ABSTRACTS:

MEDICINE & SPIRITUALITY SYMPOSIUM: MOVING FROM HOSTILITY TO HOSPITALITY

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Making medicine multilingual: Using intercultural, evidence-based and socially just spiritual care to alleviate religious, spiritual, and moral struggles of patients, healthcare providers, families and communities

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Many patients and their families experience religious, spiritual, and moral struggles in coping with healthcare crises (Abu-Raiya, Pargament, & Exline, 2015). Medical ways of talking about such struggles often implicitly use a moral approach to health crises prevalent in our culture, in which patients use their free will to make choices about what they consume and how much they exercise, such that health problems become their punishment, with God and doctors inducing guilt and shame (Arora, 2009; Doehring, 2015a; Nelson, 2003; Whitehead, 2016). Hope is offered through medical interventions for healing that are implicitly redemptive: if patients fulfill the medical covenant by conforming to treatment, they will be healed. This implicitly moral and redemptive medical language is inadequate for addressing the religious, spiritual, and moral struggles experienced by many patients, as I argue in this paper.

Maimonides on Tradition and Medical Science

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Moses Maimonides (d. 1204) is considered to be the foremost Jewish jurist-theologian ever. He was also a distinguished scientist-physician. One of the problems he faced in this dual role was when the Jewish ethical tradition assumed a particular state of affairs to be factual, but contemporary scientific consensus assumes otherwise. According to whose factual assumption is a specific norm to be applied? For example, what constitutes an immediately terminal medical condition? To whom is one to listen: to the tradition or to science when deciding what is to be done or not done in the case at hand in a morally cogent way?

Maimonides concluded that science trumps tradition in such cases. Although the tradition, not science, supplies the norms, a norm can only be properly applied in the physical world most accurately described by science. As such, science best describes a patient's condition, while an ethical tradition like Judaism best prescribes what is to be done for a patient in that condition.

Maimonides' stance on the juncture of tradition and medical science follows from his theological understanding of the proper relation of revelation and reason. His stance is also helpful today in countering the kind of fundamentalism that ignores scientific evidence in making normative decisions. And it is equally helpful in countering the ideology called "scientism," which assumes that science can prescribe moral norms based on its descriptions of the physical world around us, instead of accepting the truth that moral norms come *into* that world from somewhere else, but do not come to us *from* that world.

What Can We Learn from Psychiatry and Spirituality's Fraught History?

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Hostility characterizing the early relationship between psychiatry and spirituality was fueled both by Freud's militant atheism and later by the mechanistic focus of biological psychiatry. Until recently, religion and spirituality rarely appeared in the field's scholarly journals, and many patients felt that their faith was unwelcome in the office.

Much has changed in the past three decades: Twelve Step spirituality is widely valued. Psychoanalysts such as Rizzuto have revised Freud's understanding of faith. Mindfulness has become mainstream. Palliative Medicine includes spiritual care among its goals. Research has burgeoned into the effects of religion on health (e.g. via positive and negative "religious coping"), and into the neurobiology of spiritual experience. The Joint Commission mandates routine spiritual assessment, reflecting greater appreciation for the role of religion/spirituality (R/S) as a risk or protective factor. Most patients surveyed want R/S included in therapy. Courses, papers, journals and books in this area have proliferated, many sponsored by interest groups within mental health organizations such as the American Psychological Association, the Royal College of Psychiatrists and the World Psychiatric Association. In 2014, the American Psychiatric Association engaged in a Mental Health and Faith Community Partnership, and published a Mental Health Guide for Faith Leaders. Seven doctoral programs in clinical psychology now exist within Christian universities And while psychiatrists are less religious than physicians in other specialties, Curlin et al. found in a national survey that they are more likely to say it is appropriate to ask patients about spiritual concerns (93% vs. 53%) and that they do inquire (87% vs. 49%).

Of course, major challenges remain. No consensus among psychiatrists exists about core competencies dealing with R/S, or its importance, and only a minority of psychiatry residency programs offer formal training in this area. Research funding is limited. Coordination with spiritual care providers is the exception, despite the fact that they are consulted first about most mental conditions. In a 2013 survey of a representative sample of Americans about mental illness, a third agreed with the statement, "With just Bible study and prayer, ALONE, people with serious mental

illness like depression, bipolar disorder, and schizophrenia could overcome mental illness." A number of psychiatrists remain very concerned about harm attributable to R/S.

What can be learned from the progress that has been made? If we consider how much resistance to change has come from psychiatry's concerns with autonomy, pragmatism and pathology, and how much these have contributed to its insulation as a discipline, we can see how a degree of balance and perspective has resulted from greater attention to professionalism, patient centeredness, and positive psychiatry with its debt to positive psychology.

At a more practical level, personal relationships have catalyzed numerous examples of trust and openness to pluralism and difference. These include the inclusion of chaplains in rounds; multidisciplinary grants to study competencies, spiritually integrated therapy, and the virtue of accountability; courses and symposia bringing together differing perspectives; and interdisciplinary conferences born out of painful personal experiences with mental illness and care.

At least three sources of hope for the future are also evident: (1) respect for emerging science showing the practical importance of R/S to mental health, e.g. in the work of Myrna Weisman, Tyler VanderWeele, and Michael and Tracy Balboni; (2) globalism, with the attention it is forcing through issues such as Islamophobia, religious extremism and folk healing to the need for a cultural competence that takes into fuller account the person's R/S identity and community of belief and practice; and (3) role models of spiritually sensitive practice, including those honored by the APA's annual Oskar Pfister Award, such as Ana-Maria Rizzutto, Ned Cassem, Harold Koenig, Ken Pargament and John Swinton.

This paper aims to facilitate discussion of questions such as: What is this analysis missing? To the extent it is correct, what are the implications for the relationship between R/S and the rest of medicine? Can generic spirituality as seen in the rise of the "spiritual but not religious" bear the weight of the moral and existential distress being more acknowledged by psychiatrists? If not, what approach can? How can chaplains and faith communities better address the often complex, multidimensional struggles of individuals living with mental illness?

The Role of Religiosity in Families at High Risk for Depression: A Three-Generation Longitudinal Study

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Background: About thirty-five years ago we began a study of the offspring of depressed (high-risk) and not depressed (low-risk) parents, matched for age and gender, from the same community. We interviewed all of their biological children, blind to the clinical status of the parents. Over the years, we returned to re-interview the families at baseline, 2, 10, 20, 25 and 30 years. As the years went by and the sample grew up, we also interviewed the third generation, the grandchildren. As technology became available, we included measures of magnetic resonance imaging in order to better understand the mechanisms of risk. At the 10-year follow up, we included measures of religion and spirituality – namely, personal religious/spiritual importance and frequency of religious service attendance. We included these measures in all subsequent waves including a more extensive follow up of religious beliefs that are now ongoing at the 35-year follow up.

Issues of Focus: This talk will describe the study design and highlight the key findings of the role of religious belief in the transmission and endurance of depression using clinical and biological approaches.

Methods: We will describe study findings based on clinical measures, as well as physiological measures that employed electrophysiology and magnetic resonance imaging.

Results: Taken together, the findings suggest that religiosity is protective against depression in high-risk individuals at both clinical and physiological levels.

Implications: The findings suggest religiosity interacts with both culture and biology in its impact on depression.

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