Department for External Church Relations
of the Moscow Patriarchate
Commission on Church Formation and Diaconia
of the Inter-Council Presence of the Russian Orthodox Church
Voronezh Metropolia of the Russian Orthodox Church
Scientific Center for Mental Health

Church care for mentally ill people. Depressions: role of a psychiatrist, psychologist and priest

International Conference

Reports

15-16 December 2022

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This book presents reports of the IV International Conference “Church care for mentally ill people. Depressions: role of a psychiatrist, psychologist and priest”, 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, Brazil, 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.

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Metropolitan Sergiy of Voronezh and Liski

Dear participants of the conference!

Clergy and medical community are concerned about the rate at which mental illness is spreading. Experts estimate that at least 5% of the adult population suffer from depressive disorders. Effective care for people with depression is hampered by a variety of factors: lack of resources, lack of qualified health professionals, and social stigma associated with mental illness. Patients are increasingly turning to the Church for consolation and support.

Thus the clergy need to distinguish between depression and mood changes associated with short-term mental reactions to the challenges of modern life. It is difficult for a priest who is not aware of mental disorders to understand the emotional experiences of parishioners suffering from depression and give them the necessary pastoral advice. The clergy should have the necessary training in order to support people in need of mental health recovery, while delimiting the sphere of competence of the Church and psychiatry, establishing a dialogue with psychiatrists and psychologists.

However, in Orthodox practice, the conditions de-scribed in psychiatry as depression are viewed from a different point of view.

The impossibility of communion with God and of the knowledge of God, which were known to Adam, cause melancholy and mental suffering. The soul of a Christian experiences deep grief and sadness from the realization of the loss that humanity suffered after the fall. The sorrow of a Christian ascetic is not a pathological phenomenon. It is neither the result of psychological conflicts, nor the result of unsatisfied desires, nor damage to human nature. The sadness and grief of a Christian are a natural reaction to the fact that a person does not live the way he should and could live. The human soul feels sadness as a feeling of its unworthy state. We are stricken and oppressed by sin. Depression is the soul's dissatisfaction with the fact that it lacks Christ.

In today's world, man longs for the true purpose of his life. Neither science, nor technology, nor secular society can give it. The root cause of depression is that we have left God and replaced the union with Him with earthly things. Those who forget this in their short-sightedness will always continue to yearn for something earthly and temporal. And this sadness cannot be healed by means of medicine.

Today's meeting of clergy and mental health professionals provides an opportunity to reconcile the Church's and medical perspectives on depression and gives us confidence that the Church and medicine can work together to help people. The rich and interesting program of our meeting offers space for discussion of specific ways of interaction between pastors and psychiatrists. I wish fruitful work to all participants of the conference and call upon you God's blessing!

Kaleda V.G.

Depression as a challenge of modernity

Depressive states are one of the most pressing problems of both psychiatry and modern society in general. It is reflected both in the mass media and in numerous scientific studies. Described for the first time several millennia ago, depressive states have been embodied in numerous cultural monuments since antiquity and ancient Egypt.

According to WHO, by 2030, depression will become the most common disease and the second cause of disability; around 280 million people suffer from depression worldwide, i.e. 3.8% of the population, including 5% of adults and 5.7% of people over 601. "The Age of melancholy", predicted almost forty years ago by O. Hagnell et al. (1982), can be considered to have come.

Depression is one of the most diverse pathologies, the manifestations of which are influenced by both age and cultural factors, as well as pathogenetic and nosological aspects. In addition, comorbid pathology has a significant impact on the manifestation of depression.

Depressive states acquire special significance in pastoral practice, since they can be mistakenly regarded as an ordinary bad mood, "laziness", "despondency", "weak will", etc. Moreover, some depressive manifestations, such as low self—esteem, and in a religious context, a sense of one's own special sinfulness, can be positively regarded as manifestations of spiritual life, "grief for sins", humility. However, major depression is life threatening due to an increased risk of suicidal behavior. However, major depression is life threatening due to an increased risk of suicidal behavior. Inadequate pastoral intervention in the case of severe depression can play a critical role and lead to irreversible consequences.

The prevalence of depression is very high today. According to modern statistics, about 9 million people in Russia suffer from this disease.

Depression (from Lat. depressio — suppression, oppression) is a mental disorder characterized by pathologically reduced mood (hypo—thymia), intellectual and motor inhibition, decreased life urges, pessimistic self-esteem, loss of appetite and sexual drive. There is a triad of the main manifestations of depression: low mood, slow thinking, motor inhibition.

According to the mechanism of depressions, they can be psychogenic, as a person's reaction to a traumatic situation (deprivation of the desired in the broad sense of the word), somatogenic (if there is a severe somatic disease) and endogenous, which occur without any apparent reason and are genetically determined. St. John Cassian the Roman already in the V century singled out "causeless sorrow"2.

Currently, the bio-psycho-socio-spiritual model of depression is gaining universal recognition (R.Hefti, 2013), which takes into account, along with biological, psychological and social factors, the loss of spiritual values and moral degradation.

The main symptoms of depression are hypo-thymia — a persistent causeless low mood; anhedonia — loss of the ability to feel joy, satisfaction from what previously gave it; asthenia – a feeling of loss of strength, growing fatigue, exhaustion lasting at least two weeks almost daily for most of the daytime. For a suspicion on depression, which requires mandatory medical treatment, two of out of three above symptoms are enough. Additional symptoms of depression are difficulties in concentration and comprehension, self-doubt, low self-esteem, self-blame and humiliation, a gloomy and pessimistic vision of the future, suicidal thoughts or unwillingness to live. Quite often at a depression "absence of feelings" is subjectively noted. Patients often perceive the weakening of feelings of love, affection, moral

sensitivity, a sense of indifference as manifestations of their sinfulness, moral depravity and turn to the priest with this; they notice changes in themselves (in a negative direction), a decrease in intellectual abilities, "dullness", feel anxiety, including for their physical health, apathy — lack of motivation with lethargy, indifference to everything around them, dysphoria — gloomy sullenness, grumbling, with outbursts of irritation and claims towards others.

The physical, bodily manifestations of depression can help in identifying depression — first of all, persistent sleep disorders, which is the easiest thing to ask about when communicating with a person in confidence (difficulty falling asleep, frequent awakenings during the night, waking up early, without feeling well-rested, individually and combined), appetite disorders (hyperphagia, more often with mild depressive states, followed by a feeling of indifference, loss of taste — "all the food has become tasteless", — and aversion to food, leading to refusal of food in severe depressive states), a decreased sexual desire.

Depressive conditions can have different degrees of severity, and therefore they distinguish mild (subdepression), moderate and severe depression. Depending on the degree of severity, the mood can vary from mild sadness to gloomy, depressed with loss of life perspective and suicidal thoughts.

With depression of mild severity (subdepression), a person retains the ability to control his emotions, to fulfill social, labor and educational duties. As a rule, people around do not notice the change in state.

Depression of moderate severity in most cases is already noticeable to others. Most of the time, a depressed mood prevails, a person closes himself in his feelings, hardly goes to work or study, does not fully cope with his duties. Sleep is disturbed, the head is occupied with bad thoughts.

Patients with severe depression, as a rule, look despondent, detached, immersed in themselves, speak in a weak voice, give short, one-word answer to questions with long pauses, often fall silent, referring to impotence or unwillingness to speak. They often slouch, their movements are slowed down, their gait is shuffling, dead eyes, constipation, tachycardia, pupillary dilation. These patients have a distinct social and labor maladaptation.

Despite the above, it should be borne in mind that, especially in adolescence, there are pronounced depressions, including those with suicide intentions, when the immediate environment does not notice any signs of a severe internal condition.

When asked, patients often point to a special feeling of "heartly", vital anguish, reaching the degree of physical pain, usually localized behind the sternum. Believers often have a feeling of God-abandonment: they will say that it is difficult for them to concentrate on prayer, they have lost a sense of grace, they feel on the edge of spiritual death, that they have "a cold heart", "petrified insensibility". They can even talk about their special sinfulness and loss of faith.

Depending on which components prevail in the structure of depression, usually the following main types are distinguished: melancholic, anxious, anesthetic, adynamic, apathetic, dysphoric, senestipochondriac and metaphysical.

Melancholic (or dreary) depressions are characterized by a predominance of depressed mood with intellectual and motor inhibition. The patient complains of an oppressive hopeless melancholy, which is often accompanied by painful physical sensations in the epigastrium and in the region of the heart. Nothing pleases him, he considers himself a loser, a burden to his family, considers the past as a chain of mistakes, feels a sense of hopelessness, despair. There may be inhibition, the patient does not get out of bed or sits almost motionless during the day. The speech is quiet, monotonous.

Anxiety depressions are accompanied by anxiety, agonizing expectation of impending misfortune, catastrophe. The patient is in tension and cannot find a place for himself – he "can't sit or lie down", he is constantly on the move. At the same time, in some cases, on the contrary, he can sit motionless for a long time, only constant movements of his fingers and hands will show his inner tension.

The so-called anesthetic depressions are characterized by the predominant loss of emotional reactions to the environment. The patient complains about the lack of emotional resonance, a painful feeling of inner emptiness and loss of all feelings, including longing; he says that he has become "wooden", "petrified", "stupefied". He feels that the perception of the surrounding has changed: it loses its colors, is perceived "as if through a dim glass."

In adynamic depression, first of all, there is weakness, impotence, pronounced difficulties in performing physical and mental work while maintaining the desire for activity. The patient complains of a lack of physical strength, weakness, fatigue and asthenia.

Apathetic depressions are characterized by the of complaints about the lack of desires and aspirations for any kind of activity. At the same time, the patient does not experience feelings of longing, anxiety, he has no ideas of self-accusation.

Dysphoric depressions are characterized by the occurrence of episodes of discontent, irritability, anger, aggressiveness and destructive tendencies (the so-called "irritable weakness") against the background of a depressed mood. At the same time, a minor reason is enough to cause irritation.

With senestipochondriac depressions (somatized depressions, "depression without depression", masked depressions), the main complaints are unpleasant, painful sensations in various parts of the body. The patient is focused on his physical health, while the depressed mood itself recedes into the background or is perceived by the patient as a natural consequence of bodily ailments. There are some signs indicating this type of depression: the patient is being treated for a long time and persistently by doctors of various specialties, who, despite the use of modern diagnostic methods, do not find any specific disease in him (poorly defined diagnoses such as "vegetative-vascular dystonia" may be made); despite failures in treatment, he stubbornly continues examinations and visits to doctors.

A special kind of depression is metaphysical (existential) depression (more often develops in adolescence), which is characterized, first of all, by a sudden, sharp immersion in philosophical reflections, reasoning about the meaning of life, etc. Such reflections can lead a person to a "reasonable" conclusion about the inevitability of death, the meaninglessness of life and the development of a feeling of misunderstanding on the part of others, eventually leading a person to suicide plans.

There is also the so-called ironic depression, in which patients with a smile sneer at their condition and helplessness. At the same time, a smile on the patient's face does not mean the insignificance of his disorders and does not exclude the presence of suicidal intentions in him.

From the point of view of the greatest risk of suicide, the most dangerous are the melancholy, anxious and anesthetic forms of depression. Based on clinical observations, such depressions are most severely tolerated by patients. Perhaps the words of St. Isaac the Syrian about despondency, that “this is a taste of hell” for the soul, would be appropriate.

The manifestations of depression are significantly affected by the age of the patient. So, in preschool children, depression is manifested by forms of reaction characteristic to this age – vegetative and motor disorders. Children become motorically retarded, refuse to eat, become weepy, withdrawn, lose interest in games. Depressive states in primary school children are characterized by the behavior

disorders, problems with academic performance, enuresis, low appetite, weight loss, constipation, sleep disorders. In some cases, irritability, a tendency to aggression, absenteeism from school are observed. At the same time, children do not complain about a feeling of longing.

In adolescence, depression is characterized by big concentration problems, difficulties in focusing and comprehension, increased fixation on their appearance, anti-vital reflections with a loss of meaning in life, and a high incidence of suicidal thoughts and intentions. In addition, sleep disorders, appetite, headaches, constipation, numerous hypochondriac complaints are noted. Irritability is characteristic for boys, weepy and apathetic mood for girls.

Depression at a late age is characterized by mental slowness, anxiety, aggravation of cognitive disorders, including memory, a strong hypochondriac component, manifested in fixation on one's physical condition, as well as sleep and appetite disorders, changing body weight, constipation, etc.

According to modern research, in 20% of cases, depression lasts for more than 2 years, and in 17% of cases, depression continues throughout life. In these cases, they speak of the formation of so-called prolonged and chronic depressions.

Unfortunately, in our society, depression, including long depressive states, are not perceived as a disease. The consequence of this is criticism and reproaches against patients for weak character and "unwillingness to help themselves" instead of providing psychological support. However, volitional disorders that deprive a person of the ability to take actions to improve their condition are part of depression itself.

The first and most important thing that is required of a priest is an understanding that any depressive state is not just sadness as a healthy reaction of a healthy person to everyday troubles, but a type of mental disorders.

In the treatment of depressive states, a strictly individual approach is used. It must be remembered that it takes a certain amount of time to treat depression. Do not wait for a complete cure in the first days of taking the drugs. All modern antidepressants begin to act no earlier than in 1-2 weeks. The course of antidepressants is usually several months. The prescription, change and cancellation of an antidepressant should be carried out only by a doctor. A common mistake is the premature withdrawal of medications shortly after a significant improvement in the condition or due to "forgetfulness".

Important in the treatment of depression is the combination of pharmacotherapy with psychotherapeutic work, including individual conversations, group and family therapy, which allows patients to get help in understanding their problems, to realize that they are not alone in their misfortune, to see the possibilities of personal participation in rehabilitation activities and in public life.

A priest who has revealed a depressive state in a person should in no way condemn and support the ideas of self-condemnation, including focusing on finding possible sources of a depressive state in the behavior and character of the patient; on the contrary, it is necessary to remind the person of God's mercy, the uniqueness and value of each person, including the "worthless" and "useless", that it is not for us to make decisions about such value or lack thereof, to provide all possible support. The priest must tell the person that the point is not that he is insecure, indecisive and weak, but that a disease state has come upon him in which any person would feel like that. It is important that a depressed person understands that the world only seems empty and burdensome to him. In this state, you cannot make any vital decisions (leaving work, etc.), they need to be postponed until you completely get out of depression.

In cases of distinct depression, it is necessary to convince a person to see a doctor, trying to remove the barrier of fear and distrust in front of a psychiatrist. It is quite possible that in this case practical assistance in organizing this visit will be

required. There are many examples when a priest personally accompanied a patient to a psychiatrist and later visited him in the hospital.

It is very important to establish informal, trusting contact so that the depressed person feels that he is sympathized with, warmly treated, sincerely cared for. In depression, even some adults feel like helpless children, therefore, intonations need affection, kind patronage. Empathy and warmth can "dissolve" longing and anxiety, relieve the feeling of loneliness characteristic of depression.

Unceasing encouragement of the patient is necessary, even if it is perceived by him as if indifferent. If this depressive state is repeated, then it is necessary to help the patient, relying on the experience of his illness, to patiently wait for this phase to pass completely, as all the previous ones did.

In addition to encouragement and spiritual support, soft activation plays an important role. You can offer the patient feasible work or obedience at church. The patient should not be sent to a recreation center, on a pilgrimage trip, or sent to a monastery for "obedience", since there he will only feel his depressive remoteness from people more acutely. Help a person to be enlightened by the memories of childhood, when there were no depressions. Let him listen to consonant music, watch his favorite movies, paintings, read literature that he is in tune with.

It is helpful to schedule a day. The meaning of this is that the patient lacks an internal strong-willed push, and he can get the necessary stimulus from the outside, in a soft but persistent form. Sometimes patients themselves ask to be "pushed". It is important to start small and move towards more. It is desirable that the movement goes from success to success, which helps to engage internal resources.

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Borisova O.A., Smirnova E.V.

Phenomenological characteristics of depression with religious content

Abstract: The importance of studying depressive states with religious content is due to their high prevalence, the difficulty of identifying these conditions in the early stages of the disease because of the specifics of endogenous depressions and religious content. In studies of the psychopathological characteristics of depressive states, specific religious phenomena were described that occur both in simple depressions (melancholic, anxious, apatho-adynamic) and in complex states (depressions with depersonalization and anesthetic components, hypochondriacal depressions), which include overvalued ideas of sinfulness, God-abandonment, the phenomenon of confessional ambivalence; the phenomenon of "spiritual hypochondria", with the conviction that one's own faith is distorted and that one causes spiritual damage to others.

It is worth noting that depressive states with religious content are often not diagnosed in a timely manner as a mental disorder requiring the help of doctors, because of the specific content of experiences. This leads to a late referral to psychiatrists and severe negative consequences, in particular, to suicide attempts and development of auto- and heteroaggressive behavior.

Keywords: endogenous depression, religiosity, suicide risk, spiritual hypochondria, guilt and sinfulness, God-abandonedness.

In clinical practice, it is quite rare to find symptoms of one register, of only one lesion of mental activity. For example, clearly affective disorders can determine the clinical picture. In most cases, disorders of various lesion depths are combined with each other, forming a single symptom complex. In affective pathology, there are often thought disorders in form of pathological judgments that are either relevant to the affect and religious view of patients, i.e. congruent, or are pathological beliefs that are not compliant with affect, specific independent delusional constructions, with various topics, including religious ones.

This report deals with characteristics and typology of depressive states with congruent pathological judgments of religious content, reaching the level of overvalued ideas and overvalued delusions.

Difficulties in diagnosing depressive states with religious experiences and the management of these patients can be diverse. On the one hand, in a religious environment in which religious patients with depression stay and communicate, their experiences can often be considered as manifestations of the sin of despondency and sadness, which are recommended to fight, including by volitional efforts (Gumerov P., 2008). In this way the provision of necessary medical care is replaced by the fight against sin. The interpretation of the manifestation of the disease as personal sinfulness leads to spiritual torment of patients, which forces them to resort to negative methods of religious coping (Koenig H.G., 2012; Shankov F.M., 2015). On the other hand, in the absence of understanding on the part of the psychiatrist of the patient’s personal spiritual aspirations and values, the patient, as a rule, tends to distrust therapy, which leads to non-compliance with treatment, and negatively affects the effectiveness of therapeutic care (Prest L.A., Robinson W.D., 2006).

Let us also note the behavioral characteristics of the religious group of patients: late health encounters, since the diseased state is interpreted as a lack of faith, a sign of sinfulness; late medical treatment, since the blessing of a priest is required to see a doctor, which cannot be obtained in all cases due to the lack of proper understanding from the outside the priest; rapid development of a vicious circle: aggravation of

depressive experiences – more rare visits to church and observance of church rites and sacraments by patients – growing accusations of sinfulness, lack of faith and the emergence of the feeling of God-abandonment (Kopeyko G.I., 2020).

Thus, the identification of the characteristics of psychopathological and phenomenological manifestations of religious experiences in depressed patients is necessary for an early diagnosis of mental disorders masked by religious experiences and for alleviating the suffering of patients and prevention of suicides.

Materials and methods of research

Current research was carried out by the group for the study of special forms of mental pathology of the Department of Youth Psychiatry of the Federal State Medical University in the period from 2012 to 2022. The patient cohort consisted of a total of 109 prs. with a religious view (38 men, 71 women), who suffered from depression, who suffered from depression, its depth was moderate to severe (17 to 38 scores on the Hamilton scale). There were both inpatients and outpatients.

Results and discussion

Depending on the psychopathological structure of endogenous depressive states (Tiganov A.S., 2017), five types of depression were identified: simple depressions – melancholic (46%), anxious (13.9%) and apatoadynamic (3.6%); and complex depressions – depressive states with depersonalization and anesthetic components (28.7%), as well as hypochondriac depressions (7.8%). Melancholic depressions were predominant among all types of depression (46%).

While studying depressive-delusional states, we observed patients in whom depressive affect was combined with congruent delusional ideas of self-abasement, self-blame, moral and physical inferiority, self-failure, guilt and impoverishment. Along with this, there were also specific religious phenomena, such as delusional ideas of sinfulness, God-abandonedness, the phenomenon of confessional ambivalence; the phenomenon of "spiritual hypochondria", with the conviction of the distortion of one's own faith and causing spiritual damage to others (Kopeyko G.I. et al., 2021).

Depressive states with congruent religious ideas of guilt and sinfulness most often arose in melancholic depressions characterized by a dreary affect with the ideas of guilt. In such states, a pronounced mood worsening was combined with a feeling of melancholy and vital manifestations. Patients spoke about their own low value, self-blame. At the same time, the "individual scale of values" determined the theme of depressive ideas (Janzarik W., 1957). Due to the predominance of the guilt aspect in the value-semantic sphere in patients with a religious worldview, patients revaluated their own behavior from a religious position, accusing themselves of not living according to church canons, reproaching themselves for not fulfilling their duties, not caring enough about their family. The sense of guilt in these cases was directed towards a specific instance: not a family, judicial, or professional group of persons, but the so-called Divine instance (Hole G., 1977). If the psychopathological picture got more complicated and the condition worsened, the ideas of guilt transformed into conviction in one's own sinfulness (committing a mortal and unforgivable sin, "sin against the Holy Spirit").

At the height of depression, patients with religious feelings of guilt and sinfulness experienced hopelessness, rejection and despair, thoughts that they did not want to live, suicide intentions.

In addition, along with the delusional ideas of sinfulness, the patients had a feeling of God-forsakenness and loss of a sense of "living faith". Patients in these conditions felt especially acutely the "loss of God's mercy", they said that confession no longer brings relief, does not relieve the sin they have committed, they said that they

cannot repent or that there is no full feeling of repentance, forgiveness. At the same time, God was perceived as cruel, implacable and merciless. Cognitive disorders were manifested in the fact that patients could not pray, experienced a sense of the futility of prayer and "religious devastation." Some patients spoke of a painful feeling that there was a certain "wall" separating them from God, who "turned away from them", of "emptiness in the soul", painful unbelief, loss of "living hope in God".

According to the research such disease manifestations were most often observed in depressions with predominant depersonalization disorders with an anesthetic component, as well as in melancholic depressions.

In patients with depressive ideas of sinfulness and God-forsakenness, suicidal thoughts and intentions were observed in 67% of cases, and suicidal attempts in 21% of cases. The described conditions could be syndromologically qualified as depressive-delusional symptoms with congruent delusions within the depressive phase in affective psychosis.

One of the options for the development of a depressive state with congruent overvalued ideas was depressive phases with the formation of the phenomenon of confessional ambivalence. Such attacks were observed after a series of pronounced affective phases in patients who came to faith in the pre-manifest period, when during the period of the next depressive state doubts arose about the truth and veracity of their Orthodox faith. These depressive phases were mainly accompanied by anxious (63.6%), dreary (18.2%) and apathoadynamic (18.2%) affect.

These doubts were caused by the excessive fixation of patients on specific negative aspects of church life, as a rule, widely covered in the media, while other opinions were ignored. Doubts about whether the religion was chosen correctly gradually became more and more important in the lives of patients and were of an overvalued nature, in some cases reaching the level of overvalued delirium (about 40%), which to a high degree determined their future behavior.The main inner suffering of the patients was associated with the feeling of guilt for the mistake in the choice of faith and the fear that because the faith is not true, they will not be saved. They had thoughts about the need to move to another confession or even religion. The mood in such states was depressed with predominant anxious affect. During treatment with antidepressants (without neuroleptics), depressive symptoms gradually faded (lytically) and at the same time the relevance of the described experiences decreased.

Of particular note are depressive states in which "spiritual hypochondria" develops (7.5%). Their complex structure combined affective disorders with hypochondriacal (77.8%), anxious and melancholic manifestations (11.1%). In addition to the typical manifestations of depressive disorders, the leading role was played not by senestopathic manifestations, as is the case in classical senesto-hypochondriac depressions, but by obsessive doubts about the truth of one's faith and belief in its defect, which were based only on the perception of the patient's own spirituality. Such states were accompanied by peculiar behavior with numerous checks by religious experts, authoritative confessors. Outwardly, this is very similar to the behavior of patients suffering from hypochondriacal disorders, but in these cases, the patients were sure of spiritual ill health. It should be noted, however, that patients spoke of a state of "spiritual hunger" or "spiritual blindness", finding in physical reality comparisons to describe their own experiences.

The patients were convinced of the "poor quality", "corruption" of their religious faith. Such preoccupation with one's spiritual state, conviction of the existence of a "defect in the faith", a "spiritual illness" led to hypochondriacally stigmatized delusional behavior. Despite the fact that the patients constantly rechecked the conformity of their religiosity and sought advice from spiritual fathers in various monasteries, they did not find peace. As delusional disorders worsened, a conviction appeared about a

“corrupted” faith, which testifies that a person betrayed God, “like Judas the traitor.” Feeling anxious, they tried to find more authoritative clergymen, making pilgrimage trips to remote secluded places, while becoming more and more convinced of the defect of their own religiosity. Such conditions were actually associated with excessive consumption of financial resources of the patients themselves, their relatives and friends.

The study found that such disorders were most often observed against the background of anxious-depressed mood. The patients interpreted their condition as a sign of sinfulness, which led to a belated visit to the doctor; in addition, they needed the blessing of the spiritual father to seek medical help, which, as a rule, could not be received on time; this led to the rapid development of a vicious circle and aggravation of the mental state.

Conclusions

Due to the specific content of depressions associated with religious experiences, they are often not diagnosed as a mental disorder requiring medical help. This leads to an aggravation of the condition and a late visit to psychiatrists, which is due to the difficulties of distinguishing between a normal religious worldview and pathological pseudo-religion, and is accompanied by negative consequences, in particular, suicide attempts.

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Kopeyko G.I., Vladimirova T.V., Alekseeva A.G.

Spiritual crisis or the experience of being abandoned by God in depression

Abstract: This report deals with the phenomenon of God-abandonment from the perspective of clinical psychiatry. A detailed description of the phenomenon of God-abandonment is given, which is found in the writings of the holy fathers, as well as in the Holy Scripture. In Catholic literature, in the lives of some saints, this phenomenon is often described as a "dark night of the soul", "a spiritual crisis on the path towards uniting with God". The phenomenon of God-abandonment in mentally ill people, which is a manifestation of their pathology, is described in the scientific literature as a feeling of loss of God, the loss of the last anchor in overcoming suicidal intentions. Often, patients do not tell about their experiences to either a priest or a doctor and, accordingly, do not receive either spiritual or medical care, which results in a significant increase in the risk of suicidal behavior. The phenomenon of God-abandonment requires further clinical and psychopathological study, interdisciplinary understanding for the correct and timely provision of psychiatric, psychotherapeutic care and appropriate strategies of pastoral care.

Keywords: phenomenon of God-abandonment, spiritual crisis, depressive state, strategies of pastoral care.

The spiritual crisis of a Christian is often accompanied by a feeling of abandonment by God. The abandonment (Greek – θεϊκή εγκατάλειψη) is a feeling of remoteness from God and His grace, perceived with despair and heartache.

The writings of the Holy Church Fathers often contain testimonies and reflections on this. In particular, we find references to a spiritual crisis with the experience of God–abandonment in St. Ammonius, St. Macarius of Egypt, St. John Cassian, St. Diadochus of Photiki, St. Simeon the New Theologian, St. Isaac the Syrian, and in a time closer to us – in St. Sophrony Sakharov and St. Silouan of Athos.

The phenomenon of God-abandonment is described in patristic literature and is regarded as a natural stage of spiritual life, usually leading to further spiritual growth, the formation of a more mature religious faith. Mature faith that arises after the experienced crisis of God-abandonment turns out to be based on a conscious and deep trust in God as the Provident of our salvation. The states of God abandonment were also described in the Old Testament in the book of Job, when he experienced the silence of God without receiving an answer. The experience of St. Symeon the New Theologian and St. Silouan of Athos tally with the most numerous cases when the feeling of abandonment by God follows the brightest initial experience of grace, experienced in fullness as a vision of God.

Silouan of Athos, while praying in front of the icon of the Savior, experienced a brief mystical appearance of the Savior, which filled his soul with light, after which the peace and joy that he carried in his heart faded and gave way to confusion, then gloom, depression and despair. He very often talks about the suffering that this loss brings him: "When a soul that the Lord has sought and given her His grace loses it for some reason, it grieves greatly for it." “Oh, brethren, if you could understand the yearning of a soul that bore the Holy Spirit and then lost Him. This yearning is unbearable. The soul is then in indescribable sorrow and grief.” This sorrow takes the form of great sadness, depression, contrition, darkness, dryness, which fill the soul and contrast with the joy, peace, sweetness and light that accompanied the presence of grace. St. Silouan uses various kinds of images to express the sorrow, despondency and grief caused in him by the feeling of God's abandonment and loss of grace. In particular, he compares his inner

state with the state of a small child who has lost his mother, or with the state of parents who have lost their beloved child, but most often with the state of Adam, expelled from Paradise. St. Silouan links the loss of grace to his guilt, his unworthiness, his sins, his passions and bad thoughts.

St. Silouan also sees in God's abandonment a form of divine pedagogics. Christ, first of all, wants to teach the soul humility, showing that it is impossible to regaine grace by one's own efforts. The Lord wants to teach the soul patience, strengthen its hope (Archimandrite Sophrony the Anthonite, 2011).

Isaac the Syrian writes that God-abandonment also appears for reasons beyond the control of a person. In particular, periods of abandonment, decline, obscuration and despair occur among ascetics who live in silence. In this case, the reason is an incomprehensible Providence of God: "While we are in the dark, we will not be embarrassed, especially if the reason for this is not in us. Attribute it to the Providence of God, acting for reasons known only to God. “At times our soul is suffocated and is, as it were, amid the waves; and whether a man reads in the Scriptures, or performs his liturgy, or approaches anything whatever, he receives darkness upon darkness. He leaves off [prayer] and cannot even draw nigh to it. He is wholly unable to believe that a change will occur and that he will be at peace. This hour is full of despair and fear; hope in God and the consolation of faith are utterly extinguished from his soul, and she is wholly and entirely filled with doubt and fear… During periods of these temptations, when someone is darkened, he ought to fall on his face in prayer, and not rise up until power come to him from heaven and a light which will support his heart in a faith that has no doubts.” Another piece of advice is to read the Holy Scripture and the "books of teachers", i.e. the writings of the holy fathers. But there can be such a degree of abandonment and obscuration, in which a person does not find the strength either to read the Scripture or to pray. In this case, Isaac the Syrian gives the following advice: "If you do not have the strength to master yourself and to fall upon your face in prayer, then wrap your head in your cloak and sleep until this hour of darkness pass from you, but do not leave your dwelling " (Isaac the Syrian of Nineveh, 2008).

In the Roman Catholic Church tradition, the God-abandonment is described as a "dark night of the soul", as a spiritual crisis on the way towards uniting with God, similar to the one described by St. John of the Cross. Although this spiritual crisis is usually temporal, it can last for a long time. The "dark Night" of St. Paul of the Cross in the 18th century lasted 45 years, after which he eventually recovered. The Dark Night of St. Teresa of Calcutta, whose own religious name she chose in honor of St. Teresa, "may be the most extensive such case in history," lasting from 1948 almost until her death in 1997, with only brief breaks with relief, according to her letters.

From the diaries and letters of Mother Teresa of Calcutta:

"This terrible sense of loss – this untold darkness – this loneliness – this continual longing for God – which gives me that pain deep down in my heart. Darkness is such that I really do not see—neither with my mind nor with my reason. The place of God in my soul is blank. There is not God in me… then it is that I feel—He does not want me – He is not there… I just hear my own heart cry out "My God" and nothing else comes, the torture and pain I can't explain"…… Such deep longing for God - so deep that it is painful - a suffering continual - and yet not wanted by God: repulsed, empty, no faith, no love, no zeal. The longing for God is unbearable, and darkness thickens, painful confusion in the soul… Even there, at the very bottom of the soul, there is nothing, only darkness and emptiness, excruciating pain that does not go away. Heaven means nothing; to me it looks like an empty place, I don't think about heaven at all, why, if there is no hope. There is no faith, no love, no hope in my heart, only a lot of pain – from loneliness, from the fact that I am not needed. I can't pray anymore, prayer

doesn't connect me with God. There is no joy, no zeal, no meaning in the work. I don't have faith, I don't believe anymore" (Mother Teresa, 2010).

It should be emphasized that some crises of faith are so severe that they require special spiritual support. In some cases, there is an intersection between the experience of God-abandonment, as an expression of a specific form of religious crisis, and a depressive state with the loss of the meaning of life and a sense of spiritual emptiness (Bussing A., 2022).

Many spiritual experiences that occur in normal spiritual religious life, during the period of illness, acquire a particularly painful pathological character. Thus, eschatological experiences and thoughts about the Apocalypse, characteristic of normal religious consciousness, in a diseased state acquire the character of delusional assurance of the end of the world, when the patient is completely absorbed by these feelings and sees signs of the end of the world around him, accompanied by hallucinations, altered state of consciousness, fear and delirious behavior (Kopeyko G.I. et al., 2021).

In professional medical (psychiatric) literature of the 20th century, there are separate references and brief descriptions of the phenomenon of God-abandonment in mentally ill people W.Schulte (1954), G. Hole (1989).

In recent decades, in the works of English-speaking psychiatrists, many studies have been devoted to the fact that the image of God changes in mental disorders. In delusional, depressive, schizophrenic psychoses, patients' idea of God changes: the image of a Loving Savior is transformed into a cold and strict Judge (Pargament et al., 1998).

In the department of special forms of mental disorders of the Scientific Center for Mental Health throughout of 30 years of supervision of patients with a religious worldview and mental illnesses, manifestations of a sense of God-abandonment were observed quite often. According to the research, this phenomenon occurs in the vast majority of patients with a religious worldview in depression, severe depressive-delusional states and chronic dysthymia with moral hypochondria.

Usually patients describe this condition as a feeling that God does not hear them, turned away, left. Patients describe their experiences during prayer especially sharply. Thus, the prayerful state changes, the prayerful connection with God is lost, patients experience "petrified insensibility", "mechanical prayer" or dryness in prayer, loss of a lively response from God or the feeling that "prayer does not reach God". During such periods, the image of God changes - in contrast to the merciful, all-forgiving, loving God, as He was perceived earlier, He now begins to appear as indifferent, cold, silent, insensible, less often – as punishing. At the same time, patients report that their very meaning of existence is lost, the most important thing in life is lost – Faith in God and hope for Salvation and God's Providence, and "nothing holds them in life."

It should be noted that such experiences, perceived with excruciating pain in the soul and loss of the meaning of life, have extremely high subjective significance. Patients feel spiritually inferior, defective, having an incorrigible spiritual error. In some cases, the feeling of God-abandonment is accompanied by a sense of sinfulness and thoughts of punishment by God. In some cases, patients are absorbed with feelings of their own guilt due to "pride", "their own-selfness", for which they blame themselves and which cannot be healed by prayer and spiritual sacraments, because "God has turned away" and does not give healing grace.

At the same time, depressed patients with the phenomenon of God-forsakenness have pathological religiosity and an extremely high suicidal risk, since in this state basic semantic values disappear, and Faith loses its protective anti-suicidal role.

Conclusion. According to the research, the phenomenon of God-abandonment can represent a whole spectrum of states from a spiritual and ideological crisis to a diseased state with a different spectrum of severity of psychopathological disorders:

super-valuable experiences, anesthetic and depersonalizational non-psychotic depressions, as well as delusional states within a psychotic depressive-delusional attack.

The phenomenon of God-abandonment requires further clinical and psychopathological assessment, interdisciplinary understanding for the correct and timely provision of psychiatric, psychotherapeutic care and adequate strategies of pastoral care.

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Comparative age-related specifics of depression

Abstract: The clinical picture of depression in different age groups has significant differences. Age significantly modifies depressive manifestations. The report outlines the main clinical and psychopathological features of depressive states in early childhood, adolescence, and old age. It describes characteristic features of depression for each age period. Knowledge of the features of depression and its clinical manifestations in each age period plays an important role for timely recognition of the disease, proper treatment, drug therapy and psychological-psychiatric care, forms of spiritual support specific for each age group.

Keywords: depression, age characteristics, influence of the age factor, clinical manifestations, psychopathological features, tactics of pastoral counseling.

Age has long been considered a special factor that modifies the clinical picture of the disease. So, as early as in the XVI-XVII centuries, the medical specialty pediatrics was formed as a separate science studying children's age, and in the XVIII century – geriatrics, studying the aging processes. Over time, within psychiatry, as a field of medicine, child and adolescent psychiatry, gerontopsychiatry, as well as psychiatry of mental disorders of adulthood were singled out. Such a distinction is justified not only due to significant age-related physiological and neurobiological characteristics, but also because of the pathoplastic influence of each age stage on the clinical picture of mental pathology.

The age related modification of the clinical picture of affective states in psychiatry requires close attention. The specific age-related manifestations of depression acquire an exaggerated, sometimes grotesque character, which certainly makes it difficult to diagnose them correctly. Therefore, knowing the age-related specifics of depression manifestations is of great importance for the timely detection and correct diagnosis of the disease symptoms (Tiganov A.S., 2012).

Research over the past decades has shown that the occurrence of depressive disorders in young children is not new. Even E. Kraepelin at the beginning of the twentieth century wrote about the onset of the disease at the age of 10. Currently, the scientific literature describes depressive conditions in young children. Researchers emphasize that childhood depression is more common than is diagnosed. Young children are characterized by disorders affecting the somatovegetative level of response (Kovalev V.V., 1995). When characterizing depressive manifestations in children, it is necessary to emphasize a number of age-related features. These include: the mosaic of the clinical picture, which is due to the combination of psychopathological symptoms with various forms of impaired development of mental functions, as well as the close cohesion of mental disorders with neurological disorders which allows us to talk about a single neuropsychiatric symptom complex. Therefore, problems in young children most often come to the attention of a pediatrician and neurologist. Rudimentary nature is characteristic of affective disorders of childhood. The incompleteness and partiality of various psychoneurological symptoms is manifested as a result of the immaturity of mental functions and all morphofunctional systems of the brain. The clinical manifestations of depression in children are characterized by transience and waviness. So, short-term disease episodes can be interspersed with long "quiet" intervals between them. Distinctive features of depression in infancy and early childhood are behavioral disturbances in the mother-child dyad and the general mental dysontogenesis that accompanies depression in a deficient, distorted, dissociated or delayed type. The symptoms of childhood depression are characterized by variability under the influence of the external environment, as well as a frequent discrepancy between the cause and

the severity of emotional reactions (Bashina V.M., 1989; Golubeva N.I., Kozlovskaya G.V., Kalinina M.A., 2005).

The clinical picture of infantile depression is characterized by low mood with periods of worsening and crying after sleep. The child has unusual fatigue, lack of interest in play, communication and even food. Anxious affect is manifested by pronounced anxiety, chaotic movements of the baby, not related to external events, increasing intensity and duration of periods of crying, especially after sleep. The normal sleep-wake cycle is disrupted, there are big problems with sleep in general: difficulty falling asleep in the evening or sleep inversion. Children refuse breast, lose weight. Somatovegetative disorders develop, immune reactions weaken. As a result of depressive symptoms, the development of cognitive skills is delayed. A special type of childhood depression is "anaclitic depression", which was described by Rene Spitz, an Austro-American psychiatrist, to describe infant's reaction to separation from his mother. He found that children, getting into a hospital or an orphanage and therefore losing contact with their mother, became loud, and then refused to contact the environment, lost weight, slept poorly and got sick. This condition stopped if mom came or a replacement was found (Golubeva N.I., Lobacheva M.V., 2019).

An important distinctive feature of childhood depression (over 4 y.o. and primary school age) is its psychogenic triggering. These are violations of intra-family relations with parents, relatives and/or the result of overload. The main manifestations of depression in such children are somatic complaints, which turn out to be so pronounced and massive that sometimes they alone determine the clinical picture and obscure the depressive mood itself. Children complain of palpitations, dizziness, nausea, headache, abdominal pain, back pain, leg pain, arm pain, heart pain, etc. Such manifestations of depression with a large proportion of vegetative-somatic disorders in the structure of childhood depressions (digestive disorders, insomnia, itching, headaches, delayed motor skills, tearfulness, lack of interests) were registered by one of the founders of child psychiatry G.E.Sukhareva; thereby she described the so-called latent (masked) childhood depression (Sukharev G.E., 1974). What is typical for children is the absence of complaints of melancholy and at the same time the predominance of anxiety and fear, which usually increase in the evening and at night. Vague, free-floating anxiety can be accompanied by general anxiety and develop into a specific fear: to be left alone, to lose mother, the fear that mother will not come for him. Such phobias are very close to physiological fears and are accompanied by behavioral disorders. Characteristic and common symptoms are also increased tearfulness, constant readiness to cry, increased affective excitability.

Young men occupy a significant place among patients with depression. In adolescence, neurohormonal processes are of particular importance, leading to sharp changes in the hypothalamic-pituitary-gonadal and hypothalamic-pituitary-adrenal systems. These changes are so dramatic that they are called hormonal storm" or "explosion". In the brain, the proliferation of glial cells continues, the number of contacts between nerve cells is rapidly growing, their density is increasing, and the development of functional asymmetry of the hemispheres is completing. Against the background of significant biological rearrangements in adolescence, a complex of complicated psychological reactions and the occurrence of disorders corresponding to the emotional-ideational level of neuropsychiatric response occur. In addition to significant biological changes in adolescence, complex psychological reactions are formed and disorders develop that relate to the emotional-ideational level of the neuropsychic response. Age-related restructuring of thinking, behavior change, emotional instability combined with a lack of psychosocial maturity cause the risk of realization of suicide tendencies. All these prerequisites contribute to the formation of

special clinical types of depressive states characteristic of adolescence (Tsutsulkovskaya M.Ya., Kopeyko G.I., Oleychik I.V., Vladimirova T.V., 2003).

The clinical picture of depressive states in adolescence is dominated by indifference, apathy, boredom or a sullen-irritable mood background. The state often presents two types of affect, for example, indifference or apathy, followed by anxiety. Cognitive disorders are especially common in adolescent depressions. Difficulty in assimilation and memorization of educational material, increased distraction leads to a decrease in academic performance at school. A teenager cannot concentrate, "get thoughts together" and pass the test in the required disciplines at school. Failed academic assignments also have a negative impact on the overall condition, and the mood decreases even more. Such conditions are referred to as depression with a juvenile-asthenic failure. Anxiety manifestations of in the structure of adolescent depressions are most often found within the psychasthenic depressions. The clinical picture is dominated by shyness, self-doubt, timidity. Along with low mood and difficulties with communication, the phenomena of social phobia arise. Such states are often accompanied by ideas of low value and self-abasement (Oleychik I.V., 2011).

Changes in the processes of thinking in adolescence create conditions for the development of disorders with overvalued ideas. Close attention to their appearance, characteristic of young men, can develop into ideas about defects in their appearance. Concern about one's appearance, physical development of the body, the search for a "downside" of appearance in combination with a depressive mood background develop within the dysmorphophobic depressions. A young man's reflections may become engulfed by existential thoughts. The search for the meaning of life related to the depressive affect turns into ideas about the purposelessness of existence, inevitability of death. Thoughts about the loss of the meaning of life that engulf a teenager overshadow the rest of his life and are accompanied by a low mood with the development of a special depressive worldview. Such conditions, especially characteristic of adolescence, are defined as metaphysical depression (Oleichik I.V., Vladimirova T.V., 2005).

Adolescent depressions with psychopathoid disorders are manifested by behavioral disorders. The desire for independence is combined with ignoring authorities, exaggerated opposition to adults, parents and teachers, with protest against traditional values in society. In such states, young men are characterized by uneven and contradictory drives, a tendency to delinquent behavior, conflict along the low mood and irritation, dysphoria and dissatisfaction with others in general (Meleshko T.K., Kritskaya V.P., Oleychik I.V., Kopeyko G.I., 2007).

Aging processes also have a significant impact on the clinical manifestations of depressive states. According to various authors, the predisposition of elderly patients to depressive disorders is 2-3 times higher than in young people. This is determined primarily by specific biological factors of aging and progressive aging of brain structures. Hormonal and metabolic changes of the body that occur in old age reflect age-related physiological changes in the body. An important role is also played by somatic and organic pathologies, which serve as a background for the development of secondary depression. Researchers also pay attention to the so-called minor, “subthreshold” forms of depressive states in the elderly, which are often encountered in outpatient and general medical practice and may not come to the attention of a psychiatrist. Massive non-psychotropic therapy for chronic diseases, grief and loss inherent in this age period, social isolation - all these factors are prerequisites for the development of depression in late age (Safarova T.P., Yakovleva O.B., Shipilova E.S., 2015) .

Clinical manifestations of late-life depression also have a number of significant distinctive features. The pathoplastic effect of aging is manifested by specific age-related features of depression. In addition to general depression, loss of motivation and

initiative, gloomy thoughts, feelings of guilt, sleep disorders, loss of appetite and body weight, a complex of symptoms characteristic of late age develops – anxiety, hypochondria; and also special delusional disorders characteristic of the elderly join the structure of the depressive state. Anxious-agitated depression is characterized by a combination of depression with the experience of fear and episodes of motor agitation from internal anxiety to pronounced attacks of agitation. In such patients, anxiety for various reasons is especially pronounced, as well as sleep disturbances with difficulty falling asleep, frequent waking up in the middle of the night, and early awakening. Anxiety concerns simple everyday problems and can affect any area of an elderly person's life. Hypochondriacal depression is also characterized by anxiety and depression, coupled with fears about one's health. Hypochondriac depression is also characterized by anxiety and despondence, which are coupled with fears for own health. The attention of patients is fixed on the manifestations of the depressive syndrome itself – on disorders of intestinal function, appetite disorders, weight loss. These symptoms usually become the basis of cancerophobia. Preoccupations can also be associated with symptoms of real-life chronic diseases, and can also be combined with various pathological sensations and algia (senestopathies and senestoalgia). A characteristic feature of these clinical varieties of depression is the tendency to transform hypochondriac fears into nihilistic delusions, which are hypochondriac thoughts of extreme severity. It seems to patients that their organs are failing, ideas about dying alive appear. Depressive-delusional states in the elderly are accompanied by delusional disorders characteristic of the elderly related to the depressive affect. It seems to patients that relatives or people from their immediate environment damage their things, scratch furniture, steal, etc. They notice that someone enters their room, rearranges things from their proper places, discover the loss of an object. Delusions include a wide range of age–related topics - ideas of guilt, damage, impoverishment, sinfulness, punishment. In some cases, megalomanic, nihilistic and melancholic experiences are encountered. Apathetic depressions also occur in old age. Such states are characterized by a depressed mood background with little or no melancholy affect, a decrease in vital tone and shallow phenomena of motor and ideational inhibition, manifested mainly in the form of feelings of lethargy, weakness and powerlessness (Kontsevoy V.A., Medvedev A.V., Yakovleva O.B., 2005).

One of the important features of depressive states in general in the late age period are the psycho-organic symptoms or "depressive pseudodementia" or "reversible dementia". The clinical picture of such conditions is manifested by a decrease in memory, impoverished speech, difficulties in orientation, incomplete understanding of the situation, helplessness, episodic states of confusion at night with subsequent amnesia. In most cases, these disorders are reversible; they disappear when the severity of depression decreases. Elderly patients also often have behavioral disorders in the form of manifestations of psychopathic traits. Patients become capricious and express dissatisfaction for any reason. This mood background is assessed as dysthymic, and in the most severe conditions the status of patients acquires a rough hysteroform character with psychomotor agitation (Kontsevoy V.A., Medvedev A.V., Yakovleva O.B., 2007).

The identification of age-related features of depression is important for the development of prognosis criteria and principles of depression therapy. Knowing of the age-related features of depressive states we can recognize these disorders in a timely manner, which is extremely important both for psychological and psychiatric care and for pastoral counseling. These psychopathological features of depression require differentiated medical and psychotherapeutic approaches, as well as special forms of spiritual support specific for each age group.

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Specifics of Confession of depressive patients

Abstract: The report describes the main characteristics of depressive disorders, some typical symptoms of depression that can be seen in a person's appearance, in the patient's statements, and which every clergyman may be confronted with in his practice. It also highlights some typical mistakes that a priest can make when applying an incorrect approach to building a confession of a mentally ill person; and also offers detailed recommendations on how to build communication with a depressed person, help get rid of wrong ideas about spiritual life and misconceptions about possible treatment, how to support and encourage a person with depression.

Keywords: confession of a mentally ill person, pastoral counseling, depression, suicidal tendencies.

Depression is one of the most common mental disorders: according to WHO statistics, more than 260 million people worldwide suffer from clinical depression alone. A priest often has to interact with people suffering from depression who turn to him for prayer, advice, or witness during the sacrament of Confession. Often he is the first to understand that a person who has entrusted him with the innermost of his soul has a mental disorder. Since depression is a dangerous disease associated with the risk of suicide, it is very important to treat the spiritual state of the penitent with special attention, sensitively, so as not only to give him enough time, but, if needed, to provide the necessary assistance.

However, at the same time, the spiritual father should be strictly guided by the “do no harm” principle and be aware of the high degree of responsibility for the pastoral counseling of a sick person. For this, he needs to have the respective knowledge; otherwise he may make mistakes that will lead to tragic consequences in the life of a person who is already suffering. That is why the priest must understand that depression is a real mental illness, with which the patient himself, without outside help, even with all his desire, can hardly do anything.

There are several forms of depression of varying severity, but main characteristics for all forms are the same. These include reduced (oppressed, depressed, sad, anxious, indifferent) mood and partial or complete loss of the ability to enjoy. Usually, the main symptoms are accompanied by low self-esteem, loss of interest in life and habitual activities, a significant decrease or loss of ability to work, unwarranted guilt, pessimism, impaired attention, apathy, fatigue, lack of energy, sleep and appetite disorders, suicidal tendencies. Believers sometimes also have the fear of demon possession.

The mentioned symptoms help to find the most vulnerable sides of the depressed patient. It should be emphasized that it is important for a priest to always remember that the main danger in depression is suicidal behavior, the risk of suicide.

The fact that a person suffers from depression can be understood both by his appearance and by what he says in Confession:

- the face is most often sedentary or motionless, sluggish, lack of facial expressions;
- “inverted” look, eye tension;
- speech not emotionally colored, uncertain, slow;
- the person is stiff, the movements are constrained, tense, the body is also tense;
- dark colors prevail in clothes, no jewelry and make-up, the person often looks sloppy;

- during Confession, the person speaks of sadness, despondency, despair, a feeling of God-forsakenness, "hardened insensitivity", anxiety, fear of death, powerlessness, a constant desire to "lie down and relax", apathy, "torpidity", lack of interest in life, an influx of heavy thoughts, often associated with unwillingness to live, sleep and appetite disorders, rejection of marital relations and attempts to leave family, study, work.

With regard to any of the mentioned signs, clarifying questions need to be asked and, if necessary, a confidential dialogue can be started. But one should be careful when dealing with any topic.

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A priest who does not perceive depression as a serious illness can make significant mistakes that are characteristic of an incorrect approach to building a Confession, namely:

- rejection and misunderstanding of the essence of the penitent's words about powerlessness, "hardened insensitivity" and "emptiness inside the soul", his "complaints about life". This can easily lead to increased feelings of inferiority, guilt and
- an attitude towards a depressive patient as a healthy person, imposing on him generally accepted spiritual recommendations;
- an attempt to force the patient to lead a lifestyle of a healthy person;
- reproaches, humiliation, the desire to "humble" him by any means;
- sympathetic agreement of the priest with statements about a dull, empty and meaningless life, condolences in response to depressive thoughts, admission that "I myself am tired." Such an attitude can cause a painful response in the penitent, up to the exacerbation of suicide moods: "Since the priest is also despondent, it means that the Church can't help me." And the priest, quite possibly, simply does not have any idea of the difference between ordinary sadness and the yoke of depression. It is important to know that even among the closest relatives of the patient there is hardly anyone who sufficiently understands his condition, and the person places his last hope in the Church. But having despaired of finding understanding even in the "hospital of souls" (St. John Chrysostom, Conversations on the Book of Genesis, Conversation 32), he unintentionally thinks: "If they don't understand me in the Church, how can I live on? Anyway, why live ?!"

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It is extremely important that all the statements and remarks of the spiritual father, any polemic with a mentally weakened person in no way give rise to and intensify thoughts that push to suicide.

Of course, whenever possible, the question about suicide thoughts should be asked one way or another. At the same time, it is necessary to calmly, but firmly, without expressing horror or criticism, convey to the person the idea that suicide is absolutely unacceptable, and if he already had suicide intentions or attempts, help him repent.

If he had such thoughts and actions in the past, especially recently, the priest is obliged to ring all the bells, trying to convince both the patient himself and his relatives that urgent psychiatric treatment is needed. It is necessary to talk about emergency psychiatric care even when there are no obvious suicide intentions and actions yet, but such thoughts are present, becoming a stable background of a person's life. In any case, the priest must help him to distance himself from such thoughts, try to give them the status of "thoughts" instilled from the evil spirit and absolutely unacceptable.

"Suiciders, before their suicide, do not know at all that an ugly evil spirit is standing around them, forcing them to kill the body, to break the precious "clay vessel" that keeps the soul until God's time. And this spirit advises, and convinces, and insists, and compels, and intimidates with all sorts of fears: only for a person to press the trigger

or jump over the window sill, running away from life, from his unbearable languor ... A person does not even realize that the "unbearable languor" comes not from life, but from the one from whom all the thoughts that "justify" the killing of oneself come from. The man thinks that he himself is reasoning and coming to a suicidal conclusion. But this is not him at all, who speaks through his thoughts, but the one whom the Lord called "a murderer from the beginning". A person only limply agrees, invisibly takes the sin of the devil upon himself, unites with the sin and with the devil ... Do all people who have been saved from killing themselves or from any other sin understand that a disgusting evil spirit stood near them (and maybe still stands, or sometimes approaches them), a creature that can be detected only by some kind of spiritual sense and alert spiritual attention?"(Archbishop Ioann (Shakhovskoy) "Seven words on the Gadarene").

"In illness, do not wish death for yourself, it is a sin" (St. Pimen the Much-Ailing of the Kiev Caves).

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Depressive patients often demonstrate the type of behavior that some authors call "slow (sometimes – delayed) suicide." These are self-destructive sinful addictions – various addictions to alcohol, drugs, food, etc.

When dealing with such an addict, a priest must be especially careful and understand that in such ways the patient is trying to alleviate unbearable mental pain. Blames, reprimands and punishments can be the last straw that to break the camel's back – the person's thinking that his life has no prospects. In no case should the spiritual father become the reason for the appearance or intensification of such thoughts. Moreover, in no case should he frighten the penitent with dangers or "predictions" about the possible consequences of sins that accompany depression. When repenting for them, the patient should be told that there are various ways to overcome addiction and there is always a real opportunity to free oneself from it.

The complicating factor is that, along with a painful feeling of his own guilt, the addict develops a false idea that God cannot forgive these sins and a distorted understanding of God as a strict, unmerciful, punishing Judge. The pastor, taking into account the various states of the penitent's soul, must be guided by the instructions of experienced spiritual fathers of ancient times and our time on a differentiated approach to the sacrament of Repentance. For example, St. John of the Ladder has repeatedly said that a person in despair has to hope for the Creator's ineffable mercy. Another patristic advice: the salvation of the soul is accomplished on the royal path between fear and hope. If fear leads a person to despair, it is the pastor's duty to help him realize the infinity of God's love for mankind. For the Omniscient Lord, who created our world, foresaw all the possible sins of mankind, but at the same time He did not create the human race so that it would perish. Man could not have been created for the purpose of being punished, therefore it is in no way possible to admit the idea that God created some kind of sin that unconditionally leads people to hell.

We must always remember the indisputable Gospel word: "God is love" (John 4:16). And if a person is constantly disturbed by the idea that his sin is unforgivable, he needs to remember these words of the Apostle John the Theologian over and over again. Even write them on a piece of paper and always have them in front of his eyes, and in his mind. And as soon as a person hears something frightening from the lips of "pseudo-ecclesiastical wisdom" (it is this "genre" that such intimidation is most often characteristic of), immediately return to the words "God is love."

Even if a person, based on the texts of Holy Scripture, independently came to some depressing conclusion, the priest should remind him that this indicates only one thing: "You have not yet fully understood the meaning of the words you read, as well as the general spirit of Scripture … In such cases, always return to the idea that God is love, and begin to rebuild all your conclusions from this basis". In the same tool-box,

one can include another quote from the Gospel: "… the one who comes to Me I will certainly not cast out" (John 6:35).

We have to clarify once again that in the sacrament of Confession any sin can be forgiven: "There is no unforgivable sin except unrepentant sin" (St. Isaac of Nineveh (Isaac the Syrian), Words of the ascetic. Word 2. Of gratitude to God, with the addition of a brief summary of the original teachings).

You can neither blame the patient, nor support his conviction that punishment for the sin of this or that addiction is inevitable – this conviction, on the contrary, must be dispelled. This is not easy to do, since very often such beliefs and fears are multiplied by listening to the sermons of various Internet-preachers who threaten addicts with all sorts of terrible punishments, by reading popular pseudo-Christian brochures and books. To free a person from the terrible prison of sinful dependence, it is necessary to take into account the entire experience of the Church and the texts of Holy Scripture and Holy Tradition (remembering, however, that they are often complicated for a superficial understanding).

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One aspect of the disease may seem unexpected at first glance: depression is often compared with despondency, or even both states are considered to be identical. Indeed, depression can be quite compared with despondency, that is deeply and comprehensively examined in the ascetic practice. St. John of the Ladder teaches that "despondency is a slackness of the soul, exhaustion of the mind. It accuses God of being merciless and without love for men <...> all-conquering death" (St. John of the Ladder. Ladder. Word 13. On despondency).

A separate important point in the Confession of a person in a state of despondency is the sin of blasphemy against the Holy Spirit. The holy ascetics, who have studied the most subtle aspects of the morbidity of human souls, affirm that the passion of despondency is closely associated with blasphemous thoughts against the Creator, that go along with a severe weakening of faith, up to a complete lack of faith in the existence of God and the spiritual world. If a priest is faced with such a case, it is better for him not to accentuate these problems, but simply to take them as a fact of the Confession and not to start a discussion. In other words, don't try to prove things that don't need to be proven. May be in future, as the person recovers and if necessary, you can return to this topic. Then it will be possible to explain that the Church clearly says: there is no sin that cannot be healed by repentance. According to Athanasius the Great, blasphemy is not at all some special exception to this rule: "It should be noted that Christ did not say: 'he will not be forgiven' to the one, who blasphemes and repents, but to the one, who blasphemes, that is, who is in blasphemy. For due repentance resolves all sins" (St. Athanasius the Great. From conversations on the Gospel According to Matthew. On Matt. 12:31).

In general, when talking with a mentally ill penitent, in no case should the priest declaratively link any mistakes and sins in his spiritual life with his illness, find a cause-and-effect relationship here. On the contrary, he shall emphasize that the disease is not the result of his personal sin. Indeed, sometimes an ill person thinks, speaks, commits evil in various forms (sins), because unimaginable pain lives in him, and his actions and words are driven by the state of inner hopelessness. It is important to let him understand and feel: it is the disease that is to blame for the fact that life seems so terrible, empty, painful, meaningless. In any case, the priest should express his empathy, understanding of his suffering and, if circumstances permit, pray to God together with the penitent.

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Basic rules for communicating with a depressed patient at Confession:

- first of all, try to identify the "characteristics" of each individual person: his education, vital interests, etc. At the same time, it is important to at least approximately assess the degree of his ability to intellectual perception (at the current moment);

- in almost every case, simple and everyday speech, conventional speech patterns, deliberate conversation manner, and even somewhat soft communication are recommendable. The most wrong approach in this case would be fast speech, plenty of information and hasty switching from one topic to another;

- take into account the individual characteristics of the person, as well as track "feedback": check how much a person understands and memorizes of what is being said to him, and to what extent it is interesting, important, accessible and understandable to him;

- be patient and attentive to the diverse complaints and morbid sensations that the penitent tells about, and don't ignore them as a trifle;

- show care, sensitivity, caution and, of course, love. After all, if a person feels that he is loved in the Church, it will mean for him that the Lord also loves him – loves him absolutely, unconditionally and implicitly.

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A person suffering from depression is experiencing a deep inner discord, he is confronted with many traumatic thoughts and unanswered questions: "What is happening to me? What is the reason? What should I do?" Without going into detail of every single thought and question, the pastor can still begin to "clean up".

Every priest knows the main paths of spiritual life, and here his experience will tell him where to start the conversation. Let's give one of the possible options for starting a conversation: "Your condition is clear. Many people have gone through this ordeal. The holy ascetics say that it can be one of the stages of spiritual development, and very precisely describe such a state and possible spiritual ways to overcome it. However, do not forget that a person is a combination and unity of spirit, soul and body. And the healing of a person can and should take place at all these levels".

Since many people are not always and immediately able to perceive spiritual instructions, when communicating with them, it is quite logical to start with those problems that bother them here and now, that is, with mental and bodily problems. It is in this field that the seed of hope can be planted, and it is at this moment that the great possibilities of modern medicine should be mentioned.

A person suffering from depression, especially in severe, but often also in a moderate form, needs serious psychiatric help. If for one reason or another he does not receive it, then the priest is simply obliged to refer him to a doctor, because, as mentioned above, in depression, there is a high probability of suicide. If the priest, while receiving Confession of a person, realized that he was dealing with a depressed patient, he should refer him to a psychiatrist in order to save his life. Unfortunately, there were cases when a priest believed that he could save a person from an illness by spiritual means alone, and that person committed suicide.

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The recommendation to see a doctor is often difficult, as many people have negative misconceptions about medical care. These misconceptions stem from distrust of psychiatric treatment and physicians, as well as widespread rumors about the futility or harm of psychotropic drugs, and beliefs about demonic influences.

Misconception 1. Distrust of medicine and unwillingness to follow the advice to see a doctor.

Often a person in need of psychiatric treatment explains this reluctance as follows: "I have already been to a psychiatrist, but I did not get any relief from the treatment." Then, almost always, it turns out that the person did not fulfill exactly the

medical prescriptions made to him. If he was prescribed medicines, he either took them at his own discretion “according to his mood”, or voluntarily, without consulting with his doctor, reduced or completely stopped taking the drugs.

In this case, the priest needs to convince the patient that the doctor can and should be trusted, as well as that the prescribed drugs and other treatments are effective. He has to explain the difference between pills that "work" immediately after taking, and those that have an effect after a certain time, sometimes a long time, basically - "as their effectiveness accumulates." He has to say that it is important to use them regularly and consistently, without which a stable therapeutic result cannot be achieved, and it is also necessary to conscientiously fulfill other doctor's prescriptions. The pastor should emphasize that antidepressants are not addictive.

The pastor has to talk with the patient about the fact that doctors not only can, but should be trusted, regardless of the opinion of "famous elders and blessed elderesses." The question here is simple: can people's opinion be higher than the Holy Scriptures? Whatever the “elders and elderesses” and other “authorities” may say, the Bible states that doctors should be respected: “Honor physicians for their services, for the Lord created them, for their gift of healing comes from the Most High,… and he gave skill to human beings that he might be glorified in his marvelous works. By them the physician heals and takes away pain;… when you are ill, do not delay, but pray to the Lord, and he will heal you…Then give physicians their place, for the Lord created them; do not let them leave you, for you need them. There may come a time when recovery lies in the hands of physicians, for they, too, pray to the Lord that he grant them success in diagnosis and in healing, for the sake of preserving life” (Sirach 38:1,6,7,9,12-14).

Misconception 2. Negative attitude towards psychotropic drugs.

Most often, people express it in almost the same way: “The pills that psychiatrists stuff a person with make him a vegetable.”

Here the pastor can take a twofold approach. First, smile politely: as you know, it is non-professionals who are best versed in all global issues, that is, people who heard the song but got it wrong. And then, calmly and softly, try to explain the principles of the complex effects of psychotropic drugs, comparing them with simple and illustrative everyday situations.

For example, you can ask: “What do you think, if a person got out of the desert half-dead and is not even capable of ordinary conversations, and even more so of accepting spiritual advice, then shouldn’t he, as in a fairy tale, first be given water, food and put to sleep?” It is the same with the pills that the psychiatrist prescribes – first they give the exhausted nervous system and the tormented brain the opportunity to calm down, as if to eat, sleep and recover. For this, the doctor prescribes a precisely verified dose of the drug. And if you do not take the drug, then the situation will be similar to that when a starving wanderer who did not get the opportunity to sleep, who came out of the desert, continues to feel the same torment ... “.

Through various analogies, the priest can appeal to the pure logic and help the patient understand that doctors do their work professionally, in strict accordance with scientifically established and verified rules. But the treatment will be successful only if the medical instructions are accurately followed. And then “God …shows favor to the humble” (see 1 Peter, 5:5), and positive changes begin. “The pharmacist makes a mixture from them. God’s works will never be finished, and from him health spreads over all the earth” (Sirach 38:8).

After all, no one doubts that in various diseases, such as hypertension, pills are effective, and if the patient does not take them, then there is a high risk of a stroke or heart attack. It is the same with our nervous system, with the brain: medication can be of great help to them. And if, for example, in case of hypertension, due to insufficient

quality and / or quantity of necessary drugs, the most serious negative consequences occur, it is all the more necessary to strictly follow the medication regimen and fully trust the attending physicians, that is, not to trust either other people's idle judgments or one's own ideas about the "correctness of treatment".

Concluding the conversation about the first two misconceptions, the priest must assure the patient that psychiatry has now reached a very high level. It is able to provide concrete effective help in various mental illnesses. Depression usually has a favorable course if the doctor's recommendations are followed. This is a very important task of the pastor – to inspire the person with hope for recovery.

“Each of the arts is God’s gift to us, remedying the deficiencies of nature…The same is true, also, of the medical art… In as much as our body is susceptible to various hurts, some attacking from without and some from within… the medical art has been vouchsafed us by God, who directs our whole life, as a model for the cure of the soul, to guide us in the removal of what is superfluous and in the addition of what is lacking” (St. Basil the Great. Longer rules in questions and answers. Question 55. Whether recourse to the medical art is in keeping with the practice of piety).

Misconception 3. Depression is the result of diabolic action.

"All illnesses come from demons, so you can be healed only through their expulsion; pills, as you know, do not work on demons." This position, alas, is very common, and here the priest will have to resort to some kind of authoritative opinion or appeal to common sense. Metropolitan Anthony of Sourozh is a bright example of authority and common sense together: to the doubts of the patient's relatives, he answered very simply: "If it is a posession, then psychiatric treatment will not harm the demon in any way, and if it is just a disease, then the person will recover." The metropolitan urged to check his authoritative opinion in practice and only then draw conclusions. Of course, in such a case, in order not to get bogged down in a controversy about "authorities", the priest must have the respective knowledge.

In this matter, one can sometimes use as an argument the idea that if a person values his identity, embraced by the Providence of God, then the most unacceptable of all that can happen is suicide. This argument is addressed, first of all, to those "authorities" who forbid treatment by doctors and taking medications, ignoring the risk of suicide. But how can someone take responsibility of this level? We emphasize once again that mentioning suicide is possible only at the most appropriate moment, doing it with extreme caution.

If in Confession a depressed person shares his doubts about whether he is possessed by a demon, the priest may say: “You probably know that demon-possessed people usually behave clearly inappropriately, especially in the church, when staying close to a shrine (for example, a cross, holy relics) and when taking part in the sacraments. However you and I are now in just such a place, and you are taking part in the sacrament. So you can make a concrete conclusion for yourself, and stop worrying.“

In some cases, at this point it makes sense to ask if the person is hearing any “voices”. If not, this is quite a good moment to reassure the penitent once again, to tell him that "no one controls him." If he hears “voices”, sees some kind of visions or experiences unusual sensations, then it is necessary to advise his relatives so that they urgently seek psychiatric help. In this situation, the risk of suicide is very high.

Concluding the topic of obsession, let's touch on the so-called "exorcism". Here the priest should be guided by the draft document of the Inter-Council Presence “Attitude of the Russian Orthodox Church towards modern practices of exorcism” dated October 30, 2022. It clearly indicates in which exceptional cases it is allowed to apply this rite, and most importantly, who has the right to perform it. In this case, a person who has come to Confession must decide whether he is a member of the Church and whether he recognizes the right of the Church to decide this most important issue, or

whether he trusts the folk fabrications and dubious attitudes of unofficial healers (unfortunately, often dressed in monastic or priestly vestments).

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It is extremely important to show a person suffering from depression a way out of life's impasse, to help him see the positive prospects for mental and spiritual development.

It is important for a person to accept his illness and understand that it does not tear him away from God, from himself and the world around him, just as sin does. It is necessary to assure him that depression is the path of the Cross given to him for salvation; the Cross, which, when carried in humility, leads to God; that depression is a unique path of God's Providence, a path of good change, mental and spiritual growth intended for him.

The life of a Christian is based on constant cooperation with God. So the priest needs to underline the importance of fervent prayer not only for helping yourself, but also for your doctor, so that the Lord "through the mind and hands of the doctor manages the treatment and offers the necessary medical effect" (as the prayer for doctors in the Orthodox Service Book says) and grants to the doctor wisdom for the correct selection of medicines, and to the sick person – patience on the path of healing he has chosen. The priest should support the desire for God's graceful help through communal prayers and sacraments (Unction, Confession, Communion) and encourage a person to participate in them.

When depressed, it is difficult to concentrate on any thought, especially during prayer and reading the Holy Scriptures. Often, participation in church sacraments does not bring relief either. The priest should find words of consolation, try to pray together with the sick, help him see the mystery of God's mercy in his illness, affirm in the idea that God Himself loves us, and expects love from us, and not self-flagellation and despondence.

When the acute phase of the disease passes, we need to encourage the patient to actively fight evil and illness, keeping in mind our calling to be soldiers of Christ.

It helps a lot to make a list of those things that brought him joy before the illness. And then, little by little, but with diligence, do them, as a kind of penance (playing with animals, playing music, drawing and other arts, sports, etc.).

Sometimes, due to morbid weakness and indifference to everyone and everything, a person closes up. Here it is very important to regularly remind him of the healing power of the virtue of mercy, of helping one's neighbor, expressed in various deeds of love. The goal is not to allow a suffering person to concentrate on his weakness, insensitivity and worthlessness, and also to help him learn not only to provide help, but to appreciate and gratefully accept the reciprocal help from others.

After a person comes out of an acute period of illness, at the onset of remission, when he has the opportunity to take spiritual steps on his own, you can advise him to read the Holy Gospel, choosing good thoughts from it.

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We recommend that the pastor have a kind of "first aid kit": advice and life experience of those saints who either systematized the teaching on passions (St. John of the Ladder, St. John Cassian the Roman and others), or themselves endured depression.

With regard to the latter, extracts from the letters of St. Ignaty Bryanchaninov are very useful, who suffered a lot and considered suffering his sacred duty. According to Apostle Paul, "Because he himself suffered when he was tempted, he is able to help those who are being tempted" (Heb. 2:18).

"Here are the weapons that the holy rampage of Christ's preaching gives to the servant of Christ to fight against … gloomy thoughts and feelings of sadness that appear to the soul in the form of terrible giants, ready to erase it, devour it:

1st - the words "Thank God for everything».

2nd - the words “Lord! I surrender to Your holy will! Be with me Thy will.

3rd - the words “Lord! Thank you for whatever you send to me in your blessed will.”

4th - the words “I accept what I deserve by my deeds; remember me, Lord, in Your Kingdom."” (St. Ignaty Bryanchaninov. Letters to the monks. To a father beset by mournful circumstances. On the struggle with thoughts).

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Summing up, let's list the main tasks of a priest during the Confession of a depressed patient:

- help a person repent of his sins, and also try to help him realize and feel the forgiveness granted to him by God in the sacrament of Repentance;
- in the process of Confession, answer a number of difficult questions and clarify various perplexities associated with false ideas about spiritual life;
- free a person from thoughts about traumatic moments or alleviate such thoughts as much as possible – this is one of the main goals of a priest's communication with a sick person during Confession;
- help to understand the situation in which he is; clarify the overall picture of his current situation, while indicating the main life and spiritual guidelines;
- set the next achievable tasks for the patient, as well as outline the key prospects for further actions;
- support and encourage the penitent, invite him to continue to seek help and advice, since it is quite possible to systematically resolve many issues related to the disease, which will help him get out of depression and, with God's help, follow the life path in harmony of soul and body.

Francisco Garcia Martinez

A world of sorrow and anger, auspices of joy and reconciliation

Abstract: Based on the biblical texts about the creation of the world, the stories of Cain, King Saul, King Ahab and Jezebel, one can observe how a person constantly strives to identify himself with the whole creation, embrace it entirely and become the basis of himself, forgetting that life was originally given to him by God and is the fruit of His gift of love to man. In modern society, a person is faced with fatigue generated by the mentality of our time, which defines him as an absolute owner, a builder of himself, forcing him to think that everything depends on his will, which ultimately deprives him of energy. This is the reason for depression, fatigue and constant sadness, it is a source of obsessive ideas about the guilt of others and leads to violence against oneself and others. Modern man lives in a constant hesitation between sadness that he is less than he wants to be, and violence against himself in order to be more than he is. The Holy Scripture shows that there can be no harmonious life without self–restraint, rejection of the tendency to total possession of space, and humility is the only way that can lead to joy and reconciliation.

Keywords: paradepression, biblical narratives, apathy, despondency.

The statement that we live in a depressive society seems to have already become a topic for sociological analysis. We observe this in various studies and in different variations. In any case, depression has become not just an individual pathology, but a symptom of social deprivation, which obviously violates a person's harmonious relationship with himself. Modern people are facing what could be called *paradepression*, that is, a state of "fatigue, boredom, longing, sadness, ... mental and bodily dissatisfaction, despondency, apathy." A condition that cannot be called a personal pathology symptom, it intrudes in humans as a structure that determines the life of subjects (Cf.M.L.Rovaletti, M. Pallares, 2014).

According to Serge Lesourd, "the idea of mental fatigue has penetrated into the sphere of work, family, study, health care to such an extent that it is already inseparable from our modern society. It seems that the whole culture is conquered by this state of mind, which is manifested by sadness, anxiety, doubt, idleness... "melancholisation of the postmodern subject". According to Christian Gaudin: "Humanity collectively, everywhere loses the desire to live. Unprecedented self-depreciation on a global scale permeates the human race" (Ternynck C., 2012).

In our brief reflections, we will try to show how some biblical texts help to reveal those elements that are very close to the modern situation, being, in a sense, its archetypes, and how Christian spirituality has found ways to cope with this depressive situation. Methods that, without being therapy proper, express the therapeutic power of the Christian lifestyle in the world.

1. The joy and sadness of being a creation and knowing about it

Let's start with the story of the creation of the world (Gen. 2:4-25). In it, God addresses man with words that place his life in the context of the gift of Creation. These words are associated with bewilderment, which should become the point at which a person finds his identity. God says: “You are free to eat from any tree in the garden; but you must not eat from the tree of the knowledge of good and evil, for when you eat from it you will certainly die.” (Gen. 2:16-17). In the first part of this sentence, everything is offered to man, however, in the second, a restriction is imposed indicating that a certain part (the fruit of the tree of knowledge of good and evil) does not belong to him. Thus, the man finds himself between the fact that all reality is completely given

to him, and at the same time he cannot identify himself with all reality as a whole. This apparent contradiction is an integral part of human life and a test that a person must face in order to comprehend himself (according to Cf.A.Wénin, 1999).

The entire subsequent biblical narrative shows how to resolve this paradox, but at the same time demonstrates that a person is lost in it, as in a deadly labyrinth. The Holy Scripture shows us how a person is attached to a false interpretation of life, which he must overcome. Eventually, this paradox will become clear in the life of Christ, the teacher and Savior.

But let's return to the biblical text: by forbidding the man to eat from one of the trees, God wants to prevent the man from identifying his own life with the rest of creation. Thus, the text of Scripture contains an indication of the need to go through a radical self-limitation of the "I", which constantly strives to identify itself with the whole creation. The full knowledge of creation promised to Eve by the serpent if she eats of the forbidden fruit ("Ye shall not surely die", Gen. 3:4), ends with death, because it is based on deception, namely, on the idea that the "I" can encompass the entire creation as a whole, and in this case become the basis of itself. This is a "short-sighted" point of view on the fact that man's being was originally given to him by God, and is the fruit of the gift of His love for man.

Thus, without this self-limitation of the "I", without this rejection of the tendency to total mastery of spaces, there is no possibility for a harmonious life. The Book of Genesis essentially states that a person has been drawn into this situation from the very beginning and is going to live his life in a constant oscillation between *sadness* that he is less than he wants to be and *violence* in order to be more than he is. As we will see, it is humility that is the path suggested by Scripture as the only one that can lead to *joy and reconciliation*.

Now let's look at some biblical narratives that concretize this point of view.

2. Strange affliction of Cain (Gen. 4:2-15)

There is one strange aspect to highlight in this story that cannot be ignored. On a casual reading, it seems that Cain's strong grief ("Cain was very angry, and his face fell") should not be imputed to Cain as a transgression, since this grief would seem to stem from the unreasonable will of God.

However, we could also say that Cain could not accept the limitations of his life, which can never encompass the entire creation. Thus, Cain was in the same position as Adam and Eve. He faced the need to limit his desires and accept the insuperable otherness of the world and other people. Rejection of this position causes him to become despondent or sad, and then to kill his brother Abel, who holds the blessing of God, which Cain considers his own.

Byung-Chul Han, analyzing the crisis of love in our societies, argues that it is the "expulsion of the other" on the part of the narcissistic and consumer subject of modern society that generates depression. "Depression," he says, "is a narcissistic malady. The world appears only as adumbrations of the narcissist's self, which is incapable of recognizing the Other in his or her otherness—much less acknowledging this otherness for what it is. [...that is why] it wallows in its own shadow everywhere until it drowns— in itself." (Byung Chul-Han, 2017). This is a modern description of Cain.

3. Saul and the fear of losing the throne

In the biblical narrative about the beginning of the Israeli monarchy, we find a story related to the previous one – the story of Saul. The blessing of God, which Cain seemed to long for, now rests on Saul, because he was elected king and as such received the recognition of the people. However, despite this, he orders to kill his own son (1

Sam. 14:44) and 85 priests in Nob (1 Sam. 22:18). Having full power, he does not know how to cope with his own delusions about his omnipotence over reality, and falls into a labyrinth of envy and violence against David, very similar to the labyrinth of Cain's relationship with Abel.[1]

Then a strange situation arises: Saul, endowed with power, does not even believe that he is protected and blessed by God. In other words, from this story we can see that in the history of mankind, life has gone into a spiral of violence, in which, as we mentioned in the case of Cain, no assertion of power can satisfy the desire of the "I" to possess all reality. It is the suspicion that his election does not guarantee his absolute dominance - since he sees that David is gaining recognition from part of the people (1 Sam. 18:7) - that pushes Saul into a spiral of sorrow and violence towards David.

The only thing that brings Saul out of his severe melancholy is music. The text of Scripture says: "*Whenever the spirit from God came on Saul, David would take up his lyre and play. Then relief would come to Saul; he would feel better, and the evil spirit would leave him*." (1 Sam. 16:23). There is no need to emphasize that music is a harmony of sounds, since we are talking about the interrelation of various sounds that can be harmonized while maintaining their differences. Perhaps music is the closest natural sacramental reference to God's creation, where everything is "very good", because everything retains its difference, while being part of the whole.

4. Ahab, Jezebel and the death spiral of the absolute subject (1 Ki. 21:1-16)

Naboth's little vineyard connects him with the whole family. To deprive oneself of a vineyard means to deprive oneself of a generic identity and lose one's own identity. That is why "Naboth said to Ahab, *The Lord forbid it me, that I should give the inheritance of my fathers unto thee*." (1 Ki. 21:3).

However, King Ahab wants to appropriate this vineyard, because it borders his palace. King Ahab is not comfortable around property that borders on his own and that does not belong to him. The reason seems to be that the boundaries of his palace become a reminder of the limitations of his power and his own life. The vineyard in this story has the same meaning as the tree in the middle of the garden where Adam and Eve lived. It appears as a test space where the truth of man in relationship is constituted.

Ahab, however, like a narcissistic subject of our consumer society, is not satisfied with his possessions, he always wants more, he always wants what the other has. However, this time, Naboth becomes strong by defending the identity signified by the vineyard, which represents God's blessing, and which Ahab must therefore respect.

The biblical text indicates to us that the inability to receive Naboth's property caused King Ahab a state of depression and sadness, which is described as follows: "And Ahab came into his house heavy and displeased because of the word which Naboth the Jezreelite had spoken to him: for he had said, I will not give thee the inheritance of my fathers. And he laid him down upon his bed, and turned away his face, and would eat no bread." (1 Ki. 21:4). We can see here an analogy with the feeling of Cain: there were anxiety, grief, but now there is also a symptom of severe depression: he was lying in bed, turned away from life.

Thus, Ahab shows that depressive sadness that stems from the identification of *limitation with insignificance*, in this case because of his inability to appropriate the benefits of the surrounding world. His wife Jezebel will react strongly to this limitation. As you know, she uses her husband's power to destroy Naboth and appropriate his vineyard. In this story, Cain seems to be divided into two characters that complement

[1] "Of all the sources of anger […] cenodoxy and pride are fundamental […] Man gives himself over to different forms of anger when he feels humiliated, offended, not considered (especially in relation to the favorable image that he has of himself and that he expects others to give back to him)" (J.C. Larchet, Therapeutics of spiritual illnesses, Salamanca 2014, 197).

each other – the depressed Ahab and the vengefully aggressive Jezebel. We would like to note here that in social situations when the population has paradepressive symptoms, it is not surprising that charismatic leaders appear who, while extolling identity, form it in a totalitarian and violent way in relation to others.

5. The promise of joy and reconciliation

Jesus begins his ministry in the desert, a lifeless place where he suffered from hunger and thirst. At this moment, he was offered food, power and recognition. There doesn't seem to be anything wrong with that. Despite the fact that Satan suggested it, all this was necessary for his human nature. However, everyone must go through self-restraint, through the restriction of the desire to merge with the world and master it, which ultimately eliminates not only the otherness of others, but also hides from man the gift of his own life and the presence of other personalities who fill our lives with their love.

The life of the Savior becomes an image of the realization of a truly human life. In this sense, we could interpret the episode of temptations at the beginning of his mission as the formation of a new human identity. The forty days he spends in the desert ultimately manifest as the emergence of a personal rather than natural space, free from hunger and thirst.

Modernity, and then postmodernity, put not only the subject, who has always faced this test, but also the whole society in a position of self–affirmation and constructing reality in the only way - by obsessive attempts to appropriate the world by methods of politics and technology. However, "*For what is a man profited, if he shall gain the whole world, and lose his own soul*?" (Mat. 16:26). On the other hand, when faced with the social failure of this promised completeness, a person closes himself in his own consumer individuality, entering an endless labyrinth in which he never manages to find anything but various forms of his limitations, leading him eventually to sadness.

A person in modern society is faced with fatigue generated by the mentality of our time, which defines him as the absolute owner and builder of himself, forcing him to think that everything depends on his will, which ultimately deprives him of energy. This is the reason for the depression of modern man, his fatigue and constant sadness, which is the source of his obsessive ideas about the guilt of others and leads to violence against himself or others.

We live in a world with unprecedented possibilities for domination over reality, in a world that should provide a satisfying life for everyone; but, on the contrary, it never ceases to cause sadness. We are still in this labyrinth of sadness and violence, from which neither modernity nor postmodernity could help us escape.

As we see from the Gospel, humility is the only way that can lead people from sadness and anger to joy and reconciliation.

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Wenceslao Domingo Vial Mena

Burnout as a form of depression in pastoral work

Abstract: According to researchers, in modern society there is an increase in emotional burnout as an unhealthy consequence of prolonged stress, mainly at work. Symptoms include feelings of emptiness, exhaustion and overwhelm. It is necessary to timely recognize the initial manifestations of burnout in risk groups in order to prevent it. In addition, a priest in his ministry may also encounter the problem of burnout. There are some specific factors that need to be promptly identified and addressed. Thus, the first signals may be negative emotions experienced daily (fear, sadness, feelings of hopelessness, etc.). To prevent burnout, it is necessary to cultivate your own responsibility to other people: to be responsible and bear the weight of your own decisions; consider the need for meaning and self-esteem; and care for the balance of active and contemplative life.

Keywords: professional burnout, pastoral ministry, depressive disorders, prevention of professional burnout

I would like to briefly speak about burnout, as a form of depression, in pastoral or ministerial work. As you know, the latest edition of the *International Classification of Diseases*, has included burnout as an occupational phenomenon, but not as a medical diagnosis.

Let's go for a while to the time of Jesus living on earth. The disciples of our Lord where happy to give themselves for their Master, but they needed to rest. Jesus says to those who follow Him: "Come to me, all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me; for I am gentle and lowly in heart, and you will find rest for your souls" (Matt. 11:28-29).

We can summarize in a few words how we will tackle the subject we are about to discuss: the antidote for fatigue and lethargy in ministerial work is to go to Jesus, to rest in the One Who gives the mission, the source of peace and serenity.

We will first see the manifestations and the people most at risk of burnout, and at the end we will speak about prevention of burnout.

Burnout is an unhealthy aftermath of a prolonged stress at work. Burnout literally means to *be burned*, and it used to be identified with a mental fatigue or *surmenage*. Like so many other psychological problems, it can be seen from a distance, as if it were a brewing storm.

The very person who is at risk of burnout can perceive the warning signs inside himself or herself: especially, in the **greater frequency of negative emotions, which are contagious or attract each other,** such as anger, feelings of frustration, sadness and discouragement.

Herbert Freudenberger, an American psychologist born in Germany, gave a more precise description in 1974: he characterized burnout as type of professional stress evidenced by fatigue caused by unattainable expectations. He was the first to use the term in medicine. Freudenberger worked in a clinic for drug addicts and observed that some volunteers, after a year, began losing energy and experiencing physical and psychological fatigue and symptoms of anxiety and depression, which led him to affirm: "**These people look, act and seem depressed**."

In modern society there is an increase in burnout, and some consider it an epidemic. Byung-Chul Han, a philosopher of Korean origin, points out that one of the reasons why there is an increase in depression and similar illnesses today is the fad of thinking, saying and acting as if everything were possible. According to Han, we are in a burnout society, in which the idea of the immune system has been set aside. When

there is no immune system, there is no reaction against threat or harm. All changes, all differences are considered good. A society that is fixated on performance, perks or profits, produces depressed and failed people. For this reason, Han affirms: activism and increase of profits lead to a heart attack of the soul.

In the life of a priest, there are also several challenges that need to be properly understood and resolved. One of the latest documents of the Catholic Church on priestly formation lists six points: the experience of one's own weakness; the risk of thinking of oneself simply as a dispenser of sacred things, the challenge of contemporary culture, the of power and riches, the challenge of celibacy, and total dedication to one's own ministry.

Each one of these aspects should be a reason for frequent examination, so as to develop one's vocation and to avert the risk of burnout or suffering a *heart attack of the soul*.

1.Manifestations of burnout

The trigger for burnout is stress. This concept is borrowed from engineering principles and refers to the fatigue observed in some strong materials such as iron, which can break after use when it has been subjected to prolonged stress.

To understand how this disease develops, let us look at the way three persons who suffered burnout recount their experience, as we read in the first pages of one of the books on the subject: *Burnout. The cost of Caring*, by Dr. Christina Maslach:

-Carol, a social worker, describes her experience by comparing herself to a kettle full of water left on the fire; after a while, when the water has evaporated, she says she becomes empty, and continues to burn at the risk of breaking.

-Jim, a teacher, compared himself to a battery: at first, students take a lot of energy from it, and it must be recharged... this task is more difficult every day, and the recharging lasts longer, as happens with telephone batteries. In the end, the battery must be replaced because it is exhausted.

-Finally, Jane is a nurse who has to take care of many suffering people every day; she thinks she is like an electric cable carrying electricity; there are so many connections that the electric circuit is overloaded and the cable burns.

We discovered three fundamental signs here: the sensation of emptiness, exhaustion and overload.

Burnout develops slowly and progressively. Cracks appear little by little and get worse with time. For this reason, it may not be recognized until it is serious.

Dr. Maslach identifies three components or stages:

a) *Emotional exhaustion* as an individual response to stress: it is produced by the sustained workload. We can say, as an example, the priest or pastor who is very dedicated to all those who have some material or spiritual need. At this point, the person thinks that he can no longer give himself to others and that he already does too much. Indifference towards those who suffer sets in and drains his capacity for compassion.

b) second step: *depersonalization or cynicism*: a negative reaction towards others and towards work ensues. There is continuous mistrust in others and their motives, and the person avoids those who seek his help (penitents, for example), seeing them grudgingly and coldly.

c) The last one: *poor personal performance* at work or ineffectiveness: in this last stage there is a negative assessment of one's own performance. Frustration leads to apathy. The logical consequence of the situation created and the attitude towards it will be a feeling of inadequacy; it is common to think, for example: "I am not cut out for this kind of work"; some decide to change jobs or to break with the commitments they have made.

Various factors can cause a burnout. Symptoms may begin after a period of

unrealistic enthusiasm due to certain expectations that have no foundation in reality. In some way, it is related to the desire to prove that one is capable of carrying out a certain task. Therefore, people work hard and may become obsessive, leaving behind other activities and neglecting family, friends, rest, or a life of prayer.

The difference between burnout and the simple fact of being tired of work is that after a hard and stressful job, which is tiring but full of meaning, the person is usually happy. One finds something attractive and enjoyable about the work because it is meaningful, and experiences satisfaction and joy in seeing the fruits. In burnout there is a feeling of failure and disgust.

The priest can experience this kind of sadness, being so close to limitations and suffering, without succeeding in changing these situations.

2.People most at risk of burnout

Since the concept of burnout appeared in the 1970s, it was seen that it can afflict anyone who is dedicated to helping those who suffer or have difficulties. The most common risk factor is that of being in contact with different problems and needs and becoming too emotionally involved in them. **Not only overload but also the lack of meaningful work or lack of empathy of bosses or colleagues can lead to exhaustion**.

Burnout was first observed among nurses. Today, it is seen in many service professions: doctors (especially in intensive care units), psychologists, social workers, policemen, teachers, priests. It can be seen in both paid workers and volunteers. Several articles speak of the increase of pathology among the *millennials,* which is aggravated by an excessive desire to compete and outdo oneself, instilled by parents and by the excessive competitiveness that social networks incite. *Millennials* respond worse than the previous generations to emotional fatigue.

There has also been an increase in the number of cases in priests. A study carried out in an Italian diocese a few years ago describes the results of a questionnaire. In summary, 2 out of 5 priests showed signs of burnout; and two-thirds of priests aged 25 to 29 years fell into one of the risk categories.

Burnout has been described as “a disease of self-giving,” or “syndrome of the disappointed good Samaritan.”

The individual characteristics that can lead to this type of pathology are related to some dangerous personality traits. The most frequent are perfectionism, low self-esteem, low tolerance for frustration, insecurity, egocentrism and difficulties in interpersonal relationships.

It usually affects those who get very tired at work, because they usually do not approach their work with order and moderation. It can arise in those who are experiencing such things as behavioral alterations, difficulties sleeping, addictions, affective losses or diminution of confidence and identity.

A wrong motivation, seeking success and money instead of service, can also be a trigger or detonator of the pathological process.

3. How to prevent burnout

The austere and simple life, built on solid foundations, and not on sand, will be the best prevention of pathological exhaustion.

The objective of preventing and solving **the problem encompasses two levels**: **the subject and the institution in which the person works**. The first years of the priestly ministry call for special attention, since the risk in that period is greater. It is possible to remove the symptoms and overcome burnout by putting into practice an opposite attitude: engagement.

Engagement counteracts exhaustion, cynicism and inefficiency. One of the meanings of this word is a promise or commitment to marry. This coincidence is useful,

because the bride and groom seek to ensure that the love between them does not fail, which is important to avoid wear and tear. In the same way, a job done with love, which is maintained, prevents burnout. ***Engagement*** **(doing the pastoral work out of love) has three characteristics**: increasing energy, achieving more participation and increasing efficiency.

On a personal level, it's necessary to promote hope and the awareness of being children of God, optimism, taking distance from situations and from our own emotions, re-evaluating the situation from time to time, to have rewarding activities, and try to think more and more of others.

Dangerous traits should be identified and addressed as soon as they are detected. After determining what the expectations are, it's important to try to correct the extremes: either very low, close to zero ("I'll never convert anyone, I'm not good at this..."), or very high and unrealistic. Excessively high expectations of unrealistic greatness sooner or later lead to ruin. Low expectations, on the other hand, destroy initiative or paralyze action, which translates into a decrease in self-esteem.

About pastoral or ministerial work: We mentioned six challenges confronting priests. Finding remedies for each of them is important for carrying out a fruitful ministry. The document on the gift of the priestly vocation proposes six measures to overcome them. The first solution is to promote fraternal meetings since we are called to live in relationship with others. Then spiritual direction and confession, spiritual exercises, taking meals together, living a life in common and joining priestly associations.

Some causes of the exhaustion in priests, which can be remedied if discovered on time, are: lack of interior life, overwork, the impression of offering a product that is out of fashion, stress in coping with unforeseen situations, lack of gratitude or recognition for priests of today, tensions in institutions, the weight of decisions, excessive insistence on self-giving during the years of formation.

Therefore, in order to prevent burnout in any person, we need to keep in mind physiological aspects such as sleeping and resting properly, and spiritual aspects, which I would summarize as: forming a good character, through virtue and in virtue, coherence and unity of life, adequacy of expectations, seeing God at work, having order, also in charity, and a project or plan of life. These notes lead to finding meaning in the work and promote resilience or the ability to bounce back from any psychological wound.

To prevent burnout, we specially **need periods of meditation** and contemplation. **Pascal's phrase is noteworthy**, when he speaks of the misery of a man without God, who seeks to distract himself or to divert himself with many things that prevent him from focusing on what is most important and from knowing the reality of his limited condition: "I have discovered that all the misfortune of men comes from one thing: they cannot sit alone in a room and pray".

All personal preventive measures will be more effective if they are accompanied by changes at the institutional level. There are six areas of the person-institution relationship that deserve special attention according to Dr. Maslach: do not overburden workers and take care of their welfare; training and reassurance; provide a sufficient number of rewards; distribute jobs well; be fair with everyone; confront the values of each person and avoid conflicts.

It is a matter of achieving a suitable work environment. With good preparation, stress levels decrease, communication improves and the sense of mission is enhanced, leading to greater human and supernatural effectiveness.

Conclusions.

I will finish the presentation with some conclusions. The first one would be to

recognize the alarms, remembering that the first alarm is a negative emotionality (fear, sadness, hopelessness, etc.); then, to grow in responsibility before someone: to answer to someone, and to carry the weight of one's own decisions; the need of meaning and self-esteem; and to take care of the balance of an active and contemplative life. Disconnecting from the excess of external stimuli, also from the internet, favors connecting with others and with God. It is in silence that we listen to the Creator.

I would like to end with a Latin phrase, frequently used in sundials: sine sole sileo. Without the sun I'm silent. Thus, only with a clear meaning in pastoral work, or in any profession, is it possible to work with joy and help others.

Ivanin D.A.

Pastoral support in spiritual overcoming of depressive states

Abstract: This article considers the role and tasks of an Orthodox priest in the system of providing comprehensive assistance to Orthodox Christians suffering from endogenous depression. The potential of the Orthodox doctrine and the type of spiritual coping inherent in it, as well as the potential of an Orthodox parish, are considered. A specific area of individual pastoral care is highlighted – building relationships with God, which opposes the feeling of "God-abandonment" arising during depression.

Keywords: theology of depression, pastoral care, spiritual coping.

According to preliminary estimates of the Ministry of Health of the Russian Federation, depression affects 20% of people of working age, about 20% of children and adolescents, 25% of the elderly and about half of people suffering from somatic diseases[1].. At the same time, it is noted that the detection of depression cases by doctors is difficult, and in almost half of cases, patients try to keep silent about the symptoms of the disease. During the COVID-19 pandemic, the World Health Organization has recorded an increase in the number of people suffering from depressive disorders by 28%.[2]

Depression is most often manifested by a deterioration in mood – sadness, a feeling of emptiness, loss of interest in work and any occupation, a pathological sense of guilt or low self–esteem, a negative vision of the future, often accompanied by cognitive impairment - decreased concentration, sleep disturbance, a feeling of extreme fatigue, loss of strength and a change in appetite for most of the time for more than two weeks (Tiganov A.S., 2016; Kaleda V.G., 2021). Believers have doubts about faith, impoverishment of religious feeling, indifference to prayer, worship and the sacraments of the Church, a sense of "God-abandonment" (Kopeyko G.I., 2021). Thus, depression affects all aspects of a person's life, negatively affects his working capacity, family responsibilities, and spiritual life. According to the World Health Organization, people with a number of mental disorders, which includes depression, live 10-20 years less than the average population, are at high risk for suicide. At the same time, according to statistics, 76% - 85% of patients in low- and middle-income countries do not receive the necessary treatment[3].

Mental health issues are, of course, of concern to the Russian Orthodox Church. Currently, as a result of cooperation between the Church and psychiatric science, guidelines for clergy on the Basics of pastoral psychiatry have been published; courses in psychiatry and psychology are included in the training programs of theological seminaries and advanced training courses for clergy. A document of the Commission of the Inter-Council Presence of the Russian Orthodox Church "Pastoral care in the Russian Orthodox Church for the mentally ill people" has been issued. However, despite considerable attention to this topic, there is a lack of theological understanding of pastoral care for those suffering from depression and the phenomena of distortion of

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[3] United Nations Policy Brief: COVID-19 and the Need for Action on Mental Health, C.5. URL: https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf (Accessed 13.11.2022).

spiritual life generated by the disease; the description of pastoral tasks and ways of their implementation in the conditions of a modern city parish also requires specification.

The Church considers mental illness as one of the manifestations of the common sinful damage of human nature. The attention of the Orthodox Church to the problem of depression is determined not only by the concern for the mental health of its members, the ascetic heritage speaks of the passions of sadness and despondency that are close in symptomatology (Larchet, 2007); the latter The Ladder of Divine Ascent calls "the death of the soul" and the worst that can happen to an ascetic. The causes of sadness and despondency in patristic literature are most often called deprivation of the desired, anger and the influence of demons on a weakened soul (Larchet J.-K., 2007). At the same time, the rev. John Cassian the Roman notes that sadness and despondency can be born "without any external excitement", St Varsonofy the Great, answering the question of where despondency comes from, points out that "there is natural despondency, from impotence, and there is despondency from a demon," in which we find a parallel to the concept of endogenous depression in modern psychiatry. The work of our almost contemporary, Bishop Barnabas (Belyaev) "Fundamentals of the art of holiness. The experience of expounding Orthodox asceticism", which is still recommended for future pastors to study, suggests to distinguish between demonic and natural despondency.

The basis of the social concept of the Russian Orthodox Church, states: "Singling out the spiritual, mental and bodily levels in the structure of the personality, the holy fathers drew a distinction between the diseases which developed «from nature» and the infirmities caused by the diabolic impact or enslaving human."[4] At the same time, Metropolitan Anthony of Sourozh (Bloom) noted: "We cannot say where the emotional ends and spiritual begins, but there is an area where in the most natural way a mutual inter-penetration takes place".

In general, it can be concluded that depression is perceived by the Church as a manifestation of the inherited general damage of human nature during the fall, developing as a result of the influence of biological, social, psychological factors, as well as personal ones – the value-semantic sphere, lifestyle, coping strategies, etc.

The vast majority of secular studies also positively evaluate the influence of developed religiosity or spirituality on the course of depression. (Braam A. W., 2019; Pargament K. I., 2009; Levin J., 2010; Koenig H. G., 2012.; Bonelli R., 2012; Kopeyko G.I., 2020).

They usually associate the positive effect of religiosity with:

- giving meaning to the experience of the disease; rethinking the situation, oneself;
- greater social support that people included in the religious community have;
- available ascetic practices that resist depressive symptoms;
- a "relaxation response" generated by religious practices, which can serve as a protective factor against the harmful effects of stress on the body.

As factors inherent in the spiritual life of Orthodox Christians that have a therapeutic effect on the course of depression, we highlight the focus on the development of the value-semantic sphere (the Image of God, synergy, service), endowing suffering and experience of illness with meaning, the practice of repentance (mind change), of sobriety and struggle against thoughts, attention to the moral and ascetic state that implies the separation of illness or passion from a person, not narrowing the individual dawn to nature, and righteousness as the goal and means of healing. This undoubtedly gives a rich toolkit for countering the feelings of meaninglessness of life, hopelessness, catastrophizing and loneliness inherent in

[4]*The basis of the social concept of the Russian Orthodox Church,, URL: http://www.patriarchia.ru/db/text/419128.html (Accessed 3.11.2022).*

depression and reinforced by the stigmatizing attitude of society to mental illness. The Orthodox doctrine can also provide considerable help in "disarming" pseudo-religious beliefs and myths, in order to dismantle the disease of religious content, often found among mentally ill people who were brought up in Russian popular culture, but who did not receive Christian instruction in the faith and were not churched.

However, we consider it important that secular studies refer to the religious coping as "the use of religious beliefs or practices in order to eliminate or mitigate negative consequences and develop adaptive behaviors that maintain psychological balance in a situation of mental illness." The outstanding Russian scientist Fyodor Vasilyuk in his article "Types of spiritual coping"[5] calls this type of coping "instrumental", since the crisis situation itself is considered as a problem, as something that needs to be resolved, eliminated, overcome. In this case, consciously or not, purposefully or not, coping helps to cope with the situation, but leaves a person in the same plane of being – the plane of adaptation, which, in our opinion, is more consistent with the field of activity of a psychotherapist than a priest.

The Russian Orthodox Church also believes that the mental health of people is a field of joint responsibility of clergy, psychiatrists and other specialists of mental health services.[6] A workshop of the XXVII International Christmas Educational Readings was devoted to the topic of depression. Based on the articles and interviews about pastoral care of Christians with depression by Orthodox priests who have a secular education in psychiatry and professional experience as psychiatrists (Gusev V., 2019; Novitsky V., 2018; Odyakov I., 2019; Filimonov S., 2009) we can define the following tasks of a priest to help people with depression:

- The ability to recognize the disease. Understanding the nature and stages of the disease and of the recovery.
- Assisting a person in awareness raising about morbid nature of certain experiences and the need to consult a medical specialist, examination and, if necessary, systematic treatment;
- Understanding where exactly to send a person and his relatives to receive psychiatric, psychological and other assistance;
- Work with relatives in order to gently but persistently explain the nature of the disease and the need for medical treatment;
- Participation in spiritually oriented programs. Providing spiritual support before, during and after rehabilitation, and including the suffering person in the life of the church community.

In general, this part of the pastor's activity can be characterized as support in obtaining professional assistance or, in terms of modern Orthodox addictology, the principle of delegation. This is an important, reasonable and effective position both from the point of view of recovery and from the point of view of mercy to the suffering person (after all, suffering during depression, as experience shows, even for a Christian can become beyond his strength and lead, if not to suicide attempts, then to a secret desire for premature death) .

Often an Orthodox parish combines both the possibility of confession and of a spiritual conversation with a priest, where there are an Orthodox parish psychologist or counselor and a psychiatrist – parish member. Belonging to the same parish and the

[5] Fedor Efimovich Vasilyuk (1953-2017), Doctor of Psychological Sciences, who worked in a psychiatric hospital for more than 6 years, headed the laboratory of the scientific foundations of psychotherapy of the Psychological Institute of the Russian Academy of Education.

[6] Pastoral care in the Russian Orthodox Church for the mentally ill people (Document of the Commission of the Inter-Council Presence of the ROC URL: https://www.diaconia.ru/pastyrskoe-popechenie-o-psikhicheski-bolnykh (date of application: 10.12.2022).

same value field make it possible to establish more effective interaction of three specialists.

At the same time, the Orthodox Church believes that even with the apparent absence of psychopathological symptoms, "it is impossible to preserve genuine mental health, only taking considering the bodily nature and psychosocial well-being of a person, while ignoring his moral and ascetic state, worldview and his relationship with God."[7]

Therefore, it is important to emphasize this task of realizing and clarifying one's own worldview and relationship with God, which has a huge potential for recovery. And here the provisions of church doctrine are very helpful, such as understanding the goal of Christian life in revealing the image of God, awareness of the value of life regardless of the condition and with any "achievements", healing of human nature damaged in the fall, in the process of cooperation between God and man (and even influence on the whole creation).

It is in the Church that the state of impossibility, helplessness and impotence, trouble, which are inherent in depression, is perceived under the sign of mystery; it opens in these circumstances the entrance to a new reality in which the circumstances themselves acquire, perhaps, a tragic, but deep life meaning: "Misfortune, pain, illness remain themselves, but they are understood not as something accidental, internally unrelated to my fate, but as some kind of "geological fault" of being, which reveals the previously invisible roots and layers of my life, as something deeply meaningful, a new turn in life, as a challenge and a call. The rational approach to what is happening, the personal problem that needs to be solved, are replaced by the vision of the crisis as a mystery that opens up the possibility of the presence of not only the person himself." The focus is on man's relationship with God, its establishment and development, the fulfillment of God's plan for man.

It is worth noting here that the spiritual tradition of the Orthodox Church sees in the "way of salvation" – the healing of the human nature damaged in the fall – in the process of *synergy* – the collaboration of God and man, aimed at the maximum disclosure of the image of God in man, the ultimate goal of which the Orthodox tradition sees in *theosis*, which is possible only in such a relationship with God, which, ultimately, can be described as unity.

"Relations with God" may seem to be a rather narrow Church-related area, however, more and more psychiatrists today pay attention to distortions of spiritual life manifested by psychopathological phenomena (Kopeyko G.I., 2021):

- Feelings that support religiosity (consolation, justification, freedom, joy) disappear from prayer, sacraments, and life in the Church.
- The feeling of sinfulness becomes pathological, up to despair and delirium of guilt. A person does not find faith in forgiveness, in the afterlife and resurrection.
- There is a feeling of God-abandonment: "God does not hear me, prayer does not reach, God has left, is angry, or maybe He simply does not exist."

That is, there is a distortion of the image of God and oneself as the image of God, which deprives a person not only of spiritual support in overcoming a depressive state, but also of the basis of Christian being.

Moreover though, it is amazing how much attention pays the ascetic heritage of the Orthodox Church to this phenomenon: "For at other times our soul suffocates... this hour is filled with despair, hope in God and the consolation of faith in Him completely

[7] Pastoral care in the Russian Orthodox Church for the mentally ill people (Document of the Commission of the Inter-Council Presence of the ROC URL: https://www.diaconia.ru/pastyrskoe-popechenie-o-psikhicheski-bolnykh (date of application: 10.12.2022).

depart from the soul, and it is entirely filled with doubt and fear," "Despondency is a slanderer of God, as if He is merciless and inhuman."

On the way to promote recovery, rehabilitation and subsequent prevention, which open up in the church community, one can also see specific unique properties. This is the Eucharistic nature of the church consciousness, which pushes to discover the ability to thank, also for the experienced or even the ongoing situation. The repentance that has a leading role, gives rise to a tendency to metanoia – the need for internal changes, not wanting to return to the past, even if there was no suffering. The co-working as a way and the conciliar nature of the Church gives rise to the feeling that not only God, but also the affected person himself and other active participants are involved in the situation of the person's illness and recovery – not only physically, but also spiritually, and mentally, in some not fully understandable way.

Thus, it seems to us that the main content of the activity of a clergyman on the way to helping a person in depression, in addition to introducing him to the sacraments of the Church, to the delegating and interaction in a priest-psychologist-psychiatrist bundle are:

- maintaining the conviction of a depressed person in Christ's love and his own dignity as an image of God, which are necessary for the correct perception of God and which directly affect the relationship with Him;
- teaching the skills of genuine spiritual coping based on the theology of the Orthodox Church;
- such an organization of parish life that would allow a suffering person to use all the advantages of church life: Eucharistic, tendency to metanoia, co-working and conciliarity.

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Pavlova O.S.

Ethical and spiritual understanding of depression in the Islamic tradition

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).

Summarizing, 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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Alexander Moreira-Almeida

Bio-psycho-social-spiritual approach to depression

Abstract: The report is based on the book "Spirituality and Mental Health Across Cultures", published by Oxford University Press; in particular, chapter 1 of the book, which deals with the impact of spirituality on mental health and the various ways in which spirituality can affect depression, including biological, psychological and social aspects.

Keywords: spirituality, mental health, mental illness, bio-psycho-social-spiritual paradigm, religious involvement, intrinsic religiosity.

I will start presenting very briefly some major findings about the biological psychological, social, and spiritual aspects of mental disorders; and how can we integrate all of them in a more comprehensive approach to depression. My report would be based in our research book “Spirituality and Mental Health Across Cultures”, as well as on the position statement for the Word Psychiatric Association on religion and spirituality [«World Psychiatry», 2016].

First of all, let's discuss the meaning of religion or spirituality. Basically, what is at the core of all spiritual traditions across cultures and across ages, is that the spirituality is the relationship or contact with a transcendent realm of reality. We are stressing, that realm of reality may be God, God's, spirits, ancestors. But basically at the core of all spiritual traditions, is a trust that they are real, that is considered sacred, the ultimate truth or reality. And religion is the institution or communal aspect of spirituality.

It's important to remember that the health and disease is a dynamic balance between factors that cause disease, the patogenic factors, and also factors that promote health, the salutogenic factors – biological, psychological, social, and spiritual. The goal of our treatment is to decrease the patogenic factors and increase the salutogenic factors.

In order to study the integration of all these factors into spirituality, a very interesting work was carried out, that followed up 74,000 people over 16 years [Li, S. et al., 2016]. It was found that those who attend religious services at least once a week, had 50% lower mortality compared to those who do not attend.

Spirituality can impact health through different pathways, for example, through biological pathways. A part of this decrease in mortality was explained f.e. by lower levels of smoking tobacco – 22 % of this decrease in mortality was due to smoking behavior and biological factor. And f.e. social aspects – the social integration explains the 23 % of decrease in mortality. The psychological aspects, like depression and optimism explain respectively, 11 and 90 %. So we can see here, how a specifically religious behavior, such as religious attendance can impact health in different perspectives, different ways – through biological pathways, psychological, and even behavioral, and biological mechanisms.

The impact of spirituality manifests itself in various aspects of depression, such as f.e. suicidal deaths. In this study almost 90,000 people were followed up for 14 years, and those who attended religious services died six times less from suicide than those who never did [VanderWeele et al., 2016].

Another example is offspring children from people who had a severe depression. These children, when they consider religion or spirituality highly important to them, had 10 times lower risk of depression than those who consider the religion less important [Miller L., 2014].

In terms of the biological aspects in this same sample of children of people with major depression we studied the cortical thickness, and could find that people with high

levels of religious involvement had a cortex much thicker than those with lower levels of religious involvement (the red areas on Fig. 1 and 2).

The cortex was thicker among those who had higher levels of religious involvement. It shows the importance of the impact of religious involvement in neurobiological correlates.

Figure 1. Associations od religious and spiritual importance with cortical thickness.

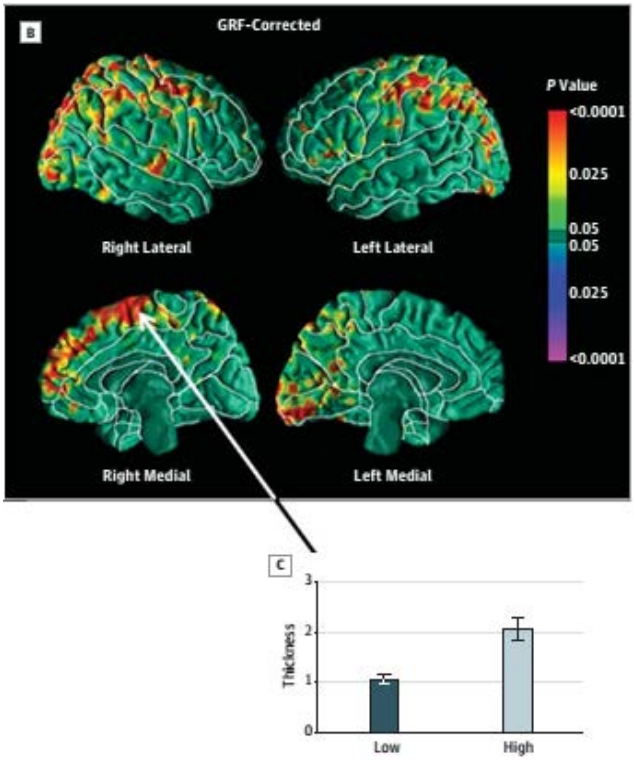
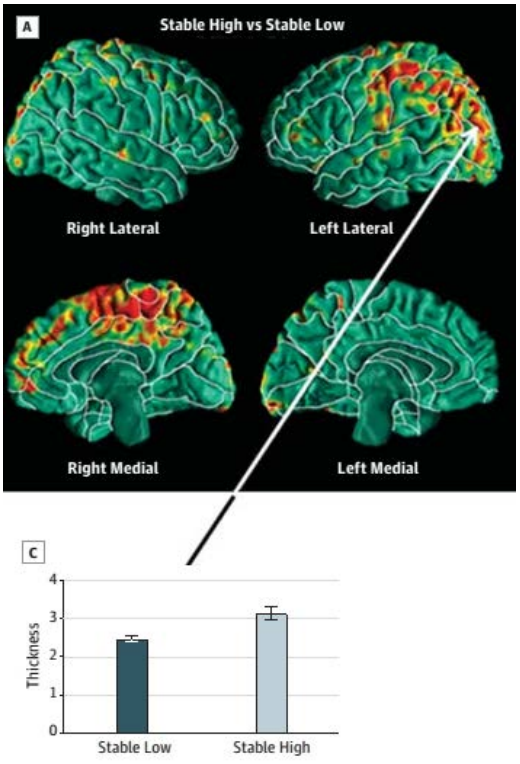
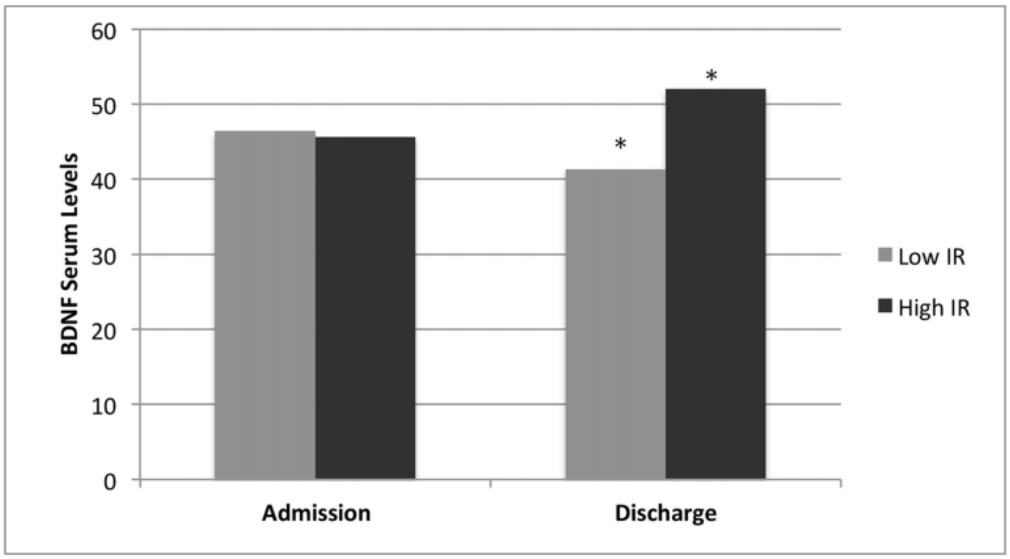


Figure 2. The effect of stable importance during a 5-year period.



In 2019 a study was published in Brazil based on the investigation of 100 inpatients with severe depression [B.Schor et al., 2019] and their BDNF - the brain-derived neurotrophic factor, related to brain neuroplasticity. We found that during the psychiatric hospitalization patients, who had higher levels of intrinsic religiosity, had a higher increase in levels of BDNF, than those who had lower levels of intrinsic religiosity. In the “admission” patients had similar levels of the BDNF, however, at “discharge” those, who had higher levels of intrinsic religiosity, had also higher levels of the BDNF (see Fig. 3). That may be a possible pathway, by which religious involvement could generate higher plasticity, higher recovery. And as we saw previously, the even cortical thickness is altered.

Figure 3. Increased levels of BDNF are associated with high intrinsic religiosity among depressed inpatients.



Our group conducted a study investigating 160 bipolar out-patients. We found that patients, who had higher levels of intrinsic religiosity, had five times less depression than those who had lower levels of intrinsic religiosity. [A.Stroppa, A.Moreira-Almeida. Religiosity, 2013].

Even when we did a two year follow up in this group of bipolar patients, we found, that positive religious coping in the beginning predicted higher levels of physical, mental, social, environmental quality of life two years later.

However the negative religious coping was a strong predictor of lower levels of mental and environmental quality of life. That means that the way that we use religion in coping, in a positive or negative way can impact. This is very important because after two years of follow up and treatment, most patients of this sample were iltimic – they had no depression, no mania, but despite of that they had a strong variation in quality of life. Full recovery is much more than just having no depressive or manic symptoms, for example, quality of life is important. And religious coping was a powerful predictor of quality of life two years later.

Because of that, increasingly higher attention is given to the investigation of the importance of integrating spiritual approach in the treatment of patients with mental disorders. A systematic review by J.P.Gonçalves et al., (2015) shows the efficacy of integrating spiritual interventions in patients with mental disorders.

Based on all these data, the Word Psychiatric Association published a position statement on spirituality and religion in psychiatry with guidelines instructing psychiatrists around the globe to take into consideration patients' religion and spirituality: “Regardless of precise definitions, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders and the patient’s attitude toward illness should therefore be central to clinical and academic psychiatry… A tactful consideration of patients’ religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking” [«World Psychiatry», 2016].

In this bio-psycho-social-spiritual approach we need to take in consideration also the physical, mental and spiritual aspects. The exploration of the patient’s spirituality must apply an open-minded approach with genuine interest and respect to

patients' beliefs, values and experiences, of course never prescribing or imposing religious or anti-religious perspectives. The clinicians also shall explore their own worldview and history on religion / spirituality issues. The approach must be patient-centered and be focused on the patient and his values; and try to understand how these religious behaviors, believes and communities can be harmful or positive to patients.

We just published a review of randomized control trials of cognitive behavioral therapy integrated with the spirituality [M.de Abreu Costa, A.Moreira-Almeida, 2022]. This systematical review has shown that spiritually integrated CBT has efficacy on a wide variety of mental health disorders. We selected in this paper the world interventions that proof the effectiveness of this approach. One important aspect in this approach is taking spiritual history, asking the patients if they have a religious or some sort of spirituality, if they attend some religious group or community, if they have religious practices, prayer, religious readings and also very important – if and how their religion or spirituality impact in a positive or in a negative way their stressors and their mental disorders. And specifically, in the treatment we could have a collaborative approach with the patient, exploring potential, useful, spirituality or resource that the patient may have. For example, the habit of reading and contemplating religious texts makes cognitive rethinking in a more meaningful perspective, that is provided by the patient's specific religious tradition and religious community. What matters is also patient's religious rituals that they are involved with, the acts of prayer and meditation, an active engagement in religious activities, for example, attending religious service, but also involvement in volunteer work, like the church choir or things like that. This is part of behavioral activation and will help patients become more active and then reduce their depression.

Taking this spiritual approach does not deny biological factor, as well as the pharmacology and psychotherapy of the patient. We need to integrate all these factors together to promote a faster and fuller recovery of the patient.

It's important to see that several leading academic journals and books have discussed about the importance of partnerships with religious communities in public health issues [C. Schumann, A. Stroppa, A. Moreira-Almeida, 2011; S. Barmania, S.M. Aljunid Faith-based health care, 2016; D. Oman, 2018; E. Idler, J. Levin, T. J. VanderWeele, A. Khan, 2019; K.N. Long, R.J. Gregg, T. J VanderWeele, D. Oman, L.D. Laird, 2019]. It is very important that people from public health and those having connections with religious communities work together in promoting health and recovery among our patients.[1]

The following reasons for the integration of religion / spirituality and mental health can be identified [F.H.A. de Oliveira e Oliveira, J.R. Peteet, A. Moreira-Almeida, 2020]:

- most of the world's population has religion / spirituality,
- usual coping strategy,
- religion / spirituality impacts health,
- addressing religion / spirituality impacts prognosis,
- patients want clinicians address religion / spirituality,
- bio-psycho-social-spiritual approach is a component of an integral patient's assessment,
- recommended by medical / health organizations.

So in respect to the available evidence into the religious and spiritual believes, behaviors and values of most of world's population it is not inappropriate, but a

[1] Training program for psychiatric residents in how to include spirituality in their training https://www.youtube.com/nupesufjf
Guidelines and the evidence on the subject: www.ufjf.br/nupes-eng

scientific and ethical responsibility of ask the nations to integrate religion and spirituality in clinical care and in public health [A. Moreira-Almeida, B.P. Mosqueiro, D. Bhugra, 2021].

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Archpriest Viktor Gusev

Two conceptions of religiosity. To the understanding of the paradigm

Abstract: The purpose of this report is a detailed analysis and comparison of different understandings of the word “religiosity”. Such an analysis is aimed at understanding the essences, meanings and will not be limited only to the consideration of theoretical and abstract ideas. To understand religiosity in the context of scientific research and evaluate the results obtained, it is important how exactly the researcher thinks about God and His relationship with the world and man, what his worldview is. The secular approach, which works quite well in certain areas, is absolutely insufficient and inadequate in the case of studying human religiosity, since God is either absent from it, or He “occupies” a position that is not appropriate to Him.

Keywords: religiosity, secular religiosity, Orthodox religiosity, attitude towards religion.

1. Problem statement

In scientific research, the question of how we relate to religiosity seems to be quite fundamental, which is related to the context in which we consider religion: the research itself and its results can take completely different, directly opposite interpretations, the context depends on the paradigm that we consciously or unconsciously adhere to.

For example, if a scientist does not admit the reality of God and, therefore, does not accept that a person can establish a real relationship with God, then such a researcher can easily and “naturally” perceive various religious experiences of a person as manifestations of delirium or overvalued ideas. In other words, how the researcher will perceive and evaluate the results he will receive depends fundamentally on how he thinks about God and about His relationship with the world and man. And here, it is not the results of the study as such that come to the fore, but the worldview of the scientist.

I will give a short illustration. Once I had a conversation with one person. He had remarkable personal qualities and moral principles, but he was also an atheist. For about two hours we talked with him about faith, and when all the arguments testifying to the existence of God that I could bring were exhausted on my part, I asked him: “Tell me, can you imagine at least some fact, phenomenon, a miracle that would show you that God exists?” He replied immediately: "No!" In this case, the main point was not the facts, or logic, or the reality around him, but the basic a priori accepted unshakable attitude, into which all arguments crashed.

2. Secular and Orthodox understanding of religion. Definitions. Comparison. Impact on the subject of study and its correctness

So, coming back to the issue of different paradigms, it should be noted that in relation to religion, there are two fundamentally different approaches. One of them is secular. The other is properly religious. Let's take a look at them.

2.1. Secular approach

First, about the secular approach. Here are a few examples of how the religiosity is defined:

•“Religiosity is a characteristic of the consciousness and behavior of individuals, their groups and communities, who believe in the supernatural and worship it.”[2]

[2] Encyclopedia of Sociology, 2009.

•“Religiosity is the quality of an individual or group, manifested in the belief and worship of the supernatural. A characteristic sign of religiosity is religious faith, which includes knowledge and acceptance of religious ideas, concepts, dogmas as true.”[3]

•“Religiosity is the worldview orientation of an individual and a group, expressed in the set of religious characteristics of consciousness, behavior, and relationships. A common feature, a criterion of religious consciousness is religious faith, which includes knowledge and acceptance as true of religious ideas, concepts, myths and confidence in the objective existence of the supernatural”.[4]

•“Religiosity is one of the main categories of the sociology of religion, reflecting the state of consciousness of believers, both at the level of an individual and a social group. A characteristic feature of religiosity is belief in the supernatural, which is the object of worship”.[5]

•"Religiosity is closely related to the worldview and religious consciousness, which are changing under the influence of freedom of conscience and a transforming society, in the realm of the modern religious situation in Russian society".[6]

You can see how organically and naturally the atheistic definition, presented in the atheistic dictionary back in 1986, fits into this series. Religiosity can be viewed as a phenomenon (or social quality) associated with the worldview or state of consciousness of a person or group, one way or another dependent on society.

Religiousness of the population and prosperity of society

Independent American researcher G.Paul (2009) performed a comprehensive cross-national analysis of the impact of mass religiosity on the prosperity of society. The analysis included only data for prosperous First World democracies with a population of about 4 million people or more. 17 countries were under review: the USA, Ireland, Italy, Austria, Switzerland, Spain, Canada, New Zealand, Australia, the Netherlands, Norway, England, Germany, France, Denmark, Japan, Sweden. The author came to the following conclusion: the more confident and comfortable people feel (primarily the "middle class") in their social environment, the less they worry about their economic well-being, the weaker their need to seek solace and protection in religion. The results of the study, according to the author, indicate that religiosity is a relatively “superficial”, flexible, changeable psychological mechanism that helps to cope with stress and anxiety in an inefficient society with a low level of socio-economic stability and security. The mass retreat from faith in God, in turn, is a natural reaction of people to the improvement of living conditions. That is, religiosity is seen as a kind of superficial, flexible, changeable psychological mechanism that helps to cope with stress, and nothing more.

Some researchers define religiosity as “excessive or affective religious zeal” [D.K. McKim, 2014]. That is, religiosity is perceived as a kind of affective manifestation, which lacks sufficient intellectual work. Such a position is not surprising - it is inherent in people of modern secularized society - non-religious and - most importantly - who do not have their own real religious experience. In such cases, there really is no adequate understanding of the essence of religion, religiosity in general, and the religious experience of a believer.

Professor of St. Petersburg State University E. A. Ostrovskaya, in her interview to the ‘Sreda’ research service, defined religiosity as follows: “By religiosity I understand the phenomenon of consciousness, worldview, adherence to a certain

[3] Russian sociological encyclopedia. — M.: NORMA-INFRA-M. G.V. Osipov. 1999.
[4] Atheistic Dictionary.— M.: Politizdat. Under total ed. M. P. Novikova. 1986.
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[6] Religious scholars Kuraev V.I., Kyrlezhev A.I., Sinelina Yu.Yu. (according to Khrapov S.A., Samaeva A.K.).

religious ideology, embodied in activity and everyday goal-setting. As a phenomenon, a special state of individual consciousness and a worldview, religiosity is studied by the psychology of religion, the philosophy of religion, and the phenomenology of religion. Within the framework of the discipline of the sociology of religion, religiosity is the subject of scientific study in its activity related, worldview, ideological manifestations.

This definition emphasizes that religiosity is embodied in human activity and goal setting. "Faith without works is dead," the Holy Scriptures teach us.[7]

Speaking of religiosity and goal-setting, I cannot but note a very important aspect. Just as in psychology there can ve declared and real values, it can also be that religiosity is only declared, but has no real effect on a person's life. In fact, this is a special and very non-trivial task - to determine the degree of religiosity of the subject. And it seems that this task should be solved on the basis of how religiosity is understood. In this sense, the methods used in assessing secular religiosity will hardly be applicable in the study of religiosity proper. Special approaches need to be developed, oriented both to Orthodox anthropology and to the practice of Christian life.

2.2. Two attitudes towards religion - secular and Orthodox

Therefore we can see that religiosity is a kind of projection of a person's relationship with God on the soul of a person and on his whole life. What a person is guided by in this world directly depends on the understanding of God, the relationship of a person with Him and on his attitude to religion in general.

There are two completely different approaches to religion in the modern world.

In the secular sense, *religion* (lat. religio) is a form of reflection of reality in fantastic images, ideas, concepts. [8] That is, the main, determinant characterictic of religion is belief in the reality of the supernatural. This is a generalized secular understanding of religion and religiosity. And we can understand religiosity just about as indicated above, and, for example, study the relationship between such religiosity and depression. The results that we will receive will, quite predictably, describe no more than one of the forms of reflection.

However, there is a different approach to both religion and religiosity, based not on their theoretical study from the outside, but on the real experience of mankind in the process of real interaction between man and the Living God; experience accumulated over several thousand years.

Hieromartyr Mikhail Cheltsov defines religion as "an interactive relationship of a person with his like, but his higher, mysterious being, called God, embracing the whole person and elevating him to union with God in prayer and to likeness to God in life." [9]

You can see how different are the realities behind these two definitions, what different life experiences, the disposition of the soul, meanings, worldviews, attitudes towards others, motives for actions, ways to cope with difficulties in life.

Religiosity based on the latter definition can be called proper religiosity - Orthodox - in contrast to the secular, described earlier. In this religiosity, we see, on the one hand, the unconditional acceptance of a really existing God, quite definitely understood and perceived, and which is a Basis for everything; on the other hand, we see the closest connection, the living interaction of man with the Living God. And by trying to study religiosity itself outside of this context, we will lose sight of the very essence of the phenomenon and, accordingly, all our reasoning and “measurements” will become meaningless.

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[7] James 2:17-20.
[8] A new dictionary of foreign words. - by EdwART, 2009.
[9] Hieromartyr Michael Cheltsov. Christian worldview.

That is, in order to study real religiosity we need to include God in our paradigm not just as another theoretical concept, but in His real Being and in His real interaction with the world and man. It becomes clear that, without being aware of what kind of religiosity we are going to explore, in principle, a real adequate way to study cannot be found. Since each type of religiosity requires a specific approach for its assessment. If this specificity is not taken into account, then we can become like a person who, studying deep psychological (or socio-psychological) phenomena – f.e., love, friendship – will pay attention only to the mass of subjects or to the physical distance between them.

2.3. Conditions for the correct studies of religiosity

So, in order for our research, one way or another related to religiosity, to be correct, it is absolutely necessary that the researcher at least:

- would be aware that there are two types of religiosity;
- would correctly understand their fundamental essence;
- would be aware of what exactly he is going to study;
- would openly declare (warn) about it;
- would use the appropriate tools, approaches and take into account the appropriate context.

3. Two paradigms: attitude to man

In terms of understanding the fundamental features of these two types of religiosity, the most important are two questions to which these two paradigms answer in different ways:

1) God's place in this world (relationship between God and the world);

2) human anthropology.

3.1. Secular paradigm

Here are the main approaches to the person in various sciences. Each following approach includes the previous ones:

1) Man is predominantly viewed as a physical body. This approach is implemented to a large extent in physics (mechanics), chemistry.

2) Man as a living being (actually an animal). The approach is characteristic of anatomy, physiology, and to a large extent of somatic medicine.

3) Man as a being endowed with a psyche (understood in one way or another). An approach that is used in psychiatry and psychology (the study of perception, memory, attention, thinking).

4) Man as a whole, in all the diversity of this life, including such spheres as social life, information, culture, history, technology, "spirituality".

Pay attention to the fact that in the first three approaches listed above, God as such is not present at all – as it were “no place” for him. In the fourth approach, the man is incorporated into the world and represented in all the diversity of this life, included in its various spheres. However, in this case, one of the features of such an attitude is the following: God is perceived on a par with all other aspects of a person's life: family, science, culture, health, career, entertainment...

It should be said separately about spirituality. This is a very broad topic. The main thing is that "spirituality" in the secular and in the truly Christian, ascetic sense has practically nothing in common. So, in the secular sense, we call "spiritual" the highest manifestations of culture (music, painting, poetry, prose) – something that is not related to the material. From the Orthodox point of view, "spiritual" is where God acts – the Holy Spirit, the second Hypostasis. Where there is no God, it is not correct to talk about

spirituality. Moreover, from the point of view of Christian asceticism, everything is even stricter. [10]

The secular concepts considered above, which work well enough in certain areas, become absolutely *insufficient* and *inadequate* if applied to the study (taking into account) the real religiousness of a person. Since God is either absent in them, or He "occupies" a position that does not correspond to Him.

At this level of perception of the world and man, a place for God appears (or does not appear, depending on the attitudes of the researcher: nothing prevents him, for example, from remaining an atheist). And this place can be completely different, ranging from a relatively "superficial", flexible, changeable psychological mechanism" or "excessive or affective religious zeal" (which we have already seen) that is, some psychological conditions, and ending with the recognition of the existence of God as one of the adjacent (that is, equivalent, located in the same row) factors of this world. For example, cultural, informational, spiritual, scientific fields… I would like to note that the place of God in such a picture of the world is very limited and fixed.

3.2. Orthodox perception

In Orthodoxy, a person is initially perceived as God's creation (that is, directly in the context of relations with God). A creation that initially has a certain meaning, the goal of its existence and the structure (arrangement), thanks to which a person is able to achieve this Goal.

God is a Personality, and man was created by God in His image and likeness and with a specific goal - deification (participation in the love, life and creativity of God) and has everything necessary to achieve it. Man is called to be in constant personal communion with the living God. Therefore, being with God is the natural state of man. Man is conceivable only in the closest interaction with God, his state of being is maintained by the good Will of God.

Moreover, God, as we know, is omnipresent. That is, "is present" at any and every point of this being. Orthodox theology says that this whole world, including you and me, is in a state of being only because God wants it. In this sense, God is not some sort of adjacent factor (albeit the most important) in this world. He is the First Cause of being and the only Reason for the existence of this world.

Figure 1. God and man

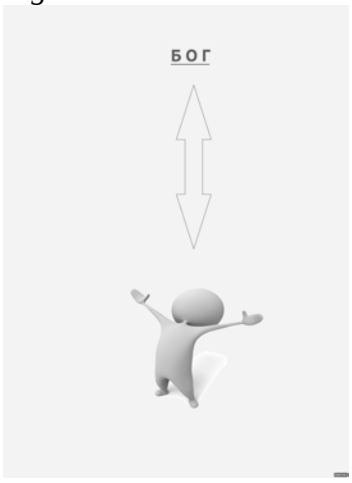
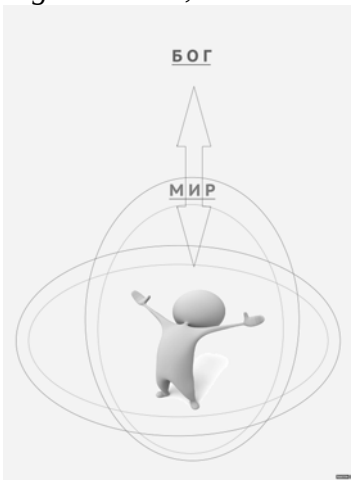


Figure 2. God, world and man



[10] From the point of view of ascetics, the true spiritual life begins only when a person (with God's help) conquers all his passions, including pride. Since only then does the person become truly capable of perceiving God, the words and actions of the Spirit of God and living, in fact, in accordance with this Spirit - i.e. "soak" with the Spirit of God, become one with Him. It is this kind of life that is, in the full sense of the word, spiritual.

That is, a person is originally and inextricably linked with God. And a person is included in all the diverse spheres of this world, which we have already mentioned (social life, culture, information, technology, etc.), but all these spheres exist in the context of the omnipresence of God (Fig. 2). God, out of His love, supports this whole world in a state of being, and as an omnipresent Being, “penetrates” this whole world. God calls man to constant communion with Himself and to deification. Man, on the other hand, exists in the world within all the diverse relations with it.

Let's make this scheme a little more complicated in order to make it more adequate, since we need to take into account that there is an ontological[11] barrier between God and this world (including man) - God and the world exist based on completely different principles of being (Fig. 3), because it is absolutely impossible to know God by purely human efforts and express Him in any human concepts. God is cognizable in such a way and to the extent that He Himself wants to reveal Himself. God Himself reveals Himself to the world and man to the extent and in those forms (concepts) in which He Himself considers it necessary. So God and this world exist, relying on completely different principles of being. It is easier to understand this with an example.

Once this world did not exist. Science introduces the Big Bang hypothesis; Revelation says that God creates this world with a word - with one motion of His Will. We shall note the following fact: there was no world, no matter, no space, no energy, no time, but God exists.

Figure 3. Ontological gap

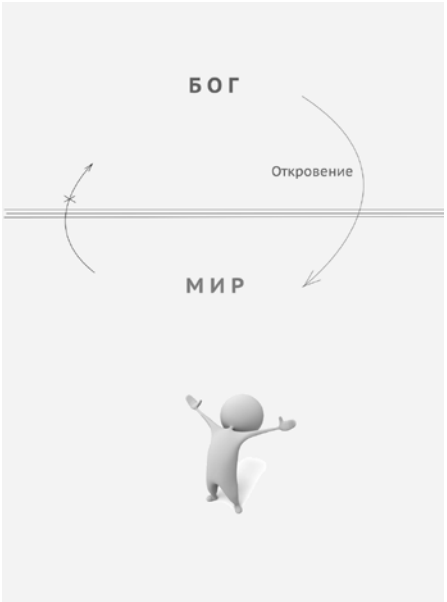
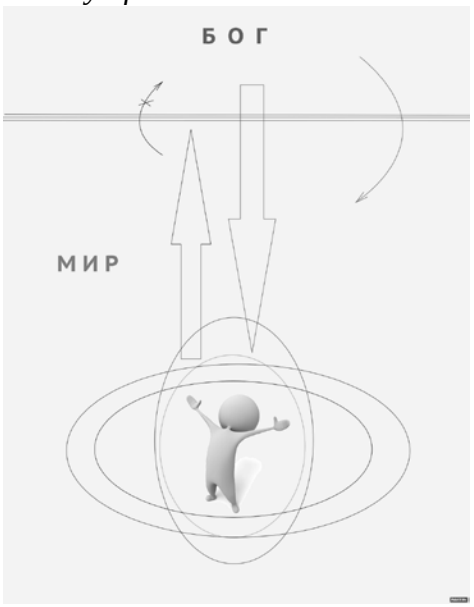


Figure 4. God, world and man in the entirety of relations



It is clear that God "relies" on some completely different, unknown to us, principles of being in comparison with our world - there is an ontological barrier between the world and God.

Can we imagine something that exists outside of time, space and energy? There is no such thing in our experience, since our entire experience and system of concepts (including scientific ones) are formed in this world. This means that we do not even have adequate concepts to realize, comprehend what is there, beyond the ontological barrier. In other words, God is absolutely unknowable by human efforts alone. If He

[11] "Ontological" - something that relates to the foundations, principles of being.

wants, He Himself can reveal to us something about Himself, this world and man. This is what we are given to know about God. This is called "Revelation". Therefore, the interaction of God, the world and man in this world (from the Orthodox point of view) - very schematically, roughly and approximately - can be depicted as follows (see Fig. 4).

The Good God, out of His Love, creates this world, bringing it from non-existence into existence and supporting it in the state of being. God creates man free in His own image and likeness. The incomprehensible God reveals himself to man in Revelation. God calls a person to fellowship with Himself and leads him to Himself, performing His Providence. Man is capable of deification (and overcoming the ontological barrier), which is accomplished by the power and will of God. God helps man in response to man's constant aspiration to God. Aspiration, expressed by human life and activity.

Thus, talking about real religiosity, its research and study with whatever approaches, we need to rely on this paradigm. That is, to consider the religious person under study, included in precisely such a context of being. Then our research will adequately take into account the realities that exist both in the human soul and in the surrounding world. And we will be able to correctly comprehend both the inner world of a person (including his religiosity), and the surrounding reality, as well as the interaction of a person with this world. In other words, we will be able to approach the Truth.

Otherwise, the meaning of religiosity, as mentioned earlier, will be reduced to a relatively “superficial” psychological mechanism aimed at coping with stress and anxiety in a society with a low level of socioeconomic stability [G.Paul, 2009]. Figures 5 and 6 present a comparison of secular and proper religiousness.

Figure 5. God – world – man relationship

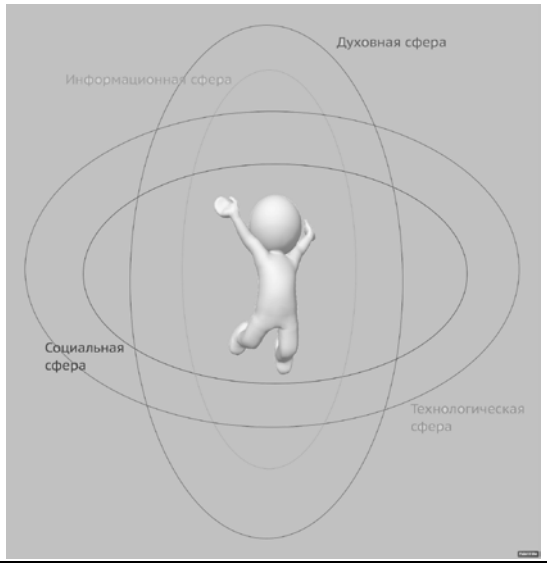
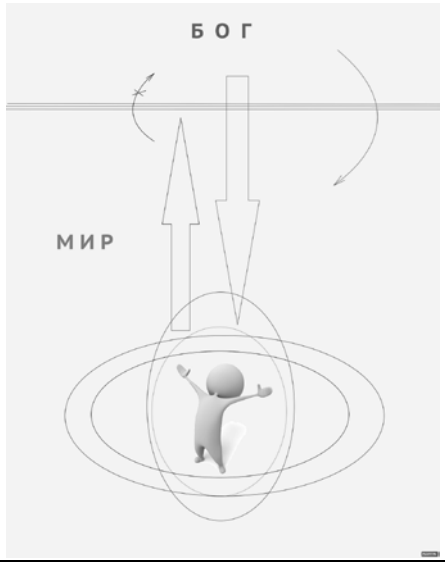
<table>
<tr><th colspan="2">GOD – WORLD – MAN RELATIONSHIP</th></tr>
<tr><td>POSITION OF SECULAR RELIGIOSITY</td><td>POSITION OF RELIGIOUSNESS PROPER</td></tr>
<tr><td> 
</td><td> 
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Figure 6. Attitude towards religion

ATTITUDE TO RELIGION	
POSITION OF SECULAR RELIGIOUSITY	POSITION OF PROPER RELIGIOUSITY
Religion is one of the forms of reflecting reality in fantastic images, ideas, concepts	Religion is the interactive relationship of a person with his like, but his higher, mysterious being, called God, embracing the whole person and elevating him towards union with God in prayer and to likeness to God in life.

Conclusions

Thus, we see that the secular approach is not adequate for the study of religiosity itself, and a correction of the research paradigm is required.

If we really want to study the impact of religiosity (in essence), we must realize that *religiosity itself*:

• does not fit into the traditional scientific paradigm;

• is not just another additional factor and does not stand among any other important factors;

• requires awareness of God as a Person;

• reflects the *interpersonal* relationship (or lack thereof) between man and God.

Such a paradigm should consider:

1. Real existence of God;

2. God, who is a *Person* (this is the greatest Revelation);

3. Religiosity as a reflection of the real relationship of a particular person with the Living God;

4. *Christian anthropology*, which is a complete picture of the interaction between man and God. That is, the existence of a person in the maximum possible context; a picture that allows a person to realize the higher meanings of his existence and build a consistent system of values based on these higher meanings.

Outside this paradigm, we will become like a researcher who does not set himself the task of understanding *what the reality he is studying in fact is*, who, not even trying to understand the *essential principles* of this *new reality unknown to him*, describes it in the way that seems right to him, relying only on his past experience and approaches that are not adequate for the new reality.

And if we hold a secular position in the study of reality, then we see a complete inconsistency and inadequacy of the research approach to the subject of study. And then we become like a small child who enthusiastically makes wonderful sand cakes in the sandbox and resolutely refuses to look around and see the wonderful huge world that surrounds him; the world that is ready to open (give) himself, true knowledge and life to this child.

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Experience of thematic analysis of the interaction of a psychiatrist, a psychologist and a priest when discussing a religious patient with depression

Abstract: This study aimed to explore the interaction of three practitioners: a psychiatrist, a psychologist, a priest, - when they analyzed the case of an Orthodox patient with an established depressive disorder. The research methodology was based on the ideas of F.E. Vasilyuk's psychotechnical theory (1992; 2016). Data collection and analysis was carried out in the format of a qualitative study involving following the method of mathematical analysis. During the research, we came to the conclusion that it is necessary to take into account the uniqueness of each specialist. In order to preserve the identity of the experience of different anthropological practices, it is necessary to organize a safe space of polyphonic dialogue in which different opinions can be heard.

Keywords: therapy of a religious patient with depression, interdisciplinary interaction, polyphony, synergistic psychotherapy, thematic analysis, religiosity, illness, personality, experience.

Nowadays, no one doubts the relevance of research into the possibilities of providing specific assistance to patients with depression, as the number of people suffering from this disease is steadily growing. During COVID, the prevalence of depression in the world, according to WHO, has increased by 25%[1]. Also the number of patients for whom the religious sphere is significant and for whom it is closely related to health, both mental and physical, is also growing. The influence of religiosity on mental health is actively discussed in psychiatry, psychology and in the field of pastoral care (Oman, Lukoff, 2018; Kaleda, 2021; Dubograi, 2018; Shankov, 2015; Shvetsov, 2003, etc.).

This study was conducted by an interdisciplinary team of psychologists, psychiatrists and a priest on the basis of the department for the study of special forms of mental pathology of the Scientific Center for Mental Health.

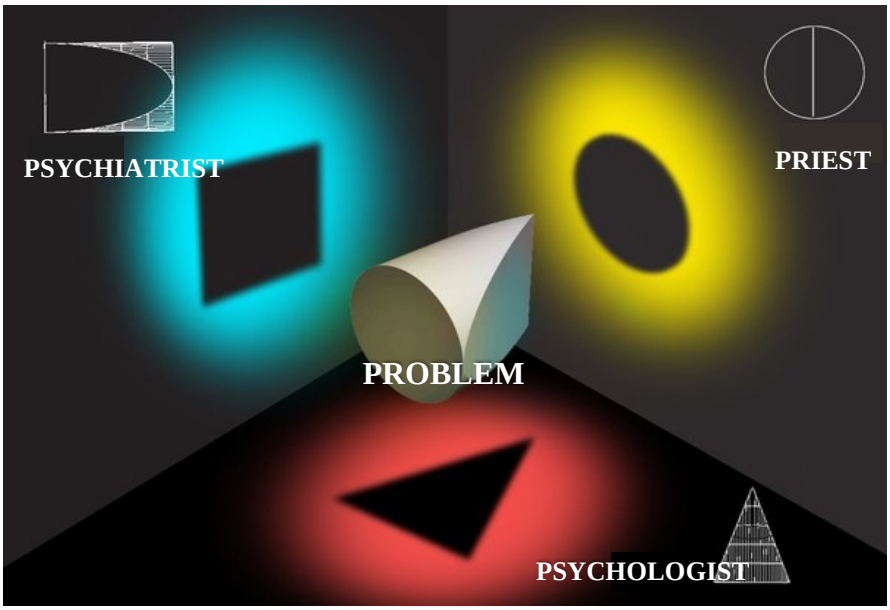
Problem statement

Until now, it seems difficult to unambiguously assess the relationship between religion and depression. Some researchers have noted that religious people cope with depression more easily (Bonelli et al., 2012; Kopeyko et al., 2020). On the other hand, cases are described when, on the contrary, the spiritual and religious beliefs can aggravate the clinical picture, since the formation of a religious world view is directly related with the mental illness (Borisova, Kopeyko, 2018). Some authors even consider the spirituality and religiosity as risk factors for mental illness (Leurent et al., 2013). A certain difficulty is involved in studying the relationship between religiosity and depression – each specialist defines religiosity, its place in the ontology of personality, and the very connection between religiosity and illness differently. Theoretically and empirically, this contradiction can be explained by the fact that studying the topic of spirituality and religiosity seems to be quite difficult, since: 1) there is no methodological approach that would allow us to come to a common understanding of spirituality and religiosity; 2) there are difficulties in separating the disease and manifestations of the patient's spiritual life; 3) the existing deficiency of measuring instruments and errors in the interpretation of the data obtained do not allow to draw unambiguous conclusions about the influence of religiosity on the mental state of a person (Berry, D., 2005).

In real practice, specialists may face the following challenges: *How to help a believer with depression? What should I do if the patient is "torn" between specialists that assist him, and work in different paradigms, think completely differently? How can specialists agree, coordinate professional actions with each other?* At the same time, the religious patient himself literally falls into a trap, receiving radically different recommendations from different specialists, sometimes contradicting each other. One specialist may express indignation about the work of another, thereby leaving the patient with a lot of unresolved questions about his own condition. If the patient does not meet "his" specialist, or he himself will not be able to creatively combine such different "optics", then, left alone with contradictions, he risks turning from a subject of health into an object of "good intentions" of helpers. In some cases, this can lead to the fact that the patient will not fully open his own experiences, will be passive in the formation of an internal picture of health, which will naturally reduce the effectiveness of psychotherapy and therapy in general.

Thus, the same case will be perceived differently by different specialists of the same field, and even more so by specialists of different helping practices (Fig. 1).

Figure 1. Views of practitioners on one problem



In the course of our research, we came to a consensus that we should not derive an arithmetic mean between views, but, on the contrary, it is necessary to take into account the uniqueness of the perspective of an individual specialist, since each of them has a “blind spot”, which is visible to another specialist. Therefore, in order to preserve the originality and experience of various anthropological practices, we focused on organizing the space itself for a polyphonic dialogue of voices expressing their opinion about the case.

A series of publications in the Moscow Psychotherapeutic Journal presents the analysis of one case by specialists of different profiles – a psychotherapist, theologian, psychiatrist, pastoral psychologist (Muse et al., 2006). Despite detailed descriptions of each specialist's own positions, as well as responses from other specialists and from the patient himself to these descriptions, a full-fledged dialogue did not take place. In our opinion, these authors failed to preserve the autonomy and originality of the experience of various anthropological practices, since they all sought to take some kind of middle

position. Obviously, the solution of such a problem requires methodological basis and solutions.

In our study, we relied on the methodological developments of F.E. Vasilyuk (Vasilyuk, 2008). He highlights common grounds on which different practices can be compared and the philosophy and anthropology behind them can be identified (Table 1).

Table 1. Characteristics of anthropological practices (Vasilyuk, 2008)

	Psychiatrist	**Psychologist (practicing understanding psychotherapy)**	**Priest**
Ultimate goal and value of practice	Health	Meaningfulness	Holiness
Ontology of practice (subject of the work)	Organism	Life world	Spirituality Soul
The problematic state of the person whom the practice addresses	Disease	Critical life situation	Sin
Ideas about the positive process of the "recipient", which the activity of the practice is aimed at	Restoration of functions, compensation	Positive experience	Metanoia
Nature of activity	Treatment	Psychotherapy, psychological counseling	Spiritual guidance, pastoral care
Methods of work	Clinical diagnosis	Understanding	Confession, conversation

The purpose of this study was an investigation of the features of specialists' categorical thinking in various fields and the possibilities of interaction between them by organizing a space of polyphonic dialogue, which would serve as a field for finding approaches to providing the most effective personalized care to a patient with depression. The subject of the study in this situation was the dialogue itself, the joint conceptualization of the case, the correlation of how specialists characterize the problematic state of a person. It was assumed that the possible tension that could be detected between the selected characteristics would not be removed, but used as a driving force for discussion and justification of their positions by specialists.

Participants and research procedure

The study examined the interaction of three practitioners (psychiatrist, psychologist, priest) who conducted an initial interview with a male 53 y.o. Orthodox patient with a diagnosed depressive disorder. The discussion was moderated by a researcher-psychologist.

Since this was the first time such a design was used, we had to solve a number of problems to implement a methodologically sound study. Firstly, it was necessary to

develop and justify the research method; secondly, to organize the space of polyphonic dialogue and establish its format; thirdly, to collect and analyze data. The study included the following stages:

1.Theoretical and methodological development of the method of interaction of specialists, called "**polyphonic concillium**" by analogy with the polyphonic supervision of F.E. Vasilyuk (a more detailed description will be given below).

2.At the first (preparatory) stage, specialists – a psychiatrist, a psychologist, a priest – conducted **individual conversations** with the patient. The psychiatrist, who had not previously met with the patient, was earlier acquainted with the anamnesis, using the traditional clinical and catamnestic research method.

3.At the second (main) stage, the case was discussed at a "**polyphonic concillium**" in two discussion circles. At the end of the discussion, some possible ways of further management of the patient were formulated.

4.At the third (analytical) stage, the collected audio protocols were **transcribed and analyzed** in line with the modern methodology of qualitative research using thematic analysis (Busygina, 2023).

5.At the final (reflexive) stage, when the obtained research results were presented to the specialists, a second discussion took place. After it, the specialists shared their individual ideas about the potential of the polyphonic method used during their practice. This stage was not originally planned and was presented at the conference.

Research methodology

While developing the research method, we relied on the ideas of the psychotechnical theory (Vasilyuk, 1992; 2016) and one of its practical embodiments – the polyphonic model of supervision by F.E. Vasilyuk (Sheryagina, 2020).

In the course of the work, based on the oral reflections of the participants, we identified the characteristics that outline the method being developed: *non-similarity, but consonance of voices; dialogic-polylogical; natural resistance in areas of tension; collaboration of participants.*

Research results

Comparison of categories used by specialists

The transcribed discussions were subjected to thematic analysis, during which we identified four main themes: **religiosity, disease, personality and experience.**

"Religiosity" and "Disease" were set in advance as part of the discussion of specialists. For example, specialists tried to answer the questions: *"How do you characterize the patient's problematic condition?", "How do you characterize his religiosity, does it influence the disease?"*. In addition, the following questions were identified for the interview with the patient, which did not lead to direct categorization: *"What is the patient's request to you as a specific specialist?", "Did the patient have any mystical experiences, and if so, how can you characterize their impact on the patient's condition?"* However, based on the results of the general discussion, two additional topics were identified – the "**personality**" found in the speech of a psychiatrist and a psychologist, as well as the specifically psychological topic of "**experiences**". For each specialist, categories were identified that are significant markers of the patient's condition on the topics described above (Table 2).

Table 2. Comparison of professional categories

Themes	Psychiatrist	Psychologist	Priest
Religiosity	- Religiosity as coping. - Living faith. - Religion as a value.	Consolation in religion. - Harmony. - A safe community space. - A living relationship with God.	- Self-sufficiency, maturity (in religious terms). - A living relationship with God (dialogical, dynamic). - Prayer as Communion with God. - Religiosity as a resource.
Disease	- Symptoms and description of the disease by the respondent. - Lack of connection of illness with spiritual life. - Illness as its own way.	- Mystical experience as one of the causes of illness. - Illness as a way to maintain contact with God.	- Illness as a special way, a plan. - Illness as a space of interaction with God. - Illness as no obstacle to religiosity.
Personality	- Preservation of humor. - Integrity. - Active search for help. - Healthy personality.	- Self-abasement. - Search for social approval. - Lack of subjectivity. Laziness, lack of will. - High demands on yourself.	—
Experience	—	- Internal conflict. - Resentment. - Regret. - Grieving.	—

In addition to the general comparison of categories, we compared specialists on each of the four topics. According to the analysis, the following were highlighted:

1) *specific categories* that occur exclusively in one specialist and are absent in other cases;

2) *"conflicting" categories* that enter into a substantive contradiction between two or more specialists;

3) *common categories* similar in content for two or more specialists;

4) *common meta-categories* that characterize similar large semantic blocks within the same topic for different specialists.

The theme of religiosity can be defined as a field of solidarity among specialists, in particular in the characterization of the patient's faith as "living" and dialogical. All specialists refer to the general meta-category of *religious coping*, however, they give it different characteristics.

Conflicting categories in the field of religiosity are found between a psychologist and a priest. The psychologist sees the patient's religiosity as a *function of social adaptation*, i.e. an opportunity for the patient to find a safe community of like-minded

people through religion. The priest, on the contrary, notes a *person's self-sufficiency in religious terms*, which is expressed in the fact that he does not seek spiritual guidance (Table 3).

Table 3. Characteristics of the patient's RELIGIOSITY by specialists

	Specific categories	**"Conflicting" categories**	**General categories**	**General metacategories**
Psychiatrist	- Preservation of the meaning of religious behavior. - Religion as a value. - Lack of search for mystical experience.	—	Living faith	Religious coping (religiosity as coping)
Psychologist	- Harmony (in religion). - Safe community space	Social religiosity	Living relationship with God	Religious coping (consolation in religion)
Priest	Prayer as communion with God	Self-sufficiency, maturity (in religious terms)	Living relationship with God (dialogical, dynamic)	Religious coping (religiosity as a resource)

In understanding the disease, all overlapping positions of specialists converge in the categories of understanding the disease. Specialists have close positions and complement each other, noting that *for the patient the disease is a special way, the way of relations with God, even the space of these relations.*

There are two differences between a psychiatrist and a psychologist. What a psychiatrist understands like patient's awareness of the *need* for treatment, a psychologist interprets as *excessive adherence to treatment*. Their opinions differ even more in explaining the connection between religiosity and illness in the patient. For the psychiatrist, the connection is not so obvious, while the psychologist notices that the development of the disease is associated by the patient himself with his mystical experience. However, there is not enough information to clarify the hypothesis, since this story is not presented clearly enough in the anamnesis (Table 4).

Table 4. Characteristics of the patient's DISEASE by specialists

	Specific categories	"Conflicting" categories	General categories	General metacategories
Psychiatrist	Symptoms and description of the respondent's illness.	- Acceptance and understanding of the need for treatment. - *The disease is not connected with spiritual life.*	The disease as one's own way.	The meaning of the disease
Psychologist	Healing from illness in a religious environment.	- Increased adherence to treatment. - *Mystical experience as one of the causes of illness.*	Illness as a way of maintaining contact with God.	
Priest	Illness as not an obstacle to religiosity	—	- Illness as a special way, a plan. - Illness as a space of interaction with God.	

When specialists discuss the patient's personality, there are practically no general categories, with the exception of "*learned helplessness*", which the patient himself initially spoke about and which was touched upon in the discussion by a psychiatrist and a psychologist. This topic most clearly shows the **confrontation of paradigms**: where the psychiatrist sees a healthy personality and integrity, the psychologist finds a lack of subjectivity and various manifestations-complaints (Table 5).

Table 5. Characteristics of the patient's PERSONALITY by specialists

	Specific categories	"Conflicting" categories	General categories	General metacategories
Psychiatrist	- Preservation of interests. - Syntonicity. - Critical thinking. - Preservation of humor.	- Active search for help. - Integrity. - Healthy personality.	"Learned helplessness" (picked up in the discussion as a quote from a patient)	—
Psychologist	- Sensitivity, shyness. - Search for social approval. - Laziness, lack of will. - High demands on oneself.	- Dependence on others. - Self-abasement. - Lack of subjectivity.		—
Priest	—	—	—	—

Complaints are revealed in more detail when the psychologist describes the patient's experiences. It is in this zone that the psychologist sees growth points and work opportunities and in conclusion, as a result of the consultation, the idea is formulated that the patient would benefit from the support of a psychologist (Table 6).

Table 6. Characteristics of the patient's PERSONALITY by specialists

	Specific categories	**"Conflicting" categories**	**General categories**	**General metacategories**
Psychiatrist	—	—	—	—
Psychologist	- Internal conflict. - Resentment - Regret. - Grieving.	—	—	—
Priest	—	—	—	—

Conclusions

Our research served as one of the stages of developing a strategy to help the patient by the team of practitioners (psychiatrist, psychologist and priest). To this end, the peculiarities of communication between specialists were studied, which made it possible to determine joint tactics at the points of greatest tension, revealed the need for specialists to listen to each other in order not to give contradicting recommendations. Though thematic analysis, four main themes were identified: religiosity, illness, personality and experience, which made it possible to identify common and conflicting categories.

During the discussion of the case, a different understanding of the "normality" of personality was noted in psychiatry (mainly reduced to the absence of pronounced negative disorders and personality transformation in the course of illness) and in psychology, which formed the basis of conflicting assessments of the patient's personality. A more detailed disclosure of complaints was noted when the psychologist described the patient's experiences. The specialist noted the therapeutic potential of work in this area; as a result the idea of conducting psychological counseling was formulated.

Thus, this study contributes to the comprehensive understanding of the phenomena of depression from three anthropological complementary positions (methodology of interdisciplinary conceptualization research). The synergistic psychotherapy practice can significantly increase the efficiency of work and assign areas of responsibility in the management of a complex case of depression.

To ensure effective team work and close interaction of specialists, it is necessary to create a united conceptual and terminological basis for further development of methodological recommendations (mapping and methodological developments based on the research of several cases).

It should be noted that in understanding the disease, specialists were close in understanding the patient's illness as a special path, a space of relations with God. In such a situation, conciliar help is a mystery, a dialogue of religious specialists who collaborate with each other and with God in the process of caring for a person and his healing.

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Nemtsev A.V.

The relationship between religion and depression in the perspective of modern psychology

Abstract: The report discusses the possibilities of using a clinical-and-psychological approach that takes into account the factor of spirituality (including religion) in the diagnosis and assistance to people suffering from depressive disorders. Two variants of spirituality have a theoretical justification: spirituality, closed on itself and open to another person. Clinical examples demonstrate the connection of self-contained, non-dialogical spirituality with the severity of depressive states.

Keywords: spirituality, religion, depressive disorders, dialogueness.

Why is light given to a man whose way is hidden, whom God has hedged in?
(Job 3:23)

For psychology, the inclusion of spirituality in its subject field is a very hard task, especially since it is actually a "reversion", which always takes more difficult and longer than exile (numerous articles have been written about the history of the expulsion of spirituality, the "soul" from psychology (e.g. Bratus' B.S., 2014). Psychology is pushed to this reversion by two reasons: internal and external. The internal reason for increased attention of psychology to the spirituality lies in the processes of development of science itself, namely in the "anthropological turn" in humanitarian knowledge. The main problem and subject of psychology is not just the psyche, but the whole person as a carrier of the psyche. Following man, spirituality returns to the subject field of science too. (Zalevsky G.V., 2019; Klochko V.E., 2013). The external reason is that the worldwide process of secularization has stopped and has been replaced by the reverse – the process of desecularization (Berger P. L., 1999). Russian scientists, following the foreign researchers, note the strengthening role of the religion – both of religious institutions and "individual" religion (V. Karpov, 2012; Sinelina Y.Y., 2013) – in public life, and therefore in the lives of concrete people.

As a result, psychology is showing an increasing interest in the study of spirituality. Spirituality at the present stage of cultural development manifests itself in at least three main forms: religious spirituality, secular (atheistic) spirituality that opposes it, and an increasingly spreading non–religious mystical spirituality that is not associated with certain religious institutions (SBNR - spiritual but not religious[1], Fuller R.C., 2001).

We will leave aside the question of the primary form of spirituality, its genesis (e.g. Viktor Frankl believed that within any spirituality there is an unconscious religiosity). Let us turn to the definition of spirituality from a materialistic position. At the end of the Soviet era, the member of the Academy of Sciences, psychophysiologist Pavel Vasilyevich Simonov writes in the book "The Origins of Spirituality", that from the position of the need-informational approach, the concepts of "soul" and "spirituality" of a person denote the individual expression in the system of personal motives of two fundamental needs: the ideal need for cognition (of the world, oneself, meaning and purpose of one's life) and the social need to live, to act "for others" (Simonov P.V. et al., 1989).

We can see that these two motives – knowledge and altruism – strangely resemble Christ's answer to the question about the main commandments in the law: love the Lord your God and love your neighbor as yourself. After all, God is Truth, Beauty, Wisdom, and to love God means striving to know Him, His will about yourself and about your life.

So then, defining even secular spirituality, the authors see the relationship between the need to know something higher and the need for an altruistic attitude to the other. This approach makes possible also the assessment of the manifestations of religious spirituality.

For our part, we assume that spirituality is not the expression of two motives (high or low), but the principle of the relationship of these motives. If the connection between them is strong, integral, conscious, we can talk about high spirituality, generosity; if weak, fragmented, accidental – then about low spirituality, "faintheartedness". (The member of the Academy of Sciences, prince and a secret monk A.A. Ukhtomsky confirms that "The most important sign of spirituality is the focus on the face of the other" (Zinchenko V.P., 2003)).

That is, such an approach to spirituality suggests that even the most sublime feelings and experiences, knowing oneself, the meaning of one's life and God, without their connection with the lives of other people (and life for other people) cannot be considered as a full-fledged spirituality, the one that can become a protection from adversity and blows of fate.

Is there any evidence for this statement?

Firstly, the human culture shows that the experience of cognition and self-knowledge is often associated with sadness. The words of Ecclesiastes are the most weighty here: " For in much wisdom is much vexation, and he who increases knowledge increases sorrow." (Eccl. 1:18). There are also other authors. Sonnet 66 by W. Shakespeare begins gloomily:

Tir’d with all these, for restful death I cry,
As, to behold desert a beggar born,
And needy nothing trimm’d in jollity,
And purest faith unhappily forsworn.

Secondly, the Russian psychiatric science, back in the Soviet period, noted a connection between a particular kind of spirituality and depressive states. In particular, prof. Lakosina N.D. (1994) described the clinical pattern of neurotic depression and identified the premorbid characteristics – straightforwardness and self-righteousness, an exaggerated and formal understanding of the sense of duty, the difficulty in making compromise decisions and deviations from "standard dogmas". In this description, one can assume followers of that non-dialogical spirituality who do not perceive another person as an equal subject of relations and who, refusing to compromise with their conscience, at the same time refuse to compromise with living people.

About ten years ago, we in the Research Institute of Mental Health of the Tomsk National Research Medical Center of the Russian Academy of Sciences conducted a research of spiritual meanings in the life world of people with depressive disorders (Nemtsev A.V., 2012). During the research, cases similar to the above descriptions were noted. For example, a 62-year-old woman (F32.1 Moderate depressive episode), who went to the hospital after the death of her son, answers the question about what spirituality is: "This is the inner world of a person. His attitudes. A person may look rude, tough, but in his soul he is sensible. Sensitive to the whole creation... A person with a rich inner world understands people, and treats the whole creation the same way, for him trees too are alive. But a person with a poor inner world thinks about himself, for him his own "ego" is above all. He treats all others with contempt... Currently, the one who does evil survives. The good is not valued." When asked about her spiritual world, she answers: "I have a rich spiritual world (with confidence)... That's why I suffer all my life and don't get rich. I worked in forestry. I could have cheated, selling timber by wagons. And by logging trucks – that's ugh. But I didn't do it. Sometimes I had to borrow money. They tell me: "Well, why are you borrowing?" – meaning that I could sell on the sly. But I get my peace of sleep. And that's the main thing for me. I

know that I can honestly look every employee in the eye." When asked what else she can relate to her spiritual world, she responded: "My kindness is in relationships with people. I helped many people. When I left, my subordinates came to see me off. They invited me to work there again... But on the other hand, I say, it disturbed my life. I could have worked not so hard, stealing from the state. But once I took the decision and didn't rethink anymore..." When asked about the purpose of life, she answers that the purpose of her life is to make a monument on her own grave and that of her son for 400 thousand rubles.

Why, with all due respect to the moral integrity of the patient, does this kind of spirituality seem to be inferior? Because despite all the severity of the moral feat that she carried all her life, she didn't understand the key thing: morality is hard not only for her, but also for others (perhaps the very people who asked for her help, were forced to do this too because of their morality, unwillingness to steal, etc.). And help out of duty, which has become a matter of pride and a hindrance, could be help out of mercy and pity for a person.

Thus, in addition to narcissism, which according to the previous speaker (Prof. Francisco Garcia Martinez), is the cause of depression and which has been examined in the context of depression by S. Freud, we can assume that the non-dialogical version of spirituality can also contribute to the development of depression. For healing of the depression in the first case the narcissism should be replaced by respect for the otherness of another person (his feelings, desires); in the second case, on the contrary, it needs understanding that the other person is like you (including his weakness).

Turning to religious spirituality, it can also be noted that it is associated with depressive disorders in two ways. On the one hand, there are facts about the positive influence of religiosity on a person's mood, the healing effect of religiosity in depressive disorders (for example, the autobiographical description of the "founder" of the psychology of religion, W. James (according to Goodman R.)). On the other hand, people with religious spirituality also suffer from depressive disorders.

Here is an example of a religious person in depression. A 28-year-old girl too turned to the Research Institute of Mental Health with complaints of a low mood, tearfulness, irritability. She was diagnosed with "F 32.0 Mild depressive episode". At the time of her visit to the doctor, she was a novice of a rural monastery in the Tomsk region, where she spent about 4 years. Depressive symptoms occurred a year after the death of the patient's mother.

In order to analyze the peculiarities of the patient's religiosity, we will quote parts of the conversation with her:

"I studied to be a speech pathologist, worked in nursery and correctional school. I started going to the church more often. Then I suddenly packed up and said that I was leaving for a monastery.

- Why?

So, everybody asked me then too: "Why?" Mom and Dad crying... I quitted my job. Do you think I didn't like my work? I loved it. And the team treated me well. The boss told me: "I won't let you go. We raised you, we made you a specialist...

All of them asked me: why? And I couldn't answer why."

Describing her life in the monastery, she said the following: "The first year you like everything. The Lord gives you grace. Then difficulties and absurdities pile on you...

- Did you want to become a nun?

- No. I lived for the moment. They give time to a person... Mother superior herself decides who and when would put on a cassock or take a tonsure."

A year later, her mother fell ill with leukemia, and for 2 years she went now home, then to the monastery. After mother's death her dad, on the advice of a priest, established a new family.

The patient went back to the monastery: "Mother superior [the head of the convent] helped me a lot, supported me... There is so much work in the monastery, it is much harder there than in the world, to live in the city... And there I had some kind of collapse ...

- How can you describe this condition?

- I stopped communicating with people. Everything annoyed me. Why is everyone laughing? – It's not funny to me. I stopped eating well… When Mom was there, it was easier. I knew that if it was hard for me, I could always come to my mother. Mom is Mom indeed . Do you understand? Mom will leave everything for the sake of the children. And father is father though. I can't rely on him. I couldn't share with him my problems. On the contrary, I had to try to make everything good. I tried to keep my emotions in my fist. He needs to know that I'm okay. And so it happened to me... I forgot how to laugh. And you know, for the first time I wanted to get drunk to pass out. I've never had a drink before. And here I got really, really drunk. And in general, there was some kind of aggression, anger, I began to get tired of people."

While in the hospital, the patient had to choose her future life path. What, from our point of view, was the difficulty in making the choice? Firstly, the patient did not develop the skill of reflection, the skill of solving a "meaning problem" that emotions pose to a person. Neither positive emotions from coming to the monastery were comprehended (for example, "as a vocation" and as the need to respond to a vocation, regardless of the content of the answer), nor negative ones – from the death of the mother (for example, as the need to mature). Secondly, despite the strong spiritual experiences associated with entering the monastery, they turned out to be self-contained and could not support the patient at the time of grief. While the care of lay people was a real help.

Thus, the examples of secular and religious spirituality confirm the connectedness of depressive states and non-dialogical, self-contained spirituality, which certainly requires further assessment.

And it may so happen that one of the beneficial consequences of depressive disorders will be the disconnection of spirituality from one's own experiences and a better knowledge of the other. Just as the book of Job ends not with the acquisition of a new personal meaning, but with the recognition of closer mutual communication: "I had heard of You by the hearing of the ear, but now my eye sees You" (Job 42:5).

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Palchikov M.A.

Psychotherapeutic process and religion

Abstract: The report considers the improvement of compliance, effectiveness of the psychotherapeutic process and adherence to therapy in religious patients. It analyzes the common points when working with automatic negative thoughts and with religious beliefs. The report suggests that the mutual work of a psychotherapist and a priest is necessary.

Keywords: psychotherapy, anxiety, depression, religion, thinking errors, CBT.

Therapy of anxiety-depressive spectrum disorders is currently an urgent issue in psychiatry and psychotherapy. In 2019, almost 1 billion people worldwide suffered from mental disorders, including 14% of adolescents. Mental disorders are the leading cause of disability, accounting for one sixth of the total number of years lost as a result of physical inability. People with severe mental illnesses die on average 10-20 years earlier than the general population, mainly due to the development of preventable physical diseases. In the first year of the pandemic alone, according to WHO, the prevalence of depression and anxiety disorders increased by more than 25%.

For a long time, psychopharmacotherapy was set off against psychotherapeutic approach and was considered a symptomatic method, with insufficient effect on the pathogenetic schemes of neurotic disorders with an high risk of relapses and chronification of the pathological process (P.A. Arean, 2002).

At the moment the effectiveness of the psychotherapeutic approach in the treatment of anxiety-depressive spectrum disorders has been confirmed, it is not inferior to pharmacological approach, and in some cases it is preferable due to high adherence to the therapeutic process, compliance, absence of side effects.

One of the most studied and evidence-based methods is cognitive behavioral therapy (CBT) formulated by A. Beck. This therapeutic method is based on the concept of formed and fixed dysfunctional thought patterns that reduce the quality of life and play a significant role in the formation of neurotic spectrum pathology; it invites the patient to work on raising the level of his own awareness, which allows him to identify those very “automatic negative thoughts”. A. Beck defined the vector of these thoughts as "thoughts about oneself, the world and the future." After working on the identification of these negative beliefs, the patient and the therapist work on the interpretation of distorted thinking and formulate rational answers for each specific cognitive distortion. I.e. an important part of the work is working with the patient's objections, the effectiveness of which depends on many factors, such as: the level of compliance of the doctor and the patient, the authority of the doctor's opinion (A.T. Beck, J.S. Beck, 2006). As a result of this systematic work, the patient forms for himself a more functional scheme of thinking that allows him to reduce the level of anxiety and, as a result, improve his condition.

Religious patients, relying on an already formed dogmatic system of values and beliefs, may have a much lower threshold of objections when working with a therapist if the correction of cognitive distortions will go along the vector of their religious thinking.

Let's look at how it is possible to build a therapeutic relationship with a religious patient using examples of specific cognitive distortions.

One of the most frequent cognitive distortions is the position of "I must" or of duty. The position of duty in patients, as a rule, is formed by the parental figure and is fixed in the course of further socialization. Based on the position of "I must", the patient experiences a state of chronic tension and depression, because there is no free formation

of his own desires and subsequent actions to implement them. As a result, the patient develops a compensatory escape behavior or dependent type of behavior. Speaking about the religious interpretation of the position of duty, we rely on an emotionally mature position of personal responsibility: "Every man according to his deeds – Unicuique secundum opera eius." That is, responsibility is determined by the person himself and his system of values and desires, and not by the desires and goals of other people. Unfortunately, this cognitive distortion is often formed and used in so-called pseudo-religious relations, when a manipulative person misinterprets religious texts, shifting the emphasis from personal responsibility for decisions made to a sense of duty to this very person, forming the behavior that the manipulative person considers correct and acceptable.

Dichotomous or black-and-white thinking. The "all or none" thinking is a common cognitive error and, unfortunately, is also often used in manipulative pseudo-religious relationships. Working with patients with this error of thinking, we can turn to the moderation position, often found in religious texts. This distortion is the basis of destructive perfectionism and contradicts the concept of original sin or the impossibility of being perfect. Therefore, it is much easier for a patient with a religious thinking paradigm to agree that neither his life nor the results of his actions should not and cannot be perfect (Eph. 4:31; Ps. 119:28).

Catastrophization is the prediction of future events exclusively negatively, without alternative positive possibilities. This distortion is based on the feeling of helplessness of a child, reinforced by the fear of punishment for imminent error. The feeling of helplessness and the subsequent fear of error and punishment contradict the religious idea of a person's free will as the highest gift and as a tool for the conscious achievement of virtue. Working with fear is also one of the main points of interaction with religious patients. The message is "be not afraid!" These are the words of God, addressed through millennia to Adam hiding in terror: "Adam, do not be afraid. It is Me." "Do not be afraid" – with these words begins the salvation of mankind, when the angel turns to Mary, telling her about the birth of the Savior. "Be not afraid" is one of the central religious ideas, the ideas of the Gospel teaching.

Devaluation of the positive is a mistake of thinking that does not allow the reinforcement system to work in full scale. As a rule, there was initially no adequate reaction from the figures of significant adults to positive experiences and successes. This error of thinking was also often formed when a patient in childhood and adolescence was compared in a negative context with peers or other emotionally significant figures: "Look what you need to be, but you are not like that." Working with this error of thinking, with religious patients, we can turn directly to the commandment "love your neighbor as yourself." The idea of a good attitude towards oneself, self-care, inherent in this commandment, as a rule, is not fully realized by the patient: it is impossible to treat people well and interact with society without fear and tension, if a good attitude towards oneself is not formed, as an image and likeness of the Creator.

As we can see, the effectiveness of CBT in religious patients may be higher if we work along the vector of habitual and understandable thinking. And in this aspect, the joint work of a psychotherapist and a priest seems promising (M.A.Palchikov, 2018).

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Spiritually-oriented rehabilitation of mentally ill patients with depressive disorders: approaches and basic principles

Abstract: Spiritually-oriented rehabilitation for depressive disorders is an effective model of helping mentally ill people. A comprehensive program is based on the concept of biopsychosociospiritual approach and uses religious coping strategies. The family approach has a special place in this work, which reflects the understanding of the family as a "domestic Church". Therapeutic communities with an integrated approach to working with depressive patients are being created in the parishes of the Russian Orthodox Church. In practical work, social-spiritual rehabilitation is combined with psychopharmacotherapeutic treatment in state psychiatric institutions. The rehabilitation program is implemented on the basis of the Mental Health Research Center in cooperation with the NGOs "Interregional Public Movement for Support of Family Sobriety Clubs" and the "Family and Mental Health" Regional Charity.

Keywords: spiritually-oriented rehabilitation, mental illness, depressive disorders.

Spiritually-oriented rehabilitation in depressed patients

Spiritually oriented methods of rehabilitation of depressed patients are understood as targeted and structured psychotherapeutic work, which is based on religious meanings and spiritual values relevant for an individual. One of the sociotherapeutic goals of rehabilitation is the development of adaptive forms of behavior, the so-called coping behaviors, which would help maintain psychological balance in a situation of mental illness. Both foreign (Pargament K., Koenig H., Perez L.) and Russian researchers (G.I. Kopeiko, O.Yu. Kazmina, O.A. Borisova) contributed to the study of the structure of religious coping. These authors note that spiritually-oriented rehabilitation of depressive patients should be carried out jointly by a clergyman, a psychiatrist, a psychologist, as well as relatives of patients, members of the religious community and social workers.

The main directions of psycho-corrective work with depressive patients is the maintenance of traditional religious values and meanings, which helps to preserve the religious basic values of life. Social support in this approach is provided through the religious community, and the religious rethinking of the situation, which consists in rethinking one's own personality, determines the religious transformative way of coping. In spiritually-oriented rehabilitation, a religious way of coping is used through the acquisition of an emotionally calm state, which is granted by religious faith (consolation, forgiveness, reconciliation).

The study of the experience of integrating mentally ill people into church life indicates that religious faith and practical life of Faith contribute to the development of religious ways of coping, and can also become the basis for discussing irrational beliefs as well as challenging negative knowledge and inadequate forms of behavior. Prayer practices under the guidance of experienced priests and spiritual fathers can be used as a Christian content of spiritually oriented therapy. As an example of a spiritually oriented strategy in cognitive behavioral therapy (to counter irrational thoughts), the experience of forgiveness based on the REACH model can be given, where R = Recall the hurt, E = Empathize with the one who hurt you, A = Altruistic gift of forgiveness, C = Commit to forgive, H = Hold onto forgiveness. Repentance becomes the result of the value-semantic transformation of the individual as a result of religious life based on religious faith and teaching (Worthington E. L. et al., 2016).

The scientific community is currently very interested in studying approaches and developing a rehabilitation program for mentally ill patients with depression, containing a spiritually oriented component. However, there is insufficient evidence in the scientific literature about successful rehabilitation programs for patients with depression. The analysis of search queries on the topic “spiritually oriented rehabilitation and depression” on the GOOGLE Academy resource in the Russian segment did not reveal relevant articles on this topic, which may indicate that there are generally no effective rehabilitation programs, or that certain spiritually-oriented practices are applied at an insufficiently systemic level.

The Tomsk psychologist A.V. Nemtsev, in his dissertation research, analyzes spiritual values of people suffering from depressive disorders, and argues that models of helping patients with depression that implement an integrative approach influencing various elements of the "vicious circle" of the disorder (for example, neurotransmitter systems and cognitive impairment), are more effective than models that affect one factor (Nemtsev A.V., 2012). The author believes that “in depressive disorders characterized by low mood, processes of loss and devaluation of meanings are observed in the value sphere, which is also reflected in a decrease in interest in previous activities (ICD-10, 1992), cognitive errors, and so on. At the same time, spiritual values that are not directly related to the vitality of a person can retain relative autonomy if this vitality decreases, which means a certain degree of freedom for a person.” Researches in the Mental Health Research Center (Borisova O.A., 2019) indicate a high degree of stability of the value sphere in case of progressive mental disorders. So the reliance in the treatment and rehabilitation of depression on spiritual values and the disclosure of their characteristics seems to be a promising direction.

Peter Verhagen cites 16 studies in which various spiritually oriented strategies are used in the complex treatment of depression. At the same time, he indicates a wide range of practices – reading and discussing spiritual literature and Holy Scripture, structured conversations with a discussion of spiritual values and meanings, encouragement to participate in religious life, joint prayer; he also speaks of the possibility of using a spiritually-oriented approach in various confessions and religious communities (Verhagen P., 2019). According to some researchers, it is especially necessary to emphasize that coping and forgiveness are very important for a spiritually-oriented approach in psychiatry (Worthington E., Sandage S., 2016).

In a study of the impact of religiosity on depressive disorders in the elderly (Coleman P., 2017), it is noted, that attention and care provided within church community towards elderly people who have suffered a loss of a loved one, have beneficial effect. At the same time, the lack of support and loneliness in a situation of bereavement and watching the suffering of close relatives negatively affects the mental state of believers, and in some cases can lead to disappointment in the church and Christian faith. Researchers speak about the need for counseling of such people by clergy and compassion of the church community towards its suffering members.

An example of a scientifically based and effectively implemented in Russia spiritually-oriented rehabilitation program for patients with comorbid pathology is a multidisciplinary program of outpatient care for endogenous mentally ill patients with comorbid addictive disorders (Kopeiko G.I. et al., 2019). The rehabilitation program successfully combines the resources of the state system of assistance to mentally ill people based on medical institutions for the protection of mental health and the experience of volunteer NGOs based on the principles of volunteerism and merciful service to others. The program is rooted in the spiritual and moral values of the Orthodox worldview and the use of spiritually-oriented technologies and approaches in the rehabilitation module. The development of the methodology and evaluation of the effectiveness of the program was carried out on the basis of the Scientific Center for

Mental Health in cooperation with the Moscow Scientific and Practical Center of Narcology.

The fundamental basis of a comprehensive assistance program is the combined application of biological therapy, psychosocial therapy procedures, as well as spiritually oriented therapy. The therapeutic module implemented on the basis of medical institutions allows effective psychopharmacological treatment and supervision of patients over a long period of time. The rehabilitation module is carried out both in a medical institution already at the early stages of treatment, and at the stage of resocialization implemented by public organizations in the therapeutic communities. In such combination, the principle of social therapy and environmental therapy can be fully realized. Over 90% of rehabilitation therapeutic communities operate on the basis of confessional offices in church parishes.

Pilot study

Theoretical studies show that the complex rehabilitation of mentally ill people can be successfully implemented in a therapeutic community based in a public organization. The 20-year experience of the “Family and Mental Health” Regional Charity in collaboration with the Scientific Center for Mental Health shows that the combination of psychoeducational, art-therapy, cognitive behavioral and sociotherapeutic approaches in rehabilitation allows patients with mental disabilities to successfully maintain the level of social functioning. As a result of systematic work in the community, the frequency of hospitalizations and requests for psychiatric help decreases, the level of quality of life grows, and positive changes in the family status of patients are observed (Solokhina T.A., 2022).

In the spiritually-oriented rehabilitation program, the emphasis is made on increasing the meaningfulness of life by relying on the spiritual values of the Orthodox worldview and developing the skills of coping behavior as a result of learning the repertoire of religious coping strategies. An integrated approach that combines medical, psychotherapeutic and spiritually-oriented methods of treatment and prevention also allows to successfully integrate mentally ill people into church life (Magay A.I., Solokhina T.A., 2022). An analysis of the motivational counseling technique suggests to use internal personal resources, which allows to fully take into account the way of thinking and behavior of the patient, and ultimately contribute to changing the entire lifestyle of a person (Miller W., Rollnik S., 2017). The internal choice in the spiritually oriented approach is made based on the spiritual values and life meanings of the religious worldview, and the need sphere and psychological experiences are restructured in accordance with the hierarchy in which the spiritual sphere has the highest value for the individual; this has a beneficial effect on the harmonization of the entire personal way of life. The psychological instrument of communication between specialists and program participants is the spiritually oriented dialogue of T.A. Florenskaya, which allows to use the free choice of a person to a maximum extent, to combine his personal position and the spiritually-peaceful delicate communication style of a specialist (Magay A.I., 2020).

In 2020, researchers of the Scientific Center for Mental Health began to study whether it is possible to use the rehabilitation program for patients with endogenous mental illness, in particular, with depressive disorders. Throughout the year, scientific literature was analyzed, the experience of rehabilitation communities in Russia and abroad was studied. In 2021, a rehabilitation therapeutic group was organized, a pilot study was conducted to evaluate the effectiveness of its work. The preliminary conclusions indicate that the structure of an outpatient rehabilitation program with a spiritually oriented component can be successfully used in patients with depressive

disorders; and principles, methodological developments and elements of technology for helping patients with comorbid pathology can be used in its work.

Thus, a therapeutic group for religious patients with mental illness was organized on the basis of one of the churches in Moscow. All patients were under medical supervision in the Department of Special Forms of Mental Pathology of the Scientific Center for Mental Health and received psychopharmacological treatment, and also took part in the work of therapeutic communities as part of a comprehensive spiritually oriented module. The work of the therapeutic community was supervised by a psychiatrist and a researcher of the Scientific Center for Mental Health.

Materials and methods

During the pilot study, a group of 20 patients was examined, of which 10 prs. suffered from mental illness with depressive disorders of varying severity and had diagnoses according to ICD-10 – F 25.x, F21.3-21.4, F 33.4, F31.7, F32.2; the age of the patients ranged from 23 to 52 years, among them there were 5 men and 5 women. The study also included patients with comorbid diseases and other disorders, their results were not considered in this study. The control group had 5 patients with mental disorders similar to the main group, however, they did not participate in rehabilitation.

For research purposes, the self-assessment scale of Ch.D. Spielberger and Yu.L. Khanin (State-Trait Anxiety Inventory, STAI) was used to assess the level of anxiety; questionnaire SF-36 (The Short -36) – for a comprehensive assessment of the quality of life associated with health; test of meaningful life orientations (LSS) by D. A. Leontiev (adapted version of the Purpose-in-Life Test, PIL), aimed at determining the meaningfulness of life in various contexts (past, present and future). Religious worldview and spiritual values were assessed using a modification of the Huber questionnaire (Huber, 2012), which informs about various aspects of spiritual life; the "Religiosity Scale" method (adapted by O.Yu. Kazmina) was also used, which allows differentiating the external and internal aspects of religious life. In the experimental part, the researchers assessed value orientations using the Milton Rokeach method.

It was assumed that the participation of religious patients with depression in a structured rehabilitation program containing a spiritually oriented component, in the settings of a church community, which is natural for the spiritual life of the patient, will help reduce the clinical manifestations of depression and improve the quality of life of believers, and will also be accompanied by changes in the value sphere of a person associated with the religious worldview. Absent changes or increased manifestations of mental illness would indicate the ineffectiveness of the rehabilitation potential of the program.

Results and discussion

Religious patients with depression attended weekly therapy group meetings throughout the year. At the two-hour sessions in form of a spiritually-oriented dialogue, personally significant issues were discussed. In addition, patients took part in psycho-educational, cultural, sports, socio-therapeutic activities of the program. The spiritually oriented module was implemented through the life in the parish community, participation in church sacraments and spiritual conversations, and pilgrimages. As part of the summer rehabilitation camp, a week-long visit to the monastery on the island of Valamo was organized, where believers lived in tents, cooked their own food on a fire, and had a daily common prayer practice.

Psychological research and a clinical survey were conducted when patients and their family members began participating in the rehabilitation program (September 2021), before and after visiting the rehabilitation camp on Valamo, and after a year of rehabilitation (September 2022).

The final examination showed a decrease in the level of *personal anxiety* (r=0.54 at p≤0.001, according to the Spielberger-Khanin scale); the analysis of the quality of life (QoL according to SF-36) revealed a higher level of "life satisfaction" and "sense of well-being" compared with the control group patients. *The religious value orientation* of patients in both the main and control groups demonstrated that the main life meanings are determined by religious faith. The rehabilitation participants developed a more meaningful religious orientation, which determined the role to the faith as a “resource” and “way to Salvation”, over time, a higher significance of spiritual and religious values was observed, as well as harmonization of internal and external forms of religiosity, which quantitatively and qualitatively distinguished this group from the control group.

A study using the “Value Orientations” method by M. Rokeach showed that before participation of patients in the rehabilitation camp on Valamo, the significance of the values of health and love prevailed in the group of terminal values, and the values of education and responsibility – in the group of instrumental values. At the same time, at the end of the camp, we registered high scores of the values of spiritual development and life wisdom and a decrease of the previously dominant values of health and love in the group of terminal values, as well as an increase of the values of tolerance and strong will in the general structure of instrumental values.

Conclusion

Thus, in the course of participation in the rehabilitation program the case group of patients, had less visits to psychiatrists for correction of therapy, while compliance with treatment remained at a high level, supportive therapy continued. There were no hospitalizations in psychiatric clinics; according to the results of a clinical survey and psychometric measurements, the overall level of anxiety and the severity of clinical manifestations of depression decreased. In the course of group psychotherapy and spiritually-oriented parts of rehabilitation, significant types of social support were established among the group of rehabilitees, as well as other believers and their immediate environment, productive forms of religious coping were learned, as well as social communication technologies. A value transformation was also noted towards an increase in the importance of spiritual development and life wisdom with a weakening fixation on the state of health and family as an absolute value, a change in the structure of religious value orientations was observed with predominant internal forms of religious life.

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Bart van den Brink

Suicidality, psychopathology, religion and spirituality

Abstract: This report is based on the material presented in the chapter “Suicide, suicidality and religiosity/spirituality” by Bart van den Brink in the Dutch Handbook of Psychiatry, Religion and Spirituality, ed. P.J. Verhagen (Dutch Handboek psychiatrie, religion en spirititeit in press; red. P.J. Verhagen e.a.). The report examines the multiple manifestations of religion, spirituality and meaning in life in relation to suicidality in the course of psychopathological and psychiatric diagnosis, and also determines their implications for prevention and treatment. Religion, spirituality and associated meanings play an important role in the dynamics of individual suicidality. Research in recent decades strongly suggests that religiosity and spirituality tend to reduce suicidality and suicide risk, and that religion is more protective if a person lives in a predominantly religious region. This protective role is further associated with the moral prohibition of suicide and the fear of going to hell if one commits suicide, as well as lower levels of aggression and hostility among believers. Regular church attendance has been associated with lower suicidality in many studies, including large studies, and is therefore considered a protective factor.

Keywords: suicide risk, suicidal tendency, religiosity, spirituality, meaning.

Allow me to introduce myself shortly. My name is Bart van den Brink, and I am working as a psychiatrist at the emergency department of the local mental health institution, in the middle of the Netherlands. At the VU University of Amsterdam, I am working as a PhD researcher on the subject of this lecture.

To introduce you to our subject, I would like to start with a case from my personal practice.

‘How could I have fallen so deeply?’

Dorothea is a 40-year-old single woman, a member of a Reformed fundamentalist church in the Netherlands and a faithful visitor to Church services. She is a teacher by profession. For about 15 years she has known recurrent depression characterized by feelings of worthlessness and meaninglessness. There is evidence of a post-traumatic stress disorder and a disturbed personality development. This dates back to abuse in the elementary school period by an older brother. Over the past 10 years, depression has been accompanied by suicidality. Several admissions have been required for treatment of depression and reduction of suicidality.

A chronological exploration of suicide thoughts and suicide attempts over the years using the CASE [Chronological Assessment of Suicide Events] approach as described by S.C.Shea (2012) shows that several factors in Dorothea's life are associated with a return of feelings of depression and futility. The first theme is that she experiences a great deal of tension and insecurity in contact with others. She has difficulty indicating her limits: increasing work pressure and expectations normally lead to feelings of despondency and fatigue: "I can't cope." Dorothea is someone who makes high demands on herself: she wants to do her job well and make the impression before others of a mature woman in control of herself. As a result, her suicide attempts are surrounded with shame: "What am I doing, how could I have fallen so deeply?" Dorothea talks to (almost) no one about her suicidality. Religious objections or guilt seem to play a weak but protective role for her: although she is familiar with and agrees with the objections from her religious background, in moments of deep despair a pessimistic side in her personality takes over from the rational side: "End your life, then

you'll be rid of everything." Internally, she experiences a constant struggle between the urge to end her life and more hopeful thoughts.

Dorothea does not see God as someone who sends people to hell without mercy. To her, the fact that she has survived multiple suicide attempts is a sign of God's goodness and gives wonder. Sometimes faith gives her courage to go on. So there is indeed a protective hand, someone safe and to be trusted. On the advice of her pastor – one of the few apart from her therapists who knows about her suicidality – Dorothea has placed a stone at the site of her latest suicide attempt, to remember this. On this "memorial stone" she wrote "Till now the LORD has helped us" (a text taken from 1 Sam. 7:12). This ritual has ensured that this place is now perceived as less risky by Dorothea, although she continues to see other methods as possible ways out of this life.

What does this case show us? Dorothea's case reveals a number of themes with regard to faith and psychopathology: the constant and dynamic interaction, the inhibiting power of beliefs, the role of the God image, the potential support of a network from the faith community, but also the shame towards this same network and to God. For Dorothea, the tension between the two sides is constantly palpable: she rejects herself, but also seeks help, albeit with difficulty. The moment her depressive symptoms subside, her suicidality diminishes and careful steps can be taken to develop contact. More space and trust is then created in her faith-experiences as well. Small and sometimes not clearly identifiable events are the prelude to a new period of depression. This dynamic fits into borderline personality pathology.

Dorothea's conviction that suicide is not consistent with the will of God and that He has her best interests at heart is a source of support and inhibits suicidality. A supportive approach of the practitioner and pastor proves essential to still engage the contact and help reduce suicidality. Concrete rituals give her faith a supportive place to help her.

Multiform

Religion, spirituality and meaning play an important role in the development of individual suicidality. They touch on various questions surrounding suicide: what makes my life meaningful? Is there something greater that comforts and guides me? What do I expect after this life? Does suicide affect that? That is not all, however. Questions of religion, spirituality and meaning are at the heart of the social discourse: how do we as a society deal with suicidal behavior? Is anyone in this society allowed to commit suicide? How are persons who commit suicide viewed? This lecture focuses on the multiform nature of religion, spirituality and meaning in relation to suicidality in the course of psychopathology and psychiatric diagnosis, and its significance for prevention and treatment.

Rejection of suicide

First, more about suicide. Suicide is defined as the act of deliberately and intentionally ending one's own life. Thinking about suicide, planning suicide, attempting suicide and actual suicide are summarized under the term suicidal behavior, or in short – suicidality. It is a characteristic of suicidal behavior that as its severity increases, the degree of psychological entrapment also increases. One becomes more and more convinced that suicide is the only way out of the experienced trap.

There is a strong commitment to suicide prevention by mental health workers in many countries. The main goal here is to reduce the number of suicides. Meanwhile, effective suicide prevention is greatly hindered by stigma and taboo, states the World Health Organization (WHO Fact-sheet Suicide, 2019) The WHO therefore advocates suicide prevention as a joint effort of multiple sectors in society. There is a greatly increased risk of suicide in mental disorders, such as depression, bipolar disorder,

psychotic disorders, personality disorders, anxiety disorders, and substance abuse. In the Netherlands, government agencies, mental health institutions and other organizations have therefore declared a 'zero-suicide' ambition.

In the philosophical and religious tradition of the West, three ethical arguments are made against suicide: "It is a crime committed by people against themselves, against society and against God" (Liégeois & De Schrijver, 2018). These arguments might feed stigma and taboo, but also feed – though not always explicitly – the general rule in Western countries: "You do everything possible to prevent the suicide of another person." The aforementioned 'zero-suicide' ambition is a telling example of this: together in our society, we are committed to helping rather than condemning suicidal people.

Does stigma or help-seeking for suicidality affect suicide rates? Reynders et al. (2016) investigated among four different regions in the Netherlands and Flanders whether seeking help was associated with the number of suicides per region. Higher levels of self-stigma and shame were associated with more suicides in a region. Intention to seek informal help, meanwhile, was very strongly associated with lower suicide rates. In the case study this tension can also be felt: Dorothea is ashamed, but also seeks help, albeit with difficulty.

What then is ultimately the effect? Does it actually matter if someone is religious? The first empirical answer to this question was given by Emil Durkheim in 1897 in his sociological study ‘Le Suicide’. Over the past decades the number of studies on this subject has increased dramatically. Three quarters of the studies on this topic show less suicidal behavior with higher levels of religiosity and/or spirituality, and only a few studies show an inverse relationship. In 2015, Wu et al. published a meta-analysis of 9 studies from all over the world, showing an overall protective effect of religion against death by suicide with a pooled odds ratio of 0.38 (95% BI: 0.21-0.71). The odds of dying by suicide were almost 3 times lower for religious persons than for non-religious persons (Wu et al., 2015). The results of this study strongly suggest that religion protects, and that it protects more strongly if one lives in a region that is mainly religious, a phenomenon that has previously been termed 'ecological effect modification'.

In general, it can be said that monotheistic religions reject suicide. Eastern religions like Hinduism and Buddhism, also regard suicide as an evil to a certain extent. In all cases there is variation and room for nuance and situational ethics. Which aspects of religiosity, spirituality and sense of purpose then play a role or are opposed in the development of suicidal behaviour of that particular person?

The importance of personal religiosity and spirituality

There are many studies of components of religion and, to a lesser extent, spirituality in developing or reducing suicidality. It is a complex task to analyze this bouquet. The main recent reviews (Gearing & Alonzo, 2018; Lawrence et al., 2016) show a varied picture. It clearly makes a difference how strongly religiosity and spirituality take shape in a person's personal feeling, thinking and actions.

In all these studies, a variety of factors have been investigated. Regular church attendance is associated in many and large studies with less suicidality and is therefore seen as a protective factor. The protection of religiosity and religious commitment is further associated in research with moral objections to suicide and fear of hell when committing suicide and a lower level of aggression and hostility among believers. Religion and spirituality can offer also an experience of connectedness with others, with God and the universe, and the hope for a better future. During mental illness, people sometimes experience alienation from and struggles in their religious life in relation to God. In extreme cases, religious guilt and alienation can be so strong that people abandon all hope and resort to suicide. On case level there are also examples that

religion, f.e. from the view that heaven awaits, can lower the threshold to suicide. This also applies to suicidality based on some religious delusions.

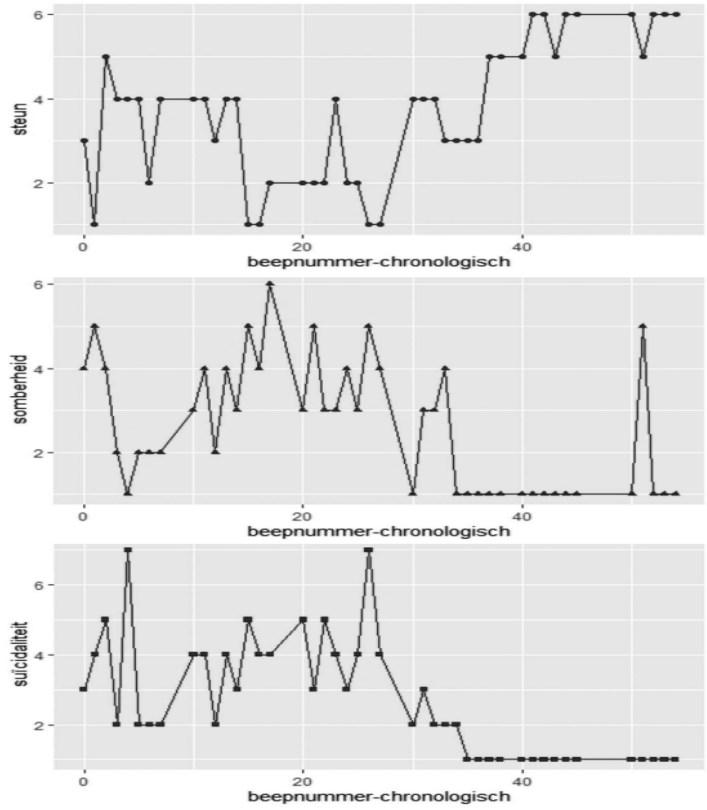
Four dimensions of religiosity and spirituality can be distinguished: sociological & cultural, practices & behaviors, affect & experience, and beliefs & cognitions. Table 1 shows these dimensions. The mutual dynamics and coherence of these dimensions and aspects are not yet well understood.

Table 1. Four dimensions and examples of aspects of religiosity and spirituality that influence suicidal behavior

Dimension	**Aspects**
Sociological and cultural	Culture-specific philosophical beliefs and laws, help from society or social/religious environment, religious affiliation.
Practices and behaviors	(Frequency of) attendance of religious meetings, prayer or meditation
Affect and experience	God-representations (affective), hope, spiritual well-being, spiritual experiences
Beliefs and cognitions	God-representations (cognitive), views on the afterlife, salience of religion, moral objections to suicide, altruism, acceptability of suicide

Together with my colleagues I have published scientific papers on several aspects (Hoeve et al., 2020; Jongkind et al., 2019; van den Brink et al., 2018). For example, we showed how variable experienced support from God, depressed mood and suicidality, were in one of our patients. We used an EMA-application [Ecological Momentary Assessment] on his phone to ask him multiple times a day to score these 3 items. *Figure 1* shows the course of experienced support from God, depressed mood and suicidality over the period of 6 days (1 item per panel: upper panel – experienced support from God, middle panel – depressed mood, lower panel – suicidality). We found that depression exerts a strong effect on suicidality, but also that mainly a stronger experience of support from God combined with a conviction of God's might and strength, together with higher moral objections, lowered suicidality.

Figure 1. Course of experienced support from God, depressed mood and suicidality over the period of 6 days for 1 depressed person; upper panel: experienced support from God; middle panel: depressed mood; lower panel: suicidality.



Entrance for interventions

On the whole, the various aspects could be grouped under two great common themes: 'alliance' and 'prohibition'. Religiosity and spirituality seem to offer protection through transcendent connectedness with others and the transcendent great Other, and through a limitation and framing by the 'No' of that great Other, Who at the same time is also a possible address for feelings of anger. Firm statements on these points are not yet possible because of the lack of sufficient multifactorial longitudinal studies.

With the above knowledge, at least the following statement can be made: psychiatric syndromes are universally recognizable, but cultural, religious, spiritual and philosophical factors are important in determining the form and sometimes even the severity of suicidality that occurs. There is a large variation and spread possible within religions and between individuals. Exploration of suicidality can therefore not be separated from the religious and spiritual context in and around the individual. This context may also offer a fruitful entrance for recovery-oriented interventions.

Step to the consulting room

But what to do when Dorothea, Thuraya or Thalia is in your consultation room and it becomes clear that she is suicidal? The simple rule of thumb is: Ask, Connect, Refer.

As always, the beginning is a good history-taking, using the CASE interview techniques (Shea, 2012). Thorough questioning about suicidality makes it clear to yourself and the other person how far the suicidal plans go, what reinforces and inhibits them, what this looked like in the past and how the patient envisions this in the future. This includes a broader social and religious anamnesis, with a specific focus on risk and

protective factors. The concrete question whether the person is religious and what influence this has on the suicidality should not be missing, as well as the question of the presence of suicidal behavior in family members. Often this conversation with religious patients offers opportunities to briefly mark inhibitory and protective aspects of religion or spirituality - without going to interventions. In any case, this conversation leads to a structural diagnosis of suicidality that includes religion, spirituality and possible points of departure for treatment in this area.

In this conversation, if all goes well, connection and a working relationship on the subject of suicidality. When the shame is very high, or information is difficult to obtain, the involvement of a loved one is essential and possibly a first step to the person in question to experience more connection. In fact, this already appeals to one of the fundamental beliefs of religion and spirituality: nobody lives for themselves alone. In practice, however, this step is often a struggle, because many suicidal persons are breaking this connection – as an extension of psychological entrapment. In that case, the social worker himself can also benefit from broadening through peer consultation. Referral to a specialist for consultation or crisis contact is an important next step. In situations where it is evident that religious themes play an important role, it is important to ask who one has as a confidant in this area.

Referring to and working with pastors or spiritual caregivers, as also recommended by the WPA (Moreira-Almeida et al., 2016), can help to work through religious or spiritual struggles and strengthen protective aspects. Research shows that also after a suicide attempt such contact can be healing.

Making room for hope

Worldwide, the research literature shows a recurring pattern: religiosity and spirituality generally reduce suicidality and the risk of suicide. The main question that remains at the end of this lecture is: what does this pattern look like for the religious and non-believing person opposite you in the consulting room? Where is the space and opportunity for a focused intervention in which healthy meaning, spirituality or religion is activated? Especially when the situation seems hopeless at the time, the question of transcendent values, a supportive environment and transcending norms for believers and non-believers is all the more important. Religion and spirituality are no panacea, but belief in something greater than oneself can make room for hope and the renewed experience of loving acceptance by the other.

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Nadyuk R.I.

Bibliotherapy and pastoral work with deep meanings in spiritual and psychological assistance to people experiencing depressive states

Abstract: This article describes the author's technique of pastoral spiritual and psychological work with deeper meanings of the patient in the process of providing primary care to people in depressive states. The article also describes the technique of bibliotherapy applied in the work with the Holy Scripture texts in the pastoral work of clergy to provide spiritual and psychological assistance to people with depressive disorders.

Keywords: depressive states, pastoral work, spiritual and psychological help, logotherapeutic dialogue, bibliotherapy, key meanings, resourceful experience, frustrating experience, deep meanings.

1. Pastoral counseling in providing primary spiritual and psychological assistance

Today, the ministry of a pastor is connected with the provision of not only salutary, but also primary psychological, spiritual care for parishioners. People suffering from depressive disorders often turn to Church ministers as healers of human souls. Undoubtedly, provision of comprehensive psychotherapeutic assistance to people diagnosed with depression is the responsibility of professionals with respective special education, professional training and work experience. Since the Church is an open community for all "who are weary and burdened", it is the pastor who often becomes the first accessible and socially safe specialist to whom the person suffering from depressive disorders is disposed to turn.

"The main patristic image characterizing the pastoral ministry and its instruments is the image of the priest as a doctor. St. Gregory the Theologian spoke about this in detail, comparing pastoral care with healing: "... the purpose of ... healing is to inspire the soul, tear it out of the world and hand it over to God, preserving the image of God, if intact, to support, if in danger, to renew, if damaged, to infuse Christ into the hearts with the Spirit." A person comes to church as to a hospital, in which he hopes to receive relief from spiritual illness. In the Church, diseases are cured not by the priest, but by God Himself. "He heals the brokenhearted and binds up their wounds." (Ps.146:3). Nevertheless, the holy fathers call the priest a doctor of people's souls. And like a doctor, a priest has a first aid kit with medicines and tools that he should be able to use correctly. And as diverse and individual as the means and approaches in the work of a doctor are, they are just as different for a priest." S. Alpatov [8]

Today, for a clergyman of any denomination, it is important to be competent in providing primary spiritual and psychological counseling and to have basic knowledge that helps to recognize the primary signs of a disorder requiring professional medical, psychopharmacological or psychological assistance, so that, providing spiritual help, he would also timely refer the person to a psychologist, psychotherapist or psychiatrist who can not only professionally help, but also safely work with religious consciousness, without equating the symptoms of a mental disorder with a person's religious beliefs.

"6.1. Pastoral care for the mentally ill requires that you keep in mind that in addition to the usual difficulties in communication, there will always be a medical component, for which the priest must be specially prepared. The priest does not have the task to diagnose a specific mental illness, but he must distinguish between normal human experiences from pathological ones and correctly build his relationship with the person, taking into account the mental state. Not only the correct spiritual guidance, but

in some cases the life of a person depends on how much he will be able to recognize mental illness among mental problems. The priest must be able to see the difference between the passions that grip a person and the manifestations of mental illness." [9]

This is how the document of the Commission on Church Education and Diaconia of the Inter- Council Presence of the Russian Orthodox Church defines the field of responsibility of a priest in pastoral work:

"4.3. The Church testifies to the need to differentiate the sphere of competence of a priest and a psychiatrist. The clergy should not interfere with the therapeutic prescriptions of psychiatrists. At the same time, the Church considers morally unacceptable the use of psychotherapeutic techniques based on the suppression of the patient's personality and using a state of altered consciousness and manipulation of behavior, both on the part of the doctors and clergy (including manipulation of false Elders and Young Elders over their spiritual "children"). The clergy should participate in a dialogue between the patient, his relatives and medical professionals in order to help the patient find meaning in life, peace with God and loved ones, and overcome the symptoms of the disease. The priest and the doctor must provide their assistance to the patient in mutual agreement and trust; otherwise their care may result in additional trials and sometimes unbearable hardships for the patient and his loved ones." [9]

The professional alliance of a priest, psychologist, psychotherapist or psychiatrist is a healthy and blessed form of professional interaction for the harmonious spiritual, mental and physical healing of a person who is created, according to the Holy Scriptures, in the image and likeness of God, as an entity that is one in spirit, soul and body.

“And the very God of peace sanctify you wholly; and I pray God your whole spirit and soul and body be preserved blameless unto the coming of our Lord Jesus Christ.” (1 Thess 5:23)

"From the point of view of Orthodoxy and church tradition, there is no reason to see any obstacles to the use of psychiatric or psychoanalytic data in the activities of the pastor. Psychiatry does not in the least fundamentally contradict pastoral care, should not interfere with it or in any way diminish the importance of pastoral care. In pastoral care, all means can and should be used to help souls in their difficulties on the path of salvation. Pastoral psychiatry, as has already been said, cannot be given equal importance to asceticism, since their fields, although they are adjacent, are not mutually exclusive, because psychiatry does not interfere in the field of pure theology. It acts in those areas where asceticism has no direct application. Psychiatry in the hands of a pastor is an auxiliary tool for detecting not sin, but pathological phenomena associated with psychiatric diseases, i.e. mental, not spiritual." (Archimandrite Cyprian (Kern)) [6]

2. People in depressive states

Speaking about spiritual and psychological assistance to people in depressive disorders, in this article we are not discussing the provision of professional psychotherapeutic assistance by a clergyman to the people, who have been given a respective medical diagnosis. The assistance by a clergyman to such people can be part of a comprehensive spiritual and medical-psychiatric care in the format of interaction of a professional team of a pastor, a psychiatrist and a psychologist. In this article, we are talking about primary care from the side of the clergy, primarily those who have common signs of a depressive disorder that can be seen by a non-professional eye. We also talk about ways to help those people who, when turning to a pastor, often identify themselves as suffering from depression, because they have done a superficial introspection or unconsciously derive secondary psychological or social benefits from the position of a “depressed person”. Such people often come to Church "answering the

call of the suffering soul" looking for positive attention, sympathy, consolation, support, faith, a miracle and new meanings.

Here is how Hegumen Evmeniy, in the Christian Interlocutor, Vol.48, dedicated to the topic "Pastoral care for the mentally ill," describes a psychological portrait of a depressed person who has applied for pastoral help:

"We are talking about people that have permanently low mood. They are born pessimists. They do not expect anything but misfortune and difficulties from the future, while the past delivers only remorse about the real or imaginary sins that they have committed. They are extremely sensitive to all kinds of troubles, sometimes they overreact. They are always gloomy, depressed, unhappy and reticent, they involuntarily push away even those who sympathize with them, thus closing the vicious circle they create - "no one loves me." Their self-expressions, movements, facial expressions, for the most part, show some kind of inhibition: reduced facial expressions, helplessly hanging hands, slow gait, weak sluggish gestures - it all reeks of hopeless despondency. They notice mostly mistakes in what they have done, and there are so many difficulties in what lies ahead that they involuntarily give up… Psychotic outbursts develop from time to time: either manic or depressive. The pastor should treat such people with particular care. He shall help them focus their attention primarily on the joy that Orthodoxy, the Gospel, and church life bring." Hegumen Evmeniy [4]

The document of the Commission of the Inter-Council Presence of the Russian Orthodox Church "Pastoral care in the Russian Orthodox Church for the mentally ill" suggests that the clergy shall pay attention to the following while working with the community:

"7.2. 2) depressive states with a strong feeling of melancholy, hopelessness, despair, loss of life perspective, with ideas of self-accusation and humiliation, low value, excessive sinfulness;

3) depressive states with reflections on the meaninglessness and aimlessness of life, anti-vital reflections, suicidal thoughts and intentions;

4) depressive states with a feeling of God-forsakenness, loss of meaning in life and hope for God's mercy, "petrified insensitivity"". [9]

3. The importance of pastoral work with deep meanings

Following the pastoral model of spiritual and psychological work in primary care for depressed people, we suggest to consider the depressed states as a crisis of internal meanings that are life-affirming, important for acceptance of self and the world itself.

If we would choose from a wide range of psychological and psychotherapeutic methods of helping people with neurotic, including depressive disorders, the logotherapeutic model of work with the internal states of a depressed person would be the most appropriate one. Viktor Frankl's logotherapy has become a methodology and applied assistance practice, which is very close to the model of pastoral care due to its focus on working with personal meanings, beliefs, inner values of a person, with everything that a pastor always deals with in providing spiritual support to a person that asked for help.

3.1. The purpose of psychotherapy and logotherapeutic approach

"Although the purpose of psychotherapy is spiritual healing, religion is the salvation of the soul...logos in logotherapy implies meaning. Human existence always strives beyond itself, always strives for meaning. Thus, the main thing for human existence is not pleasure or power and not self-fulfillment, but rather the realization of meaning. Therefore, logotherapy talks about the " will to meaning "." V. Frankl [2]

3.2. Logotherapeutic approach in the pastoral work in providing spiritual and psychological assistance

The technique of pastoral work with deep meanings suggested by the author of this article is a technique of logotherapeutic (meaning–oriented) dialogue with the person, which implies the actualization of personal meanings and the experience of the person that can be used to find individual resources and hidden meanings in overcoming depressive states. The technique is an adaptation of the "logoanalysis", as it is called in professional literature, for the use in a church parish.

Logoanalysis *was developed by James Crabo, a student of the founder of Logotherapy V. Frankl. Logoanalysis uses two main techniques: the expansion of consciousness field, the so-called "conscious knowledge", and the stimulation of creative imagination. After each step of the inventory, the results are discussed with the therapist. This allows the person to develop the skill of looking at his life more often, as if evaluating it from the outside. The main theses of logoanalysis:*

1. *There are always answers, even if they are not visible now.*
2. *These answers are within us.*
3. *The way to discover these answers is to take a deep, penetrating look at one's own life (life inventory) and stimulate creative imagination.*

4. "The technique of pastoral work with deep meanings" (R. I. Nadyuk)

"However, in order to help the person to find himself anew, to get out of the vicious circle of self-reflection, the pastor must first deeply feel into the person, understand and hear his inner state, his inner request, the way out of the impasse in life, which is intended for him by the Divine Providence." Hegumen Evmeniy [4]

As part of the proposed technique of logotherapeutic dialogue, the pastor is recommended to implement the following five stages of the pastoral conversation.

4.1. Case review, acceptance and non-judgment

At the initial stage of the dialogue, when acquaintance with the individual case of the person takes place, it is important for the pastor to internally **adopt a non-directive, non-judmental, supportive position** motivated by the attitude not to judge and assess, but to learn and understand the inner world of the person.

4.2. Search for "key phrases"

While listening to the person addressing the respective issue, or while actualizing the conversation topic with suggestive questions, it’s necessary to **pick up and identify the key phrases and concepts on the meanings of which the person’s consciousness** in the subject under discussion **relies**.

Key phrases are words or phrases that the person often and emotionally uses to describe personally significant values, phenomena or states.

With key concepts or phrases, a person always associates “key meanings”, which he often does not fully realize. These are personal definitions of concepts important for a person, such as "happiness", "trouble", "problem", "good", "bad", "to really live ", "be healthy" or "successful". For each person, these concepts are colored by personal (key) meanings that motivate or frustrate his personality.

4.3. Revealing the "key meanings"

The “key meanings” are revealed through suggestive questions to the key phrases and concepts of the person: "What does this mean to you?", "How do you understand it?", "What does it mean, in your opinion?" Here it is very important to be able to ask "non-judgmental" questions that actualize personally significant (and not correct or incorrect) key meanings of the person. By answering them, many people for

the first time begin to realize their personal concept or key meanings of “good”, “evil”, “help”, “love”, “success”, etc.

Key meanings are personal concepts and definitions imprinted in personally significant associations and mental images that are actualized in the conscious or irrationally sensed unconscious of a person when he meaningfully pronounces a keyword or phrase. People use the same terms, but have different, individually colored meanings, expressing them "in their own, personally significant definitions." Understanding the "personally significant definition" of a key phrase or term is the task of this stage.

4.4. Resourceful / frustrating experience: the search for an associative bond

After that, **questions are asked to the “key meanings”, which are aimed at updating the frustrating or motivating resource experience**, with which the “key meaning” of the phrase is associated. " Has this happened in your life?" – the "key meaning" phrase. "Can you remember when and under what circumstances you realized it, felt it, experienced it?" – the "key meaning" phrase. "Can you remember when you really had it?" – the "key meaning" phrase.

Key phrases actualize key meanings, and key personally significant meanings are associated with the resource experience of a particular period, segment, fragment of a person's life, namely, with the experience that influenced the formation of those deep meanings that frustrate or motivate the person in the present.

This is the most sensitive stage in the search for an associative connection between key meanings and resource experience, which requires the pastor to show tact, respect and skills of non-directive, client-centered active listening, that allows the person to feel support, acceptance and Christian love. The result of such an associative search is a story or several similar stories from the life of the person, in which he received a resource experience that influenced the formation of motivating or frustrating attitudes, which we call "deep meanings", noting their irrationally determining potential.

4.5. Disclosure of deep meanings – rationalization of a life lesson

Rationalizing questions are asked to resource experience (that is, to a story or stories from the past that emerged as a result of the analysis of the associative connection of key phrases and key meanings): "What did you then understand about yourself / your soul / abilities / capabilities?", "What exactly did you experience?", " What was it for you?", "What did you learn then?", "What did you understand better about your neighbors / people /about this world?", "What did you understand about your life?", "What did you understand about God?".

Resource experience is associated with personal history or stories from the past, in which motivating or frustrating deep meanings of a person have been formed.

This is usually the story in which the person experienced joy or sorrow, fear or success in the most concentrated form. Remembering, living through and rationalizing such a story makes it possible to identify, understand and correct the deep meanings of a person.

Deep meanings are irrationally motivating or frustrating attitudes derived from resource experience, irrationally determining a person in life "here and now", which are associated with key meanings, key phrases.

The disclosure of deep meanings occurs in the process of rationalizing resource experience as a lesson, a resource for understanding oneself, people, the world, which is the main task of this stage of the pastoral conversation.

In the future, the pastor can correct the rationalizations formulated by the person with a supportive or critical instruction, approving or correcting them, depending on the religious coordinates of good and evil of a particular pastor.

If the experience turns out to be resource-creating, the pastor can transfer the lesson and deep meanings to the situation or life "here and now". If the experience was frustrating, the pastor actualizes the necessary religious imperatives that motivate the person to push off the negative experience of the past and trust in a new religious soul-saving experience / take a “step of faith”.

"It is important to teach a person to "switch" from a state of depression to a state of trust, hope, prayer." Hegumen Evmeniy. [4]

5. Advantages of implementing the technique of pastoral work with deep meanings

5.1 for the pastor:

- allows one to quickly build a trusting alliance, build accepting relationships;
- forms a nonjudgmental attitude towards the person in the spirit of Christian brotherly love;
- engages the person into inner spiritual and psychological work;
- allows to quickly identify a resourceful or frustrating experience and adopt a strategy of the pastoral care that would be most appropriate for the soul of the person;
- prevents spiritual and psychological burnout of the pastor, as it forms the skill of joint search and sharing responsibility for the spiritual and psychological result in the life of the person.

5.2 for the patronized person:

- quickly forms a trusting relationship as a result of the manifestation of the pastor's interest for the opinion, thoughts, feelings, meanings of the person;
- includes self-reflection resources, expanding the inner field of awareness, associative connections, thoughts, feelings and past experiences;
- forms the effect of insight or revelation, or finding important meanings, due to leading questions of the pastor stimulating consciousness;
- develops the skill of spiritual and psychological self-help, forming the skill of rationalization of irrational states.

6. Bibliotherapy

BIBLIOTHERAPY (from the Greek "biblion" – book and "therapeia" – care, healing, treatment) is a field and method of psychotherapy and psychocorrection using literature of various genres as a therapeutic factor. The healing effects of literature have been known for a long time. The first scientific research on this issue began in the XIX century. The possibility of its targeted application was noted by V.M. Bekhterev, who proposed libropsychotherapy (therapeutic reading), and V.N. Myasishchev (therapy through a book, bibliotherapy). Various aspects of reading and bibliotherapy are devoted to the works of B.D. Karvasarsky, V.A. Nevsky, A.F. Lazursky, N.A. Rubakin, A.A. Gaivorovsky, I.Z. Velkovsky, R. Barker, K. Menninger, A.M. Miller, O.L. Kabachek, Yu.N. Drescher, E.N. Isaeva, I.N. Kazarinova, Yu.B. Nekrasova, I.A. Stolyarova, etc. The basis of the impact on the reader in bibliotherapy is the identification mechanism: identifying with the character of the book, a person puts himself into the situation of the book character, emotionally reacts, empathizes. The therapeutic effect is based on the fact that the patient recognizes his problem, his traumatic situation in the book and follows the patterns set in it for getting out of such

situations, for their psychological overcoming. Aspects of the relationship between the reader, the text and the author are also interesting. There are three main approaches to the multilevel process of bibliotherapy: prescription, motivation and pedagogics. The methodological arsenal of bibliotherapy is being actively developed and systematized. There are library, family (home, family reading), individual and group bibliotherapy. Different literature genres can be used in bibliotherapy – poetry, fairy tales, etc.; bibliotherapy can be used in working with various problems, in a wide age range of participants, in different social groups, etc. [7]

6.1. Bibliotherapy as pastoral work with the texts of the Holy Scripture

In pastoral care for the "toiling and burdened", including people experiencing depressive states, a powerful motivational and transformative resource is the reflection on certain texts of the Holy Scripture.

«"Reading also refers to the instruments of pastoral counseling – instruction by word. However, unlike oral teaching, here the word affects people in written form, whether it is Holy Scripture or other books." S. Alpatov [8]

“Indeed, the word of God is living and active, sharper than any two-edged sword, piercing until it divides soul from spirit, joints from marrow; it is able to judge the thoughts and intentions of the heart.” (Heb. 4:12)

This text of the Bible has become a guide for us in the development of the author's technique of bibliotherapeutic reading of the Holy Scripture texts in spiritual and psychological assistance to people in depressive states. Reading certain texts of the Holy Scripture with such people using the technique of logotherapeutic dialogue, the pastor encourages the person to reflect on the states, experiences, conclusions and decisions of the biblical character described in the text, associatively linking them with his personal experience. Such reflexive reading develops a high degree of involvement, self-reflection, self-identification and emotional reaction of personal frustrating experience and acceptance of the values of the biblical character.

In the consciousness of the Russian multinational people there is an innate respect and reverence for the Bible, as for any Holy Book. This spiritual-transcendent feeling is actualized during personal reading of the Bible in the context of a logotherapeutic dialogue and becomes a powerful spiritual-psychological motivator of personality transformation. The motivation of respect, reverence and trust, formed in the process of joint reflection on the Bible, contributes to the self-disclosure and trusting attitude of the person, provided that the pastor remains in the non-directive, non-judgmental position of a mentor-friend who, within the framework of a logotherapeutic dialogue, asks questions about the meanings in the Holy Scripture.

6.2. Resourceful texts for bibliotherapy in pastoral care

- **The psalms of lamentation from the book of Psalms of the Bible synodal translation** are the optimal beginning for the actualization of depressive feelings, thoughts, attitudes of the person for their further reaction and confession. There are more than sixty of them, including individual and general lamentation prayers. The individual lamentations (for example, Psalms 3, 22, 31, 39, 42, 57, 71, 120, 139, 142) help a person expose struggle, suffering or disappointment to the Lord.

  Here are some examples:

  Psalm 31

  “10. Have mercy upon me, O LORD, for I am in trouble: mine eye is consumed with grief, yea, my soul and my belly. 11. For my life is spent with grief, and my years with sighing: my strength faileth because of mine iniquity, and my bones are consumed. 12. I was a reproach among all mine enemies, but especially among my neighbours, and a fear to mine acquaintance: they that did see me without fled from me. 13. I am

forgotten as a dead man out of mind: I am like a broken vessel. 14. For I have heard the slander of many: fear was on every side: while they took counsel together against me, they devised to take away my life. 15. But I trusted in thee, O LORD: I said, Thou art my God. 16. My times are in thy hand: deliver me from the hand of mine enemies, and from them that persecute me. 17. Make thy face to shine upon thy servant: save me for thy mercies' sake." (Psalms, Psalm 31:9-16)

Psalm 142

"1. I cried unto the LORD with my voice; with my voice unto the LORD did I make my supplication. 2. I poured out my complaint before him; I shewed before him my trouble. 3. When my spirit was overwhelmed within me, then thou knewest my path. In the way wherein I walked have they privily laid a snare for me. 4. I looked on my right hand, and beheld, but there was no man that would know me: refuge failed me; no man cared for my soul. 5. I cried unto thee, O LORD: I said, Thou art my refuge and my portion in the land of the living. 6. Attend unto my cry; for I am brought very low: deliver me from my persecutors; for they are stronger than I. 7. Bring my soul out of prison, that I may praise thy name: the righteous shall compass me about; for thou shalt deal bountifully with me." (Psalms, Psalm 142:1-7)

When a depressed person lives through together with a biblical character the meanings of loneliness, rejection and states of longing, sadness and despondency, which are close to him, doing so in the presence of a supportive pastor, this, on the one hand, takes the depressive person out of the closed space of neurotic loneliness, destroying the illusion of a tragic the exclusivity of his mental suffering, on the other hand, allows him to experience and confess conflicting thoughts and feelings in a controlled way, reveal accumulated aggression and self-aggression, and actualize key issues and meanings.

- **Psalms that include elements of self-reflection and hope** have a transformative resource, especially those passages where the author interacts with his soul, as, for example, in **Psalm 42**:

"4. My tears have been my meat day and night, while they continually say unto me, Where is thy God? 5. When I remember these things, I pour out my soul in me: for I had gone with the multitude, I went with them to the house of God, with the voice of joy and praise, with a multitude that kept holyday. 6. Why art thou cast down, O my soul? and why art thou disquieted in me? hope thou in God: for I shall yet praise him for the help of his countenance. 7. O my God, my soul is cast down within me: therefore will I remember thee from the land of Jordan, and of the Hermonites, from the hill Mizar. 8. Deep calleth unto deep at the noise of thy waterspouts: all thy waves and thy billows are gone over me. 9. Yet the LORD will command his lovingkindness in the daytime, and in the night his song shall be with me, and my prayer unto the God of my life." (Psalms, Psalm 42:3-8)

A conversation with the soul of a biblical character allows the person to switch to the "moans of his soul", verbalize them, identify himself with the character of the Bible and switch to the meanings offered by him: trust, faith, hope, soul-saving actions.

- **Biblical imperatives** that encourage the manifestation of inner values and virtues. For example, Psalm 36:3 "Trust in the LORD, and do good; Dwell in the land, and feed on His faithfulness." (The Bible. Psalter. 37:3). Biblical imperatives encourage one to get out of his comfort zone, but only if a depressed person has found an associative connection of his experience with the meaning of the text. The skillful inclusion of elements of the previously presented technique of **pastoral work with deep meanings** helps well in this, if the biblical imperative is chosen as the key word with which the work begins, for example, "Trust in the Lord".

6.3. An example of the application of the technique of pastoral work with deep meanings in bibliotherapy (R.I.Nadyuk)

"Trust in the LORD, and do good; Dwell in the land, and feed on His faithfulness." (The Bible. Psalter. 37:3).

6.3.1. The key imperative

The pastor can ask a question to one or all of the imperative keywords. What does it mean to you? / How do you understand? / What do you think "trust in the Lord, do good, feed on His faithfulness" means?

The imperative that gives a greater emotional response becomes the key in analogy with the key phrase in the technique of pastoral work with deep meanings. For example, "hope".

6.3.2. The key personal meaning of the Biblical imperative

The explanation formulated by the person is accurately remembered or recorded and clarified by the pastor. For example, "to hope means to trust deeply and wait." In the future, a series of questions, shaping the associative connection with resourceful experience, is put to it (to the personal explanation of the imperative), as to the key meaning.

6.3.3. Search for resourceful experience

The pastor is asking leading questions trying to find personal experience, which is associated with the key personal meaning of the biblical imperative. For example, *"to hope is to trust and wait."*

"Can you remember when you needed / had/ managed to *"hope – trust and wait"*? When did you really *"hope – trust and wait"*?" or "When did you do it best of all?" or "... in the strongest possible way?"

These and other similar questions, asked by the pastor with a supportive intonation and nonverbal speech, with pauses that allow him to think, help the person to associate the key meaning of the biblical imperative with a resourceful or frustrating experience, when the person lived it thorough, for example, "hope – trust and wait."

6.3.4. Reacting and rationalizing the resourceful experience

When the resourceful experience, in our example "*hope – trust and wait*", is found and the person "fell" into the associatively-related history of his personal experience of hope and expectation, the pastor works with a state of confession or psychotherapeutic catharsis. He listens to the story, hears the meanings, asks about the main thing, talks about the experience and inspires the person to be frank and live through the story.

6.3.5. Deep personal meanings of the Biblical imperative or a rational lesson

As in the case of applying the above technique of pastoral work with deep meanings to the resourceful experience of a story from a personal past, associated with the biblical imperative, in our case - "*hope – trust and wait*", rationalizing questions are asked: "What did you learn then?", "What did you understand about yourself / your soul / abilities / possibilities?", "What did you understand about your neighbors / people / the world?", "What did you understand about life?", "What did you understand about God?"

If the experience is defined as resource-creating, the spiritual pastor can transfer the lesson of resourceful experience and deep meanings to the situation or life "here and now". If the experience is defined as frustrating, the pastor actualizes the necessary religious or spiritual imperatives that motivate the person to evaluate the negative experience of the past and trust the new, religious, soul–saving action in the present. In

other words, to take a "step of faith" in the opposite positive direction, "from avoidance to achievement, from fear to faith."

This technique of logotherapeutic technique in bibliotherapy can be used in the process of joint reading of various resource texts of the Holy Scriptures and other Sacred books and legends.

7. Advantages of implementing the technique of pastoral work with deep meanings in bibliotherapy

7.1 For the pastor:

- allows to quickly engage the person into the search for important meanings actualized by the Holy Scriptures;
- it stimulates the person to comprehend the Biblical story and to personally reflect on the significant associative connections of the Biblical imperative with personal experience;
- allows to instill spiritual values in a dialogical, client-centered, and not in a monologue-directive format;
- it prevents spiritual and psychological burnout of the pastor, as it allows him to be emotionally in a corrective, not a formative position.

7.2 For the patient:

- acquires a personal interest in reading the Bible as a book that actualizes personal experience;
- forms the effect of insight or revelation from the Bible, God, God's man and the pastor.
- The Holy Scripture becomes a Book that guides towards personally important meanings;
- develops the skill of spiritual and psychological self-help, forming the skill of self-reflection in the process of reading the Holy Scripture.

This technique has been tested for 6 years on more than 300 persons of Christian faith of different denominations, students of the program "Church counseling" of the Seminary of Evangelical Christians, including those in subdepressive states. According to the reviews of the patients, most of them acquired positive and soul-saving meanings, personal insights and revelations, found for themselves a new, personal format of reading the Holy Scripture and an effective way of spiritual care and self-help.

Conclusions

The advantages of using logotherapeutic techniques of **pastoral work with deep meanings and pastoral bibliotherapy** are as following:

- quite effective in providing primary spiritual and psychological assistance in the church or parish premises;
- easily integrated into any style of pastoral interaction with the community;
- they can be easily mastered, provided the initial communicative competence is available;
- do not require a lot of time to implement;
- allow to work with the soul of the person safely, avoiding the effect of psychological pressure;
- the techniques have a self-learning resource, developing the skills of spiritual and psychological self-help in the person;
- the use of logotherapeutic techniques prevents spiritual and psychological burnout of the pastor, due to their client-centric implementation style, which

allows the pastor, paying attention to each soul, to remain emotionally resourceful for a long time in order to care for a large community.

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The experience of providing psychological and psychiatric assistance to combatants who are being treated in a military hospital: the view of a doctor, psychologist and sister of mercy on depression and anxiety

Abstract: The report is a summary of the experience of providing psychiatric, psychological, spiritual and moral assistance to the combatants who are being treated at the Federal State Governmental Institution "Military Clinical Hospital №1602" of the Defense Ministry of the Russian Federation, Rostov-on-Don. The practice of providing psychiatric care to the patients of military hospitals that were wounded and injured during military operations and have anxiety and depression syndromes, is briefly described by the psychiatrist Dmitry Tarumov, medical colonel, Doctor of Medicine, associate professor of the Department of Advanced Medical Therapy # 1 of the S.M. Kirov Military Medical Academy of the Ministry of Defense of Russia. The experience of providing psychological assistance to this category of patients being treated at the Military Clinical Hospital №1602 is described by Fattakhova Tatiana Ivanovna, an advanced medical psychologist. The psychological and spiritual assistance of sisters of mercy to the patience of the Military Clinical Hospital №1602 is described by Belanova A.M., psychologist at the above hospital and founder of the St. Seraphim of Sarov Sisterhood of Orthodox sisters of mercy.

Keywords: depressive disorders, anxiety disorders, therapy for post-traumatic stress disorder, “mother's psychotherapy.”

Doctor's view

One of the most common mental combat pathologies is an acute reaction to stress (up to 5% of all wounded and injured), clinically manifested by signs of psychomotor agitation, disorientation or, sometimes, vice versa – numbness or weakness. Often, such a reaction is also manifested in trained, experienced combatants who have been on the battlefield more than once. Short-term **depression and anxiety** manifestations in these states quickly disappear on their own or after a single use of tranquilizers or neuroleptics. As a rule, the combat capability is restored already on the next day.

The initial attitude and orientation of the participants of special forces to perform a combat mission certainly reduce the likelihood of such a reaction occurring. However, in modern realities, such training for large groups of military personnel is often not carried out. The role of clergy in these circumstances should not be underestimated.

Our observations in the SMO zone show that a few parting sincere and kind words from a priest before a battle can replace in the short term part of the military-political work.

The **depression and anxiety** manifestations characteristic of severe persistent astheno-neurotic syndrome that occurs in the context of long-term uninterrupted participation in combat operations on the front line and in conditions close to the front line, can be supervised by psychiatrists, who are part of medical teams working in the SMO zone, and stopped by the use of psychopharmacological drugs. It should be noted, however, that the number of military psychiatrists in the Armed Forces of the Russian Federation is limited, which makes it impossible for them to work in each such medical team.

Anxiety and **depression** symptoms occur in acute stress reactions, in adaptation disorders, as well as in post-traumatic stress disorder, which is the final component of the first two nosologies in continuum in the absence of a proper symptomatic therapy in the early stages. The development of **anxiety** and **depression** syndromes one way or

another leads to the formation of the disease and requires treatment even before the appearance of its clearly defined symptoms.

At this stage, treatment of prolonged **anxiety** and **depression** reactions is no longer possible without psychopharmacological interventions. Psychiatrists use tranquilizers, antidepressants and neuroleptics in this case.

Psychotherapy makes a great contribution in the context of a special psychotherapeutic intervention for the management of such patients. A separate issue is the treatment and further socialization of patients after being in captivity. Their spiritual and mental state is of particular concern to doctors and psychologists.

Of great value is the presence of a clergyman who carries out his service in a medical unit in the SMO zone, providing spiritual care for military personnel, mostly those who were mobilized, who, due to their psychological state, have lost hope, are burdened by living conditions. Experience shows that priest's counsel raises the patriotic spirit, awakes religious feelings, which strengthens the manifestations of a healthy personality, and then, even if the patient is sick, it helps him to resist the disease, adapt to it and compensate for the defects caused by it (Hegumen Evmeniy, 1997).

A separate important issue is the creation of departments for the so-called "shell-shocked". A large number of evacuees from the SMO zone do not have a clearly defined mental or neurological pathology. Due to the large number of incoming patients, this group of patients remains without proper care, not falling under responsibility of either psychiatrists or neurologists. This condition is associated with the impact on a person of extreme factors of military operations, which he suffered directly on the battlefield, when his brain, ENT organs and the body as a whole were affected by an explosive wave. This condition most closely corresponds to the concept of "concussion". Clinically, it can be manifested by subjective complaints of headache, tinnitus, dizziness, nausea, feeling of nausea and weakness, hearing loss, etc. Such patients may show signs of anxiety, agitation or detachment, stuttering speech, or even mutism. However, later, after examination by specialists, the diagnosis of closed craniocerebral injury, akubarotrauma or any mental pathology may not be confirmed. If a decision is made to evacuate such a patient, the curation of this pathology is carried out in the therapeutic departments.

Psychologist's view

The experience of an extreme situation, as a rule, leaves a traumatic trace in a person’s psyche. Post Traumatic Stress Disorder Syndrome is common in combatants returning from a military operation zone. Depression is a frequent symptom of PTSD.

Psychologists consider depression as a negative emotion, a "stop signal of the soul" that comes after periods of fear, anger, grief associated with a traumatic experience. Depression does not allow you to move forward, works as a brake on the individual. Exacerbation of depression can have disastrous consequences, including suicidal thoughts or even attempts. The common definition of depression is anger turned inward.

In our experience, anxiety and depression, as symptoms of PTSD, are healed by self-compassion, as well as the humanity and kindness of others.

The combatants are radically changing the perception of events and people, attention, thinking, value system, relationships with others. In order to survive in a combat situation, the functioning of brain, nervous, hormonal, and cardiovascular systems changes significantly. These changes are needed to increase the level of vigilance, combat alertness, increase the speed of response to changes in the situation, and muscle strength to overcome barriers. The so-called "combat reflexes" are formed, allowing in case of danger to act instantly, without thinking. Combatants get used to **living in alarm mode**. In order to meet the danger fully armed and perform the combat

task efficiently, they repeatedly scroll through the upcoming actions in their thoughts, focusing more on possible negative consequences. The lack of time for decision-making leads to the fact that combatants get used to simple interpretations of events, divide them into dangerous and safe, useful and useless, good and bad, moral and immoral, evaluate also people in black and white colors, unambiguously, and sometimes aggressively react to what seems unfair to them.

“Emotional numbness” is registered. At the same time, the memory of difficult moments of the combat past, of fallen comrades in a distorted form, in the form of vivid and painful memories, nightmares can come back to the combatants again and again.

It should be noted that much of what helped to survive in a combat situation, in peaceful conditions, can become interfering, seem inappropriate, redundant or scarce to others.

In most cases, this is a temporary phenomenon: just as a person gets used to combat conditions, he adapts also to a peaceful situation.

Working with combatants, a psychologist explains to them that they need to notice the above phenomena and try to get rid of them as quickly as possible; they need to try to understand the reactions of others and not to react to them with irritation and aggression; they need to learn how to use the simplest techniques of mental self-regulation to improve their mental state; it is extremely important to keep a clear mind, an open heart and stable condition.

The experience of a psychologist working with this category of persons shows that in a state of **anxiety**, there is often a reluctance to confront specifically with the somatic aspect: muscle tension, fear, sleep disturbance, discomfort in the heart or stomach. Avoiding an anxious response forms a vicious circle, which is the key point in the formation and consolidation of **anxiety**. At the same time, hormones accumulate in the body, which generate autoaggression (aggression directed inward), randomness, and this destroys health, both physical and mental.

After witnessing the military events, 3 basic illusions are destroyed in a person:

1. The illusion of justice
2. The illusion of immortality
3. The illusion of simplicity of the world structure.

Therefore, the first task of the psychologist is to establish a trusting contact with the client so that the person can open up and start talking (this can be done through drawing, asking the client to draw a place where he felt calm and well). The task of a psychologist is to listen carefully and give the client an opportunity to speak out.

One can use various techniques, for example, suggest to draw 3 trees: a young tree, a wounded tree, a wise reborn tree, and then ask what the client felt during the drawing process, how he perceives each tree, etc.

Some participants avoid all kinds of memories of what happened. People don't want to talk about their problems; they think that only their people can understand them. In such cases, the combatant says: "I've become different." Through communication or through your own experience, you can establish contact with a person.

Delicately and tactfully, the psychologist should listen to the client and convey to him that he is normal, he will cope with everything, just in his situation it takes time to recover. The task of the psychologist is also to teach self-regulation techniques. The "activation of parasympathics" works well (short inhale/long exhale, square breathing, attention to the feet, Chinese gymnastics, joint gymnastics).

The Military Clinical Hospital №1602 of the Defense Ministry of the Russian Federation follows the program of socio-psychological support and development (improvement) of tolerance (resistance) to extreme situations for military personnel and their family members, the purpose of which is to form resistance to the adverse effects of difficult, emergency situations, the development of personal capabilities in using

such situations as "catalysts" of personal growth. The development of tolerance in relation to extreme situations means, first of all, the ability to endure these situations without damage, and in the best case, even receive a certain gain for oneself, which implies gaining experience, acquiring certain qualities that promote a person to a new stage of development, formation of stability to stressful situations.

The view of a sister of mercy

For many years, the Military Clinical Hospital №1602 of the Ministry of Defense of the Russian Federation has accumulated a unique experience of gratuitous assistance of Orthodox sisters of mercy to wounded combatants. This was both assistance in caring for wounded soldiers and psychological support of a spiritual and moral kind.

Our sisters of mercy treated the sick and wounded patients of the hospital according to the Gospel teaching as if they were our brothers, sons, grandchildren (depending on the age of the sister of mercy). The well-known psychologist Fyodor Efimovich Vasilyuk, who became acquainted with the work of our sisters of mercy during the Second Chechen War, called it “mother's psychotherapy.”

Often in our work we encounter manifestations of anxiety and depression in patients, especially in soldiers who have lost limbs and received severe wounds and injuries. Often the reason for the depressed state is the loss of comrades. Open-hearted communication during the care assistance, the personal life experience of the sisters of mercy in comprehending the meaning of illness, loss, sorrow, based on the Orthodox faith, is of great psychotherapeutic importance; often after such conversations, a person wants to talk with a priest and participate in the sacraments of Confession and Holy Communion. We have repeatedly witnessed a decrease in depressive and anxious manifestations in wounded combatants when turning to God's help. Often, conversations with a priest and sisters of mercy were the beginning of inchurching.

There are numerous testimonies of the wounded themselves, that the psychological support and spiritual assistance provided by the sisters of mercy and the clergy are invaluable for them, as they help the combatants to find inner balance and calmness, overcome a sense of despair, see positive prospects, and gain support in faith in God's help.

Archpriest Alexiy Baburin

Positive attitude towards life and peaceful acceptance of natural death is a necessary basis in suicide prevention

Abstract: The report addresses the role of the individual's value system, in particular affirmation of a positive attitude towards life and peaceful acceptance of natural death, in stopping suicide thoughts and behavior. It suggests to use axiopsychotherapy as widely as possible to relieve suicide tension leading to suicide.

Keywords: suicide, personal values, moral choice, religiosity, axiopsychotherapy.

> *"I call heaven and earth to testify against you today! I've set life and death before you today: both blessings and curses. Choose life, that it may be well with you – you and your children"*
> *(Deut. 30:19).*

Suicide is a complex biopsychosocial-spiritual phenomenon.

From the WHO Report "Preventing suicide: A global imperative" (2014), we know that "over 800 000 people die by suicide every year" and that "in high-income countries, mental disorders are present in up to 90% of people who die by suicide". According to WHO, "the lifetime risk of suicide is estimated to be 4% in patients with mood disorders, 7% in people with alcohol dependence, 8% in people with bipolar disorder, and 5% in people with schizophrenia".

Although, according to combined data from family and twin studies, as well as studies of adopted children, "the role of hereditary factors in the development of suicidal behavior is estimated at 30–55% (R.N. Mustafin et al., 2019), epigenetic factors still remain decisive factors in suicide tendencies; they are "modulated by environmental influences, especially stress" associated with a life paradigm, including the respective system of basic values.

"It is precisely what is especially significant for a person that ultimately acts as the motives and goals of his activity and determines the true core of the personality," wrote back in 1946, Doctor of Pedagogical Sciences, Professor, Corresponding Member of the USSR Academy of Sciences Sergei L. Rubinstein (1946).

In a cross-cultural study, Ravlin E.G. and Meplino B.M. "On the influence of values on perception and decision-making" it was found that values are indeed hierarchically organized in memory, and people are guided in their behavior by them. The dominant values of an individual play the role of a kind of standard for decision making (Ravlin E.G., Meplino B.M., 1987).

It is known that the value system of suicide victims reveals the absence, loss or conflict of attitudes that determine their understanding of life, pain, suffering and death.

Highlighting the main milestones of the long-term creative path of the founder of Russian suicidology A.G. Ambrumova in connection with her 100th anniversary, suicidologists Lyubov E.B. and Tsuprun V.E. (2013) write that "suicide, according to Aina Ambrumova, is rarely the result of a rational weighing of life circumstances, arguments for accepting or rejecting life; The crisis is based on a range of negative emotions: despair, grief, fear, feelings of helplessness, guilt, anger, desire for revenge or to interrupt unbearable mental (psychalgia E. Shnaidman) or physical suffering. However, the "cold suicides" mentioned by A. Ambrumova are unlikely to be a consequence of painful experiences of the collapse of value systems and the "I"; but more of a negative balance reaction, when everything is "weighed, calculated, measured," leading to a carefully planned suicide. She took into account the role of a

very common cause – depression, including the one with an existential facade." "Antivital experiences of denial of the meaning and value of life are closely related to a depressive worldview, and suicidal thoughts reach a certain level of super-value. But the origin, development and dynamics of suicidal tendencies are not explained only by clinical (psychopathological) symptoms."

Considering suicide as a result of decision-making, which is influenced not only by rational reasoning, but also by beliefs, moral principles, and implicit preferences, the Scientific Center for Mental Health studied the connection between making "moral personal" decisions and implicit attitudes toward "death" and "life" in healthy people and clinic patients who had a history of suicide attempt or clearly talked about suicidal thoughts and ideas. "The results of the study showed that an implicit preference for "death" is associated with instability of moral preferences. In turn, stable moral preferences, which cannot be shaken by rational reasoning, are associated with an implicit preference for life" (S.N. Enikolopov et al., 2018).

The researchers suggested that "the stability of moral principles in the face of rationally understood 'benefit' may be one of the protective barriers to making a 'rational' decision to commit suicide."

Based on the experience of confessional-oriented rehabilitation work with mental patients accumulated at the Scientific Center for Mental Health, a special study examined the value-semantic structures of the worldview of people with a religious worldview suffering from mental disorders in comparison with control groups (Borisova O.A., et al., 2019). A comparative analysis of the structure and content of the value-semantic sphere of believers and non-believing patients showed significantly greater stability and stability of the value-semantic structure of believing Orthodox patients, and even a serious illness did not fundamentally change its structure. At the same time, the structure and content of the value-semantic sphere of non-believing patients changed significantly during the course of the illness. Orthodox patients retained an active desire for God and the development of spiritual qualities in themselves. The concepts of "health", as well as "illness", were organically included in the general context of their spiritual, mental and physical life, and the fact of the appearance of mental illness did not make critical changes in the worldview of these patients.

"Each act of suicide is unique in its own way and has its own set of reasons, intentions, goals, methods and meanings. But, despite the fact that any suicide always has a meaning and purpose, in some cases they may not be fully realized. This directly applies to individuals who attempt suicide in a state of acute psychosis with hallucinatory-delusional symptoms.

Suicide behavior, which is formed in an extreme situation, is most often regarded by researchers as one of the types of human behavioral reactions with a wide range of individual variations - from a relative psychological norm to severe mental pathology" (Zhuravleva T.V., 2022).

Depending on what idea of death in a person's mind becomes his belief - "death is a transition to another level of existence" and "death is a complete cessation of existence" - the emphasis in life is placed either on the values of development, improvement and knowledge, or on the quality of this only lived life, the value of which is productivity, eventfulness, achievements, public recognition (Shutova L.V., 2005).

The worldview of a deeply religious person prevents suicide due to the concept of exclusivity and transcendence of the human personality present in his axiopsychological sphere. "For the believer, death indicates the fragility of his existence and his dependence on God. He places his life in the hands of God in an act of complete obedience" (E. Sgreccia, V. Tambone, 2002). Peaceful acceptance of natural death is achieved with complete trust in God - "Thy will be done" (Mat. 6:10).

“To the question: why do we continue to live? - in the end, one must answer: the determination to live is significantly different from the determination to take one’s life. Since I did not give myself life, I decide only to let what already exists exist.” This is how Karl Jaspers formulates his thesis against suicide.

The life paradigm of modern Western society, which is obsessed and suppressed by the fear of death, excludes the acceptance of death and the value of suffering. “Death makes sense only when, by depriving a person of earthly goods, it opens for him hope for a more complete life. The inability to comprehend death leads to two interconnected attitudes towards it: on the one hand, they do not want to know it, they expel it from consciousness, culture, life, and, most importantly, it is excluded as a criterion by which the authenticity and value of life is checked, on the other hand, it is anticipated in order to avoid a direct confrontation with conscience” (K. Jaspers, ed. 2012).

A clear proof of a similar secularized perception of the problem of death among students was revealed at the Department of Philosophy, Humanities and Psychology of V. I. Razumovsky Saratov State Medical University, Ministry of Health of Russia.

Savinskaya A.A. et al. (2016) conducted a questionnaire survey of 60 students of 18-19 y.o. to identify fear of approaching death and attitudes towards immortality. Here's what was found:

- “In the attitude of students towards death, a scientific-materialistic approach prevails, which is most likely due to the specifics of the university (most students define death as the cessation of biological existence; death is a law of nature, etc.).
- The most respondents (80%) do not see positive potential in thinking about death, but believe that it only darkens our lives, so it is better to leave it and snap out of this. The tradition of preparing for death is in most cases perceived as an anachronism that has lost its deep meaning.
- 75% of respondents believe that science is able to make a person completely or partially immortal.”

Such superficial judgments by medical students indicate that they underestimate the spiritual dimension of human life and are focused on purely material needs.

In this regard, it should be noted that among the deaths of young people (aged 15–29 years) globally, suicide is already the second largest cause, and among the adult population, for every person who died from suicide, there are over 20 people that attempted suicide (World Health Organization, 2014).

Apparently, the alarming increase in suicide rates over the past half century is associated with a prevailing sense of randomness and meaninglessness of existence and a weakening of religious sensibility.

Meanwhile, in a non-secularized environment among religious people, the desire to live a meaningful life, for the sake of spiritual values that rise above the simple satisfaction of physical needs, prevails.

“Focus on such values can be experienced as immanent, as ensuing from the individual himself, or as transcendental, as prompted, inspired or even as commanded by an Entity superior to the genus humanum, which ultimately decides the fortunes of the species. In the latter case, we arrive at religion. At a postulated, supernatural, mythical authority named God. That God has expectations and makes demands. For the believer, meeting these is both a duty and a source of satisfaction. For him, God is the ultimate, sublime giver of meaning” – says Herman M. van Praag (2020), the founder of biological psychiatry in the Netherlands, one of the most secularized countries in the world.

In the article “The Role of Religion in Suicide Prevention,” Herman M. van Praag makes it clear that “religious commitment — religiosity, and to a somewhat lesser extent religious affiliation — is associated with less suicidal behavior”. He explains this

relationship by the fact that religious communities provide their members with a support group, that religion itself can give relief and hope to a person in difficult times, for a believer God is the supreme Comforter, that God's punishment here and now or in the afterlife is not excluded.

Referring to the Abrahamic religions, he says: "Judaism considers life as a personal gift of God: 'and surely your blood of your lives will I require'(Gen. 9:5), an injunction which Rabbis took literally, and based on it the prohibition of suicide. Christianity adopted the same attitude based on the sixth commandment: 'Thou shall not kill' (Ex. 20:13). The same holds for Islam. Suicide is condemned. 'Don't cast yourself into perdition'. It is God who gave life and He alone is entitled to take it" (Herman M. van Praag, 2020).

At the same time, it is very important how the believer perceives God: as merciful and humane, or as punishing and formidable. "Love comes from God. Everyone who loves has been born from God and knows God. The person who does not love does not know God, because God is love" (1 John 4:7-8).

Religions such as Hinduism, which view reincarnation as part of the life cycle, may have a more liberal attitude toward suicide.

According to the World Health Organization, "Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community."

This definition does not include the ethical dimension of health. Whereas, the cause of many diseases is a morally vicious choice, an irresponsible attitude towards one's health. For example, alcohol and drug use, tobacco smoking, promiscuity, overeating, aggressive behavior. When it comes to responsibility, an ethical dimension is always implied.

The state of well-being with which the concept of health is associated is ensured by the integrity of the individual and the harmony of his ethical and religious values. When, in the hierarchy of a person's significant meanings, reverence for the gift of life is replaced by contempt for it, and instead of a "shameless and peaceful" death, a violent end to life is preferred in a state of bitterness or "from human resentment or in some other case from cowardice" (St Nicodemus of the Holy Mountain (Kallivroutsis)), then all spiritual, medical-social and psychological-psychiatric efforts should be aimed at the formation of a stable life-affirming system of values and a genuine human attitude towards leaving life, warmed with humility and love.

It must be said frankly that truly believing representatives of traditional religions have a number of advantages over atheists and agnostics. They have higher developed value and life-meaning orientations, explicit value orientations towards love, a higher developed empathy, a positive attitude towards others, self-acceptance, emotiveness, and non-aggression. Although believers are more susceptible to fears than non-believers, religion helps them overcome fears and gives them a sense of psychological security. In overcoming difficult life circumstances, believers more often use the strategy of seeking social support, self-control, and less often the strategy of confrontative coping (Achinovich T.I., 2013).

I will give here one example of pastoral healing by St. Nikolai Velimirovich (1881-1956), bishop of the Serbian Orthodox Church, of a religious woman who was in despair and tried to take her own life.

"I know how difficult it is for you. A few years ago your husband died. Grief - over the edge. You survived. Soon the son got married - the joy returned. You were especially comforted by your beloved grandson. But the one whom you loved, the Lord also loved and took to Himself. Soon after this, the daughter-in-law became seriously ill. Sadness and grief dried her up, and she followed her son. Your only son followed them. You tried to poison yourself - you survived. You prepared a rope to hang

yourself, but a neighbor girl interfered. Seeing you with a rope, she said what she heard from her elders, that suicide is a mortal sin that cannot be forgiven either in this world or in the next. She said it correctly; this girl saved your soul. Truly, thanks to her, you will be able to see your son, daughter-in-law, grandson, and husband in the next world.

From the beginning, the Church of Christ resolutely opposed suicide as a mortal sin. The teacher of the Western Church, Blessed Augustine, said: "He who kills himself kills a man," that is, a suicider is equated with murderers. But in our Eastern Church, suicide was condemned even more strictly. The Orthodox Church has established strict punishment even for attempted suicide. For this, a twelve-year penance was imposed. This may seem like too strict a measure, but this severity is born of mercy, the Church is strict towards suicides out of love for people. For the Church stores in its "sacristy" the real experience that suicides do not inherit the Kingdom of immortal life and eternal mercy. With its severity, the Church wants to warn people from eternal death.

The Holy Scriptures mention two people who took their own lives. The first is Ahithophel, the traitor of King David (2 Sam. 17:23), the second is Judas, the traitor of the Lord Jesus Christ (Mat. 27:5; Acts. 1:16–18). Don't allow the thought of finding yourself in their company on the other side of the grave.

"He who endures to the end will be saved," said the Lord (Matthew 10:22). He allows people many different trials, but the goal is one - to heal human souls from sin through bitterness and thereby prepare them for eternal salvation. No matter how difficult it may be for you, remember two things: first, that your Heavenly Father Himself determines the measure of suffering; second, that He knows your measure. Whenever the thought of suicide comes to you, drive it away. For this is Satan's whisper.

May God's mercy strengthen you" (St. Nikolai of Serbia).

Since one of the sources of suicidal tension leading to suicide is value tension arising from a conflict of values (J. Zhang, 2020), axiopsychotherapy is important in suicide prevention. This technique was developed by Candidate of Medical Sciences Larichev Valery P. at the All-Union Suicidology Center at the Moscow Research Institute of Psychiatry of the Ministry of Health of the RSFSR in 1983 and tested in the Crisis Hospital at Moscow City Clinical Hospital No. 20. The axiopsychotherapy was preceded by a psychological, psychopathological and axiopsychological analysis of the personality. The latter identified the patient's individual meanings and values in their hierarchy, as well as associated conflicts, frustrations, deprivations and deficits in coping skills in the context of a life crisis. Depending on the data obtained, within the framework of rational-cognitive and/or suggestive psychotherapy, either actualization or de-actualization of individual meanings, their re-emphasis or reorientation were carried out. If the patient had a rigid emotional-cognitive attitude ("axiopsychological paradigm"), it was corrected.

Thus, through targeted changes in the patient's system of individual meanings and values, it is possible to positively influence suicidal mentality, reconfiguring it to a positive attitude towards life and peaceful acceptance of natural death.

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Mental disorders, suicidal behavior and religiosity

Abstract: The report highlights issues related to attitudes towards suicide in Christianity and some other traditions. The general influence of religiosity on suicidal behavior is considered and anti- and prosuicide types of such influence are identified. It presents the results of a study of the characteristics of the early post-suicidal period in psychiatric hospital patients, which was conducted over four years and took into account heredity, the presence of somatic pathology, "triggers" of suicidal behavior, church involvement and other factors. The main misconceptions about the suicidal behavior of mentally ill patients are described. New principles (approaches) for the care of persons with suicidal behavior have been formulated, involving close interaction between psychiatrists and clergy.

Keywords: suicidal behavior, religiosity, suicide prevention, counseling for persons with suicide behavior.

The suicide rate is an important characteristic of public health and is considered one of the main criteria for quality of life. In the Russian Federation, despite the overall positive dynamics in recent years, the frequency of suicides in a number of regions exceeds a critical level, and the share of regions with an extremely high level of suicides (more than 30.0 per 100 thousand population) is about a quarter (Polozhiy B.S., 2019).

The main factors that negatively affect mental health are: work and professional problems, personal and family tragedies (crises), serious illnesses and various types of addiction, financial and economic instability, information warfare, emergencies, terrorism, military conflicts, increased social aggression and some others.

St. Luka (Voino-Yasenetsky) also said (1945, 1947): "... the life of the spirit is inseparably and closely connected with all neuropsychic activity. All our thoughts, feelings, acts of will are imprinted in it (spirit) - everything that happens in our phenomenal consciousness..."

A person's mental health depends both on the system of interpersonal connections (relationships) in which he is involved, and on the state of mental and spiritual-moral health of society as a whole. The latter is largely determined by the spiritual maturity of the population in matters of true national (primarily Orthodox) values, preservation of the "spiritual bonds of society," national and cultural traditions, and respect for national history.

One of the most pressing "practical" problems in the implementation of medical-psychological and spiritual-moral measures for the prevention of suicidal behavior is the need for close interaction between clergy and medical specialists (psychiatrists, psychotherapists), medical and social psychologists, as well as nursing and junior medical personnel. The effectiveness of such interaction can only be ensured by taking into account all historical (Christian, clinical) experience, modern methodological and scientific approaches.

The negative attitude towards suicide in Christianity has been known for many centuries. Thus, back in 452, the Council of Arles determined that suicide was a crime, and that it is nothing more than the result of some diabolical fury. The Council of Prague in 563 decided that suicides would not be given the honor of commemoration during the holy service, and the singing of psalms would not accompany their bodies to the grave (Durkheim E., 1912).

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.

Christian anti-suicide postulates are well known:

- 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.

Considering the general influence of religion on suicidal behavior, two main vectors can be distinguished: anti- and prosuicidal. The first includes Abrahamic religions (Christianity, Judaism, Islam), church involvement from childhood, upbringing in the faith, the actualization of religious ideas among older people, as well as the perception of suicide as a sin. Thus, Peter’s Military and Naval Regulations (1716-1722) stated: “If someone kills himself, then the executioner must drag his body to a dishonorable place and bury it, first dragging it through the streets or a convoy... And if someone did it while unconscious, in illness, in melancholy, then bury this body in a special, but not dishonorable place.” [1]

Prosuicidal influence is associated with some Eastern religions (for example, Buddhism), totalitarian sects and mental disorders (psychoses) with pseudo-religious content.

Historically, the following main theories of suicide are known: philosophical, sociological (G. Lebon, E. Durkheim), psychological (S. Freud, K. Menninger), medical (E. Esquirol) and antipsychiatric (R. Laing), etc. Thus, E. Durkheim (1897, 1912) wrote that “the term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result”. According to K. Jaspers (1913), “suicide is not a symptom of a mental disorder, not a syndrome, or even a sign of a mental abnormality; suicide is a form of behavior (behavioral act) of a person in a difficult situation (psychological crisis).”

For many years there have been common misconceptions about suicidal behavior:

- only mentally ill people commit suicide;
- people who all the time talk about suicide, will never commit it (8 out of 10 suicidal people previously spoke about wanting to commit suicide);;
- suicide is always unexpected for others (in most cases, people spoke about their suicidal intentions before committing suicide);
- - suicide is a hereditary phenomenon, it happens only in certain families;
- suicides are always determined to take their own lives
- suiciders are always determined to take their own life;
- suicide is the prerogative of certain segments of the population (either poor (from need) or rich (from glut) people).
- after overcoming the crisis, the danger of suicide passes.

A separate problem is the risk of repeated suicidal acts. The risk of a repeated suicide attempt is considered to be very high during the first year; and the ratio of repeated attempts in the population is 22-25%. The suicide attempts increase the risk of completed suicide in the following 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.

[1] http://www.historyru.com/docs/rulers/piter-1/piter-1-doc20.html#19

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 × n. At the same time, among family members involved in the problem, the risk of committing suicide also increases dramatically – n × 8. Therefore, a previous suicide attempt is one of the most significant risk factors for re-attempted suicide.

The problem of suicidal behavior in mental disorders is quite relevant. According to many authors (Ambrumova A.G., 1971; Polozhy B.S., 2019; Rozanov V.A., 2021), mental disorders are one of the main preconditions for suicidal behavior.

For the prevention of repeated suicidal acts, the most important thing is to analyze the characteristics of the early post-suicidal period in patients with various mental pathologies, as well as the main suicidal (anti-suicidal) factors that increase (reduce) the risk of repeated suicide by patients, thereby determining the adequacy and focus of preventive measures (Polozhiy B.S. et al., 2019; Kaleda V.G. et al., 2020; Nechiporenko V.V., Shamrey V.K. et al., 2019).

In order to study the characteristics of the early post-suicidal period in psychiatric hospital patients and optimize measures to prevent repeated suicidal acts in them, a study was conducted in 2019-2022 at the Department of Psychiatry of the Military Medical Academy and at the St. Petersburg P.P. Kashchenko Psychiatric Hospital No. 1.

At the first stage, a study was carried out of 370 archival medical records of patients: those admitted to a psychiatric hospital after making a suicide attempt (260 medical records) and those expressing suicidal intentions before hospitalization (110 medical records). An analysis of the structure of mental disorders was carried out, the significance and contribution of the prevailing suicidal and anti-suicidal factors on the course of the early post-suicidal period was assessed.

At the second stage, a comprehensive examination of patients with various mental disorders who had made suicide attempts (81 prs.) and expressed suicidal intentions before admission to a psychiatric hospital (80 prs.) was carried out; The structure of mental disorders, features of the early post-suicidal period and the nature of the influence of various suicidal and anti-suicidal factors were studied.

An analysis of the methods of committing a suicide attempt in the examined patients showed that the most common among them were drug poisoning (34.6%) and self-cutting (24.7%), with the second method predominant in people with mental disorders and behavioral disorders associated with the use of psychoactive substances, especially alcohol. Less common methods were: attempts to jump from a height (18.5%), knife wounds (11.1%) and self-hanging (8.6%). According to the results of the analysis of archival medical records, the most common methods of suicide attempts (with the exception of knife wounds) were poisoning with medications (43.1%), self-cutting (34.6%), attempts to jump from a height (8.1%) and self-hanging (7.7%). At the same time, a subsequent follow-up analysis of the methods of repeated suicide attempts (follow-up duration 3.5-5 years) showed a peculiar “narrowing” of their spectrum: a less frequent use of “combined” methods (2.6%, versus 3.8%), as well as the absence of previously used (in primary suicide attempts) “pretentious” methods (self-strangulation, self-injury of the head, injection of air into a vein, falling under a vehicle, self-incineration, etc.) and the more frequent use of self-poisoning with medications (53.2%), often accompanied by alcohol intoxication.

Special attention was paid to the study of social adaptation of the examined patients, which was carried out using a special technique “Assessment of the level of social adaptation”, which made it possible to evaluate (on a 5-point scale) such areas of adaptation as level of education, work (study), family adaptation, interpersonal relationships, leisure, general attitude to life, and also determine the general (integral)

assessment of social adaptation. The survey results showed that the lowest level of social adaptation was observed in patients suffering from mild mental retardation (2.0 ± 0.0), as well as among patients suffering from schizophrenia (2.1 ± 0.6) and personality disorders (2. 1 ± 0.9). In turn, the highest rates of the general level of social adaptation occurred among patients with neurotic, stress-related and somatoform disorders (2.9 ± 0.5), as well as affective disorders (2.6 ± 0.4). It was also established that among all the examined patients, unemployed persons predominated, while in the main group, compared with the control group, the number of employed people was slightly higher (38.3% and 22.5%, respectively).

When assessing the triggers of suicidal behavior belonging to the group of social factors, it was found that family conflicts (conflict with a spouse or partner) were dominant and were significantly more often registered in the main group compared to the control group (27.2% and 11. 3%, respectively, $p < 0.05$). Regarding other triggers (suicide or death of a loved one, anniversary of the death of a relative, serious illness of loved ones (relatives), divorce, conflict with friends (acquaintances), poverty, debt, financial losses, criminal prosecution, problems at work or school, and etc.) the differences between the groups did not reach a statistically significant level.

Particular attention was paid to studying the influence of the religious factor on the suicidal behavior of patients. For this purpose, in the process of clinical and psychopathological examination of patients, a specially developed questionnaire “Peculiarities of religious worldview” was additionally used. As a result of the study, it became clear that “practicing” Orthodox patients were significantly more often found in the control group of people, in contrast to the main group (21.1% and 5.1%, respectively, $p < 0.05$), such patients more often attended divine services (76.7% and 42.9%, respectively, $p < 0.01$). At the same time, in the main group (contrary to the control group), there were significantly more people actively involved in occult practices (20.5% and 5.3%, respectively, $p < 0.05$). In addition to occult practice, some of these patients were adherents of destructive sects and, in general, most of them were characterized by a low level of church involvement.

The distribution of patients by type of post-suicide period was made on the basis of the typology proposed by A. Ambrumova and V. Tikhonenko (1980), highlighting four main types: “critical”, “manipulative”, “analytical”, “suicide-fixed”. Among the patients we examined, there were also people with a “complicated” type of post-suicide, when it was not fully possible to evaluate a critical attitude towards a suicide attempt, as well as people who denied suicide actions, despite their clear evidence. Such patients were divided into two separate groups – with “complicated” and “denying suicide actions” types.

It was established that the most common types of post-suicide were: “suicide-fixed” (30.9%), “denial of a suicide attempt” (19.8%), “critical” (16.0%) and “complicated” (14. 8 %). The “manipulative” (9.9%) type of post-suicide was registered less frequently, and the “analytical” type (8.6%) was most rarely recorded. At the same time, the “critical” type prevailed in patients suffering from organic, including symptomatic, mental disorders (46.2%), “suicide-fixed” - in patients with schizophrenia, schizotypal, delusional (36.0%) and affective (32. 0%) disorders, “complicated” – in patients suffering from schizophrenia spectrum disorders (83.3%).

It was stated above that an important component of the prevention of suicide behavior is close interaction of clergy and medical specialists. In this case, we can highlight the following basic principles (approaches) of counseling:

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

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

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

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

5.“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);

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

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

In conclusion, I would like to note once again that further improvement of suicidological care is possible only with close cooperation between psychiatrists and priests with a clear delineation of their areas of competence.

Currently, serious experience has been gained in cooperation between psychiatrists and priests, which began in the early 90s, when a new subject was introduced at the Moscow Theological Seminary - pastoral psychiatry. This work was initiated by Professor Dmitry Evgenievich Melekhov (1899–1979), who wrote the first special manual on “Pastoral Psychiatry.”

At the same time, it is no less important to teach theological knowledge in medical universities and, first of all, the basics of Orthodoxy, other traditional confessions for Russia, and sect studies. At the Military Medical Academy, the traditions of the theology department, which was closed in atheistic times, are currently being revived for various categories of students (now optional).

In conclusion, I will cite the famous phrase of A.P. Borodin, professor of the Department of Chemistry of the Imperial Military Medical and Surgical Academy: “Everything that we do not have, we owe only to ourselves!”

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Existential flight to monastic life in depression

Abstract: In the psychiatric clinical practice, there are cases when patients with mental illnesses are trying to overcome their diseased state and go to a convent, where they hope to find spiritual help, reassurance and a certain social status. Such patients see a convent as an opportunity to get rid of worldly life problems that they could not cope with due to changes in their mental state. However, starting their journey in the monastic community, they are faced with problems of monastic life that are insurmountable for them, and the disease largely prevents the continuation of this path, and can lead to decompensation of the mental state, aggravation of psychopathological symptoms and deterioration of social functioning.

Keywords: depression, withdrawal to a convent due to illness, psychopathological features of rejection reactions, recognition of depressive symptoms, tactics of pastoral counseling.

Problematic timely recognition of mental illness hiding behind the mask of deep religiosity is often the reason for cases when patients with mental illness, trying to cope with their disease, go to a convent. As an illustration of such a case, the following clinical example can be presented.

Clinical case

The patient was born and grew up in a religious family in Siberia, her church formation was influenced by her family. At the age of 14, after telling classmates that she was a believer, she felt how the attitude towards her changed: interest in her increased significantly, while she liked to be the center of attention from the very childhood. In high school (15-16 y.o.), a desire to enter a convent gradually developed. She didn't prepare for a change of lifestyle in any way, just waiting for the end of school. From that time on, her range of interests narrowed significantly, she stopped attending various workshops, her previously small circle of friends shrank, and she completely lost interest in secular sources of information (television, fiction) and in communicating with peers who did not share her religious views. She often attended church services, was absorbed in reading spiritual books. Sometimes she skipped school for the morning service (mostly on church feasts).

At the same age (15-16 years old), the mood dropped for no reason, melancholy, sadness appeared, which later (within six months) became permanent and was accompanied by a feeling of discomfort in the chest, "heart heaviness ". There were no other changes in her condition, and her performance at school did not decline.

At the age of 17, by her own decision, she entered a convent as a novice, and mainly worked in the refectory. She coped with the work, despite the fact that her mood during this period of time remained low, with a constant feeling of melancholy. Gradually, over the course of a year, her condition began to deteriorate: headaches appeared, she began to notice episodes of severe weakness, dizziness, and increased fatigue. The background of her mood was unstable, with fluctuations from low to “tolerable” (with a predominance of low), but she never felt healthy.

A year later (at the age of 18), she could no longer cope with the work in the refectory, and therefore was transferred to easier obediences, mainly doing sewing. Sometimes, due to severe weakness, she needed assistance while walking. She tried to hide her condition from others, explaining its nature by spiritual reasons.

At the same age (18 years), despite the worsening mental disorders, she was tonsured into the ryassophore, after which there was a short health improvement (about

a week), however, the psychopathological symptoms continued to progress; this forced the patient to turn to doctors for the first time - first to a neurologist, then to a psychiatrist; she was hospitalized in a psychiatric hospital at her place of residence. After discharge from the hospital, her condition improved slightly, daily mood fluctuations persisted, anxiety and melancholy continued to bother in the evenings. Due to unsatisfactory mental state, she did not return to the convent, and stayed with her parents.

In the same year, the patient's family moved to the Moscow region, as her father was offered a job in Moscow. At the insistence of parents, she moved with them. Depressive disorders persisted. Once, at the height of a strong feeling of despair, she took more than 150 different, mostly psychotropic drugs, however, a few hours later she informed her parents about her act. She was hospitalized by ambulance to a psychiatric hospital at her place of residence and was transferred to the Scientific Center for Mental Health clinic for further treatment. The clinic doctors noticed that she had severe lethargy, anxiety, and a vital feeling of melancholy. The condition did not change significantly during the first one and a half months of staying in the hospital. Several courses of treatment with antidepressants, 8 sessions of electro-convulsive therapy were given. She stayed in the clinic for about six months. She was discharged with some improvement in her condition, however, manifestations of asthenia, apathy and anhedonia persisted.

Six months later (at the age of 19), at the insistence of her parents, she entered the consumer goods industry technical school, but due to another worsening of depressive disorders, she had to leave school a month later. From time to time, privately, she worked as a seamstress to the best of her ability, occasionally worked in the church, and communicated only with family members. She was constantly monitored by psychiatrists, including repeated inpatient treatment; her apathy intensified and episodes of anxiety persisted.

After 5 years from the onset of the disease, she was assigned to group 2 disability. By now, despite the fact that she is on maintenance therapy, psychopathic-like disorders of the hysterical circle have begun to manifest themselves more and more clearly, demanding increased attention from parents, psychiatrists, and priests. As the disease progressed, episodes of vital melancholy were less frequent, and apathy and anxiety prevailed. Until recently, she continued to attend church and participate in the sacraments.

Analysis of a clinical case and some psychopathological and psychological features of rejection reactions

The psychopathological symptoms that took place, accompanied by a decision to leave worldly life for a convent, which was observed at the beginning of the disease, can be regarded as a so-called refusal reaction (Ilyina, N.A., Ikonnikov, D.V., 2004). Such reactions are most often observed in adolescents and were first described by psychologists (Michaux L., Duché D.-J., 1957), and later by psychiatrists (Buitelaar, J.K. et al. 1994; Flakierska, N., Lindstrom M., Gillberg C., 1988). From a psychological point of view, the patient's choice of monastic life could be related to the desire to escape the disease and search for healing.

Back in the last century, P.B. Gannushkin described a kind of “withdrawal from reality” of the patient (1964), which consisted of avoidant behavior and refusal to carry out necessary activities in certain, usually unfavorable, conditions. The most typical "provoking" situation could be the need for active interaction with others and/or increased workload (for example, entering an educational institution or employment).

In the study of Tkhostova A.Sh. et al. (2005) it was found that in endogenous diseases accompanied by refusal reactions, there is a basic deficiency of motivation.

The psychological meaning of the rejection reaction is the expectation of failure and the rejection of activity as an opportunity to preserve fragile self-esteem. Refusal reactions, according to some authors (Burns Ch., 1952), may be one of the first signs of the manifestation of an endogenous disease and reflect the patient's desire to get rid of the decompensating situation (Morozov V.M., Tarasov Y.K., 1951; Lichko A.E., 1979; Anufriev A.K., 1975).

Reactions when a person refuses to study can occur in adolescence, when a depressive state develops with predominant cognitive disorders; they are considered by some researchers as manifestations of “juvenile mental incompetence” (Tsutsulkovskaya M.Ya et al., 1999). In these cases, due to the development of depression, patients lose interest in studying, cannot master the educational material and leave school, this goes along with a lower need for communication, less contacts with peers. In some cases, all the attention of these patients is concentrated in one area, usually associated with unusual hobbies and interests that have no practical application. At the same time, a tendency to strong dependence on others is formed. Often, rejection reactions are accompanied by hysterical disorders in the form of erethistic, demonstrative reactions (Ilyina N.A., 2003).

Personality changes in the first stages of their development are often accompanied by existential reflections about the meaninglessness of existence and can lead to the desire to "flee into religion" (E.D. Sands, 1956). Subsequently, pathological personality development occurs due to dissociative disorders: changes in self-awareness of the “I” and the formation of the phenomenon of subjectively desired, “alternative (masked) life” (J.Vie, 1935). In this situation, actual ties with past life (family, profession) are often broken, and the patient adapts to new actual circumstances of life that correspond to his capabilities. The level of dissociative disorders sometimes reaches the point of replacing real self- and worldviews with imaginary ones that correspond to grandiose plans and demands, but compete with the actual capabilities of the patients, which sooner or later, on the contrary, leads to their significant maladjustment.

Conclusion

The analysis of this case shows that the patient apparently became ill in adolescence, when the first symptoms of endogenous depression developed (low mood, accompanied by anxiety, melancholy with vital manifestations, suicide thoughts). After the onset of the disease, changes in the value-semantic sphere of the personality took place, which consisted of a complete change in interests and abandonment of habitual activities and chronologically coincided with the emergence of the idea of entering a convent. Once inside the walls of the convent, the patient could not adapt there, even if she was assigned light obedience. Not only could she not perform them, but she herself needed assistance (support when walking), which, apparently, could be associated with a heavier depressive state. The gradual progression of the disease, despite multiple hospitalizations in psychiatric hospitals, led to growing personality changes of hysterical type and led to disability and social maladaptation.

Thus, as this example shows, the onset of an endogenous mental illness, like any other serious illness, often prompts the patient to search for ways to get rid of suffering or to overcome it and find his place in life. Entering monastic life may seem like such a means. Such expectations rarely coincide with the real picture of life in the convent, which requires high working capacity and discipline. These qualities, due to the development of mental illness, become inaccessible to the patient, which, in turn, leads to social maladaptation, frustration and despair.

Based on the given clinical example, it can be concluded that today it is impractical to send mentally ill people to monasteries for "spiritual treatment" and

recommend them to live in a monastic community, since religious communities do not have the appropriate capabilities to provide qualified assistance to mentally ill people. Such cases also show that it is important for a priest to know the clinical picture of depression and other mental illnesses in order to determine adequate strategies for pastoral care.

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Depression: spiritual, existential and psychopathological aspects. Proposal of intervention models

Abstract: The fundamental feeling for different types of depression is sadness, which has different levels. While various types of sadness, which have specific clinical manifestations, can be correlated with the biological and mental levels, then spiritual sadness is a feeling of awareness of one's own creatureliness and imperfection. At this level, a religious feeling arises, a question about the Other, the Supreme, a call to the Mystery. Similar experiences of sadness are found among believers, poets and artists, and they cannot be attributed to diseased or psychopathological phenomena. The report examines various types of depression, specifics of treatment and care for depressed patients, and notes the need for a holistic therapeutic approach to the treatment of depression and the creation of conditions in which the dignity and freedom of a person in such a condition is respected.

Keywords: depression, endogenous depression, existential depression, psychogenic depression, suicidal behavior, treatment of depression.

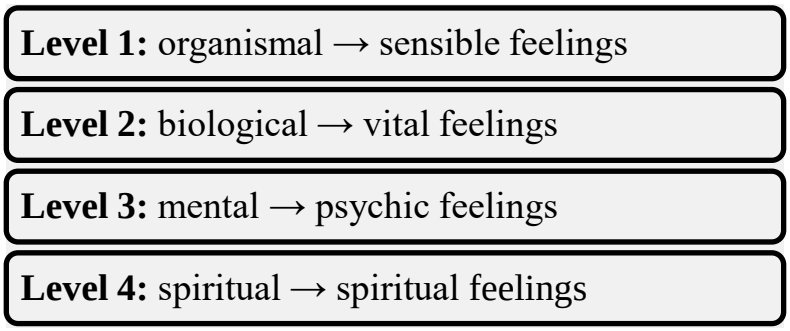
Introduction.

Depression is a condition that is too complex and profound for only psychologists or, even worse, only psychiatrists to deal with it (Romano Guardini).

There is not just one type of depression: there are many depressions. Some of them are pathological, others aren't. The dominant feeling of depression is sadness; but sadness also has varied expressions. According to the stratification of human emotional life by the philosopher Max Scheler, it has various strata (levels):

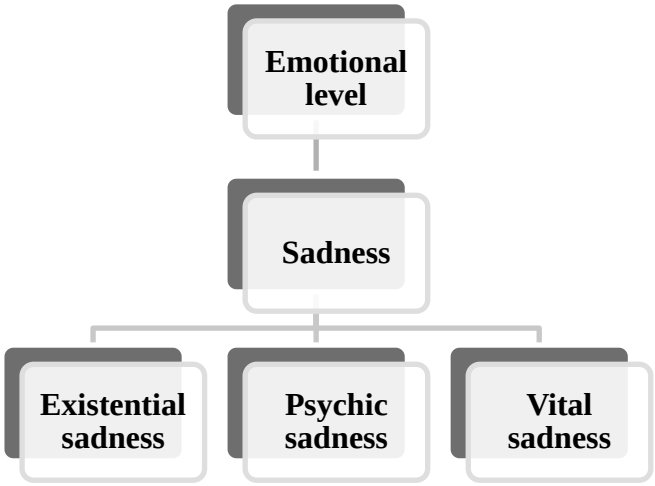
Level 1: organismic (vital-sensorial sadness); level 2: biological (vital sadness); level 3: mental (existential and psychic sadness); level 4: spiritual (the highest level of the so-called "sacred sadness", spiritual sadness, which does not concern psychopathology, clinics but religious sciences, poetry and literature).

Figure 1. Stratification of emotional life:



The first 3 levels correspond to different types of sadness that have clinical relevance:

Figure 2. Types of sadness:



1.Spiritual sadness

Spiritual sadness is not included in the classification of pathological sadness but is an expression of human feeling when the man realizes his condition of being a creation and being imperfect which represents the culmination of human reason and feeling. This is where the religious sense originates, the question about the Other that is different than oneself, the cry to the Mystery. This type of sadness, defined as "spiritual" by Scheler, is inherent to deeply religious people, poets and other gifted individuals: psychology and psychiatry shouldn't enter in this field because it has no relation to illness or psychopathological phenomena.

According to Thomas Aquinas, sadness is a "desire of good not as yet possessed"[2]. It is born out of disproportion between the infinite desire and the human ability to "grasp".

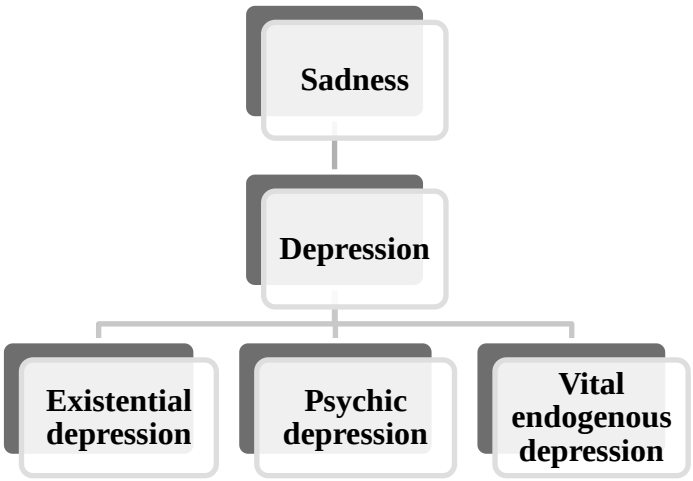
Fyodor Dostoevsky, "Demons": "[Stepan Trofimovich] managed to touch the deepest strings in his friend's heart and to call forth in him the first, still uncertain sensation of that **age-old, sacred anguish** which the chosen soul, having once tasted and known it, will never exchange for any cheap satisfaction. (There are lovers of this anguish who cherish it more than the most radical satisfaction, if that were even possible.)[3]"

2.Types of clinical depression

The classification of the various forms of depression from a clinical and psychopathological point of view is based on this model by Max Scheler. Actually the 3rd and 4th levels characterize endogenous or psychotic depressions with minimal clinical nuances so we consider them one and the same: endogenous vital depressions (Fig. 3).

[2] Thomas Aquinas. Summa Theologiae, I, q. 20, art. 1.
[3] Fyodor Dostoyevsky. Demons. P. 1, ch. 2.

Figure 3. Types of depression:



A.Sadness and existential depression

Existential depression is a type of depression motivated by and resulting from evident documentable facts and reasons in one's personal or social life. They result in depressive experiences that, however, do not go so far as to compromise the continuity of one's life.

These disorders are caused by a particular personal or sociohistorical circumstance, such as, for example, forced isolation caused by the COVID-19 pandemic, a state of crisis or social and political conflict, such as the one we are experiencing nowadays, an emotional crisis, or a period of change or stress in one's life.

The help that can be provided in this case is not so much medications, specialized treatment with antidepressants; it is rather finding a motivation that helps to accept the difficulties of life through a presence, a listening, offered that helps to accept the life situation with educational, cultural or relational support interventions.

In this case, moments of listening, meeting groups, moments of empathetic sharing with somebody (not necessarily an expert in the field) who knows how to make a person feel welcome and included is particularly important.

B.Psychic sadness and psychic depression

Compared to the previous type of depression, patients with psychic depression experience various disorders and symptoms such as insomnia and slowing down, lack of motivation, apathy and even desperation up to suicide, if the person is left totally alone.

Psychic feelings are intentional feelings, that is, feelings always directed and turned outside of oneself, towards an object, a personal reality; they are therefore relational feelings that permanently link our ego with the external reality. From this level of feelings, non-endogenous depressions arise, which we have called reactive or neurotic. Those who experience this type of depression are always aware of the illness and endure deep suffering.

These are motivated depressions, reactive to events, personal experiences that can cause mental suffering that persists over time and reaches a greater intensity than in existential depression.

However, this depression generally occurs in people who have a fragile personality and a neurotic internal conflict with deeper problems linked to the history of their childhood and adolescence.

Here a psychotherapeutic, psychoanalytic or support type intervention is necessary which can also treat the person's internal conflicts.

C.Vital sadness and vital or endogenous depression

Vital sadness is a feeling that manifests into a corporeal sensation, which can also be localized in a certain body part: patients who suffer from this type of depression don't talk about "feeling sad". Instead, they "feel their heart clutched in a steel vise". The heart turns to stone; the stomach not only refuses to function, but becomes a nonliving thing, a dead thing. The feelings are somatropized, become vital, incarnate, losing their internal quality and, instead, gaining a corporeal expression.

Among aspects of endogenous depression, there are vital sadness that is expressed as blockage, lack of energy and the feeling of heaviness up to actual paralysis and psychomotor inhibition.

In endogenous depressions (especially in cases when a patient suffers from delirium or is unconscious of the illness): the patient falls more or less rapidly into this vortex of inhibition, of blockage without almost realizing it.

An important criterion to distinguish psychotic, endogenous depression from the non-psychotic type is the difference in the **circadian rhythms**: in psychotic depressions the symptoms aggravate during the first half of the day and subside in the evening; while in non-psychotic depressions the symptoms are accentuated and exacerbated in the evening hours.

Another criterion that helps differentiate between the two types of depression is the disturbance of sleep patterns: in reactive depression the patient complains of considerable difficulty in falling asleep, spends the night hours anxiously waiting for a sleep that is slow in arriving; in psychotic depression, however, sleep begins immediately but then stops after a few hours and never returns.

In summary, the key symptoms of psychotic or major depression are:

1 rhythmological alterations,
2 changes in mood (vital sadness),
3 psychomotor inhibition.

Psychotic depression can be:

1.Unipolar: always repeats in the form of distinctive depressive episodes;
2.Bipolar: depressive episodes alternate with manic ones.

Table 1. Main and associated symptoms of depression

Major depressive disorder	
Main symptoms	**Associated symptoms**
1. Circadian rhythm alterations (being asleep – being awake) 2. Mood alterations (vital, psychic sadness) 3. Psychomotor retardation	1. Delusion (depressive themes) 2. Impairments in self-awareness (depersonalization) 3. Catatonic disorders

Table 2. Main characteristics of unipolar and bipolar depression

Depression type	**Unipolar depression**	**Bipolar depression.** ***Depression and mania***
Age of Onset	30	25
Heredity Genetic predisposition	+/-	++
M/F ratio	1:3	1:2
Treatment	Antidepressants	Sedatives, lithium salts
Prognosis	+/-	+

Manic syndrome

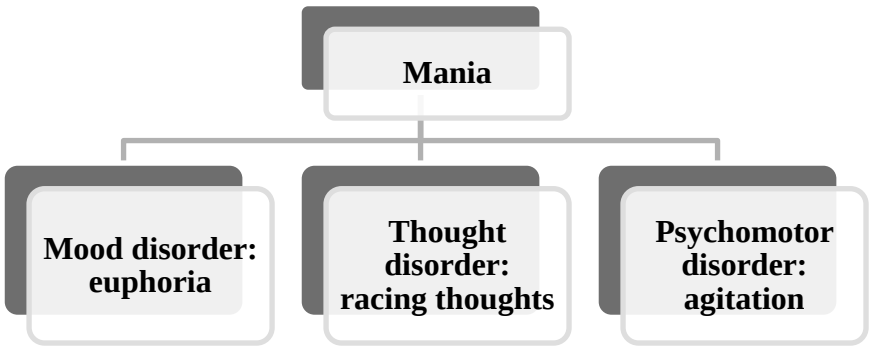
Manic syndrome represents the counterpart of major depression: although the symptoms of mania are contrary to those of the major depressive disorder, their affective origin is the same. This is why patients with this condition suffer from alternating distinctive episodes of these two forms, which Kraeplin called **manic-depressive psychosis, or which we today call bipolar depression (in addition to the depressive episode, at least one manic episode occurs).**

While the treatment of reactive neurotic depression is based on psychotherapy, psychotic and endogenous depression is predominantly treated by means of pharmacotherapy. Numerous new antidepressants have been developed in recent years. Their reasonable use, coupled with attentive and empathetic treatment of a patient can be effective and lead to recovery.

There is a risk of recurrence (seasonal or caused by serious stressful factors): currently we have at our disposal preventive drugs called “mood stabilizers” that can be prescribed and used for the purpose of preventing relapse (lithium salts and other mood stabilizers).

These new antidepressants are also widely used by general practitioners, not specialists who consider depression as a single large cauldron that can be treated with the use of a pill, one or more psychotropic drugs. The effect obtained from this extremely superficial attitude, in which even a reactive or motivated depression is treated with a medicine, a psychotropic drug, was to cause "chronification" of depression.

Figure 4. Mania



Suicidal behavior

Attempted suicide (SA) refers to self-harming behavior, which, however, does not have the goal of self-destruction, one's own death, but asking for help from another as an extreme cry for help in a context of helplessness and despair. Sometimes it can be used as a blackmailing or manipulative tactic (especially by adolescents over their families).

A *failed suicide* (FS), instead, is an expression of a true intention to die that is foiled by pure chance or by an intervention of unforeseen events.

They have different **characteristics and indicators**:

Table 3. Main characteristics and indicators of suicidal behavior

Characteristics	SA	FS
Age	< 25 y.o.	> 30 y.o.
Sex	F (3:1)	% higher among men
Method	Medications (80%)	More harmful (guns, defenestration)
Pathologies	Reactive/neurosis	Psychosis
Intentionality	No	Yes
Rescue avoidance	No	Yes
Preparation of final documents (last will and testament)	No	Yes
Aim	Manipulative	Self-destruction

Table 4. Suicide key risk factors among different age groups

Age	Key risk factors
15-24 y.o.	▪Previous suicide attempts ▪Personality traits (impulsivity, proneness to anger) ▪Substance abuse/addiction ▪Dysfunctional families
25-44 y.o.	▪Substance addiction ▪Mental disorder ▪Unemployment
45-64 y.o.	▪Disabling pathologies ▪Somatic/masked depression
> 65 y.o.	▪Illnesses that limit the autonomy of an elderly person ▪Loneliness

Table 5. Psychiatric diagnoses in 6000 cases of death by suicide

Diagnosis	No.	%
Psychoorganic syndrome	308	5
Substance abuse	947	16
Schizophrenia	612	10
Affective disorders	**1400**	**24**
Neurotic and personality disorders	1340	22
Other mental disorders	1259	21
No diagnosis	137	2
Total	**6003**	**100**

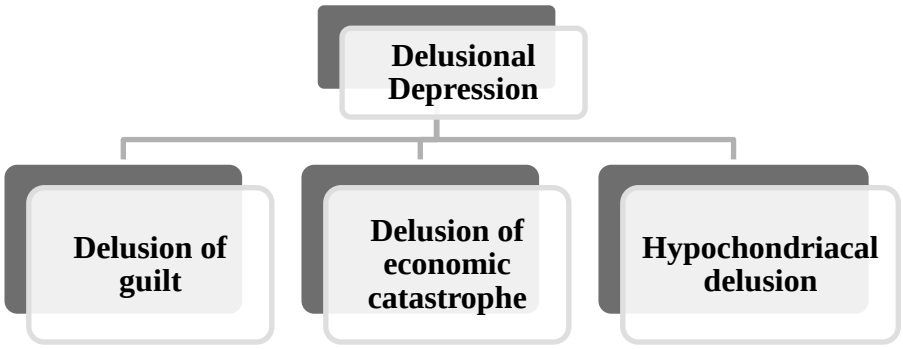
Particular forms of depression

Patients who suffer from psychotic (unipolar) depression can also experience delusion (convictions not based on reality).

Delusion is what does not meet the criteria of reality: the person is convinced that he has a serious illness with a risk of imminent death (hypochondriac delirium - first variation); or of being on the verge of economic bankruptcy (which does not meet

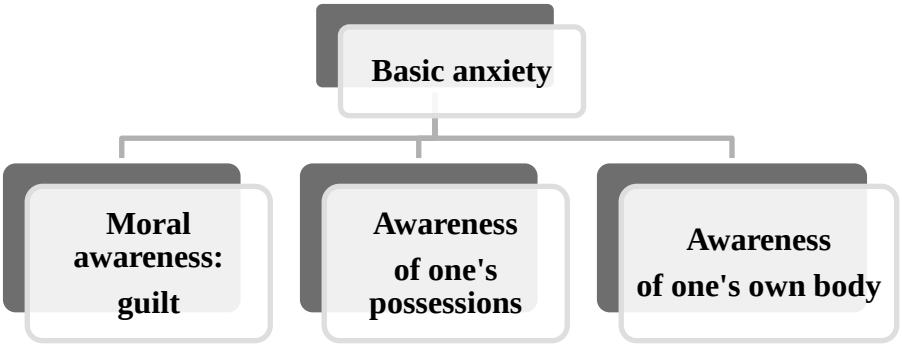
reality criteria; the second option); or of having committed extremely serious acts(the third option).

Figure 5. Delusional depression



The feeling of guilt is crucial in some types of psychotic depression. It is associated with the emergence of primordial anxiety, described by Heidegger as anxiety that is related to a human's basic values: his own body, his possessions and the sphere of moral values. In depression they are present only in the acute phase, and disappear completely in the phase of recovery and euthymic well-being (M. Heidegger, 1962).

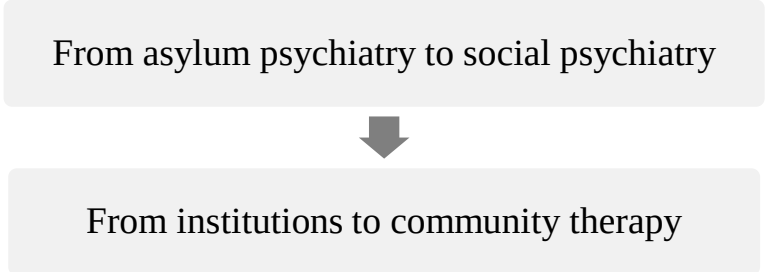
Figure 6. Heidegger on anxiety



Patient care and treatment of depression

Conceptually, patient care is a sequence of acts in the context of a relationship. Therapy is always an encounter of two destinies, two freedoms. Illness is no longer an obstacle, a punishment; instead, it becomes a meaningful experience. This is only possible in those places and in human contexts where the dignity and freedom of the other, even if sick and wounded, is respected.

Figure 7



After the 1978 Reform in Italy we no longer treat patients in isolated institutions. Now, they receive care in general hospitals or in psychiatry departments in the acute phase.

In the post-acute phase the treatment continues in:

1.Local clinics

2.Rehabilitation communities.

Very important is the work with families (especially with adolescents but also with adults who live with the patients) following a psychoeducational model.

The families are taught to recognize the symptoms, and an alliance is formed with the Services to ensure trust, which is a fundamental element of the treatment.

The use of technical jargon creates distance and inauthenticity. An authenticity is necessary that shows attention and truly lives it. If you don't feel an internal resonance it's better to keep quiet. Attention, a smile, compassion, a glance – always available and constantly adapting, instance by instance – this makes the relationships with families and, consequently, with patients more authentic.

Conclusion

When we deal with a person affected by depression, we have to identify its type and then react accordingly. Special medical treatment is only necessary in treating certain types of depression; in other cases we have to become travelling companions who share the burden of a suffering person. All in all, only compassion will save those who struggle with this type of mental illness.

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Lazko N.V.

Features of depressive disorders in a socially significant situation (effects of COVID-19 and special military operation)

Abstract: The report presents results of a clinical surveillance of 119 patients aged 13 to 69 years in 2021-2022 who applied for psychiatric help, complaining of a depressive state, which, according to experts, was caused by the psychogenic influence of the situation of the special military operation (SMO) and the consequences of the COVID-19 epidemic. The main psychogenically determined depressive symptom complexes of these conditions were identified: anxious depression with elements of confusion and disorganization; hypochondriacal depression - "flight into illness"; dysphoric depression – with a tendency to brutal behavioral reactions; hysterical – with pseudo-dementia and "childish" behavior; persistent asthenic – with feelings of impotence and fatigue, thoughts about "loss of the meaning of life" (predominant in the aftermath of COVID-19). “The psychogenic impact of COVID-19 and the ongoing SMO, in addition to medical consequences, including psychiatric ones, explains a number of psychological and spiritual problems. The identified polymorphism of depressive mental disorders, the complexity of psychological response in micro- and macrosociety, the personal crisis of worldview require active medical, psychological and spiritual support, which can be most optimally carried out in coordination of a psychiatrist, psychologist and priest.

Keywords: depressive disorders, psychogenic disorders, mental health, clinical picture polymorphism, psychogenic depressive symptom complexes.

The Lord warned of social cataclysms in human history: “And you will hear of wars and rumors of wars. See that you are not troubled; for all these things must come to pass,… And there will be famines, pestilences, and earthquakes in various places. All these are the beginning of sorrows” (Matt. 24:6-8). “And when you hear of wars and tumults, do not be terrified, for these things must first take place, but the end will not be at once” (Lk. 21:9). Such phenomena entail for people experiencing them the need to exert physical, mental, spiritual and moral strength, which can significantly worsen the mental state. As scientific and practical experience shows (Khasanov D.R. et al., 2021; Kholmogorova A.B. et al., 2021; Augustin M. et al., 2021), the onset of depressive disorders, which are one of the most common form of psychopathology (according to WHO, currently up to 25%) can often be triggered by socially significant events taking place in a particular region or globally. The current events of the last period of world history (consequences of the COVID-19 pandemic) and domestic (ongoing special military operation, SMO) history determine all aspects of everyday life, which is a **trial** for the vast majority of people. The Holy Fathers paid special attention to the impact of such events on a person's spiritual condition. So, St. Tikhon of Zadonsk instructed that “... every sorrow comes from sin, and if there were no sin, there would be no sorrow. For this sake, sorrow is sent, so that sin will be cleansed; and when the sin causing that sorrow, is cleansed, the sorrow itself will be taken away..." According to St. Paisios of the Holy Mountain, “trial strikes are necessary to save our soul, for they purify it ...”, but “… if a war were to break out, God forbid, many would simply die of fright while others would lose heart, because they’re used to an easy life”. Currently, medical professionals, including psychiatrists, are gradually gaining experience in the assessment of physical and mental disorders associated with the consequences of the pandemic and SMO. The whole set of problems, medical and social, could not but affect the spiritual state of people, which both priests have to face unwittingly, but also doctors of all categories when they are asked for medical help.

The purpose of this report is to identify the main social factors and associated clinical manifestations of depressive disorders that have developed in the context of the COVID-19 aftermath and ongoing SMO. In this regard, clinical observations of 119 male and female patients aged 13 to 69 years in 2021-2022 were analyzed, who applied for psychiatric help at the consultative and diagnostic department of the V.P. Serbsky National Medical Research Center of Psychiatry and Narcology and the St. Tatiana Church at the Moscow State University. They had various complaints, mostly of a depressive character. At this stage, the objectives of the study did not imply an analysis of the age and gender characteristics of this contingent.

The obtained data testify, first of all, to the psychogenic impact on the state of mental health, caused by both the SMO situation and the consequences of COVID-19 (in the latter case, the psychogenic impact is combined with the somatogenic effect due to multiple organ damage by the SARS-COV virus). So, common psychogenic influencing factors, characteristic of both COVID-19 and SMO, are: 1) unexpectedness; 2) coverage of all population groups (directly total for COVID-19, partial and indirectly total for SMO); 3) predictive uncertainty (health consequences of COVID-19 and SMO situation); 4) the magnitude of the social consequences (already understandable with the COVID-19 implications – changes in the daily routine according to epidemiological regulations, online work, change of profession and occupation, in particular, courier activities; unfinished consequences – with SMO). Along with this, in a situation of the ongoing SMO, the following have a special psychogenic impact: 1) conflict of opinions (including with aggressive, verbal and physical, forms of response) and, as a consequence, 2) change in communication in micro- and macrocommunity (closest family members and close friends practically stop communicating due to constantly arising conflict situations; rigid opposition among colleagues at work hinders productive discussion and resolution of operation issues); 3) the difficulty of accepting the need to update national self-consciousness (S. Prilepin: “For 30 years the opinion has been instilled that no one owes anything to anyone”); 4) attempts to voluntarily or involuntarily deny the fact of the transition of "historical memory" from the theoretical field to everyday reality; 5) the conflict of illusory "inclusion", which is caused by cinema and interactive means, in military operations with the real events of the SMO, with subsequent emotional disorganization and general confusion in everyday life.

It should be noted that the information factor plays a special role. As we know, for thousands of years, information about socially significant events was spread not widely, gradually, in limited ways (messengers, conventional signs), intended for a small circle of decision makers, which made it possible to largely “regulate” the information flow. Over the past 150 years, due to the development of the media, especially in recent decades and since the advent of the Internet, any information, reliable or not, is distributed instantly and everywhere, which contributes to: a) *emotional charging of people*, followed by a tendency to make unconstructive decisions; b) *pathological interpretation of events*, which can lead to inadequate forms of response, including in persons with enhanced social responsibility; the consequences of their decisions can be especially significant; c) *the emergence of a state of “fainting from fear and the expectation of the things which are coming upon the world”* (Lk. 21:26), in which the usual stereotype of everyday life is distorted, including refusal to participate in liturgical life (or other active forms of religion in other confessions).

According to the data obtained, the above factors (consequences of COVID-19 and SMO) have a psycho-traumatic effect and determine a *polymorphous* clinical picture of depressive manifestations. In accordance with the nosological principle, these psychopathological disorders, if patients have disorders of the schizophrenic spectrum or other endogenes, correspond to a psychogenically induced *exacerbation* of affective

pathology; in patients with organic mental disorders, personality disorders, mental retardation, neurotic and somatoform disorders, which developed before the situation under study, depressive symptoms are considered within the psychogenic *decompensation*; in individuals without a clinically delineated picture of any mental disorder in history, as a rule, a *reaction to stress with an adjustment disorder* is recorded. At the same time, according to B.V. Shostakovich and N.K. Kharitonova (2004), it should be borne in mind that psychogenic depression may not even be limited to clearly defined affective syndromes. In a psychogenic-traumatic situation, emotional-affective disorders are registered that have no clear clinical form, have indeterminate boundaries and are not easily identifiable.

When determining the main symptom complexes in which depressive manifestations predominated in the context of the COVID-19 aftermath and SMO, the opinion of most of the researchers was taken into account, indicating a long intensive anxiety, low mood, and sleep disturbances in patients who survived COVID-19; it was noted that frequent psychopathological manifestations of a long-term post-COVID syndrome include asthenic, post-traumatic, stress and anxiety-depressive symptoms (Mosolov S.N., 2021). Along with this, according to N.N. Ivanets, M.A. Kinkulkina (et al., 2017), the moment of onset of psychogenic depression is determined by the collision of an external psycho-traumatic influence with an internal complex of factors of the patient's vulnerability to stress (the importance of constant participation in liturgical life – author's note); the stronger the stress, the less significant the presence of premorbid "ground"; high susceptibility to stress does not by itself cause depression; a prerequisite for the development of psychogenic depression is a traumatic event.

The results of the analysis of clinical observations made it possible to identify the main psychogenic depressive symptom complexes characteristic of the COVID-19 aftermath and ongoing SMO. 1) *Anxious* depression, the most characteristic of the initial stages of SMO, with confusion and disorganization elements, with a tendency to impulsive actions without considering the consequences. Later, after the improvement of patients' mental state and after starting therapy, they reported a sudden onset of anxiety and fear with a feeling that "the familiar world collapsed", "it is not clear how to live on", "I wanted to shout to the whole world so that everyone would hear, and everything would stop", at home "everything fell out of hand", at work, "no one understood me, they assigned me all sorts of nonsense, and my life ended," thought "to end my worthless life on my own." Different types of depression, observed in approximately equal proportions in the aftermath of COVID-19 and SMO: 2) *hypochondriacal* depression - "flight into the disease" with a tendency to a protracted course (patients are regular visitors to both psychiatrists and internists, private clinics and laboratories, alternative medicine specialists, noting numerous side effects from therapy, but, nevertheless insisting on the use of more and more new drugs and methods); 3) *dysphoric* depression with a tendency to brutal behavioral reactions (more common in organic mental disorders and personality disorders; such patients, as a rule, become unbearable for family members, find it difficult to stay at work, and at the same time they are extremely negative about suggestions that they need therapy; if they were previously engaged in liturgical and parish life, now they categorically refuse to attend worship services and participate in the sacraments, saying that "nothing will help them"; they are prone to demonstrative suicides, which indicates not only mental, but also serious spiritual crisis); 4) *hysterical* depression with a tendency to pseudo-dementia and puerile manifestations (with external melancholy-anxious manifestations and general motor inhibition, patients demonstrate failure in everyday life, strive for simple playing pastime, for example, they ask to buy play dough in order to "have fun with modeling"; during medical examinations they appeal to the attendant, citing that "everything is complicated, impossible to understand", they deliberately confuse the

name of the drugs, require daily care and attention); 5) *persistent asthenic* depression prevailing in the aftermath of COVID-19 with typical, in addition to weakness, feelings of powerlessness and fatigue, thoughts about “loss of the meaning of life”, attempts of pointless rethinking of the past, inability to adequately respond to current banal events. Such patients, if they were active Church goers, once encouraged and accompanied, as a rule, agree to attend parts of divine services, do not refuse to participate in the sacraments.

An analysis of the clinical picture dynamics of the depressive disorders shows that in the COVID aftermath, they have a predominantly *regressive* development with a gradual successful resolution of medical and social problems; and in the context of the SMO consequences, despite ongoing treatment, depressions have typical *undulating* symptoms, depending on the information flow, the quality of interpersonal and social interaction.

Thus, the psychogenic impact of the consequences of COVID-19 and ongoing SMO, in addition to medical problems, including psychiatric ones, determines a number of psychological and spiritual problems. The revealed polymorphism of depressive mental disorders, the complexity of psychological response in micro- and macro-society, the personal crisis of worldview require active medical, psychological and spiritual support, which can be most optimally carried out with the interaction of a psychiatrist, psychologist and priest.

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Archpriest Pavel Velikanov

The 'dark night of the soul' and depression: on the issue of disidentification of concepts

Abstract: The report examines the concept of God-forsakenness (ἐγκατάλειψις) as a special period in the spiritual life of an ascetic; it uses the sayings of the holy fathers and spiritual teachers. Descriptions of similar states by Catholic saints of the Roman Catholic Church are also given. So, for example, San Juan de la Cruz (John of the Cross) calls it "the dark night of the soul." A number of differences are indicated between the "night" and depression, in which religious patients complain of a feeling of being abandoned by God. In particular, "the way out" of depression is seen in a return to the previous "self-identity", in the restoration of emotional life, while the result of the "night of the soul" should be the abolition of "I-identity", the spiritual transformation of the ascetic to "life without selfhood".

Key words: God-forsakenness, depression, "dark night of the soul."

The concept of God-forsakenness (ἐγκατάλειψις) as a special period in the spiritual life of an ascetic is found many times in the writings of the Holy Fathers. St. Isaac the Syrian says that the trial of God-forsakenness is not a manifestation of punishment, but of Divine pedagogy, and is given only to the "faithful and humble." If a man is unable to endure a great temptation, he cannot receive a great gift; accordingly, God-forsakenness precedes the initiation of a qualitatively different relationship of the ascetic to God. God-forsakenness for St. Isaac is "a subjective feeling of the absence of God, which comes not from the fact that a person is really abandoned and forgotten by God, but from the fact that, for one reason or another, God wants a person to be left alone with the reality that surrounds him».[4] "Let us not be perturbed when we are in darkness, - writes St. Isaac…, especially if we are not the cause of it ourselves. For it is brought about by divine care, for causes which are known only to it. Our soul is then suffocated and, as it were, in the midst of storms. Whether a man approaches unto a book of service – to whatever he approaches, it is darkness upon darkness which he finds in it, so that he desists from all efforts. How many a time is he not even allowed to approach. He is wholly unable to believe that a different state will come upon him so that he will be in peace again. This hour is full of despair and fear; and the hope in God and the consolation of faith are wholly effaced from the soul, which is totally filled with doubt and fear" [5]. St. Gregory the Theologian calls God-forsakenness "the highest suffering of man". [6]

Evagrius writes in "On Thoughts", chapter 10: "Hatred against the demons contributes greatly to our salvation and helps our growth in holiness. But we do not of ourselves have the power to nourish this hatred into a strong plant, because the pleasure – loving spirits restrict it and encourage the soul again to indulge in its old habitual loves. But this indulgence – or rather this gangrene that is so hard to cure – the Physician of souls heals by abandoning us. For He permits us to undergo some fearful suffering night and day, and then the soul returns again to its original hatred, and learns like David to say to the Lord: `I hate them with perfect hatred: I count them my enemies' (Ps.139:22)".

[4] Metropolitan Hilarion (Alfeev). Isaac the Syrian // Orthodox Encyclopedia [URL: https://www.pravenc.ru/text/674153.html]
[5] Ibid. [URL: https://www.pravenc.ru/text/674153.html]
[6] Shevchenko E. V. Gregory the Theologian // Orthodox Encyclopedia [https://www.pravenc.ru/text/166811.html]

St. John Chrysostom in the homily “Concerning Lowliness of Mind” writes: “God left them so that they would know that they accomplished these deeds not by their own strength, but by the divine grace” (Word 7, Concerning Lowliness of Mind). [7] In another place, he writes: “When He leaves and forgets us, and the soul is torn, and the heart is tormented, and sorrows attack, so that, stung in every way, the careless with great zeal return to where they fell from. “Your wickedness will punish you,” it says, “and your backsliding will rebuke you” (Jeremiah 2:19). So abandonment by God is a kind of His providence. When He finds neglect while providing for and caring for people, He withdraws a little and leaves, so that the careless, casting aside carelessness, become more zealous.” [8]

The first person to pay special attention to the phenomenon of God-forsakenness in spiritual life in the 20th century was Archimandrite Sophrony (Sakharov). In his experience, which he describes in detail in his correspondence with David Balfour, he repeatedly had acute states of God-forsakenness, and could not understand what exactly their cause was. This is how he describes his experience: “A terrible change has taken place in me. Light, Divine grace have departed far from me. I have suffered an unrequited loss, and this is the inexhaustible source of my suffering, which has again reached a power that exceeds the measure of my strength; both soul and body are sick. From great sorrow, like Job, I am sometimes FURIOUS”.[9]

In another letter he wonders: “Sometimes I am in a tense struggle, and sometimes I spend a lot of time stricken with internal spiritual paralysis, the nature of which I cannot understand, that is: is it the result of complete exhaustion of the soul and body, or, worse, sin, loss of grace, God-forsakenness?” [10]

The same correspondence quotes from the book of San Juan de la Cruz's book – or John of the Cross – dedicated to the state of God-forsakenness, referred to by John as "the dark night of the soul". It is the exegesis of this work that allows us to get closer to understanding how the “night of the soul” differs from depression as such.

Here is how John of the Cross describes the beginning of the "night": “And thus He leaves them [ascetics] so completely in the dark that they know not whither to go with their sensible imagination and meditation; for they cannot advance a step in meditation, as they were wont to do afore time, their inward senses being submerged in this night, and left with such dryness that not only do they experience no pleasure and consolation in the spiritual things and good exercises wherein they were wont to find their delights and pleasures, but instead, on the contrary, they find insipidity and bitterness in the said things. For, as I have said, God now sees that they have grown a little, and are becoming strong enough to lay aside their swaddling clothes and be taken from the gentle breast; so He sets them down from His arms and teaches them to walk on their own feet; which they feel to be very strange, for everything seems to be going wrong with them”. [11]

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[7] St. John Chrysostom, Homily Concerning the Lowliness of Mind, Complete collection of the works of St. John Chrysostom. Volume 12. Part 2, St. Petersburg, 1906.

[8] St. John Chrysostom, Homily on that the Church of God and the Holy Sacraments should not be neglected, Complete collection of the works of St. John Chrysostom. Volume 12. Part 2, St. Petersburg, 1906

[9] Rev. Sophrony (Sakharov). Feat of Knowledge of God. Letters from Mount Athos, part four. The gap. Letter 23. Let him live his own way [https://azbyka.ru/otechnik/Sofronij_Saharov/podvig-bogopoznanija/4]

[10] Rev. Sophrony (Sakharov). Feat of Knowledge of God. Letters from Mount Athos, part five. Outside the Church. Letter 29. The cross of Christ [https://azbyka.ru/otechnik/Sofronij_Saharov/podvig-bogopoznanija/5]

[11] St. Juan de la Cruz. Dark night [https://coollib.com/b/406227/read] https://anucs.weblogs.anu.edu.au/files/2013/11/St.-John-of-the-Cross-Dark-Night-of-the-Soul.pdf

Denys Turner, professor of historical theology at Yale University, in his book 'The Darkness of God' points out that the "night of the soul" is impossible without previous active asceticism. Through asceticism, the ascetic transforms "carnal egoism" into "spiritual", from which he can get rid only through the "night of the soul" and the "drying out" of any feelings whatsoever. A person, who is morally irresponsible, indulging his vices, does not yet exist as an "I-identity", which appears only through resistance to temptations. Following Aristotle's Nicomachean Ethics, Denys Turner shows that the "morally weak" (or Feeble) is dependent on the image of the "innocent" (or Prig) existing in his mind, which could overcome all the adversities and temptations, before which the "weak" is powerless. The third stereotype is "akolastos", Shameless. But in fact they all play a role in the construction of the self in their own way. "What all three have in common is their egoism, their self-obsession." [12] At the same time, it is the "weak" who is fixated on his sense of guilt that is the "ascetic" per se. "Active ascetics are well disposed, generously intentioned, heavily disguised, spiritual egoists" [13].

Turner argues that active asceticism as such is the process by which we create the very self that is destroyed by the "passive nights". But before destroying it, it must be ... created: the state of a person who has not even begun to practice active asceticism is far from any kind of "selfhood", this is a state of unrevealed, unrealized selfhood, which is actualized by asceticism: "The self produced by this active asceticism is but an egoism reconstructed by the discipline of a higher, but still self-interested will". [14]

This is the difference between "night" and depression: if the way out of depression is seen in a return to the previous "self-identity", then the result of the "night of the soul" should be the abolition of "I-identity", "the deconstruction of the whole panoply of 'possessiveness'"[15] and, in first of all, the fruits of active asceticism. Denys Turner writes: "Depression, then, is the revolt of this self in despair at its disintegration. The passive nights, on the other hand, are the dawning of a realization that in this loss of selfhood, nothing is lost; it is the awakening of the capacity to live without the need for it. When the passive nights pass, all is transformed. When depression passes, all is restored, normality is resumed, the emotional life is rehabilitated and so, for all the sufferings of the depressed, which are otherwise indistinguishable from the passive nights, nothing is gained." [16] Thus, for John of the Cross, depression and the "night of the soul" are "mirror-images of each other"[17]. Turner calls depression "symptom of an under-constructed selfhood." [18]

Elder Ephraim of Philotheus in the memoirs about his teacher, the Monk Joseph the Hesychast, describes one remarkable episode. Once, Elder Joseph fell ill: a huge abscess had formed in his neck, so large that pus was scooped out of it with a spoon. No wonder the ascetic was on the verge between life and death. When the crisis was over, the elder told his disciple what was really happening to him: the devil "put a crowbar under the foundation and wanted to turn the whole structure of my faith upside down. Everything that was built by feat and grace, he wanted to overturn. He wanted to remove God from the foundation of my faith. And when I saw that the foundations of my faith were shaking, I said to myself: "Where am I going? Where am I taken to?" And when I spoke to him about blessed states, he presented them as worthless: "That was by accident, and this is purely human." He said that this happened to me because of

[12] Turner Denys. The Darkness of God: negativity in Christian mysticism, Cambridge University Press. 1999 P.242.
[13] Ibid. P. 237.
[14] Ibid. P. 237.
[15] Ibid. P. 237.
[16] Ibid. P. 243.
[17]. Ibid. P. 243.
[18] Ibid. P. 229.

delusion, that – because of various circumstances, another thing – because of a simple deception of feelings, bodily or spiritual, and behind all this there is nothing but delusion, the devil, human nature. That is, everything that was from grace, everything that I learned from my experience, he explained it all to me and discarded it. And stripped me of everything. I said, "Wow!" Therefore, I asked God to get well in order to repel this attack." [19]

This is the testimony of a man in whom, from a young age, the grace of God was obviously working, who already at the age of 24, even before being tonsured a monk, had the gift of unceasing mental prayer, – it makes you think about a lot of things. The state of God-forsakenness, which Elder Joseph speaks of, is what many great ascetics went through. Here we are not talking about some kind of action of unhealed passion, it is something completely different: a blow to the most basic, fundamental internal foundations, an enemy attack on the most important thing – the faith.

John of the Cross – according to Peter M. Tyler – is characterized by "agnosticism" in relation to the center of the soul: an apophatic approach prevails here – he literally "pulls out from under me the strong rug of the spiritual center"[20], because "the center of the soul is God", Who cannot have a certain location.

Paralysis of the will characteristic of "nights" differs from simple "lukewarmness" in that "a lukewarm person is very lethargic and negligent in his will and spirit and does not care about serving God, while "a person suffering from" night of the soul " usually cares, worries and suffers because he does not serve God. The author specifies: "Although in this cleansing dryness the sensual part of the soul is very oppressed and loose and weak in its actions because it finds little satisfaction, the spirit is fit and strong."

The selfhood that a person loses as a result of the "darkness of the soul" is, in fact, a phantom of the Ego, an illusion. However, this illusion is more than real, it is precisely this illusion that most people live, whose "selfhood" it constitutes. [21] Moreover, the more the ascetic needed this "false ego", the more intense the "night of the soul" will be. [22]

The elder Archimandrite Emilian (Vafidis) shares this idea: "Sorrow is the result of some kind of pressure. The Greek word "mourn" is close to "squeeze, crush." What is crushing inside us? My "I" is being crushed by something else. [23]

Thus, thanks to the "night of the soul", crystal transparency and harmony with the action of God is formed in the ascetic: there is nothing in him that could resist and oppose, because his conditional "identity", based on opposing himself to God ("I am me, and God is God" or "God = the Other") disappeared. "For through the law I died to the law, that I might live for God. I have been crucified with Christ; yet I live, no longer I, but Christ lives in me; insofar as I now live in the flesh, I live by faith in the Son of God who has loved me and given himself up for me."(Gal.2:19-20)

D. Turner notes that for John of the Cross, grace does not destroy nature, but rather improves it. However, this "perfection" occurs by ceasing the autonomous action of the forces of the soul. "…their autonomous operation would consist in their being

[19] Elder Ephraim of Philotheus (Moraitis). My life with Elder Joseph / Translation from Greek and notes by Archimandrite Simeon (Gagatik). - Moscow, Akhtyrka: Akhtyrsky Holy Trinity Monastery, 2012. P. 195 - 196.

[20] Peter M. Tyler. To Centre or Not to Centre: Ss Teresa of Avila and John of the Cross and the 'Centre of the Soul '// Christian mysticism and incarnational theology : between transcendence and immanence / edited by Louise Nelstrop and Simon d. Podmore. Ashgate 2013. P. 185.

[21] Turner Denys. The Darkness of God: negativity in Christian mysticism, Cambridge University Press. 1999 P. 244.

[22] Ibid. P. 245 - 246.

[23] Archim. Emilian (Vafidis), Interpretation of the ascetic words of Abba Isaiah. M., 2015. P. 77.

moved by anything other than the divine action of grace," [24] and thus would be a barrier between man and God. Thanks to the "night of the soul", human identity ceases to be different, contrary to the Divine. At the same time, subjectivity does not disappear anywhere; a person does not dissolve like the "salt doll" of Buddhism in the ocean of Divinity. The dialectic of transcendence "demonstrates the failure of all our language of oneness and distinction. Within that dialectic a dichotomy between grace and freewill is as impossible to construct as any between union with God and distinction… The union of God and the soul is such that they no longer exclude one another either way. If I can have no identity as contrasted with God's, then my identity with God cannot be opposed to my identity with me". [25]

The only proper way out to escape from the "I-identity" can be compared to how a young butterfly squeezes through a cocoon, which once was comfortable, but now is cramped - the way out is accepting God as He is. This is probably the most acute crisis of any human life: to meet God and understand that you used to go around and around, and now, through the abolition of your identity, experience "unconfused oneness" with God. The greater the difference between what you expected and assumed, and what is happening, the sharper the pain. After all, it is necessary to give up your dearest ideas and feelings, on which the whole building of your faith was previously built, and accept Him as He is revealed in your pain.

D.Turner pays the main attention to the epistemological aspect, more precisely, to the fact that the inner life cannot be reduced to its reflection in the mind. "We can be and are much more 'interior' than we can know. To be truly 'interior' is to know, but only in the 'obscure' conviction of faith, that our inwardness is beyond all possible experience, that our agency is moved by that which we cannot incorporate into any experienced selfhood." [26] It would seem that a person is able to feel himself as a free and self-moving being. However, the author strongly challenges the very possibility of understanding or even feeling the One Who moves it – God or Divine grace: all of this can be known and experienced only by faith. "This faith is the negativity of experience: the negative experiences of the dark nights are but the perplexity of the soul and the desolation of desire at the loss of its self-of-experience. Our deepest centre is God… It is the conviction that our deepest centre, the most intimate source from which our actions flow, our freedom to love, is in us but not of us, is not 'ours' to possess, but ours only to be possessed by. And so faith at once 'decentres' us, for it disintegrates the experiential structures of selfhood on which, in experience, we centre ourselves, and at the same time draws us into the divine love where we are 'recentred' upon a ground beyond any possibility of experience. There is. At the centre of our selfhood, a ground which is unknowable, even to us." [27]

D. Turner's ideas find support in the reflections of Metropolitan Athanasius of Limassol on God-forsakenness. He writes: "God wants to keep us from the "grocer's feeling," that is, the feeling that we are buying grace. After all, it is called grace because God gives it as a gift. We don't buy it. We don't let it go between us and God. God just gives it to us. Not by some law that we fulfilled, not by our works, but by His love and mercy. He saved us, and by His grace given to us as a gift, our salvation and our eternal unity with Him came." [28]

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[24] Turner Denys. The Darkness of God: negativity in Christian mysticism. Cambridge University Press. 1999 P.247.
[25] Turner Denys. The Darkness of God: negativity in Christian mysticism. Cambridge University Press. 1999 P.247.
[26] Ibid. P. 251.
[27] Ibid. P.251.
[28] Athanasius of Limassol, Do not let your hearts be troubled [URL: https://ekzeget.ru/mediateka/detail-da-ne-smusaetsa-serdce-vase/?glava=cast-iiperehod-cerez-pustynubesedy-o-strastah-5]

“Who has no Cross, has no Christ”. This folk wisdom contains the deepest truth: without following the way of the cross, it is impossible to be born into a new life in His Kingdom. But this following inevitably presupposes what He experienced during His terrible torment on the Cross, being betrayed, spat upon and left to shame, abandoned by His beloved disciples. And - the last, the most unbearable - "My God, my God, why have you abandoned me?" (Ps. 22:2) – and endless surrender of Himself to the Father: “Father, into Your hands I commend My spirit!” (Luke 23:46).

And that's the only reason His Glorious Resurrection and Victory over the devil lie ahead, who failed not only to destroy, but even to shake the foundation of the faith and love of the Son for His God and Father!.. “Utter selfemptying precedes the fullness of perfection,” writes Archim. Sophrony (Sakharov), and this is the main answer to the question about the meaning of God-forsakenness. [29]

[29] Archimandrite Sophrony (Sakharov), We Shall See Him as He Is. Essex, 1985, pp. 49–50.

Osipova N.N., Mashkova I.Yu., Bardenstein L.M.

Affective disorders and comorbid pathology (bio-psycho-socio-spiritual approach)

Abstract: The report examines the features of affective disorders combined with somatic or narcological pathology, which can be mediated by hereditary, genetic and behavioral mechanisms. From a psychological point of view, the core of affective disorders is self-denial, withdrawal from responsibility for one's life, which can be described in various approaches as "denial", "violation of the self-concept", "depersonalization". Modern Orthodox authors and Church fathers described such states as sadness, despondency, depression, melancholy, and pointed to the connection of somatic diseases with ailments of the soul. Assessment of comorbid pathology on the basis of the bio-psycho-socio-spiritual model contributes to the discovery of convincing evidence of the unity of pathological mechanisms at all levels of pathology formation: biological, psychological, social and spiritual.

Keywords: affective disorders, comorbidity, bio-psycho-socio-spiritual approach.

Among affective pathologies, disorders with multifactorial comorbidity predominate, in which the classic symptoms are distorted and intertwined, complementing each other. The difference in the clinical manifestations of comorbid diseases from the classical picture of mental, neurological or somatic disorders makes it difficult to diagnose, and the isolated management of such patients by specialty doctors reduces the effectiveness of therapy. Comorbidity determines an increase in the risk of an unfavorable course of the disease, suicidal activity, social distress due to the disease. Mononosological approach in psychiatry and narcology, according to L.M. Bardenstein et al. (2008, 2017) limits the possibilities of diagnosis and selection of the optimal treatment strategy. The comorbidity concept based on a bio-psycho-socio-spiritual approach develops by creating multifactorial models of the relationship between chronic depression, addiction and somatic diseases.

The biological component of affective diseases and addiction syndromes includes, first of all, hereditary mechanisms and genetically determined features of the work of mediator systems.

There is a common neurobiological substrate for depression and addiction diseases at the level of neurotransmitter systems for serotonergic (da Cunha-Bang S., Knudsen G. M., 2021) dopaminergic transmission (Allain F. X et al, 2021; Park C. I., 2021). The similarity of the distribution of the genetic risk of depression, individual somatic diseases and dependence on surfactants suggests the formation of a "genetically comorbid" cluster of diseases characterized by the presence of common links of pathogenesis. Analysis of the "genetic architecture" of comorbid diseases according to Shmukler A.B. et al (2020) is an urgent task of a comprehensive study of pathological processes.

Both general genetically determined physiological mechanisms and behavioral specifics contribute to the realization of the comorbidity developing risk, therefore, in addition to assessing the genetic control of biological factors (chemical, physiological), it is necessary to consider the genetic influence on personality traits, temperament, which is estimated at 55-65%, and the genetic role in providing systems for responding to stressors of the social domain, amounting to 30-35% (Kasyanov E.D., Mazo G.E., Kibitov A.O., 2018).

The psychological core of affective pathology is the rejection of oneself, the avoidance of responsibility for one's life, which is described in various approaches as "denial", "violation of the Self-concept", "depersonalization". A. Beck's cognitive triad

describes typical dysfunctional patterns characteristic of depression: a negative attitude towards oneself, a negative attitude towards the world and a negative attitude towards the future.

According to the multifactorial model of emotional disorders (Kholmogorova A.B., Garanyan N.G., 1998) and the four-aspect modeling analysis of the family system (Kholmogorova A. B. et al, 2004, 2016) the structure of the parental family of depressed patients is characterized by violations of the hierarchy with pronounced dominance of the mother, a high level of control, parental criticism and elimination of emotions is manifested in intra-family microdynamics, a large number of stressful events, abuse, accidents, early deaths, alcoholism, the cult of perfectionism is inherent in the family ideology for the development of the family in a number of generations, external duty and respect for decency.

Considering the functioning and development of a person in the family, the founder of the theory of family systems, Murray Bowen, suggests distinguishing a person "... isolated, independent, differentiated from the family and subordinate, dependent, fused with the family." "Differentiation" can be understood as " the ability to distinguish between thoughts and feelings." A *poorly differentiated personality* is at the mercy of feelings, being in fusion with the family system, it is not capable of separation. A *well-differentiated personality* makes decisions rationally, autonomously, independently of others and is less affected by the system. The higher the level of differentiation among family members, the healthier the relationship develops between them. In an undifferentiated system, family members are in fusion, "soldered" with each other. There is a lot of anxiety and interdependence in such a family, healthy relationships with the world do not develop, opportunities for integration into society are limited. The undifferentiated family system is the main arena for the development of affective, psychosomatic pathology and addiction diseases.

In various patristic works and in books by modern Orthodox authors ("Melancholy, Despondency, Depression" by Archimandrite Gabriel (Bunge), "The Words" by Elder Paisios of Mount Athos, "Orthodox Psychotherapy" by Metropolitan Hierotheos (Vlachos)) depression is most often described as "despondency", which means "passion", "illness of the soul", "sinful thought". The image of the human personality in the patristic teaching is determined not by heredity and impressions of childhood, but by freedom of will and goes back to God. However, the absolutized natural attachments of children and parents turn them away from the love of God.

Evagrius of Pontus defines despondency as "the exhaustion of the soul", which "weakens in strength", does not have what is natural to it and does not have courage to withstand temptations. First of all, this is "weakening", decline, "hypotension of all the natural functions of the soul", when a person is unable to cope with painful thoughts. "From this state of weakening, there is a feeling of emptiness, boredom, hostility, nausea, instability of mind, exhaustion, "heart anxiety" (John Cassian); all these mental states include the concept of despondency." Sadness anticipates despondency, it is associated with an unsatisfied desire. Despondency is irrational, the despondent resents everything that gets in his way, showing rage, and longs for everything that he is deprived of. Everything available is hateful, everything inaccessible is coveted. Which leads to a "tricky intermixture" of depression and aggressiveness. Since despondency is associated with all other passions, it has a significant extent, representing a dead end for the life of the soul. Despondency is understood as suffering, but it is also a vice for which a person is responsible. Unlike melancholy, which can be considered as a natural predisposition, for which a person is not responsible. Evagrius of Pontus also points to the connection of somatic diseases with ailments of the soul (Archimandrite Gabriel (Bunge), 2014).

Assessment of comorbid pathology based on the bio-psycho-socio-spiritual model reveals convincing evidence of the unity of pathological mechanisms of various forms of addictions and depressive disorders at all levels of pathology formation: biological, psychological, social and spiritual.

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Priest Jose Antonio Fortea Cucurull

Depression and spirit. Reflections on the ability of spiritual life to heal depression

Abstract: The report presents the chaplain's reflections based on personal experience of communicating with people suffering from depression, and discusses the features of building communication between the chaplain and the parishioner suffering from depression. The importance of the spiritual aspect of a person in normalizing the state and leading to happiness is emphasized. Due to the widespread prevalence of depression nowadays, clergy need to have knowledge that this illness is not God's punishment and not the result of sins. Full cooperation between clergy and psychiatrists is necessary, since spiritual factors can influence the occurrence of depression and its treatment.

Keywords: depression, spiritual life, pastoral counseling, religiosity, hospital chaplain.

My thoughts about depression are addressed to psychiatrists, though I'm not going to discuss here topics that they already know. Religion unanimously accepts relation between depression and brain biochemistry, hormones, genetic predisposition, as well as a special structure of personality that is not genetically determined. It would be ridiculous to explain to psychiatrists the issues of their own specialty, however, it is necessary to express several considerations about relevant to the spiritual life of a person and society in the XXI century aspects of depression from the standpoint of Christianity. Even though the report is devoted to the spiritual side of depression, there is no doubt that I recognize the biological and chemical mechanics of depression.

First, I would like to note that even considering the biology of the brain itself, the priest can and does play an important role in relieving the depressed patient of guilt. Depression is not a sin, and in many cases, it is not a consequence of personal sin. This does not mean, however, that sin has no influence or effect on human nature - this influence can be enormous. In some cases, sin will be an additional element, pushing the disease development in a certain direction.

The importance of guilt should not be underestimated by focusing only on the study of its exogenous and other causes. Will a priest be able to be a person perfect enough to treat a patient with depression in a fatherly, positive, beneficial way? What will he do with the feeling of guilt? Of course, there shall always be clergymen who, based on their own erroneous ideas, would try to convince one that depression is a sin, everything can be corrected by prayer, that there is really no depression, and the patient simply needs to be more thorough in faith. Of course, there will always be priests who will view depression in such a one-sided way. But the priest is also able to show another human dimension. After all, if a person perceives himself as bad, then this will make him depressed to the same extent, which means he will cause even more evil and even more sorrow. Of course, someone will say: "I know very bad people who feel no sadness at all." Of course, this also happens, but evil usually entails sorrow.

We will not talk about how diverse the forms of moral life are, envy, aggressiveness, and the desire to make others suffer. Of course, when I do evil, this evil can have very different consequences for a person, because each person is a whole world. Evil begets evil - this is true, and this dark sphere of human life must also be taken into account. But it would be a mistake for a priest to consider the problem of depression only in context of sin and prayer, just as it will be a mistake if a psychiatrist does not realize vast amount of depressions based on existential questions, for example

the question of the meaning of life. The question "why do we exist?" is a spiritual question.

It is worth mentioning this because I am often approached by people suffering from depression who have been previously consulted by a psychiatrist. It seems to such people that their suffering has nothing to do with the meaning of life or with sin, because their condition has already become very acute, the problem they are faced with has become so complicated that its essence remains hidden very deeply, under various pathological layers , in which there is no longer a conscious choice of the person. However, at the beginning of the development of the state, in many cases the problem came down to the question of moral good.

I'll give you an example. When a person comes with a certain cardiological problem, with a coronary arteriostenosis, for example, doctor urgently needs to start treatment. However, many years ago, a different approach would have been used, aimed at preventing the aggravation of the condition with the help of a variety of diets and physical exercises. Currently, it would be incorrect to tell a patient with arterial occlusion: "Start doing exercises, and everything would get better!"; now completely different measures are needed, since medical treatment methods are continuously developing. But still, initially it would be possible to approach the essence of the problem from a different point of view, which leads us to the above. This is where I could make my humble contribution by looking at the problem of depression beyond its biological causes.

The ability of the spiritual dimension of a person to normalize the condition and bring happiness to at least some people suffering from depression should not be underestimated. Will this ability help all patients? No, of course, not everyone. Obviously in certain cases medicine is absolutely necessary. Of course, medications and psychotherapy are often needed. However, when the patient meets a priest, whom he accepts as his spiritual father, offering him advice similar to those that his own father would give him, and who, unlike a psychiatrist, accepts him with love, the patient discovers this love.

The priest comes to patient for the sake of goodness, and not in order to get anything from him. During the first meeting or the later ones, the priest tries to introduce the patient to prayer, to the liturgy, to the content of the hymns. In communities where God is praised, psalms are sung, the word of God is read and discussed, there is something that a psychiatrist can never give – grace. Grace is in the sacraments, in the liturgy, in the church. Contemplation of divine services, icons, shrines – this is not the pure psychology. For those who believe in God, there is grace that transforms a person from within. I in no way deny medicine, with these words I in no way deny the incredible work of psychiatrists and psychologists, or the need for medications. But the fact is that the element of spiritual life in many cases can be so powerful that, being only a constitutive element of personality, it will lead a person not only to mental normality, but also to happiness.

I'll give an example: a person develops depression associated with medical and biological reasons: the brain stops producing some substance or experiences decompensation and, finally, depression occurs. There are many types of depression, I'm only talking about one of these types, but this example will be indicative for others. In this case let's assume that the root of the disease is completely organic, biological, and yet spirituality can force this person to overcome himself and change. Because some change in biochemical substances affects the brain, which leads to melancholy, depression and irritability. Would a person's will be suppressed in all cases? No, absolutely not! Spirituality can change the psyche - in some cases on its own, in other cases with the help of a psychiatrist. It is possible that the cause of depression cannot be

eliminated. However, spiritual life can prevail over this cause and can outweigh the psychological damage that this cause of depression does to the human soul.

It is true that some people end up in a hospital in a very serious condition: I know this well as a hospital chaplain. It happens that hospitalization, the medications are necessary to return a person to mental activity, so that he has at least a minimum amount of mental strength to force himself to do something. But the spiritual element cannot be left aside either. It is also true that the spiritual cannot be imposed on a person, it can only be offered. And a good psychiatrist will tell the patient – are you religious? Are you a Christian, are you Catholic, are you Orthodox? Why aren't you looking for that healing environment that you can easily get into? Let yourself be carried away by its benefits – prayers, liturgy... Even the most atheist-minded psychiatrist would recognize the healing aspect of worship. But if a psychiatrist is a believer, he will also recognize that there is grace, there is something invisible that affects a person.

Since depression is widespread, priests in seminaries need to learn that this disease is not God's punishment, not the result of sins. This understanding would be wrong, since we know that the vast majority of people suffering from depression are usually good, simple and religious people.

One last aspect that I wanted to discuss. There is a certain discrepancy between reality and human thinking. Sometimes this discrepancy, the collision between reality and what a person thinks about it (due to his distorted thinking), causes sorrow. I know this may seem like a very philosophical statement. But this mechanism underlies some depressions. Today we see depression in fifteen-year-old children living in a loving family, physically healthy, who have parents who have money and are able to provide them with a future, but despite this, they develop depression. To understand this, as I said earlier, we cannot ignore certain spiritual factors that can affect the occurrence of depression and its treatment.

Another example. A sixty years old man, divorced, feels lonely, he lives alone, no children, no wife, his parents are in a nursing home. He already has considerable health problems, he spends half of his free time stuck at home staring at his mobile phone, does not physical exercise, nor participates in public life, his sexual needs have nothing to do with reality. However, under the influence of the media, he believes that he deserves much more than he has, that the world is unfair to him. It is logical to assume that such a person would develop depression. Of course, he will be depressed, because the reality of his life is very gloomy. A psychiatrist can deal with his psyche, however, what needed to be changed in the first place is his reality.

A vivid example of reality as a substrate contributing to the emergence of depression is a situation where the whole society promotes some ideas and views that have no connection with reality. There are many examples. In particular, the case of a sixty-year-old divorced man who lives stuck in his house without any social life. There is no doubt that millions of people live this way, considering such a life to be the normal for the elderly of the XXI century. But reality does not correspond at all to their ideas about it, about what their work and social aspirations should be. We must apologize to them for constantly showing them movie actors on TV – young people who earn fortunes almost without any difficulty, or great athletes and a perfect society, the image of which is imposed on them. Thus, there is a distortion of the image of reality, followed by a reckoning: if this image or our thought does not correspond to reality, their collision occurs, sometimes very violent, and frustration sets in, generating depression.

Today, this is the case in the West, in Western Europe. It’s a little different in the United States and Russia. In America, also in Russia, and in Eastern Europe, there are many believing Christian psychiatrists. However, this is not the case in Western Europe.

There are more and more psychiatrists here who do not lead the patient to the natural law, to the area where norms exist – the very norms that are not recognized as norms of reality by either the psychiatrist or the state. In Western Europe, there is less and less freedom to cite certain examples. There's a price to pay for this. They instill in you: don't think about deep meanings, there are much less significant things that determine a person's happiness. For example, sexuality. If a young girl or a guy are attracted to each other, and she can spend the night with a new partner every weekend, considering it completely normal, well, she will pay her price for this - it will be impossible for her to create a family, loyalty, love that goes beyond a weekend affair. It takes effort to understand that there is a natural law, and if you want to break it, there will be consequences. There are many forms of human behavior that deviate more and more from the natural law.

The problem largely lies in the fact that in Western Europe more and more psychiatrists consider normal what is contrary to natural law. Here we enter the religious sphere, of course. In this area, the answers to the questions will depend on whether the doctor is an atheist or a Christian. Usually, many psychiatrists say that their work is of a non-religious nature, that they are not interested in this area. But that's not true. There are many psychiatrists in Western Europe who, while communicating with patients, simply promote their own ideas about religion. I understand that many may disagree with this, but, in my opinion, the most frequent advice given by many modern psychiatrists is: stay away from the priest, live religion for yourself. They will deny it, but it is true, psychiatry is used by them to impose their own ideas on patients.

The position of religion is to cooperate fully with psychiatry. However, since the situation described above has already arisen in Spain, in France, in Germany, in the United Kingdom, the clash between psychiatry and religion is inevitable, because everyone chooses what he likes. Psychiatrists give their own answers to the questions: what is the being of things? What is right and what is wrong? What are the laws that govern us? In addition, they do it from a completely subjective point of view, telling believers: if you do not agree with me, then you are a fanatic.

I have known cases when a psychiatrist, a psychologist, even the head of the mayor's office set their own standards regarding religion. I will give an example that may seem like a manifestation of stupidity. I remember one mother who was visited by representatives of the social affairs department of the city Council. And when they saw a very large image of the Blessed Virgin Mary in the living room, they said:

"- You have to take this off!

- Why?

- Because your son feels insulted, oppressed, being under the pressure of such a large religious image in the apartment. And this is not our wish. You have to remove this image, and this person will make decisions about custody of your child. If you don't obey us, people from social services will do it."

We live in a Western society where the clash of psychiatry and religion is inevitable, but not because of religion. I would like to emphasize that, despite the fact that depression can have different causes, the spiritual dimension can lead a person to recovery. It is logical that the priest should go hand in hand with the patient. But sometimes the patient does not in any way want to see a psychiatrist. We always say in this case: "Go to a psychiatrist and keep coming here to church, but go to a psychiatrist." However, often people categorically refuse. In this case, the priest, in addition to continuing to insist on contacting a psychiatrist, can still have a positive influence on the patient. We all, including myself, often call out: "listen to a psychiatrist," but at the same time we find that for many years people have been gathering around us who did not want to go to a psychiatrist in any case and, nevertheless, gained health… In most cases, when they are able to go to church every

day, they have enough strength for the spiritual to lead them to restore happiness, and this drives out sadness.

There are many examples of the healing power of spiritual life. It's like a stream of water that washes away all the bad things, whatever the reasons for it. Of course, there are believers with depression who go to church, but there are also cases when they cannot even get to church because of illness. In any case, most of those patients with depression who come to church are in a state in which they can struggle, get closer to God, experience something new. They regain the love of the Heavenly Father who loves them, and every day such patients set themselves certain goals and tasks that they must fulfill simply out of love for God.

We live in interesting times, when society is increasingly moving away from the natural existence of things, which makes the work of psychiatrists more and more difficult.

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