrenia (N=215). Lifetime prevalence estimates of suicide ideation, plan and attempts were assessed with the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). Psychopathology was assessed with Positive and Negative Syndrome Scale of Schizophrenia (PANSS).

Results: 215 subjects with schizophrenia were recruited into the study, 109 (50.7%) were males, mean age =38.8 years (S.D=9.4); 64.4% were Christians, 34.1% had low spirituality, 34.6 % medium spirituality and 31.3% had high spirituality. Mean score on DSES was 60.6 (S.D=12.4). Lifetime prevalence estimates of suicide ideation, suicidal plan and suicidal attempts were 30.2% 11.2% and 5.6% respectively while 5.1% currently felt they were better off dead. There was significant negative correlation between spirituality score and the negative (P<0.001), general (P<0.001) and total sub-scales of the PANSS (P<0.001). There was significant association between spirituality and employment status (P=0.002), having suicidal thoughts (0.05) and remission status of the subjects (0.009).

Conclusion: Spirituality may be a useful complementary form of treatment that should be better explored in the treatment of schizophrenia.

RELIGIOSITY AND SPIRITUALITY (R/S) IN ACADEMIC TRAINING COURSES ON HEALTH IN BRAZIL

Solange Andrea Díaz Alcocer[1], Maria Beatriz Barreto do Carmo[3], **Marcus Welby-Borges**[2]
[1]Rede Universitária De Pesquisas Em Espiritualidade (Reupe), Universidade Federal Da Bahia, Salvador Bahia, Brazil, [2]Departamento De Biointeração, Universidade Federal Da Bahia, Salvador, Brazil, [3]Instituto De Humanidades, Artes E Ciência, Universidade Federal Da Bahia, Salvador Bahia, Brazil

Brazilian production on Religious and Spirituality (R/S) on health is still scarce, with gaps that interfere in the debate and insertion of this theme in higher education. To know how Religious and Spirituality (R/S) is worked in health academic formation of majors in Brazil two studies were carried out. The first one aimed at characterizing the scientific production about R/S in academic training of health majors in Brazil. The second identified the theoretical references that have been used to address this issue in health higher education in Brazil. We use articles as bibliographic sources, researched in four databases and the following descriptors “spirituality”, “religiosity”, “undergraduate” and “health”. Twenty-three publications were analyzed and categorized into four areas of health training. The nursing area led to the publication of papers about R/S in academic education, comprising 52,1% (12/23) of the publications found. Medicine was the second area most studied, with 34,7% (08/23) of the publications included in this study. Psychology was studied by 8,7% (02/23) and Bacharelado Interdisciplinar em Saúde (BIS) at UFBA was studied by 4,3% (01/23) of the papers included in this study. In general, most researchers, professionals, students and professors recognize the need and relevance of R/S in the academic training of health majors in Brazil. However, it is noted that the undergraduate health programs in Brazil still do not treat these contents comprehensively. A wide variety of definitions are observed to address the R/S concepts. That makes it imperative to homogenize the meanings and conduct multicentric research that can contribute to the systematization of concepts and their insertion in the academic field. In this sense, it will be possible to grant patients/users a humanized health care, that considers all dimensions of the human beings and that promotes values in keeping with the paradigm of integrality in health.

SUFI MUSIC THERAPY AS A POTENTIAL INTERVENTION FOR COMMON MENTAL HEALTH DISORDERS

Rumeysa Nur Gurbuz Dogan
Psychiatry, University College London, London, UK

This research project aims to develop Sufi music therapy guidelines to evaluate the effect of makamic therapy's effect on mental distress by following the Medical Research Council Framework for developing and evaluating complex interventions. To reach this aim the five steps were designed as follow; (1) a systematic review of the literature and meta-analysis to establish an evidence-based overview, (2) a theoretical review of the literature to identify an appropriate theory, (3) a qualitative study to design the intervention (4) development of a manual to model the process and outcomes (5) a feasibility randomised clinical trial to assess how Sufi music might be delivered in a community setting to people with mental distress.

To provide a critical overview of the reported evidence on the efficacy of makamic music interventions in mental health, I carried out a systematic review and meta-analysis of Sufi music therapy effects on mental well-being as a first step. According to this study Sufi music therapy was found beneficial.

A qualitative data was collected on attitudes/views held by adults attending two Turkish community centres (one in Newcastle and one in London) towards Sufi music, the emotions evoked by the music and the best mode of delivery of the music as therapy. Forty-one adults were recruited. Additionally, 3 experts were interviewed via Skype. Participants found at least one piece of Sufi music as beneficial.

In order to explore each part of the intervention, to denote whether it is working in a coordinated manner, and evaluate does Sufi music therapy reduce anxiety/ depression and improve spiritual and mental well-being, a feasibility trial will be undertaken between May- August 2019.This feasibility study will comprise a repeated-session, randomised controlled control group design. The study will recruit adults who live in Newcastle/London area and who experience mild/ moderate level of depression or/ and anxiety.

REGULAR PRAYER AS PREVENTION OF SOCIAL EXCLUSION IN YOUNG PEOPLE

Izet Pajević[1,2], **Mevludin Hasanović**[1,2]
[1]Department of Psychiatry, University Clinical Center Tuzla, Tuzla, Bosnia Herzegovina, [2]School of Medicine, University of Tuzla, Tuzla, Bosnia Herzegovina

Aim: of this paper is to establish what kind of influence may have regularity of Islamic prayers' performing and age of tested adolescents when they acquired basic instruction about prayers on mental stability and health of adolescents, in order that how these may have influenced on preventing of their social excluding.
Methodology: The sample was consisted from 240 mentally and physically healthy secondary school adolescents of both genders, of age 15-18 years, equal in regard of school achievements, conduct, family structure and level of exposure to psychosocial distress. Participants were assessed in regard of regularity and frequency of prayer performing. Personality profile was assessed with Freiburg questionnaire of personality. Statistical analysis was done in SPSS 16.00 program; we used Pearson's correlation test (r).
Results: indicated that regularity of prayer performing and earlier acquired basic instruction about prayer was in positive correlation with mental stability during adolescence, particularly among boys.
Conclusion: Performing of Islamic prayers engages physical, mental and spiritual potentials of personality on individual and also on social plan; so it helps that developmental potentials direct to the way of forming emotionally more stabile person and in that way these will diminish risk of appearance of different forms of unadjusted behavior, in other words these preventing social excluding of young people.
Key words: Islamic prayer – adolescence – mental stability – social excluding

A CALL FOR SPIRIT: UNDERSTANDING THE REEMERGENCE OF PSYCHEDELICS IN PSYCHIATRY

James Robert Henry
Psychiatry, University of California San Francisco, San Francisco, USA

Most psychiatrists are not trained to recognize the spiritual crisis beneath emotional syndromes. What then happens in times of widespread existential and spiritual distress? We see a rise in "treatment-resistant" depression and suicide, as patients become trapped in a cycle of chasing symptoms [1]. This confusion of etiology, with neglect of psycho-spiritual roots, is one way to understand the increasing morbidity from depression despite advances in our biological model [2].

In the midst of this healthcare crisis, there has been an extraordinary resurgence of interest in psychedelics [3]. Psilocybin therapy received U.S. FDA breakthrough therapy designation for treatment-resistant depression in 2018. One researcher estimated "on any given night in Manhattan, there are a hundred ayahuasca 'circles'" [4]. If "necessity is the mother of invention," this wave of popularity can be seen as the emergent response to an unmet need. Psychedelic-assisted therapy, as a space to explore matters of spirit, may be offering a path that is absent from our psychiatric paradigm. In a high-dose, high-support setting, 96% of psilocybin recipients rated it among the "top five most spiritually significant" events of their lives [5]. Of relevance, the quality of the mystical-type experience predicted therapeutic efficacy for treatment-resistant depression [6]. Insights arising from psychedelic therapy— such as a sense of interconnection and responsibility for others— cross into the domain of spiritual growth [7].

This emerging integration of psychiatric and spiritual healing calls for a renewed dialogue between medical and religious institutions. Psychiatrists offering psychedelic-assisted therapy can learn from people devoted to "the great matter of life and death." Spiritual practitioners have wisdom to share for transforming "altered states" into "altered traits" [8]. Through this conversation, we help our model of care evolve to meet the spiritual needs of our time.

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SPIRITUALITY AND LIBERATION PSYCHOLOGY IN THE REVISED GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH GIRLS AND WOMEN

Frederick M. Jacobsen, Lillian Comas-Díaz
Department of Psychiatry and Behavioral Sciences, The George Washington University School of Medicine, Washington Dc, USA

In the U.S. and beyond, the results of rapid technological and sociocultural change has dramatically transformed both day-to-day and developmental trajectories of many individuals, particularly girls and women.

In May 2019 the largest U.S. mental health professionals organization, the American Psychological Association (118,000 members), published revised "GUIDELINES for Psychological Practice with Girls and Women"[1] focusing on changes in critically impacted areas such as education, work, reproductive and caregiving roles, and personal relationships.[2]

Notable experiences or contexts for this re-envisioning of clinical practice include economic/employment inequities, interpersonal and/or sexual violence (estimated to occur in 90% of American women[3]), discrimination, devaluation, oppression (including stereotypical/unrealistic media portrayals), and relationship disruptions,[1] all of which may inflict even greater burdens on females of diverse racial/ethnic, social class, sexual orientation/gender identity, and life experiences backgrounds.[1]

In this presentation we review the 10 Guidelines, among which are stipulations particularly relevant to spirituality - ensure that treatment:

- *Is* **developmentally appropriate, gender** and **culturally relevant,**
- *Promotes* **strengths** and **resilience**,
- *Considers* how **attitudes, beliefs,** and **orientations** affect **prescription practices**,
- *Promotes* **agency, critical consciousness** and **choices for girls** and **women**,
- *Provides* **unbiased assessment** with **understanding** of **sociopolitical** and **geopolitical contexts**,
- *Incorporates* **community, indigenous** and **complementary alternative healing practices**.[1]

With a view towards psychospiritual and ethnocultural implications, we present cases from the perspective of ***Liberation Psychology*** to illustrate how these treatment guidelines for women and girls may be applied to mental health practice in the U.S. (and possibly beyond).

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COUNSELING ORTHODOX JEWISH PATIENTS CONFRONTING UNWANTED SAME SEX ATTRACTIONS

Dovid Asher Schwartz
Private Practice, Crown Heights, Brooklyn, USA

As an Orthodox Jewish psychotherapist, counseling people for over 50 years with a large variety of issues, I have noticed over the last 10 to 15 years an increase of people (almost entirely orthodox Jewish patients which is my sole practice now) coming to me because they have Same Sex Attraction (SSA) feelings which they feel quite disturbed with and for psychological and relgious reasons want these feelings to stop and not be expressed in any manner. This paper will examine what it means to be a man or woman; the relationship between objective body and subjective mental states; when and in what relationships sexual and reproductive relationships are right or wrong; how individuals should respond when their inclinations or their conduct fail to match their religious/moral convictions; and whether humans have free will and the capacity to change, or are helpless agents of chemistry. From my extensive experience and literature on this issue, there are many motivated indivuals who have in fact changed. The globally respected religious leader, the Lubavitcher Rebbe, obm, taught that such change is possible. He (the Rebbe), wrote to an indivdual wth SSA issues, that there are doctors and psychiatrists who treat it, and have been successful in many cases, and he knew of a number of cases of people who had this problem, eventually overcame it, married and raised a family. There are studies that show a large majority of young people who experience gender dysphoria ultimately "desist" -- that is, achieve comfort in the identity defined by their sex. This paper will examine these issues from a spiritual, religious, clinical, and political perspective.

DEMONIC POSSESSION - NEGATIVE SPIRITUAL COPING IN SEXUAL VIOLENCE, EASTERN CARIBBEAN

Hazel Angela Da Breo
Psychotherapist/director, Sweet Water Foundation, St. George's, Grenada

Childhood Sexual Abuse affects 48% of girls in the Caribbean, or almost 1 in 2. There is now an alarming increase in rapes of girls and boys in the Under 5 age demographic. With no mandatory, standardized psychological treatments available, and very few child-centred clinicians in the population, a range of serious psychological and psychiatric issues is predicted to beset this community. Given the convergence of powerful and diverse religious traditions making up the Eastern Caribbean, including African, Asian, Middle Eastern and Western influences, this paper looks at the strong belief in demonic possession as a causal factor behind PTSD and Schizophrenia in children and adolescents who have suffered from childhood trauma. Exorcism is often considered as a real treatment choice. Within this paradigm, victims go unhelped, perpetrators are neither held accountable nor offered treatments, bystanders are not mobilized to make interventions, and a global health crisis grows ever more complex and embedded within the collective.

EMBODIED SPIRITUALITY; THE SECRET INGREDIENT IN NATURE BASED THERAPIES

Lia Naor
Department of Counseling and Human Development, Haifa University, Haifa, Israel

This presentation is part of the current surge in discussions and research of spirituality in psychology (Miller, 2015; Pargament, 2007; Pargament, Mahoney, Exline, Jones, & Shafranske, 2013), focusing specifically on nature as a therapeutic spiritual resource. The natural environment offers various opportunities to experience ultimate aspects of existence, commonly described as the spiritual dimensions of life (Pargament, 2007). These qualities are experienced in nature through boundless and beautiful landscapes, the powerful forces of nature, and extraordinary forms of life (Ashley, 2007). This presentation focuses on the therapeutic effect of experiencing spirituality in nature from the perspective of nature-based therapists (NBT). Grounded theory methodology was applied, and data included in-depth interviews with 26 experienced nature-based therapists worldwide and field observations of six nature-based therapeutic workshops. Spirituality emerged as involving an actual and tangible experience of the spiritual in physical form—nature as an embodiment of spirituality. The findings link this form of spiritual experience to significant therapeutic effects, including the experience of nature's immensity, contributing to an expansive perspective; experiencing interconnectedness, which elicits a sense of belonging to the large web of life; and the reflection of internal nature and truth by external nature as an accepting setting, contributing to the discovery of an authentic self. These results are discussed in light of current perspectives on the psychology of spirituality contributing to our understanding of the therapeutic effects of spirituality that may be evoked and implemented through nature. The practical and clinical implementations of spiritual connection through nature in therapeutic frameworks are discussed.

THE BODY AS CONTAINING THE MIND AND THE SOUL IN PSYCHOTHERAPY

Sigalit Ben David Shalit
Center for the Study of Human Spirit, Haifa University, Kochav Yair, Israel

The body enables us to move, explore, feel and sense, so many kinds of feelings, emotions, and sensations. The body contains the self-sensations, the borders, the meeting points and the distinctions between the notions of "me" versus "not me", both in perception and in reality.
The current presentation will explore the position of the body, as a container of mind and soul in psychotherapy. It will discuss the possibility that experiencing the body in that manner in psychotherapy, allows to create, discover and establish the "learning body", a body that learns how to expand, make space, contain mind and soul, and create new paths within, supporting and allowing transformations. Experiencing the body containing mind and soul creates "anchors" in the "learning body"; bodily internalizations and sensations of the spirit or the soul presenting itself through the body. These "anchors" enable future shortcuts formation for re-experiencing, therefore becoming the realization of the unity and wholeness of mind body and soul. Thus, the body containing the mind and the soul, integrates the expanding sense of self.
The term "the body remembers" is often mentioned, when discussing trauma and stressful conditions. It is well acknowledged that traumatic memories, illness and physical harm are embedded in "memory cell". This presentation will suggest that experiencing the body as containing mind and soul, enables us to replace the traumatic cell memory while encoding new cell memories; therefore, modifying bodily consciousness and allowing evolvement through psychotherapy. This approach allows shared search of patient and therapist, through therapeutic processes of expanding consciousness. Exploring, anchoring and creating space for the spirit or soul and onto the entire body, may generate a change in the physical experience. Observing benefit derived from it in therapy; for example, relieving symptoms of anxiety, obsessive thoughts, physical and emotional pain, releasing restrictions and barriers that contribute to limited functioning. It will also be considered that this physical transformation, affects and changes consciousness.
In therapy, in order to make change, implement as experience and not remain at mental level- this awareness must become an expanding sensual physical being. It is actually experiencing the body as containing the mind and the soul, expanding one's consciousness and being, that emphasizes understanding. In psychotherapy, this realization enhances emotional and physical transformations.
Clinical examples in psychotherapy will be presented and discussed.

MEDITATION INDUCED FLEXIBILITY OF THE EMBODIED SELF: NEURO-PHENOMENOLOGY EVIDENCE, AND PROSPECTS FOR PSYCHOPATHOLOGIES

Aviva Berkovich-Ohana
Counseling and Human Development And Learning, Instruction And Teacher Education, University of Haifa, Haifa, Israel

The notion of "sense of self", a core aspect of our consciousness, is grossly divided by cognitive philosophers to two important concepts: the narrative-self (conceptual, autobiographic identity with continuity across time), and embodied-self (a momentary, perceptual and minimal self). The two notions of self-constitution find confirmation in cognitive neuroscience, largely related to different brain regions and networks.

It is widely accepted that the default mode network (DMN) supports the narrative-self, or self-related processing. Similarly, regions responsible for multi-sensory integration and interoception are suggested to support the embodied-self, via self-specific processing.

One missing aspect in this field is conceptualizing a third level, beyond the regular two types of self, referred to here as "self-transcendence", as well as uncovering its underlying neural activity. The lecture describes a series of projects carried out in the last few years using a neuro-phenomenological approach and magnetoencephalography (MEG), which enables such a subtler study of the sense of self, beyond the embodied self. These projects employed contemplative practitioners which demonstrated the ability to stably produce and describe in the laboratory setup unique states of self-transcendence.

A malleable embodied-self might be fundamental for inter-subjective experience, as well as for mental health, as evidenced by a lack thereof in some psychopathologies including schizophrenia and PTSD, characterized by a rigid embodied-self boundary. Thus, an important aspect of mental health and effective social functioning seems to be the ability to flexibly regulate the level of self boundaries. Our results emphasize the trainable flexibility and neural plasticity of the embodied-self experience, and

Suggest widening the focus in contemplative interventions from the attenuation of the narrative-self to alterations in prereflective embodied self-experience. Such applications would have far reaching potential for supporting treatment of psychological disorders involving perturbed self-boundaries, and for fostering resilience, well-being and social connectedness in healthy populations.

RELIGIOUS BELIEF OR DELUSION--DISTINGUISHING DIFFERENCES

Kayla Fisher
Department of Psychiatry, University of California Riverside, Riverside, USA

As our world grows steadily more culturally heterogenous within a given population area, psychiatric patients adhere to increasingly varied expressions of religious belief. As a result, psychiatrists run a greater risk of labeling a belief as delusional, when the belief actually constitutes a facet of a given religion. To provide ethical diagnoses and treatments, it is incumbent upon clinicians to equip themselves with mechanisms needed to avoid misdiagnosing a religious belief as a delusion. This presentation will provide: 1) an overview of the challenges in distinguishing religious belief from delusion; and, 2) tools and concepts from current literature to aid in the task of correctly identifying religious belief from delusion.

A NATIONAL SUICIDE STUDY WITH POTENTIAL TO INCREASE UNDERSTANDING OF THE PROTECTIVE ROLES OF SPIRITUALITY AND RELIGION

Christina W Hoven[1], George Musa[2], Larry Amsel[3], Mythili Ananthasayan[3], Alan Apter[4], Megan Ryan[3], Helen Herrman[5], Samuel Tyano[6], Connie Svob[7], Danuta Wasserman[8]
[1]Child and Adolescent Psychiatry, Columbia University Medical Center, New York, USA, [2]Epidemiology and Child and Adolescent Psychiatry, Columbia University Nyspi, New York, USA, [3]Child and Adolescent Psychiatry, Columbia University Nyspi, New York, USA, [4]Child and Adolescent Psychiatry, Schneider Children's Medical Center, Petach Tikva, Israel, [5]Psychiatry, University of Melbourne, Melbourne, Australia, [6]Child and Adolescent Psychiatry, Tel Aviv University, Tel Aviv, Israel, [7]Translational Epidemiology, Columbia University Nyspi, New York, USA, [8]Psychiatry and Suicidology, Karolinska Institute, Stockholm, Sweden

Suicidal behaviors include suicidal ideation, non-fatal suicidal attempts, and completed efforts (i.e., fatal), and taken together give rise to a leading cause of preventable deaths, ultimately claiming 800,000 lives each year. There is a consensus that individual, contextual and genetic factors significantly contribute to the occurrence of suicide behaviors. However, one of the central dilemmas of suicide research is that while significant risk factors have been identified the ability to predict or prevent suicidal behaviors remains poor. There is an increase in understanding how religion and spirituality may protect its adherents from destructive behaviors, including suicide. In the West the weight of evidence suggests that religious affiliation, attendance at services, or degree of observance are protective against suicide. However, religions are not equal in providing protection and a longitudinal study of completed suicides found that being Catholic provided greater protection than being Protestant among regular church attenders. Others, have found that religiosity was not protective against suicide attempts in India and Vietnam, raising questions about imposing Western cultural assumptions on non-western religious practices.

Insights into the risk differences across religious groups are wanting, mostly due to lack of ideal multi-religious samples in which to conduct rigorous investigations. That is, availability of a population with not only high suicide rates but also the presence of multi-religious groups with a shared context. A recently funded national, longitudinal investigation of suicide in Guyana by the US National Institute of Mental Health has great potential to help us understand the roles of spirituality and religion in suicidal behaviors. Guyana has one of the highest rates of suicide in the world, where the major religions include Hinduism, Islam and various sects of Christianity (Catholicism, Pentecostalism). Guyana data indicate that Hindus account for over 50% of suicides while Pentecostals are the next highest, accounting for 35%.

This presentation is designed to describe the planned suicide study to be carried out in collaboration with Columbia University-NYSPI, PAHO, the Guyana Ministry of Health, with input from the WPA and Karolinska Institute. It is desirable to elicit interest in and suggestions about issues of spirituality and religion that should be considered for this investigation.

THE ROLE OF RELIGION AND SPIRITUALITY FOR CHILDREN'S MENTAL HEALTH IN DISASTERS

Lawrence Amsel[1], Christina Hoven[1], Sam Tyano[2]

[1]Psychiatry, Columbia University, New York, USA, [2]Psychiatry, Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Throughout the world, with increasing frequency, natural and person-made disasters wreak havoc on the physical and mental health of our fellow human beings. We have come to appreciate that children exposed to mass disasters, are particularly vulnerable, and that the successful outcome of their fragile development hangs in the balance in those crucial moments before, during, and after a disaster. One question that has not been adequately described is: what role religion and spirituality play in regard to the wellbeing and resilience of children before, during and after such disasters. In this research we examined over a dozen of the worst mass disasters of the last several decades from the perspective of those who were directly involved in delivering interventions for these children. From their descriptions of the interventions that were helpful in promoting resilience, we draw a preliminary conclusion regarding the role of Resilience and Spirituality in children's response to these disasters, and we will expand on the points in this talk. 1. As S/R are often an important, stabilizing and comforting factor in the cultural setting within which a disaster occurs, disaster mental health workers must understand the S/R background of children they are hoping to help and utilize this S/R background as part of intervention when appropriate. 2. As religiously-motivated violence is sometimes the very source of the disasters, children need honest discussions to help understanding the difference between R/S as a legitimate source of human growth and social cohesion, and its vulgar and violent misuse by extremists. 3- Clergy can be an effective part of the disaster recovery, if they are properly trained in the relevant psychological aspects of children's disaster responses, and if they are used by choice and without subtle coercion. 4. The larger meaning of the disaster for children will often include its impact on R/S beliefs and such discussions need to be encouraged and handled with sensitivity. With tis presentation we hope to further the discussion on this topic based on our recently published book published in collaboration World Psychiatric Association: An International Perspective on Disasters and Children's Mental Health.

RAJYOGA FOR DEADDICTION

Nikhl G Patel[1], Barbara Giorgio[2]
[1]Neuropsychiatry and Deaddiction, Global Hospital and Research Centre, Mount Abu, India,
[2]Department of Psychology, Australian Catholic University, North Sydney, Australia

RajYoga Mediatation taught and propagated by the Brahma Kumaris World Spiritual University, an Indian School of spirituality is seen as an sdjuant / sole therapeutic intervention especilly in the psychosomatic and addiction medicine. The retrospective study carried out by the Department of Neuropsychiatry and Deaddiction, Global Hospital & Research Centre, Mt Abu, India amongst 380 expatriats from all the continents that included a sizable number of Americans, Europeans found RajYoga to be an efficacious method to overcome hard and soft drug addictions in more than 90 % individuals.

AUSTRALIAN ABORIGINAL SPIRITUALITY IN ADDICTION TREATMENT

Kelly Ridley
Psychiatry, Albany Health Campus, Albany, Australia

Aboriginal Australians are a diverse group of people with varying spiritual beleifs and customs which impact on everyday life, physical and mental health. Care provided in a traditional medical model for management of addictions and mental health can result in poorer engagement and treatment outcomes.
Key aspects of Australian Aboriginal spirituality will be reviewed, along with how these beliefs can impact on diagnosis and treatment decisions in an addiction psychiatry setting. A case study discusses the care for an Aboriginal gentleman with schizophrenia and alcohol dependence by adapting the 'Wise Choices' components of Acceptence and Commitment therapy to integrate the patients spiritual beleifs and needs and to seperate culturally appropriate experiences from psychotic symptoms.

FEMALE GENITAL MUTILATION: SPIRITUAL TRADITION OR SEXUAL ABUSE?

Annemarie Middelburg[1], Haim Belmaker[2]

[1]Founder & Director, Middelburg Human Rights Law Consultancy, Maarssen, The Netherlands,

[2]Psychiatry, Ben Gurion University of the Negev, Beer Sheva, Israel

Female Genital Mutilation (FGM), also referred to as 'female circumcision' or 'ritual female genital surgery' is defined by the World Health Organization (WHO) as "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons." At least 200 million women and girls worldwide have undergone the practice. FGM can cause serious adverse health consequences, since it involves removing and damaging healthy female genital tissue. FGM interferes with the natural functions of girls' and women's bodies and does not have any known health benefits. FGM is practiced across religions, including among Muslims, Jews, Christians, Animists and followers of traditional religions. Although none of the holy texts prescribe FGM, the primary cited reason for performing FGM in the Middle East is 'religious obligation'. In the 1990s, the practice was found in Israel among two different ethnic groups, namely (i) Six Bedouin Muslim tribes, originally nomadic, in the southern part of Israel; and (ii) Ethiopian Jews who had emigrated to Israel. However, over a period of 15 years, FGM effectively disappeared among both groups. This is very unique, as many countries in the world are trying to eliminate the deeply-rooted practice, but seem not to succeed. The overall progress in terms of elimination of FGM has been very slow. Therefore, many lessons can be learned and inspiration can be drawn from the successful change that occurred in Israel.

THE INVERTED ARROW: TIME FLOW IN ZEN AND PSYCHODRAMA

Dani Yaniv
The School of Creative Arts Therapies, Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel

When Westerners are asked to reflect on “past, present & future” and to depict a schema of this time-triangulate, they usually envision an arrow spanning from past to present to future. This culturally-based schema represents a view common in the West, in which a person is rooted in his past which in turn determines his present and, somewhat indirectly, his aspirations and hopes of the coming future. This schema implies that the three “times” are relatively distinct and that one’s life is mainly composed of past and future whereas the present is a hair-like thread in between. Zen’s view is opposite, and is reflected in an “inverted arrow” that points from future to present to past, depicting the actual direction of time flow. It further claims that past and future are transient illusions and that only present, or Now, is real.

The Now is an essential part in the philosophy and practice of psychodrama, a method of psychotherapy in which clients are helped to enact situations in individual sessions or, more typically, group settings. Whereas attention to the present moment is ubiquitous in contemporary psychotherapies, Now is therapeutically recruited in psychodrama and made available to clients by acting out situations that happened in past or are expected to happen in the future, as if they are occurring in the moment. In this way, the “inverted arrow” of zen is embodied on the psychodramatic stage. Furthermore, the concrete nature of the psychodramatic production create zen’s Tathata – the ‘Thusness’ or ‘Suchness’ of the real, non-verbal world. Therapeutically, such spontaneous and unstructured enactments aim to stir subjects up to be on the stage what they *are* more deeply and explicitly than they appear to be in 'reality'. Taken together, psychodrama offers a method of in-action meditation in service of functional therapy.

SPIRITUALITY/RELIGION AND PSYCHOPATHOLOGY BOUNDARIES IN A PSYCHIATRIC RESIDENTIAL FACILITY IN ITALY: A CASE SERIES

Jacopo Santambrogio[1,2], Antonino Giancontieri[2], Ettore Caloni[2], Cesare Soletto[2], Alessandro Pirola[2], Massimo Clerici[1,3], Pietro R. Cavalleri[2]

[1]Department of Medicine and Surgery, University of Milan Bicocca, Monza, Italy, [2]As.fra. Onlus Foundation, Vedano Al Lambro, Monza, Italy, [3]Mental Health and Addiction Department, Asst Monza, Monza, Italy

Background: S/R and mental health are distinct areas of a person life, that can interface one each other. A good mental health status could positively interact with S/R dimension. For example, when patients are unwell and under neurotic or psychotic crises, S/R attitudes are negatively influenced, determining compulsive praying, rituals, mystic delusions, hallucinations. AS.FRA. (Casa San Paolo) was founded in1970 by Adele Bonolis, a fervid catholic from Milan, with the aim of taking care of psychiatric patients going out from the asylums, in the respect of catholic principles of charity. Nowadays, AS.FRA. Has a catholic chapel and every week a chaplain says the Mass where some patients regularly attend.

Aims: to describe a case series where psychopathology and S/R overlap, identifying possible boundaries between S/R and mental health.

Matherials and method: a case series of 8 patients with diagnoses of paranoid schizophrenia, schizophrenia with hypochondriacal features, bipolar disorder, intellectual disability with comorbid psychotic disorders and S/R issues will be described in their mental exam and psychopatholgy underlying how S/R issues could interact with health condition.

Conclusions: In all the clinical cases here described, S/R interface with psychopathology. If psychic condition is under balance, S/R can contribute to pathology stability itself and a residential facility offering the possibility to participate to religious services could improve health outcomes.

WPA CHILD AND ADOLESCENT PSYCHIATRY SECTION PERSPECTIVES ON THE FUTURE OF CHILD AND ADOLESCENT PSYCHIATRY

Norbert Skokauskas
Department of Child Psychiatry, Ntnu, Trondheim, Norway

Mental health is an essential part of children's and youth's health. It interacts complexly with general physical health and significantly impacts upon ability to succeed in school and society.
According to the World Health Organization, approximately 10-20% of youth experience mental health disorders. Furthermore, 70% of mental health disorders have their onset prior to the age of 25 years. Untreated mental health problems in childhood and adolescence can be transmuted into various psychiatric diseases. Moreover, there are several psychiatric disorders (i.e. early onset neurodevelopmental disorders) that are most often diagnosed in childhood and that require early interventions.
There are many factors which could protect or prevent children and adolescents from developing mental health problems and disorders.
A few recent studies have indicated that people who attended weekly religious services or prayed or meditated daily in their childhood reported greater life satisfaction in their 20s. People who grew up in a religious household also reported fewer symptoms of depression and lower rates of post-traumatic stress disorder. While religion and spirituality can have positive influences on children and families, some situations can also lead to distress or family tensions.
Hence, it is important to understanding the religious and spiritual lives of children and adolescent. Such understanding can offer insights into their inner lives, believe systems, coping strategies and vulnerabilities.
This presentation will highlight WPA Child and Adolescent Psychiatry section perspective on the future of child and adolescent psychiatry, including religion's and spirituality's role in child and adolescent mental health.

SPIRITUAL ASSESSMENT TOOLS AS A COMPONENT OF AN INTEGRATED APPROACH FOR PSYCHIATRIC ASSESSMENT AND TREATMENT PLANNING

Veronica Marchese[1,2]

[1]Spiritual Care, St. John's Regional Medical Center Hospital, Oxnard, USA, [2]Pastoral Education, St. John's Catholic Seminary, Camarillo, USA

Our religious beliefs and spiritual practices can be a resource or hindrance to healing, sometimes both. In order to provide effective patient-centered treatment, a spiritual history is an important aspect of gathering critical data that will inform an assessment and treatment plan. The personal beliefs and values of a patient are an important aspect of their identity. Thus, utilizing effective tools to assess for religious beliefs, spiritual practices as well as, spiritual distress can provide critical information for treatment, such as strengths and challenges of an individual's beliefs and practices. Additionally, a deeper exploration of these initial findings allows for an increased awareness of the psycho-social obstacles keeping someone stuck in old patterns of behavior and thinking. Even when an individual does not affiliate with any specific religious or spiritual tradition or belief system, this exploration can identify values that are central to the healing process.

Finally, awareness of the practitioner's biases toward the patient's beliefs is also a critical aspect of our assessment. Bringing to light our biases assists in building rapport that creates an effective therapeutic relationship and improved patient experience. This presentation will demonstrate how using research-based spiritual assessment tools can facilitate the gathering of this critical information. Three tools will be presented that can supplement psychiatric and psychological assessments of strengths, resources and obstacles in an individual's path toward healing and well-being. Additionally, a brief exploration of awareness techniques will be presented to assist the practitioner in their self-assessment of biases that may be present.

RELIGION AND MEANING IN LIFE AMONG PATIENTS WITH SEVERE MENTAL DISORDERS

Roland Hasler[1], Sylvia Mohr[1], Sonia Vidal[1], Nader Perroud[1], Pierre-Yves Brandt[2], Philippe Huguelet[1]

[1]Department of Psychiatry, Geneva University Hospital, Geneva, Switzerland, [2]Faculty of Theology, Lausanne University, Lausanne, Switzerland

There is evidence that psychiatrists are rarely aware of how religion may intervene in their patient's life. That is particularly obvious concerning patients with severe mental disorders, such as psychosis.

Yet, even for patients featuring delusions with religious content, religious activities and spiritual coping may have a favourable influence. Indeed, patients with psychosis can use religion to cope with life difficulties related to their psychotic condition, in a social perspective but also in order to gain meaning in their lives. Also, religion may be part of explanatory models about their disorder with, in some cases, a significant influence on treatment adhesion.

RELIGIOUS DELUSION OF POSSESSION IN SCHIZOPHRENIA: PSYCHOPATHOLOGICAL FEATURES AND PHENOMENOLOGY

Gregory I. Kopeyko, Olga Borisova, **Ekaterina Gedevany,** Ivan Samsonov
The Research Group of Special Forms of Mental Disorders, The Scientific Center of Mental Health, Moscow, Russia

Objective: to analyze psychopathological features of religious delusion of possession, to determine the place of this phenomenon in psychotic syndrome, and to identify the prognosis and dynamics of schizophrenia due to this disorder.

Material and methods: 30 patients with religious delusion of possession were examined by psychopathological and follow-up methods, who were observed from 1994 until 2018 at the the Research Group of Special Forms of Mental Disorders of the Mental Health Research Center (Moscow)

Results: It was found that hallucinations of a general feeling are the crucial psychopathological phenomenon of states with religious delusion of possession. Other delusional disorders are connected with this phenomena (delusion of possession or metamorphosis delusion - "reincarnation in a demon", delusions of spoilage, witchcraft or hypochondriacal delusion) and delusional behavior (special forms of defense), haptic, olfactory hallucinations, and affective (depressive) disorders, suicidal activity.

In most cases, the progression of religious delusion corresponds to paranoid schizophrenia disorders. However, in many cases it starts with circular bipolar affective disorder as distinguished from classical, hallucinatory paranoid schizophrenia.

Disease with religious delusions of possession in most cases has specific course. At the symptomatic stage continuous psychopathological symptoms are combined with disorders that are more common for paroxysmal flow of schizophrenia. As a rule, the outcome of manifest psychosis is unfavorable.

The complete reduction of hallucinatory-delusional symptomatic was never observed, patients were uncritical to delusional disorders. There were also seen significant negative disorders (reduced energy potential, emotional poverty and rigidity.

Conclusion: Religious delusion of possession has some psychopathological features that lie in specifics of hallucinatory-delusional syndrome with a religious plot. This phenomenon rarely could be seen in usual psychiatric practical work. Therefore, to confirm the findings and expand our understanding of the psychopathological diversity of syndromes with religious content it is necessary to continue the observation of cases.

FAITH BASED COMMUNITIES, UNIVERSAL HEALTH COVERAGE AND MENTAL HEALTH

David Chinitz[1,4], Katherine Marshall[2], Jean-Francois Livaison[3]
[1]Health Policy and Management, School of Public Health, Hebrew University Hadassah, Jerusalem, Israel, [2]Katherine Marshall Senior Fellow Walsh School of Foreign Service, Executive Director of the World Faiths Development Dialogue, Georgetown University, Washington Dc, USA, [3]Ahisma, World Health Organization, Lyon, France, [4]School of Public Health, Hebrew University Hadassah, Jerusalem, Israel

We may be at the dawn of, or perhaps well into, a fourth industrial revolution. Writers like Yuval Noah Harari have mapped the challenges facing humanity in the realms of work, environment and global conflict and sought to suggest directions for going forward. If we accept Harari's premise that societies are anchored by stories, and that new stories are needed to cope in the 21st century, religion and faith based communities are, as he himself points out, likely to play a significant role. For example, ultra religious Jews who receive subsistence grants from government while not participating in the current labor market, may actually provide a model for future economies in which automation and artificial intelligence will make human labor as currently carried out obsolete. Research has demonstrated the relatively high levels of health and quality of life reported from these communities. The AHISMA project of the World Health Organization is dedicated to realizing the potential of faith based communities to enhance social solidarity and organize universal access to health and mental health services. In this paper we report on recent findings emerging from the AHISMA project on the ways in which faith based communities around the world have engaged with mental health services by channeling their focus on spirituality, community support and the worth of every human being to reduce stigma and contribute to individuals' mental and social well being, along with expanding access to health care services. The paper will also analyze policy options for taking advantage of faith based communities' resources to maximize the ability of health services to assist individuals and families in adapting to technological change, climate change, and globalization that will no doubt challenge their mental well being in the coming decades.

"NEAR DEATH EXPERIENCES": INTEGRATING THE KNOWLEDGE INTO CLINICAL PRACTICE

Elaine Ruth Drysdale[1,2]
[1]Dept. Of Psychiatry, Fac Of Medicine, University of British Columbia, Vancouver, b.c., Canada,
[2]Dept. Of Psychiatry, Vancouver General Hospital, Vancouver, b.c., Canada

An "NDE" occurs when consciousness and altered perception are experienced by some individuals during cardiac arrests, surgery, or in life-threatening situations or crises. "NDEs" are common, occurring in 5% of the population, yet the phenomenon is often kept private by patients due to its profound nature and the fear of having the experience trivialized or dismissed as "delirium." The "NDE" is compared to delirium, and the limitations of biological theories are addressed.

It is vital that clinicians recognize when an "NDE" has occurred and to acknowledge its significance for the patient. Clinicians can also use NDE stories as powerful therapeutic interventions to help non-NDE patients struggling with such situations as fear of dying, terminal illness, grief, suicidal ideation, or lack of life purpose. Understanding the NDE can broaden our perspectives of consciousness; of how we perceive life and death; and of how we can come to terms with the end of life for ourselves and for our patients.

Learning Objectives:

1. Recognize key elements of the "Near Death Experience," comparison to delirium, and challenges in various biological theories.
2. Appreciate the importance of providing support to patients who have had a "NDE".
3. Be able to consider the use and application of stories of "NDEs" to help patients with fear of dying, terminal illness, suicidal ideation, grief therapy, and those struggling with lack of life purpose.
4. Consider broader implications of "Near Death Experiences".

THRIVING, SURVIVING OR BURNING OUT? THE CONTRIBUTION OF SPIRITUALITY TO RESILIENT FLOURISHING AS A PSYCHIATRIST

Alison J Gray
Institute of Clinical Sciences, University of Birmingham, Birmingham, UK

Burnout is reaching epidemic proportions amongst doctors worldwide, leading to misery, depression, addictions, divorce and suicide. Psychiatrists are affected as much as those from other medical specialties. In this presentation we will consider the impact of working in psychiatry on the mental health and wellbeing of psychiatrists. Religion, spirituality and existential meaning making are major factors which increase resilience for many people; we will look at the scientific and biographical evidence for the impact of spirituality on human flourishing and consider how individuals can be supported to thrive and how this might practically impact our individual personal and professional lives.

RESILIENCE AND THERAPEUTIC BENEFITS OF SPIRITUALITY IN OLD AGE

Prasad Rao Gundugurti
Schizophrenia & Psychopharmacology, Asha Hospital, Hyderabad, India

Health is the ability to adapt and manage self in the face of social, mental and physical challenges of life; this definition emphasizes on the personal strengths of the individual which make one healthy, even in adversity and/or diseased status. However, a healthy person skilfully adopts the challenges of life by applying his/her all calibres his own growth and development, able to resolve adversities of life and lead a purposeful life. This helps in building resilience in each individual to build up strength to fight the adversaries in the lives of older adults.

It will be worth mentioning that religion, spirituality and/or belief are having significant impact on many lives as these provide meaning and understanding to day to day life and support during challenging situations. Religious involvement and spiritual practices are one of the major tools for protecting against loneliness and support in facing the challenges of life. Such practices drive the person towards positivity which further enables one to remain calm and cool in the face of adversities. It can be said that positive outlook in various domains of life with a spiritual outlook (developing self by understanding one's own abilities in terms of self-actualization and self-realization) contributes to a healthy life. A spiritual person has the understanding about self therefore he/ she easily remains positive throughout his/her life and develops resilience for handling tough situations of life.

Spirituality helps in preventing depression in old age and it is known to have protective effect. Regularly practice of spirituality in any form immunises the individual to have a healthy aging.

RESILIENCE, DEPRESSION AND SPIRITUALITY

Bruno Paz Mosqueiro[1,2], Marcelo Pio de Almeida Fleck[2]

[1]Psychiatry, Ghc, Porto Alegre, Brazil, [2]Psychiatry, Universidade Federal Do Rio Grande Do Sul, Porto Alegre, Brazil

Over past decades, religion and spirituality (R/S) have become increasingly important topics in psychiatry research. More than 83.4% of people around the world report affiliation to religious denominations. Very often, in face of adversities and stressful life events, people also turn to R/S searching for support, meaning and strength. Furthermore, evidences demonstrate that R/S is mainly protective factor to depressive disorders. Measures of R/S are associated with decreased depressive symptoms and better course of depression over time. Nevertheless, the exact mechanisms by which R/S dimensions exert effects in mental health and depression are still not fully understood.

Major depressive disorder (MDD) affects 300 million people worldwide, and constitutes the leading cause of mental health-related disease burden in the world. Adding to that, depressive disorders represent a relevant global health concern accounting for 59-83% of all deaths by suicide. Understanding how specific R/S dimensions promote benefits in depressive disorders certainly represent a key challenge to psychiatry and R/S research.

Different R/S domains have been correlated to MDD. For instance, religious attendance and personal importance of R/S have been differently associated with depressive outcomes. R/S measures were also associated to positive mental health measures (e.g. optimism, meaning, hope, purpose, resilience, social engagement and support) potentially implicated with prevention and recovery of depressive symptoms. Regarding biological markers of depression, previous studies have reported an association between religious attendance and decreased levels of interleukin-6, a pro-inflammatory cytokine. Other studies have shown that individuals declaring a higher importance for R/S had decreased risk of depression and higher cortical thickness. A recent study reported that higher intrinsic religiosity was correlated to higher brain-derived neurotrophic factor (BDNF) levels, a brain neurotrophin responsible for synaptic plasticity, dendritic and neuronal fiber growth, a potential biological marker of neuroplasticity and resilience.

The aim of the present lecture is to review (1) the evidences of pathways to understand the relationship between R/S and depression and (2) the role of psychological resilience and BDNF as potential pathways to understand positive effects of R/S on depressive disorders.

ON THE NEUROBIOLOGY OF LOVE

Yoram Yovell
Division of Clinical Neuroscience, Hadassah Ein Kerem Medical Center, The Hebrew University of Jerusalem, Jerusalem, Israel

Jaak Panksepp has outlined seven subcortical basic emotion systems that are common to all mammalian brains.
These systems are causally involved in all emotional phenomena in humans, including love. Some of the puzzling and at times contradictory behaviors that are seen in people who love can be traced to the actions and interactions of these systems. We will briefly review Panksepp's seven basic emotions, and discuss the effects of four of these emotional systems - SEEK, LUST, CARE and LOSS on the many manifestations and stages of human love.

THE ROLE OF HOPE AND SPIRITUALITY IN PSYCHOLOGICAL STAGES OF FORCED MIGRATION TO IMPROVE REFUGEE MENTAL HEALTH OUTCOMES

Essam Daod

Research and Advocacy Unit, Humanity Crew r.a, Haifa, Israel

More than 70 million refugees and asylum seekers are currently forcibly displaced from their homes due to civil war, ethnic cleansing, genocide, and hunger. This mass forced displacement has created a global human rights crisis and a global public mental health epidemic. Indeed, tragically, forced displacement and migration, in addition to various post-migration stressors, has been linked to high rates of trauma- and stress-related mental health problems. Although rates of trauma- and stress-related mental health problems are elevated among refugees, only a small proportion of this population receives treatment, let alone interventions grounded in a strong evidence-base. This state of affairs stems in large part from a lack of resources and the complexity of providing treatment to large and diverse populations of refugees. These barriers to care and trauma recovery may, however, be made even worse by a lack of research that is specifically designed to guide the development of brief, effective, disseminable, easily implemented, and cost-effective mental health interventions tailored to these culturally and linguistically diverse, geographically dispersed and mobile populations. Building on knowledge to-date and years of fieldwork, we propose that our understanding of refugee mental health, global public health and clinical research and intervention development, policy and related decision-making may be facilitated by refugee mental health framework that is built around: (a) the stage(s) of forced migration and (b) the psychological stage(s) or state-of-mind of forced migration. And thereby helps to characterize, (c) the (mal) adaptive movement or transition between these stages over time following forced migration and (d) key markers of resilience and vulnerability per stage. And in so doing, directly inform (e) assessment and respective intervention needs and decision-making, for individual refugees, as well as (f) research foci and questions that may be beneficial to improve the mental health of refugees and their children.

RELIGIOUS, SPIRITUAL, AND EXISTENTIAL ISSUES IN PROFESSIONALISM IN PSYCHIATRY

Gerrit Glas[1,2]
[1]Philosophy, Vrije Universiteit, Amsterdam, The Netherlands, [2]Psychiatry, Dimence Groep, Zwolle, The Netherlands

The thesis is defended that religious, spiritual, and existential issues are at the heart of professional role fulfilment in mental health care. The argument for this thesis is built up in three steps.

First, it will be shown that professional competence not only consists of well-defined knowledge and skills, but also includes a 'second-order' capacity which enables the professional to appropriately make use of this knowledge and these skills. As the therapeutic relationship unfolds, a broader range of considerations and values and commitments appear to be relevant than those that can be based on science and empirical evidence alone.

Secondly, and more precisely, it will be argued that in the way the professional performs his or her role, there is also always something communicated about how the professional relates to his or her role performance. This 'indirect' communication is not an undesirable by-product of the communication between the patient and the professional, it is structural and intrinsic and should therefore be part of everyday supervision practices.

Thirdly, it will be shown that the shaping of this 'self-relatedness' can be conceptualized as the result of an interaction between religious, spiritual, and existential attitudes, inspirations and motives in the professional and the normative appeal and challenges of the therapeutic setting.

A conceptual model of the professional – patient relationship will be presented that clarifies the different dimensions and relations which are addressed in the talk.

Literature: G. Glas (2019). Person-centered care in psychiatry. Self-relational, normative, and contextual aspects. London: Routledge.

SOTERIA: A SHARED JOURNEY FROM THE CLOSED WARD TO A VISION OF REDEMPTION

Pesach Lichtenberg[1,2], Avraham Friedlander[3,4,5]

[1]Psychiatry, Hebrew University in Jerusalem, Jerusalem, Israel, [2]Psychiatry, Soteria Israel, Jerusalem, Israel, [3]Clinical Research, Soteria, Jerusalem, Israel, [4]Psychology, Ariel University, Ariel, Israel, [5]Psychiatric Clinic, Tel Hashomer Hospital, Ramat Gan, Israel

We relate the personal stories of a patient with unrealistic messianic aspirations who was hospitalized against his will in a closed psychiatric ward, and the psychiatrist who headed the unit. Treatment consisted of a religious ritual, and complete recovery was achieved without medication. The encounter led doctor and patient to independently think about the state of psychiatric care, and to seek a different approach to mental health care which would find a place for the spiritual dimensions of the patient while respecting sacrosanct human rights.

With time, the parallel stories of psychiatrist and patient fuse into a shared odyssey with quasi-messianic dimensions to reform the system of psychiatric care. Inspired by the Soteria model (Soteria is the Greek term for salvation), institutional care is replaced by a warm home, and rather than mental health professionals "doing" treatment to patients, non-professional companions provide the warmth, support, and community for people in psychotic crises and other mental health emergencies.

Three Soteria homes currently operate in Israel. Beyond the hundreds of people who have been helped, the homes have spurred the government to revise regulation in order to promote the establishment of similar homes. We look forward to the day when these homes will replace the psychiatric department as the first line locus of treatment for people in crisis requiring round the clock care, in Israel and elsewhere in the world.

HONOURING AUTHENTIC EXPRESSION IN RECOVERY - MENTAL HEALTH SPIRITUAL CARE

Jennifer Greenham
Mental Health Leader, Spiritual Health Victoria, Melbourne, Australia

This presentation will focus on the key conference theme of translating knowledge into practice. Spiritual Health Association (SHA) a not for profit organization in Melbourne Australia has been contributing its expertise to the mental health and spirituality space through advocacy, training and education for over thirty years. With funding from the Department of Health and Human Services and in keeping with contemporary academic and lived experience literature confirming the positive role that spirituality can play in supporting human flourishing, health and wellbeing; SHA actively provides consultation to sector workers to meet the spiritual care needs of people with mental ill health.

I will present the findings of a pilot program that was offered in 2019, showcasing a recent initiative in which SHA partnered with the Victorian Transcultural Mental Health service to offer a series of face to face spirituality and diversity conversations around themes that sector workers routinely struggle with. Self-selected participants were encouraged to nominate and explore challenges they have encountered when spirituality or religion came up in their work. Through the sharing of experiences, reflections and insights, together with input from the group facilitators including mental health spiritual care practitioners, a psychiatrist and education consultant, participants were able to develop a deeper understanding of how to explore conversations with mental health consumers about their diverse spiritual beliefs.

Data from this project confirms the issues that workers encounter, be it the lack of training in their undergraduate degrees, unclear organizational policy or the ongoing difficulty in having this domain of a person's life valued by the dominant medical model. What is abundantly clear is the need for sector workers to have a space to share their views and experiences. The success of this initiative may see it being expanded and offered as an online webinar forum to reach greater need.

THE INFLUENCE OF DISCARNATE PEOPLE IN AUTISM SPECTRUM DISORDER PATIENTS AND THE BENEFIT OF A PSYCHOTHERAPY APPROACH TO THEM

Sergio Thiesen
Internal Medicine, National Institute of Cardiology, Rio De Janeiro, Brazil

Objectives: Different cultures worldwide believe that the spirits, discarnate human beings, interact with incarnate people. By caring of these spirits, related to different moderate or severe autistic patients through simple, direct mediumship techniques, during healing sessions, we could test the relevance of their influence in autism spectrum disorder patients.

Background and Aims: By using mediumnistic techniques, and medical doctors mediums we have come into contact with discarnate spirits and spiritual contexts that have a defined relationship with each patient. This has happened in healing sessions in Spiritist Centers for patients of moderate and severe autism. We compare the clinical manifestations of disease before and after this healing approach.

Materials and Methods: The diagnostic method to uncover the spiritual aspects of each case happened with the aid of team of doctors-mediums. In all cases the spirits were of human beings who have lived their lives in the past such as we live ours in the present. The ties between these spirits and the patients were stablished in previous reincarnations. In a non-controlled prospective study of 26 patients with moderate or severe autism we were able to perceive them and to act in a psychotherapeutic manner.

Results and Conclusions: Comparing the clinical manifestations of disease before and after this psychotherapeutic approach we could detect a very clear reduction of signs and symptoms of patients in 76% and a decrease of medication needs in 82% of them.

These results suggest that we need to consider the influence of discarnate spirits as a mechanism of disease. This approach may open new possibilities to the treatment of autism.

MYSTICAL EXPERIENCES IN PSYCHEDELIC THERAPY AND RESEARCH

Keren Tzarfaty
Clinical Research, Maps, Santa Cruz, USA

One of the exciting areas in medical science these days is the area of psychedelic science and specifically the use of psychedelic based psychotherapy in mental health care and psychiatry. In this presentation, Dr Tzarfaty will present the field of psychedelic research and specifically its contribution to clinical work with treatment resistant psychiatric disorders such as PTSD and depression. The presentation will discuss the FDA approved phase II trials of MDMA assisted psychotherapy that have demonstrated safety and efficacy for the treatment of PTSD, and research that has demonstrated the safety and efficacy of psilocybin-assisted psychotherapy to treat depression, even in cases where all other treatments have failed. Lastly, Dr Tzarfaty will present current Israeli psychedelic research and the new Open Access protect that was approved by the Israeli MOH, offering MDMA assisted psychotherapy for 50 participants who suffer from severe PTSD, in five governmental hospitals in Israel.

SPIRITUAL PATHWAYS: AN INTEGRATIVE MODEL FOR SPIRITUAL DEVELOPMENT

Ofra Mayseless
Faculty of Education, University of Haifa, Haifa, Israel

In the lecture I will present a new tentative model of spiritual development based on a phenomenological study with adults who have undergone spiritual change and insights from other models and extant research. Specifically, spiritual development was experienced more as "work" than a path or journey. Three major "spatial" dimensions of spiritual growth and development emerged: Up and beyond towards connecting to the transcendent, Deep within to cleanse the self of excessive burden and reach the true authentic self, and Sideways interconnected that relates to the sense of interconnectedness to all that exists and the responsibility and prosocial responding that such realization entails. Development entailed progress in each of these directions. However, often such development was not at the same pace or investment in each of these dimensions. Progress in spiritual development thus included better alignment of these three directions of growth and increase in alignment with behavior in daily life. Spiritual traditions appear to have different focus on each of these dimensions. Respondents also underscored similarities and differences comparing spiritual development and emotional maturity or psychological development either in general or as part of a therapeutic context.
In the lecture I will also address the uniqueness of spiritual development compared to emotional maturity and personality development as perceived in light of conceptions of psychological health and wellbeing.

A GENERAL MODEL FOR THE INTEGRATION OF SPIRITUALITY AND PSYCHOTHERAPY

Aya Rice
Department of Counseling and Human Development, Haifa University, Haifa, Israel

This presentation offers a general model for the ethical integration of spirituality in psychotherapy that is relevant for health professionals in various fields, including psychiatry. The model is based on a review of the R/S literature of the last three decades as well as preliminary findings from the researcher's ongoing dissertation on the interplay between the personal professional spiritual development of psychotherapists.

The model proposes viewing the potential integration at three levels: the level of the patient, the therapy itself and the therapist. These levels are not mutually exclusive and may indeed overlap.

The first and most prevalent approach addressed in the literature views the need to address spirituality within psychotherapy as another aspect of multicultural competence (Plante, 2016).

The second level is defined as spiritually-oriented psychotherapy (Sperry & Shafranske, 2005) and relates to conventional forms of psychotherapy that have been adapted to the needs of clients with spiritual or religious orientations, as well as additional forms of psychotherapy that will be delineated. The third level of integration is at the level of the therapist and relates to the therapist's general approach towards the spiritual that is a type of listening and sensitivity to the spiritual in all forms of therapy. I propose broadening Pargament's (2007) approach and contend that such integration is contingent on the therapist's own spiritual growth, and is a way of being - an openness and awareness on the part of the therapist that enables the ultimate integration of spirituality and psychotherapy at this level.

The model enables mental health professions to conceptualize at what level they currently address spirituality in their clinical work and thus may use this model to consider how they may further integrate the two dimensions in their professional and perhaps in their personal lives as well.

Pargament, K.I. (2007). Spiritually integrated psychotherapy: Understanding and addressing the sacred. New York & London: The Guilford Press.

Plante, T.G. (2016). Principles of incorporating spirituality into professional clinical practice, Practice Innovations, 1 (4), 276-281.

Sperry, L. & Shafranske, E.P. (Eds.). (2005). Spiritually Oriented Psychotherapy. Washington, DC: American Psychological Association.

SCIENCE AS RELIGION – A CRITICAL OUTLOOK AT THE SCIENTIFIC DISCOURSE OF HYPNOSIS AND ITS CORRELATION WITH RELIGIOUS AND SPIRITUAL PHENOMENA

Marianna Ruah-Midbar Shapiro
Mysticism and Spirituality, Zefat Academic College, Safed, Israel

In light of scientific disputes over the very essence of "hypnosis," committees held by the American Psychological Association (APA) have offered various definitions of it, in 1993, 2003, and 2014. Differences in definitions are natural, however, the depth of the dispute becomes clear with the rise of voices that dare refute hypnosis' very existence. Some scientists claim that it can be falsified, that we can never know if someone is truly hypnotized, and that there may even be no difference between hypnotic suggestion and mere suggestion, thus rendering the term "hypnotic state" meaningless.

The verdict on these scholarly disputes has significant implications that affect our understanding of the human psyche, the practice of therapy, and the application of the Israeli criminal law which limits the implementation of hypnosis to a small group of experts.

The fact that this law has led to a fight against alternative-spiritual practitioners is testament that experts on hypnosis consider themselves part of a parallel, rival, and competing field. Accordingly, from a cultural-critical standpoint, this situation can be seen as an expression of the struggle between the different authorities of knowledge and practical expertise in the same field. Thus, this is a rivalry between alternatives – the scientific and the alternative-spiritual – in a field that is, in fact, religious. This, along with the deep-rooted disputes within scientific discourse, calls for the implementation of a critical religious-studies outlook in regard to the scientific discourse (regardless of its validity), which views it as religious discourse – that of a religion which seeks to replace its rivals: the religion of science.

Indeed, contemporary scholarly literature on modern hypnosis claims that its own roots lie in shamanic rituals, trance states of magicians, and the therapeutic activity of mesmerism. However, in order to apply the term "hypnosis" to cases from other times and cultures, we must first understand… what *is* hypnosis?

'CONSCIOUSNESS THINKING' ('YEMIMA') AND ART THERAPY: A FRUITFUL INTERACTION

Liat Zucker[1], Alon Raz[2,3], Dani Yaniv[4]

[1]Counseling and Human Development, University of Haifa, Haifa, Israel, [2]Department of Counseling & Human Development Faculty of Education and School of Art Therapies Faculty of Social Welfare & And Health Sciences, University of Haifa, Haifa, Israel, [3]Social Sciences and Education Departments., The Max Stern Yezreel Valley College, Yezreel Valley, Israel, [4]The School of Creative Arts Therapies, University of Haifa, Haifa, Israel

This lecture presents a clinical example of the connection between the concepts and the tools of Yemima Avital's teachings, called 'consciousness thinking', and those of art therapy. 'consciousness thinking' is a spiritual learning (LIMUD) of mental growth that takes place through the understandings of the human psyche and the internal structure of human beings. These teachings were developed in the 80`s by Yemima Avital and continued and expanded after her death to many learning (LIMUD) groups, and today numbers tens of thousands of learners, secular and religious alike.

The lecture is based on an M.A. thesis describing development processes that took place following learning 'consciousness thinking', with an emphasis on aspects related to the field of art therapy (Zucker, 2018). This is one of the first studies to engage in 'consciousness thinking', in the field of academic research. One of the main findings of the study indicates a change in learners centered on Yamima's conceptualization that divides the internal human structure into 'burden' ('OMES') and 'essence' ('MAHUT'). This conceptualization and its derivatives will be presented through a clinical example of an original therapeutic model that combines art therapy with 'consciousness thinking'.

The case study depicts structured group sessions that combine learning 'consciousness thinking' with creative expression of visual images and artworks, inspired by the personal insights that emerged during the learning. Under a pseudonym, I will present the process of one of the members of such a group, who has given her consent. Her visual images will be displayed alongside a description of the personal, internal processes that took place throughout the sessions. Through this clinical example I will discuss the mutual influence between ‘consciousness thinking’ and creative expression, i.e., how a visual image can create consciousness transformation, and how consciousness affects the therapeutic aspect of art creation.

Zucker, L. (2018). Know thy-good-self: The learning experience, the meaning of writing and reading, and the developmental processes in Yemima learning. Thesis submitted in partial fulfillment of the requirements for the Master's degree.

HOW TO INTEGRATE SPIRITUALITY AND RELIGION INTO MEDICAL AND PSYCHIATRIC CARE: GENERATE A BIOPSYCHOSOCIAL NARRATIVE

John H. Davidson
Hopsital Internal Medicine, Mayo Clinic, Rochester, USA

The merits of spiritual/religious affiliations and practice as positive correlates with decreased morbidity and mortality have been well-established in recent decades. They are compellingly tabulated in Koenig's **Handbook of Religion and Health (2012).** These findings were presaged by the seminal work of Engel (*Science* 196, 1977), House (*Science*, 241, 1988), and Viederman (*General Hospital Psychiatry*, 2, 1980), respectively, who articulated a "biopsychosocial" as opposed to "biomedical" model for medicine, recognized the impact of "social relationships" directly on mortality, and demonstrated the use of "psychodynamic life narratives" as beneficial at the bedside of the "physically ill." The most sensible, effective integration of these findings, perspectives, and techniques in mental health and general medical settings is an insistence upon generating a biopsychosocial narrative, a personalized "text of the spirit," as the starting point for all patient encounters. This can be readily demonstrated with clinical vignettes taken from recent general hospital admissions.

TEACHING RELIGION/SPIRITUALITY IN AN UNDERGRADUATE HEALTH COURSE IN A BRAZILIAN FEDERAL UNIVERSITY: NEWS PROPOSALS OF RESEARCH

Taís Oliveira da Silva[1], André Bomfim Dias[2], Andre Luis Mattedi Dias[4], Marcus Welby-Borges[3]
[1]Rede Universitária De Pesquisas Em Espiritualidade (Reupe), Universidade Federal Da Bahia, Salvador Bahia, Brazil, [2]Programa De Pós Graduação Em Estudos Interdisciplinares Sobre a Universidade, Universidade Federal Da Bahia, Salvador Bahia, Brazil, [3]Departamento De Biointeração, Universidade Federal Da Bahia, Salvador, Brazil, [4]Instituto De Humanidade, Artes E Ciência, Universidade Federal Da Bahia, Salvador Bahia, Brazil

Despite the greater recognition of the importance of the relationships between health, Religion and Spirituality (R/S) in clinical care, Brazilian universities provide little or no training in this area. Bacharelado Interdisciplinar em Saúde (BIS) at Universidade Federal da Bahia (UFBA) is an attempt to implement in Brazil undergraduate interdisciplinary courses. In this work, ten BIS professors answered to a semi-structured interview with questions about their personal relationship with R/S, clinical practice and teaching. The interviews were recorded, transcribed and analyzed according to Bardin content analysis technique. Predominantly the professors perceived religion in a negative way and spirituality, positively. They emphasized the problematic aspects of the relationship of health, R/S. R/S teaching was not considered a priority and the beliefs of the faculty seem to influence this position. WPA and APA recommend that R/S should be approached in the training of these professionals. In order to expand this analysis, including the perceptions of other actors involved in the educational process, a quantitative and qualitative study is being carried out to analyze the development of the important competence to differentiate R/S experiences from psychopathological symptoms among students who started a major in Psychology after they graduated in BIS. A questionnaire and the Spiritual Well-Being Scale will be applied to investigate beliefs regarding these experiences and the relationship between students and spirituality. In-depth interviews will be held to discuss the training from a clinical case. The answers to the objective questions will be counted in absolute number and percentage and the open questions will be submitted to discourse analysis. We believe that this competence is not developed by the major in psychology, and the results of these researches will show the need to the implementation of compulsory courses on the R/S theme in health majors at UFBA and in others Brazilian universities.

THE RELATIONSHIP BETWEEN RELIGIOSITY AND MENTAL SUFFERING EXPERIENCE AMONG USERS OF THE BRAZILIAN PUBLIC MENTAL HEALTH SYSTEM

Stephan Malta Oliveira[1,2], Mônica Monteiro Peixoto[1], Octavio Domont de Serpa Jr.[1]
[1]Institute of Psychiatry, Federal University of Rio De Janeiro, Rio De Janeiro, Brazil, [2]Maternal Child Department, Federal Fluminense University, Niterói, Brazil

This research aims explore the relations between religiosity and the mental suffering experience among users of the public mental health system of a medium-sized city located in the Southeast of Brazil. Its specific objective is to investigate the means by which the transformation of the experience occurs. The theoretical framework used is the interface between cultural phenomenology and medical anthropology. The study's design consisted of the conduction of semi-structured interviews with the administration of McGill Illness Narrative Interview (MINI). The study's participants were patients of the public healthcare system, who regularly practice a religion. The results led to the construction of the following categories of analysis: causal factors, suffering experiences, healing practices, religious view, social support and positive transformation of the experience. Here we present two narratives that exemplify, respectively, the categories 'religious healing practices'(subcategory) and 'positive transformation of experience': "*It is the moment* (about the Adoration of the Blessed Sacrament in the Catholic Church) *when we're in an intimate conversation with God, talking, speaking, praising. There are moments of worship and moments of silence. The presence of the Holy Spirit, right?"; "You feel very hot (...) and suddenly you start manifesting, speaking in tongues. It's pure joy*". In one of the interviews, the religiosity had a negative impact on the mental suffering experience due to the rigid rules of the participant's church and lack of social support. In all other reports, it was positive. We concluded that different performances of healing practices - such as in prayers, praises - religious view - as in protection against suicidal behaviors - and social support contributed to a positive transformation of the experience and the main mechanisms involved were embracement, symbolic processes and processes that affect the body. There is similarity with the processes that operate in psychosocial approaches within professional ethnopsychiatries.

ENGAGING A PATIENT'S BIBLICAL THINKING IN THE PSYCHIATRIC EMERGENCY DEPARTMENT: A CASE REPORT

Aaron E Winkler
Psychiatry, University of Maryland / Sheppard Pratt, Baltimore, USA

A taxi delivered a man without identification to the Psychiatric Emergency Department of an urban academic hospital in the United States. This man stated calmly and without pressure that the God of Abraham had spoken to him, telling him to end his life just as Abraham had been willing to sacrifice Isaac. He had heard this call from the God of Abraham 20 years before but had refused. He said quite clearly that he would not refuse again. He would not give any identifying information. Staff could not break through his powerful, erudite and profoundly grandiose thinking. He would not accept medication and offered no aggression to justify giving any against his will. Despite a strong professional movement toward cultural awareness, it remains outside the ken of psychiatrists to speak using the language of religion. He was black, but black staff could not break through. Asian-american and female staff tried without luck. By accent he seemed natively African, but even native African staff failed. This case presentation documents a successful use of religious language and concepts within a single clinical interview to engage a psychotic patient to accept help. Difficulties included beginning without sacrificing the clinical frame, navigating resistance without boundary crossing, and moving through the patient's demand for evidence of the doctor's own faith without self-disclosure.

IMPACT OF RELIGIOUS COPING ON TREATMENT OUTCOME: A SYSTEMATIC LITERATURE REVIEW

Austin Lemke[1], **Vitaliy L Voytenko**[1,2], Gabby Oechsle[1], Claire Voelker[1], Catherine Wei[1], Michal Kocum[1], Curtis Beeman[1], Aubrey Hoffman[1], Kevin Biondolillo[1], Niko Amitrano[1]
[1]School of Psychology, Counseling and Family Therapy, Wheaton College, Wheaton, USA,
[2]Division of Psychiatry and Behavioral Medicine, Michigan State University College of Human Medicine, Grand Rapids, USA

Religion/spirituality (R/S) has been largely associated with salutary effects on mental health through its plausible enhancement of self-regulation, attachment and connectedness, compassion for oneself and others, and provision of emotional comfort and sense of meaning in the midst of suffering. At the same time, R/S can sometimes contribute to mental illness or otherwise interfere with treatment by fostering anxiety, rigid thinking, excessive guilt, and compulsive practices, producing familial strains, and delaying diagnosis and effective mental health care. One such example of R/S associated with deleterious effects on mental health is what has been termed "negative religious coping". According to Pargament et al. (2011) and Exline (2013), "negative religious coping" (also referred to as "religious struggle") reflects a form of internal struggle or conflict in the spiritual realm in relation to oneself, others, or the divine. While positive religious coping is linked to improved psychological functioning, literature has shown that negative religious coping has strong associations with negative mental health outcomes, such as depressive and anxiety symptoms (Tarakeshwar et al. 2005; Areba et al. 2017). Additionally, there is evidence that both positive and negative religious coping play a role in the outcome of various treatments psychiatric conditions, such as substance use disorders, post-traumatic stress disorder, and psychosis (Rosmarin et al., 2017; Medlock et al., 2017; Currier et al., 2015). The present study is a systematic literature review examining the association between religious coping and outcomes in treatment for psychiatric disorders. PsychInfo, PubMed, and MedLine databases were searched for relevant peer-reviewed articles published between 2003 and 2017. The purpose of this review is to synthesize the findings from the existing literature on religious coping and psychiatric treatment outcomes. The present literature review also identifies gaps in existing literature and proposes additional areas for future research.

MENTAL HEALTH "AND / OR" SPIRITUAL CRISIS: AN ETHNOGRAPHY OF UK SPIRITUAL PEER-SUPPORT NETWORKS

Raphaelle Fischler
Medical Anthropology, University of Amsterdam, Amsterdam, The Netherlands

Background: There is a growing body of literature on experiences of psychotic-like phenomena reported by clinical as well as non-clinical groups, often advocating for a shift in diagnostic categories in favour of a psychotic continuum to better understand the diversity of experiences. This research is based on an ethnography of Spiritual Peer-Support Networks' (SPSNs) community in the UK, encompassing organisations like Spiritual Crisis Network and Emerging Proud. SPSNs provide support for individuals who identify as having experienced a mental health and / or spiritual crisis. These crises range from what could be labelled psychotic episode to mystical experience – and everything in between these. The terms "and / or" or simply "/" are used to encompass the diversity of experiences without pinning them down. SPSNs promote seeing these experiences on a spectrum, rather than as separate ontological categories.
Methods: The author took part in events, meetings, conducted participant observation of peer-support groups and interviews with individuals, mostly in the UK, from January to April 2019. A total of 20 individuals were interviewed, a majority (15) of whom had encountered psychiatric services (ie. clinical) and a few (5) who had not (ie. non-clinical). They all identified as having experienced a mental health and / or spiritual crisis, and knew about SPSNs.
Findings: The analysis focused on how narratives and experiences of mental health / spiritual crisis can become types of knowledges, and the extent to which these can be beneficial or healing for individuals. The author found that knowledges from narratives and experiences are beneficial insofar as they give meaning to individuals' crises - a breakthrough after breakdown. What seems most healing is for this breakthrough to transcend individuals. It is not defining knowledges gained from crises that is most healing, but applying them to heal others, becoming "scarred healers".

IF THERE IS NO HEAVEN, I'M GOING TO KILL MYSELF: THE PHILOSOPHER OF RELIGION AS THERAPEUT

Todd DuBose
Clinical Psychology, The Chicago School of Professional Psychology, Chicago, USA

This presentation will explore the Continental philosopher of religion as therapeut regarding the aporias inherent in the existentially weighted issues in comparative philosophy of religion, particularly, for this presentation: the irredcuibility of unknowing and uncertainty, invisible and immeasurable realities, the collision of finitude and transcendence, or alienation and communinon, and their relation to loss, hope and nihilism. Using the context of a particular therapeutic situation of the threat of self-annihilation predicated on whether or not reunion with loved ones is possible, we will explore the therapoetic dance on a precipice of assurance and doubt in therapeutic care. This presentation will critique several ideological assumptions related to this aporia, including: (1) the stance that intellectualization is a defense against affect; (2) the separatist bifurcation of the therapeut and the philosopher of religion; (3) the essentialist, neopositivist positing of "E"vidence, "R"eality and "K"nowing, and its subsequent pathologizing of privations of such Capitalization; (4) and the faith-phobic, colonizing and hegemonic hermeneutical violence of evidence-based practice when addressing “ultimate concerns”. Throughout the presentation we will explore the possibility of a the(o)ra-poetic science of khora-tic hospitality, a postmodern vigil-ance, as a therapeutic way of caring beyond deficit-correction or interpretive-understanding. Finally, we will explore an alternative perspective on faith-based practice as a postmodernist khora-tic pisteuo of "the impossible" and the inherent nature of existence as homo religiosus, whether one is a theist, atheist, polytheist, nontheists or misotheist.

UNIVERSAL ETHICS AND THE MORAL STRUCTURE OF PERSONALITY. INSIGHTS FROM FRANKL, FREUD AND THE MAHARAL (RABBI JUDAH LOEW) OF PRAGUE

Shimon Cowen
Director, Institute for Judaism and Civilization, Melbourne, Australia

When religious tradition speaks of the human being as created in the image of G-d, it refers to the soul in its ability to model and resonate with the Divine attributes. The modelling of the Divine attributes, moreover, translates, for humanity at large, into the ethical conduct of the seven Noahide laws, the root and shared core values of the great world faiths. The universal ethics of the Noahide laws – belief in, and respect for, G-d, sexual morality, a system of justice, prohibitions of killing and theft and a norm of the proper treatment of nature – constitute the normative content of the human "conscience" or soul.

Viktor Frankl's "logotherapy" appealed to the individual's self-transcending spirit (soul or conscience) to intervene wherever possible in each of the – bodily-somatic, mental and noetic (or meaning) – faculties of personality to assist in their healing. The Maharal of Prague, whom Frankl claimed as the "forerunner" of his own "dimensional ontology" of personality, constructs a matrix out of the three – bodily, mental and "unitive" or noetic – faculties of personalities in the twin personal and interpersonal dimensions of human existence. This creates a matrix of six elements suffused by a seventh, the self-transcending spirit or soul. These elements of personality, under the aegis of the soul, align with the ethical disposition of the Seven Noahide laws. He indicates, then, how Frankl's structure of, and logotherapeutic approach to, personality – following his own – aligns with the universal ethics.

Frankl was aware that logotherapy, which seeks therapeutically to engage the intrinsically healthy human spirit, needs supplementation by therapy that treats the sub-rational and sub-spiritual unhealthy personality – psychotherapy. Of all psychotherapies, he sought particularly to reclaim the psychoanalysis of Freud, even though its meta-framework was antithetical to logotherapy. The Maharal's work helps with this reclamation of Freud too. He correlates the Divine attributes both with the Noahide laws and with a structure of personality. Personality, as a structure of Divine attributes, is paralleled by the Freudian structure of personality as an organization of instincts, which parallel, but as corrupted forms of, the Divine attributes and their associated ethical behaviours. In other words, the Maharal brings to the psychoanalytic-psychotherapeutic treatment of raw personality – the instinctual melee of impulse, perception and "collective neurosis" (cultural pathology) – the template of universal conscience.

The choice before psychiatry today is either to acknowledge an objective existence of the human soul or conscience and its linkage to universal ethics – or to reject its existence and to relativize values. Contemporary mainstream psychiatry has chosen the latter. It sees impulse and perception and vagaries of the Zeitgeist, in all of what Freud termed "polymorphous perversity", as the determinants of human "identity" itself. A psychiatry, which acknowledges the soul – however repressed or submerged – as an objective reality within the human being, will validate the role of conscience in its struggles, with raw impulse, mere perception and cultural ideologies, to contain and transform these in accordance with the template of the ultimate "I", the soul or conscience.

DETERMINISM, PSYCHIATRY AND THE RELIGIOUS EXPERIENCE

Haim Belmaker
Psychiatry, Ben Gurion University, Beer Sheva, Israel

Two seemingly contradictory belief sets have been dominant in Western psychiatry for the last 100 years: On the one hand, there is a strong sense of psychiatry as the profession that deals with the whole patient, that respects the patient's inner experiences and his complaints, and takes into account the patient's subjective perception of external events that have occurred to him in the past including his childhood. On the other hand, psychiatrists have been convinced determinists who believed that all mental and behavioural activity is part of a causal chain explainable by strict scientific principle. A minority of psychiatrists felt that these principles might always remain psychological but the great majority of psychiatrists, including Freud himself, believe that ultimately all mental behaviour and activity could be reduced to neurochemistry. The deterministic model, however, is no longer the only option in physics or mathematics and this changing paradigm is relevant for psychiatry.

OTHERNESS, RELIGIOSITY/SPIRITUALITY AND CHEATING – RESULTS FROM STUDENTS, GENERAL AND CLINICAL POPULATION

Marek Preiss[1,2], Tereza Prihodova[3], Martina Barcaj[3], Adela Pruchova[3], Tereza Jirsová[3]
[1]Psycology, National Institute of Mental Health, Klecany, Czech Republic, [2]Psychology, University of New York in Prague, Prague, Czech Republic, [3]Department of Psychology, National Institute of Mental Health, Klecany, Czech Republic

Despite the fact that religiosity and spirituality (R/S) are often pointed out as a protective factors for cheating or other undesirable phenomena, results of studies are contradictory. The purpose of these studies was to focus on the relationship between the degree of R/S, the perception of otherness, the perception of cheating, and actual cheating behavior. The relationships between religiosity and the measures of cheating were expected to be statistically significant in the negative direction. The studies used one specific method - Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997). Results are presented from several samples: (1) the preliminary results of relations between R/S, integrity as an anti-cheating variable, and the acceptance of otherness (The Stranger as a Symbol of Otherness – How Personality Influences Our Attitudes), which was measured using a modified version of an experience sampling method (ESM, Csikszentmihalyi et al., 1977). Furthermore, included were also results from previous studies of cheating using - (2) general population – white and blue collars, (3) clinical population, (4) university students from different study background - theology or economy, (5) people from the opposite end of the spectrums, such as people consecrated to God vs. control group, (6) multicultural study comparing three countries differentiating in their religiosity levels - Czech, Slovak and Polish university students. Cheating was measured by The Perception Scale of Cheating at University and The Behavioral Scale of Cheating at University (Klein et al., 2007). Results revealed mixed support for influence of R/S on measured variables. Contradictory findings will be discussed along with the cultural, personality and the environmental issues that influenced these factors.

SPIRITUAL ASSESSMENTS IN PSYCHIATRY: A SURVEY OF PSYCHIATRISTS' PERCEPTIONS AND ATTITUDES ABOUT SPIRITUAL CARE- ARE WE REALLY MEETING OUR PATIENTS' NEEDS?

Nadia Saleem`, Rupinder Kaler, Hafsa Sheikh
Mental Health, Coventry and Warwickshire Partnership Trust, Coventry, UK

Background: Spirituality as a concept has been mentioned in history in various disciplines of life ranging from religion to healthcare. There is an ever growing emphasis on spirituality being used as part of wellbeing approach in health sector. NICE guideline in Palliative care has recommended healthcare teams ensure accurate and timely evaluation of spiritual issues through regular assessment. The past century saw the technological advances in field of medicine shift focus from care service oriented model to a cure-oriented model (Puchalski 2001). More recently there is a recognition that until modern times spiritually was in integrated part of health care.
Aim: The aim of this study is to investigate the attitude of psychiatrist towards spiritual care and its use in clinical practice.
Methodology: The study methodology included carrying out a manual, anonymised cross-sectional survey questionnaire across all psychiatrists at a local mental health trust.
Findings: The unsurprising finding was that doctors felt there was need to ask questions around spiritual beliefs in patients routinely and where appropriate to include spiritual practises in the management plan. Majority reported infrequent discussions of spiritual issues with patients and infrequent referrals of patients for spiritual support. Lack of training and knowledge were identified as barriers to spiritual assessment.
Recommendations: It has been suggested that mental health professionals in western societies are generally less religious and receive little training in religious issues (Dien 2004) even though empirical evidence suggests that religion promotes better mental health. There is need for integrating spirituality and religion in mental health training programs to develop competency and comfort levels in clinicians (Pearce 2019).

THE ROLE OF RELIGION AND SPIRITUALITY IN DEPRESSED PERSONS.

Bart van den Brink
Eleos, Centre for Christian Mental Health Care (Kicg), Amersfoort, The Netherlands

Could research shed light on the role of religion and spirituality in psychiatric disease? There is substantial evidence to support the claim that religion can protect against suicidal ideation, suicide attempts and completed suicide. There is also evidence that religion does not always protect against suicidality. Research on 155 in- and outpatients with major depression from a Christian Mental Health Care institution will be presented.
In this lecture ongoing research is presented also, including and Experience Sampling Study, using a mobile app to follow these different factors over time.

CROSS-CULTURAL ADAPTATION AND PSYCHOMETRIC PROPERTIES OF THE PORTUGUESE VERSION OF THE BELIEF INTO ACTION SCALE (BIAC) AMONG MEDICAL INPATIENTS IN BRAZIL

Laura S Castro[1], Talita C Lobo[1], Rita Simone L Moreira[1], Harold G Koenig[2], Fatima Cintra[1]
[1]Department of Medicine, Division of Cardiology, Universidade Federal De Sao Paulo, Sao Paulo, Brazil, [2]Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina, USA

Introduction: Most of the existing religiosity and/or spirituality (R/S) measures have difficulty discriminating religious groups, particularly those high on R/S, or have not been designed to be brief and identify levels of religious commitment.
Objective: To validate the Portuguese version of the BIAC in a sample of hospitalized patients and analyze its association with sociodemographic and clinical profiles.
Methods: Interviews were carried out by two psychologists between December 2017 and October 2018, including the BIAC, the Duke Religious Index (DUREL), the Functional Assessment of Chronic Illness Therapy Spiritual Well-Being (FACIT-SP), and the Profile of Mood States (POMS). Electronic medical records were used to identify newly admitted patients and to assess clinical characteristics. Diagnoses were categorized according to International Classification of Diseases-10 (ICD-10). Cronbach alpha coefficient was used to examine internal reliability; bivariate correlations to test convergent and divergent validity; and principal component analyses (PCA) adopting both the Kaiser-Guttman rule and parallel analyses to evaluate the BIAC's factor structure.
Results: A total of 152 patients (51% men; mean age of 48.9±15.2) were included in analysis. The mean BIAC total score was 43.4±16.6 and Cronbach alpha was 0.80. Lower scores were observed among men, Caucasians, and those with higher education, no religious affiliation, smokers, and heavier drinkers. The BIAC was positively correlated with the DUREL and the FACIT-Sp, and weakly correlated with the POMS. PCA suggested a unidimensional structure for the BIAC. While individuals with cardiovascular diseases (26%) scored lower on the DUREL (16.9±5.3) as compared to those with cancer (26%), rheumatologic (20%), or other diseases (27%), this difference was not seen for scores on the BIAC.
Conclusion: The BIAC is a reliable and valid measure of religious commitment among Portuguese-speaking medical patients in Brazil, with incremental validity as compared to other R/S well-established measures.

SPIRITUALITY IN THE LIVES OF PEOPLE WITH INTELLECTUAL DISABILITY

Stephen Glicksman[1,2]

[1]Makor Disability Services, Yeshiva University/makor Ds, New York, USA, [2]Department of Psychology, Yeshiva University/makor Ds, New York, USA

While ideally connected, "spirituality" and "religion" are not necessarily identical. Spirituality concerns ideas, beliefs, and concepts that give meaning and direction to people's lives and help them cope with the challenges and understand the celebrations that living entails. Religion, on the other hand, is defined as, "a personal or institutionalized system grounded in…belief and worship" (Turner, et al. 2004; Glicksman, 2011). In other words, religions are more specific versions of spiritual expression that come along with their own specific rituals, symbols, and communities. In discussing how to support spirituality and religion in the lives of people with Intellectual Disability, there are really two ways to view the topic. The first is internally, with regard to the person's spiritual beliefs and understanding. In other words, we can discuss a person's own spiritual growth, and the use of spirituality to help an individual person add meaning to his or her life. The second is externally, with regard to how to support a person's religious lifestyle to enhance quality of life through what are, in fact, essentially non-religious (or meta-religious) ideals such as normalization, socialization, and community inclusion. This presentation focuses on the use of both spirituality and religion to enhance the quality of life of people with ID and, in turn, how we might use these concepts to address psychiatric and behavioral challenges specific to this population as well as to generalize these lessons to the broader community.