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Church care for mentally ill people. Church and psychiatry: facets of cooperation

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This book presents reports of the III International Conference “Church care for mentally ill people. Church and psychiatry: facets of cooperation”, made by representatives of Orthodox, Catholic and Protestant religious communities – theologians, psychiatrists, clergy, teachers of theological schools, specialists of public health institutions from Russia, the Netherlands, Italy and Spain.

The conference was initiated by the Commission on Church Formation and Diaconia of the Inter-Council Presence of the Russian Orthodox Church. The co-organisers were the Moscow Patriarchate’s Department for External Church Relations, the Voronezh Metropolia of the Russian Orthodox Church, Section on clinical psychiatry, religiosity and spirituality of the Russian Society of Psychiatrists, Saint Tikhon's Orthodox University of Humanities and Scientific Center for Mental Health. The conference was held with the support of the ‘Aid to the Church in Need’ Charity.

CONTENT

REPORTS

REPORTS

Metropolitan Sergiy of Voronezh and Liski

Church care for mental health

Dear participants of the conference!

The Church of Christ is deeply concerned about a rapid spread of mental illness and helps those suffering from mental disorders.

According to the experts of the World Health Organization, about 15% of adults over 60 y.o. suffer from mental disorders. [1] Half of all mental health disorders occur before the age of 14. Worldwide about 20% of adolescents have mental disorders that are not properly diagnosed and do not receive proper treatment. [2] According to experts from the World Psychiatric Association, less than 50% of people in need of such treatment receive therapy for mental illness. [3] Among people with war or other conflict experi-ence, more than 20% suffer from depression, anxiety disorder, post-traumatic stress, bipolar disorder or schizophrenia. [4] Often, these people, who are unable to get the necessary access to medical care, make up a significant part of the refugees. Finally, none of us is free from periods of anxiety, stress, anxious or annoying thoughts. The soul of every person was wounded by the consequences of original sin and became weakened and vulnerable.

Mental illnesses deeply damage a person, affecting thoughts, emotions and behavior, and thereby affect the most important aspects of human life: work, recreation, family relations, culture, relations with the state and spiritual life. It turned out that a society damaged by mental distress is not able to reproduce mentally healthy people. It seems that, starting from a certain level of incidence of mental disorders, the preservation of the mental health of society becomes an elusive task. It would not be a big exaggeration to say that following the spread of godlessness and the multiplication of sin, people were struck by immorality, which, along with mental illnesses, continues to destroy human souls, filling houses and streets with mentally ill people.

The true source of mental health is a person's relationship with God, as evidenced by the experience of the Church and Holy Scripture. Thus, the prophet Isaiah described the ministry of the coming Messiah as "healing of hearts" (Isaiah 61:1): "The Spirit of the Lord God is upon me, because the Lord … has sent me to bind up the

[1] Mental health of older adults. WHO fact sheet. 12.12.2017.
https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults
[2] Adolescent mental health. WHO fact sheet. 28.09.2020.
https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
[3] Reducing the treatment gap for mental disorders: a WPA survey.
Vikram Patel, Mario Maj, Alan J. Flisher, Mary J. de Silva, Mirja Koschorke, Martin Prince, WPA Zonal and Member Society Representatives. World Psychiatry. 2010 Oct; 9 (3): 169–176. doi: 10.1002/j.2051-5545.2010.tb00305.x
[4] Mental health in emergencies. WHO fact sheet. 11.06.2019.
https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies.

brokenhearted...". The prophet Jeremiah wrote about the Messiah as someone who can transform the state of mind of people: "I will turn their mourning into joy; I will comfort them, and give them gladness for sorrow" (Jer. 31:13).

The ability of the human heart to cry out to God creates an opportunity for a healing relationship between the wounded human soul and the loving God. The grief of a broken soul, imprinted in the words of the Psalms, expresses the impulse of a believer who turns to God in a time of despair. The psalmist's lament, full of feelings, reminds us that in mental distress a person, first of all, asks for help from God and only after that — from a doctor. And in response to this request, the Lord always strengthens us, meets us in our pain and sympathizes with us. Because we, the members of the Church, make up His mystical body. It is no coincidence that representatives of the clergy are often the first to whom patients and family members of a sick person turn in case of loss of mental health. At the same time, clergy often cannot talk about mental illnesses, because they feel not prepared for this. The clergy are expected to help and instruct in how to find peace of mind and silence. To do this, the pastor needs to understand medical problems related to the practical application of certain principles of moral theology. For example, to answer questions:

Are the experiences and behavior of the person related with the specifics of his moral and ascetic structure or with his illness?

What is the degree of moral responsibility of people with various mental illnesses?

Is it possible to distinguish between manifestations of passions and mental illnesses in a person?

Where is the divide between normal and pathological manifestations of human sexuality?

What is the difference between pathological and normal manifestations of age-related human crises?

On the other hand, psychiatrists without religious upbringing and education note that they feel insecure whenever their patients speak about a spiritual problem. Doctors feel the need to receive information that could help them understand the importance of religious life for their patients. Their medical training does not help them in this regard. Specialized medical educational institutions and advanced training courses do not even discuss with them the psychology of religion and the basics of religion. But this is exactly the knowledge that should help psychiatrists understand the role of spirituality and religiosity in the lives of their religious patients.

Educational programs in psychiatry do not allow doctors to comprehend their own religious (or atheistic) life history. No surprise that the attending doctor of a mentally ill person often simply cannot understand that his own worldview affects the treatment of patients. After all, people deeply feel everything that is connected with religion and spirituality. If they are not understood or their faith is not respected, it causes them additional mental suffering, which can push them away from treatment by psychiatrists, can permanently close the doors of a medical organization to patients. If a person is tormented by spiritual issues, these touch the very depths of his existence. Unresolved spiritual problems are a source of suffering. Their neglect will make it impossible to help the patient. It is the atheistic position in medicine that is one of the most important reasons why believers have suspicions about psy-chiatry or clinical psychology and question their compatibility with the Christian faith. The splitting of our culture into religious and secular influences the therapy of mental illness more deeply than we tend to think. That is why understanding religious issues is so important for doctors and, in particular, for psychiatrists.

The dialogue between the Church and the psychiatric community has been going on for a long time. However, there are difficulties on the way of such a dialogue that

have not been overcome so far. Our cooperation is hampered by the lack of a comprehensive understanding of medical and church terminology, as well as differing understandings of the connection between mental health and the spiritual and moral state of a person. But the key issue is the secular worldview and culture, in the context of which mental health is still understood exclusively through the prism of scientific assumptions, which do not take into account either a person's religious beliefs or the experience of healing people's mental distress by the Church.

The program of our conference makes a distinction between the concepts of "religiosity" and "spirituality". For believers, this distinction may seem artificial, because spirituality and religion are inextricably linked in their lives. However, we can also talk about the difference between these terms.

"Religiosity" is a concept that often refers to a way of living with God for the entire community of believers, the entire people of God. Throughout its history, the Church has transmitted various forms of religiosity from generation to generation: its teaching, sacraments, forms of worship, prayers. But the main thing is that special way of life of believers, which reproduces love in their souls. The role of faith, hope and love in maintaining mental health has long been recognized by medicine. One of the most famous summaries of research in the field of the influence of religiosity on mental health was carried out by Harold Koenig (USA). After analyzing more than 3 thousand studies that were published in scientific journals from 1872 to 2010, he came to the conclusion that three-quarters of publications demonstrate the positive influence of religion on various indicators of mental health. [5]

"Spirituality" for a Christian is the work of the Holy Spirit in a person. When talking about spirituality, first of all they usually pay attention to personal relationships with God. Spirituality refers to the inner life of a person: to his ideals, to the meaning of his existence, to how religiosity is realized in his daily life. After all, participation in church life itself can become a dead routine if we do not participate in it personally, that is, spiritually. Psychiatrists inevitably encounter the personal attitude of their patients to God, with a personal refraction of their faith, which is called spirituality. In our opinion, distortions of spiritual life by themselves can lead to mental disorders and require help of clergy.

Of course, the word "spirituality" is often used not in the church related meaning. Usually in order to emphasize a person's aspiration to eternity (or to its likeness). A person is always open to his future, which has the features of eternity: from the desire to preserve himself in children and the search for public recognition to the desire to save himself for eternal life. This openness to the future forms a life path, a movement towards a goal, without which mental health is at serious risk of destruction. Without a clear understanding of the meaning and purpose of his life, a person easily loses mental stability, full integration in the family and society and, eventually, his mental health.

Speaking of representatives of non-ecclesiastical "spirituality", let us recall what the Apostle Judas wrote about them: "These are the people who divide you, who follow mere natural instincts and do not have the Spirit" (Jude 1:19). The leading Russian writer Mikhail Prishvin said well about the spiritual signs of mental health: "Human health is not in the heart, not in the kidneys ... or in the back… But the very essence of purely human health is when he is irresistibly drawn to say something good to another person, as if it were even a law: if I feel good, then everyone should feel good!" [6] However, it is much easier to lose mental health outside the Church, outside the grace of the Holy Spirit.

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[5] Koenig H. G. Religion, Spirituality, and Health: The Research and Clinical. Implications / ISRN Psychiatry. Vol., 2012. Article ID 278730. P. 5. doi: 10.5402/2012/278730

[6] Prishvin M.M. Diaries. 1936-1937. V.7.S. 42. St. Petersburg: 2010.

The Church knows another form of spirituality. De-mons are also spirits. Demonic possession can be considered as a special "spirituality", which consists in demonic influence on a person. When demons take over nature and deprive a person of his will through passions directed at the outside world, the patient will suffer from passions and their consequences, but will come to terms with them. He will not be able and will not want to get out of his painful state of mind and will resist attempts to heal, skillfully justifying himself and blaming others for his painful condition. "My name is Legion: for we are many" (Mk. 5:9), — writes the evangelist Mark, telling about the mental state of a person torn apart by demons to such an extent that almost nothing human remains of him. Since then, the influence of demons on people has not changed. Only today such a person, exhausted by passions, gradually becoming helpless and tormented, with signs of mental disorder will get to the doctor. Then a meeting with Christ is necessary in order to get rid of the spirits that cloud the mind and reason, exhausting spiritual strength. The help of a priest is needed to heal spiritual delusions. In such cases, a psychiatrist and a priest can only jointly restore a person's lost mental integrity.

In the dialogue between psychiatry and the Church, it is clear that clergy, health professionals and scientists should cooperate for the sake of people's mental health. Our meeting is a visible expression of the fact that there is a growing number of scientific studies demonstrating the benefits for mental health of prayer, religious repentance, participation in church life, cultivation of Christian virtues like humility and forgiveness. Modern medicine rediscovers that there is a deep connection between faith and the state of the soul.

All truth comes from God. Therefore, the achievements of psychiatric science, properly understood, and the truths of the Christian faith, properly understood and accepted, will never contradict each other.

I wish everyone God's help for fruitful work at our conference and for the realization of our intentions and efforts to preserve the mental health of society.

Kaleda V.G.

Spirituality and religiosity in the context of clinical psychiatry

«The spiritual dimension cannot be ignored, for it is what makes us human»

Viktor Frankl

Currently, in clinical psychiatry, a personalized ap-proach to the patient is becoming increasingly relevant, while the patient is considered not only as an object of therapeutic interventions, but also as a subject with a complex inner world that has its own worldview, ideals, beliefs, spiritual and religious values.

In 2003, Rene Hefti widened George Engel's (1977) bio-psycho-social concept of the development of mental diseases, to include the spiritual sphere; since then the bio-psycho-socio-spiritual concept has been gaining increasing recognition, representing a practical basis for the implementation of a holistic approach to the individual in psychosomatic medicine and psychi-atry.

D.E. Melekhov (1992) was the first Russian researcher who raised the importance of spirituality and religiosity in the context of psychiatric research and rehabilitation of mentally ill people, based on a trichotomous understanding of the human personality. His work "Psychiatry and aspects of spiritual life" became fundamental in the field of religious psychopathology. According to a number of modern researchers [Kondratiev F.V., 2017; Polishchuk Yu.I., 2010; Voskresensky B.A., 2015; Ovsyannikov S.A., 2015], trichotomy – body-soul-spirit, introduced into modern psychiatric literature by D.E. Melekhov, should be accepted and adopted in scientific and practical psychiatry. It is noted that the most important component of the spiritual sphere is religiosity and religious faith, and the human personality should be considered in the unity of its bodily, spiritual and mental organization [Tokareva N.G., 2015].

That a psychiatrist needs to be aware of the religious views and peculiarities of the spiritual life of patients has been noted by many researchers [Logutinenko R.M., 2014; Sidorov P.I., 2014; Savenko Y.S., 2013], while F.V. Kondratiev (2017) wrote that the spiritual sphere is always uniquely individual, and reflects the identity of a person.

D.E. Melekhov (1992) noted the twofold nature of religious experiences of mentally ill people: in case of pathology, they can reflect disease symptoms, at the same time they can be a manifestation of a healthy personality, and then religious faith helps the patient to resist the disease, adapt to it and compensate for the defects imposed by the disease onto the patient's per-sonality.

As early as at the beginning of the last century, academician V.I. Bekhterev, identified along with the social and biological needs of the man also spiritual needs (the level of ideals), which were determined not by consumption, but by service to people, a look into the future based on moral values, concepts of justice, conscience.

In recent decades, the concept of spirituality was broadly introduced into the scientific world not only in religious studies, sociology and psychology, but also in clinical psychiatry.

Currently, there are no generally accepted definitions of spirituality. From the perspective of clinical psychiatry, spirituality is considered as the highest form of human consciousness, characterized by meaningful life, creative and productive activity, striving for self-development and service to society, with predominant intellectual, moral and aesthetic motives over against biological needs and material motivation in behavior.

In addition to the "secular" definition of spirituality, there are also religious spirituality concepts. Thus, within the Christian tradition, spirituality is considered as the result of an intense religious life, "prayerful work", "the breath of the Holy Spirit". At the same time, according to some Orthodox authors, in particular St. Ignatius (Bryanchaninov), a well-known Orthodox ascetic of the XIX century, who distinguished the mental, bodily, spiritual state of a person, wrote that there are only a few truly "spiritual" people. However, many Orthodox authors allow for a wider use of this term in relation to people who seek to attain religious ideals in their lives.

Spiritual phenomena are currently considered as the most important subjective indicators of the quality of life. Thus, the well-known Personal Wellbeing Index (PWI) includes a question about spiritual well-being. The DSM-5 recommends taking into account cultural characteristics of a patient, which include information about his spirituality/religiosity.

While some researchers define mental health as the absence of a mental disorder [Voskresensky B.A., Radi-onov D.S. 2018], D.E. Melekhov (1992) wrote that genuine health is achieved under the condition of the predominant influence of the sphere of the spirit, having in harmony the three spheres of the human personality – spirit, mind and body. Several decades earlier, Viktor Frankl noted that human behavior is primarily driven by values and meanings localized in the spiritual and ethical dimension, that a person is free and fatefully not subjected to determining influences by factors of the lower levels (mental and bodily)."

Spirituality and religiosity are of high importance for people with mental disorders in terms of forming their spiritual aspirations and finding the meaning of life. The loss of axiological orientations is the leading cause of high suicidality in mentally ill people.

In 2015, the Executive Committee of the World Psy-chiatric Association (WPA) approved a Position Statement on religion and spirituality in psychiatry, which notes that religion/spirituality have significant implications for prevalence of a number of mental illnesses (especially depressive and substance use disorders); they need to be considered in diagnosis (e.g., differentiation between spiritual experiences and mental disorders), religion/spirituality have implications for conscious and mindful therapy, out-comes and prevention, as well as for quality of life and wellbeing [Moreira-Almeida A. et al., 2016]. The State-ment underlines that patients would like to have their religion/spirituality concerns addressed in healthcare. It also states the need for more research on both religion and spirituality in psychiatry, especially on their clinical applications.

Recognition of the special importance of spirituality and religiosity for psychiatric patients actualizes the problem of differentiation of normal religiosity from pathological [Voynovskaya O.A., 2010; Voskresensky B.A., 2018].

It is necessary to note both the absence of clear boundaries between the norm and mental pathology, and the absence of clear criteria that make it possible to distinguish between normal religious feeling and pathological.

In modern literature, the criteria of a normal harmonious religious faith within traditional confessions have become generally accepted [Frolov B.S., 1982; Arterburn S, 2001], which is characterized by focusing on God; reverence and love; respect for one's own personality and the beliefs of others; orientation to warm interpersonal relationships; awareness of one's imperfection. Mentally healthy people maintain social adaptation, they do not impose their religious beliefs on those who disagree with their point of view, continue to take care of their loved ones, sympathize with them, not focusing only on their faith, are tolerant towards other faiths and confessions.

Hans Küng (2013) noted that healthy religiosity liberates, not enslaves; it stabilizes, not shatters the inner world of a person, promotes personal growth, does not suppress the will, provides freedom of choice and responsibility for preserving the dignity and sovereignty of the individual, it is the basis for true self-realization and purposeful achievement of tasks, both in personal and public space.

With normal religiosity, faith contributes to adaptation to difficult life situations, a healthy personality is characterized by integrity, harmony, compliance with social norm, maintains trustful relations with the spiritual father and the religious community [Kopeyko G.I., 2019].

The main characteristic of pathological religiosity is that it appears on pathological grounds, against the background of current mental illness, has a wide range of manifestations, which include both distortion of spiritual life against the background of neurotic disorders and character accentuation, and pronounced negative disorders with hallucinatory delusional disorders of religious and mystical content. At the same time, religious life is distorted, and "painfully disformed interpretations of certain dogmas" appear, which lack proper sensory depth in understanding the essence of religious actions; a critical attitude towards one's own personality is disrupted and pathological religious behavior is developing [Borisova O.A. 2017; Brovchenko K.Yu., 2017; Kondratiev F.V., 2017]. Often, the desire for a full spiritual life is replaced by an exaggerated performance of religious rituals. Metropolitan Anthony (Blum) said that when a mentally ill person turns out to be a believer, his mental state casts a shadow on everything, including his life in the Church.

One of the varieties of pathological religiosity is neurotic religiosity or toxic faith. These concepts imply neurotic disorders arising under the influence of religious upbringing or religious faith in accentuated or psychopathic personalities [Velikanov P., Archpriest, 2020; Pfeifer S., 1994; Arterburn S, Felton J., 2001]. These conditions are characterized by a gross distortion of traditional religious beliefs, they are perceived not in their entirety, but fragmentary, superficially, often with a mercantile attitude in the "God-man" relationship. At the same time, contradictory tendencies are noted: "humility" towards the leaders of religious communities goes along with an arrogant attitude towards people who are not members of this community; "righteous piety" is combined with hatred towards all others [Filonik M.C., 2015].

Special scales are used in scientific research to assess religiosity, including the Duke University Religion Index (DUREL), 1997, the S. Huber and K. Pargament Centrality of Religiosity Scale, 2012. In addition, a Russian-language version of the MIR SPB questionnaire (Multidimensional Inventory for Religious Spiritual Well-Being) has been developed, which has good psychometric properties [Pfeifer S., 1993].

G. Allport formulated such concepts as external and internal religiosity [Allport G., 2002], which generally correspond to the criteria of social and spiritual religiosity highlighted earlier by G.E. Lenski [Lenski G.E., 1961]. Manifestations of external religiosity are conditioned by habit, tradition, social requirements, as well as in some cases obtaining some benefit with the help of religious faith. Inner or spiritual religiosity is characterized by conscious inner spiritual needs, an undisguised desire to build one's life in accordance with religious precepts, and the ability to mystical experiences. It should be noted that the risk of depressive disorders, as well as intolerance towards others, is higher in people with external religiosity [Larson D.B, 1989; McCullough M.E., 2005; Mahmoodabad S.M., 2016; Morawa E., 2018].

C.Y. Glock (1962), proposed to assess religiosity by five factors: experiential (subjective emotional religious experience reflecting personal religiosity); ritualistic (participation in religious practices, actions, rituals, for example, attending religious services); ideological (acceptance of a certain belief system); intellectual (the

intellectual side of religion, which includes religious knowledge and is often measured through practices such as reading religious literature, striving for knowledge of the laws of faith, its history, as well as the general level of life experience); by measuring the consequences (consequences, results, influence of the previous four manifestations of religion on values and behavior outside the religious context).

Since the 1990s there has been a large number of studies dedicated to various aspects of religious psychopathology, the influence of religious beliefs on the manifestations and course of mental illness. In recent years, there have been more and more works devoted to the issues of religious coping [Bogatyreva N.L., 2017; Kopeyko G.I., 2019; Barber C.W., 2014; Toussaint L., 2015; Fradelos E.C., 2018], the specifics and prognostic significance of delusional disorders of religious content, in particular, the capture syndrome and diabolic possession [Kopeyko G.I. et al., 2019; Samsonov I.S., Kaleda V.G. 2021], messianic [Dyga K., 2018], apocalyptic and eschatological delusions [Borisova O.A., Orekhova P.V., 2020], delusional disor-ders with religious content in the structure of juvenile endogenous paroxysmal psychosis with an analysis of religiosity in the premorbid and postpsychotic period [Romanenko N.V., et al., 2019; Popovich U.O. et al..2021]. Paranoid religious states, which began in adolescence with the phenomena of metaphysical intoxication of religious content, are also of particular interest for the modern research [Tsutsulkovskaya M.Ya., 1986].

In a special study of the role of religious coping strategies in the rehabilitation of mentally ill people [G.I. Kopeyko et al. (2016)], based on a comparison of the axiological structures of the personality of patients with religious and non-religious worldviews and comparison with the corresponding groups of healthy individuals, the effectiveness of various types of confessional-oriented coping strategies for patients with schizophrenia was established. The religious factor, according to the researchers, should be taken into account as the most important potential personal resource that a patient can use when faced with illness and other life stresses. This study also confirmed the position of a number of foreign researchers [Teppe L., 2001, Yangarber-Hicks N., 2004; Mohr S., 2006] that religion (including spirituality and religiosity) is very important in the lives of patients suffering from schizophrenia and schizoaffective disorder.

Modern researchers [Baskakova S.A. et al., 2009; Polishchuk Yu.I. et al., 2017] also note the special im-portance of religious coping strategies in patients with anxiety and depressive disorders and grief reactions at a late age. In addition, there is a greater risk of the formation of pathological reactions that turn into a depressive disorder in people who do not use religious resources to overcome crisis situations [Bogatyreva N.L., 2017]. At the same time, the strategies of religious coping should not be used in isolation, but as one of the means and methods of supporting patients within the framework of an integrated approach to rehabilitation [Slonevsky Yu.A., 2017]. A number of authors emphasize [Nosachev G.N., 2017] that the psychother-apeutic method in its various models cannot fail to include religiosity and the main religions, cannot fail to assimilate them, not to use them both in theory and in practice. According to B.A. Voskresensky [Voskresensky B.A., 2007], religious faith brings mitigation of the disease, therefore it is important to include religious components in the psychotherapy of mentally ill people. It should be noted that V.M. Bekhterev (1994) recognized the possibility of psychotherapeutic influence of induction and self-induction in the states of religious exaltation. Some psychiatrists attribute religious psychotherapy to a separate type of psychotherapy [Bratus B.S., 1997; Koenig H.G., Pritchett J.T. 1998]. Some researchers [Kazmina E.A., 2017] consider religious communities as "alternative support systems", where the leading type of social assistance is emotional, problem-oriented, with full acceptance from the environment.

Religious faith is considered in many studies as an antisuicidal factor, which is associated with the strict prohibition of suicide in most traditional religions [Pashkovsky V.E. et al., 2015; Baykova M.A. et al., 2017; Rutkovskaya N.S., 2017]. Therefore, the high psychoprophylactic and psychotherapeutic potential of religious values can be used in programs for the prevention of suicidal behavior. At the same time, it should be noted that a number of religions that are not widespread in our country, as well as some sectarian communities, not only do not prohibit, but even encourage suicide [Rutkovskaya N.S., 2017].

Most researchers [Polishchuk Yu.I., 1995; Kondratiev F.V. et al., 2006] note the pathogenic influence of some sects with destructive cults on the psyche. A similar point of view was held by P.B. Gannushkin [Gannushkin P.B., 2011]. In his article "Voluptuousness, Cruelty and Religion" he describes the psychopathology of mental disorders arising in religious sects in which religious "rejoicing" is accompanied by ecstatic states with drive disorders. S.S. Korsakov (1901) noted that "religion itself has no influence on mental illness, but religious fanaticism and superstition are often the causes of mental illness. Belonging to some sects in which a religious cult is combined with a strong emotional excitement, reaching ecstasy, contributes to the development of mental illness." This thesis has been confirmed in modern foreign studies [Beit-Hallahmi B., 1977; Sanderson S., 1999], where it is shown that the more individual religious experience deviates from traditional religious norms, the higher the risk of mental disorder. A number of authors [Polishchuk Yu.I., 1995; Kondratiev F.V. et al., 2006] note a high frequency of mental disorders in persons who belong to some non-traditional religious organizations that use psychotechnologies that have a destructive effect on the mental health of their members. These authors consider these disorders as a result of psychological manipulations to which patients were subjected in the cult and meet the criteria of "dependent personality disorder" (F60.7 according to ICD-10). At the same time, as the researchers note, there are many people with pre-existing mental disorders among those involved in the activities of sects, and participation in some such organizations is a trigger factor contributing to their aggravation.

When analyzing the patient's religiosity, it is important to establish the time when it appeared in relation to the manifestation of mental disorders [Logutinenko R.M., 2014; Pashkovsky V.E. et al., 2005, Voskresensky B.A., 2016]. R.M. Lagutenko (2014) suggests that it is essential to collect a religious history of the patient and identify traditional religious experience and the experience of extreme mental induction (turn to healers, sorcerers, psychics, etc.).

Many researchers [Melekhov D.E., 1991; Pashkov-sky V.E. et al., 2005; Logutinenko R.M., 2010; Dvoin-in A.M., 2016; Minakov A.A., 2017] note that the problem of distinguishing individual non-pathological religious experience from mental illnesses with a religious plot has not been developed, and there are no criteria for evaluating religious-mystical conditions outside of mental disorders. The complexity of the problem lies in the fact that often religiosity and psychopathological symptoms are intertwined and coexist simultaneously [Melekhov D.E., 1992; Pashkovsky V.E., 2005]. At the same time, many re-searchers note the complexity of this differentiation, especially in states of religious ecstasy, which V.P.Osipov (1931) considered as a pathological disorder, but at the same time pointed out that the divides between pathological affect in the form of ec-stasy and similar physiological affect are difficult to define.

V.E. Pashkovsky and I.M. Zislin (2005) consider the most important achievement of psychiatry in recent decades [Dein S., 1999; Grossley D., 1995; Pereira S., 1995] that the fact of the existence of special, other than psychosis, religious-mystical states is recognized (in American literature they are referred to as

"spiritual emergency", literally translated – "critical spiritual situation"). They noted that despite the similarity of the plot of experiences, ecstatic mood, the presence of altered perception, these states are fundamentally different. Their differentiation is possible on the basis of the traditional clinical and psychopathological approach that implies collection of anamnesis (previous religious experience), study of mental status (concomitant psychopathological disorders), analysis of constitutional and personal characteristics. At the same time, in some cases similar religious-mystical states should be evaluated as variants of religious experience, in other cases – as psychotic states. Religious fables are assessed as delusional with greater certainty if they do not correspond to the religious and cultural traditions to which the patient belongs [Pashkovsky V.E., 2007]. F.V.Kondratiev (2012) noted that religious feeling can be "anthropogenically (i.e. artificially by human intent) exalted to a sense of visual communication with divine or satanic images."

The WPA Statement on the place of religion and spirituality in psychiatry states that psychiatrists will not use their professional position to impose their spiritual or secular world views; they will always respect the spiritual/religious beliefs and practices of the patients, their families and caregivers. Leading Russian psychiatrists also wrote about this [Melekhov D.E., 1992; Kondratiev F.V., 2012]. It should be noted that some modern studies raise the question of the need for mental health professionals to have basic knowledge about religious doctrines and rituals, as well as about the structure and organization of religious communities [Greenberg D., 1991]. Many Russian authors emphasize the importance of cooperation between a psychiatrist and a priest in the treatment of mentally ill people with a religious worldview [Melekhov D.E., 1992; Sidorov P.I., 2014; Voskresensky B.A., 2016; Kaleda V.G., 2012], at the same time, as Yu.S. Savenko (2013) notes, even their remote cooperation significantly enhances the effec-tiveness of therapy.

According to a number of psychiatrists, religion in many cases is an important and one of the first resources that patients and their relatives turn to when faced with a severe, chronic or incurable disease [Sidorov P.I., 2014; Kopeyko G.I. et al., 2016; Kaleda V.G., 2008]. In this regard, the question of the need for special psychoeducational work among the clergy in relation to the main manifestations and patterns of the course of mental disorders is currently being actively raised [Melekhov D.E., 1992; Voskresensky B.A., 2016; Kaleda V.G., 2012]. The first textbook in the field of pastoral psychiatry was a book written by D.E. Melekhov (1992). Compared to the book by K. Schneider (1999) "An Introduction to Religious Psy-chopathology", in addition to describing mental pathology, it offered a conceptualization of the disease and a Christian attitude to the disease. He formulated a concept of a special course of "Pastoral Psychiatry" for Orthodox theological schools. It should be noted that by that time a special chapter on this problem had already been written in a special manual for future clergy [Kern Cyprian, Professor Archimandrite, 1957]. In recent years, modern curricula on psychiatry have been written, adapted for future clergy [Voskresensky B.A., 2016; Kaleda V.G., 2021].

It should be noted that analyzing the role of religious and ideological attitudes in the professional activities of psychiatrists, the researchers concluded that these attitudes increase the adaptive potential in professional activity [Bashmakova O.V., 2017], while the level of religiosity among psychiatrists is relatively lower than among the general population [Shafranske E.P., 2000].

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Why it is necessary to consider spirituality in mental health?

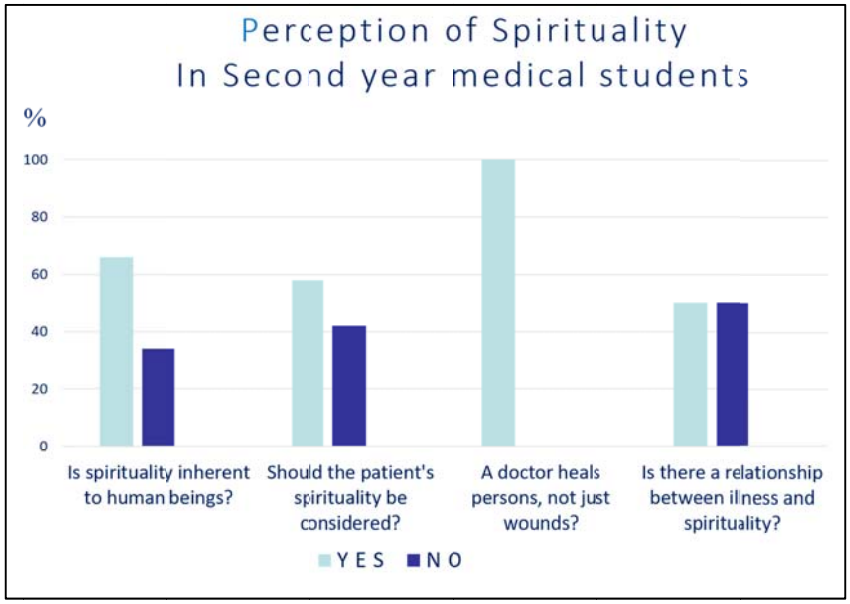
Introduction

I would like to start by recalling the image of some flamingos in a lagoon in northern Chile. They are able to withstand the ice of the nights, which traps them as if it were cement... and the heat and radiation of the desert days. All this in order to mate and perpetuate the species, in a closed cycle of birth, procreation and death. They have no other objective or project, or dream: they are not free in their process of growing in maturity.

The human being develops, but in a process open to many possibilities. We make the process of growing in maturity our own, we possess it and little by little we know it. We are free and capable of loving. That is to say, we are spiritual beings.

The interest of spirituality in mental health is widespread. The American Psychiatric Association has a committee on religion, spirituality and psychiatry, and a specific agenda for it[1]. Many scientific studies demonstrate a positive influence of spirituality on health.

However, in medical practice and medical education, spirituality is poorly understood and little considered. I have been teaching spirituality for four years to second year medical students[2]. I asked several questions about the relationship between spirituality and medicine, you can see them on the chart:



I was surprised that when I asked if the physician should consider the patient's spirituality only 58% answered yes. But, when asked if the doctor should cure persons and not only pathologies, 100% answered yes. This is something of a paradox because the person is precisely the foundation of spirituality.

The World Health Organization defines health as «a state of complete physical, mental and social well-being and not merely the absence of disease»[3]. In 1998 it was

[1] Cf. John R, Peteet, Francis G. Lu, William E. Narrow, *Religious and spiritual Issues in Psychiatric Diagnosis*, American Psychiatric Publishing, 2010.

[2] This was a Medical Anthropology course at the Universidad de Los Andes, Chile, which included two hours of Medicine and Spirituality. Each year the responses were similar. The total number of students was about 480.

[3] The quotation comes from the *Preamble of the WHO Constitution*, which entered into force on April 7, 1948.

proposed to include the term "spiritual", but it has not been adopted. Several factors of a lack of well-being could be included in spiritual dimension. Incoherence, lack of meaning, activism and haste, that increase stress. Byung-Chul Han points out that one of the reasons of this activism is the fashion of thinking and acting as if everything were possible, in accordance with the slogan "yes we can"[4].

We are in a society of fatigue in which there is no reaction to what is threatening. There is no immunological response: the defenses, the antibodies against the viruses of the spirit are not activated. What is different is accepted, whatever it is, without anything causing surprise or being considered bad. And sometimes it ends in heart attacks of the soul, in a spiritual illness.

1. Spirituality in its mystery

Spirituality is the dimension that differentiates us from animals, robots and plants or fruits. It makes us capable of asking ourselves about the meaning of life. It allows us to intuit good and evil unlike a robot. We are not determined by blind instinctive forces, like animals. We need others and education, unlike a fruit that requires only sun and time. And, also unlike a fruit, we can become unripe or immature again[5].

So we have three dimensions: physical, psychic and spiritual. It is not possible to understand the person if only one dimension is considered. It would be, in an example of Viktor Frankl, like wanting to distinguish an object from the shadow it casts on a single plane. A cylinder, a cone or an ovoid can appear identical, like a sphere[6].

The spirit is immaterial and cannot be directly observed or measured. It maintains the unity of the whole, penetrates or permeates the organic and the psychic. It is the center of the person, the seal and foundation of his dignity, which makes him unique and unrepeatable, the principle of self-knowledge and self-acceptance.

It does not have a place, it does not occupy a space, but to understand the spirit, it is necessary to reach the heart, the deepest part of our being and metaphor of the affective world. Like the center of a labyrinth. Pier Augusto Brescia was a heart surgeon at the Gemelli hospital in Rome. In the 1980s, he discovered that he was capable of painting and began to dedicate himself to it. When I met him, I liked a phrase of his: «I used to touch hearts with my hands, now I touch them with my works of art». A manifestation of spirituality is this heart capable of reacting or "letting itself be touched" by beauty, goodness and truth.

To reach the heart is to discover the «what is essential is invisible to the eye»[7], as Antoine de Saint-Exupéry wrote. Or the place where the person decides for or against God. We know that «the heart has its reasons that reason can't understand»[8], as Pascal said, but it is worth trying to understand them.

The spirit also shows itself in the mind. Joseph LeDoux is one of the leading researchers of the cerebral amygdala, known since the beginning of the 19th century. He has studied the cerebral amygdala system, with its interactions and capacity to store emotional memories[9]. This system can act independently of the rational cortex and "decide" if we like something or not, if we are in danger or not: for example, it triggers

[4] Cf. Byung-Chul Han, *The Burnout Society*, Stanford University Press, 2015.
[5] You can see the website www.psychologicalmaturity.com; and Wenceslao Vial, *Madurez psicológica y espiritual*, Palabra, 2019 (4ª).
[6] Cf. Viktor Frankl, *Der Wille zum Sinn. Ausgewählte Vorträge über Logotherapie*, Hans Huber, Berna 1982. Frankl calls this phenomenon «*dimensional ontology*».
[7] Antoine de Saint-Exupéry, *The little Prince,* Chapter XXI.
[8] Blaise Pascal, *Pensées*, n. 277.
[9] Cf. Joseph LeDoux, *The Emotional Brain: The Mysterious Underpinnings of Emotional Life*, Simon & Schuster, 1996.

the alarm before a viper, before the presence of the animal is noticed by the cortex and the person is aware of the danger.

But we are spiritual, that is free: this system is not blind. A famous phrase says: «Between a stimulus and the response there is a space. And in that space lies our freedom and the power to choose our response. In our response lies our growth and freedom»[10].

To mature spiritually is to enter into that "mysterious space" and guide the responses. Walter Mischel's experiment, known as the marshmallow test, shows some of this mystery. In the late 1960s and early 1970s, they studied preschoolers[11]. They were left alone with one marshmallow, promising them two if they waited for them to return. Some would eat the candy immediately, others would try a little bit..., or were able to wait for what was called delayed gratification.

They followed them until they finished school. It was found that those who had been able to wait as children were more socially competent, with better frustration and stress tolerance, more capable of challenges, projects and self-confidence, and were better students. The third part of the children, those who immediately ate the marshmallow seeking immediate gratification, had fewer of these qualities and a complex psychology. Lack of control was also the best predictor of delinquency and drug use in adulthood.

Twenty years later, Mónica Rodríguez, a disciple of Mischel's, did a similar experiment in Chile, filmed with a hidden camera. She left 5-6 year old kids with a chocolate cookie, offering them more if they waited. One of the children, Roberto, when Monica left, separated the two parts of the cookie and ate the white part quickly, putting them back together. When the test was screened, this child was praised and at a university in the United States they said he deserved a scholarship.

But I wanted to look at another child in the experiment. Agnes, 6 years old, was not only able to wait for Monica to arrive and get more cookies, but when these cookies arrived, she put them in a bag to take them to her mother. This gesture goes beyond something conditioned by expectation. It shows a capacity of spirituality: self-transcendence.

Animals are also capable of waiting, although it is more difficult. If a dog sees a sausage, it will probably eat it, dominated by its instinct; although it may learn that, if it pounces on the sausage, the master will beat it up, and so it holds back. What a dog will not do is take the sausage to a friend he loves. It will not do what Agnes did. He cannot offer his own reward to another, selflessly, out of love, out of service. He does not have the capacity for self-transcendence.

To affirm spirituality is to affirm intelligence and will, which leads us to know something and to want it. Denial, on the other hand, considers the human being obliged to act as he acts, because of the way he is made and the materials of which he is composed, just like a boomerang, which comes back to the one who throws it because of how it is constructed, in the classic example of John Watson, who started the behaviorism[12].

I summarize this point with a quote from Kierkegaard: «What is the spirit? It is the self. Man is a synthesis of the infinite and the finite, of temporal and eternal, of freedom and necessity»[13].

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[10] It has been attributed by some to Frankl, but I have not found it in Frankl's work.

[11] The experiment was first published in *Develomental Psychology* in 1990. See Walter Mischel, *The marshmallow test. Understanding self-control and how to master it*, Penguin Random House, 2015.

[12] Cf. *Behaviorism*, Transaction publishers, New Brunswick, New Jersey 2009, p. 86

[13] Sören Kierkegaard, *The Sickness unto Death: A Christian Psychological Exposition of Edification & Awakening by Anti-Climacus*, Penguin Classics, 1989. Our translation is from Spanish edition, *La enfermedad mortal*, Sarpe, Madrid 1984, p. 35.

2. Mental health in harmony

One of Brescia's works is called *The bay of innocence* and shows a human being in balance walking on a rope, helped by a bar with two counterweights, representing his spiritual and material dimensions.

There are two psychological currents: those who point out as a health goal the balance or homeostasis of emotions, reasoning and desires, which causes peace and tranquility. And those who place the goal in harmony, highlighting the importance of effort or tension to reach ideals; to love with sacrifice, to give oneself. Balance points to the self and harmony to others.

The exclusive search for balance looks to oneself and is closed in the psyche. This is why it has been called "*selfism*"[14]. Behind it are the ideas of Maslow, for whom man realizes himself in an increasing process of satisfaction of needs, from the most basic, such as food or sex, to the highest, such as love and contemplation. Maslow transforms St. Augustine's phrase, «Love and do what you will», into: «Be healthy and you could be driven by impulse»[15].

If the goal is harmony, on the other hand, one goes out of oneself in a movement of spiritual self-transcendence. This is Allport's line[16]. Harmony reminds us of what happens with a stringed instrument: each string has to have the right tension to hit the right note. Harmony makes us mature with and towards others, developing spiritual capacities.

At each stage of development, we see the relationship with others, the need to open up to a transcendent meaning. For Erikson[17], the child grows in hope and strengthens his will. The adolescent and the young person discovers who he is, his identity and his intimacy, he becomes capable of fidelity and love. The adult grows in capacity for self-giving, wisdom, integrity and acceptance. The key lies in two binomials: identity/intimacy; fidelity/love.

Another sign of harmony is the capacity to convert instincts into tendencies: Advertising often points to the instincts in order to sell products, it mentions the need to «liberate instincts». But a healthy liberation would be to transform and guide them.

It is about moving from vice to virtue. To act according to the reality of our being, and to grow in freedom, as Aristotle explained. Vice puts evil in front of us, leads to lies and slavery. Virtue shows the good, the truth and makes free, which favors health.

For full harmony it is necessary to find the meaning of life. The human being is not only driven by instincts, impulses or the past. We have the capacity to look to the future and be attracted by something outside of us: meaning and values. Our main motivational force is not the will to pleasure or the will to power, but the will to meaning.

By this path there is a Copernican revolution in the inner world and of psychological aspirations. «Did not really matter what we expected from life, but rather what life expected from us»[18], Frankl wrote. This search for meaning is the first step of religiosity as manifestation of spirituality: the desire to find an Absolute, God, and to deal with Him.

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[14] Cf. Paul Viz, *Psychology as Religion: The Cult of Self-Worship*, Paternoster P., 1994.
[15] Abraham Maslow, *Motivation and personality*, Harpers, 1954. Our translation is from Spanish edition, Motivación y personalidad, Días de Santos, 1991, p. 76.
[16] Cf. Gordon W. Allport, *Pattern and Growth in Personality*, Holt, Rinehart and Winston, 1965.
[17] Cf. Erik Erikson, *The life Cycle Completed: A review,* W W Norton & Co, 1985.
[18] Viktor E. Frankl, *Man's Search for Meaning,* Beacon Press, 1992, p. 85.

3. The doctor before the person

Medical science is not only technical, and let's hope that it will not be completely replaced by robots. Karl Yaspers said that technique and medical specialization cannot forget suffering, death, guilt, struggle, the life of the spirit. Only the lack of seriousness of modern man, who is carried away by comfort and lack of faith, can give rise to a «confusion between doctor and pastor of souls»[19].

A health professional encounters people who suffer and wonder about the meaning of their pain, have shame, guilt, or have a hard time, or have to face death. And they always need hope. The physician who includes these concerns in his or her agenda humanizes medicine.

In the doctor-patient relationship we find two binomials. On the one hand, the need to objectify the patient: in order to cure him, he must be treated in a certain sense as an object. This is what the surgeon does when he isolates the operative field with drapes. This must go hand in hand with compassion, suffering with the other, sharing his pain, in moderation, so that this emotion does not impede the perhaps painful but necessary act. The second binomial is that of realism, to face the diagnosis and prognosis, and hope in making it known. Objectification-compassion and realism-hope are related.

The physician encounters unique and unrepeatable people, with a given temperament, which is worth knowing. There are tests that allow us to approach the initial way of being, to see it as a gift, discovering the defects and skills and virtues to be developed[20].

To know what is a healthy personality is a great challenge of mental health. It involves getting to those phenomena of war and peace, the personality disorders, from which many illnesses arise. At the bottom are often found somehow spiritual difficulties: egocentrism and existential emptiness.

Tolstoy, in *War and Peace*, describes Pierre's situation after separating from his wife and having fought a duel: «It was as if the main screw in his head, which held his whole life together, had become stripped»[21].

That screw is the meaning of life, and it is possible to lose it or not find it with a disordered life. Existential emptiness is frequent, the apparent happiness of a faceless person, with a damaged personality. Frankl called this *the pathology of the spirit of our time*[22], with its activism, massification and loneliness. And, as a consequence, a lack of identity.

We could talk about many diseases related to the spiritual substratum, or to the relationship between morality and health. I mention only one example: addictions, which try to fill the void with substances or behaviors. Some scientists say that they are not diseases, but a choice, because there are addicts who can say: no more alcohol, or no more gambling and stop being addicted, which is impossible in other diseases. The most common opinion is that the disease and the choice are related, as in many other pathologies. This is also why the physician must consider spiritual aspects in his patients.

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[19] Cf. Karl Jaspers, *Wahrheit und Bewährung. Philosophieren für die Praxis*, R. Piper & Co. Verlag 1983 (article from 1947 to 1964). Our translation is from the Italian version *Verità e verifica. Filosofare per la prassi*, Morcelliana, 1986, p. 89.

[20] Cf. Temperament Test: Russian: https://www.psychologicalmaturity.com/p/temperament-test-in-russian-alex-havard.html; English: https://www.psychologicalmaturity.com/2020/12/temperament-test-knowing-yourself.html.

[21] Leo Tolstoy, *War and Peace*, Oxford University Press, 1998, vol. II, part two, 1.

[22] Cf. Viktor Frankl, *Homo Patiens: versuch einer Pathodizee,* Franz Deuticke, 1950.

Conclusions

I will conclude with another phrase from Kierkegaard that reflects the importance of spirituality and its openness: «The door to happiness does not open inward. It opens toward the outside»[23]. Spiritual phenomena, including transcendence and religiosity, influence life, health and illness. That is why they must be considered in mental health.

Including spirituality is a challenge that we can summarize in a positive attitude, enjoying goodness, beauty and truth. This produces good feelings, which are related to acting well and thinking well, giving rise to positive and healthy affections, a healthy mind and a healthy heart[24].

Searching for the meaning of life is a deep need of the soul. It is well manifested by these verses of Neruda, with which I will end: «The world is a crystal sphere / man is lost if he does not fly: / he cannot understand transparency / That is why I profess / the clarity that never stopped / and I learned from the birds / the thirsty hope, / the certainty and truth of flight»[25].

[23] Sören Kierkegaard, *Enten — Eller* (original in Danish, 1843); Our translation is from French edition, *Ou bien... Ou bien...,* Gallimard, 1984, p. 21.

[24] For a deeper look at the personality, see: Wenceslao Vial (edited by), *Be who you are. Developing your Christian personality*, Scepter, New York 2018

[25] Pablo Neruda, *El vuelo*, en *Arte de pájaros*, Editorial Sudamericana, Buenos Aires 2004, pp. 50-52. The translation is ours.

Archpriest Alexiy Baburin

Faith as a requirement of a highly developed mind

Abstract: different types of the phenomenon of faith are compared in their correlation with reason. It is concluded that genuine spiritual care is impossible without a strong developed faith, and it is faith that creates support and protection for the human psyche in life's trials.

Keywords: faith, unbelief, reason, unreason, knowledge, soul, counseling, mental health.

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Pastoral care means care for the soul. So it is assumed that we recognize the existence of a soul in man. Can we define the soul? It is no easy matter. Of course, we know what it means that "the soul rejoices", "the soul has gone to the heels", who is a "big-hearted person". Even before any definition, we intuitively understand what a soul is, but we cannot explain our understanding in any way. We simply believe in the existence of the soul without sufficient evidence, we have learned this concept from early childhood, mastering the spoken language. This is faith from hearing. It can be called a simple, naive, irrational belief (δοαασσα).You can live with such faith, but you will not be able to practice soul healing professionally.

So what kind of faith should there be, so that the care for the soul of a neighbor would bring him gracious help?

This is a faith that has no doubt about what it believes in. Such faith is "the contemplation of the implicit, and it leads to the complete conviction in the invisible as in the visible," wrote St John Chrysostom in his comments to the Epistle of the Apostle Paul to the Hebrews (Heb. 11:1) [1].

According to John Locke, “Faith is nothing but a firm Assent of the Mind” and “cannot be afforded to anything but upon good Reason; and so cannot be opposite to it "[2]. Faith is “a lively idea related to or associated with a present impression”; "it is something felt by the mind which distinguishes the ideas of the judgment from the fictions of the imagination. It gives them more force and influence; makes them appear of greater importance; infixes them in the mind; and renders them the governing principles of all our actions," sais David Hume [3].

This is already rational faith (πσστη).

On the other hand, it can be divided into scientific and religious faith. Scientific faith is a source of science. For example, we certainly believe in the objective existence of the external world itself. According to A. Einstein, "the belief in an external world independent of the perceiving subject is the basis of all natural science" [4]. We firmly believe that universal laws of nature inexorably operate in the universe. According to N. Wiener, "Without faith that nature is subject of law, there can be no science.” [5] And the very possibility of our mind to perceive the world is based on faith. A.Einstein stated too: “The basis of all scientific work is the conviction that the world is an ordered and comprehensive entity, which is a religious sentiment. My religious feeling is a humble amazement at the order revealed in the small patch of reality to which our feeble intelligence is equal” [6]. Michael Polaniy, a prominent specialist in the field of physical chemistry, an honorary doctor of many universities around the world, the author of the "tacit knowledge" concept and "personal knowledge" theory argues that there is a hidden dimension at all stages of scientific research and says directly: “We must now recognize belief once more as the source of all knowledge” [7].

According to the teachings of St. Cyril of Jerusalem, there are two kinds of religious faith. **“For there is one kind of faith, the dogmatic, involving an assent of**

the soul on some particular point: and it is profitable to the soul, as the Lord says: *He that hears My words, and believes Him that sent Me, has everlasting life, and comes not into judgment* (John 5:24) and again: *He that believes in the Son is not judged, but has passed from death unto life* (John 3:18, 36). Oh the great loving-kindness of God! For the righteous were many years in pleasing Him: but what they succeeded in gaining by many years of well-pleasing , this Jesus now bestows on you in a single hour. For if you shall believe that Jesus Christ is Lord, and that God raised Him from the dead, you shall be saved, and shall be transported into Paradise by Him who brought in there the robber. And doubt not whether it is possible; for He who on this sacred Golgotha saved the robber after one single hour of belief, the same shall save you also on your believing" [St Cyril of Jerusalem, Catechetical Lecture 5, 10].

Here we can recall Tertullian's treatise"On the flesh of Christ", where he writes: "The Son of God was crucified: I am not ashamed — because it is shameful. The Son of God died: it is immediately credible — because it is silly. He was buried, and rose again: it is certain — because it is impossible"[8].

In other words, Christian doctrine is based on faith in the mysterious revelation of the theanthropic Person of Jesus Christ. It would be appropriate to recall here the words of Johann Caspar Lavater, the famous Swiss pastor, theologian and writer, who corresponded with Empress Maria Feodorovna, wife of Russian Emperor Paul I, historian N.M. Karamzin, a friend of the writer and philosopher I.F. Goethe. Shortly before his death, from Erlenbach, on August 6, 1800, he wrote on a postcard intended for Philippe Bief from Strasbourg: «Zahllos und schrecklich sind die Zweifel des denkenden Christen; Aber sie alle besiegt die Unerfindbarkeit Christi». ("Countless and terrible are the doubts of the thinking Christian; but they are all defeated by the impossibility of inventing Christ»)[9]. Such a belief stems from the trust inherent in the Biblical Forefathers.

But there is a second kind of faith, which is bestowed by Christ as a gift of grace.

"For to one is given through the Spirit the word of wisdom, and to another the word of knowledge according to the same Spirit: to another faith, by the same Spirit" (1 Corinthians 12:8-9)… For, when enlightened by faith, the soul has visions of God, and as far as is possible beholds God, and ranges round the bounds of the universe, and before the end of this world already beholds the Judgment, and the payment of the promised rewards. Have thou therefore that faith in Him which comes from your own self, that you may also receive from Him that faith which works things above man" [10].

St. Augustine, Bishop of Hipponia, says: "According to the teaching of the Orthodox Church, the Christian mind must first feed on simple faith so that it can comprehend the heavenly and eternal. After all, this is what the prophet says: If you do not believe, you will not understand (Isaiah 7:9)" [11].

According to Martin Buber, the phenomenon of faith is an attitude of trust in someone or recognition of the truth of something without sufficient reason. "Reasons of course can be urged for it," writes M. Buber in his widely known work "Two Images of Faith", " but they are never sufficient to account for my faith. The 'Why ?' is here always subsequent, even when it already appears in the early stages of the process; it appears, that is to say, with the signs of having been added. This does not at all mean that it Is a matter of 'irrational phenomena'. My rationality, my rational power of thought, is merely a part, a particular function of my nature; when however I 'believe', in either sense, my entire being is engaged, the totality of my nature enters into the process, indeed this becomes possible only because the relationship of faith is a relationship of my entire being" [12].

A prominent Russian religious scholar, philosopher, doctor of philosophy, professor Daniil Pivovarov considers faith to be a special spiritual knowledge, the attraction of the soul to the ultimate foundations of being, a mystical stay in them, a direct vision of transcendental essences and (or) substantial connections. He considers faith to be the true beginning of human knowledge, a direct source of knowledge about the world as a whole and large spheres of being. Moreover, with the help of this type of faith, a person realizes what remains beyond understanding [13].

Alexander G. Spirkin, Ph.D., psychologist, corresponding member of the Russian Academy of Sciences (since 1974) considers religious faith as "an intrinsic human connection with the essential Truth (‘religare’ — lat.), which constitutes one's own Self; when this connection with absolute being is destroyed, the Self perishes" [14].

"Although spiritual and religious experience is subjective, this experience cannot and should not be based on the denial of rational," Ivan Ilyin notes in the “Axioms of Religious Experience”, and further explains— "a religious person cannot put up with the fact that he believes in something rejected by his mind; or with the fact that his mind asserts something against which his faith revolts. If he reconciles himself to this, then his faith will be weak and his thought shy; his faith will be under the censorship of a legitimately rebellious mind, and his mind will be under the anathema of a legitimately rejecting faith; he himself will be an eternal traitor and betryer: now a traitor to his faith, then a betrayer to his mind. And therefore he will either condemn himself for his faith, or suppress his rational views in himself. He will not trust either his reason or his faith; and he will end up not trusting himself and will lose respect for himself. . . What needs to be achieved is not just a "reconciliation" of faith and reason or a synthesis of their teachings, but the oneness of faith and reason. Faith must become reasonable, and reason must become believing" [15].

The great Russian writer F. M. Dostoevsky acquired such a faith. In his last Notebook, in rough sketches for the “Diary of a Writer” for 1881, formulating objections to K.D. Kavelin, who criticized his “Pushkin Speech”, F.M. Dostoevsky wrote: “...“... I believe in Christ and I confess him like a boy, but my hosanna passed through a great crucible of doubts...” [16].

Alexey Losev, another Russian philosopher and a secret monk Andronik, sometimes shared his innermost thoughts with people close to him. His secretary and assistant Vladimir Bibikhin, translator, philologist and philosopher, and I, being Alexey Losev’s masseur, independently of each other and in different years, recorded conversations with him.

It would be appropriate to quote here some of of A.Losev's statements concerning the issue of faith under discussion.

From V. Bibikhin’s notes.

"I will open up to you, I am a religious person from an early age, and my faith rests solely on the mind. But the soul squeaks all the time, resists. Therefore, I do not understand when people say that they believe with their hearts, but the mind objects. How can it object? Even the simple Kant, who is not very deep in religion — such a small Protestant — defined: God is the unity of universal history! God is the principle of the fate of universal history! What can the mind object to? Only the soul objects. But when it squeaks — nothing to eat, kicked out of work, the ceiling collapsed — when the soul is bulging, then in my opinion this is the most insignificant reasoning, "which cannot be taken into account, which is not worth wasting time on" [17].

"Faith begins from the moment when you know that God is good, that He is absolute love, and yet the world lies in evil. And unless you accept it, you are an

nonbeliever. At the very least, a seeker. However, the search is an indefinite thing. You can keep on searching, but find tosh" [18].

"The faith begins when you realize that almighty God exists, but He has been crucified. God was crucified! When you try to understand it, you see that there is a mystery here. An incomprehensible and unexpressible mystery! And the believer is the one who has seen this mystery" [19].

"There is an undefeatable thing — faith, as deep and irresistible as thought. In faith too there are truths like 2x2 = 4 that cannot be changed" [20].

From my notes.

To my question: "How are you, Alexey Fedorovich?", I hear in response: "My soul is so-so, my mind is bestens".

"I live only by reason. Reason is above all logic, it does not recognize the whims of the soul, the reasoning of the mind. The mind sees directly, it contemplates. The mind asks: is the existence of God compatible with the incalculable suffering of people? The mind answers: be silent, you silly, perishable soul, God exists!" [21].

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"What is faith?" — I asked.

A.F.: "Faith is the affirmation of a fact as a fact, without any conclusions about it."

"Everyone knows what God is, what the soul is; even if someone tries to deny his faith, he is deceiving himselves and others or just pretending. One can only argue here about the definitions of God and the soul. As this is already the science of fact. Blind faith is pre-understanding. Faith and reason can be set against each other in a structure, but not in the cognition of an object. We comprehend the subject with the help of faith, logic and reason. Faith itself does not need any logic or any evidence, although there may be proofs of the subject of faith, for example, of the existence of God. God appears to us also in the mind. Hegel has such an argument. He calls God an absolute Idea. This concept in Hegel is a highly integrated reality, being. In this sense, Hegel is a pantheist" [22].

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I quote to Alexey Fedorovich the Nativity of Christ troparion and kontakion. “In this Christmas time they sing in the Church: “Your birth, O Christ our God, Has shed upon the world the light of knowledge…” and “…“on us, who recognising You, now with knowledge sing outyor prise”. What kind of knowledge are we talking about?

"Knowledge here should be understood as mind (nus), but not reason. Unlike the reason, the mind is endowed with creativity." "Reason is based or rooted in obvious, sensuous facts. The mind is based on the facts of faith. It has its own arguments, its own intuition". "Orthodoxy recognizes not only the mind, but also mindlessness — that which is above the mind. It teaches that both are one" [23].

"Faith in the theanthropic personality of Christ is a requirement of a highly developed mind". "But trust is higher than faith. Belief in God is a theory. Trusting God is practice. It is much harder to trust than to believe. We must completely rely on the will of God, despite the most unbearable conditions of existence".

"Liturgical theology is the best school for Christians," [24] concludes Monk Andronik.

From all that has been said, it follows that genuine pastoral counseling is impossible without a strong developed faith.

"If any of you is sick, let him call the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord," advises Apostle James (5:14) [25].

The evangelist Matthew tells how a man approached Jesus Christ and, "kneeling down to Him and saying, “Lord, have mercy on my son, for he is an epileptic and suffers severely; for he often falls into the fire and often into the water. So I brought him to Your disciples, but they could not cure him.”" (Matthew 17:14-16) [26]. Jesus frees the boy from this posession, and explains to his disciples their powerlessness in the face of a serious illness of a suffering person by their unbelief. The apostle and evangelist Mark describes in detail the dialogue between Christ and father of the raging boy, and testifies to the need for genuine, pure, living faith in the Omnipotence of God and trust in Him. The father said, “But if you can do anything, take pity on us and help us.” “‘If you can’?” said Jesus. “Everything is possible for one who believes.” Immediately the boy’s father exclaimed, “I do believe; help me overcome my unbelief!”? [27] (Mk 9:21-24). "With God, in His realm, in His nearness and fellowship, there exists a universal possibility, that therefore all things otherwise impossible become and are possible here" [28].

"Faith in God and observance of religious prescriptions generates an incomparable positive effect in human organism, which is not found under any other stimulating factors" [29]. "No other faith, except faith in God, gives such peace and harmony to the mind and heart of man" [30]. This is a statement of a cardiologist, founder and honorary director of the Benson-Henry Institute of Massachusetts General Hospital in Boston, trustee of the American Institute of Stress, Professor Herbert Benson of Harvard Medical School, studying the influence of faith on human health.

Why the faith? — asks the researcher of the psychology of faith, Professor Rada Granovskaya. She makes the following statement: "Faith in a supreme being is a sense-forming landmark, scale, it allows everyone to organize and adjust his model of the world and implement humane and life-loving principles of interaction with people and nature" [31].

And further: "What does a believer gain? As you know, belonging to a certain faith gives a person norms and traditions, rituals and accepted patterns of behavior within its framework. If a person follows them, then he significantly reduces the likelihood of conflict with others. To the extent that a person owns the deep symbols of faith, he has support in the most dangerous and disturbing moments of his life. Faith creates massive protection for his psyche, allowing him to withstand trials without destroying his personality. Besides, the system of concepts of this religion offers a person a set of ideals, following which he can not only understand the meaning of his existence, but also direct his life to a great goal” [32].

Russian religious philosopher, Doctor of Philosophy, the first elected rector of Moscow University, Prince Sergei Trubetskoy writes: "Man was often defined as a bipedal animal, a rational and verbal animal, a political animal. You can also define him as a believing animal. A person believes in a certain purpose of the world and the purpose of existence, in an unconditional aim, the ideal of his being. And when such faith is taken away from him, his existence seems to him meaningless, purposeless, accidental and superfluous” [33].

"Faith is an important element of value based consciousness. Man, being a spiritual being, manifests his identity in setting goals. The level of his spirituality can largely be judged by his ultimate goal, the highest one in his hierarchy of goals. It reveals the meaning of individual being. Of course, there are people who do not think about the ultimate goal of their life. But such a being is usually called animal or vegetative. Setting and accepting the ultimate goal of human existence is always an act of faith" [34].

The question arises: how is faith realized?

Archpriest Ilya Gumilevsky in his master's thesis "The Teaching of St. Apostle Paul about the natural and spiritual man" shows the deep connection of faith with the will through active love. Here is what he writes about it.

"Faith acts, shows energy, is the inspiration of the will not by itself, not by its essence, as contemplation: the reason for its activity lays in love, it acts with love or, otherwise, love acts in faith, love manifests its essence in faith, as an irresistible attraction of the heart to its Prototype. Faith is enlivened through the fact that it loves contemplated objects, by the power of which it moves the will to the respective activity" [35].

One way to express this faith is prayer. Prayer is the very soul and essence of religion. It saturates the soul with "psalms, chants, and spiritual songs", causes moral ecstasy, religious delight, leaving no room for anxiety, fear, despondency. Spiritual ecstasy "gives strength, makes you cheerful and strong... does not distort thoughts, but excites spiritual thoughts" [36].

The above mentioned Dr. Herbert Benson devoted 35 years of his life to finding a scientifically based answer to the question: does prayer have a therapeutic effect?

In an interview for the website pyles.tv he confirmed that there is a direct relationship between prayer and healing. In particular, he said: "We examined people who intently repeated the words of prayer many times. The magnetic resonance imaging showed thereby a decrease in metabolism, heart rate, blood pressure, respiratory rate and brain activity. Thus, we have received scientific evidence that such prayer affects functions of the body and coping with stress" [37].

Citing many statements of prominent scientists and thinkers, I want to show how important it is to understand the value of strong rational faith, active love, prayer to God by those who have devoted themselves to the care of souls suffering from various bodily and mental diseases.

The councelor, be it a priest, a psychologist, a doctor, may in his practice encounter such phenomena as hypnosis, "placebo" and "nocebo", "hand-wringing", religious and mystical delirium, belief in magic, jinx, the evil eye, adherence to alternative medicine methods (osteopathy, homeopathy, naturopathy, acupuncture, Ayurveda, energy therapy, etc.), to the detriment of allopathy. Faith is behind all of the above. Is it permissible? Is it useful? Won't it hurt?

To answer these questions, one has to learn how to differentiate genuine religious and scientific faith from pseudo-religious and irrational faith, healthy faith from toxic, quasi-faith from existential, mystical faith from fanatical.

The main thing is not to be among the strange people, gentlemen of all ranks, about whom N.V. Gogol sarcastically remarked in the poem “Dead Souls”: “What a strange creature man is! He does not believe in God, but he does believe that if the bridge of is nose itches he is surely going to die” [38].

"By faith we understand!"

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Martín F. Echavarría

Mental illness according to Thomas Aquinas

In this article I will explain the ideas of Thomas Aquinas on mental illness. Although he is an author of the 13th century, and a theologian and philosopher, not a physician, I think he has some ideas about mental illness that are still worthy of consideration today. Aquinas applies the expression disease in an analogous way to three disorders of the soul, namely: mental illness with a bodily cause, moral disorder, and a specific disorder of the sensitive part of the soul.

1. Bodily mental illness

In Aquinas' philosophy of nature, the concept of illness is precisely delimited. According to Aquinas, illness is an indisposition of the organic body, which places it outside the natural order, as opposed to health, which is a good disposition of the body whereby its various components are in harmony. This indisposition is the consequence of the action of a pathogenic agent that produces a passion in the body, which drags it out of its natural disposition, and makes the body unable to produce its vital functions normally (Echavarría, 2008). When this bad disposition affects the organs of mental life, we find what today we would call a "mental illness".

The pathogenic agent that produces the indisposition that leads to illness can be a physical agent. Thus, Aquinas often speaks of dysfunctions of the faculties of the soul (such as imagination or memory) due to a lesion of the area of the brain in which these faculties are placed. But a mental agent can also cause illness, since, according to Aquinas, the passions of the soul (what today we would call "emotions") are not a purely spiritual reality, but a psychosomatic one (Echavarría, 2018, 2019; Lobato 1994). Therefore, for Aquinas, the extreme passions, especially the negative ones, such as sadness, fear or despair, can produce a true illness. Thus, even bodily mental illnesses can have a mental cause.

These are the natural causes of illness. Certainly, Aquinas states, following the Holy Scriptures, that illness can be caused by demonic influence. But, even when this happens, it is because the demon influences the organism, disturbing its functioning (Echavarría, 2005).

Aquinas does not make a detailed exposition of each mental illness, nor of its physical causes, nor of its medical treatment, although, in his allusions to these subjects, one can perceive the influence of Avicenna's Canon of Medicine, of Nemesius of Emesa and of the medical school of Salerno (Izquierdo Labeaga, 2002). To refer to mental illnesses, Aquinas uses, in a not too technical way, words such as melancholy, mania, fury, epilepsy, etc. (Echavarría, 2009).

2. Moral vices as diseases of the soul

By analogy, Aquinas sometimes calls moral disorders diseases or illnesses. First of all, for Aquinas, grace is a disposition infused by God into the soul, which is often called its spiritual health. On the contrary, original sin has left the soul deprived of that spiritual health, and can also be called a spiritual sickness or illness. Similarly, moral vices, that is, dispositions that are opposed to virtue, are often called diseases (morbus). These illnesses are cured by the medicine of the sacraments and by the exercise of the virtues (Echavarría, 2005a).

The virtue of temperance (*temperantia*, in Latin, *sophrosyne*, in Greek) has a special place in the health of the mind. Aquinas explains that the Greek word *sophrosyne* means mental health, and explains that, on the contrary, intemperance is a disease of the mind, by disturbing the right use of reason (Commentary on the Nichomachean Ethics, Book VI, lecture 4):

“Hence we call temperance by the name sophrosyne, as it were, a thing preserving prudence. Prudence does preserve an estimation of the kind mentioned, for while pleasure and pain do not distort or pervert all judgments (for example, that a triangle has or has not three angles equal to two right angles), they do affect those dealing with the practicable. The principles of practicable things are the ends for which they are done. But the principle is not clear to a man corrupted by pleasure or pain, nor does he see the obligation to choose and do everything for the sake of it and on account of it, for vice is corruptive of principle” (Aquinas, 1964).

Besides, following Aristotle, Aquinas puts some intermediate situations between the total health of temperance, and the deadly disease of intemperance. This is the situation of the continent and the incontinent men. Both suffer from an inner division between reason and emotions, due to the disorder of their passions. But the continent, applying his or her willpower, succeeds in resisting the passions, while the incontinent person succumbs to them, out of weakness. The word Aquinas uses for "weakness" of the soul is "infirmitas," which is a Latin word that also means illness or sickness, as Aquinas himself points out. We could cite, for example, the following text (De malo, q. 3 a. 9 co.):

"When any affection is not moderated according to the rule of reason, but falls into excess or defect, it is called an infirmity [infirmitas] of the soul. And this happens especially in the affections of the sensitive appetite, which are called passions, such as fear, anger, desire, etc.; hence the ancients called these kinds of passions diseases of the soul [aegritudines animae], as Augustine says in the book The City of God. It is said that man does out of weakness [infirmitas] what he does out of some passion, as out of anger, fear, desire, and the like."

Aquinas compares the incontinent to the sick person. The incontinent person is sick in his soul, because his parts are in a state of anarchy, and do not respond to the command of the faculty that naturally directs, reason, but, even though he knows what it is good for him to do, he is prevented from acting in that way at the moment when he is assaulted by the passion that dominates him (Echavarría, 2005b). Aquinas, commenting on St. Paul, says: "The sickness of man is manifested because he does what he understands that he should not do" (Super ad Romanos, c.VII, l.3, n.15).

3. The "animal (or psychological) sickness" (*aegritudo animalis*)

There is a third situation, distinct from bodily mental illness and moral disorder, which Aquinas describe and which, in my opinion, it is an original contribution of him, and which I have not found in other medieval authors. It is what Aquinas, commenting on Book VII of Aristotle's Nicomachean Ethics, calls "aegritudo animalis". It is a special kind of disorder, the specificity of which has not been extensively noticed.

In the Book VII of the Nicomachean Ethics, in dealing with the forms of incontinence by analogy, the Stagirite speaks of some vices which, by excess, go beyond the genus of human moral vices. These are the so-called vices *contra natura*. These disorders would occur in all kinds of vices, as extreme and unnatural versions of that vices. Thus, there would be intemperance against nature (paraphilias), cruelty against nature (sadism), fear against nature (phobias), gluttony against nature (bulimia), etc. While moral vices are affective disorders against the rule of right reason, these disorders are contrary, not only to right reason, but to the natural disposition of the sensitive appetite of the human species. Quoting John Damascenus, Aquinas emphasizes that all vices are against nature, but that human moral vices are contrary to man's specific difference, which is his rationality, while vices against nature are also opposed to the natural inclination of genus to which man belongs: “animal” (Super ad Romanos, c. 1, n. 149).

According to Aquinas, following Aristotle, these disorders of the animality of man are sometimes based on a bad organic constitution, sometimes on an organic illnes, and sometimes are caused by unnatural costumes that have affected the development of character, especially during childhood. Aquinas calls the sensitive appetite disorder that has a mental or behavioral cause "animal sickness" (*aegritudo animalis*). I quote Aquinas (Super Ethicorum, book 5, l. 5, 1374):

"Last, at 'Others become,' he offers examples of things contrary to nature that become delightful by reason of habit. Some enjoy unnatural pleasures because of mental unbalance or habitual perversion. For example, certain men out of habit take pleasure in pulling out their hair, biting their nails, eating coal and earth, and having sexual intercourse with males. All the preceding can be reduced to two classes. Some people do them because of the tendency of bodily temperament that they had from the beginning; others because of habit, becoming accustomed to things of this kind from childhood. Such people are like individuals who fall into this condition by reason of physical sickness, for evil habit [*prava consuetudo*] is a kind of psychological sickness [*aegritudo animalis*]." (Aquinas, 1964).

A perverse habit (*prava consuetudo*) is the disposition produced by a behavior contrary to nature. This "habit" can be called in a certain way an "animal disease" or "psychological sickness". We are here at a delicate boundary between moral vice and disease. These dispositions are contracted by habits, but they resemble a disease.

Following Aristotle, Aquinas points out the following three causes of unnatural tendencies with a behavioral cause: the lack of good laws, which favors perverse habits; affective shocks or trauma, especially in childhood; and progress in malice, which can lead to limits of enormous unnaturalness (Aquinas, 1964).

These disorders against nature, says Aquinas, could occure in all genus of vices (Super Ethicorum, Book VII, 1379):

"On the first point we must consider that such an excess of vice can concern vices opposed to all virtues, for example, folly opposed to prudence, timidity opposed to fortitude, intemperance opposed to temperance, and harshness opposed to gentleness; and it can concern each one of the vices, for some of them are brutish habits arising from a malignant nature, others are diseased habits arising from physical or psychological sickness, i.e., a bad habit." (Aquinas, 1964).

Among these disorders are counted, for example, paraphilias. St. Thomas deals with this subject by dividing lust into two genus: human lust and unnatural lust. The first consists of sexual intercourse outside of marriage. These are the disorders included in this category (Summa Theologiae, II-II, q. 154, a. 11):

"In one way, if without any kind of union, because of venereal pleasure, one procures pollution: which corresponds to the sin of impurity, which some call blandness. In another way, if it is done by union with a thing that is not of the same species: which is called bestiality. In a third way, if it is done by union with the unbecoming sex, as of a male with a male, or of a woman with a woman, as the Apostle says in Rom. 1; which is called sodomitic vice. Fourth, if the natural mode of union is not respected: either because unbecoming instruments are used; or by other monstrous and bestial modes of union" (Aquinas, 1947).

Also, as was pointed out, there can be a pathological disposition of aggressiveness, which corresponds to what today we would call psychopathy or sadism. In dealing with the vice of cruelty, opposed to the virtue of clemency, St. Thomas explains the difference of this sadism from wrath and cruelty in this way (Summa Theologiae, II-II, q. 157, a. 1, ad 3):

"The vice of anger, which denotes excess in the passion of anger, is properly opposed to meekness, which is directly concerned with the passion of anger; while cruelty denotes excess in punishing. Wherefore Seneca says (De Clementia ii, 4) that

‘those are called cruel who have reason for punishing, but lack moderation in punishing.’ Those who delight in a man's punishment for its own sake may be called savage or brutal, as though lacking the human feeling that leads one man to love another” (Aquinas, 1947).

The sadist feels pleasure in making his neighbor suffer, which is contrary to the natural tendency according to which every man is a friend of every man.

St. Thomas explicitly places this vice among the bestial or pathological ones (Summa Theologiae, II-II, q. 159, a.2 co.):

"’Savagery’ and ‘brutality’ take their names from a likeness to wild beasts which are also described as savage. For animals of this kind attack man that they may feed on his body, and not for some motive of justice the consideration of which belongs to reason alone. Wherefore, properly speaking, brutality or savagery applies to those who in inflicting punishment have not in view a default of the person punished, but merely the pleasure they derive from a man's torture. Consequently it is evident that it is comprised under bestiality: for such like pleasure is not human but bestial, and resulting as it does either from evil custom, or from a corrupt nature, as do other bestial emotions. On the other hand, cruelty not only regards the default of the person punished, but exceeds in the mode of punishing: wherefore cruelty differs from savagery or brutality, as human wickedness differs from bestiality, as stated in Ethic. VII, 5. (Aquinas, 1947).

A similar disorder can also be found in fear. It corresponds to the current "phobias": "He does this at ‘Someone’, saying that temperament may be so timid as to make some afraid of anything, even the squeak of a mouse. This is the timidity of a dumb animal. One man became so fearful from a pathological condition that he was afraid of a ferret. "

We see then, that the Angelic Doctor explicitly mentions: unnatural lust; pathological cruelty, which seems to correspond to sadism; some forms of eating behavior disorders; phobias.

Conclusion

We see that Aquinas has some considerations that can be inspiring for those who research and work in the field of mental health. His conception of mental illness is broad and nuanced: we have mental disorders that are diseases in the strict sense, that is to say, imbalances of the organism that alter the functioning of the mind. On the other hand, we have moral disorders that undo the harmony of human life according to nature, the moral vices, which are like moral and spiritual diseases. Finally, we have those disorders of the sensitive mental life, caused by behavior, which are a psychological sickness (aegritudo animalis), whereby the imaginative and emotional life of man deviates from its natural disposition. I think that many neurotic, personality and behavioral disorders could come under the heading of the aegritudo animalis. These three categories should not be seen as closed compartments, but as realities that are mutually related in concrete people. Bodily illnesses sometimes condition moral freedom, and, in turn, mismanagement of the passions of the soul can make us sick. Between aegritudo animalis and moral disorder there can often be a close relationship. For this reason, a person-centered perspective from an ultimate transcendent and spiritual point of view is necessary to understand how, in each one, they are interrelated in a unique way. This is a perspective favored by the thought of Aquinas, who maintains that the person is the most individual being of all (Summa Theologiae, I, q. 29, a. 1).

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Priest José M. Vegas

Fatherhood and its role in mature interpersonal relationships and in the formation of religious consciousness

A correct understanding of faith in God the Father (in God of Christian revelation) in no way entails (as they sometimes think) a state of total and permanent dependence on God in human and psychological sense. On the contrary, if God is the Father, this means, as human experience itself shows, that dependence is temporary and relative until a person reaches full independence. Analysis of the various levels of human relationships can help to understand the right conditions for healthy relationships in their various forms, not only between people (between parents and children, in functional and strictly interpersonal relationships), but also in the field of religious experience. After all, a relationship with God is not a kind of connection between a human subject and some incomprehensible "object", but it is a kind of interpersonal relation where freedom, independence, openness and responsibility on the part of a person are mandatory conditions. Hence it becomes clear that human independence is not identical with self-sufficiency.

Keywords: fatherhood, relationship, dialog, faith-confidence, love, hope, independence, God the Father.

It is a gross mistake of so-called "scientific atheism" to equate knowledge and attitude towards God with the kind of subject-object relationship (I-it) that is inherent in scientific research. God would be an object of which we have no empirical experience, and therefore a non-existent object; and the knowledge we have about God, faith, would be reduced to pseudo-knowledge. Here we want to show that the realm of relationships concerning knowledge and relationship with God is the realm of interpersonal relationships in which faith plays an indispensable and central role.

On the other hand, a common prejudice against religion, and in particular the Christian religion, is the idea that faith in God the Father implies a constant childish dependence that prevents true human maturity. Based on the concept of faith that we are going to present, we want to show that, on the contrary, it is faith in God, who is considered the Father (revealed to us in Jesus Christ), that favors and makes possible true human maturity, as well as the establishment of mature, balanced and responsible interpersonal relations. [1]

1. The main forms of relationships with other people

In contrast to liberal individualism, which treats human relations as something secondary and contingent (and reduces the "other" to a theoretical problem), and in the face of various forms of collectivism, which dissolves the individual in a network of social relations and reduces him to a simple, completely social function, the personalistic position affirms both the individual himself (inalienable, irreducible) and his relationship. At the same time, the "other person" ("others" in general) is not something secondary or accidental, nor is it the result of the conclusion of one's own self-consciousness. On the contrary, a human being is initially aware of the other - "you", and only from him reveals his "I". However, this primordial and decisive presence of others in a person's life does not reduce the human individual to a mere social function, but, on the contrary, shapes him as such and allows him to be himself.

[1] Speaking here of "fatherhood", we also mean "motherhood." We can say that by the word "fatherhood" we mean "parenthood".

Different authors, in different forms and from different (but complementary) points of view, have described this primary nature of relationships. Here we mean, first of all, M. Buber [Buber 1993], H. Subiri [Zubiri 1988, 242-244] and V. Solovyev [Solovyev 1990, 119-183].

<table>
<tr><th>M. Buber</th><th>V. Solovyov</th><th>H. Soubiri</th></tr>
<tr><td>I - it
(one-sided – "monologic" – attitude, technical, manipulating, dominating)</td><td>Attitude towards low nature in oneself
(feeling of shame – scetic moral principle: requirement of self-control)</td><td></td></tr>
<tr><td rowspan="3">I – you
(dialogical interpersonal relationships)</td><td rowspan="2">Attitude towards equal nature
(to one's own kind)
(feeling of pity and principle of justice)</td><td>The other as "ego" (he/she)
(relationship between equals – interest and right)</td></tr>
<tr><td>The other as "you"
(interpersonal relationships – love)</td></tr>
<tr><td>Relation to higher nature
(sense of reverence – principle of obedience: based on religious attitude)</td><td>The other as "mine"
(family bond relationship)</td></tr>
</table>

There are three forms of the most important relations between human individuals that determine our essence and also influence the psychological development of a person – from the initial dependence on one's family environment (corresponds to the third form of relations, and this is the basis of religious experience) to the full identification of an undoubted “you” in another. Here we are talking about a gradual discovery, the identification of the “other”. Little by little the child finds, discovers the other, and this happens in three stages.

1) The other as "mine". At the initial stage, others appear in the individual's space formally not as "others", but as "mine": they are directly related to the child and his needs and are present in his life as "my mother", "my father", etc., like an integral part of it. He perceives himself inside the environment, the vital "we" and has almost no inner world, lives in an open space outlined by others, which he feels as his own. By saying "I", the child actually says "we", referring this "we" to specific persons who directly determine his lifestyle.

This level, singled out by H. Subiri [Zubiri 1988, 242], corresponds to V. Solovyov's relationship of a person with the highest reality: “The moral rules of justice and mercy, psychologically based on a feeling of pity, although they include in their *scope* the entire area of living beings, but the *content* of these rules does not cover all moral relations even between human faces” [Soloviev 1990, 170].

“In addition to these two basic feelings, there is one more in us, a third, which cannot be reduced to them, is just as primary as they are, and determines the moral attitude of a person not to the lower side of his own nature, and also not to the world of beings like him, but to what something special that he recognizes as the *highest*, of which he can neither be *ashamed* nor *regret*, but before which he must *bow*. This feeling of *reverence* (piety, *pietas*) or reverence for *the highest (reverentia)* constitutes in man the moral basis of religion and the religious order of life” [Solovyev 1990, 129].

Filial piety is the core from which the cult of ancestors develops; it then grows into various forms of natural religions, then it grows more and more until it begins to include all of humanity as an object of Providence on the part of God the universal

Father. All this allows us to understand why intra-family relationships are so important when it comes to the transmission of faith: it is in the family atmosphere that the germ of a correct attitude towards religion appears, consequently, it is precisely here, in the case when intra-family relations are undergoing serious deformations and distortions, that fundamental obstacles to the adoption of faith can arise.

2) The other as "ego" equal to my "I" (or the other as "he/she"). Starting with the experience of one's "I" in the meaning of "mine" (and others as "mine"), there is a gradual complication of the perception of others, in the sense that the other in the meaning of "mine" becomes one's own "I": others turn into other "I", similar to mine (or, better, I become like others), and we find ourselves in a situation of *equality* [Zubiri 1988, 243].

3) The other as an "ego" other than my "ego" (or the other as "you"). Here a radical otherness is revealed in the sense that the other appears as *someone different from me*. Thus, the other person appears as "one of his own," endowed with his own identity and an inner world that is not directly accessible to me. At this third level, the individual reality of the other is revealed in full. The other here is already internally determined, unique and not reducible to any other individual: he becomes a unique "you", a personal individual. Now, in contrast to the previous level, "I" (mine and of every person) is given to us not as equal to any other, but as strictly *different* [Zubiri 1988, 244].

Relations "I" – "you", i.e. a relationship between two people that is unique and irreplaceable for each other is the highest form of interpersonal human relations. And this highest form, when it comes to relations between a man and a woman, also turns out to be the most important, i.e. the source from which all other forms of relationship originate and depend.

2. Fundamental Structure of Human Relations

The personal state of a person is located between two poles: unique individuality, due to which each human being is a unique absolute in its own way, and otherness, which inevitably connects it with other people. At the same time, otherness is an inevitable consequence of individuality: the other person in relation to me is different in an absolute and unchangeable sense, and only under these conditions can I, and sometimes I must establish interpersonal relations with him. Even when these relationships are purely instrumental and formal, they still have a personal dimension as the horizon of legitimation of this instrumentality: the other person is a unique person, an end in itself, and must be treated.

The personal state of a person enriches, but also infinitely complicates human relationships. They are not regulated by the wise and comparatively simple mechanisms of the animal instincts. Man is forced to "create" them *ethically* (as his second nature). The starting point of such relationships is precisely in the distance and difference between "I" and "you", which are not reducible to each other, each of which has its own inner world, which is largely opaque and inaccessible to the other: many differences - sexual, age, worldview, etc. - come down, in the end, to a radical difference: I am I, and you are you. But at the same time, each needs the other. Man is absolute only relatively: he is not self-sufficient, this is already indicated by the difference between the sexes, and besides, this absolute character is acquired precisely with the help and through the mediation of other people.

So, if a person wants to establish relationships with others, he must open up, show his inner world, speak out.

It is clear that the basic structure of interpersonal relationships is the structure of "revelation". To establish a relationship, you need to show yourself, open up, expose the inner world, in principle, inaccessible to another. And although it is true that a person is

inclined to open his inner world, it is also true that he can always hide it or show it in part or in a distorted way. In the field of relationships, human freedom is certainly present.

Due to the fact that the inner life of each is in principle inaccessible to another, revelation itself needs expressive means: words, actions, gestures, symbols (for example, gifts), etc., which serve as a kind of bridge between people. Mediation is an essential structure of interpersonal relationships. If a person does not open up, expressing himself, if he is closed in himself, then it is impossible to recognize him and engage in dialogue with him.

But all these means are inevitably dual: they are precisely the *mediation* of our inner world and do not directly convey it. Therefore, because of the distance between the medium and what is transmitted through it, and because of the inevitable presence of human freedom in this process, there is always the risk and possibility of pretense, deception and manipulation. Opening up to others, expressing yourself and accepting someone else's self-expression, is a risk that you have to take on yourself. Here, both the one who expresses himself by opening the doors of the soul to another, and the one who accepts someone else's revelation, are at risk, since they can be deceived.

The only way not to eliminate risk (which is impossible), but to avoid the relationship-damaging effects of ambiguity, is to build on trust. Faith is a prerequisite for human relations, the main core of their logic. And faith means, first of all, trust, that is, the ability to accept someone's means of self-expression, given, figuratively speaking, on credit. "Believe in..." in general means "to trust someone", "to rely on someone". Consequently, the main meaning of faith is not to “know about something”, as the positivist criticism of religion claimed, which saw in it only a form of knowledge about higher objects (making God precisely the subject of scientific knowledge), i.e. instrumental knowledge, but false, fictitious, in contrast to scientific knowledge.

Trust is a paradoxical quality of human relationships that does not give any guarantees, but is itself a guarantee that human life is meaningful. Trust as a basic approach to life reflects the existential conviction that life is good and worth living, that it is a gift, no matter what, and that this gift is undeserved. Here we touch upon such things as grace and gratitude. To live meaningfully, with trust, means to recognize that life is a free gift, and it should be accepted with gratitude.

It is only on the basis of trust that love is possible, which in all its forms is the core and backbone of all positive interpersonal relationships. Love knows how to overcome difference, preserving it. After all, the relationship of love *between individuals* is not a merger or a mixture, it is not a “positive energy” that “melts” us; love does not make us *similar*, even less makes us be *the same*, on the contrary, love confirms the otherness of each, because to love means to affirm the other in his fundamental right to be “different” and to wish him to be himself, to love him as he is, what he is. At the same time, it is precisely by affirming the otherness of the other that the difference is overcome: the other person comes out of the state of impersonality, when he is simply “some person”, “someone”, and becomes for me a unique and unrepeatable “you”, endowed with his own face and name. Thus, difference is overcome (and preserved), as E. Levinas [González R. Arnáiz 1992, 135] says, as “not indifference in the face of the other”. In love for another, a person manifests his responsibility to the highest degree. It is a response to the original gift. And the responsibility of accepting the other in his otherness entails (to varying degrees - depending on the type of love) self-denial, i.e. ability to self-sacrifice. To love means to affirm and choose another, and accordingly, to renounce oneself. [2]

[2] Since love implies a change in the center of gravity of the “I” towards the “other”, as well as the affirmation of the other as such, it also implies a certain excess of one's own “I”, which is not afraid to “go beyond” its limits. Unlike that love, which in Greek is called "eros", i.e. love exclusively for someone

Love, understood in this way, fully corresponds to the absolute character of the human being. The statement, constantly repeated in our time, that "everything is relative", at first glance, entails the conclusion that everything, absolutely everything depends on space and time - the a priori conditions of our human existence, to which we are inevitably doomed in this world. But if absolutely everything depends on space and time, then there is nothing that could surpass these dimensions of our world: neither truth, nor value, nor the dignity of (each) person, nor, of course, love. What is true in one place is false in another; what is good today, may become bad tomorrow; the rights we think we have may be taken away tomorrow; love itself is relative: no one can promise to love another "all his life until death."

We will not try to prove here that relativism is a false theory, and its arguments, although they seem strong, are in fact quite weak. But with regard to love, suffice it to say that it really occurs in space and time, like everything human, but does not depend on them. Love, [3] like goodness and truth, transcends space and time. For example, in order to have fun, you need to agree on “where”, “when” and “how”. It is impossible to organize some kind of "abstract entertainment". It is just as absurd to say that I love someone only from five to six, or only in the evening and in Moscow. Saying to someone: “I will love you for the next three months” is the same as telling him that I don’t love him at all. Love has a vocation for eternity.

But human love, like everything human, is weak, and the bonds of space and time, passions and human limitations (in the form of selfishness, disappointment, boredom, routine...) threaten it constantly. The call to eternity operates in such a way that love can never be fully realized in the present moment. Love, even the truest one, always includes a promise of the future, so it is projected into the future in the *hope* of reaching its fullness. Without hope love dies.

We understand that hope is the second essential side of love. Faith and hope are not relationships that more or less coincidentally coexist with love. They are the essential conditions of love and its logic, its function. That is why the apostle Paul says that of these three - faith, hope and love - love is the greatest (cf. 1 Cor. 13:13).

Hope is the fortress of love. Thanks to it, love passes through space and time and overcomes many difficulties, internal and external, that oppose it and try to weaken it. In this sense, love is a promise: no fulfillment, no expression or experience exhausts it to the end, its fullness is always beyond them. Therefore, to love means to be able to wait and be patient, i.e. able to suffer for the sake of the loved one and because of his shortcomings, and to keep faith in the promise of the fullness of love. Hope builds faith

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or something higher than the person in question, Christian love (ágape) is not afraid to descend to those who are in need. In this sense, Christian love completes and perfects the Greek concept of love, which reflects a situation of such need that seeks a way out and overcoming. The fullness of love in the Christian sense surpasses the moral norm, it becomes part of the Divine love of the Persons of the Most Holy Trinity, while individuals mutually strengthen each other, respond to each other with the fullness of reciprocity and abide in complete unity, which, however, does not cancel or eliminate differences. . Christian love in its concrete realization in this world, therefore, means the possibility of giving one's life for another, i.e. includes a readiness to suffer for another. It is clear that such love is more than just a feeling, it is an act of free manifestation of the deepest essence of a person, which affects both feelings, mind, and will. Only from this one can understand why Christian love also extends to enemies (who, as often happens, turn out to be the same friends, that is, close people in relations with whom frictions and conflicts arise that make us suffer).

[3] There are other things that, although they are always realized in space and time, nevertheless do not depend on them, are not secondary to them. For example, unlike pleasure and entertainment, justice is an absolute concept and can never be legally waived. The idea of "legitimate injustice" is itself controversial: it would be some kind of "unjust justice". Another thing is that sometimes a particular norm of justice (for example, telling the truth) must yield to another norm of justice, more important (for example, saving the life of an innocent person). In this case, it is justice that compels us to do so. But it is unacceptable to do injustice for the sake of enrichment or entertainment.

and trust, which over time and in the struggle against difficulties, limitations and inevitable disappointments become loyalty. Loyalty is a constant responsible and firm will to persevere in love under any circumstances; also hope is a protest and a critical look at present limitations in the light of a future fullness already foreseeable in the promise rooted in love itself.

3. Source of Trust

If trust is a necessary condition for love, then the initial trust is not limited to will, i.e. is not the result of a simple choice. This raises the question: where does trust come from? How can we ensure that our trust grows and strengthens so that we can allow ourselves to take risks, open up and go towards relationships, and not feel the persistent distrust that makes us prisoners of ourselves?

Here we will have to go back and recall the main forms of relationships that in a sense precede us and do not depend on us, on the contrary, we depend on them: relationships with a reality that exceeds us within a specific biography and psychology are experienced in relationships with our parents, they are the natural basis of religious experience. At the same time, these relationships represent the first phase of gaining and discovering the other: "the other, who is the same as me."

A baby comes into this world absolutely unprotected, needs help of other people, constant help, he is dependent on others (much more so than baby animals). On others, first of all on the mother and secondly on the father, the child receives warmth, protection, food ...

He perceives such relationships as an omnipotent providence that provides him with everything necessary for life and well-being. And if he, who cannot do anything, is in the center of attention, because everyone takes care of him, then he receives very important (emotional) information: he is very important, significant, his life has value and meaning. That is, he receives the main stock of trust.

As the child's self-awareness grows, the same providence allows him to assert himself and acquire a sense of self-confidence (when his successes, first words, first steps are noted); when his behavior is corrected, he learns to navigate in various situations, which helps him not to become isolated within certain values (for example, in the immediate satisfaction of everything that young children spontaneously demand): by limiting the child in pleasures, he is helped to open up in relation to other values, and also to other people, for example, to discover that other children also have certain rights, etc. In a balanced parenting based on love, punishment can also play a positive role, strengthening the child's self-identity. It is here that the gift of initial trust is acquired, which later will allow a person to take the risk of relationships, calmly accept disappointments and bitter experiences (and the first such experience is the gradual discovery that his parents are not omnipotent and not perfect), become able to sacrifice himself for others.

We can schematically outline the individual elements of the functions that parents perform in relation to their children, but first we will talk about the general functions of the father and mother, and then about the specific functions of each of the parents.

Parents are an omnipotent providence that provides everything a child needs: food, warmth, cleanliness, care, attention ... If a child, who still cannot do anything, receives all this with love that he did not deserve, then gradually he begins to understand that he is very important and needed by someone (this can be compared with what you hear so often in Russia: “Nobody needs me”). However, this common, solidary role of parents is realized through the division of their complementary roles.

The mother plays a special role: the very first relationship of the child is tied up with her; this is the soil that supports and nourishes, gives him a solid footing so that he

is not suspended in the void. Chance is taken for granted. The child feels unconditionally accepted. God in the Bible loves a person with "compassion", that is, the love of a mother. Although the explicitly maternal image of God is not present anywhere in the Bible, this feature of God is implicit in many ways, for example: “And even the very hairs of your head are all numbered” (Matt. 10:30). This image is borrowed from the practice of looking for lice, usually done by the mother. This is where the main source of trust lies.

The father is a power that both protects and calls to account; this power calls not to remain forever in the arms of the mother, but to grow, looking forward and upward, to take on risk and responsibility. We've said before that relationships require trust, but faith calls for courage and risk. The father is actually the child's first object of faith. Coming out of the womb of the mother, having separated from the breast that feeds him, the child discovers an external being, "not-I", which invades his life and appears before him in the form of a father.

Siblings represent the first contact with peers (but also "mine") and play a fundamental role in the process of socialization.

4. God the Father - is it just a metaphor?

We have already said that the development of religious consciousness finds its culmination in the understanding of God, the Father of all people. This peak is achieved with the revelation of the Good News by Jesus Christ. We need to clarify what this revelation means. This is not just a metaphor about God, in the sense that He is the beginning of all things. It would be a metaphorical expression that can be found in different religions, outside of Christianity. Accepting that everything we say about God does not suit Him (apophatic theology), we want to get closer to understanding God the Father from the perspective of New Testament revelation.

So, we do not say that God is the Father because He is the Creator, but, vice versa, He is the Creator precisely because He is the Father. That is, his Fatherhood precedes (if one can speak of God in this way) his creative activity and is an essential feature "inside" divine relations. God the Father is precisely the Father of the Son, the second Person of the Holy Trinity. These relationships are with God himself from eternity, this is his essence. These are relations of complete unity (there is only one God), but such a unity that does not abolish the difference between persons. The difference-preserving unity is love. The relationship between the Father and the Son is a relationship of pure love, that is, it is the Holy Spirit himself, the third person of the Holy Trinity. Therefore, we do not say only that God loves, but that He is Love - this is his essence, full of unity in the difference of persons. Love, of course, is not some kind of “positive energy”, as they say today. The word "energy" suggests some impersonality, but love always implies a personal approach.

Love spreads by its essence. This is how the creation of the world out of nothing can be explained: as a free act of divine love. And if God created the world out of love, that is, not for himself (after all, He does not need it), then He created the world for the sake of the world itself, out of pure love: the absolute self-sufficiency of God establishes the (grounded) independence of the world. This independence (reflected in the "secondary causes" (*causae secondae*), as they were called by medieval philosophy) is expressed in a great and most perfect way in human freedom. The relationship between God and man is not a slave relationship, but a call for freedom, for independence. If anyone thinks that the essence of religious relationships, especially in Christianity, lies in childish dependence and denial of responsibility, he does not understand the real essence of biblical revelation. In it, we constantly hear a call to get out of ourselves, to leave security, to take risks, to take responsibility.

The very act of man's creation is described as a demand to take responsibility: "... God said to them, 'Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth.'" (Gen. 1:28). This also applies to the very beginning of the salvation story, when God called Abraham: "Now the Lord said to Abram, 'Go from your country and your kindred and your father's house to the land that I will show you'." (Gen. 12:1); and to the formation of a people, which is liberation from slavery and a call to difficult freedom in the wilderness. It is not difficult to see the same spirit in the prophetic texts, where the true cult of God is reflected, first of all, in the ability to take responsibility for justice, for the poor and needy. From this it can be understood that the model of the relationship between God and man in the Bible is not a slave relationship, where a person must forcibly submit to God (that is, a purely vertical despotic relationship), but a "covenant", that is, an alliance, an agreement that presupposes the freedom of both sides. God offers and waits for a free response from man.

Of course, all this is strongly reinforced in the New Testament. Jesus Christ forgives, heals, saves, but also calls for independence. He constantly talks about it: "Get up, walk, take it ...".

Even when it comes to possible suffering, limitations and negative aspects of our life, that is, when it comes to the cross, Jesus does not promote a passive and submissive relationship, but on the contrary, commands to take upon ourselves and go forward: "...If any want to become my followers, let them deny themselves and take up their cross and follow me" (Matt 16:24).

Of course, one can always object that man depends on God for salvation (cf. Matt. 19:24-25). But this is simply a confirmation of the fact that a person, although he is independent, is still not self-sufficient, and this is true even outside a religious perspective: if he is free and independent, then he did not give himself that freedom (like life itself), and therefore he always somehow dependent. But maturity is precisely manifested in recognizing these limitations, reconciling with them and giving thanks for everything that you received from others.

The main feature of the New Testament revelation is the new image of God that Jesus conveys to us: God the Father. Jesus presents God as his Father, and salvation as participation in a filial relationship with God through him. Doesn't this again mean choosing a childish, infantile model in understanding the relationship with God? Although in the understanding of God as Father (Father of the Son, Jesus Christ, and in him also our Father) there is that aspect of dependence, which has already been mentioned, but it is not the only one and, most likely, not the most important one. Fatherhood (and motherhood) involves the dependence of children, but it is temporary and transient: thanks to it, children grow up and acquire independence and maturity to such an extent that they, too, must take responsibility for their parents. And this is not only a fact, it is also an obligation: parents just want to see how their children grow up and become independent. And God also wants this from his children: that they recognize where they got the gift of life from and give thanks for it, but also that they accept this gift responsibly, and, like those talents in the Gospel parable, multiply them on their own, bearing fruit, acquiring new talents , good deeds that reflect in man the creative power of God himself.

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Representations of God as a mental resource of a person: theoretical view

The ideas presented in the report are set out in the logic of organization and development of the discipline "*psychology of religion*". The psychology of religion as an interdisciplinary area of scientific research and development at the intersection of psychology and religious studies is not a confessional version of psychology (like Christian psychology or Islamic psychology, for example), but is based on the principles of ideologically neutral scientific research, generally accepted psychological theories and standards of empirical knowledge. In our research, we rely on the principle of exclusion of transcendence by T. Flournoy (1913), according to which the researcher of religious phenomena of the psyche must refrain from judging whether religious ideas are true or false, and maintain ideological neutrality.

The relevance of addressing the problem of personal resources associated with its religious ideas, within this conference, is determined by the importance of the factor of religiosity in the treatment and rehabilitation of mentally ill people [Borisova, Gusev, Dvoynin, Kopeiko, 2019; Heilman & Witztum, 2000; Koenig, George & Peterson, 1998]. Faith in God and religious beliefs of patients can significantly influence the effectiveness of therapeutic and rehabilitation interventions [Mohr, Huguelet, 2014; Pesut, Clark, Maxwell, Michalak, 2011; Serfaty, Cherniak, Strous, 2020]. In this report, we will present a number of new theoretical ideas that we are currently developing in the context of working with the psychology problems of a religious person.

The vast majority of psychological studies of a religious personality have been carried out in line with the direction that we will call ***dimensional-dispositional***. This direction is formed by numerous studies that measure *religiosity as a certain characteristic* inherent in the personality. The rationale for such studies lies in the desire to operationalize religiosity through scales and questionnaires specially developed by researchers for the subsequent determination of the level of religiosity, identification of types of religiosity, finding correlations between religiosity and non-religious personal characteristics (for example, such as dogmatism, conformism, narcissism, Machiavellianism, etc.) . Classical examples of this approach are the studies of G.W. Allport & J.M. Ross (1967), who proposed to single out internal and external religious orientations and then, based on measurements of their severity, determine one of the four types of a person's religiosity (consistent internal religiosity, consistent external religiosity, inconsistent religiosity, non-religiousness). There are numerous other examples of this kind of research and typology [Faulkner & De Jong, 1966; Saroglou, 2011; Worthington et al., 2003].

Of course, for certain purposes, such religiosity measurements can be useful, for example, for assessments of religiosity and subsequent assessment of its dynamics in various social groups and communities, for applied psychological diagnostics - operational (screening) assessment of the religiosity in patients in psychiatric clinics or potential employees when hiring. However, religiosity scale measurements cannot reflect the differentially complex organization of a religious personality.

The enthusiasm of psychologists of religion for the dimensional-dispositional approach (with respective scale measurements) generates a huge heap of semi-structured facts about the various features of a religious personality in different specific groups (age, confessional, etc.); then these features are very difficult to link and conceptualize. Over the decades of research, an integrated picture of the psychology of a religious person has not yet been formed. The results of empirical research are sometimes very contradictory, since it is not clear what measurable mental reality

(motivation, system of meanings, mechanisms of self-regulation, psychological defenses, etc.) lies behind the operational dimensions of religiosity.

An alternative to the psychometric studies of religiosity described above is the *functional approach*. This approach, which has been developed and spread in cognitive and evolutionary religious studies, assumes as an initial point of departure that religious ideas and beliefs are not inherent in man by nature, but have an important evolutionary function. For example, P. Boyer & C. Ramble (2001) believe that the faith in the existence of supernatural forces and agents seems to arise as a by-product of systems that have emerged in the course of evolution, whose task is to understand the physical, biological and interpersonal environment. Analyzing the patterns of cultural transmission of beliefs in certain deities, the researchers came to the conclusion that the "success" of the transmission of a particular deity is determined by its ability to be easily remembered and attract attention, due to a certain optimum combination of intuitive and counter-intuitive properties [Boyer, 2000; Sperber, 1996].

If, based on the functional approach, we would identify the *psychological functions* of religion, then we will see their extreme diversity. Religion is characterized by: ideological (meaning-forming) function; function of psychological protection; social identification; communication; psychotherapeutic (coping with difficult life situations); narrative (reassessment and reformulation of the life path); function of existential or spiritual growth (self-actualization), etc. In addition, religion models the social environment, making all human actions meaningful and coordinated.

The psychological functions of religion are diverse and heterogeneous; this does not contribute to the development of a unified idea of its psychological role. If we think in an evolutionary way, then it is possible that religion, originally intended for the implementation of one specific function, later, as a successfully used means for solving life problems, irradiated to adjacent areas of human existence.

At present, we do not see facts that would definitely show that religion is designed to solve some limited and specific type of life tasks ("tasks for religiosity"), in contrast to how, for example, human fingers are designed to effectively grasping physical objects. Most likely, a person does not have a special "mental apparatus" or a functional "organ" of the psyche, which would be specially intended for the reception of religion, just as we have no scientifically sound grounds to assume that a certain religious need or desire for the supernatural is inherent in a person by nature.

This means that the diversity of the psychological functions of religion is due to its non-specificity, i.e. more or less universal in nature, applicable to various psychological tasks (from giving meaning to life, removing uncertainty to the psychological solution to the problem of loneliness, security and getting confidence in physical healing). We are confident that all of the above functions of religion can be given a common logical explanation - religion gives believers the opportunity to acquire a life resource. Our empirical studies show that the key motive for turning to religion among Orthodox and Muslims is, in fact, a request for a resource – a search for support and consolation [Dvoinin, Danilova, 2013a, 2013b].

The concept of resource has recently become more and more popular in various fields of psychological science. In the most general sense, resources are defined as the livelihood, the possibilities of people and society [Muzdybaev, 1998]. In fact, resources include all external properties of the environment and internal properties that the subject uses to effectively solve certain problems. For example, S.E. Hobfoll (1998) classifies rather heterogeneous characteristics as resources: work, work experience, family, social status, professional skills, interests, abilities, character traits, knowledge, personal merits, etc.

All resources can be divided into environmental resources (external) and personal resources (internal). In this report, we will only talk about internal resources,

leaving outside external resources. It should also be noted that the concept of a personal resource in psychology can not only indicate the *internal resources of an individual* in the most general sense, but, as a rule, implies certain personal individual psychological characteristics that allow a person to achieve psychological well-being and high performance.

We do not share the interpretation of resources as personal characteristics, since the internal, mental resource that religion provides becomes a resource for the transformation of the personality itself (values, beliefs, psychological relationships, etc.), makes it possible for personal development, for example, increasing self-esteem, autonomy, control of mental states of anxiety, frustration, etc. [4]

In psychology, a rather large layer of scientific literature is devoted to faith in God as a resource of resilience and vitality [Polishuk, 2001; V. Frankl, 1990; Masten, 1994; Pargament, 1997; Vaillant, 1993; Werner & Smith, 2001 and more. etc.]. Indeed, the "resource" role of religious faith, in principle, is obvious. However, the internal resource that a believer has formed on the basis of representations of a supernatural agent (God) in the process of expanding religious experience (let's call it a *religious resource*), is not limited to ensuring the resilience and vitality of a person, to overcoming crises and difficult life situations, although its significance is especially evident in this context. A religious resource is used by many believers everywhere in life to solve a wide range of problems: for example, a believer can turn to God to achieve clarity in making a decision or for help in small everyday tasks, for example, in finding a free parking space. By appealing to God, the believer may be trying to block out his sinful thoughts, or may be delegating to God the responsibility for the eventual development of everyday events. At the same time, the representations of the supernatural agent (God) for many believers function not as a resource that can “turn on” when life is out of balance, and “turn off” after its stabilization, but as a *resource basis of life itself in the diversity of its everyday manifestations*. In other words, God is represented in the mind of the believer not only on an explicit, but also on an implicit level - as a constant companion of everyday life, to whom one can turn on any occasion and who is always there.

The most adequate to these considerations is the concept of a *mental resource*. It has been developed in the writings of E.V. Volkova (2016), E.A. Sergienko (2009), S.A. Khazovoy (2014, 2015), M.A. Cold (2019) and others. Making a distinction between the concepts of "resource", "feature" and "ability", S.A. Khazova reveals the essential characteristics of the resource, such as activation by a situation of challenge, relation with the experience of behavioral achievements, the ability to be a source of additional energy, but not to set the “range” and the maximum possible level of achievements, the importance of not so much the ingtensity as the presence/absence and the ability to mobilize [Khazova, 2014].

The mental resource, according to the author, is presented in individual *mental experience* as a product of the *conceptualization of events and one’s own capabilities*: “In this sense, only those qualities can be a resource, that are reflected in mental experience as useful, giving an additional advantage, that is, acting as a kind of “amplifiers” that increase the efficiency of activities and allow you to withstand challenges in the context of solving life problems" [Khazova, 2014, p. 117–118].

[4] It should be noted that the acquisition of an internal resource through religion does not always contribute to positive personality changes. Under unfavorable conditions (for example, violent indoctrination, personal pathologies, etc.), negative trends in personal transformation (anomalies of a religious personality) may appear: increased conformity and dependence, self-depreciation, reduction of meaningful connections in the sphere of values and meanings, etc.

The concept of a mental resource makes it possible to look at a religious resource from the point of view of how it is formed, structured in mental experience, and what conditions for access to it arise.

It is not religion itself that acts as a religious resource, but the representations of a supernatural agent (God) in the *subjective religious experience* of a believer.

What is the functional power of a religious resource? Why is it so widely in demand in the world and why does it continue to be significant for modern humanity? It seems to us that the answers to these questions can be found in its properties.

We assume that the strength of a religious resource lies in a number of its properties, namely, that it:

- ***Has a low "entry threshold"***. This means that in order to experience a religious conversion - a conversion to a supernatural reality - one does not need to have special physical, social, or psychological characteristics that would enable this conversion. From a religious point of view, it can be formulated something like this: everyone is “allowed” to come to God.
- ***Potentially available***. The availability of a religious resource lies in the ability to actualize the connection with a supernatural agent (in your own system of representations), anywhere and anytime: you can ask God, standing at a bus stop, to send the right bus so as not to be late for work or ask for help to successfully pass the exam.
- ***Universal***. A religious resource can be used by believers to solve a wide range of life tasks: from facilitating physical survival and healing to optimizing small daily activities, a positive mood or raising self-esteem.
- ***Additive***. This means that a religious resource can be applied as an addition to all other resources of a believer. For example, a believer can rely on God and be passive in solving a life problem, or he can solve it with the help of social and intellectual actions, additionally “using the help” of a represented supernatural agent.
- ***Safe***. When resorting to a religious resource, a believer most often expects specific changes in reality (physical, social, etc.). However, if visible changes do not occur, then, as a rule, there is no destruction of the religious resource (and, accordingly, representations of the supernatural agent). Because it is highly likely that a cognitively acceptable explanation will be found for this (“God’s will”, “didn’t pray hard enough”, “got out of God’s spiritual protection”, etc.). As a rule, the believer expects empirical results, but they are not a measure of the truth of his religious ideas; religious doctrine usually provides a wide range of causal attributions acceptable for the preservation of religious beliefs.

In conclusion, it should be noted that the interpretation of the religious resource presented in the report, as empirical research develops, will make it possible to overcome the limitations of the dimensional-dispositional approach implemented in numerous studies of religiosity and, in the future, move on to building a holistic theory of the religious personality based on a worldview-neutral methodology.

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Diversity and unity of spiritual resources of coping with critical situations, based on the screening of the population at the beginning of the COVID-19 pandemic

Working for several years at the "Psychological Hotline" in the Moscow Psychological Assistance Service under the tuition of Professor Fedor E. Vasilyuk, who stood at the origins of Christian psychology in Russia, we were again and again surprised how, from the depths of depression, grief, lostness, after the experience of violence, loss, a cry suddenly breaks out of a person's soul, addressed to fate, God, life, and, it would seem, the faith that has been dormant until now is resurrected in search of a source of meaning. In the current situation, the pandemic has also become a condition for a variety of manifestations of spirituality, where people tried to find understanding, consolation, hope, strength. Our study, the results of which are offered for discussion in the context of counseling, was conducted by a research team (see Shankov et al., 2021) at the end of May 2020. 1900 prs. took part in it, and after a careful elimination of invalid data (too fast response, uniform pattern of responses, incorrect answers in attentiveness questions, etc.), data from 1100 respondents were selected for analysis: 47% male, 64% aged from 25 to 44 years old with higher education, people with low, medium and high material income - 33% each. The data was collected online, the testees were payed for the full passage.

The research was conducted in three stages:

1. Screening survey, where the main instruments were the modified S. Hobfoll's scale of the loss and acquisition of resources and the Short Multidimensional Measurement of Religiousness/Spirituality of the Fetzer Institute;

2. Content analysis of answers to an open question: "What would you yourself indicate as your personal spiritual resources, i.e. sources of inspiration and strength, which may also have been lost to some extent or, conversely, replenished in the current situation of the pandemic over the past two months (resources can be objects, conditions, personal qualities and some opportunities)", – 2500 responses were received;

3. Semi-structured interview with 15 respondents.

We applied the Conservation of Resources Theory by S. Hobfoll (see Ivanova, 2013) and used the respective questionnaire as the main one. This was had several reasons, among which, first of all, are the availability of accumulated data and explanatory models based on the study of natural, economic, political disasters; convenient operationalization and measurement of stress when using the self-assessment of resources. At the same time, resources are understood not as vaguely as in everyday psychology; they are considered as specific entities, as something, what a person turns to in order to overcome critical situations, as well-being sources, supports for solving significant personal problems. Resources include:

1. physiological (health, strength, endurance, etc.);
2. personal (eg, self-esteem, confidence, sense of control, self-disclosure);
3. cognitive (learning, thinking styles, etc.);
4. social (for example, support from loved ones, quality of life, sense of security);
5. energy (time, money and knowledge, i.e., the availability and proper use of which contributes to the acquisition of other listed resources).

In our study, the following resources were identified through peer review:

1. good sleep;
2. free (personal) time;
3. good relations with loved ones;

4. family stability;
5. personal health;
6. health of loved ones;
7. good relationship with at least one friend;
8. high status at work;
9. steady job;
10. support from colleagues;
11. financial stability;
12. feeling of independence;
13. feeling that life has a purpose and meaning;
14. feeling that I am in control of my life;
15. things and material resources (car, clothes, good food, housing, etc.);
16. sense of competence and success;
17. hope and optimism.

The leaders in loss were *financial stability, a sense of security: national, family, social and personal, a sense of life control* (for detailed statistics, see Shankov et al., 2021).

At the same time, *free personal time, good relationships with loved ones and good sleep* were the leading acquisitions.

We also specifically asked the respondents: what is the most valued resource? At the beginning of the pandemic, the most valuable resources were the *health of family members, personal health, good relationships with loved ones*.

It should be noted that in our sample, the degree of real loss was lower than the fear of loss. This is precisely the difference between experiencing the onset of a pandemic and experiencing disasters such as hurricanes or military conflicts.

Hobfall's research showed that a person falls into a "loss spiral": losing, for example, a spouse or job, financial and social status, respect, relationships with loved ones, sense of security, which ultimately often leads to a loss of meaning and self-worth. According to the preliminary data of our study during the pandemic, when falling into such a “loss spiral”, the discovery and acquisition of at least some of the resources associated with loved ones (“good relationships with loved ones”, “good relationships with at least one other person”), is a turning point in terms of preventing further loss or starting an upward spiral of acquisition, which depends on the degree of representation of these resources, which depends on how far these resources are available.

Another phenomenon of Hobfall's research echoes the well-known words of Christ: "*Whoever has will be given more, and they will have an abundance. Whoever does not have, even what they have will be taken from them*" (Matt. 13:12). A person who is initially rich, endowed with a variety of resources, is less likely to fall into this "loss spiral". And vice versa, those who initially had few resources, for example, financially poor people, lost more. So, in our study, working single mothers with children were in the group of the highest risk of developing post-traumatic stress disorder. While wealthy men without a family, on the contrary, gained more in the first months of the pandemic, during the lockdown, primarily due to free time, which was freed up because they did not have to go to work.

S. Hobfall in recent articles openly writes that spiritual resources and the so-called post-traumatic growth of the personality, in his opinion, do not help to restore the well-being and quality of life of the individual, because do not directly relate to lost resources. According to him, only financial compensation for the lost money can prevent stress. We decided to challenge this statement, and included in our study questions related to spiritual resources, including asking the respondents what they themselves understand by these. Unlike Hobfall, our approach does not imply an

economic, but rather an energetic, synergistic paradigm. That is, a person, turning to resources, energy sources of one type, can “convert” them, transform them into other resources, and also exchange them with other people. For example, having lost health, being hospitalized with viral pneumonia, a person acquires knowledge and experience that he can share with others; he begins to value health itself more and show supportive sympathy for others in a similar situation. His or her quality of life, ability to cope with critical situations and solve life's problems grow, "resource capital" becomes larger and deeper.

So, in the second part of the study, when answering an open question, the respondents, first of all, identified *relationships with loved ones* as a spiritual resource. Some participants noted that *relationships with children, serving them, relationships with a partner* filled them with strength and hope. In addition, contact with nature, prayer, hobbies, art, and meditation were named among the spiritual resources. Again, yet in the answers to open questions, the quality of relationships with relatives and friends remains in the center.

In the screening questionnaire to measure the parameters of spirituality, we used a questionnaire based on the Fetzer Institute's Brief Multidimensional Measure of Religiousness/Spirituality (Neff, 2006). This group of researchers collected the most significant questions from questionnaires on spirituality and religiosity that were used in health care and made apparent found the most significant relationship with indicators of well-being, quality of life and health (a detailed article describing the questionnaire and the data obtained is being prepared for publication).

The study identified the following factors that can be interpreted as spiritual sources of power and meaning and that our testees turned to:

1. Communication with the Higher Power (experiencing the presence of God, closeness with Him, the practice of personal prayer).

2. Spiritual perspective (practice and experience of gratitude, seeing crisis as an opportunity, believing in a divine plan).

3. Experience of peace and harmony (feeling of inner peace, contemplation of beauty, reconciliation with others).

4. Spiritual practice (reading of religious literature, communication with a spiritual mentor, prayer practice).

5. Spiritual self-transcendence (the belief that life will continue after death, understanding one's life as part of the universal experience, part of the history of generations before and after oneself).

In our sample, four clusters were identified, differing in the severity of one or another factor among the testees.

Religious spirituality, when building and experiencing *relationships* with God is most significant for a person. If he experiences or strives to experience the presence of God in everyday life, then other factors are also bright and significantly expressed in this cluster.

Conscious spirituality. In this case, if what is happening in life is comprehended by a person, first of all, philosophically, then for a person belonging to this cluster, the experience of harmony, spiritual practices are of little importance. It can be said that this is a “knowable”, but not lived spirituality.

Experienced spirituality. Representatives of this cluster, first of all, strive for feelings of calmness, harmony, while all other factors (sources of spirituality) are not significant for them and are weakly expressed.

Alienated spirituality, when the significance of all factors of spirituality in a person is low, negative values for each of the parameters prevail.

At the moment, we only show how our testees reacted. At the current stage of the study, we are trying to identify how a person's belonging to a particular style of

addressing spiritual factors affects mental health, well-being, and the ability to grow personally despite the crisis and losses. Perhaps this will also help in the future to build various strategies and tactics for the counseling of people belonging to different groups, depending on the constellation of the representation of spiritual resources for a particular person and his ability to access them in times of crisis.

In order to understand not only the statics (snapshot), but also the dynamics of the experiences of the study participants, we interviewed them on the topic of coping, in particular, spiritual coping with the difficulties caused by the pandemic. We received at times surprisingly poetic testimonies, which cannot be presented here in full. People told how they turned to God and perceived the pandemic as an opportunity to serve and assert their personal spiritual values; how they went from melancholy, despondency, loneliness to the realization of universal loneliness and of the task of serving and supporting others. We have preserved these wonderful testimonies of acquisitions, as well as the opposite ones – lostness and deepening in helplessness – in people in similar situations, in similar "loss spirals". The resulting differences can best be described through the comparison of the spiritual and secular worldview, which is formulated based on the work of F.E. Vasilyuk (2007, 2021).

Religious experience	Secular experience
Service to the highest value, to another	Personal life as a value in itself, pragmatism
Trust, listening, patience	Control, management
Religious teaching	Rationality
Mystery	Personal problem
Metanoia (focus on change)	Conservation, the desire to preserve
Catholicity, dialogue	Inwardness, monologue

Thus, within a secular worldview, personal life is a value in itself. With spiritual coping, the problem is transformed into the task of serving the highest value. Attempts to control and manage living life are replaced by trust, listening and patience, building relationships with the world, with the Whole and Higher, of which the respondent thought he was a part. The rational approach to what is happening, solving a personal problem is replaced by the vision of the crisis as a mystery, an opportunity that does not put a question in front of you, but puts you in question.

So, our comprehensive research showed that the most unstable, fragile, vulnerable and uncontrollable in a person's state came to the fore. What is usually the ground of life has now become a figure: *human relationship*. From the point of view of various aspects of our study, this is a central resource that allows a person to pull himself out of the state of drowning, from the experience of loss (of work, health of loved ones, of feeling of control, security) and helps to creatively rethink the crisis into a story of acquisition, salvation. It seems that nowadays, despite all the worries, only through maintaining warm relations with loved ones, through our humane attitude, we can give our patients, families the most important thing that will mysteriously grow into the fruits of a sense of connectedness, security, peace, dignity, hope and meaning.

The example of St. Martin of Tours can serve as a Christian model of such ministry. Tradition says that when he was a Roman army captain, he once saw a freezing beggar, and despite his nobility, at the risk of being ridiculed, [5] cut his uniform cloak into two pieces (according to the law, one half belonged to him, the other to the emperor) and covered with one piece the poor man. At night, an angel appeared to him in a dream and said: "Today you warmed Christ." From this began the amazing ministry of this saint. We dare to suggest that before covering the beggar with his cloak, St. Martin, who is usually depicted on horseback, got of a horse – went down from the top of his noble birth and military rank, and leaned towards the beggar. And the sword, which we see in his numerous images and with which he cut his cloak, symbolizes the very sword with which Christ came into the world, dividing not into the norm and illness, into sinfulness and righteousness, but separating between sounding brass of fear, tinkling cymbal of justice without mercy and words and deeds inspired by humanity and love. In conclusion we would like to invite such attitude quoting F.E. Vasilyuk: "With this our profession we are responsible for whether a person will look for Oedipus in his soul [i.e., *illness, demons, sin - F.Sh.*] or for Christ."

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Specifics of rehabilitation of patients with endogenous mental illnesses – application of religious coping strategies

In the last 2 decades, there has been a significant increase in scientific interest in the problem of the influence of religion on the mental state and psychological functioning of a person. In many cases, religion is an important and one of the first resources that patients and their relatives turn to when they face a serious, chronic or incurable disease. To date, there are more than 3 thousand scientific studies that are dealing with the influence of religion or spirituality on health (Koenig H. At al., 2012) [1]. Notably, more than 72% of recent studies have registered a positive relationship between religiosity and mental health (Verhagen P., 2019) [2].

Multiple works indicate that religious beliefs help patients alleviate the severity of both somatic disease (Pargament K., 1997) [3] and mental illness, and stress (Neeleman J., Lewis G., 1994) [4]. The level of religiosity is inversely proportional to the level of depression, especially among people facing serious life situations (Smith T.B. et al., 2003) [5]; it correlates with a lower level of anxiety among patients with panic disorders (Bowen R. et al., 2006) [6]. A strong connection has been proved between the positive influence of religiosity and drug use, delinquency and crime reducing (McCullough M.E., Willoughby B.L., 2009) [7].

Analyzing the positive impact of religiosity on mental health, one of the leading researchers in the field of psychiatry and religion, Professor Koenig, identifies the following factors:

1) religiosity provides resources for coping with stress by influencing the cognitive assessment of negative life events. It forms an optimistic worldview, helping to cope with losses;

2) being a complete value-normative system, religion helps people build their behavior in such a way as to avoid stressful events (divorce, imprisonment, problems with children, financial difficulties);

3) most religions encourage a person's "pro-social" behavior, his communication based on altruistic love: meetings and caring for loved ones, mutual assistance, increases positive emotions and distracts from his own problems (Koenig, 2012)[1].

Understanding the role of religiosity and spirituality of a person in maintaining mental health and their impact on mental illness, an analysis of the value-semantic sphere of a person's personality in its relationship with religious faith can provide significant help. According to domestic and foreign researchers, value-semantic orientations determined by religious faith become an important element of people's consciousness and an effective regulator of behavior: Dvoinin A.M., 2007 [8]; Gumnitsky M.E., 2013 [9].

Value-semantic sphere of personality and religious faith

In the modern world, value-semantic orientations determined by religious faith are becoming an important element of people's consciousness and an effective regulator of behavior.

(Dvoinin A.M., 2007, Gumnitsky M.E., 2013, Koenig H., 2012)

The Department for study of special forms of mental pathology, initiated a study that analyzed the value-semantic formations in patients with endogenous mental disorders (Borisova O.A. et al., 2019) [10]. The analysis of the value-semantic sphere of religious patients with mental pathology was carried out using Kelly's personal construct methodology in order to identify the specifics of the composition and structure of the semantic formations in religious patients. The obtained data was statistically processed through factor and correlation analyses.

Research of the value-semantic sphere of religious patients with mental pathology

(Borisova O.A. at al., 2019)

Hypothesis – the structure of the VSS of persons with a religious worldview, unlike in non-believers', is less susceptible to destruction under the pressure of mental illness.

Study participants – 4 control groups.

Methodology is based on the study of personal constructs by G. Kelly (method of triads, Hinkle's laddering technique, eliciting repertory grid. Statistical processing using the Pearson correlation coefficient and factor analysis within each group, followed by comparison of pairs of groups).

№	*Group*	*Description*	*No of parts.*
1	Orthodox patients	Based on a structured interview conducted by a clergyman who was a former psychologist	24
2	Non-believing patient	The patients considered themselves non-believers and did not show any religiosity	12
3	Orthodox healthy prs.	Healthy Orthodox testees	15
4	Non-believing healthy prs.	Healthy testees who consider themselves non-believers	14

The subject of study were both common values (creativity, communication with other people, material benefits, professional success) and a number of values exclusively characteristic of a believer (striving for God, striving to develop spiritual qualities in oneself, realizing the purpose of one's existence).

Results showed that patients with a religious worldview had high rates of active spiritual aspiration for realizing the purpose of their existence, alongside with a careful and sensitive attitude to other people, and a desire for God. In contrast, patients without a religious worldview mostly demonstrated the greatest importance of value-semantic formations in the sphere of communication with relatives and friends.

People with a religious worldview differ significantly from groups of non–believers in their attitude to the values studied – especially to health and to the spiritual sphere. Thus, patients with a religious worldview, unlike non-religious patients, have a

different understanding of the attitude to the world, the concepts of "health" and "disease". In case of patients without a religious worldview, the lack of health entails the loss of basic values and the loss of the life purpose. Religious patients had a higher level of self-control, as well as social communication due to the preservation of their involvement in the life of the church community. Creativity was high in the hierarchy of values within a group of religious patients. These specifics must be considered when choosing and carrying out psychocorrective activities in during therapy and rehabilitation.

Comparative analysis showed significantly greater sustainability, stability of the value-semantic structure in Orthodox believers: for example, severe mental illness did not fundamentally change its structure.

When planning and conducting treatment and rehabilitation work with mentally ill patients, it must be taken into account that, of course, psychopharmacological therapy, using a wide range of psychotropic drugs, modern atypical antipsychotics, which can reduce the negative manifestations of the schizophrenic process, is in the first place.

At the same time, an extremely important component of work with patients and their relatives is psychocorrection aimed at coping (overcoming) with the crisis caused by mental illness, coping with painful experiences, as well as adapting to new conditions of existence. This is the so-called coping work ((eng. “cope” – overcome, L.Murphy, 1962). In recent decades, issues related to religious coping have been widely discussed. The **religious coping is defined** as turning to religion when experiencing life difficulties; it includes coping with one's own value system and beliefs, strengthening the connection between people in the community of fellow believers, as well as through the development of relations between man and God.

Coping work with religious patients is primarily confession oriented, taking into account the peculiarities of the value-semantic structures of these patients and relying on their preserved spiritually-oriented values.

Main religious coping strategies

- Preservation of traditional values and meanings – in order to preserve the basic values of life.
- Finding an emotionally comfortable state – through consolation, reassurance, forgiveness, reconciliation.
- Religious support by the community – finding a close connection with other people and getting closer to God.
- Transformational coping – religious rethinking of the situation, rethinking of one's own personality, rethinking of the sacred.

(Pergament K., 2000, 2013)

In the practical work of the department, the following religious coping strategies were used:

1) preservation of the basic values of life – preservation of traditional values and meanings;

2) religious support by the community – social support strategy;

3) the strategy of finding an emotionally comfortable state within the religious faith (consolation, reassurance, forgiveness, reconciliation) and

4) methods of religious transformational coping – religious rethinking of the situation, rethinking of one's own personality and the so-called united religious coping.

Preserving coping (Clifford Geertz, 1966) [11] helps protect the basic values of life and the purpose of life once confronted with a serious illness or loss. It is aimed at preserving traditional values and can also manifest itself in the religious reassessment of negative events from a favorable point of view, that is, negative events are given a potentially beneficial and favorable meaning as allowed by God for correction, improvement, protection from mistakes and falls. In the worldview of religious patients, the concepts of illness and health are included in the general context of their spiritual, mental and corporeal life; therefore, when a mental illness is detected, it does not cause very critical changes in the worldview of these patients. It helps to believe that God has the power to change a stressful situation into a favorable one.

The second strategy – religious support by the community, **the strategy of social support** – is the leading one in the Christian Orthodox community and helps patients with a religious worldview to avoid feeling their inferiority (Kazmina O.Yu., Polyakov Yu.F., 2000) [12]. The study of the quality of social connections showed that the total number of connections and the density of the social network are significantly higher in patients with a religious worldview belonging to the community than in patients with a secular worldview, which provides more resources for an adequate choice of social support. A stronger system of interpersonal interactions is largely due to a single religious worldview and the canons of Christianity. Thus, a religious community is an effective way of supporting patients.

An important component of psychocorrective work with patients are the **methods of so-called religious transformational coping**, which consist of rethinking negative events from a religious point of view, getting a new dimension and a different meaning, that can prevent a more terrible situation. In any case, it is believed that God will not let a person suffer beyond what he can bear. It is important to rethink oneself and one's misfortunes, which are perceived as tragedies, however, they are attributed not to the person himself, but to divine forces. God offers man an opportunity to look at himself and his life, gives a chance for spiritual growth.

Rethinking the sacred – the united religious coping – consists of searching for control through a relationship with God in solving problems (Erich Fromm (1950) [13]. Even the so–called religious surrender – the active transfer of control to God - to surrender into the hands of God, allows patients to cope with a sense of tension and anxiety, accept mental illness as God's providence, agree with the need for medical treatment, medication, hospitalization in a psychiatric hospital. This way of coping goes through the acceptance of the disease, through understanding and isolating it in the general value-semantic structure of the personality; through finding the meaning of existence in the situation of the disease. The disease is considered in the context of the entire life path of a person – the integral, inseparable path (before – during – and after the disease), that has a purpose. Despite the lack of a proper critical attitude to their condition caused by the schizophrenic process, our patients accept the assessment by the spiritual father of the manifestations of their illness as pathological from a spiritual and religious point of view (false mysticism, delusion), are disciplined in receiving supportive therapy, and even hospitalization in a psychiatric hospital is perceived as obedience. This allows for long-term supportive therapy with modern antipsychotics that affect negative disorders, prevent relapses of the disease even in cases of chronic continuous course, as well as improve the social functioning of patients and their quality of life.

Religious methods of transformational coping

- Rethinking the situation from a religious point of view – negative events can get a new dimension and a different meaning, for example, in this case a more terrible situation is prevented.

- Rethinking oneself - misfortunes and failures are perceived as tragedies, but they are attributed to the person only, not the divine forces. God offers an opportunity to look at oneself and one's life, gives a possibility for spiritual growth.

- Rethinking the sacred - united religious coping - the search for control through partnership with God in solving problems (Erich Fromm (1950)). Active religious surrender - active transfer of control to God as "surrender" (to surrender into the hands of God, for example) and "self-surrender". Through union with the sacred, feelings of tension and anxiety are reduced.

Various coping methods were used by a psychologist and a priest in their work with patients, both in individual and group psychocorrection work. For twenty years, long-term Orthodox camps were held, that for quite long time brought together patients and psychologists, who were supervised by a priest. The work of the camps was aimed at the formation and development of social and communication skills of patients, the preservation of basic values and finding the meaning of life in a situation of chronic mental illness, as well as the possibility of rethinking one's illness from the standpoint of the Orthodox faith.

Currently, the work is going on. At this stage, the implementation forms of religious coping are being polished up in individual and group work, whereby not only priests serving in our center are involved into the coping work, but also several clerics from parishes and monasteries in Moscow and Moscow region, who can refer patients to us and continue caring for them locally after discharge from the hospital or in the outpatient psychiatric work.

In this context, we would like to quote His Holiness Patriarch Alexy II, who in 1992 during the consecration of the hospital church in honor of the Mother of God Icon the "Healer" at the Research Center of Mental Health said: "Faith is the greatest shrine of the human soul, it is the main value of life, without which life and death lose meaning, they become humiliation and disgrace. In a state of hopelessness, doom, loneliness, a person discovers faith for himself and finds in it a source of full understanding of being. Being in possession of faith, a person is able to overcome the inherent infirmities and diseases of human nature, realize his original value and fulfill his individual destiny. The meaning of human sorrows and sufferings finds its justification in faith, which is the deepest and most mysterious foundation of every human personality."

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Spiritual meanings: post-non-classical understanding

Abstract: This report considers possibility of using a post-non-classical approach in the clinical and psychological sphere, namely, in providing psychological assistance to religious people with mental disorders. The post-nonclassical approach considers semantic reality (including religious meanings) as the main subject of psychology. A clinical case study demonstrates the possibility of re-interpreting the meaning of religious life in order to achieve a healthier and more harmonious mental state.

Keywords: post-non-classical approach, biopsychosocial-spiritual model, religious meanings, schizoaffective disorder.

It is well known that since the advent of scientific psychology in 1879, it has influenced the development of psychiatry. Such luminaries of national and world psychiatry as V.M. Bekhterev, S.S. Korsakov, E. Kraepelin, physiologist I.P. Pavlov, at the beginning of their scientific career, studied at the psychological laboratory of W. Wundt in Leipzig, and then used the gained knowledge in their work [3].

At the end of the 19th century the field of mutual interest was dominated by elementary mental functions – memory, attention, but at the beginning of the 21st century the focus of interest shifted to meanings and values. Meanings and values, according to the apt expression of the greatest Russian psychologist A.N. Leontiev, is the "rocket science" of psychology.

This complex topic should be approached based on ideas about the development of psychology as a science. From the perspective of V.S. Stepin's philosophy of science concept [7], all sciences, both natural and humanitarian, have gone through two stages of their development – the stage of classical science and the stage of non-classical – and are now at the post-non-classical stage. The logic of the transition from one stage to another consists in the increasing inclusion of the subject of knowledge (the researcher) into the picture of reality. The understanding comes that the studied reality does not exist by itself, but depends on the very fact of the study, research methods and even the values of the researcher.

The development of psychology from the classical stage to the post-non-classical was traced by the Russian psychologist Klochko V.E. [2, 4] in his works. His own scientific path began with the study of cognition in the "school" of O.K. Tikhomirov, and ended with the postulation that the spiritual component of the psyche is the main one in the construction of a person's life world. Based on the approach of V.E. Klochko, we will trace how the development of scientific thinking affects the understanding of the psyche in general and the understanding of the religious psyche in particular.

At the *classical* stage, reflection was the leading category. The mind reflects the objective reality. As in a mirror, everything that is in reality gets into the psyche. Philosopher K. Popper proposed the following image: consciousness (and psyche) is a "tub" into which all the facts of the external world are poured. It looks as if consciousness and psyche are "passive". The classical stage is characterized by linear causality – a cause produces an effect, and no other way.

The classical stage in the development of psychology poses the following questions to the psychology of religion: if the psyche reflects reality, then what kind of reality do religious experiences reflect? If every experience has its causes, what is the cause of the religious experience? And this, strange as it may seem, begs the question: is there a God? Because, if there is a God, then religious experiences reflect the reality of

divine being. And if there is no God, then aren't religious experiences painful manifestations of the psyche, along with delusions and hallucinations, the subject of which are also non-existent or distorted objects and connections?

Thus, at the classical stage, religion itself can be called into question: is religion not a disease? S. Freud, A. Beck, A. Ellis believed that religion itself, even in the person of its best representatives, is morbid, is a form of neurosis or a consequence of irrational beliefs [9, 11].

At the *non-classical* stage, the view of the psyche changes through the rejection of the category of "reflection". L.S. Vygotsky, who is called the "Mozart of psychology", says directly that the main role of the psyche is not to reflect, but "subjectively distort reality in favor of the organism" [1, p.347]. His image [ibid.] – "if an eye could see everything, it would be precisely because of this that it could not see anything" – indicates the selectivity of the psyche and consciousness in favor of man. Even a healthy person can see the limitations of his perception of reality when some facts are revealed to him that he never noticed because he was not ready for this, or his psyche “kept” him from these facts. The projective theory of consciousness, in Popper's terminology, just indicates that the attentional beam or activity beam is directed to highlight a certain part of reality.

Instead of objective reality, the concept of the “lifeworld” appears. Linear causality is replaced by a systemic one (including in psychiatry and narcology): a cause can be an effect, and an effect can be a cause [6]. Diathesis-stress model, biopsychosocial model and biopsychosocial-spiritual model are being developed in science. These models are designed to resolve the question that periodically appears in the practice of psychologists, psychiatrists, narcologists: did the event affect the person, or is the person inclined to perceive only such events?

At this stage, the psychology of religion does not raise the question: Do religious experiences reflect objective reality? Religiosity is perceived as one of the properties of a person. There is another question: is the religiosity of a particular person healthy or pathological? An example is the identification by G. Allport of internal and external religiosity [5]. Studies have shown that internally accepted religiosity is associated with greater adaptability, psychological health, understanding of the other, while external religiosity, which is the result of habit, cultural tradition, is associated with greater aggressiveness, stereotypes and prejudices [10].

We can also mention V. Frankl, who said that the presence of a spiritual (religious) meaning can integrate a person's personality and improve his psyche. While the lack of religious meaning or unrevealed religiosity can be one of the causes of noogenic neurosis, characterized by the lack of meaning in life [8].

At the *post-non-classical* stage, psychology comes to an understanding that the psyche creates reality: from objective reality, it forms the lifeworld of a person. At this stage, it is almost impossible to do without the concept of "spirit", which is perceived as the pinnacle of the psyche. The spirit generates the reality of human existence by translating the meanings and relationships of a person into the surrounding reality. It is the spirit that ensures the creation of the “world for man”, his life world, out of a neutral reality indifferent to a person [4].

There are many life worlds. They are subject to interpretation. This leads the psychology of religion to the question: what is the meaning of religious life for a particular person? This perspective, on the one hand, sets the field for multiple interpretations of religious life, but this allows a specialist who provides assistance to a person with mental disorders to ask the following question: which of the meanings of religious life contributes most to the health of a particular person?

As an illustration of the practical application of the post-non-classical approach, one can cite a clinical case related to the search for the most healthy meaning of

religious experiences. A., a woman 39 years old, came to us privately for psychological help. The main complaints were about the threatening "voices of demons" that come from inside and sought to drive her crazy. The voices that tormented her for 9 years were predominantly male, came from inside her head, but sometimes were projected outside. 2 years ago, she disclosed them to a psychiatrist because they became too strong, interfered with work, and communication with loved ones. She was diagnosed with F25 schizoaffective disorder, which led to her dismissal from her job (she worked as a kindergarten teacher), increased tension in family relationships. Her husband forbade her to go to church, because, according to her, the voices intensified after attending the church. Her 16-year-old son was also extremely worried about this situation.

The client interpreted these voices as the voices of demon spirits that came because of a broken promise to God. She asked God for help in the birth of her son, for which she promised to raise him in the faith (not being, by the way, a practicing believer at that time). Having failed to fulfill her promise, she came to the church next time only 7 years later, and at that moment she felt “diabolizing”. At the peak of her illness two years ago, the voices threatened to drive her insane, which was to lead her to being completely in their power – the power of demons – in this life, and going to hell in the future. The latter worried the client greatly, since the fear of torment after death was the main reason for attending the church.

We did not have the task of clarifying the nature of the voices, specifying the diagnosis, since psychiatric care was already provided, and the woman continued to receive it in the form of outpatient therapy, which had a certain positive effect – no exacerbations for 2 years. Therefore, we divided the religiosity of this woman into two components: pathological experiences (“voices of demon spirits”), which could not be corrected by psychological methods and which were the “target” of pharmacological therapy, and a personal attitude (values) to pathological religious experiences and religious life in general. In particular, we questioned the woman's belief that the logical connection is correct: "voices" – "madness" – "state without God" – "going to hell". We gave examples of a gentler attitude of the Church towards people with mental disorders: for example, the funeral service for people who have committed suicide at the peak of a mental disorder, the more merciful attitude of saints towards people with impaired mental organization. We have taken the liberty of suggesting that God may also be more merciful to people with mental disorders. That is, we examined how much the belief in the causal relationship "madness" – "hell" corresponds to the position of Christianity, trying to show that this relation is not correct.

The second and main "target" of the value based analysis was the woman's conviction that her pathological religious experiences are the essence of religious life. We asked her how the negative consequences of these experiences (dismissal from work, increased tensions in the family) correlate with the goal of the Christian life? Although reflection on this issue did not lead to an immediate switch to true religious meanings, which are always associated with other people (for example, relatives, colleagues), – this would have been a miracle, but we questioned the significance of pathological experiences that destroy the natural way of life. After the counseling, the woman felt relieved in her condition. In the follow-up – six months after the first meeting – she returned to social life (employment in a new job of desk-work type, appropriate for her mental resources), greater importance of relationships with relatives in the structure of the client's feelings, etc.

The next – promising – stage of counseling may be the acquisition of true religiosity. Religiosity not as removing the fear of hell, but religiosity as a search for meaning in the life that God gave her (in relations with people, in the realization of her own talents).

Summarising, we can note that the complication of scientific thinking (from classical to post-non-classical) leads to a simplification of the questions posed by the psychology of religion – from the question "Is there a God?" to the question "What is the meaning of religious life for a particular person?"

This relieves a specialist providing assistance in the field of mental health from ideological discussions that are not characteristic of his profession, allows him to understand the semantic sphere of a person's life world and, together with him, seek religious meaning that will help restore and strengthen his health.

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Role and place of religious experience during a spiritual crisis

In this report we will speak about the role and place of religious experience in a spiritual crisis. Back in 1902, the American philosopher and psychologist William James raised the question of spiritual experience within psychology. He did the first large-scale psychological analysis of spiritual experience; the results are to be found in his book "The Varieties of Religious Experience". While doing research, he found this experience extraordinary, on the verge between normal and pathological. However, W. James made a conclusion that at that time hardly anyone could have expected: "*Few of us are not in some way infirm, or even diseased; and our very infirmities help us unexpectedly. <…> What, then, is more natural than that this temperament should introduce one to regions of religious truth, to corners of the universe, which your robust Philistine type of nervous system, forever offering its biceps to be felt, thumping its breast, and thanking Heaven that it hasn't a single morbid fibre in its composition, would be sure to hide forever from its self-satisfied possessors*?" [James, 2017, p. 22]

It turns out that spiritual experience, its psychological reality, can become a field in which relations develop not only between a person and the environment, but also between a person and God.

In our country, Fedor E. Vasilyuk made a huge contribution in the field of the psychology of spirituality. This outstanding Russian psychologist developed the notion of emotional experience and the concept of life worlds [Vasilyuk, 1984]. According to him, the life world is a "reference system" in which the same facts have completely different meaning not just for different people, but for people who are in fundamentally different systems in relating with the outside world. In addition, he tells us that it is possible to move between these worlds, solving problems existing in form of various critical situations. The life worlds are dynamic and mobile, but at the same time they are relatively stable and durable.

Developing these views, we came to the idea that there are "gaps" between stable life worlds, i.e. semantic gaps, because, **moving from one logic of explaining the world to another, a person finds himself in a special space of "inter-world"**. Fedor E. Vasilyuk says that each world is characterized by its own critical situation (stress, frustration, conflict, crisis), felt by a person as a crisis, that is, a catastrophe. The possibilities of a person's life world of in certain circumstances may be exhausted, and in this case the task is to overcome the previous view of being; it is necessary to make a qualitative jump through the abyss into a new life world (ibid.).

We assumed that the crisis as a separate phenomenon is not some kind of momentary jump. Experience shows that people can be in this state for a long time. M. Sh. Magomed-Eminov raises the question that existence in this transit state, that is, the transition, has a special quality that he calls "inter-existence": *"Multiple life worlds of a person, connected into a single integrity, and the person's travel through life worlds, suggests the idea of a "between-existence" – specific life between life worlds*" [Magomed-Eminov, 2006, p. 186].

We assumed that the **spiritual crisis is a special case of the transient (that is, transitional) world, and is the experience of a critical situation that has occurred in a person's relationship with God.**

We also assumed that the spiritual crisis has many faces. In order to determine the types of spiritual crisis, we have determined the psychological criterion by which it is possible to draw a demarcation line between different transient worlds. It is important to emphasize that we present not a spiritual or

religious, but a psychological typology, which does not have the task of classifying a spiritual crisis as a spiritual phenomenon, but tries to highlight the features of the subjective experiences of this transition.

In order to single out the psychological criterion, we turned to the writings of Lev S. Vygotsky, the brilliant Soviet methodologist of psychology, who at a certain stage of his scientific work defined the concept of "meaning" as a unit of psychological analysis [Vygotsky, 1999], or rather, "dynamic semantic system" [Asmolov , 1983, p. 124]. Under "meaning" we understand the united individual experience and a culturally and individually determined system of meanings [Vitko, 2021]. We will use the term "**mythologeme**" to denote a culturally determined system of meanings that an individual uses when describing his spiritual and religious life [Isina, 2015]. And by individual experience we mean **spiritual experience**, that is, a nonverbal impression, the experience of Meeting (with God) in the transcendent, beyond the personality [Goryunov, 2009]. The criterion of preverbality means that spiritual experience goes beyond the capabilities of the categorial framework that is used to describe it: "*The handiest of the marks by which I classify a state of mind as mystical is negative. The subject of it immediately says that it defies expression, that no adequate report of its contents can be given in words*" [James, 2017, p.298].

Thus, we were focused on spiritual crisis, that is, on those experiences that are implicitly qualified by a person as spiritual. As criteria of the crisis, we have two components – religious experience and mythologeme.

To explore the phenomenology of a spiritual crisis, we conducted a study following the modern methodology of qualitative research. The study involved 31 respondents: 10 male and 21 female (age: average (M)=27 years; Min=19 years; Max=52 years). In the interviews the psychotechnical method of F.E. Vasilyuk [see Vasilyuk, Dr. I., 2008] was applied, the results were processed using descriptive phenomenological analysis by A. Georgi [Georgi, 1997]. 5 experts were invited to assess the compliance of the theoretical model with empirical data.

Our research resulted in a typology of four transient worlds (or subjectively experienced spiritual crises), the criterion for their separation were signs of presence or absence of religious experience and mythologeme (see Table 1).

Table 1. Typology of transient life worlds (spiritual crises).

		Spiritual experience	
		No	Yes
Mythologeme	Yes	Mythological transient world	Religious transient world
	Nno	Symbolic transient world	Metaphorical transient world

So, in the first — **mythological transient** — world, the respondent reports that there is a mythologeme, but at the same time does not have a spiritual experience that would correspond to it. At some point, this "empty" religiosity falls apart due to contradictions that cannot be resolved, religion turns into a myth, a fairy tale, etc. for a person. The **religious transient world** is characterized by both – a mythologeme and spiritual experience – that come into conflict with each other. The **symbolic transient world** is a type of crisis experience in which neither spiritual

experience nor mythologeme are represented. In this regard, we have the right to say that the symbolic transient world is not a truly spiritual crisis, but, perhaps, it is an attempt to move towards this spirituality. And, finally, the **metaphorical transient world** is characterized by a situation of collision with an extraordinary spiritual experience that cannot be described and comprehended within the existing mythologeme.

Let's analyze some statements in order to more clearly recreate the phenomenological picture of each crisis experience.

Respondents attributed to a mythological spiritual crisis (see Table 2), noted, for example, that they experienced it in adolescence, when they suddenly realized that they had no living faith in God. Many respondents have attended church since childhood and participated in divine services together with their parents or other close relatives. However, at some point they realized that they did not understand the meaning of the sacraments of Confession or Communion, did not experience contact with God and, in fact, God himself was rather Someone distant and incomprehensible to them, whom they had never felt as a real figure in their lives. The respondents also said that their main motivation for participating in religious sacraments came from the fear of punishment by adults. Religion was perceived by them as a set of rules that must be followed in order to get the approval of close people who were important to them. Many of those who were attributed by us to a mythological spiritual crisis left the Church due to the fact that they adopted a secular worldview spread among friends. Those who overcame this crisis and remained in a religious community said that as a result of the crisis, a sensual feeling of God opened up for them, the opportunity to build a dialogue with Him as with a living Person.

Table 2. Examples of respondents' statements classified as belonging to the **mythological** transient world.

Semantic category	Quote
Lack of understanding of the meanings of religious rituals was realized.	*"I never really understood what the meaning of confession was, because I didn't feel any remorse for something."*
Doubts whether the choice of faith was conscious.	*"I had these thoughts – mine/not mine."*
It is found that there is no living faith in God.	*"In short, I stopped believing in God. I probably never believed in Him."*

The respondents of the **religious transient world** (see Table 3) stated that they had a living relationship with God before the crisis, consciously fulfilled the commandments and attended divine services. The central problem of the religious crisis was a sudden discrepancy: either between the image of oneself and the image of a Christian, or between the image of God and some of His manifestations in life. Some respondents said that they committed a sin that they could not admit, and for which they were overtaken by a strong sense of guilt. Therefore, those experiencing a religious crisis began to feel a barrier between them and God. This barrier made itself felt also in prayer. The performance of religious rites caused fear, resistance; after some time it became mechanical and was no longer filled with special spiritual experience. Another part of the respondents spoke about encountering a situation that undermined their ideas of God as merciful, kind and loving. Those experiencing this type of crisis felt resentment against God, anger, conducted internal dialogues with Him, in which they

expressed discontent. Some respondents left the Church as a result of the crisis, as in the previous case. Those who went through this crisis said that they began to feel faith as a way, they admitted that they might be imperfect themselves, and they might, among other things, not know all of God's plans for the world and their lives in particular.

Table 3. Examples of respondents' statements classified as belonging to the **religious** transient world.

Semantic category	Quote
Experiencing a situation that contradicts the religious paradigm.	*"Especially if He is love, if He is good, if He is kind. Because if I were kind, I wouldn't do that to people. And God did this to me and, accordingly, I began to doubt."*
The feeling that one is unworthy of contact with God.	*"It seemed to me rather in those first six months that I had no right to pray because I was so bad. That is, well, not that it doesn't make sense, but that, well, I didn't deserve it."*
Discrepancy between the image of oneself and the image of a Christian.	*"Can I call myself a Christian if I can't even maintain some kind of consistency in simple things?"*

The stories of respondents who are in a **symbolic spiritual crisis** (see Table 4), as a rule, did not relate directly to the relationship with God and religion. The interview participants talked about solving existential issues related to the meaning of life, loneliness, death, and values. One of the respondents said that as a result of this crisis, she became a member of the church, because it helped her to survive a difficult period of life, find support and answers to her questions related to her personal life.

Table 4. Examples of respondents' statements classified as belonging to the **symbolic** transient world.

Semantic category	Quote
Deep living-through of existential reality.	*"I realized that all of them (existential realities) exist, and somehow I have to live with it, invent some meaning, put up with my finiteness, with the fact that I am totally alone – that's all."*
Living between old and new values.	*"And you are trying to build these new values, that is, you are trying to rebuild, <…> make them the basis of perception."*
Change of worldview (as a result of the crisis).	*"I got a life credo, principles, a model of the world in my head. All this calmed me, relief came, joy, I realized that in fact I was mistaken about life."*

The last crisis we are considering, a **metaphoric** one (see Table 5), was described by respondents as the result of an extraordinary spiritual experience that did not correspond to their ideas about the world (for example, some respondents were not deeply religious before the crisis). It was in the metaphorical transitory world that the

vast majority of respondents said that their experiences had reached the level of psychopathology, so some sought psychiatric help. Respondents reported that they heard the voices of demons, talked about the experience of direct contact with the Spirit, with God, etc. Subsequently, this experience became a powerful impetus for changing the lives of the respondents, since for them the question arose of finding a new language that could describe the new world that opened up to them in this experience, and with which they can enter into a dialogue with another reality.

Table 5. Examples of respondents' statements classified as belonging to the **metaphoric** transient world.

Semantic category	Quote
Feeling contact with the transcendent (Higher Power / Spirit / God) in the situation of being on the "subjective bottom".	*"And at the same time, God Himself came. It felt like He came and stood there. I saw Him with my back, spiritual vision. <...> He sympathized with me with all His soul and tried to support me."*
Difficult to verbalize and comprehend spiritual experience.	*"And with them [superhuman beings] you can make contact <...>. But this requires language. And now it seems to me that I can't say anything yet."*
Search and approval of a new way of life and worldview.	*"The search for a new way of perceiving the world, a new way of life, a search for a new self <...>. The feeling of a soul that cannot find peace and is looking for something."*

The above typology is an attempt to systematize, from a psychological point of view, those transient worlds in which people find themselves experiencing a certain "situation of impossibility" [Vasilyuk, 2005] in relations with the transcendent. Our research shows that **the line between psychology, psychiatry, and theology can be very thin when it comes to a person experiencing a spiritual crisis**. The one who sits in the psychologist's chair, talking about the experience of a critical situation in his religious life, can be the same person who talks during the confession about the influence of dark forces on him, and the same patient who tells the psychiatrist about hallucinations.

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"By His wounds you have been healed." The healing force of weakness

The desert that inhabits us

The pandemic that we are suffering has pushed us to rediscover a dimension of our lives that our technified welfare society thought it could ignore, namely that we are vulnerable creatures, continually harassed, from within and from outside of ourselves, by failure, degradation and death. Uncertainty has become the content of our consciousness to a degree that it has not been for a long time, and all the other events that take place in social and personal life seem to be read from it, at least in the developed West [1]. A society that thought it had controlled or could control the fragility of life has collapsed.

However, *nihil novum sub sole*. Natural or social disasters cyclically affect populations and cultures.

These situations correlate with personal situations that continuously affect people throughout their lives: violence suffered, personal failures, inhuman dependence, old age with its mental and physical deterioration, severe illnesses, mental illnesses or a simple, but often heavy burden of life with limitations that we cannot easily integrate.

Being confronted with these situations in which the created reality seems to be possessed of a logic that is not only mortal, but also malevolent and cynical, the human being has always felt, beyond his believing conscience, an absolute mandate that impels him to order the world in such a way that that it would be a habitable space, a protected space, a humanized space. For the consciousness of the believer, this is a task that humanity has received from God and which is its very essence, as it is said in the narrative of the creation of the world, when God commands man *to have dominion in His image* over the world that carries chaos in its bowels (Gen. 1:27-28). In other words, in order for the world to continue or to be continuously a space where reality is not determined by chaos, God gives man a higher vocation: to be His image, his representative.

Thus, the believer knows that the world is constantly threatened by the forces of death, which must be subdued and inscribed into the logic of life. And it is here that man's influence on the world is manifested, the work that people must do in the image of God. This work is nothing more than caring for God's creation in all its spheres: in natural, personal and social life. The believer knows that creation, although the Spirit of God works in it, bringing harmony to created matter, is not yet complete and suffers from the forces of death, which must be subordinated or already subordinated to the power of the resurrection of Christ (Phil. 3:10).

A believer must understand that he will not find a perfect life in the world, and that an attempt to build a paradise on earth leads to the absolutization of individual dimensions of life or lives, creating spaces of exclusion. He knows that life consists of matter, which is chaotic in itself, that it must be continuously ordered, and we are unable to do this because we are mortal, limited and weak. Thus, people live in an unstable equilibrium, which they cannot always maintain.

Therefore, the care for the world, commanded to man, will consist not just in building an order that protects lives, something that is obviously necessary, but also in caring for a life affected by suffering, which the human order is unable to eliminate and which in many cases it creates itself.

It would seem that this activity does not always have a concrete impact on the structures of earthly life, but it inscribes into history an "eschatological reserve" that

[1] Ch. André, “La incertidumbre invita a la sabiduría” y Y.-A. Thalmann, “Mantener la calma en tiempos de incertidumbre”, Mente y cerebro 108 (2021) 1-19.20-25.

prevents the forgotten people from being forgotten and, consequently, the absolutization of worldly orders. Thus, we see that the care of creation and history is embedded in the Christian vocation as a care that, in the image of God himself, is addressed primarily to the unprotected and suffering, and which constantly opposes the life or society, satisfied in their own order[2]. And here the Church acts as an "expert on humanity"[3], because it sees a person in someone whom the world orders want to make invisible.

Speaking about the disease, which can be considered as a "metaphor of the human condition"[4], we know that it is not easy for the patient to recognize and accept it, nor for those around him who usually tend to hide it from him, making his position in society more marginal, as it is masterfully described in the novel by L.N. Tolstoy's "*The Death of Ivan Ilyich*". According to how the main character is presented in this novel, only the servant of Ivan Ilyich, who has known the hardships of a subjugated life, is able to comfort and encourage him during his fading away. I would like to emphasize one point: wounds can become a source of humanization when they are accepted and integrated as part of life. They can revive the sources of our authentic existence, realized in the image of God, and the sources of human brotherhood. It is in this anthropological possibility of fragility that the radical action of Christ will be based.

Thus, the life of people affected by crises, including believers, inevitably bears the imprint of these crises, which are a test for them, to which their own being exposes them. Speaking about the COVID-19 pandemic, Pope Francis emphasized that people "will not come out of the crisis the same as before: they will become either better or worse"[5]. Through these trials, we can either move into a true relationship with ourselves, with others, and with God, or we can destroy the very humanity of our lives[6]. Therefore, such trials should be, as far as possible, the time that allows the believer to stop and consciously accept Christ as a model for himself.

Christianity as a dramatic salvation proposal

Christianity is an offer of life that brings a person to the limit of suffering, rather than protecting him from it; it forces the believer to accept and bear his own cross and even the cross of other people in order to find the true solid ground for a perfect life. It is

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[2] Here are the Beatitudes, in which the Evangelist Luke contrasts the Kingdom preached by Jesus and a world of satisfied people that hides the suffering: “But woe to you who are rich, for you have already received your comfort. Woe to you who are well fed now, for you will go hungry. Woe to you who laugh now, for you will mourn and weep.” (6, 24-25). And from here also comes the category of "preferential option for the poor", received in the universal Church from the III General Conference of the Latin American Episcopate in Puebla in 1979.

[3] Paul VI, Address to the United Nations organization in 1965 (https://www.vatican.va/content/paul-vi/es/speeches/1965/documents/hf_p-vi_spe_19651004_united-nations.html. As of 19.10.2021).

[4] D. Innerariti, “Antropología del hombre enfermo. La enfermedad como metáfora de la condición humana”, en: E. Anrubia (ed.), La fragilidad de los hombres. La enfermedad, la filosofia y la muerte, Madrid 2008, 91-102.

[5] Video message of the Holy Father Francis on the occasion of the 75th UN General Assembly 25.09.2020 (https://www.vatican.va/content/francesco/en/messages/pont-messages/2020/documents/papa-francesco_20200925_videomessaggio-onu.html)

[6] “The psychologists and the theologians, the poets and the mystics, assure us that impasse can be the condition for creative growth and transformation if the experience of impasse is fully appropriated within one's heart and flesh with consciousness and consent; if the limitations of one's humanity and human condition are squarely faced and the sorrow of finitude allowed to invade the human spirit with real, existential powerlessness; if the ego does not demand understanding in the name of control and predictability but is willing to admit the mystery of its own being and surrender itself to this mystery; if the path into the unknown, into the uncontrolled and unpredictable margins of life, is freely taken when the path of deadly clarity fades” (C. Fitzgerald, “Impasse and Dark Night”, en: T. H. Edwards, Living with Apocalypse. Spiritual Resources for Social Compassion, San Francisco 1984, 93-116 (96). https://www.baltimorecarmel.org/wp-content/writings/CF_Impasse_and_Dark_Night.pdf (15-9-2021).

in this situation that a paradoxical saving companion is offered to a person, who himself has also experienced suffering, but who is full of life and can share it.

In Kierkegaard's polemic with the Danish Church of his time, this may have been a Gordian knot of tension. The philosopher condemned the bishop's desire to get believers out of anguish with a consolation that did not mention extreme poverty and, consequently, devalued the way of salvation offered by Christianity. Only in sorrow, the philosopher believed, do we know who we are. Only in sorrow do we find the way to salvation. It is impossible to get the experience of salvation and consolation without touching the abyss of despair.

Some religious leaders illustrate this paradox:

> Let us think of Saint Juan de la Cruz thrown into a cell, in fact a prison, by the brothers of his order, and almost abandoned to death, if not to physical death, then to the death of his vocation and, thus, his personality. It is in this anguished situation, in the midst of extreme physical weakness, dirt and contempt that he is given the highest experience of God, which he reflected in a Spiritual Song and his other poems composed there[7].
>
> In the same way Dietrich Bonhoeffer, locked up in a prison at a time when the power of evil seemed stronger than that of God, writes the profound prayer In me there is darkness... [8], which describes his own experience of anguish, in which God reveals Himself as a Savior without modifying the external situation.
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> And, finally, the experience of suffering of a person who has realized the abyss of his sin, from which he can no longer free himself, and yet knows that sin has been overcome by grace. This is a gospel story telling about a robber crucified next to Jesus (Luke 23:40-43). And the person who turned this into a principle of spiritual life was Saint Silouan of Athos, who said: "Keep thy mind in hell and do not despair."[9]

These experiences, which occur in a simple and hidden way in many Christians, unite the Christian faith, since salvation always comes as an overcoming of the possibilities of the world, offering what it longs for, but cannot give itself. This is the core of what happened in the paschal mystery of Christ who gives himself to participate as an event of salvation. That is why it is in connection with this event that the ultimate foundation of eternal life is received, which frees the human being from his fear of limitation and death.

The weakness of Christ as a salvific event

The affirmation of the descent of Christ into hell and, even more, the resurrection as ascent from hell[10], confirms the salvific radical nature of the ministry of Jesus in this context. "For you know the grace of our Lord Jesus Christ, that though He was rich, yet

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[7] Cf. F. Ruiz (dir.), Dios habla en la noche. Vida palabra ambiente de san Juan de la Cruz, Madrid 1990, 157-188: "Noche oscura. Transfiguración en Toledo".

[8] "O God, early in the morning I cry to you. Help me to pray And to concentrate my thoughts on you; I can't do this alone. In me there's darkness, But with you there's light; I'm lonely, but you don't leave me; I'm feeble in heart, but with you there's help; I'm restless, but with you there's peace. In me there's bitterness, but with you there's patience; I don't understand your ways, But you know the way for me." (Resistance and submission. Letters and notes from captivity, Salamanca 2008, 105). Shortly before he died he wrote: "Our joy is hidden in suffering, and our life in death" (Quoted by E. Bethge, *Dietrich Bonhoeffer. Teólogo-cristiano-hombre actual*, Bilbao 1970, 1245).

[9] "Without this experience of descent into hell, it is impossible to truly know what the love of Christ, His Golgotha and His resurrection are" (Archimandrite Sophronius, Writings of St. Silouan of Athos, Madrid, 1996, 192). Jean Lafrance explains this phrase as follows: "It is a matter of realizing that hell is not only an objective reality, but that each of us is in hell to the extent that he is separated from God, from others and from himself. Hell is the division that I experience in myself, not doing the good that I want, doing the evil that I do not want" (The Power of Prayer, Madrid, 2000, 73).

[10] Cf. A. Gesché,«L'agonie de la Résurrection ou la Descente aux Enfers», Revue theologique de Louvain 25 (1994) 5-29.

for your sake He became poor, so that you through His poverty might become rich." (2 Cor 8:9), says Saint Paul, turning the event into a statement of faith.

Certainly, throughout his ministry, Jesus has worked to create an order of life where the excluded would be uprooted from the social chaos that swallowed them up, disidentifying them and annulling their presence in the world. Now, this ministry develops, assuming the fragile and harassed life of the creature.

With His birth (with His incarnation) He becomes our *brother in flesh and blood* not only in the space of human activity, but also in the space of inaction (Phil. 2:6-8). He becomes one of us with an existential poverty typical of the human, as described in the story of the beginning of His ministry - in the narrative of temptations. He is threatened by the forces of destruction, he is harassed by the historical forces of hatred, trying to deprive him of his dignity (Matt. 4:1-11; Luke 4:1-13). And in this situation, when "cries and tears" come out of His chest (Heb.5:7), he will nevertheless pull himself together and accompany the creation, " subjected to frustration" (Rom. 8:20).

The appropriation of this situation gives Him the possibility of becoming the ultimate and radical intercessor of men. This intercession will no longer be a foreign word to suffering, but the same human suffering that cries out for its redemption within God. Inserted in the very life of God, the wounded body of Christ begs to be definitively transformed within the life of God (1 Cor 15:28). Pascal pointed to it when he affirmed that "Jesus will be in agony until the end of the world"[11]. Thus, the intercession of Christ becomes a hope for salvation for man.

In addition, the basic and solidary experience of His infirmity makes Him a *mystagogue*, pointing the way to God from within His opposite - darkness. In the Epistle to the Hebrews, Jesus is presented as a model of saving faith, and the path of His suffering becomes a source of encouragement and hope for the believer (Heb. 12:1-3). This idea is taken to the limit by the Apostle Paul when he speaks about dying with Christ in order to be resurrected with Him (Rom. 6:8; 2 Tim. 2:11-13).

Thus, for the believer, the historical infirmity of Jesus and the constant memory of Him are a refuge, meaning and future, and we see this in the prayers that poor and humiliated people offer before the cross.

Thus, the infirmity of Christ marks the direction of the Church's activity. This activity should not be limited only to taking care of the world - that is, to organizing and transforming it. But it is also called to enter into its own poverty and suffering and from there illuminate the way for a compassionate, welcoming and encouraging accompaniment of humanity, which will help people to accept not only the riches of life, but also human existential infirmity as a space in which being is realized.

Epilogue. "You are the light of the world"

On this path, which passes through existential infirmity and suffering, and which turns into caring for others in the image of God, the experience of Julian of Norwich, which some recalled during forced isolation during the pandemic[12], is very important. The space of her mystical experience is a disease that puts her in the hands of death and from which she begins to recover at the moment when the priest hands her a crucifix. It is when she stops fighting death that she understands the tenderness of the crucified Christ's love for her. And at this moment she begins to come back to life to announce to everyone: “All shall be well, and all shall be well and all manner of thing shall be well.” A message that does not amount to a naive and unrealistic statement that everything will be resolved, but which should be read as a paraphrase of the exclamation of the Apostle Paul from the Epistle to the Romans: "For I am persuaded, that neither death, nor life, nor angels, nor

[11] *Pensées*, "Le mystère de Jésus", 553.

[12] See, for example, Michael Fox's book, Julian of Norwich: Wisdom in a Time of Pandemic-and Beyond, Bloomington 2020.

principalities, nor powers, nor things present, nor things to come, nor height, nor depth, nor any other creature, shall be able to separate us from the love of God, which is in Christ Jesus our Lord.“ (Rom. 8:38-39); or like the affirmation of Jesus, from the Gospel of John: "These things I have spoken unto you, that in me ye might have peace. In the world ye shall have tribulation: but be of good cheer; I have overcome the world." (John 16:33).

His imprisoned life, after experiencing pain and agony firsthand, becomes a source of evangelical hope in an environment plagued by wars and plagues, with the poverty and pain that they always bring with them.

The Church and the believer must allow themselves to be led into this space of radical infirmity and acquire there that humility which, paradoxically, endows them with equally radical strength and turns them into the light of the world. This is the Easter mystery, which one way or another must be realized in every believer and in the Church itself. Speaking here in Moscow, I can't help but recall that Fyodor Mikhailovich Dostoevsky also walked the same path, who with his wounded life witnessed in his literature the victory of light over darkness[13].

[13] “OnApril 14, 1867… Dostoevsky takes his wife to the museum to show her the Sistine Madonna by Raphael. He believes that this painting perfectly illustrates the idea that suffering creates beauty; *he achieves the same in his novels, in which the characters acquire moral splendor through misfortune, cleansed of everything ugly, vulgar, dirty, pitiful*” (V. Tanase, Dostoievski, Barcelona 2021, 146. Highlighted by us. - F.M).

Kirillin V.M.

Foolishness as a form of Christian asceticism

Abstract: The article reveals the concept of holy foolishness from a church point of view. The author points out that the phenomenon of foolishness as a special kind of spiritual asceticism took place already in the Old Testament era; Apostle Paul reflected on it; the feat of foolishness was occasionally encountered in the era of early Christianity and in the Byzantine Empire, and written evidence of this has been preserved. Foolishness as an imitation of Christ was widely spread in Russia, in the XI-XVII centuries; but also later, in the XVIII-XX centuries there were many fools in Christ. Some of them are ranked by the Church as saints, some remain a good memory to this day. Due to the fact that the line between true holiness and feigned, false "holiness" is barely noticeable, the criteria for evaluating foolishness, that is, distinguishing a genuine feat from an ostentatious, artificial one, or from illness, present a difficulty. The article explains why in the old days the holy fools were treated with respect, why the attitude in society towards the holy fools changed over time, why, finally, the very word "foolishness" began to be perceived by modern consciousness as a definition of madness or apery. The article concludes with a description of the traits and characteristics in the behavior of holy fools, which should be considered indicators of a true feat or, on the contrary, indicators of simulation, pretense.

Keywords: holy fool, blessed, holy, spiritual feat, veneration, church experience.

In our everyday language, we often use the words "foolishness", "foolish", sometimes referring to some kind of abnormality in human behavior [1]. However, the concept and phenomenon of foolishness has since ancient times been associated with a special kind of spiritual asceticism. Thus the question naturally arises about what is a feat of foolishness in the church's understanding [2] and who can and cannot be considered a fool in Christ? [3]

The concept of foolishness is known from the Old Testament. For example, some prophets indulged in the feat of foolishness, performing unexpected, shocking acts for people as a kind of call to repentance and return to God. Thus, the prophet Isaiah walked naked for three years, warning the Jews about their impending Egyptian captivity (Is. 20:2-3); the prophet Ezekiel for some time lay in front of the stone marking the besieged Jerusalem, and ate bread baked on cow dung (Ezek. 4:15); the prophet Hosea married a harlot, thereby pointing out the infidelity of the descendants of Israel to God (Hosea 3).

Apostle Paul reflected on foolishness in his epistles: "For the message of the cross is foolishness to those who are perishing, but to us who are being saved it is the power of God" (1 Cor. 1:18) or: "For since in the wisdom of God the world through its wisdom did not know him, God was pleased through the foolishness of what was preached to save those who believe" (1 Cor. 1:21). Obviously, apostle Paul should be understood as follows: Christianity from the point of view of the philistine consciousness is madness, it is a rejection of the usual, "worldly" system of values. It is impossible to fit Christian hope into this system. It doesn't mean, of course, that a Christian cannot have normal human needs, but that one should not put these needs at the forefront, but on the contrary, one should strive for spiritual perfection and reject everything that hinders this, everything that "brings down to land" a Christian.

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[1] "*Holy fool*. 1. Mentally ill, insane, crazy" [9, column. 2003].
[2] See : [5; 6].
[3] See: [3].

However, the denial of worldly attachments, that is, asceticism, is a broader concept than foolishness. But what is this feat in the perspective of Christian ascetic tradition and in its concrete manifestation?

The holy fools (from the Greek. σαλός) were blessed men and women who voluntarily assumed the image of stupidity and madness for the sake of, firstly, serving Christ and, secondly, "defaming the world" and its values. In this feat, the antithesis of the apostle Paul was realized: “Let no one deceive himself. If any of you thinks he is wise in this age, he should become a fool, so that he may become wise. For the wisdom of this world is foolishness in God’s sight. As it is written: “He catches the wise in their craftiness”” (1 Cor. 3:18-19).

In addition to the external madness, through which pride is destroyed, the characteristic signs of foolishness have always been the humble acceptance of reproaches and beatings, bold denunciation of vices, secret prayer and demonstrative impiety, finally, the ability to see what is closed to ordinary people, i.e. prophecy, only slowly comprehended by society.

The most, if you will, scientific characteristic of foolishness is contained in the book by Georgy Fedotov "Saints of Ancient Russia". In his opinion, foolishness is "1. Ascetic trampling of vanity, that is always dangerous for monastic asceticism. In this sense, foolishness is feigned insanity or immorality for the purpose of reproach from people. 2. Revealing the contradiction between deep Christian truth and superficial common sense and moral law in order to draw the world ridicule. 3. Serving the world with a kind of preaching, which is done not by word or deed, but by the power of the Spirit, the spiritual power of a person, often endowed with prophecy." [10, p. 163-164]

People, who took the path of foolishness saw in it for themselves the only way to salvation, saw the most adequate way to imitate Christ — again, for themselves personally! After all, from both a Christian and a historical point of view, the first fool was the Savior Himself, who completely rejected the values of this world and called humanity to a different way of life in the Holy Spirit.

Foolishness emerged in the East around the IV century as a special kind of asceticism. Thus, the testimony of Bishop Palladius of Helenopolisabout (IV c.) the Egyptian ascetic Isidora, in Coptic ‘Varankís’, who, while in the Tabenna monastery, pretended to be insane and possessed by demons, for which she was very despised by the sisters of the monastery [7, p. 147-149]. Evagrius Scholasticus (d. 600) also reports about a similar feat in his "Church History", telling, in particular, about certain insane people, called "grazing", who retired to desert places, were dressed only in waistcloths, completely indulged in prayers and ate plants, herbs, what the earth produced; and after returning to the world, continued their asceticism.At the same time, Evagrius claimed that this feat is the highest [1, p. 99-100].

In the ancient period of Christian history, foolishness was not widespread as a form of asceticism. So, in Byzantium, before the baptism of Russia, only six ascetics of this type were beatified (Simeon of Emesa, Serapion the Sindonite, Thomas of Coelesyria, Andrew of Constantinople, etc.). However, there are cases when some holy ascetics indulged in foolishness only for a while, devoting most of their lives to asceticism of a different type (Rev. Basil the Younger, Rev. Simeon the Studite, St. Leontios, patriarch of Jerusalem, etc.). In the Greek-Byzantine literature there were also stories about "God's people" who pretended to be mad, walked naked, wore chains and were very revered by the people. However, such unfettered forms of asceticism were negatively qualified by the official church authorities.

The feat of voluntary insanity was particularly popular in Russia. After St. Isaac of Kiev Caves Lavra (XI c.), the heyday of foolishness fell on the XIV-XVII cc. According to G.P. Fedotov, "the revered Russian fools are distributed over the centuries as follows: XIV century — 4; XV — 11; XVI — 14; XVII — 7", these are Avraamiy of

Smolensk, Prokopiy of Ustyug, Mikhail of Klopsk, Basil the Blessed of Moscow, Maxim of Moscow, Nikolai Salos of Pskov and many others. Of course, in this case we speak only about the fools, who were beatified, canonized. Historically, of course, there were more of them [Fedotov 2000: 162]. However even these data show that the feat of foolishness is not widespread, that it is always a unique phenomenon. It is appropriate to emphasize here that in the times of Kievan Rus there were practically no fools. More precisely, some ascetics of that era — for example, Isaac of the Caves [4, p.79, 183-184] or Abraham of Smolensk [2, p. 34, 35] — sometimes indulged in this feat, but then changed for a different way of asceticism. However, in northern Russia or Moscovia, foolishness was given great importance. Fools were usually perceived as accusers of unrighteous power and heralds of God's will. That is why they were often revered during their lifetime and, of course, after their departure to the Lord. In this regard, the memory of St. Xenia of St. Petersburg, who died at the beginning of the XIX c., is very illustrative [8]. Her popular veneration was and remains so great, the belief in her intimacy with the Lord is so strong that after her death the path to her grave does not overgrow to this day, and not figuratively, but literally. This kind of popular veneration is extremely important. This example shows that the veneration of a saint by church people is not caused by some official decision of the Church — no, the sequence is reversed: the recognition by the Church is based on a deep popular veneration of a person with an unshakable reputation of “God’s man”.

There are quite a lot of written testimonies about the Northern Russian fools in form of their biographies or stories about particular episodes of their life. But all such narratives usually were compiled after the death of their heroes, and, of course, they are always incomplete and mainly reflect popular ideas about the past. Nevertheless, substantially these sources contain sufficient information about the feat of foolishness.

Usually, the fools did not give any explanations for their strange words and actions. However, this was not necessary. In general, Orthodox people understood that the unusual behavior of the fools was not an end in itself, but a means to make society think about the meaning of being, the meaning of Christ's teaching and in general about the way of salvation. In this regard, the legend about the Pskov fool Nikolai Salos and Tsar Ivan the Terrible is interesting, not known by the way from ancient Russian sources, but recorded by Giles Fletcher, who visited Moscovia in 1588.

"... There was another such saint, who was highly respected in Pskov (Nikola of Pskov by name – V.K.), who did a lot of good at the time when the father of the current Tsar (Feodor Ivanovich) came to plunder the city (Pskov after Novgorod in 1570 – V.K.), as he thought that a revolt was being planned against him. The tsar (Ivan the Terrible – V.K.), having previously visited the Blessed man at home, sent him a gift, and the holy man, in order to thank the tsar, sent him a piece of raw meat, while at that time they had a fast. Seeing this, the king ordered to tell him that he was surprised how the holy man offered him to eat meat during the lent, when the Holy Church forbade it. "Does Ivashka think (said Nikolai – V.K.) that it is sinful to eat a piece of meat of some animal during the lent, but there is no sin to eat as much human meat as he has already eaten?" Threatening the Tsar that some terrible accident would happen to him if he did not stop killing people and did not leave the city, he thus saved the lives of many people at that time. People love the blessed saints very much, because they ... point out the shortcomings of the noble ones, which no one else dares to talk about. But sometimes it happens that because of such audacious freedom, which they allow themselves, pretending to be fools, they are secretly disposed of, as it happened with one or two at the time of the last tsar, as they too boldly criticized the reign of the tsar" [11, p. 101-102].

According to G.P. Fedotov, after the XVII c. the foolishness in Russia was an increasingly rare type of asceticism in Christ. The most famous fools in Christ of later

times were Prokopiy of Vyatka (d. 1627), Ioann of Verkhoturie (d. 1701), St. Xenia (d. 1803), Ivan Yakovlevich Koreisha (d.1861), Paraskeva of Diveevo or of Sarov (d. 1915), the Leningrad fool Grigoriy Kalinovich Deyanov (d. 1932), Vera Leontievna Gureeva (d. 1968). Generally there are quite a number of them, but only very few are recognized as saints. Obviously there are reasons for that. From a certain point on — more precisely, during the Synodal period — the Russian Orthodox Church became cautious about this feat, since foolishness could have different causes, although the external manifestations could be similar. Firstly, this could be foolishness in the strict sense of the word, that is, a feat based on the struggle with one's own pride in order to overcome the temptations of this world and for the sake of salvation. Secondly, this is the behavior of people with some mental disorders (such people were called "silly"). Thirdly, this is pseudo-foolishness, when people really put on the image of madness, but not for the sake of high Christian goals, not for the sake of following Christ, but for the sake of satisfying their own pride and gaining some benefits — that is, here we are already talking about a spiritual illness, a state of delusion. And it was not always easy to understand what kind of phenomenon one was confronted with each time. However in terms of a philistine perception of life in Christ, apparently, the feat of foolishness was more understandable to people than the feat of an ascetic monk. After all, it is one thing when a monk reaches spiritual perfection behind the walls of a monastery, in his quiet cell, mostly cut off from people; and it is quite another thing, when a person lives in full view of everyone, communicates with people, talks to them, demonstrates by his "non-standard" behavior how hard one can work, following Christ, not sparing either his own beauty, or youth, or physical health, live in spite of normal human values, in poverty, disgrace, and at the same time maintain pure spirit and heart. It is clear that the words and behavior of the fools — that were poor, in need of help and care — somehow stimulated others to kindness and mercy. That is to say, there was also a kind of pedagogical impact of these interactions. The fools by the very fact of their existence, by their challenge to the values of worldly life, influenced the consciousness of people. In church community, they were perceived as people of God, and in public opinion it was impossible to offend such people, as it was the same as competing with God. Moreover, it concerned not only the fools in the strictly ecclesiastical sense of the word, but also just week, sick, poor and disadvantaged people. Offending such a person was considered a sin, and a dangerous thing: God could intervene. That is, both mercy and the fear of God were combined here.

Rationalistically minded people share the opinion that fools in Christ should actually be considered mentally ill or mentally retarded people, that even if they act as mediums, as heralds of God's will, their condition is still a problem of psychiatry. However, I think this is a complex problem. Its solution probably requires a good knowledge of church experience and the ability to see this or that case of foolishness simultaneously in spiritual, cultural, historical, and social perspective. Of course, for a materialist who denies the existence of God and the possibility of the Holy Spirit influencing a person, foolishness as a phenomenon is unacceptable, and the deviation from the standard stereotype of behavior can only be explained by a mental illness. But in the eyes of a believing Christian, a fool can be completely healthy mentally, and his actions can be motivated not by medical, but by spiritual reasons. At the same time, it should be borne in mind that in modern consciousness the word "fool", as already mentioned, is really synonymous with "mentally ill". However, it is important to remember that the meaning of words changes over time, whether due to the laws of language development or, what is more important in this case, under the influence of various changes in society. For example, the well-known process of secularization in the Russian society, that is, the process of displacement of the Church and Church

traditions, since Peter the Great, from social, intellectual, cultural, behavioristic[4] life and the gradual replacement of the Christian ethical and spiritual value system by some other worldviews and foundations. The words remain in the language, but they acquire new semantic shades in the new coordinate system. Apparently, this is why in modern perception, foolishness is considered synonymous with mental abnormalities. The secularization of life foundations is also manifested in the fact that people have become spiritually callous. So, in particular, if earlier the fools were seen as messengers of the will of God, then later, when society distanced itself from the Church, the fools began to be perceived as mentally handicapped people, who belong in a madhouse. Nevertheless, the feat of foolishness was quite widespread even in Soviet times. Indeed, no matter which diocese you come to today, they will definitely tell you about the local fools, men and women, who lived there in the 1920s — 1930s, during and after the Great Patriotic War and even in the times of Khrushchev, and they will also show you the grave, which certainly would be well taken care for. Yes, there were some people who told the truth to society, but clothed it in a very unexpected form, sometimes even completely going beyond the bounds of decency.

Of course, there is always a problem of authenticity. The question is how to distinguish true foolishness from false? I think we can still offer some criteria.

Firstly, it is an external goal setting. If it is a real fool in Christ — he will proclaim the truth of God, not of man. That is, if his "message", as they say now, boils down to the protection of human rights, to the demands of political and economic reforms, to the denunciation of certain power institutions or personalities — you can be sure that this is not foolishness in the ecclesiastical sense of the word. At the same time, of course, it is incorrect to say that all these goals are a priori bad and there is no need to fight for them. But in such cases, we have an ordinary political struggle, and not a feat of foolishness.

Secondly, it is internal motivation. Of course, it's more difficult to talk about it, because we can't know what's going on in a person's mind if he doesn't tell us about it himself. But from the church tradition, from the hagiographic literature, we know that people most often took on the feat of foolishness, striving to be as Christlike as possible, and not from purely rational, pragmatic considerations. Therefore, if we know that someone started behaving like fools, based on a sober calculation, for the sake of "public benefit" — we have the right to question the authenticity of such foolishness.

Thirdly, it is an undoubted deep faith, characteristic of real fools. The faith that was characteristic of them even before taking on the feat of foolishness. If someone is declared a fool who has not previously shown his faith in any way, whose lifestyle did not in any way testify to following Christ— then we have every reason to doubt.

Fourthly, a real fool is ready to endure ridicule, indignation, vilification humbly, fearing nothing and no one. Such a person decides to go in for the feat of foolishness because his main goal is to save himself from pride, to accept insults, bullying, persecution and do so with the fear of God. The fool sees this as his way to follow Christ, who voluntarily accepted the crown of thorns, beatings, spitting, ridicule and, most importantly, death on the cross. Therefore, if a person behaving like a fool is surprised and outraged by public condemnation, rushes into a counterattack, defends his rights... — this is a sure sign that there was no real foolishness. There is no foolishness without humility.

Fifthly, the real fools in Christ, beatified by the Church, not only proclaimed the truth of Christ to those who evaded it, but also had a prophetic gift, predicted some events to society, which happened soon.

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[4] *The term "behaviorism" used in psychology goes back to the English word "behavior" - act, conduct, mannerism.*

And finally, the last and most obvious criterion: if the activity of a "fool" causes a split in society, if mutual bitterness increases as a result of his shocking behavior, if people do not come closer to God, but, on the contrary, move away from Him, then there are no God inspired works and proclamation.

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Religious fanaticism and religious delirium

The problem of religious fanaticism, which is of a multidisciplinary nature, has now acquired particular significance. Guided by various approaches (sociological, politological, philosophical, historical, medical, legal, etc.), experts have different views on this problem and even differently define the term itself [1, 2, 3, 4]. Some believe that the word "fanaticism" comes from the Greek "thanatos" – the god of death in ancient mythology, thus emphasizing that to be a fanatic means to be devoted to something until death [5]. Other authors are convinced that the term "fanaticism" comes from the Latin word "fanatismus", therefore a fanatic is a person frenzied, frantic, ecstatic, driven to an extreme degree of excitement and commitment to certain views [6]. Specialists who study the problem of fanaticism emphasize that there are at least two components to fanaticism: a special personality and a special dominant idea; they define fanaticism as a state associated with a certain personality structure and characterized by conviction, fixation on narrow value systems, this is combined with a high degree of identification of a person with these values, the intensity of fixation on these experiences [7, 8]. Such people are not capable of compromise, dialogue with others, and those who express other views are considered by fanatics as enemies, against whom all means of struggle are used, and no attention is paid to possible consequences.

Let's look at this problem from a clinical point of view. As already mentioned, fanaticism occurs in individuals of a special type with a paranoid temperament, while they have overvalued ideas and are possessed by them. These ideas fill their psyche and have a dominant influence on behavior. P.B. Gannushkin adhered to this point of view, he described religious fanatics as “indifferently cold or demandingly strict, ... human grief does not touch them, and heartless cruelty is their quality” [9]. The main strength of fanatics lies in the invincible will that helps them do what they see fit, which makes them dangerous to society.

Overvalued ideas, first described by the German psychiatrist S.Wernicke [10], or rather overvalued formations, involve the entire sphere of the patient's consciousness, are associated with affective catathymic mechanisms. B.V. Shostakovich [11] wrote: “Overvalued ideas are beliefs closely related to personality traits that arise under the influence of a real situation, are logically developed, acquire excessive importance due to high emotional charge and occupy a dominant place in a person’s mind, influencing his actions and behaviour. Overvalued formations are characterized by high emotional richness, stamina, full conviction, and, as a rule, cannot be corrected by opposite ideas.

Specialists differentiate between essential (primary/classic) and induced (infected) fanaticism [7]. Content wise, fanaticism can be political, legal, national-racial, and fanaticism can also be found in such areas as sports, art and health.

The subject of our brief presentation today will be religious fanaticism in its most typical variations. Religious fanaticism arises as a result of the crisis of an individual's religious identity and is an extreme form of religiosity of an individual or group, potentially dangerous for society, which actively invades and negatively affects the worldview of other believers [1]. In these cases we are dealing with an extreme form of religiosity. Fanaticism is a "distorted child of religion" according to Voltaire, since a religious fanatic sees himself as the bearer of the highest truth, considers himself a weapon in the hands of God.

The most important feature of people with fanaticism is the anti-social orientation of their behavior, the systematic violation of social norms, the tendency to self-destruction, up to suicide. Fanaticism is always "gloomy and cruel", fanatics are judges who pass death sentences on those who think differently than they do. As P.B.

Gannushkin writes, often under the leadership of fanatics, “savage deeds, monstrous crimes were committed: self-torture, torture, torment, murder”; fanaticism implies "the absurd fury of people blinded by malice" [9]. Examples are the religious wars (1618-1648) between Protestants and Catholics, the collective suicides of the Priestless Old Believers at the end of the 17th-19th centuries, the terrorist attacks of September 11, 2001, and other events.

Fanaticism has a destructive power that destroys society, as we have seen in recent decades with the example of companies unleashed around a TIN, a bar code, refusing a passport, waiting for the end of the world. In such cases, religious people with fanatical faith were no longer convinced by the appeals of either the Patriarch or spiritual fathers.

Another fairly large group should also be mentioned - the so-called fanatics of emotions - enthusiastic adherents of religious sects. They serve as mere instruments for the implementation of the goals of the leaders, quickly fall into full obedience and are solely in the grip of one affect, an emotional mood. They are completely uncritical about what is their deified object of worship. In these cases, specific social conditions play an important role, namely, social exclusion, social maladaptation, poor adaptation to reality.

A few words must be said about the difference between true religious belief and religious fanaticism. Let us take an example from the patristic tradition.

The “Ancient Patericon” tells the story of Abba Macarius the Great, “walking to the Mount of Nitria with his disciple, he told this disciple to go on ahead. When the latter had gone on ahead, he met a priest of the pagans, who was in a hurry somewhere, carrying a large piece of wood. The disciple shouted after him saying: ‘Oh, devil, where are you off to?’ The priest became angry and beat him and left him half dead. Then he hurried on. When he had gone a little further, Abba Macarius met him running and said to him: ‘Greetings! Greetings, you hard working man!’ Quite astonished, the priest said: ‘What good do you see in me, that you greet me?’ The old man said to him: ‘I greeted you because I saw you working hard and wearing yourself out and hurrying somewhere’. The priest said to him: ‘I have been touched by your greeting and I realize that you are a great servant of God. But another wicked monk who met me insulted me and I have given him blows.’ Then the priest fell at his feet, hold them and said: ‘I will not let you go till you have made me a monk.’ They went on together. When they came to the place where the beaten brother was, they put him onto their shoulders and carried him to the church, because he could not walk... The priest converted to Christianity, and then became a monk; through him many pagans became Christians. On this occasion, Abba Macarius said: ‘A proud and evil word directs good people to evil, but a humble and good word turns evil people to good’ (Patericon by Bishop Ignatius Brianchaninov).

Thus, we see that Christianity calls to hate the sin, but to love the sinner. It is wrong to believe that for salvation you need to perform only a certain set of actions (self-immolation, bodily fasting up to death from exhaustion, many hours of night vigils), in which the performance of bodily feats, religious rites, i.e. the adherence to the letter of the law stands in place of sacrificial love for one's neighbor. For a fanatic, blind adherence to religious rules, to one or another dogma is more valuable than another person; in other words, for such people, "the Sabbath is more important than the man." It is much more difficult to live in Christ, to listen to those neighbors whom the Lord sends, and to meet them with the humble and sacrificial love of Christ. The fanatic sees only perishing people and thanks God that he is not like all other people, he thinks that everyone will perish, and he alone will be saved.

It is important to note that in the case of an endogenous disease, especially at its initial stages, an overvalued formation with religious content creates a wrong picture of a traditional religious worldview. Later, overvalued ideas are transformed into

overvalued delirium, which is psychologically understandable and is seemingly based on religious beliefs. The subsequent modification of psychopathological symptoms, which usually occurs 5-8 years after the onset of the disease, is reviled in the replacement of overvalued formations with a disorder of a more severe register – interpretive delirium. Poorly systematized unstable delusional ideas are gradually transformed into a complex paranoid system, delusional ideas of a religious nature are expanding, delusional ideas of relationship and persecution are adding up, capturing an increasing number of imaginary ill-wishers. As a result, a complete reassessment of one's own personality occurs, delusions of grandeur develop, and in some cases hallucinatory manifestations, which very quickly turn into verbal imperative hallucinatory syndrome. At this stage, the entire behavior of patients is determined by religious delusions and often leads to severe and dangerous acts of aggression.

It is important to emphasize that religious delirium, in contrast to overvalued formations, is not determined by the temperament of the individual, and its content may be in sharp contradiction both with the latter and with religious traditions objectively existing in society.

One feature of religious delusions, in particular, of the delirium of the end of the world with religious content, is specific destructive delusional behavior. According to the research data of the Scientific Center of Mental Health, one in ten patients with delusions with religious content showed an explicitly asocial and/or antisocial behavior.

This aspect was described in detail by K. Jaspers [12], who believed that such patients could be extremely dangerous for those around them, especially at the peak of the described mental disorder, due to their readiness for fanatical actions." According to the author, the most frequent acts of violence are: attacks on clergy, misbehavior during Church worships, desecration of churches and blasphemy over icons, often sick people kill their loved ones. Insanity of this kind may also acquire judicial or social significance because such patients often refuse to obey established laws and regulations. Patients with religious delusions can be dangerous for themselves due to refusal of food and self-torture, going in some cases as far as self-crucifixion on the cross.

According to modern researchers [13,14,15,16], an important feature of endogenous psychoses with a religious plot of delusion is a specific form of delusional behavior associated with a high risk of non-suicidal self-destructive actions (penetrating eye injuries, autocastration) and suicidal, as well as, in individual cases, heteroaggressive actions. V.E. Pashkovsky [17] was one of the first to develop a detailed classification of the behavioral characteristics of such patients. Some researchers [18] described the self-destructive behavior of patients with a religious delusion of the end of the world, who misinterpreted the Gospel of Matthew as a call to inflict bodily harm on themselves.

One example of delusions with religious content, involving aggression, may be associating oneself with the Antichrist [15]. The authors give the example of a patient involved in an active religious Protestant life since childhood, who abducted and raped two women. He considered his actions acceptable because, as the Antichrist, he could make them to have sexual intercourse with him and could do it with force, since he was evil.

Torres P. in his study of aggression and violent behavior highlights the concept of "apocalyptic terrorism", citing such destructive religious organizations as Aum Shinrikyo, ISIS, CSA. The ideological basis of all these organizations is the idea that the modern world must be destroyed in order to be saved and cleansed. Incorrectly interpreting the texts of the main religious treatises, the leaders of these extremist groups, together with their numerous followers, staged terrorist acts all over the world [19].

In cases where relatives do not interfere in any way with the delusional behavior of patients and, on the contrary, support their delusional beliefs, one can speak of induced delusion – a delusional disorder that develops in a loved one or in a group of people having a close emotional connection with the delusional patient. In this situation, they fully share the patient's delusional beliefs and, accordingly, are not able to seek the necessary medical help, since they themselves need it, while there is no criticism of both the "inductor" state and their own state.

According to numerous researchers, religious delusions have a worse prognosis compared to delusional disorders that have a different, non-religious plot. The reason is the later terms of admission of patients for treatment due to the lack of criticism of their condition, the significant severity of psychopathological disorders due to the lack of timely and adequate therapy, deeper disorders of social functioning, as well as the need for repeated hospitalizations.

In patients with religious delusions, delusional constructions have a plot of pseudo-religious concepts, which, as a rule, contain a ridiculous and bizarre mixture of ideas from various religious systems. Mental illness contributes to alienation both from people who adhere to traditional values for a given society, and from one's own family. Such patients most often do not maintain contact with the religious community and come into confrontation with their spiritual fathers due to a negative attitude towards traditional religious institutions. Patients with religious delusions show a high degree of non-criticality, rigidity; and patients have features of a personality defect.

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Toxic religiosity and non-clinical psychocorrection in extra-liturgical activities of a parish

One of the difficult issues that almost any parish priest is facing is the problem of mental health of parishioners, namely believers with mental health problems of varying severity. Although this problem seems to be universal, it has its own specifics in the church environment.

The first and basic difficulty we face is the problem of defining the norm. Though in psychiatry the divide between the norm and pathology is relatively definable - albeit with some difficulties, - in psychology this line is greatly expanded depending on the scholarly tradition and the system of criteria. In religion, the problem of the norm becomes practically nonsolvable. Christianity affirms Jesus Christ Himself as the only norm of man; accordingly, all the other people automatically find themselves in the area of abnormality, pathology. But even within this "abnormal" community, we will see by no means a linear gradation from "closer to Christ" or "farther from Christ", but many intersecting, often conflicting with each other planes, facets, shades, each of which will claim that its understanding of how much it corresponds to the Spirit of God or not, is true.

How can we talk about the phenomenon of "toxic religiosity" in such a situation? After all, what a secular researcher can call "toxic", from the position of a church person is the norm for a believer, and perhaps even a desired ideal!

For example, Stephen Arterburn and Jack Felton – who introduced the concept of "toxic faith" into the scientific vocabulary – point to the following religious attitudes, which, in their view, are clearly toxic:

1. "God's love and favor depend on my behavior.
2. When tragedy strikes, true believers should have a real peace about it.
3. If I have real faith, God will heal me or someone I am praying for.
4. All ministers are men and women of God who can be trusted.
5. Material blessings are a sign of spiritual strength.
6. The more money I give to God, the more money He will give to me.
7. I can work my way to heaven.
8. Problems in my life result from some particular sin.
9. I must not stop meeting others' needs.
10. I must always submit to authority.
11. God uses only spiritual giants.
12. Having true faith means waiting for God to help me and doing nothing until He does.
13. If it's not in the Bible, it isn't relevant.
14. God will find me a perfect mate.
15. Everything that happens to me is good.
16. A strong faith will protect me from problems and pain.
17. God hates sinners, is angry with me, and wants to punish me.
18. Christ was merely a great teacher.
19. God is too big to care about me.
20. More than anything else, God wants me to be happy.
21. I can become God."

If this list is read to almost any Orthodox parish (and not only orthodox!), without special comments, believers will easily agree with most of the statements. Is the Christian religion really inherently toxic in itself? And what is toxic for a researcher is a desirable norm for the church environment itself?

We should note that Samuel J. Pfeifer in his article "Faith-induced Neurosis: Myth or Reality?" criticizes Arterburn's and Felton's approach, saying that they create labels that can easily be misunderstood as (mono-) causal models of psychopathology in a religious patient . According to Pfeifer, neurosis can be not only "ecclesiogenic", but also "ecclesiomorphic". But in any case, according to Hark (1984), "neurosis disturbs religious life, whereas positive religiosity contributes towards healing."

Toxic (neurotic) religiosity can be defined as a concept in psychology and psychiatry that reveals the causal relationship between religious faith (or religious formation) and the development of neurotic disorders. This concept describes heterogeneous phenomena and factors in a person's religious life that have a negative impact on his psychological state and mental health . St. Porfirios Kavsokalivitis says that the essence of Christianity is love, inspiration, hunger for the Divine, and striving for it is a natural desire of our soul. But for many people, religion is a struggle, disturbance and stress. Therefore, many "religious" people are considered unhappy people because it is obvious what a deplorable state they are in. And it is really so. If you do not understand religion in its depth, if you do not live it, then religion (piety) turns into a disease, and even into a terrible disease. So terrible that a person loses control over his actions, becomes weak-willed and powerless, suffers from anxiety and stress, he is guided by an evil spirit. He bows, cries, beseeches, as if humbling himself, but all this humility is a satanic act. Some of these people perceive religion as a form of torment. In the church they bow, cross themselves, say: "We are sinful, unworthy," but as soon as they go out into the street, they begin to say blasphemy if someone annoys them even a little. It becomes obvious that there is a demon in them."

According to Marina Filonik, any neurotic is characterized by "neurotic unconsciousness", which manifests itself as an absolute certainty that his ideas are true; but when "such a person finds himself in an authoritative system of norms and rules with a strict distinction between "what is good and what is bad", often his already existing "neuroses" are fixed, which leads to even greater personal unfreedom." "Righteous piety combined with hatred of all others can be a typical example of this kind of substitution," the researcher believes .

Toxic religiosity has several factors.

1. Psychopathological (neurotic). It can be caused either by specifics or deviations in the work of the psyche, or by psychological traumatization. The corresponding dysfunction leaves its bright specific mark on the particular type of toxic religiosity.
2. Existential. The lack of clarity in relations with God, the world, people around you and yourself. The fear of being unworthy of a relationship when the things will be sorted out.
3. Spiritual (ontological). Lack of deep faith in the goodness of God and His willingness to gather the "prodigal son" in His fatherly arms. Inner alienation from the grace of the Spirit that illuminates the soul.

In each specific situation, the significance of each of these factors may be different, but in any case they are all present to a certain extent.

What factors of parish life can provoke neuroticism?

1. Rigidity of social roles, "blind obedience". A spiritual child cannot question whether the father confessor's blessings are really correct and appropriate, since this will be perceived by both sides as a sin of disobedience. Only in a situation of acute crisis is it possible to go beyond this form of behavior.
2. Mutual alienation while maintaining external friendliness. In a more or less large parish, especially with a high turnover of parishioners, it is impossible to build deep and safe interpersonal trusting relationships.
3. Fear to declare one's own "spiritual failure".

4. Justification of violence and overstrain.
5. Cultivating hatred for any manifestation of corporality.
6. False understanding of "self-distrust".
7. Blindness to the didactic word due to its "obliteration".
8. Identification of the penitential attitude with the psychopathological position of a "victim", repressive practice of confession of sins.
9. A spiritually justified ban on the expression of feelings, "internal censorship" of feelings.
10. Non-recognition of personal boundaries, habituation to life with a bare soul.

Thus, once in the church, a person with an unstable or disturbed psyche can easily find himself trapped: the specifics of the church environment will not allow him to form a request for healing, while a faint hope would loom somewhere in the distance that only the Church will help him. It seems that it is possible to provide assistance, while not always help by spiritual and ascetic means can be provided precisely because a person is not ready to accept it due to a neurotic or mental disorder.

What if we look at the phenomenon of neurotic religiosity through the prism of the Gospel description of Christ? Here is the result in the form of a comparative table (Table 1).

Table 1. Criteria for distinguishing between healthy and pathological (toxic) religiosity.

Healthy religiosity	*Toxic religiosity*
Dialogue. The answer from Above often does not meet person's expectations. "Abba, Father," he said, "everything is possible for you. Take this cup from me. " (Mk. 14:36)	Monologue. The object of the religious action corresponds to person's expectation. He is convinced that God can be understood in essence, although declaratively he can state that God is incomprehensible. He is unwilling to accept reality in all its incomprehensibility and versatility.
Internal stability. The new and unexpected circumstances, not even necessarily positive, are accepted calmly and even with anticipation of "intrigue": I wonder what will come of it in the end? What will it lead to? A conditional "amount of faith" is enough not to "collapse" and not "break" under the load of circumstances. "Yet not what I will, but what you will" (Mk. 14:36).	Instability. Any change of context, circumstances, appearance of something unpredictable and uncontrollable knocks a person out of a rut. He wishes to foresee everything, to predict, to "cushion the blow ". "The amount of faith" is not enough, it leaks out and is quickly depleted. The declarative minimum of faith is preserved, the loss of which is equivalent to self-destruction.
Flexibility. If necessary, the degree of flexibility can vary, but does not turn into surrender. (Conversation with the Samaritan woman. Most of the dialogues of Christ. Relations with Pharisees and Scribes)	Rigidity. Getting stuck and "sticking" on negative feelings and experiences. "All-or-nothing!" Either to achieve one's purpose, get what one wants, or go for a complete and unconditional surrender.

Delicacy. A person does not seek to enjoy the situation in which he causes pain or suffering to another. He is not malicious, not vindictive. (The story of the Samaritans who refused hospitality. "You don't know what kind of spirit you belong to!" (Luke 9:55).The story of the healing of the Gadarene demoniac and the expulsion from that place. "Father, forgive them, for they do not know what they are doing! (Luke 23:34)).	Impudence. A person does not feel the other, does not appreciate his experiences, does not have empathy. He gets pleasure when he gets the opportunity to hurt another for the sake of high spiritual goals.
Prudence. At the same time, a person leaves a certain "gap" for the unexpected, for the occasion and direct intervention of God. (All the disputes of Jesus. Most vividly – in parables).	Hyperrationality or, on the contrary, recklessness. A person perceives falling out of the framework of any habitual "matrix" (dogmatic, ethical, canonical, etc.) as a catastrophe.
The ability to accept one's own limitations. A person is not afraid of manifestations of his own weakness or imperfection (a call to the apostles to share the burden of the Gethsemane prayer. Falling under the load of the Cross).	Rejection of one's limitations and fear of one's own weakness. A person carefully hides his weaknesses, does not allow external help.
Accepting forgiveness. A non-destructive experience of guilt. A person feels guilty when committing a sin, which pushes him to repent and receive forgiveness. The evidence of forgiveness gives confidence in God's good attitude and strengthens the hope for salvation as a deep and stable source of joy. (Not directly applicable to Christ, Who was sinless. But, in fact, the Parable of the Prodigal son is about this).	Non-acceptance of forgiveness. Understanding guilt as inevitable. A person feels a strong sense of guilt, sometimes is overwhelmed by it and tries to hide it. Does not allow himself to rejoice, relax, deeply "exhale".
The ability to regulate the boundaries of interpersonal relationships. A person allows others to enter, destroy boundaries, but in certain situations of close relationships is also able to let another person in deeply enough without fear. (The story when the Mother of God called Jesus – "Who is My Mother? Who are my brothers?" (Matt. 12:48))	Inability to set boundaries. A person is rather alert than trusting. Either he is in a sealed bunker, or keeps the doors wide open.

The ability to forgive betrayal. (The story of Apostle Peter's betrayal)	A person does not forgive betrayal, especially to those whom he has trusted.
Acceptance of one's corporality. A person feels the needs of his body as his own, finds ways to satisfy them and can manage them ("The Son of Man came eating and drinking, and they say, 'Here is a glutton and a drunkard, a friend of tax collectors and sinners.' But wisdom is proved right by her deeds" (Matt. 11:19). (The story of Jesus sleeping on the stern)	Disidentification from one's own body. A person does not know how to listen to the body, does not feel it as an instrument that can be easily tuned up.
The ability to experience joy. A person feels mostly gratitude and joy than negative emotions. He is able to recognize the good Providence of God in the events of life, directing everything to the best possible outcome.	Anxiety and inner disorder. The person lives in anticipation of trouble and in anxiety, justifying it by sinfulness.
Emotional openness and adequacy (Jesus crying at the tomb of Lazarus, angry at those who forbid bringing children, tender at the Last Supper, languishing in spirit in anticipation of suffering, etc.).	Alexithymia. Emotional "closedness".
A person tolerates people with different views and accepts the other while maintaining his own point of view and personal boundaries ("John said to Him, ""Teacher," said John, "we saw someone driving out demons in your name and we told him to stop, because he was not one of us." "Do not stop him," Jesus said. "For no one who does a miracle in my name can in the next moment say anything bad about me, for whoever is not against us is for us." (Mark 9:38-40))	Close-mindedness. A person feels acute discomfort when being in the company of people who clearly do not share religious views. He feels endangered.
Self-irony. A person loves and shows interest in humor, jokes, including over himself. Understands the boundaries between good irony and malicious sarcasm, knows how not to cross them. "To what can I compare this generation? They are like children sitting in the marketplaces and calling out to others: " 'We played the pipe for you, and you did not dance; we sang a dirge, and you did not mourn.' For John came neither eating nor drinking, and they say, 'He has a demon.' The Son of Man came eating and	Aggressiveness. Impatience and a strong emotional reaction (anger, resentment, rancor) to any jokes directed to the person. A grim aggressive reaction even to harmless irony. Tendency to sarcasm and devaluation.

drinking, and they say, ‘Here is a glutton and a drunkard, a friend of tax collectors and sinners.’ But wisdom is proved right by her deeds” (Matt. 11:16-19)." "Are you betraying the Son of Man with a kiss?" (Luke 22:48)	
Accepting crises, including the crisis of one's faith, as a normal stage of spiritual growth. ("My God, My God! Why have You forsaken Me?" (Matt. 27:46))	Fear of crisis, especially in the sphere of faith. Unwillingness to admit to oneself that faith is "seeping" somewhere.
The desire for knowledge and development. Organic, natural expansion of the sphere of interests and gradual deepening of its subjects (The Boy Jesus in the Temple. Life in Galilee).	Total loss of interest in everything that is beyond the boundaries of the religious proper (knowledge, experience).
Openness to spontaneous (simple and natural) behavior, to "living" an actual situation (a conversation with a Samaritan woman, a miraculous catch of fish, appearance after the Resurrection on the Lake of Galilee, the assurance of Thomas, etc.)	Self-obsession and internal rigidity, viscosity, awkwardness in situations requiring quick decisions.

The problem with toxic religiosity in a parish is further complicated by the fact that a priest who does not have a specialized psychological education cannot serve as a psychologist; despite the fact that to some extent every clergyman is confronted with psychological problems and is forced to deal with them in one way or another.

However, is it really not possible to do anything at a parish to help people with obvious neurotic religiosity – if they do not want to seek psychotherapeutic help in principle? At the parish, it is possible to create conditions during extra-liturgical activities that will help, if not resolve the neurotic conflict, then at least significantly weaken it.

Is there a way out of this impasse? I propose to consider a new approach to solving this issue through the application of the recent psychological and pedagogical technologies and methods within the parish's extra-liturgical activities.

Why does extra-liturgical activity have a high therapeutic potential in relation to neurotic religiosity?

1. A person suffering from a neurotic disorder is prone to social isolation rather than to active interaction with other members of the parish. The divine service itself does not presuppose (within the prevailing tradition) joint "doing": the choir sings, the priest serves, the believer prays in his place and does not interfere anywhere. Extra-liturgical activity helps to overcome this "tightness".

2. Neuroticism occurs along the line of "you have to" – "it's impossible!" Setting short-term and achievable goals, for example, completing any activity with some small but tangible result, helps a person to believe in his ability to achieve the goals.

3. Manual labor is of particular importance in order to "bring the neurotic back to himself" from the hassle of the "ideal Self". Muscle memory, skills, participation of the body in activities with a correctly chosen balance between skills and the tasks (requirements) (see M. Chiksentmihayi) restores the neurotic's lost or weakened contact

with himself. "Alienation from oneself" is the first most important unconscious means of reducing destructive neurotic tension, and therefore restoring connection with oneself is the most important element of therapy.

4. Extra-liturgical activity in small groups (for example, the practice of Gospel reading), in which there is no hierarchical subordination, but equality and respect for the otherness of the other prevails, helps a person suffering from a neurotic disorder to feel the joy of being accepted by other members of the community. The atmosphere of trust gradually reduces the fear of showing others "your real nasty face", the neurotic mental spasm opens.

5. The neurotic need to "be able to cope with everything yourself" in the process of building working relationships with a "common cause" is gradually "unsealed": the neurotic gets used to turning to others for help and advice and gradually no longer sees this as evidence of his own deep inferiority.

6. For a neurotic, a systematic and structured study of a particular subject or skill also has a psychotherapeutic effect. From the report on the results of educational classes for prisoners in 1913, we learn that "School classes and homework, complementing the detainee's free time in the prison, gave healthy food to his mind and created a cheerful and balanced mood to patiently endure heavy captivity. The peaceful relations with each other are especially evident among the students-prisoners".

According to St. Theophan the Recluse, properly organized leisure is an important element of education, since any idleness disposes to sin. St. Theophan believed that the basis of leisure should be a certain handwork, which would help to develop creativity, and at the same time give rest. In the "Paper on Theological Schools" he writes: "If this way of studying would allow them to have enough home time, then oblige them to do handwork, depending on who is capable of what — drawing, carpentry, turning, tailoring, etc."

The most promising is the use of some socio-pedagogical models of work with art-therapeutic approaches. It is necessary to develop technological protocols describing the sequence of the main stages and technical actions at each stage when using the pedagogical model of systemic art therapy with different categories of parishioners.

Art therapy in the modern sense is the use of almost all types of art with therapeutic, correctional and developmental purposes. . This includes bibliotherapy (treatment using the influence of literature), singing therapy, drama therapy (means of theater and role-playing), visual art therapy, imagotherapy (therapeutic effects of theater and images), music therapy.

According to the chairman of the Russian Art Therapy Association, Doctor of Medical Sciences A.I.Kopytin, the main tasks of art therapy are the following:

1. Correction of disturbed personality relationships.
2. Formation (restoration) of a healthy self-image.
3. Improving adaptive behaviors based on creative interaction with the environment.
4. Support for the creative identity of clients.
5. Finding existential, spiritual guidelines and reasons for existence.

Practicing art therapists note that it is "artistic activity that often makes it possible to escape the "censorship of consciousness", therefore it presents a unique opportunity for the study of unconscious processes, the expression and actualization of latent ideas and states, those social roles and behaviors that stay in a "repressed" form, or are poorly manifested in everyday life."

Of particular importance for the church environment is the fact that through creative activity, the right to be emotional is rehabilitated as such: "The factor of artistic expression," writes A.I. Kopytin, "is associated with the expression of the client's feelings, needs and thoughts through his work with various visual materials and creation

of artistic images. Artistic expression is not a one-time act, but a process unfolded over time, which includes several main stages".

What is interesting about art therapy, including eco- and environmental therapy, from the perspective of theological reflection? First of all, this is a rethinking of the therapeutic potential available in the church spiritual tradition, which is only slightly revealed in modern practice. Art therapists actually create their own "rituals," Ronen Berger says bluntly about this, that some specialists see art therapy as a form of modern ritual. The lack of a common symbolic, spiritual mode of communication in modern society makes it difficult to use traditional rituals and requires the use of secular, non-religious rituals to resolve existential issues in the process of psychotherapy. A logical question would be: what prevents the actualization of traditional rituals in the context of therapy?

The second aspect is a new reading of the actual therapeutic effect of church life. The Church is the "healer of human souls and bodies". But if in psychotherapy and psychiatry there are, albeit conditional, but still quite clear criteria for health and illness, so for the church consciousness, especially in the field of mental health they are too vague. This is a whole area for theological research - the possibility of determining the measurable parameters of the mental health of an Orthodox Christian.

And finally, the third aspect is the theological understanding of the therapeutic side of synergy, the co–creation of man and God in a religious act. If, according to Fr Pavel Florensky, there is only one criterion of ecclesiality – i.e. beauty, then why not consider the spiritual significance and therapeutic effect of the involvement of the parishioner in creative activity according to his talents and needs?

All of the above are just rough accents on the first sketch on the topic of what can be done for our parishioners to improve the quality of their church life.

Psychopathological specifics of religious delusions of sinfulness in patients with depression

For clergy, in their pastoral care for spiritual children, it is extremely important to be able to distinguish true repentance from a depressive state when a person's soul is under the painful burden of ideas of guilt, sinfulness, despair. In order to distinguish the experiences of a believer from the experiences of a person suffering from depression with religious delusions of sinfulness, it is necessary to understand the essence of true repentance.

The Holy Scripture, the 2nd Epistle of St. Apostle Paul to the Corinthians 7:10, says: "Godly sorrow brings repentance that leads to salvation and leaves no regret, but worldly sorrow brings death." Holy fathers interpret these words in the following way: "He that sorroweth for sins, he alone attains some advantage from his sorrow, for he maketh his sins wane and disappear. For since the medicine has been prepared for this thing, in this case only is it potent, and displays its profitableness; and in the other cases is even injurious". Those who mourn with worldly sorrow, "after they have sorrowed vehemently condemn themselves, bringing forth this greatest token of having done it unto harm… "For no one will condemn himself if he have sorrowed for sin, if he have mourned and afflicted himself" (St. John Chrysostom, Homily XV on second Corinthians). "Just as, if someone's tongue has suffered damage, honey might seem tart to them and they need to be cured in order to taste the sweetness, the same is true of the fear of God: in souls where it is engendered, on hearing the message of the Gospels, it causes sorrow, since these souls are still surrounded by the wounds of their sins; but as soon as they cast these off, through repentance, they feel the joy of the good news, according to the words of the Savior: "Your grief will turn to joy."")(St. Gregory Palamas, Homily XXIX on the healing of the paralytic in Capernaum).

St. John Climacus spoke about the meaning of true repentance: "Repentance is the renewal of baptism. Repentance is a contract with God for a second life. Repentance is the daughter of hope and the renunciation of despair. Repentance is reconciliation with the Lord by the practice of good deeds contrary to the sins" (The Ladder of Divine Ascent, Step 5. On painstaking and true repentance which constitute the life of the holy convicts; and about the prison).

The Old Testament also find warns against harmful of worldly sorrow: " Do not give in to sadness, or torment yourself deliberately. Gladness of heart is the very life of a person, and cheerfulness prolongs his days. Distract yourself and renew your courage, drive resentment far away from you; For grief has killed many, and nothing is to be gained from resentment. Envy and anger shorten one's days, and anxiety brings on premature old age." (Sirach, 30:21-24).

The specifics of the worldview of depressive patients with religious delusions of sinfulness lies in a strong sense of guilt, which completely absorbs a person, taking him away from God. This feeling cannot lead to true repentance, to deliverance from difficult emotional experiences, since in this case, manifestations of mental illness are hidden behind the outer facade of pronounced religiosity, and they require obligatory medical intervention. The danger of such conditions is that a person can harm his own health and well-being, and in the most severe cases, attempt suicide (Pashkovsky V. E., 2009; Huguelet, P., et al., 2007; Weber, Samuel R.A; Pargament, Kenneth I.B, 2014).

The phenomenon of religious delusions of sinfulness has attracted the attention of both clergy and healers for several centuries (Griesinger W., 1871; Schneider K., 1955; Leonhard K., 1957; G. Stöber, E. Franzek, H. Beckmann, 1993). The demonological interpretation of this phenomenon, which was established in the Middle

Ages, retains a certain meaning even today, since the depressive delusions of sinfulness are often combined with the delusions of possession, which was called “demonomania” or “demonomaniac melancholy” or “demonomelancholia”. Meanwhile, hallucinations also appear in such descriptions; in addition, there are indications of a special relationship between religious melancholy and the "sexual system".

In the literature of past centuries, one of the most common names for depression with religious delusions of sinfulness is Melancholia religiosa (Griesinger W., 1871). In this disease, along with the clinically obvious symptoms of melancholia, the feelings of guilt, "remorse" and thoughts of sinfulness caused by the disease are at the forefront. Mention is made of the constant self-accusations of patients who have never considered themselves worthy of Divine Grace. E. V. Feuchtersieben (1845) uses the definition of "religious obsession", which is "associated with repentance for actually or supposedly committed sins."

Among the first researchers of the clinical picture, defined as "religious melancholy", there were often theologians and counselors, which was determined by the religious content of these states. However, they tried to separate "religious melancholy", which was understood as clearly somatogenic, from real piety.

One of the first researchers to describe in detail the state of religious delirium of sinfulness in depression was Ideler K.W. (1947), he also called this state "gentle melancholy". The theory of the origin of this condition was based on his general, etiological theory revolving around religious "passions". He especially singled out extreme feelings of guilt and pangs of conscience precisely in the context of experiencing the loss of grace and faith. However, he also added that the "motive" of religious melancholy often does not arise at all from hypertrophied piety, but can be present "in any serious mental illness"; besides, he notes that, therefore, of all types of melancholy, religious melancholy is the most common.

In the course of the further development of clinical psychiatry, descriptions of "Melancholia religiosa" appear, which is characterized not only by an explicitly low mood and delusional ideas of sinfulness, but also by a painful feeling of God-forsakenness. R. Kraft-Ebing (1874) writes about such states. He attributes them to "traditionally religious" patients. He talks about their experience of "repressed feelings of reverence and relief associated with prayer", which makes prayer "ineffective" and drives the patient to despair, as he feels as if "he is forsaken by God and has lost salvation".

In the course of the study of depressions with religious delusions of sinfulness, it was noted that delusional ideas of sinfulness more often appear in melancholic depressions, characterized by a dreary mood with ideas of guilt and a depressive interpretation of previous and present events (Kopeyko G.I., Gedevani E.V., Borisova O .A., Shankov F.M., Smirnova B.V., Kaleda V.G., 2021).

In such cases, an explicitly low mood was expressed in a dreary affect, ideas of low value, a sense of guilt directed at the patient himself. The peculiarity of depressive ideas was predetermined by the "individual scale of values" (Janzarik W., 1957), associated with the assessment by patients of all their misdeeds in the religious plane, which was determined by the dominance of the religious worldview in the value-semantic sphere of patients. So, for example, patients accused themselves of "carnal indulgence", of "lack of love for one's neighbor”, "of negligence." There was a fairly clear formation of the instance in relation to which the feeling of guilt was directed: guilt before God, and not a family, judicial, professional group of reference persons. All the patient's attention was focused on misdeeds in the religious sphere. There were also fantasies about the coming punishment: about going to hell, and so on. Along with this, real offenses, such as neglected duties or insufficient care for one's family, developed strongly when the sense of one's own guilt began to extend into the past, with an

exaggeration of "actual, long-committed offenses." There were also fantastic delusions about imaginary wrongdoing. Such experiences contributed to the rapid formation of judgments about their own sinfulness. The patients were overcome by ideas of sinfulness, up to the most serious and unforgivable sin, "sin against the Holy Spirit" (The “sin against the Holy Spirit,” namely, the “slander” of the Holy Spirit, is specifically mentioned in the New Testament as the only sin in general that will not be forgiven forever and ever).

In an acute depressive state, patients often said that confession did not bring relief, did not relieve the sin they had committed, stated that repentance was not accessible or they did not feel the fullness of repentance that did not restore spiritual harmony and a sense of forgiveness.

Of particular note is the painful feeling of God-forsakenness, which is acute in depressive states and was felt by patients as a loss of a sense of God's mercy: God is "cruel, implacable, merciless" (Rosmarin DH, Bigda-Peyton JS, Öngur D, Pargament KI, Björgvinsson T., 2013). Changes were also noted in the ideational sphere, which in these observations was characterized by a distorted prayer: an inability to “pray fervently” or read prayer rules, or a feeling of “prayer futility”, “religious emptiness”. In especially severe depressions, there were feelings of rejection and damnation, despair and hopelessness, thoughts of sinfulness and unforgiveness (Miller, F. and Chabrier, L.A., 1987). The described experiences were interpreted clearly as a "demonic attack", which often led to the search for help in a purely religious environment, for example, in exorcism rites. There were also individual cases when delusional ideas related to achieving in suicide a "new erasure of the boundaries of being", "the last possibility of the manifestation of life", "the last hope for union with God", which determined the extreme suicidal danger of these states.

In patients with depressive delusional ideas of sinfulness and God-forsakenness (n=43), suicidal thoughts and intentions were observed in 67% of cases, and suicidal attempts were observed in 20% (n=13). In connection with this fact, I would like to note some features of counseling work with such patients. What is needed is to help the patient make some adjustments to his "individual scale of values", which was mentioned earlier, in suppressing the "unreasonable fear of sinning" and any incipient delirium formation, which may be evidenced, for example, by statements like: "I am afraid of being damned" and etc.

It should also be understood that sick people, in particular, depressive ones, can also have “correct” religious experiences (fully corresponding to the foundations of the Orthodox tradition), which can be a support in spiritual care. Any suspicion of an acute mental condition with religious content should be a reason for the temporary suspension of spiritual counseling work in order to avoid aggravation of delusional disorders. It is very important for the spiritual counselor to identify the psychological differences between the depressive message of "the impossibility of believing any longer" and "conscious unbelief".

In conclusion, we shall emphasize the importance of the fact that, due to the specific content of depressions with religious delusions of sinfulness, directly related to religious experiences, they are often not recognized as a mental disorder requiring medical assistance. This is due to the difficulty of distinguishing between a normal religious worldview and pathological pseudo-religiosity. This often leads to aggravation of the condition and late referral to psychiatrists, and in extreme cases can lead to negative consequences, in particular, to suicidal attempts.

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Kurasov E.S.

Pastoral care in the modern system of approaches to the treatment of mental disorders

Literally translated from Greek, the word "psychiatry" means the science of healing the soul (psyche – soul, iatrea – heal). At the time this term first appeared, the soul was thought to be sovereign, independent of the body, although there was an assumption that one of the vital organs (diaphragm, heart) served as its receptacle.

In the modern sense, psychiatry is the science of recognizing and treating mental illness. This formulation quite accurately reflects the tasks facing psychiatry, if we bear in mind that recognition, along with an assessment of the disease pattern, is based on the study of the etiology, pathogenesis, development and outcome of the disease, and treatment also includes prevention and rehabilitation of patients.

Mental disorders have been accompanying mankind since the time when it acquired the ability for rational activity. The attitude of society towards mentally ill people differed in various countries and in different eras. Based on the study of the social organization of assistance to the mentally ill people, of the scientific and ideological foundations in the theory of psychiatry, the following periods in the development of psychiatry can be conditionally distinguished:

I. Pre-scientific period. From ancient times until the emergence of medical schools in Greece (Hellenic medicine), people explained the behavior of mentally ill people based on the primitive theological approaches.

II. Greco-Roman medical schools. For eight centuries (from the 5th century BC to approximately the 3rd century AD), numerous attempts were made to provide medical care to the mentally ill, whose diseases began to be considered from the natural scientific positions of that time.

III. Middle Ages. In European countries, a religious and mystical attitude towards patients with mental disorders prevailed, which led to their mass executions at the stake of the Catholic Inquisition. At the same time, the foundations were laid for the organization of public assistance for the mentally ill (mainly of a forcible nature). With the strengthening and general spread of Christianity, the view that the mentally ill are people possessed by the devil, was firmly established, and therefore the concern for their healing belonged to the representatives of religion.

IV. The 18th century is called in France the era of F. Pinel (1745–1826), who removed iron chains from the mentally ill. This fact, along with the general social and scientific progress, made it possible to provide medical care to the sick and to study mental disorders scientifically.

In Russia, the first hospitals for the mentally ill (Tollhaus) were established starting from 1762 after the Decree of Peter III. During the reign of Catherine II, the number of Tollhäuser steadily increased. In 1775, with the establishment of Public Welfare Boards in Russia, psychiatric departments at hospitals began to open and special shelters were built.

V. Late 18th and early 19th centuries were characterized by rapid development of organizational forms of assistance for the mentally ill people. This period is often associated with the name of the English doctor J. Conolly, who managed to ensure the qualitative improvement of many psychiatric institutions.

VI. During the 19th century, the forms and methods of providing psychiatric care have intensively improved, the network of psychiatric hospitals and clinics expanded, psychiatric departments were created at educational institutions for doctors, and scientific works, monographs and textbooks were published.

VII. During the 20th century, in the context of rapid progress in the field of basic sciences and medicine, achievements in the science of mental illness may seem more modest. Many researchers consider the creation in the 1950s of a fundamentally new class of psychotropic drugs, neuroleptics, to be the most significant event for psychiatry. Their use not only changed the image of a psychiatric hospital, but also allowed a significantly larger number of patients to stay in extramural conditions, maintaining their ability to work.

It should be noted that the attitude towards the mentally ill varied in certain historical periods in different countries. Thus, the most striking example is the civilizational "division" in relation to the mentally ill in the Middle Ages in Europe and Rus'.

Since the 15th century, the Bedlam Hospital, located in the Abbey of Our Lady of Bethlehem, has been operating in London.

Behind the stone wall of this hospital for several centuries, until the end of the 18th century, the sick were beaten and chained to the walls, naked people lay on the straw in solitary cells, where the light barely penetrated. The public, for a fee, was allowed into the hospital, as if into a menagerie. Similar clinics were created in other cities in Central Europe.

Unlike this, such restraint measures were not used in Russia. The humane attitude towards the mentally ill in Russia was, first of all, due to the Orthodox religion of the people. Holy fools were considered "God's" people and many of them were accommodated in monasteries.

N. M. Karamzin quite briefly tells about St. John, the fool in Christ (popularly called the Big Cap), who was the contemporary of Boris Godunov: “At that time there was a fool in Christ in Moscow, respected for either real or imaginary holiness: with loose hair, walking naked through the streets in severe frosts, he prophesized disasters and solemnly slandered Boris; and Boris kept silent and did not dare to do him the slightest harm, whether fearing the people or believing in the holiness of this man. Such fools in Christ often appeared in the capital, wore chains or fetters, could reproach to face anyone, even a noble person, for their a lawless life ...".[1]

Today, few historians of medicine recall that the first stage in the development of psychiatry is called the monastic stage. From all over Rus', the mentally ill and possessed people were brought to the monasteries. The brethren in the cloisters relieved their suffering with Christian love. The patient was not superfluous and not a stranger, but a brother in Christ who needed help. It is known from the history of medicine that in Rus' the formation of doctoring as a special social care system for the sick is closely linked with the integration of Christianity into the life and customs of people. Since the Baptism of Rus', healing was under the direct patronage of the Orthodox Church.

At the Hundred Chapter Council in 1551, Ivan the Terrible requested assistance in caring for the poor and the sick, including the "amental". By order of the Hundred Chapter Council, the monasteries took over the care of the mentally ill, in particular, those who had committed crimes. The monasteries performed these functions before, but the resolutions of the Hundred Chapter Council clarified and expanded their responsibilities.

It should be noted that approaches to the treatment of mental illness in the past, if viewed from the standpoint of today, may seem quite primitive, and sometimes even inhuman. Thus, modern psychiatry knows such “instruments” as a cell for the mentally ill (16th century), treatment by “cold water dousing according to Horn” (18th century), and a device for rotating restless patients (18th century).

[1] N.M.Karamzin, History of the Russian State (URL: https://rvb.ru/18vek/karamzin/4igr/01text/01text/vol_10_04.htm / 11.03.2022)

The evolution of modern (60s of the 20th century – to present time) targets for the treatment of mental disorders (using the example of schizophrenia) can be presented as follows:

1. Achieving response to treatment (recovery of social functioning).
2. Achieving remission (reduction of symptom severity).
3. Restoration of social functioning (functioning in everyday life, including the spiritual aspect).

Treatment approaches nowadays include: biological therapy (psychopharmacotherapy, methods of shock therapy, extracorporeal efferent therapy, oxygen barotherapy, neurosurgical correction), psychotherapy (individual and group), rehabilitation (anti-relapse therapy, supportive therapy, socio-psychological rehabilitation). A special place in this system is hold by pastoral counseling.

Pastoral counseling is a term most often used in the context of spiritually oriented, psychologically supportive, edifying communication aiming at providing help with the resources of the Christian faith (such as positive attention or kindness, acceptance, biblical truth, prayer, hope, and faith itself). Quite often, pastoral counseling is called something that, in fact, is not it (for example, the provision of psychological assistance by Christians or people with Christian religious values). Even though pastoral counseling and psychological counseling have a common form (positive dialogue in search of a solution to a problem), they differ in their essence.

A psychologist in his daily activities works with the resources of a person and society, helps to find a solution "from person to person" and actualizes, mobilizes and develops a person's psychological resources. Unlike him, the priest works with the resources of God and the Church, helps to find a solution “to a person from God” and actualizes, teaches to practice and find such spiritual resources that “launch” the psychological resources necessary to solve the problem (repentance, prayer, faith, communication with the Word of the Bible, worship, sanctification, churching, service to one's neighbor). In general, the goals, tasks and functions of pastoral counseling and psychological counseling differ from each other as much as Christ's Sermon on the Mount from the "Moral Code of the Builder of Communism".

By way of illustration, we can consider the role of pastoral counseling for understanding the essence of the disease on the example of neurotic disorders. According to St. Theophan (1815–1894), “the inner world of a sinner is full of arbitrariness, disorder and destruction… A person must abide in God with all his being and consciousness. At the same time, the power of the spirit over the soul depends on the Divinity co-inherent in it, the power of the soul over the body depends on the spirit that possesses it. After falling away from God, confusion occurred and was bound to occur in the entire composition of man: the spirit, having moved away from God, lost its strength and submitted to the soul; the soul, not uplifted by the spirit, submitted to the body”. [2]

In this perspective, a neurotic disorder is an indicator of moral ill health, spiritual and mental disorder.

Generally, pastoral counseling (for patients, medical staff and students) includes: 1) care for a person, that is carried out in the light of the Gospel teaching and is aiming at overcoming sinfulness, revealing in him the image of God, acquiring righteousness, virtues in accordance with the ideal presented in the Person and life of the Lord Jesus Christ and 2) spiritual guidance, mentoring by spiritual father.

On the whole, pastoral counseling helps to understand and resolve a moral conflict in favor of spiritual and moral values.

[2] St. Theophan the Recluse. Outline of Christian morality (URL: https://azbyka.ru/otechnik/Feofan_Zatvornik/nachertanie-hristianskogo-nravouchenija/3 / 11/02/2022)

It should be especially noted that pastoral counseling at the Military Medical Academy has always been an integral part of not only the medical, but also the educational processes. From the moment of its formation, the Imperial Military Medical (Medical and Surgical) Academy "… cured not only the body, but also the soul", and, as a rule, with the help of the Word of God. It is known that before the revolution, the Academy occupied an outstanding position among European educational medical institutions in terms of its educational and scientific potential, the number and variety of clinics. It occupied an outstanding position among all the secular institutions of Russia also in the number and wealth of churches, chapels and baptisteries. At the Academy, there were perhaps even more of them than in any large monastery. Here are just a few of them.

The Church of the Smolensk Icon of the Mother of God (the main Church of the Academy) was located on the first floor of the main building of the Imperial Military Medical (Medical and Surgical) Academy. The Church was consecrated on September 15, 1809 by Archpriest Stakhy Kolosov, rector of the Sts. Peter and Paul Cathedral. In 1894, the architect Alexander von Hohen started the reconstruction of the church, making it two-tiered, changing the decoration and restoring the icon wall. After the annual commencement, on October 19, 1896, Metropolitan Pallady of St. Petersburg consecrated the renovated church.

Commemorative plaques were placed on the walls with the names of the teachers and graduates of the Academy who fell in battle and in the line of duty. In 1882-1908, the well-known preacher Archpriest Nikolai Rozanov served in the church. The last priest before the revolution was Priest Mikhail Lebedinsky. Nowadays, on the site of the church, there is temporarily a museum of the history of the Military Medical Academy (1st floor) and a small conference hall (2nd floor).

Church of the Archangel Michael at the Mikhailovsky Clinical Hospital of Baronet Willie (now the Department and Clinic of Faculty Therapy). The foundation stone for the central hospital building and the church was laid in 1865; the grand opening took place in the presence of Emperor Alexander II on December 27, 1873. A thanksgiving worship was served in the house church in the name of St. Archangel Michael, which has already been consecrated on the day the hospital was opened (November 8, 1873). The two-tiered single-altar church was located on the 2nd and 3rd floors of the central building, oriented to the east; it had a belfry and choirs. The cupola and walls were decorated with elaborate molding. The large altar icon of Christ the Savior enjoyed special reverence. It is known for certain that St. John of Kronstadt served in the church on several occasions.

Church of the Mother of God Intercession at the Military Feldsher School. The school was founded under the auspices of the President of the Academy, Baronet Ya.V. Willie in 1838 at the Military Land Hospital. The church (consecrated on October 19, 1895) was located on the 2nd floor of an outbuilding in the school yard (1805-1806, architect A.D. Zakharov). Funds for its construction were partially provided by St. John of Kronstadt. The main icon of the church was the image of the Mother of God Intercession, painted by K.P. Bryullov, handed over in 1869 from the Primary Military School of Arkhangelsk.

The first independent department for the mentally ill at the Military Medical Academy was opened in 1859 in one of its outbuildings. A quarter of a century later, it became necessary to build a separate clinic specifically focused on providing care to this category of patients. The humanistic attitude towards the mentally ill, who were treated in the clinic for mental and nervous diseases, was reinforced by their constant spiritual guidance. It is no coincidence that during the construction and opening of the clinic, it was also planned to build and open a church in the name of the Mother of God icon "Assuage my sorrows".

Initially, the church was placed on the upper (third) floor above the entrance of the clinic and consecrated on June 24 (old style) 1892, together with the entire clinic, by Protopresbyter of the army chaplains Alexander Alekseevich Zhelobovsky (chief priest of the army and navy clergy of the Russian Empire) in the presence of His Highness the Prince Alexander Petrovich of Oldenburg (adjutant general, senator, member of the State Council).

The main icon was originally located in Moscow, in the church of St. Nicholas the Wonderworker in the Kuznetskaya settlement, Zamoskvorechye, where it was brought by the Cossacks during the reign of Mikhail Fedorovich Romanov in 1640. Ten copies were made of it, one of which was in the church of the clinic for mental and nervous diseases of the Academy.

In March 1919, the church in the name of the Smolensk Icon of the Mother of God, assigned to the main church of the Military Medical Academy, became a parish church. On December 13, 1922, it was closed along with other churches of the Academy, and the premises were transferred to an auditorium (now the conference hall of the Military Field Therapy Clinic).

Head of the Military Medical Academy B.V. Gaidar and Metropolitan Vladimir of St. Petersburg and Ladoga decided to restore the church in the eastern wing of the psychiatric clinic. The church was restored in a historical building. On December 8, 2007, after a 85-year break, regular worship services were resumed in it.

In addition to regular worship services and spiritual care for the patients of the clinic, the church holds weekly Bible classes, a library has been furnished with religious literature for parishioners and patients of the clinic, and "corners of Orthodox literature" have been set up in each clinical department. Also at the church there is a group for icon painting study, group meetings are held for addicts.

An important component of the counseling work at the Academy is Orthodox spiritually oriented psychotherapy. It has two forms - mutually penetrating and complementary: 1) scientific and practical (actually medical) and 2) church related (spiritual).

In the first case, all types of assistance are provided by professional doctors using psychotherapeutic and psycho-corrective methods. At the same time, not only the pathogenesis of the disease is taken into account, but also the “destructive” effect of passions. In the second case, we are talking about the psychotherapeutic effect of sacraments, the practice of pastoral counseling, rituals and discipline established since the apostolic times and developed in the patristic period.

Spiritually oriented psychotherapy has a clear specific component. St. Theophan the Recluse (the forerunner of spiritual psychotherapy) quite accurately formulated the psychotherapeutic meaning of the word itself: “The word ... being akin to our spirit... passes inward to the bifurcation of the soul and spirit, enlivens the latter and inseminates it for the fruitfulness of the deeds of spiritual life. Its excitatory power is all the more significant because it acts simultaneously on the whole person, on his entire composition - body, soul and spirit. The sound, or composition of the word, strikes the ear, the thought occupies the soul, and the invisible, hidden energy in it touches the spirit... "[3]

In general, few works emphasize that the main task of Orthodox (spiritually oriented) psychotherapy is to lead the suffering person to repentance through his awareness of the psychological (passionate) mechanisms of the disease, through the activation of significant emotional experiences, through the awakening of reserve (resource) opportunities.

[3] St. Theophan the Recluse. The path to salvation. – M.: Blagovest, 2001. P. 100.

On the whole, while reviving and developing pastoral counseling at the Military Medical Academy, we have now also instituted the position of assistant chief of the Academy for work with religious servicemen (Father Fyodor); a permanent commission was established to restore the main church of the Academy in the name of the Smolensk icon of the Mother of God and other shrines of the Military Medical Academy (opened in 2014); a decision was taken to establish a off-schedule department of theology at the Military Medical Academy; regular divine services are held in the restored churches of the Academy (the church in the name of the Mother of God icon "Assuage my sorrows" at the psychiatric clinic, the church of Sts. Apostles Peter and Paul).

An important role in the moral upbringing of cadets and students of the Academy is played by their pastoral counseling. Therefore the Church of Sts. Apostles Peter and Paul (October 30, 2015) was restored, where regular worship services are celebrated, a Sunday school and St. Lazarus scientific and educational Center operate.

Thus, pastoral counseling currently occupies an important place in the system of treatment and rehabilitation approaches of modern psychiatry. The Word of God not only grants healing to the suffering people, but also shows them the way to a new life, the opportunity to change themselves and find harmony in themselves on their life path.

"He [the Lord] lifts up the soul and makes the eyes sparkle; he gives health and life and blessing" (Sir 34:20).

"[The Lord] who forgives all your iniquity, who heals all your diseases" (Ps. 103:3).

Voskresensky B.A.

"Pathological mysticism" as a clinical, psychotherapeutic and cultural-historical problem

Before proceeding to the presentation of the main material, we would like to apologize for the fact that sometimes we will go beyond the competence of a doctor: thinking about the problem of "religiosity and mental disorders", one always moves "on a thin line".

Both in practical religious life and in certain mental disorder states special, unusual, previously unfamiliar experiences may occur, as well as (as a certain result of this spiritual path or, alas, of a painful process) mental profile can change. Distinguishing these two fundamentally different mental phenomena is an important theoretical and practical task facing both clergy and doctors. This report considers psychiatric aspects of such situations.

We shall start with definitions. "We are always in the presence of mysticism when we find a human being looking upon the division between earthly and super-earthly, temporal and eternal, as transcended, and feeling himself, while still externally amid the earthly and temporal, to belong to the super-earthly and eternal" – (Albert Schweitzer, 1992). For psychiatric and diagnostic purposes, we made this definition more specific: mysticism is a complex of interconnected peculiar experiences, the peak of which is a special transformation of self-consciousness, including a change in the perception of space, time, and a sense of direct sensation of God, the Absolute (or «dissolution» in it).

"Pathological mysticism" – pathomistics (our term – B.A.) – is psychopathological experiences filled with religious and mystical content. They unfold in the sphere of the soul.

False mysticism is experiences (and their interpreta-tion) that are inconsistent with the fundamental provisions of a certain religious worldview, creed. This is a phenomenon of spiritual life.

This distinction-contraposition also takes into account the true mystical experience. It naturally unfolds also in the spiritual sphere and does not lead to painful mental changes. Isn't that what Gen. 32:30 says: "For I have seen God face to face, and yet my life has been delivered," although, probably, then the soul was understood differently than today.

The mention or even a kind of juxtaposition of spirit and mind directs us to the trichotomous concept of personality: spirit-soul-body. As you know, it was introduced into psychiatry by the outstanding Soviet psychiatrist Professor D.E. Melekhov (1997). It is based on Christian anthropology. In our opinion, it is the trichotomy that is the methodological basis for differential diagnosis and psychotherapeutic approach when meeting patients with mental disorders of religious and mystical content, as well as when resolving many other socially and professionally (for psychiatrists) significant collisions. In modern psychia-try, the threefold nature of a person is formulated as a biopsychosocial paradigm of mental disorders, however, it is not a fundamental novelty.

The body is organs and organ systems in their interrelation and interaction. The soul is mental (mental in the narrow sense) processes and states. The spirit is a sphere of values, it is what a person puts above himself, for which he lives: faith, art, science, family, personal well–being – material, physical, etc. This is the clinical understanding of the sphere of the spirit, it allows us to distinguish the content of the patient's feelings and the organization ("structure") of his mental (spiritual) processes, which is the most important requirement for the diagnostic conclusions by a psychiatrist. This juxtaposition becomes clear if we use the aphoristic formulas of Viktor Frankl (1990): a

priest saves the soul of a layman seized by sin, and a doctor treats dis-eases, an internist treats diseases of the body, a psychiatrist treats diseases of the soul.

The subject and object of internal (bodily-somatic) pathology seems obvious, but the soul, both in the trichotomy and in the biopsychosocial model, turns out to be only a shaky superstructure over the "body" (aka "bio") or an appendage to the "spirit" ("socio").

The reality of the mental=spiritual can be justified by the language model of a person – part of the concept of "natural semantic metalanguage" by the Polish linguist A. Wierzbicka (2001). Presumably that was what was meant in the Bible: "Now the whole world had one language and a common speech" (Gen. 11:1). One of the results of A. Vezhbitskaya's research is that she introduces the concept of "linguistic anthropology", on the basis of which the structure of the soul (psyche in the narrow sense of the word: perception, thinking, emotions, will, etc.) is built, understanding it as an immaterial reality (Voskresensky B.A., 2021).

A mental disorder is a "distortion" and the associated "devastation" (the terms are conditional, used for clarity) of normal, natural mental processes.

The criteria for diagnosing the conditions under discussion are (their number and severity may vary): features of premorbid (premorbid character trait), often - suddenness, momentary (“suddenly”) of “religious conversion”, “otherness” of experiences (compared to previous or everyday spiritual experience), the disappearance of the experience of "I" at the height of the state, other clinical signs of an acute psychotic state, negative disorders (the aforementioned devastation of mental processes, which is detected after an acute attack or increases gradually), clinical dy-namics - a change in the manifestations of the disease in general and in individual syndromes (all of the symptoms), in particular, hallucinatory-delusional and depersonalization disorders.

Visual hallucinatory images (the appearance of indi-vidual characters, plants, clouds, rays of light, etc.) lose objectivity as the disease progresses, becoming more symbolic, ambiguous in their possible interpretation. Auditory pseudo–hallucinations (acoustic images that forcibly, contrary to the will of the patient, "invade" his head) acquire an elaborate localization – they come from the depths of the mouth, from the chest, from places and / or from distances that human hearing cannot overcome.

Depersonalization disorders (changes in the experience of one's self, self-consciousness, soul) deserve special attention. First of all, we note that not every mentally healthy person will immediately answer the question "Where is your soul located"? Patients, regardless of how familiar they are with psychology, when in an acute condition, usually easily answer this question, indicate that the soul moves through the body - down, up, “flies out through the crown” (expression of a patient), dissolves in the Universe.

These transformations seem to be particularly significant and encourage us to focus on the forms of organization of consciousness. Consciousness is the feeling of the "I"; the "I" being at this particulat moment, in a given place. In the cultural history of mankind, consciousness was formed gradually. Its initial, earliest stage was panpsychism, the most mature stage is reflexive consciousness. It consists of two components – the objective part – "O" (these are thoughts, feelings, motor activity of a person "as such") and the subjective part – "S" (an assessment – "do I understand everything", "are my emotions adequate", "is motor activity appropriate") (our definitions – B.V.). This consistency of "O" and "S" can be violated in different ways, "I" can be transformed (various variants of depersonalization).

Within the mental norm, reflexivity functions as evaluation, "self-criticism", which turns out to be an instrument of both mental development in the narrow sense and spiritual growth in general. In the cultural and historical development of mankind, this

elementary reflexivity - the interaction of "O" and "S" – has been transformed into ethical categories (law–abiding – crime), into aesthetic (beautiful – ugly), into religious (piety – sinfulness). (Note that in French, la conscience is both consciousness and conscience). Looking at oneself, a person sees not so much good, especially perfect. Everything could always be done better, act wiser, be more compassionate. Therefore, reflexive consciousness is critical, we believe, one might even say tragic, but at the same time it is creative, because it opens up opportunities for improvement, moving upwards. And that is why the reflexive consciousness is Christian: "The soul is by nature Christian" (Tertullian).

There is no reason to consider the evaluative mechanism contained in reflexive consciousness as an instrument of condemnation and pride: "... forgive them, for they know not what they do" (Luke 23:34), "hearken to yourself" – these and many other maxims of Christianity are what warns and protects a believer, a Christian from complacency.

I can assume (as a not theological, but cultural-historical and professional reflection) that the moment of the fall is also the moment of formation of reflexive consciousness – awareness of one's finiteness–mortality, and (less pathetic) – of one's imperfection in a variety of ways. The classic masterpiece of literature and art of the XV century "Magnificent Book of Hours of Duc de Berry" (2009) has in particular, the miniature "The Fall and the Expulsion from Paradise". Art historians emphasize that the faces of Eve and the serpent on this miniature are very similar. This is, as we believe, the artistic expression of the emerging reflexive – critically-creative, essentially Christian – consciousness.

Let's go further in our reflections on conscious-ness/self-consciousness. As authoritative philosophers emphasize, the most important property of the psyche is to "go off the scale." Although this expression is very figurative, it is perceived as very ambiguous, so let's replace it with another term borrowed from S.S. Khoruzhy (1998) – self-transcendence. He identifies three directions of self-transcendence (we shall transform them a little in accordance with our topic): 1) spiritual practices – they, so to speak, elevate a person, lead to the contemplation of uncreated light (S.S. Khoruzhiy was engaged in hesychasm); 2) art – it leads to cathartic experiences, also to a kind of fusion-dissolution; 3) "madness" (S.S. Khoruzhiy's expression, a doctor will say "mental disorder") leads "down" – to impoverishment, destruction of mental-spiritual pro-cesses.

Note that these "streams"– the directions of self-transcendence can mix. For example, painful – "mad" – experiences can be transformed into works of art, of course, very peculiar (but over time, some of them are recognized as standard) or into no less controversial creeds, which are also sometimes widely spread. A psychiatrist should also take into account these "different directions" and evaluate them within his competence.

Painful experiences themselves acquire qualities that are characteristic of earlier, elementary forms of organization of the psyche - the disintegration of the content of hallucinations, the archetypal nature of images, the deindividualization of the "perception of the soul", panpsychism instead of reflexivity. The validity of spiritual experience as such can be assessed by spiritually experienced and authorized people - clergy, theologians, religious philosophers. Their approaches are completely different than in medicine. "Only in spiritual experience and the thinking attached to it can one ask about the correspondence of reality.... Spiritual realities themselves are revealed in spiritual life, and therefore there can be no question of the corre-spondence of reality to what is revealed in spiritual life" (N.A. Berdyaev 1994).

The psychiatric understanding of some collisions of the spiritual and the mental sphere was formulated by K. Jaspers (1999): "Perhaps the deepest metaphysical

experience, the feeling of the absolutely sacred and gracious, is granted in the conscious perception of the supersensible only when the soul relaxes so much that it remains afterwards destroyed." V.F. Khodasevich (1991) formulated it in poetic form: "The gift of secret hearing is unbearable to a simple soul. Psyche falls under it."

Treatment, especially in the acute period, involves drug therapy. Psychotherapy and rehabilitation are also necessary at all stages of treatment, although their role and effectiveness largely depend on the degree of awareness of the patient of the morbidity of his condition.

When a patient complains about the impact / invasion of otherworldly forces, we try to form his mood for treatment, for cooperation with the doctor, and for the inception of a critical attitude towards delirium, we tell the patient: God (and even more so the forces of evil) never invade forcibly, and we appeal to Rev. 3:20: "I stand at the door and knock. If anyone hears my voice and opens the door, I will come in and eat with that person, and they with me." You can also ask the patient if he understands the phrase: "... And someone's names and numbers stick into the torn brain..." (V.F Khodasevich, 1991). And if the patient answers: "It's clear to me, it's about me" (which happens quite often), then we emphasize that normally such feeling does not occur. [1]

A painful experience – an extraneous "intrusion", "impact" – cannot be identified with the lack of mental activity of the person himself. Unfortunately, we have to meet situations when the phrase "I do not understand what I do. For what I want to do I do not do, but what I hate I do." (Rom. 7:15) is regarded as a confirmation of the intervention idea.

As part of cognitive behavioral psychotherapy, we ask the patient to "mentally" increase the distance between himself and the source of influence, that is, to emphasize, strengthen the experience of his own "I": I think, I feel, I do.

If the patient refers to the mystical experience of the saints, we talk about trichotomy, we emphasize that the disease lays in the sphere of the soul, and the spiritual may not be affected at all, or at least resist the experiences caused by the disease. We oppose the thesis of the patient "I have a temptation in the form of an illness" with an inversion – "You have an illness in the form of a temptation". In this distinction between the spiritual and the mental, the rehabilitation potential of trichotomy is also manifested.

We strive to bring the patient to the Christian ac-ceptance of the world: "And now I have seen through the prism of the church what you will not find in the church at all" (I. Brodsky, 2012). However, straightforward missionary-catechetical efforts in such situations are hardly legitimate: "One should not restrict the life of patients more than it is required for medical purpose and the order in the hospital. It goes without saying that patients who have a need for religious consolation should be given the full op-portunity to do so. True religiosity is expressed not in imposing spiritual reading on the patient or embarrassing him as a guilty schoolboy, but in doing everything necessary and useful for his health," wrote the outstanding German psychotherapist of the turn of the XIX–XX centuries A. Moll (1903) in his "Medical Ethics".

At the same time, the psychotherapeutic and rehabilitation tasks in relation to the group under consideration obviously can be solved most effectively only with the friendly cooperation of a clergyman and a doctor.

In conclusion, we will again quote A. Moll, who, as we can see, was not a straightforward atheist: "Some laws of causality, found in the study of natural phenomena, have turned naturalists' heads… The relation of matter to spirit has been reduced to a simple scheme. ... Fortunately, the triumph of narrow rationalism was

[1] K.G. Jung (1998) emphasized that to an undeveloped soul thought comes by itself, it is not a product created by the soul. A healthy, mature psyche has the ability to experience its own mental activity, spontaneity, and freedom.

short-lived, and among doctors and naturalists, the conviction that medicine and religion can freely go hand in hand is again beginning to make its way vigorously... and that an impartial study of nature does not lead to either materialism or renunciation of religion."

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Pre-manifest stage in the first psychotic seizures with religious content in adolescence

Relevance. The early stages of schizophrenia are crucial for further development and outcomes of the disease [1, 2]. This is especially true for the pre-manifest stages of the first psychotic seizures with religious delusions, primarily due to the lack of a clear differentiation between normal and pathological religiosity [3, 4] and, as a result, a relatively longer period of an untreated psychotic state. Patients with religious delusions later come under the supervision of psychiatrists, these patients have more impaired social adaptation, there is a high frequency of rehospitalizations; due to late presentation and severe condition, more drugs are prescribed, the prognosis and outcomes of such conditions are naturally worse [5, 6]. Existing works on pre-manifest stages in paroxysmal psychosis with religious delusions show conflicting results: some researchers argue that religiosity in itself is not a pathoplastic factor in the formation of religious delusions [7, 8, 9], without denying, however, the fact that religiosity often gives specific features to hysterical, depressive states [10]; according to others, religiosity in premorbidity corresponds to a higher frequency of the emergence of a religious delusional plot in the structure of a psychotic attack [11, 12].

In modern literature, the criteria for a normal, healthy religious faith have become generally accepted: 1) focusing on God; 2) reverence and love; 3) respect for one's own personality and for the beliefs of others; 4) focus on good interpersonal relationships; 5) awareness of one's imperfection. Mentally healthy people maintain social adaptation, they do not impose their religious beliefs on those who do not agree with their point of view, they continue to take care of their loved ones, not focusing only on their faith, they are tolerant towards other religions and confessions. At the same time, there are concepts of external and internal religiosity. Manifestations of external religiosity are determined by habit, tradition, social requirements, and in some cases the need to achieve personal gain using religious faith. Internal religiosity is characterized by a desire not demonstrated to other people to build one’s own live in accordance with religious commandments, the desire for spiritual and moral perfection.

Pathological religiosity is associated with mental disorders and is characterized by a distortion of traditional religious ideas, the supersedure of the desire for a full spiritual life, exaggerated performance of religious rituals. At the same time, both the religious behavior and the way of life of patients naturally change.

The aim of the research is to identify the conditions for the formation of religious delusions in adolescence, to analyze the characteristics of premorbid in such conditions, to analyze the correlations between religiosity at the pre-manifest stage and the subsequent manifest psychotic attack with religious delusions of various content.

Materials and Methods: The research included 51 adolescent male patients (16-25 years old). All patients were hospitalized with a manifest psychotic attack with delusions of religious content (F20, F25 according to ICD-10) to the Department of Youth Psychiatry in 2015-2020. (Director - Prof. V.G. Kaleda) Scientific Center of Mental Health (Director - Prof. T.P. Klyushnik).

The criteria for inclusion of patients into the research were the formation of religious delusions in the structure of a psychotic attack in adolescence (16-25 years), the onset of the disease in adolescence.

Exclusion criteria: a concomitant mental, neurological or somatic pathology.

The research used clinical psychopathological, psychometric (DUREL, PAS) and statistical methods. During statistical processing, Pearson's $\chi 2$ test was used to test

statistical hypotheses about the compliance rate between nominal or scoring (ordinal) indicators in the studied groups. The significance of the statistical relationship between the parameters (provided that the distribution of the studied quantitative variable was normal and the variances were equal in the compared general populations) was assessed using the Student's t-test (significance level $p<0.05$ was considered significant). Calculations were performed using the statistical software package Statistica 8.0 for Windows (StatSoft, USA).

Special attention was given to the patients' religiosity at the pre-manifest stage – upbringing in a religious family, patients' attitude towards it at different age periods, specifics of the emergence of religiosity in the absence of religious formation in childhood, as well as its dynamics in connection with the development of psychopathological processes.

For the psychometric assessment of premorbid, the PAS (premorbid functioning) scale was used [13, 14], which evaluates functioning in terms of social activity, interpersonal relationships, educational and work adaptation in childhood, early and late adolescence, which allows analyzing the level of functioning in premorbid in general . A coefficient below 0.23 corresponds to a conditional social norm. Results in the range from 0.23 to 0.53 are considered borderline. A score above 0.53 is unfavorable, indicating a low level of social functioning.

The religiosity of premorbid patients was assessed using the Duke University Religious Index (DUREL) [15]. This questionnaire includes 5 items and 3 subscales: 1) public religious activity (frequency of attending a church, a religious community); 2) personal religious activity (prayer, reading of the Bible); 3) evaluation of inner religiosity, which is the subject of three questions. Each item is estimated at 5-6 points, the total score is 5-27 and is taken as an assessment of the individual's degree of religiosity.

Research results: in the course of the research, the pre-manifest stages in 51 patients were studied: 11 patients with delusions of sinfulness (type I attacks), 15 with delusions of demonic possession (type II attacks), 20 with antagonistic and messianic delusions (type III), 5 - with oneiroid of religious content (type IV).

Approximately one third of patients (15 prs., 29.4%) were brought up in religious families. They considered themselves believers from childhood, their religiosity was regarded as meeting the criteria of a normal, healthy faith [16, 17], religion shaped their way of life and value system (21-25 points according to DUREL). At the initial stage, in a third of them (33%), religiosity acquired psychopathological features: religious experience increasingly deviated from traditional religious norms, religiosity became ambivalent, fanatical, rigid, and inadequate to current life circumstances [18, 19].

Of the four types of seizures, the greatest number of points on the DUREL scale was scored by patients of group IV, who subsequently suffered a manifest psychotic seizure with a oneiroid of religious content; they also had the highest score on the internal religiosity subscale, however, it should be noted that in 80% of cases their religiosity did not become overvalued at the initial stage and was not pathological: religious delusions arose only at the height of the psychotic state.

The most patients (23 prs., 45.1%), although they called themselves believers, however, did not have religious upbringing, did not follow religious traditions (11-15 points according to DUREL, the "formal religiosity" group), but here, too, patients with IV type of seizures prevailed by the number of points.

13 patients (25.5%) before the onset of the disease described themselves as atheists and had the lowest possible score (score 5 according to DUREL).

Thus, it was found that for the vast majority of patients (70.6%), traditional religiosity with participation in church life was not characteristic before the onset of the disease and started at the initial stage, including in the form of a syndrome of supervaluable formations - metaphysical intoxication; at the same time, the most common was the affective type (43.1%), when a special religious worldview with a pronounced affect developed rather quickly, while the emerged beliefs contradicted the previous ones, and the state itself was “ecstatic” and, in fact, subpsychotic [20]. The patients said that they “understood everything” about their lives and the lives of their relatives, “learned the Truth through God”, interpreted religious literature in their own way, tried to involve relatives in the sphere of religious interests, regardless of their attitude to this issue. In terms of incidence, the classic type was in second place (17.6%).

In most patients, the emergence of an overvalued interest in religion was preceded by affective disorders, more often related to the depressive pole.

In 15.7% of cases (8 prs.), the patients had endogenous psychoses in parents as hereditary background, and 3 of them had religion as the theme for past psychotic episodes. In 37.3% of patients, one of the parents had severe pathocharacterological features, impulse disorders in form of alcoholism, depressive episodes of mild and moderate degree, which were overcome without specialized assistance. The greatest hereditary burden for both endogenous psychotic states and pathocharacterological features was observed during seizures with delusions of demonic possession (66.7%).

As for ontogenesis, normal ontogenesis, which implies no mental and physical development lagging behind the age norm, was observed in most cases (20 patients, 41.2%). It was found that in the studied cohort of patients, accelerated ontogenesis was observed in almost a third of patients (27.4%) and most often occurred during seizures with antagonistic and messianic delirium, as well as in oneiroid states with religious content.

In the studied group of patients with all four types of seizures, the most common were pathological and exaggerated types of puberty (58.9%), when adolescents demonstrated addictive behavior, including a non-chemical type of addiction in the form of a hobby for computer and online games, they were characterized by educational maladjustment. Some patients from the groups with delusions of demonic possession and antagonistic delusions were characterized by a demonstrative rejection of the traditional religious way of life of the family, they initiated conflicts on this basis, defiantly refused to attend church, called themselves "militant atheists".

The normal pubertal crisis was characterized by opposition to relatives, the desire for self-assertion, but these manifestations were not pathological, social and educational adaptation was preserved, although academic performance could decrease somewhat, but remained satisfactory (29.4% of cases).

With regard to the premorbid personality structure, schizoid (56.9%) prevailed in our study, psychasthenic (23.5%) were in second place in terms of frequency of occurrence, which is confirmed by the classic studies of E. Krechmer (1930) [21] and P.B.Gannushkin (1907) [22].

As for social and labor adaptation, the most patients received higher (45.1%) or specialized secondary (27.4%) education by the time of manifestation. In a relatively small number of patients (15.7%) at the pre-manifest stage, there was an increase in negative symptoms, they either did not study and did not work, or were engaged in low-skilled work, despite of their special education.

It was found that exogenous provocations play a significant role in the occurrence of manifest seizures. Moreover, psychogenia (35.5%), after which reactive affective disorders arose, apparently contributing to the formation of "religious quests",

were more common than the use of psychoactive substances (25.5%) and somatogenia (5.9%).

When assessing premorbid functioning on the PAS scale, it was found that in 51% of the studied group, premorbid functioning was consistently satisfactory, however, in these patients it also tended to decrease as it approached the manifest state.

The condition of patients with a regressive type of functioning (29.4%) worsened more clearly by the beginning of adolescence. In all age periods, they were characterized by low initiative, limited circle of contacts. A small number of patients (19.6%) had consistently unsatisfactory premorbid functioning, which revealed itself in lack of sociability, passivity and formalism in communication with peers. The worst indicators here were demonstrated by patients belonging to type II seizures (delusions of demonic possession).

In juvenile endogenous paroxysmal psychoses with **delusions of sinfulness (type I)**, often even in childhood, patients were characterized by ideas of self-blame with the theme of sinfulness and depressive affective episodes that resolved on their own. So, one of the patients, who suffered the death of several relatives at the age of 7-8, claimed that it was his fault and responsibility, a “punishment” for bad behavior and poor school performance. Another patient, brought up in a religious family, at the age of 5 during Great Lent left only boiled potatoes and bread in the diet, categorically refused other food, could not explain the reasons for such selectivity in food, during the entire period of fasting he looked sad, thoughtful, did not play with other children. The beginning of the initial stage was, on average, at the age of 16-18 years, most often its affective type was encountered. In more than half of the cases, psychogenies acted as exogenous provocations, after which the mood steadily declined, and ideas of guilt before relatives and God developed. Refusal to eat, excessively strict observance of fasts were characteristic. Religious canons were exaggerated, their own, more restrictive, rules were developed (“so as not to fall into the sin of gluttony”), there was a significant (on average 15-20 kg) weight loss. Almost all free time was spent reading religious literature, at the price of studying, while quotes from the Bible, the Gospels were taken literally: so, since “Sunday is the Lord’s day,” they could sit or lie idle throughout the day. They refused to shave despite the permission of the spiritual father. They skipped work or school if a church holiday fell on a weekday. The bewilderment of the authorities and the dissatisfaction of relatives in this regard were ignored. Closer to the manifestation of an attack, they experienced confusion, indecision (for example, they could not choose a priority exam for preparation during the exam session, which led to a lack of preparation in principle). Patients sought help in the church, lit candles for the highest grade, prayed "to pass the exam." Ideational obsessional disorders of religious content with weird ideas could also arise (for example, thoughts that the rite of Baptism in childhood was performed incorrectly for some reason), which forced them to make numerous pilgrimage trips in search of a clergyman who would perform the rite “correctly” , "as it should be." The psychotic state usually started subacutely.

Most patients with **type II seizures (delusions of demonic possession)** were raised in non-religious families. Hereditary burden here was severe: the parents of almost 70% of patients had endogenous psychotic episodes or severe pathological characteristics, which created unfavorable social living conditions. In childhood, neurotic episodes in the form of obsessive-phobic disorders often occurred, various fears were characteristic.

Often in late adolescence – early adulthood, patients had attenuated psychotic symptoms: fragmentary auditory true hallucinations, "images", an episodic feeling of "openness of thoughts", a feeling of "impact". There were no more psychotic episodes before the manifest attack.

By early adulthood (16-17 years old), patients gradually developed an interest in sects, fortune-tellers, and yoga with meditation. Overvalued religiosity arose here somewhat later than in other groups: by the age of 19-21, often under the influence of friends or colleagues who “brought them to the Church” and recommended this or that thematic literature. The initial stages were most often neurosis-like or paranoid: there was an increased social withdrawal, panic attacks with fear of death, senestalgia, which during an attack expanded and reached the level of senestopathies and were interpreted as "demonic influence". Suspicion grew and intensified: patients believed that people at school or at work was unfriendly to them, they were “bedeviled”, so they prayed for healing from this and asked the priest about it. At the same time, in parallel, they often continued to visit paranormalists, fortune-tellers in order to “remove the curse” and bad sensations, which as they thought, were associated with its effect.Gradually increasing cognitive impairment contributed to a decrease in the patients’ professional and educational level. In the Church and at home during prayers blasphemous thoughts of religious content appeared. Such thoughts were also regarded as the result of a "curse", "evil eye".

Often there was a desire to retire to a monastery, and the reasons indicated were either a desire to end conflict relations with relatives, to stop living together with them, or “gratitude” for the fact that God “helped” resolve a difficult life situation. They did not want to be novices, insisted on being tonsured as monks as soon as possible, and refused to thoughtfully study the rules of monastic life before taking the vows. Also, patients actively planned to enter the seminary without a clear understanding of the responsibilities and specifics of education.

The most numerous group consisted of patients who had an acute psychotic attack **with antagonistic, messianic delusions (type III attacks).** Adolescence was characterized by cyclothymoid-like mood swings from short-term hypomanic (2-3 days) to subdepressive (2-3 weeks). Some patients, starting from adolescence, occasionally showed interest in esoteric practices, mystical teachings, however, the interest was mostly superficial. Patients explained episodic use of PAS by the possibility of "opening a channel of communication with God, the other world." After that, they said that in a state of drug intoxication they received “answers to important questions”, joined the “world’s wisdom”. Gradually (at the age of 17-19) interest in religious and mystical problems grew, an overvalued interest in religion was formed, metaphysical intoxication naturally proceeded along an affective type. Patients “transformed” the room in accordance with their concept of the room in which a believer lives: they painted the walls in monochrome soft colors, replaced almost all literature with religious books, hung a lot of icons, and built self-made altars. Patients of this group, in comparison with others, most often tried to influence their relatives, to “instill” in them “the only correct religiosity”. They stubbornly insisted that their loved ones shall follow the rules established by them, pray correctly and together with them, and strictly observe fasts. Any comments, indications of misconceptions on the part of the spiritual father were perceived painfully or negatively, often after that the patients changed the church parish. Despite this state, labor adaptedness did not decrease for a long time. There were also “secret escapes” to monasteries in this group, breaks in successful relationships with partners, relatives, when in the morning the patient, as usual, went to work or study, and then disappeared without a trace and was found a few months later as a novice in one of the monasteries, or relatives accidentally found out that the son had already been tonsured a monk. At the same time, in these cases, the patients neglected the feelings of loved ones, did not think about them, and explained that “God is more important than anything in life.”

In **type IV seizures** at the pre-manifest stage, the most distinct affective disorders of both poles were registered. In childhood, patients were characterized by

sensitivity, daydreaming, and a desire for creativity. In this group, patients before the onset of the disease were very religious and were brought up in religious families. As a rule, at the age of 16-17, patients for the first time had slight affective disorders in the form of short-term cyclothymoid-like seasonal mood swings. Gradually, affective disorders became more clear and deep: both hypomanic states with increased sociability, ease of establishing contacts and activity unusual for patients, and depressive states replacing them were registered. Hypomanic phases were generally characterized by increased intellectual and creative productivity, allowing the patient to maintain good social and labor adaptation. However, development of psychotic states here in 60% of cases was associated precisely with manic affect: productive hypomania with hyperactivity, creativity, a desire to expand the scope of activity, slowly, as it approached the onset of a psychotic attack, acquired the features of a manic state with dysphoria, agitation. Pathological religiosity in the vast majority of cases was formed directly in the structure of a psychotic attack, avoiding the stage of overvalued idea disorders. Psychosis, as a rule, manifested itself acutely.

Conclusion. The research found that the majority of patients from the cohort were not traditionally religious people before the onset of the first symptoms of a mental illness, and the religiosity itself, which arose at the initial stage of the schizophrenic process, differed from the traditional one in many respects towards a pathological form. If patients were brought up in religious families, then religiosity only in one of three cases became pathological at the initial stage. In the vast majority of observations, religious themes of the delusional level arose in them at the height of an acute psychotic state and were not involved into the formation of the plot of delusional disorders at the initial stage of the disease. Of greater importance in the formation of psychotic seizures with religious content are hereditary burden, premorbid personality structure, high scores on the PAS scale. In order to confirm the obtained data, it is planned to continue the study of pre-manifest stages in a larger sample of patients.

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Psychotherapy and spiritual life

Abstract

Background: In psychotherapy we also have to deal with multiple manifestations of faith (religiosity, spirituality and meaning-giving).

Aim: To draw attention to the place and meaning of religiosity, spirituality and meaning in psychotherapy on the basis of three concepts: lived religion, spirituality as a limit language and sacred moments in psychotherapy.

Method: Based on the literature, discussion of the three mentioned concepts and recommendations.

Results: More and more research shows that attention to religiosity, spirituality and meaning leads to valued outcomes of psychotherapeutic treatments.

Conclusion: The application of available knowledge and research results deserves attention in the Russian context and its own elaboration, also in collaboration with the church.

Keywords: Psychotherapy, lived religion, spirituality, limit language, sacred moments.

Introduction

The title of the conference includes the following section: 'multiple manifestations of faith'. This caught my attention, because we are indeed increasingly dealing with an enormous variety of beliefs, both inside and outside the church, at least in my part of the world. However, in psychiatry and psychotherapy we were already used to various idiosyncratic expressions of faith. Idiosyncratic is perhaps not the right word to express what I mean. What I do mean me is that we meet very odd, many times but not always, pathological manifestations of faith and religion, but sometimes also very impressive and creative manifestations within a pathological presentation. But I mean one more thing. I also mean that we encounter what people actually belief and that is often not in the first place what they ought to believe or are taught or expected to belief. In fact, as mental health professionals we are more interested in how people believe, how they practice their faith, I think, than in what they should believe. Sometimes people are not aware of the difference. But not only we can assess an uncomplicated discrepancy between these possibilities, but people can actually struggle with it. I want to briefly discuss this with you on the basis of three concepts: lived religion, spirituality and sacred moments in psychotherapy. First I will start with a self disclosure.

A question and a disclosure

Allow me to start right off with a brief philosophical clue as a starting point and a self disclosure. Is it true that a human being can exist in a good and authentic way only if that same human being accepts his mortality? Does the essence of life revolve around the end, and is the fact of that end the task before us? Or is it so that man can only become someone if that person succeeds in being born again and again? Does human life revolve around the beginning, and is that beginning the assignment we are given? Is authentic life mainly to be able to end or to start over again? In other words, is it that a tragic-ironic view of reality predominates, a view focused on the inescapable and inevitable, in which everything that seems positive always contains something negative, a view of reality with attention to dilemmas and paradoxes, to inner contradiction and ambivalence, combined with putting things into perspective and taking distance? In the vein of Nietzsche, Freud and Lacan (Shafer, 1976, 35-54)? Or is

it the more romantic view of reality: the adventure, challenged to live passionately and compellingly? Life as an endeavor is full of risks and dangers that must be faced. A view with a strong emphasis on self-examination and integration, with a very different view of psychopathology (Shafer, 1976, 31-35; Akhtar, 2013). Natality then comes first, in the line of Arendt in contrast to that of Heidegger, for whom finiteness and mortality are paramount.

It is primarily a question intended to invite you to reflection. Because the position we take determines what kind of diagnostician and what kind of therapist we are. How does the professional him/herself relate to life, and thus to the practice of psychotherapy?

By way of disclosure, let me clarify my position with a song text by a Dutch comedian (Paul van Vliet). It's a song with the title: 'I've started over so many times'. He sings: 'From today I'm going to do everything differently, but in today is part of the past. And together you take that with you to tomorrow'. And then he continues: 'It's not new, it's not different or special. It has been done more in the past. But for a child it is 'the greatest wonder in the world, when it sits and stands for the first time'. Personally, I hold on to being able to start over. Or as one patient put it at the end of long-term group psychotherapy, something like this: 'When I started, I thought I had to get back to my old self as soon as possible. Now that I am closing, I've found that it's by far the best never to be the old one again'.

Lived religion

What do we mean by ‘lived religion’? Lived religion is nowadays used as concept in practical-empirical theology (McGuire, 2008; Verhagen, 2022). As a concept it became popular at the end of the twentieth century. And in a rather simple way one could say that lived religion is individual religion, or individual religiosity, or to put it slightly different: personalized religion. And I guess it is not difficult to image within which cultural context this interest in lived religion blossomed, so to say. It is of course against the background of the decline of the monopoly position of institutionalized religion. That problematic background can be heard in all terms that are used as synonyms for lived religion, such as every day religion, invisible reli-gion, implicit religion, unchurched religion. All these terms point at one and the same aspect of lived religion: its focus on individual spirituality and religiosity. Let me give you two definitions. (1) Lived religion refers to the complex contemporary religious and spiritual experience of people within, outside or on the border of traditional religions. (2) Lived religion is about how religion and spirituality are practiced, experienced and expressed by ordinary people in the context of their everyday lives, whether they are affiliated to a church community or not. It is important to note that the term lived religion is used to distinguish the actual experience of religious persons from the prescribed religion or institutionally defined beliefs and practices. Having said that lived religion is individual religion does not necessarily mean that it is a pure individual practice. On the contrary, lived religion can be highly relational oriented. That is why I prefer the term personalized spirituality or personalized religion in order to avoid that misunderstanding. So lived religion is a highly personal, though not pure individual religious or spiritual practice in everyday life, committed to church or outside church.

I think it is an important concept because it broadens our scope. It invites us as therapists to consider highly personal wording of beliefs and coloring of particular religious or spiritual practices. And it can alert us to how those personal practices, whether unusual or not, are meaningful for the client's life in a healthy or unhealthy way. That is of course the therapeutic point of view. Of course the professional can choose to only pay attention to official or formal religiosity in the practice as a psychotherapist. Then the question would be whether that is ethically responsible and

whether that fits with the vocation as believers; but that is of course up to your professional reflection on what the professional is actually doing.

From a theological point of view lived religion is also an important construct. It invites theologians to think about their theology and teaching, and to ask themselves what is going on and what that could mean for their thinking and practice as pastors, unless he is convinced that tradition is tradition and questioning is out of the question. This does not mean that theology cannot adopt a normative position, quite the contrary. The question is how this normativity functions. Is it only demanding or also supportive? Well, that is of course far beyond the scope of psychiatrists but they do see in their consulting room the difficulties people can have with that.

Definitions: 'limit language'

There are lists of definitions of religion, spirituality and meaning-giving, but there is no consensus about one of these definitions. According to many, that is not a good idea, because how can we work with it, if it is possible to work with it at all. Let me briefly focus on the term spirituality. Is a vague and controversial, fashionable term like spirituality useful? However, if we don't exactly know what something is, that doesn't automatically mean it isn't there. We could try to look at it in another way. What does spirituality actually do? Is the experience described by the word spirituality of practical significance, such as in healthcare and in psychotherapy? Would it benefit users of care and therapy if care providers and therapists also (learn to) use that language? Could that even benefit care and treatment? It were two British theologians, Swinton and Pattison (2010), who formulated these questions and their answers are very enlightening.

When does spirituality arise? In difficult circumstances, in chaos, in struggle and stress, in illness or under too much pressure. Then it pops up (sometimes). Swinton and Pattison argued that spirituality emerges under certain circumstances and responds to certain needs, needs in difficult circumstances, and yet, even then, controversially, because it is not yet unambiguously clear and simple. Isn't this worded too broadly? On the other hand, there are many terms in our field that are rather loose. By loose I mean terms that are subject to many changes and influences and therefore change; take terms like health, care. Moreover, psychiatry is in any case characterized by a certain vagueness when it comes to numerous terms and constructions (Keil, Keuck & Hauswald, 2017). In other words, a lack of clarity is not necessarily a lack of meaning or value. It is perhaps not at all surprising that vague or controversial words and terms appear in difficult situations; that is what matters, namely a search for words, for vocabulary in such disturbing circumstances.

Swinton and Pattison (2010) introduce the term 'limit language' at this point. Spirituality as a term is vague, it is not concrete, but it points to a boundary beyond which it is not so clear at all what can be said and how it will be said. But again, that hesitation or faltering, that searching for words, doesn't mean it is misplaced or meaningless. It says as much as there are limits to words in some life situations complicated for all sorts of reasons. Just because I'm not sure what I'm talking about doesn't mean I might as well just leave it for what it is, that it's not worth it, that it's nothing.

(The association with the concept of borderline situations, as elaborated by the philosopher and former psychiatrist Karl Jaspers, is obvious; in fine German: ‘Situation wird zur Grenzsituation, wenn sie das Subjekt durch radikale Erschütterung seines Daseins zur Existenz erweckt’ (Jaspers, 1973, 56). In English: Certain circumstances become borderline situations when they awaken the subject to existence by radically shaking his being there.)

One step further, if spirituality is such a limit word, it could also be that the term functions to name what is not there ('absences') instead of what is ('presences', Swintin & Pattison, 2010). After all, that is what people in limit situations are confronted with then, with what is not there (anymore). That is of course completely different than in bio-psycho-medical language. Limit language as spirituality might be vague, soft, but it is about meaning, hope, purpose, connection, love. These are words that (can) come up in the definitions of spirituality, but they are missing, are absent, not immediately available in the experience of the person concerned. And on a clinical level, they are lacking in the practice of care and therapy, with exceptions of course. With that, the vague, soft word suddenly takes on a critical focus. The interesting thing is that in a secularized context such as the Dutch, this approach again seeks words that previously found expression in religious language, while they are often missing in a medical-psychological discourse. Again, the vague, soft word suddenly points to a gap between care practices and the experiences of users of that care. In this way it turns into a protest word, which despite vagueness and softness is a powerful word. So it is certainly useful and meaningful to talk about spirituality.

Sacred moments

If we now make the transition to clinical practice and psychotherapy after these reflections, I want to draw your attention to the so-called 'sacred moments' in psychotherapy. That is of course not the only aspect we could look it. There is also the very interesting and important issue of the so-called adapted therapies; I talked about that issue at the this conference in 2018 (Anderson et al., 2015; Verhagen, 2019).

Sometimes unexpected things happen in psychotherapy. Various terms are used to describe such special moments: 'moment of meeting' (The Boston Change Process Study Group, 2020), 'sacred moments' (Lomax, Kripal & Pargament, 2011), 'authentic relational moments' (Békés & Hoffman, 2021). The idea is that spirituality is not merely something individual-personal but something relational. With 'sacred moments' is meant something like moments when people in relationships, also in helping and therapeutic relationships, experience something of spiritual value or meaning. That can be something of authenticity, of connectedness and transcendence, of truth, of emotionality such as awe, gratitude, joy, peace. At the same time the concept of sacred moments suffers from the same vagueness and lack of concreteness as spirituality. But again, that does not mean that these moments are meaningless, on the contrary. These moments have a sense of timelessness, purpose and transcendence. Two characteristics can be found in literature: 1) these moments inherently possess spiritual qualities as just mentioned, and 2) they are imbued with descriptive qualities as precious, dear, blessed, cherished and/or holy. Incidentally, this also means that not all important moments in psychotherapy are experi-enced as 'sacred'. It is equally important to bear in mind that these moments are not extremely exceptional or very special incidents. No, it is much more mundane, but no less a source of power and meaning. The relational aspect is also expressed in the fact that the therapist does not remain unaffected (Pargament et al., 2014; Wilt, Pargament & Exline, 2019). Now there is some indication of when the chance of such moments could be greater. Predictive client variables are: experienced communication with God ("God hears me", "I have heard something from God"), secure attachment, the importance religion/spirituality has for one, openness to new experience and spirituality (this is also a certain order from more to less important; Wilt, Par-gament & Exline, 2019). That is what we can learn from studies in this particular field. Higher levels of sacred moments are related to higher levels of religious belief salience. Furthermore, it is apparently the case that people who experience such sacred or special moments report more spiritual growth (transformation). People who reported higher

levels of sacred moments reported more positive spiritual and struggle-related outcomes, such as higher spiritual growth and lower spiritual decline.

But then, how can a psychotherapist know all this? By asking, and by being aware of the possibility of such moments! This is a decisive quality of the therapeutic relationship, that plays a crucial (positive) role.

Conclusion: recommendations

With these three concepts: lived religion, spirituality and sacred moments I hope I have cleared the space for multiple manifestations of faith, religion, spirituality and meaning giving in psychotherapy.

To conclude with. Based on the literature I come to six recommendations (Hook et al., 2019). The first recommendation (1) is to include religion and spirituality as potentially valuable to a client in psychiatric and psychotherapeutic assessment and treatment. This can be done during the examination or the assessment for psychotherapy, as part of the developmental history. It could be about values in relation to therapy, about commitment and adherence to therapy, and also in relation to other aspects of diversity. It should become clear what meaningful beliefs and values are and what obstacles may arise from these. When indicated, (2) it appears to be helpful to include religion and spirituality in the treatment plan and treatment. This should be possible regardless of the psychotherapist's religious, spiritual or philosophical background. Integrated or adapted therapy (3) could be considered if it can benefit the client's religiosity or spirituality. The significance is even greater (4) when it has become clear that religion, spirituality or meaning is an important factor in the daily functioning of the client. Avoid making too hasty assumptions (5) and follow the client's indications of religious or spiritual beliefs or practices. Respect and sensitivity (6) always come first in asking about beliefs and practices. This also includes sensitivity to one's own sensitivities and bias. Attention should be paid to the cooperation with team members who hold religion or spirituality in high regard, and also to the cooperation with chaplains or spiritual leaders of (church) groups to which clients could belong. Finally, it is also important to realize that a willingness on the part of healthcare professionals can be expected to contribute to 'health advocacy' in the field of religion and spirituality from their own expertise, also in the social debates.

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Pastoral care for persons with suicidal behavior

Modern psychiatry does no longer challenge the significance of the work of clergy in helping people with mental disorders, including those with suicidal behavior. No wonder that believers who find themselves in a difficult life situation, with severe mental trauma, most often go to the church, to the priest or their father-confessor, and not to the psychiatrist. Therefore, one of the most urgent problems in this regard is the need for close cooperation between clergy and medical specialists (psychiatrists, psychotherapists), medical and social psychologists, as well as middle and junior medical personnel. Optimally, such "co-operation" can be implemented in those medical institutions, hospitals and clinics, which have permanently functioning churches. The most humane attitude towards patients was precisely the hallmark of our great predecessors at the Imperial Military Medical (Medical and Surgical) Academy, which, unfortunately, was largely lost in subsequent atheist times.

It is known that before the revolution, the Academy occupied an outstanding position among European educational medical institutions in terms of its educational and scientific potential, the number and variety of clinics. It occupied an outstanding position among all the secular institutions of Russia also in the number and wealth of churches and chapels. A significant number of miraculous icons and particles of holy relics were collected in the churches of the Academy, true ascetics of faith and piety served in them, some of whom were canonized as saints (Archpriest Alexy Stavrovsky and St. Evgeny Botkin). Whereby one of the main tasks of the clergy and parishioners of these churches was charitable assistance and spiritual care for the wounded and sick in close cooperation with medical personnel.

Since the formation of the Imperial Military Medical (Medical and Surgical) Academy, "... not only the body, but also the soul" have been cured here. On the territory of the “hospital settlement” (Vyborgskaya side), where domestic medicine actually originated at the beginning of the 18th century, a unique church and hospital architectural ensemble was created (“Mercy Island” – as contemporaries called it). At different periods of its "pre-revolutionary" history, the church complex of the Academy included one cathedral, the main Academy church, as well as a significant number of churches, chapels and baptismal churches.

Currently the Military Medical Academy is undergoing a period of revival, a return to its traditions and origins; churches are being restored, including the church in the name of the Mother of God icon “Assuage my sorrows” at the clinic for mental illness (psychiatry); communities of sisters of mercy are being established, and cadets, students, employees of the Academy, clergy and all caring people are actively involved in their work; new methods of treatment, medical and spiritual-psychological rehabilitation (“spiritual guidance”) of patients are being introduced.

Of course, suicidal individuals occupy a special place among such patients. It should be noted that the problem of suicide remains extremely relevant all over the world, including in our country, where suicide is still among the ten main causes of death. And although the overall death rate from suicide has been steadily declining in recent years (since 2014, for the first time, the death rate from suicide among the Russian population has fallen below the level defined by WHO as critical – 20 suicides per 100 thousand people), their frequency in a number of regions of the country remains at a high and even ultra-high level (more than 30.0 per 100 thousand of the population), especially among young people (Polozhiy B.S., 2019). Moreover, the level of teenage suicide is still very high.

In many ways, this situation is determined by the ongoing active spread of the so-called "pro-suicide subcultures" and the increasingly aggressive and negative influence of social networks on youth (the infamous "Blue Whales" and others). Such influence is, in fact, an element of the modern information war, the essence of which is the destruction of the national, state and civil identity of a potential "enemy". Attempts to forcibly plant alien cultural values in society, colliding with traditional value imperatives, inevitably cause an intrapsychic conflict among a significant number of the population, especially young people, and can provoke an increase in borderline mental disorders, various forms of “deviant” behavior, including suicide. Speaking about the influence of the media, including individual "works of culture", on the mental health of young people, it is enough to mention the seemingly "innocent" (by modern standards) so-called "Werther Effect". When, in an effort to cope with depression, Goethe poured out in his famous story (“The Sorrows of Young Werther”) feelings because of unrequited love, ending it with the suicide of his protagonist, this episode gave rise to a whole series of suicides among German youth, who at that time experienced a spiritual crisis associated, among other things, with the decline of religiosity.

Along with the efforts of state bodies in solving these problems (blocking pro-suicide websites, limiting the dissemination of information about suicide methods, etc.), joint, individually oriented, practical efforts of the church, social and medical workers are equally important in the prevention of suicidal behavior. Along with the efforts of state bodies in solving these problems (blocking pro-suicide websites, limiting the dissemination of information about suicide methods, etc.), joint, individually oriented, practical efforts of the church, social and medical workers are equally important in the prevention of suicidal behavior. Because every, even a single, case of suicide is doubly tragic, also because such a death could have been prevented.

Joining efforts of clergy and medical workers in the prevention of suicidal behavior involves taking into account all historical (Christian, clinical) experience, as well as the use of uniform methodological (primarily terminological) approaches and modern scientific achievements in this field. Speaking about the Christian attitude towards suicide, it should be noted that the Holy Scriptures describe seven cases of suicide:

1) King Abimelech ordered the armor-bearer to kill him after a woman threw a piece of a millstone on his head during the siege of the city of Thebez. Being a proud man, Abimelech could not accept the possible death by a woman's hand (Judg. 9:50-57);

2) The Old Testament hero judge Samson, who became famous for his heroic deeds in the fight against the Philistines, brought down a house on himself and on them; of which he and his enemies were buried under its ruins (Judg. 16:25-30);

3) King Saul committed suicide under the pressure of defeat and out of fear of torment and mockery from his enemy (1 Samuel 31:1-4);

4) King Saul's armor-bearer committed suicide out of solidarity with his master (1 Samuel 31:5);

5) The adviser Ahithophel, having betrayed King David, began to serve his son Absalom and give him advice. The advice of Ahithophel at that time was considered as important, as if someone were asking God for guidance. When Absalom disregarded one of Ahithophel's advices, the latter returned to his native home and committed suicide by hanging (2 Samuel 17:23);

6) Zamri, who usurped power, reigned for 7 days. When the people revolted and Zamri saw that the city was taken, “he went into the citadel of the king’s house; he burned down the king’s house over himself with fire and died” (1 Kings 16:15-20);

7) Judas Iscariot, the son of Simon, betrayed Jesus for 30 pieces of silver and then hanged himself (Matt. 27:3-5).

Of the listed cases of suicide, only the situation with Samson is not so unambiguous, since he had no actual intentions to die, and the driving force behind his act was the desire to destroy enemies.

In Christian society, as soon as it was established, suicide was formally banned. As early as 452, the Council of Arles declared that suicide was a crime and could only be the result of some diabolical fury. But it was only in the following century, in 563, at the Council of Prague, that a penal sanction was added to this ban: the Council decided that suicides would not be "honored by any commemoration in the holy sacrifice of the mass, and that the singing of psalms would not accompany their bodies to the grave."

In the Orthodox tradition, the sin of suicide consists of both the very fact of murder (of oneself in this case), and the sins of unbelief and lack of faith, cowardice, sins of despair and despondency, through which the suicide refuses to bear his “life cross”, doubting the saving Providence of God for everyone. According to church canons, suicides and even those suspected of suicide cannot have funeral service in the church, commemorated in church worship at the liturgy and at memorial services. Thus the basic Christian “anti-suicide postulates” remain unshakable:

"... suicide is a kind of murder",

"... the suicidal person rejects the power of God over himself and takes on the role of judge and master of his life",

"... suicide is a rebellion against the Creator",

"... suicide is a result of “being led” by Satan",

"... Jesus Christ did not come to take away, but to give us life",

"...our life belongs to God."

F.M. Dostoevsky best postulated the Christian attitude to suicide: “Suicide is the greatest human sin ... but the Lord alone is the only judge here, for He alone knows everything — every limit and every measure”.

At the same time, a person's religious worldview in itself can be both anti-suicide in nature and provoke (directly or indirectly) the development of suicide tendencies. Historically, such culture-forming religions as Christianity, Islam, Judaism, in most cases have a negative attitude towards suicide. However many "Eastern" religious movements demonstrate a tolerant, controversial, and even encouraging attitude towards it. Sectarian and schismatic groups, as a rule, are a springboard for committing mass suicides and often provoke individual suicides.

It must be taken into account that the true religiosity of a person is determined not so much by his self-identification as a Christian (often the Christian life is limited only to the “Easter cake”), but by his real adherence to the Church, starting from childhood. Our research has shown that for the prevention of suicidal behavior, the degree of parishioners’ adherence to the Church is of particular importance.

In general, Christianity has a significant controlling, "sanitizing" and deterrent effect on suicidal activity, drawing the attention of believers to the spiritual aspects of their life and death.

True religious motives reflect the postulates about suicide as a sin, the fear of destroying one's immortal soul, dooming oneself to eternal torment, etc. As already noted, from the point of view of a believer, life is given by God, and only He can control a person's destiny.

According to a number of suicidologists, the actualization of religious ideas is more severe in people of "mature", elderly age. The results of other researches (Vagin Yu.R., 2011) indicate that even those people who formally deny any religious beliefs perceive suicide as a sin. In countries with a high religious culture, the suicide rate is traditionally lower than in secular states.

There are various scientific theories of suicide: philosophical, sociological, psychological, medical and even anti-psychiatric. The first attempt to scientifically

define suicide was made by Emile Durkheim (1897, 1912). He viewed “all classes of deaths resulting directly or indirectly from the positive or negative acts of the victim itself who knows the result they produce”. Modern suicidologist M.Farber (1968) provides a more concise definition of suicide – a deliberate, intentional and quick taking of one's own life. E. Shneidman (1979) defines suicide as "human act of self-inflicted, self-intentional cessation". No less common is the position of K. Jaspers (1913), who believed that suicide is based on a special form of behavior (behavioral act) of a person in a difficult situation (psychological crisis).

From a practical point of view, the definitions given by the World Health Organization (1982) are quite concise and theoretically balanced, in which “suicide” is considered as “an act of self-murder with a fatal outcome”, and “attempted suicide” as “an analogous act with nonfatal outcome."

The study of the problems of suicidal behavior in Russia began only in the late 18th century. At first, this problem was considered mainly within the framework of law and philosophy, then – in literature, and only later, it gradually began to acquire the character of proper scientific research. At the same time, the main debatable issue was – who commits suicide: mentally ill or healthy people? Most of the Russian psychiatric scientists of that time (V. M. Bekhterev, S. S. Korsakov, I. A. Sikorsky, N. I. Bazhenov, S. A. Sukhanov, V. F. Chizh, etc.) believed that suicide is not the prerogative of the mentally ill alone. This position in general is shared by modern scientists, however, it is still believed that a number of mental disorders may also underlie suicidal behavior (Antohin G.A., 1979; Bacherikov A.N., 2005; Nechiporenko V.V. et al., 2007; Vaulin S.V., 2012; Lyubov E.B., 2016; Khritinin D.F. et al., 2016; Polozhiy B.S., 2019).

At the end of the 19th – beginning of the 20th century, the study of “private” aspects of suicidal behavior also began (V.M. Bekhterev, N.P. Brukhansky, P.F. Bulatsel, M.N. Gernet, A.F. Koni, N.P. Ostrovsky, G.S. Petrov, L.A. Prozorov, E.N. Tarnovsky). At the same time, until 1926 they were extremely small in number, and from 1930 to 1970s (mainly for ideological reasons), they practically stopped. It was during these years that many popular misconceptions were cultivated (supported by pseudoscientific knowledge), which “routinely” are also currently spreading in the modern society (including religious): that “only mentally ill people commit suicide”, “people who all the time talk about suicide, will never commit it”, “suicide cannot be prevented, it is always sudden and unexpected for others”, “suicide is a hereditary phenomenon and happens only in dysfunctional families”, “real suicides are always determined to take their own lives”, “after a failed suicide, its danger decreases”, etc.

The real formation of suicidology as a scientific discipline took place only in the middle of the 20th century, thanks to the research of the "scientific school" of Professor Ayna Grigoryevna Ambrumova. However, to date there is no universal theory of suicidal behavior, primarily due to its multifactorial genesis, especially in mentally healthy individuals. In the most general form, according to the concept of A.G. Ambrumova (1979), the combination of negative factors that are psychologically significant for a particular person, with certain personality traits, leads to an "irresolvable" conflict, which causes severe maladaptation and a "collapse of values". As a result of the overlapping of provoking factors (“something happened”), a person’s ready motivation (“disappointment in himself and his abilities”) and predisposing factors (“open window”), a reaction in the form of suicide may follow. Thus, according to this concept, suicidal behavior is a consequence of the mental maladaptation of a person in a situation of an individually significant microsocial conflict.

A.G. Ambrumova identified three main stages of such behavior: pre-suicide, suicidal act and post-suicide. The pre-suicide period can be of varying length, starting with “passive thoughts” about possible death and later adding a “suicide plan” (“suicide thoughts”). However, the final stage of “suicide intentions” is of particular danger, at

which a volitional component is added, although outwardly the suicide person may seem “quite well” and even “better than before” (since “the final decision has already been made for oneself”). Therefore, it is at this stage that much in the prevention of suicide depends on the close circle, including the clergy, to whom, as already noted, people with severe mental trauma often turn.

In the perspective of prevention, along with the concept of "suicide risk" (potential preparedness to commit suicide), one should single out the concept of "suicide attempt" intentional use of means of taking of one's own life, which did not end in death) and its main types: "true" (the goal is to take one's own life); “demonstrative-blackmailing” (the purpose is demonstration of this intention, “a cry for help”); "affective" (occur at the height of strong emotional experiences – affect, mainly in adolescents and young people).

At the same time, it is important to take into account the main motivation for a suicide act (Vagin Yu.R., 1998): “altruistic” (death for the sake of others); "anemic" (loss of the meaning of life); "anesthetic" (unbearable suffering); "instrumental" (manipulation of others); "autopunitic" (self-punishment); "heteropunitic" (punishment of others); "post-vital" (hope for something better after death).

The post-suicidal period itself can also develop in various ways and have different types. The early post-suicide period (its main types: “critical”, “manipulative”, “analytical”, “suicidal-fixed”) is especially important for prevention, as it is a result of many components (the situation preceding the suicide attempt, the suicide act itself and the new, post-suicide, situation). The most favorable is the “critical” version, when there is a realization (full or partial) that the act was erroneous; less favorable - "manipulative", since "having received the desired attention from others", the suicide person may begin to perceive his suicidal behavior as "a good way to resolve difficulties." However, it should be kept in mind that each subsequent demonstratively blackmailing suicide attempt increases the likelihood of a "true" suicide. With the “analytical” option, the suicide person understands that the problem could have been resolved differently, but often leaves such a method “as an extreme option for solving the problem” for himself. Finally, in the "suicidal-fixed" type of post-suicide, the likelihood of repeated suicide acts is especially high.

The risk of a repeated suicide attempt is considered to be very high during the first year after the initial attempt (especially in the first 5-6 months). The proportion of repeated attempts in the population is 22-25%, and their lethality is several times higher than in the primary attempts. According to I. Overstone (1973), suicide attempts increase the risk of completed suicide in the next year by 100 times. Of those who have made a suicide attempt, one in four repeats it, and one in ten dies as a result of a completed suicide. Even with demonstratively blackmailing suicidal behavior, 30% of suiciders end their lives by suicide. Therefore, a previous suicide attempt is one of the most significant risk factors for re-attempt and completed suicide.

According to the WHO recommendations, there are about 10-20 suicide attempts for “n” completed suicides, and the number of people with suicide intentions (“internal suicidal discourse”) is $100 \times n$. At the same time, among family members involved in the problem, the risk of committing suicide also increases dramatically – $n \times 8$. It is important to emphasize that relatives of a suicide person suffer for two main reasons: they mourn for the deceased relative and, at the same time, are not inclined to talk about his suicide, which makes it much more difficult to help them. At the same time, such people consistently experience a number of severe painful manifestations – from primary shock (denial of the tragedy, helplessness, self-blame), feelings of guilt, shame and fear to depressive disorders and a wide range of psychosomatic problems, including their own suicide tendencies.

Thus, preventive measures with persons who have committed suicide attempts are extremely important and should be carried out taking into account the characteristics of the early post-suicide period (the predominant type of post-suicide), as well as the leading suicide factors identified in each of them (positive family history of suicide, personality traits, degree of social alienation, participation in sects and occult practices) and anti-suicide factors (lack of severe personality disorders, social adaptability, belonging to a traditional religion). Based on this, the main principles for the prevention of recurrent suicidal actions should be early diagnosis of suicide intentions, a differentiated approach (depending on the type of post-suicide, prevailing suicidogenic and anti-suicide factors) and the complexity of ongoing psycho-prophylactic measures, including psycho-educational work with such individuals.

Religion is of particular importance in the prevention of suicides and repeated suicide acts. In this regard, from our point of view, a quote from the founder of suicidology as a science, Emile Durkheim, would be appropriate here: "The beneficent influence of religion… [that] protects men against the desire for self-destruction, …[is due to] the existence of a certain number of beliefs and practices common to all the faithful, traditional and thus obligatory. The more numerous and strong the collective states of mind are, the stronger the integration of the religious community, also the greater its preservative value".

The main efforts to prevent suicidal behavior (regardless of the category of suicide) should be directed to: a) prevention of primary suicides; b) readaptation of persons who have committed suicide attempts; c) formation of a healthy lifestyle (in the spiritual, mental and physical spheres).

Traditionally, there are three levels (types) of such prevention:

1. Primary ("non-selective"): improvement of the social, spiritual and moral life of people; elimination of factors that contribute to the formation of suicidal behavior; formation towards moral and value oriented activity.

2. Secondary ("selective"): identification of risk factors and selection of groups for "preventive registration" (persons with various forms of deviant behavior); early identification of persons with neuropsychic disorders; spiritual guidance and medical correction of suicide persons.

3. Tertiary (“indicative”): strengthening the “anti-suicide barrier” of the suicide person; spiritual and psycho-corrective work with a suicide person and his immediate microsocial environment; dynamic monitoring and treatment in case of a suicide person with a mental illness.

Direct practical work (both by clergy and medical personnel) should, first of all, be based on the “individual anti-suicide potential” of a person (according to Romek V.G. et al., 2005), including his “internal” (instincts of self-preservation; intellect; social experience; communicative potential; positive experience in solving previous problems, etc.) and "external" resources (support of family and friends; social stability; adherence to religion, degree of church involvement; stable financial situation; the possibility of obtaining social, medical, psychological assistance and etc.) to solve emerging problems.

“Anti-suicide factors of a person” can also include intense emotional attachment to the most significant relatives; parental responsibilities; pronounced sense of duty, commitment; focusing on the state of one's health, fear of causing physical suffering or damage to oneself; dependence on public opinion and avoidance of judgment from others; notions of the sinfulness of suicide, unused life opportunities; availability of creative plans, trends, intentions, etc. Focusing on these resources, one can choose the most significant of them for individual psychoprophylactic activities. At the same time, it is expedient to include in the crisis assistance strategy: compilation of a list of the main problems; selection of the highest priority of them, not only based on the degree of

significance, but also on the basis of possible short-term effectiveness; identification of possible solutions, encouraging the options offered by the suicide person himself; step-by-step implementation of the selected solution; anticipating and identifying obstacles that may arise from doing so (including not only difficulties associated with circumstances, but also cognitive and emotional problems); assessment of failures and support for any, even small, results achieved.

On the whole, any, including pastoral, psycho-prophylactic work in this direction should be focused on solving the Aaron Beck's “cognitive triad”:

a) suicide people, for the most part, exaggerate the scope and depth of their problems;

b) they are not self-confident;

c) they do not see successful problem solving in the future.

In this regard, the following basic principles (approaches) of counseling of persons with suicidal behavior can be identified:

"Information" (active promotion of a healthy lifestyle, cultivation in the media of traditional historical, religious, cultural and moral values);

"Worldview" (taking into account religious affiliation, ethical and moral aspects of the personality of the suicider);

"Personalized" (taking into account the cultural, ethnic, age, gender, professional and other individual aspects of the suicider);

"Differentiated" (taking into account the contributing or hindering factors; and the characteristics of the stage of suicidal behavior: pre-suicide, post-suicide);

“Microsocial” (taking into account the peculiarities of the microsocial environment, the need to provide assistance to both the suicide person and his family members and relatives);

"Clinical" (taking into account the characteristics of the mental and somatic health of suiciders);

“Collaboration” (involvement of priests, psychiatrists, psychotherapists, psychologists and other mental health professionals into providing help);

Thus, there is no doubt that the improvement of suicidological care is possible only with the close cooperation of psychiatrists and clergy. Viktor Frankl once said: “Religion provides man with a spiritual anchor and with a feeling of security, such as he can find nowhere else.”

At present, serious experience has been accumulated in such cooperation, which began in the early 1990s, when a new subject was introduced at the Moscow Theological Seminary - "pastoral psychiatry." Professor Dmitry Evgenyevich Melekhov (1899–1979) was at the origins of this work, he wrote the first special manual on this discipline. At the same time, we think it is no less important to teach theological knowledge in medical universities, first of all, the basics of Orthodoxy (other confessions traditional for Russia) and cult studies. It is our deep conviction that such a closer interaction of spiritual educational institutions and medical universities on various (both theoretical and practical) issues of "Medicine, Mercy, Faith", with "cross" training: seminarians and clergy – in the basics of medical knowledge (primarily, in the field of psychiatry); doctors and students - in the foundations of Orthodox ethics, will be extremely useful in solving many of the tasks facing our Fatherland.

The main thing is that these noble undertakings should not fade away, but continue to multiply and strengthen. In this regard, the words of the professor of the Imperial Military Medical Academy, the great composer, founder and champion of women's medical education in Russia, Alexander Porfiryevich Borodin, acquire a special, somewhat prophetic meaning: “Everything that we do not have, we owe only to ourselves”.

Religiousness of psychiatric inpatients with suicidal behavior

Introduction. Along with studying the influence of biological, social, personality-psychological, ethnic and other factors on the frequency of suicides, a number of modern researchers pay special attention to the influence of the religious factor [1,3,4,7,8,9], which, in their opinion, has not yet been sufficiently studied.

Aim of the study: research of characteristics of religiosity in persons with mental disorders who have committed suicide acts.

Material and research methods. The research was carried out on the basis of the psychiatry clinic of the Federal State Budgetary Military Educational Institution of Higher Education "Military Medical Academy (named after S.M. Kirov)" and St. Petersburg "Psychiatric Hospital No1 (named after P.P. Kashchenko)". A total of 161 patients were examined (the main group – 81 prs. with suicide attempts, and the control group – 80 patients with suicide threats).

The clinical and psychopathological method was the main research method. The following scales were used to objectify the results of the study: Hamilton psychiatric rating scale for depression, Columbia Suicide Severity Rating Scale, Pierce Suicide Intent Scale (Pierce, D.W.), Global Assessment of Functioning Scale, "Assessment of the level of social adaptation" (Rustanovich A.V., 2000), "Assessment of the type of adaptive behavior" (Volovik V.M., 1985), questionnaire "Peculiarities of the religious worldview" (MMA, 2015). Statistical data were processed with the programs "Statistica 10.0 for Windows", "Microsoft Excel 2016". The mean group research results, standard deviation, minimum and maximum values of the indicators were calculated by the "Descriptive Statistics" tool. The character of the distribution was checked for normality by the Shapiro-Wilk W-test. The significance of differences between the indicators of different groups was assessed for parametric data based on the Student's t-test, for non-parametric data – according to the Mann-Whitney U-test – with independent samples. For non-parametric qualitative features, the calculation of relative frequencies (shares) was used, and Pearson's $\chi 2$ test was used to compare relative frequencies. The level of statistical significance adopted in the study is $p \leq 0.05$.

Results and discussion.

The mean age of patients in the main (C1) group was 42.2 ± 18.8 years, in the control (C2) group - 42.7 ± 16.0 years. In the main group, men accounted for 51.9%, women - 48.1%, in the control group - 46.3% and 53.7%, respectively.

The structure of mental disorders in patients of the main and control groups, examined in a hospital, was relatively uniform, the differences between the groups did not reach a significant level ($p>0.05$). Both in the main (suicide attempts) and control (suicide threats) groups, patients suffering from schizophrenia spectrum disorders prevailed (37.0% and 38.8%, respectively). The lowest representation in both groups was observed in patients with mild mental retardation (2.5% and 0%, respectively). At the same time, in patients with attempted suicide, diagnosed organic disorders were somewhat more common than in patients with suicide threats (24.7% and 18.8%, respectively, $p>0.05$). In turn, among patients with suicide threats there were more patients with affective disorders, compared with the group of patients who made suicide attempts (21.3% and 12.3%, respectively, $p>0.05$). Slightly more frequently in group C1, compared with group C2, there were patients with personality disorders (3.7% and 1.3%, respectively, $p>0.05$). The distribution of patients of the main and control groups by diagnosis is shown in Table 1.

Table 1 – Structure of mental disorders in patients of the main and control groups.

Diagnostic rubrics (ICD-10)	Main group, n (%)	Control group, n (%)
F01-F09	20 (24,7)	15 (18,8)
F10-F19	6 (7,4)	7 (8,8)
F20-F29	30 (37,0)	31 (38,8)
F30-F39	10 (12,3)	17 (21,3)
F40-F49	10 (12,3)	9 (11,3)
F60-F69	3 (3,7)	1 (1,3)
F70-F79	2 (2,5)	0 (0)
Total	81 (100)	80 (100)

As for the methods of committing a suicide attempt, poisonings were most often registered (37.0% of patients), and in most cases they were poisoning with medicines and much less often with other substances (toxic liquids, helium). The second most common method was self-cutting (usually forearms), 24.7% of patients. In third place were attempts of throwing oneself from a height (18.5%). Less common were stab wounds (11.1%), self-hanging (8.6%), self-suffocation (4.9%), and other social methods (8.6%). In 13.6% of patients, combined suicide attempts were noted, when several suicide methods were used during one attempt.

The severity of suicidal intents in patients was assessed using the Pierce scale (PSIP). The assessment was carried out in patients with suicide attempts, examined in a hospital – 81 prs. The assessment was made once during the early post-suicide period. The low level of suicide intents predominated in patients with neurotic, stress-related and somatoform disorders (60.0%), as well as in patients with mental retardation (100.0%). An average level suicide intents were observed in patients suffering from alcoholism (66.7%) and organic disorders (55.0%). A high level of suicide intents was in patients with personality disorders (66.7%), affective disorders (60.0%) and schizophrenia spectrum disorders (50.0%). In general, patients most often had moderate and high levels of suicide intents (Figure 1).

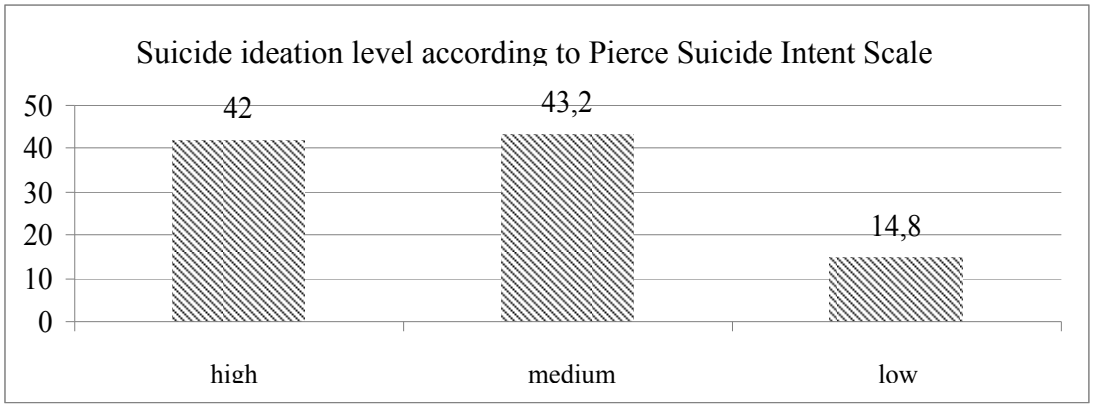

Figure 1 – Level of suicidal intents in main group patients.

A survey using the Columbia Suicide Severity Scale in these patients showed that 50.0% of them had the most severe suicidal ideas with a specific plan for their implementation. Such ideas were mostly in patients with personality disorders (100.0%), as well as in patients suffering from organic disorders (50.0%). Much less frequently, this type of suicidal ideation was present in people suffering from alcoholism (16.7%). Actual suicidal ideas, including only some intention to act (without

a specific plan for their implementation), mainly occurred in patients with affective disorders (70.0%), and were absent in patients with personality disorders. Other types of suicidal ideation (in isolated form) were rare.

When describing the frequency and duration of suicide ideation, it should be noted that the highest frequency (4.3 ± 0.6 points) and duration (3.7 ± 0.6 points) were detected in patients with personality disorders. Suicidal thoughts in this category of patients, on average, occurred every day or almost every day and lasted for quite a long time. Also, a rather high frequency of suicidal ideation (3.4 ± 1.8 points) was registered in patients with affective (depressive) disorders. Suicidal ideation in this group of patients arose, on average, 2-5 times a week. In addition, patients with affective disorders experienced the greatest difficulty in trying to control suicidal thoughts on their own (controllability 3.1 ± 1.9 points). The role of deterrent factors was significant in all groups, with the most significant grounds for suicidal ideation in patients with affective disorders (3.7 ± 1.4 points).

Non-working persons predominated among the examined patients, and in the group of patients with suicide attempts, the number of working people slightly exceeded their number among patients with suicide threats (38.3% and 22.5%, $p>0.05$). Within this study, a comparative assessment of the patients' social functioning was also carried out. The lowest level of social functioning in patients with suicide attempts (less than 10 points on the GAFS scale) was observed in patients suffering from personality disorders (4.0 ± 1.0), disorders associated with substance use (6.7 ± 4.6) and affective disorders (8.3 ± 3.5).

The level of social functioning from 10 to 20 points was observed in patients suffering from organic disorders (10.9 ± 10.6), schizophrenic spectrum disorders (13.7 ± 11.2), mild mental retardation (16.5 ± 2.1). The highest level of social functioning was observed in patients with neurotic, stress-related and somatoform disorders (19.3 ± 14.7). The level of social functioning of patients with suicide threats, in general, was above 20 points (24.8 ± 10.9). At the same time, among patients with suicide threats, the lowest level of functioning was found in organic mental disorders (22.8 ± 10.6) and schizophrenia spectrum disorders (23.5 ± 9.2).

Along with this, the type of adaptive behavior (ATB) was also evaluated in similar groups of patients. The majority of the examined patients (54.0 %) showed a maladaptive type of adaptive behavior. Moreover, the maladaptive morbid type was more common than the maladaptive antisocial type (34.8% and 19.3%, respectively, $p>0.05$). The second place in frequency was the regressive type (34.2%), the constructive (3.1%) and indefinite (8.7%) types of adaptive behavior were much less common. At the same time, when comparing groups of patients with suicide attempts and suicide threats, no significant differences in the type of adaptive behavior between the groups were found ($p > 0.05$).

Depression of various etiologies plays a significant role as a predictor of suicide [1,2,5,6]. According to the Hamilton Depression Scale, it was detected in a significant proportion of patients (88.9% of the main group patients, 98.7% of the control group patients). It was found that in patients of the main group (after suicide attempts) more often than in the control group, mild depressive disorder (33.3% and 30.0%, respectively) and depressive disorder of extreme severity (12.3% and 7.5%, respectively) ($p>0.05$) were detected. Moderate depressive disorder (29.6% and 40.0%, respectively) ($p>0.05$) and severe depressive disorder (13.6% and 21.3%, respectively) ($p>0.05$) were less common in the main group than in the control group. Derealization and depersonalization were detected more frequently in the control group than in the main group (11.3% and 7.4%, respectively) ($p>0.05$). Obsessive-compulsive symptoms were observed in isolated cases (0% in the main group and 2.5% in the control group). Daily mood fluctuations were also rarely observed, in general, they were detected only

in 5.0% of patients in the main and in 10.0% of patients in the control group. The average score for the severity of depressive symptoms was almost the same in the group of patients with suicide attempts (15.0 ± 6.6) and suicide threats (15.4 ± 5.2). Noteworthy is a significant number of patients who had paranoid symptoms (44.4% of patients in the main group, 40.0% of patients in the control group) ($p>0.05$), which confirms the important role of depressive-paranoid symptoms in the formation of suicidal behavior.

During the research, 39 patients of the main group and 38 patients of the control group reported data on their religious affiliation. In the main group (after suicide attempts), Orthodox Christians made up slightly more than half of the patients who reported their religious affiliation (53.8%). In the control group, the percentage of Orthodox Christians was higher – 73.7% ($p=0.07$). Data on patients with different religious affiliations in the main (C1) and control (C2) groups are presented in Table 2.

Table 2 – Religious affiliation of patients of the main (C1) and control (C2) groups.

Religious affiliation	Suicide attempts (group C1)		Suicide threats (group C2)	
	absolute	%	absolute	%
Orthodox	21	53,8	28	73,7
Protestant	1	2,6	0	0
Islam	2	5,1	0	0
Judaism	1	2,6	0	0
Sect	5	12,8	3	7,9
Atheism, Agnosticism	9	23,1	7	18,4
Total	39	100	38	100

At the same time, a greater diversity of religious views was revealed in the main group. For example, there were a small number of Protestants (2.6%), Muslims (5.1%), Jews (2.6%), while the control group didn't have representatives of these religions at all. Patients of the main group visited sectarian organizations more often than patients of the control group (12.8% and 7.9%, respectively). In the main group, there were more frequent visits of neo-charismatic sects, less frequent – of the organization "Jehovah's Witnesses". In the control group, patients attended various sectarian organizations, such as the Society for Krishna Consciousness, Aum Senrique, gatherings of Satanists, medical cults, and Jehovah's Witnesses. Atheists and agnostics were united in one group; they were more often found in the main group than in the control group (23.1% and 18.4%, respectively). The involvement with occultism in patients is shown in Figure 2.

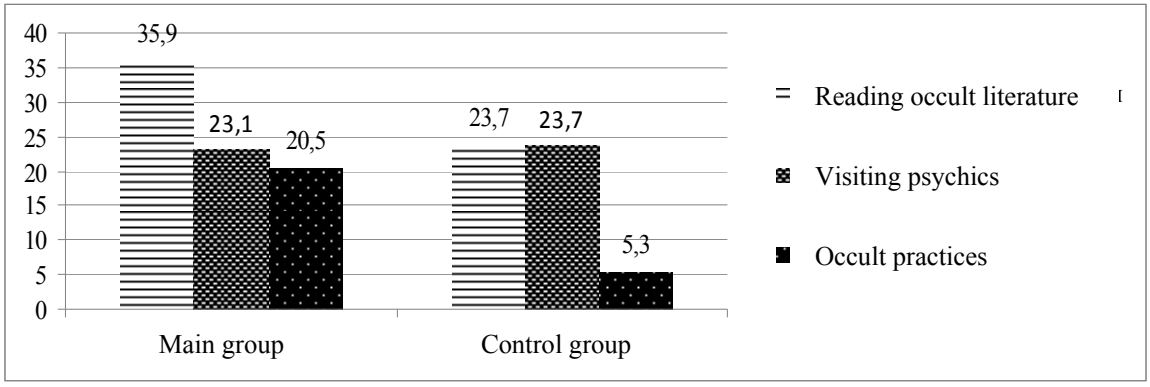

Figure 2 – Involvement with occultism in patients of the main and control groups.

In the main group, more often than in the control group, there were patients with occult interests (46.2% and 34.2%, respectively). At the same time, patients of both groups were fond of reading esoteric literature (35.9% and 23.7%, respectively), turned to psychics and fortune-tellers (23.1% and 23.7%, respectively), were actively engaged in occult practices (20.5% and 5.3%, respectively, $p = 0.046$).

Among Orthodox patients, we have identified 2 subgroups: “churched” (regularly attending the church, receiving the sacraments of Confession and Communion at least once a year) and “unchurched” (visiting the church irregularly, not receiving the above sacraments or resorting to them less often than once a year). It was found that "churched" persons were significantly more in the control group compared to the main group (21.1% and 5.1%, respectively, $p < 0.05$).

At the time of the examination, Orthodox patients were not members of religious sects. In the past (before hospitalization), 14.3% of Orthodox patients of the main group belonged to religious sects. These were mainly Protestant neo-Pentecostal groups (such as the Bright Way, the Church of Jesus Christ, the Word of Life). In the control group among the Orthodox patients, no former members of religious sects were identified.

There were no significant differences between the groups in terms of observance of religious rites and reading of religious literature. Orthodox members of the main group observed some religious rites (fasting, regular praying, etc.) even more often than Orthodox members of the control group (38.1% and 33.3%, respectively) ($p>0.05$). 33.3% of Orthodox patients in the main group and 29.6% of Orthodox patients in the control group read religious literature. Both in the main and in the control group, the vast majority of patients were baptized in childhood (85.7% of patients in the main and 92.6% of patients in the control group). Those who were consciously baptized in both groups were in the minority.

A significant difference between the Orthodox patients of the experimental and control groups was revealed in the frequency of attendance of worship services. Orthodox patients in the control group attended church services more often than patients in the main group. 42.9% of Orthodox patients in the main group and 76.7% of Orthodox patients in the control group attended services regularly, the differences reached a significant level ($p = 0.008$).

In order to clarify the role of the religious factor in patients with suicidal behavior, we compared a group of Orthodox patients (21 prs.) and "non-Orthodox" people (60 prs.) who attempted suicide. At the same time, Orthodox patients showed a significantly more frequent depression during a suicide attempt than "non-Orthodox" patients ("Orthodox" – in 92.0% of cases, "non-Orthodox" – in 75.0% of cases, p=0 .04), a stronger sense of guilt according to HAM-D (1.02 points and 0.36 points, respectively, p=0.04), daily mood fluctuations according to HAM-D were detected more often (0.29

points and 0 points, respectively, p=0.02) and the presence of a critical attitude to the depressive state according to HAM-D (0.45 points and 0.93 points, respectively, p=0.005). The real risk of a suicide attempt (according to the Columbia Suicide Severity Scale) was less in the group of Orthodox patients (the "Orthodox" – 0.75 points, "non-Orthodox" – 1.21 points, p = 0.036). "Non-Orthodox" patients were more likely to have repeated ("Orthodox" in 4.0% of cases, "non-Orthodox" in 36.0% of cases, p= 0.0001) and combined suicide attempts (2.0% and 14.0%, respectively, p=0.03).

According to the catamnesis results, two patients of the main group committed completed suicides, no such cases were detected in the control group. In addition, repeated suicide attempts occurred in 3.7% of patients in the main and 2.5% in the control group.

Of the two patients who committed completed suicides, one patient threw herself out of a window on the 8th floor, the other patient poisoned himself with psychotropic drugs. At the same time, the patient, who committed suicide, suffered from a mental illness in the form of paranoid schizophrenia and, importantly, was a member of the Jehovah's Witnesses sectarian organization. The second patient also suffered from schizophrenia, was involved with occultism (he visited "sorcerers"). These patients, among other things, avoided visiting the psychoneurological dispensary, although they were registered with it.

Conclusions: As a result of the research, it was found that "churched" Orthodox patients were significantly more common in the group of people with suicide threats compared to the group of patients who made suicide attempts (21.1% and 5.1%, respectively) ($p < 0.05$). At the same time, patients with suicide threats attended church services more often than patients who made suicide attempts (76.7% and 42.9%, respectively) ($p < 0.01$). In this group of patients, more often than in the group with suicide threats, there were patients actively involved with occult practices (20.5% and 5.3%, respectively) ($p < 0.05$). In general, along with the formal belonging to the Orthodox Church, most of the suicides had a low level of churching, the presence of occult interests and involvement; some patients were adherents of destructive sects.

Thus, the data obtained in the research confirm the "anti-suicide" significance of patients' belonging to a traditional (in particular, Orthodox) religion and the degree of their churching, and also indicate the negative role in this regard of active occult practices in mentally ill patients. In addition, the results obtained suggest that Orthodox patients are less likely to make severe and repeated suicide attempts, despite the fact that they have depressive symptoms even more often than "non-Orthodox", since it is accompanied by a critical attitude towards their condition. However, an increased sense of guilt in Orthodox patients requires, in most cases, additional psychotherapeutic correction.

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Merinov A.V.

Clinical suicidology and the Russian Orthodox Church: points of the most effective interaction

Relevance: Russia is one of the leaders in the world in terms of the number of suicides, and in terms of teenage suicides, it is the leader. Domestic suicidology is not yet sufficiently scaled and close to the population. But there are definitely institutions that are very close to people, having numerous representatives in most of the country's settlements. One of them is the Church. We have to admit that par-asuicides often do not consider the Church as a resource for help.

Probably, the modern clergyman does not have enough skills in recognizing the "signals" of trouble and there is no "road map" regarding the suicidal parish-ioner.

The question is extremely urgent: have the possibilities of the Russian Or-thodox Church been realized in the suicidological aspect? What are the application points of the respective activity?

It is absolutely clear that the clergyman is able to be the first to know that there is suicidal activity. Does it have a clear and tangible response scheme, any relevant standards?

In this regard, the following ways of optimizing and collaborating with clin-ical suicidology seem logical: raising the awareness of clergy about general and private psychiatry; creation of a basic set of diagnostic suicidological knowledge and formation of a clear response logic in the event of detection of suicidal tenden-cies; possibly, establishing of an independent emergency service in the Russian Or-thodox Church; informing citizens about available anti-suicide opportunities.

Thus, clinical suicidology and the Russian Orthodox Church have a significant number of effective points for joint work, which creates prospects for further fruitful cooperation in the creation of a highly effective network of primary anti-crisis structures.

Priest Ioann Melnik

Coping strategies in pastoral care for people, who have lost their loved ones (according to the writings of Metropolitan Anthony Blum)

Abstract: In a state of grief resulting from the loss of a loved one, people, facing the problem of death and loss, seek to find support in the Church and turn to the priest. This article is an attempt to combine the possibilities of coping strategies and the experience of a pastor in bringing a person out of a state of grief and in stabilizing his mental and spiritual state.

Keywords: state of grief, coping strategies, death, pastoral counseling, pathology, symptoms.

Grief is defined as a reaction to the loss of an object or connection that is significant for the person. It is not necessarily about physical death, it can also be the loss of relationships, a strife, loss of significant things, disappointment in religion or worldview [1]. In this report, we will consider the reaction of grief in relation to the death of a loved one.

The state of grief is caused by information about the death of a loved one, which entails destruction of the vital relationships of the individual.

Mourning is a natural, rather long and multi-stage process that every person, who has suffered the loss of a loved one, lives through.

Among the natural manifestations of grief caused by the death of a loved one, physical suffering is in the first place; it comes in form of periodic crying jags with throat spasms, asthma attacks, shallow breathing and a constant need to fetch a deep sigh, loss of appetite, weakness. Along with the bodily manifestations, a person experiences emotional stress, mental pain. As a rule, there is a preoccupation with the image of the deceased loved person, a slight feeling of the unreality of what happened. Often a person in a state of grief feels guilty, tries to find his own mistakes and omissions, blames himself for what he did not do for the deceased. Often a person reacts to others with irritation and even anger, expressing a desire not to be disturbed, he cannot always control his outbursts of anger. The behavior of a person during a period of acute grief can change so that he becomes incapable of ordinary organized activities, temporarily loses the previous natural patterns of behavior. Over time, a person, as it were, learns to do everyday things again, overcoming the experience of loss and the lack of meaning of any action after what happened [2]. A normal acute grief reaction lasts about 4-6 months, go-ing through a certain dynamic, which the German psychiatrist Lindemann called "grief work" [3]. The goal of grief work is to get over it, to become free of the loss, to adjust to a changed life, and to find new relationships with people and the world.

Psychologists distinguish, as a rule, 5 stages of grief and coping with loss [4]:

- Denial or the stage of shock and stupor, which manifest themselves in the refusal to believe that what happened is real (on average, 7-9 days, but can last up to several weeks).
- Anger / bitterness, or the search stage — is expressed in form of resentment, aggressiveness and hostility towards others. The grieving person unleashes his anger and aggression on many, alternating with denial and shock. He grieves that he is alone in his misfortune that no one helps or sympathizes with him. He is angry at himself, swears at the Sky, and even at the loved one who died, whose death allegedly destroyed the rosy plans. The main task of this period is the transition from formal recognition to inner acceptance and humility before the fact of loss

- Bargaining /negotiation stage (the stage of acute grief according to Vasilyuk F.E.) [5] is an attempt to escape from mental pain. The grieving person contemplates various situations, often associated with an obsessive "if" ("if I do this and that, it will bring him back...", "if I were there...", etc.), and tries to answer his own questions. After all, this helps not only to realize that a loved one can no longer be returned, but also to survive what happened, to regain a sense of control over what is happening.
- Depression (the stage of “residual shocks” according to Vasilyuk F.E.) [5] follows the previous stages, is manifested by a feeling of sadness, emptiness, a person may lose confidence that he can return to normal life, he often avoids contacts alienating from others. The period of alienation is natural for the process of grief, but if this stage prolongs, a pathological state of depression may develop.
- Acceptance / adaptation ("completion", according to Vasilyuk F.E.) [5] — at this stage, the grieving person not only understands that the departed will not return, but also accepts the bereavement. Gradually, the feelings of loss that dominated a person are weakening, and destroyed social ties are being restored. F.E. Vasilyuk describes this period as a gradual transition of a grieving person from the psychological “staying in the past with the departed” to the state of the present. This period involves the search for a new meaning of relations with the image of the departed person, a new role for the departed in the present life [5].

The pathological reaction of grief differs from the natural reaction to loss by a longer duration (the acute stage can last more than 6 months, sometimes up to several years), the depth and severity of grief experiences that can develop into clinical depression, accompanied by persistent insomnia, self-negation and self-punishment. The feeling of guilt towards the deceased person because of with possible but not taken actions that could prevent the death is relentless and is accompanied by dominant (sometimes compulsive) thoughts and memories associated with the loss. Feelings of loneliness and abandonment, ideas about the meaninglessness of the future life, often with suicidal thoughts, are extremely persistent and painful. A long-term pathological grief reaction is often accompanied by somatic disorders in the grieving person, such as ulcers, rheumatoid arthritis, asthma, often dulled response, asthma attacks. Sometimes, a person with pathological grief reactions who has bereavement disorders, actually depression, may develop the symptoms that the deceased suffered from. Changes in social life are also a marker of pathology; a person can completely change his lifestyle, as well as disrupt relationships with friends and relatives. The grieving person may withdraw from social activities; strive for privacy. In some cases, he may talk about suicide to reunite with the deceased [6].

Various factors can contribute to the pathological grief reaction, for example, that the loss was sudden or unexpected; excessive dependence relationship with the deceased person, which gave rise to despair; multiple losses over a short period of time; lack of personal support, as well as personal and psycho-physical characteristics of a person who has experienced the loss.

It is important to note that many modern researchers deem it appropriate to consider each type of loss separately: the loss of a child, partner, parent, friend, etc. [7]. So, when children die, the reaction of parents to the loss can be especially severe and have a very destructive effect on the personality, accompanied by an all-consuming feeling of guilt and helplessness [8]. Manifestations of grief can last for the rest of the parent's life. Studies show that 50% of spouses who survive the death of a child divorce, unable to cope with the situation of loss.

The death of a loved one is a severe stress, especially for elderly and senile people, almost half develop a pathological grief reaction with severe depression, often accompanied by suicidal attempts, severe somatic distress [9]. The grief reaction in ado-

lescents can be manifested by behavioral problems, learning problems, aggressive or even antisocial behavior.

In psychological and psychotherapeutic practice, coping strategies are an effective way out of a pathological state, which involve overcoming the crisis state of the individual and gradual adaptation to new living conditions. The word "coping" comes from the English "cope" (overcome). This term was first used by L. Murphy in 1962, later it was adopted by the scien-tific community dealing with stress issues. Now the term "coping" is used in the sense of adaptive coping behavior [10] in response to a stressful situation and the elimination of problems that prevent the continuation of a meaningful life of the individual.

The main tools of coping strategies are personality-specific features and environmental resources. Based on these features, the way of behavior is projected, which is directed to solving a crisis situation [11]. This is consistent with the person-centered principle of treatment, which implies analysis of the basic characteristics of the individual, such as worldview, religious experience, values, spiritual ideals, the state of ethical and moral awareness, etc. [12]. Although the forms of grief progression and its manifestations are very individual, the content of the grieving process is invariable, and this allows us to highlight those universal steps that a grieving person, and his doctor or psychologist, must take to return to normal life. The tasks of mourning do not change, because they are determined by the process itself, and the forms and methods of their solution are individual and depend on the personal and social characteristics of the grieving person (J.W. Worden, 2001).

Tasks one must accomplish in the process of grieving:

1) Accept the loss, overcome the denial of the loss and its significance;

2) Openly live through the feelings — feel and process the pain of loss. At the same time, it is important to overcome the obstacles that a person himself creates in order to avoid working through the pain of loss (keeping himself occupied with work, idealizing the deceased, escaping painful feelings through absorption by travels, etc.);

3) Develop skills to cope with those areas of life which were influenced by the deceased at most. Sometimes it is useful to reformulate the loss in a positive perspective: "What did I gain from the loss";

4) Create new emotionally rich connections. Withdraw emotional energy and reinvest it in other relationships (sometimes despite the feeling of guilt and the inner prohibition that the grieving person puts on himself (for example, not to remarry, etc.)). Often the task begins to be implemented only after a few years. The task four does not imply either oblivion or the absence of emotions. The attitude towards the departed needs to be rebuilt in such a way as to continue to live and enter into new, emotionally rich relationships [13].

Both in natural and pathological grief reactions after the loss of a loved one, turning to religious faith and spiritual life is essential and contributes to the effective development of coping behavior and the resolution of adaptation problems. According to V. Frankl, religious faith can give an individual peace and support, which are difficult to find in another area, and this, in turn, can bring about effective and psychotherapeutic results [14].

The famous Russian psychiatrist D.E. Melekhov, who gave particular importance to the issues of the spiritual sphere in the life of a healthy and sick person, pointed out that a holistic view of the patient cannot be reduced only to pathological symptoms and syndromes [15]. In his opinion, religious beliefs and experiences, especially in emotional and neurotic disorders, can help resist mental illness, adapt to it and compensate for its manifestations and consequences, help find a stronger life orientation based on the authority of God. The American researcher G. Allport, the author of the concept of internal and external religiosity, showed in his works that an

internal, deep religious faith contributes to the preservation and strengthening of mental health and has great psychotherapeutic potential [16].

Assistance in situations of loss of a loved one is covered in great detail in the writings of Metropolitan Anthony (Bloom), in particular, in his well-known work “Life. Disease. Death” (record of conversations with Metropolitan Antony in the period 1993-1994 as part of the radio broadcasts series “Priest at the Bedside”). The pastoral approach to the loss of a loved one, presented by Metropolitan Anthony, largely corresponds to the modern understanding of religious coping strategies.

Metropolitan Anthony also raises the problem of overcoming the existential crisis after the loss of a loved one in his work “Death: those who leave and those who stay”. It is worth noting that Metropolitan Anthony lived through the loss of all his loved ones and more than once faced the loss in his pastoral ministry. He shares with us his personal experience of losing a loved one and the experience of pastoral counseling, which is based in the Gospel.

Speaking about pastoral care, Metropolitan Anthony notes that a priest needs experience in pastoral ministry, as well as scientific knowledge in order to understand the manifestations and development of a mental illness. At the same time, it is important to take into account the fact that mental disorders, as well as the emotions of a person in a state of spiritual crisis and the loss of a loved one, affect the manifestations of religiosity and church life of a person. It is important to distinguish the symptoms of a pathology from religious experiences [17].

The examples of priest behavior as described by Metropolitan Anthony, though not systematized in terms of modern methods of coping with grief, are very close to religious coping strategies for overcoming grief and illness, which are currently described in professional literature. In particular, at the first stages of grieving, he pays special attention to tactile contact.

In times of acute grief, pastoral support should not be in the nature of rational persuasion, using verbal logical arguments. It is much more important to participate in the grieving, holding a person by the hand, as if saying: “I am with you” [18]. In such cases he advises not strive for heroism in restraining emotions. The following words express a very important spiritual aspect: “... pain is our love. Love expressed itself through joy, now it expresses itself through pain. This is love too, and there is nothing shameful in feeling it ...". The problem of not expressing emotions in a state of grief is that a person does not allow love to be realized, and the energy that was directed to parting with the deceased can come out in a different capacity, harming the person. Undoubtedly, it takes courage to be open in the face of death, and the lack of this action can provoke a person to turn to self-destructive behavior (aggression, suicide, alcohol and drug use).

According to Metropolitan, tears are a gift from God. Christ wept for his friend Lazarus, realizing that through the original sin death entered the world and contaminated the man with corruption. One can’t prevent crying, but there is a difference between tears and hysterical crying, which means they affect a person in different ways. Metropolitan Anthony recalls the words of St. Theophan the Recluse at a funeral service: "Brothers and sisters, let's cry, because a loved one has left us, but let's cry like believers ...". The Christian weeps over the dead, because his vocation was not to die, but to have eternal life. Death entered our lives through human falling away from God, that is why death as such is a tragedy [19].

Metropolitan Antony believes that it is wrong for a person to artificially stir up a feeling of grief in himself. A person does this out of fear that if the grief for the deceased goes away, then this will mean that there was no true love. According to the Meropolitan, sorrow should be transformed into love, through the understanding that one himself has to go this way and in the end meet with his beloved [20].

After the shock and grieving, as Metropolitan Anthony writes, a person begins to look around and seek support, in particular in the church. At this stage of grief, meaningful church prayer for the deceased can bring relief. This is what Metropolitan writes: "…when we stand and pray for the deceased, we actually say: "Lord, this man did not live in vain. He left behind an example and love on earth; the example we will follow; love never dies"". Praying at the funeral service we thereby testify before God of love for the deceased and thereby affirm him in eternity [21].

Metropolitan Anthony points to guilt as an important symptom of grief. It is natural for a person to experience guilt associated with his actions in relation to the deceased. Especially often people regret the lack of love in their relationship with the deceased. According to Metropolitan, this is not the way to think, because God called each of us into the world out of His love and prepared eternal life for us. Therefore, our love does not die, and we should continue to love a person after death, erasing the border line of death. "We must always use the present tense to say: "I love him (her)", who has passed away from this life, be-cause, as the Old Testament tells us: "Love is as strong as death" (Song of Solomon 8:6). Love is the only force that can resist death and not be defeated," says Metropolitan Anthony [22].

The mourning of a person is often exacerbated by resentment or unresolved conflict with the deceased. In this case, a person feels a particularly acute guilt and becomes unable to overcome this crisis, since in earthly life there is no longer an opportunity to talk and resolve the conflict. Here it is very important to address the departed in personal dialogue and in prayer.

Metropolitan Anthony describes such a case. A man during the war becomes an unwitting source of death of a loved one, a beloved woman with whom he planned to start a family. He was in a severe crisis and was unable to overcome this state due to a strong sense of guilt. Metropolitan advised him to address his beloved, share his pain, ask for forgiveness and for help in obtaining peace in his soul. After this conversation, the person was able to get rid of the oppressive feeling and cope with grieving that had lasted for so long in his life.

After the shock, grieving, search for support, the question arises, what to do next? The stage of restoring relations with the outside world begins. At the same time, a very important condition for living in new circumstances is the awareness of what kind of memory remains with us about the deceased. Metropolitan Anthony advises us to evaluate the role that the deceased person played in our life: his love, care, respect that he invested in us, and what we learned from him. And after that, "to continue his life" through the love that we received from him [19]. Thus, a person continues to live with us, in our love spreading in the world. Metropolitan Anthony refers to the words of the Gospel: "Unless a grain of wheat falls into the earth and dies, it remains alone; but if it dies, it bears much fruit" (John 12:24).

An analysis of Metropolitan Anthony's service in consoling people facing the loss of a loved one showed that in his pastoral ministry and work he followed principles of religious coping strategies for grieving, which are used by specialists in modern psychotherapeutic assistance. Metropolitan describes from personal experience those pastoral methods that he used in the process of consolation. Thus, the religious principles of spiritual pastoral support, de-scribed by Metropolitan Anthony, allow us to talk about the conceptual help of a pastor to people grieving about the loss of a loved one.

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Integration of mentally ill people into Church life: pastoral and medical support

Abstract: modern comprehensive programs of biopsychosocial-spiritual support for mentally ill patients with a religious worldview include an important spiritually oriented component. As part of a holistic approach, the organization of a therapeutic environment on the basis of a church parish contributes to the implementation of rehabilitation activities, and also helps to include the patient in church life, taking into account the mental characteristics of his functioning.

Keywords: spiritually oriented psychotherapy, religious worldview, therapeutic community.

Introduction

The place of spiritually oriented therapy of endogenous mental patients is determined by the significance of the spiritual model in the diagnostics and treatment of mental disorders. Helping patients with a religious worldview, it is necessary to take into account the axio-semantic features of this category of patients, and the psychological and social context should be expanded to include the spiritual level. Therapeutic interventions should be differentiated at various levels – individual, family, social, and confessional, which contributes to the mobilisation of the religious resource. Researchers register a variety of positive functions of the religious worldview that contribute to the formation of stable remissions in the case of chronic mental pathology (Kopeiko G.I. et al., 2021; Verhagen P., 2020).

Help for people with mental illness

Scientific literature describes special methods of rehabilitation of patients, which include both individual and group forms of work. The most widely used among them are training in social skills, communication, self-esteem, confident behavior, independent living, training in the ability to cope with residual symptoms of psychosis, and family therapy. Adequate and timely application of these approaches ensures successful and effective psychosocial therapy and rehabilitation of mentally ill patients. The practice of such work indicates the need to use elements of rehabilitation soon after the patient exits the acute state, when he has the opportunity to more or less adequately perceive the surrounding reality.

The rehabilitation activities help the patient to feel that his is functioning autonomously and to take responsibility for his condition. Support from family, doctors and a multidisciplinary team of specialists in case of difficulties or exacerbations of the disease helps patients to form their own style of behavior, which can be as close as possible to a full healthy lifestyle. Compliance management strategies are of significant importance in this process, which include improving the safety and tolerability of drugs, psycho-education of patients and their families, adherence to clinical recommendations by the doctor (R. Gray et al., 2002; J. Kane et al, 2006).

Place of community-based care

The analysis of various rehabilitation programs and forms of providing psychiatric care today in various countries shows a wide spread of out-of-hospital approaches. The study of the world's best practices in psychosocial rehabilitation has led a number of experts to the conclusion that the use of group methods of psychosocial and cognitive rehabilitation contributes to the improvement of the system of social adaptation of patients and the further development of psychosocial rehabilitation. Of great importance are socially oriented types of psychiatric care, the formation of which was facilitated by evidence of the negative impact on patients with mental illness of

prolonged stay in institutions (social deprivation), awareness of the need to include the various needs of patients and social support in the organization of psychiatric care, the desire of patients to choose and control the provided assistance to them if they live independently in the community. It should be noted that there are cases of abuse on the part of the medical personnel in institutional forms of assistance. Psychosocial therapy and rehabilitation implemented by public organizations as part of mental health activities are effective, as they have the opportunity to use the various resources of social communities at the stage of recovery and resocialization of people with mental disorders.

In the current economic and social conditions of life in Russia, the importance of socially oriented non-profit organizations and the public sector in the system of mental health care is growing. In a significant number of cases, assistance in such organizations is provided by volunteers with special professional education (doctors, psychologists, psychotherapists, social workers), or volunteers who have undergone special training. The training of volunteers, as a rule, is controlled by public organizations, however, the most appropriate is the training of volunteers in specialized psycho-educational programs based on evidence-based technologies at research clinical centers (Kopeiko G.I., Solokhina T.A. et al., 2020).

Comprehensive care for patients with mental disorders

Assistance to patients with endogenous mental illness should include biomedical therapy, psychosocial and sociotherapeutic rehabilitation. It is necessary to use psychoeducational technologies, creating a therapeutic community. The development of European and world research thought in the treatment of mentally ill patients with a religious worldview implies the availability of resources to solve the problem within the patient's personality, and therapeutic efforts should be aimed at changing the way the patient thinks and acts, and, ultimately, changing the whole way of life of a person. We can see this both in the widely used motivational counseling technique (Miller W.R., Rollnick S., 2012) and in the socioecological approach (Hudolin V., 2013), which is used in an outpatient family-oriented program to help people with behavioral disorders (Zoricic Z., 2019). To develop a healthy family life skill, it is necessary to use systemic family psychotherapy (Nastasic P., 2017).

Influence of the spiritual component on life of a mentally ill person

The last decades have been marked by fundamental research in the field of religious psychiatry (Koenig H.G., 2012; Van Praag H. M., 2013), which noted the need to use a spiritual resource in working with mentally ill people with a religious worldview. Van Praag claims that religiosity is inherent in man, is an attribute of the human mind, rooted in our very being, genetically predetermined. The influence of the religious factor, which has a “protective” function in the case of substance abuse, determines the inverse correlation between the intensity of religious life and the intensity of substance abuse (Chamberlain & Hall, 2000; Koenig et al, 2001; Koenig, 2005). As a rule, behavior patterns generally accepted in a religious community and social support, which is specifically tuned within confession-oriented social networks, are aimed at forming a community that has the function of “motherly support”. In some cases, belonging to a religious community contributes to the formation of moral values that are antagonistic to substance abuse.

Believers with severe chronic mental illness are more motivated for spiritual support, since religious beliefs make it possible to find meaning in life and find spiritual comfort (Mohr S., Brandt P. Y., Borras L. et al. 2006). A value-oriented, spiritually-oriented reorientation leads to the weakening of counterfeit attachments and allows one to immerse oneself in a relationship of love to God.

Scientific studies in people who practice traditional religions show a positive impact of spiritual and mystical experiences on indicators of overall mental health; this is evident in a better quality of interpersonal relationships, a lower level of anxiety, a more positive outlook on life in general (Newberg A. et al., 2002). Allport believes that helping a person in a situation of actual problems and existential quests may consist in the transition from an external religious orientation to a mature, comprehensive, internal religiosity (Allport G., 1967).

Principles of spiritually oriented therapy

Modern rehabilitation programs that holistically consider the nature of comorbid disorders can basically use the principles of a therapeutic community, a family systems approach, ideas about coping behavior or coping strategies, as well as spiritually-oriented models of helping patients. The study of religious coping strategies in religious patients made it possible to identify the most effective religious strategies that can be used in the rehabilitation of patients with endogenous mental disorders: 1) religious methods of preserving the basic values of life - the conservation of traditional values and meanings; 2) social support strategy through the religious community; 3) religious transformational coping methods; 4) a religious coping strategy for gaining an emotionally comfortable state that religious faith gives (consolation, comfort, forgiveness, reconciliation) (Verhagen P., 2019, Pargament, K.I. et al, 2014).

Spiritually oriented models, using religious coping based on the inner presence of the living Word and the Holy Spirit, use religious faith and practices to support religious ways of coping, as well as religious teachings to discuss irrational beliefs and to challenge negative knowledge, emphasize the importance of prayer and Christian content in therapy, Christian spiritual justifications for cognitive behavioral therapy procedures are applied (namely, to counter irrational thoughts). The religiously oriented forgiveness strategy is based on the REACH model, where R - remember the offense, E - sympathize with the offender, A - altruistic gift, C - choosing to forgive, H - holding forgiveness. Repentance becomes the result of a axiological transformation of the individual as a result of religious life based on religious faith and teaching (Worthington E. L. et al, 2016).

Rehabilitation programs using spiritually oriented therapy

In Russia, since 1992, a multidisciplinary program of outpatient care for endogenous mental patients with comorbid addictive disorders has been implemented, which includes spiritually-oriented therapy.

The program uses the resources of the state system of assistance to the mentally ill people on the basis of the Scientific Center of Mental Health, the methodology of family sobriety clubs according to the method of Vladimir Khudolin, the experience of pastoral counseling in the parishes of the Russian Orthodox Church (Baburin A.N., 2015). The combined use of biological therapy, psychosociotherapeutic procedures, and spiritually oriented therapy determines the effectiveness of helping comorbid patients with addictive disorders.

In 2020, on the basis of a successful rehabilitation program for mentally ill patients, implemented by the Regional Charitable Public Organization "Family and Mental Health", a set of spiritually oriented activities is being carried out, including group work in small therapeutic groups, group meetings with relatives of patients using spiritually oriented dialogue in accordance with the methodology of T.A. Florenskaya, discussing the issues of the spiritual life of patients from the perspective of the practice of religious life in the Church. Under the guidance of representatives of the professional community, a multidisciplinary model of care has been implemented that allows the use of a rich set of preventive and rehabilitation procedures (Solokhina T.A. et al., 2018).

The structure of the activities used in these programs makes it possible to formulate the basic principles and approaches for integrating mental patients with endogenous mental illness into the life of the church community in cooperation with the professional community.

The fundamental provisions of the comprehensive program include the following:

1) in the rehabilitation assistance, an individual approach is important, ensured by the friendly work of a multidisciplinary team of specialists: the cooperation of a psychiatrist and a narcologist with a clinical psychologist, a priest, a social work specialist is necessary;

2) the restoration of social status, associated with the return of professional and family well-being, is achieved through the participation of the patient and his family members in the work of the therapeutic community in an outpatient or outpatient setting;

3) an integral part of rehabilitation is the voluntary involvement of patients and their family members in a religious Orthodox community, with the church sacraments inherent in life in such a community, participation in worship, conversations with a priest on spiritual issues, and explanation of the basics of Orthodox asceticism;

4) in the process of rehabilitation, thanks to the mechanisms of group communication, even in the absence of all members of the patient's family, it is necessary to strive to update the family type of communication and establish social support in the context of the existing social network;

5) in addition to outpatient group work, a wide range of social rehabilitation activities are used, such as pilgrimages, sports and creative events, outreach camps and meetings of rehabilitation participants within festivals and forums.

In organizational terms, the main coordinator of assistance to endogenous mentally ill patients based on a spiritually oriented approach in the system of community-oriented care is a socially oriented NGO – the Interregional Public Movement for Support of Family Sobriety Clubs. The advantage of this form of organization of rehabilitation activities is the active participation of volunteers who have undergone special training, the use of the resource of the confessional community, increased motivation for treatment and rehabilitation due to improved social functioning and environmental therapy, and constant interaction of patients with a multidisciplinary team of specialists.

The program includes therapy and rehabilitation modules. The therapy module is implemented in a governmental medical institution (Scientific Center of Mental Health), where diagnostics and selection of drug therapy are carried out, as well as complex medical treatment for the underlying mental illness. Outpatient meetings within the therapeutic community are held once a week for 2 hours. The meeting is moderated by a professional psychiatrist, as well as volunteers who have undergone special training. During participation in the rehabilitation module, patients choose different levels of involvement in the activities of the program. At the initial level, patients take part in rehabilitation groups for one year. At the advanced level of the program, starting from the second year, patients and their relatives are actively involved in various activities within the rehabilitation module.

Importance of a multidisciplinary team

The multidisciplinary principle underlying the work of the program involves the cooperation of a team of specialists at every level of work. In the therapeutic community, professional supervision is provided by a clinical psychologist, a psychiatrist or a volunteer trained in a rehabilitation program, who interacts with the

spiritual father of the community, as well as with psychiatrists in a psychiatric institution, to achieve a successful and stable functioning of the community.

The specialist is a leader, or facilitator, who helps build community relationships with the parish and other organizations, including a mental health clinic. The coordinator organizes the internal life of the community, reminds its members of the need to follow the internal rules of the group, interact with the spiritual father and the church parish, seek help from medical specialists if necessary. The collaborative work of a team consisting of a priest, the head of the therapeutic community, a specialist doctor in a psychiatric institution, where the patient goes if necessary, ensures the success of the rehabilitation program implemented by a public organization in the church parish.

Particularly important is the participation of a priest in the activities of the therapeutic community, who, being the regular priest of the parish, also acts as the father-confessor of the community and helps in meeting the urgent spiritual needs of its members. The practical experience of church life, the priest's commitment to the life of the people under the care of the community, as well as the necessary knowledge in the field of psychiatry acquired by the priest in the process of preparing for church service, create the necessary conditions for fruitful and effective assistance to patients in the structure of the community-oriented part of rehabilitation activities.

Psychoeducational programs for volunteers

The continuity of the treatment process and rehabilitation activities is ensured by the special training of volunteers who implement their work within the organization. For these purposes, a psychoeducational program can be used, which was developed on the basis of the Scientific Center of Mental Health and is being implemented at the Volunteer School.

The School of Volunteers provides knowledge on topical issues of psychiatry and narcology, psychotherapy and family psychology, social pedagogy and spiritual asceticism, training sessions and master classes are held. Psychosocial training includes classes to develop social skills (communication), methods of coping with negative emotions and problem-solving behavior. Master classes in art therapy may include film therapy, handcraft, and other types of joint activities. These types of psychosocial interventions should complement psychoeducation, forming a system of knowledge, skills, and abilities of leaders of therapeutic groups, which, during practical work, can help program participants in preventing relapses of the disease, increasing stress resistance, compliance, and social competence.

The basic provisions of the therapeutic group work program are:

1. the use of a complex four-part model (biopsychosocial-spiritual), according to which personality changes that occur during the progression of behavioral disorders due to mental illness can be corrected, and the course of diseases can have a favorable prognosis due to the formation of a stable and long-term remission;
2. involvement in the rehabilitation process and synergetic work of a multidisciplinary team of specialists, which provides the most complete therapeutic effect and a combination of various types of assistance - drug treatment, psychosocial support, sociotherapeutic interventions and spiritually-oriented assistance;
3. the induction of remission is the result of voluntary cooperation of specialists, the patient and his family members on the way to a conscious change in the entire personal structure and, as a result, lifestyle;
4. Comprehensive rehabilitation is achieved in the therapeutic community, which operates in the structure of a non-profit organization with direct scientific and methodological support from specialized governmental medical institutions.

The importance of spiritually oriented therapy for the rehabilitation process can be considered from the standpoint of religious coping strategies:

1. Religious faith contributes to the acquisition of meaning and purpose in life; this is especially evident in the experiences of illness, suffering and death. In this case, religious faith helps to strengthen the personality and increases the ability to endure difficult life trials.

2. Religious experience positively influences the sense of control over the situation. A person experiencing life's difficulties and losing the ability to control the situation turns to God, who is able to take care of a person in any case. In the case of chronic illness, the feeling of being cared for is essential and has a beneficial effect on recovery or relief of suffering.

3. People with religious experiences have a feeling of well-being that results from the positive emotions of a believer, such as joy and gratitude. At the same time, a religious worldview helps to cope with negative feelings, such as anger, and also develops the ability to forgive offenses.

4. A religious organization forms in a person feelings of kinship and connection with common values and meanings. Due to the fact that members of a religious organization feel like-minded, relations develop in the community, close relationships are formed among the members of the community. The religious community becomes a source of additional resources for those in need of help.

5. The religious worldview is capable of transforming the value-semantic formations of the individual, due to which the views of a person are reoriented and a different direction in his actions is acquired.

During the implementation of the program, the life style of patients is changing based on a religious worldview, social support is provided among patients and their relatives, training of family members in a new repertoire of social skills, as well as mastering new experience of family interaction due to the mental illness of one of its members. Additional opportunities are being provided in crisis situations.

An important part of the participation in the rehabilitation program is attending group sessions within the therapeutic meetings, as well as being active in achieving therapy goals. In this case, restrictions on participation in the program are contraindications for group work, as well as non-compliance with the conditions of classes and meetings in the group.

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