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: modern view of religious experiences in health and disease. Church and psychiatry: facets of cooperation

***International Conference Reports***

**24-25 November 2023**

**Moscow**
**2024**

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**Church care for mentally ill people: modern view of religious experiences in health and disease. Church and psychiatry: facets of cooperation**. International conference. Reports. 24-25 November 2023: – M., 2024. – 160 p.

This book presents reports of the V International Conference “Church care for mentally ill people: modern view of religious experiences in health and disease. Church and psychiatry: facets of cooperation”, made by representatives of Orthodox, Catholic and Protestant religious communities – theologians, psychiatrists, clergy, teachers of theological schools, specialists of public health institutions from Russia, Italy, Spain, Argentina, Egypt, India, Armenia and Iran.

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*

**Opening word**

*"Blessed are those who hear the word of God and keep it"* (Luke 11:28)

Dear participants and guests of the conference, dear brothers and sisters!

I am happy to welcome everyone gathered in this hall to discuss one of the most significant problems of our time – the mental health. Mental illness is a manifestation of the general damage of human nature by sin. It distorts people's relationships with each other and with God's creation and poses a threat to human well-being and life. Mental disorders have not only biological and social, but also spiritual origins, which raise difficult ethical, philosophical, and theological issues that we need to address.

In 2018, with the blessing of His Holiness Kirill, Patriarch of Moscow and All Russia, we held the *first* international conference "Church care for mentally ill people". The conference was held in this hall and was attended by theologians, psychiatrists, clergy, and representatives from theological schools and healthcare institutions from various countries such as Russia, Belarus, Kazakhstan, The Netherlands, Cyprus, Great Britain, Romania, Italy, Spain, and Poland. The interest in the topics discussed at the conference was so great that it was decided to make it an annual event. Through our interactions with clergy and scholars from abroad, we realized that not everywhere is there an opportunity for such meetings. We saw that in many countries, religion is still being pushed out of scientific and public space into private life.

Let me remind you that previous conferences were dedicated to the problem of dialogue between the Church and medicine in providing assistance to the mentally ill people, as well as the relation between mental health and spiritual experience, and the interaction between doctors and priests in helping patients suffering from depression. The materials from these conferences are available on the DECR website and on the scientific and educational portal "Pastoral Psychiatry".

In 2020, the Presidium of the Inter-Council Presence of the Russian Orthodox Church adopted and recommended for use the document that we have developed "Pastoral care in the Russian Orthodox Church for mentally ill people". The relevance of this document has only grown over time, because people who do not want to follow the law of God and live in His grace continue to multiply lawlessness and evil, exacerbating their mental illness. According to Apostle Paul, "they are darkened in their understanding and separated from the life of God because of the ignorance that is in them due to the hardening of their hearts. Having lost all sensitivity, they have given themselves over to sensuality so as to indulge in every kind of impurity, and they are full of greed" (Eph. 4:18-19).

Our conferences reflect the high interest in exploring the impact of religious faith on mental health, which is a topic that is being discussed globally.

A psychiatrist should understand the religious views and peculiarities of the spiritual life of patients. As a prominent Austrian psychiatrist, Viktor Frankl, has said, "The spiritual dimension cannot be ignored, for it is what makes us human."

Dmitry Melekhov, one of the most prominent psychiatrists of the 20th century and one of the founders of social psychiatry, dedicated his work "Psychiatry and Questions of Spiritual Life" to the issue of the relationship between religion and science and medicine. He believed that in some cases, it is necessary to conduct a "spiritual examination" on patients. Melekhov argued that a diagnosis of a "spiritual crisis" is legitimate and can be added to a psychiatric assessment. In some cases, he believed that spiritual healing could lead to both mental and physical recovery.

In his work, "Psychiatry and Problems of Spiritual Life", D.E. Melekhov discussed the twofold nature of religious experiences in mentally ill patients. On the one hand, he noted that in cases of pathology, religious experiences can be a direct reflection of symptoms of the illness. On the other hand, Melekhov argued that religious faith can also be a manifestation of the patient's healthy personality. In this case, even if there is a disease, religious faith can help the patient to resist the morbid process, adapt to it and compensate for the defects caused by the disease in the patient's personality. Thus, D.E. Melekhov was one of the first at the present stage of the development of Russian psychiatry to consider religious faith as the most important personal resource for rehabilitation.

For religious doctors, the possibility of the influence of demons on mental health remains a stumbling block. Pastoral experience shows that mental illness creates favorable conditions for destructive demonic influences on the human soul, weakened by illness. However, possession is less common than other health conditions caused by a sinful lifestyle. Therefore, doctors and priests must be extremely cautious about the claims of those who believe their torment is the direct result of demonic influence, rather than a consequence of their own actions, which require sincere repentance and turning to God.

Even in cases of demonic possession, liberation from demons is the fruit of serious spiritual efforts: both for the one who sought help and for the priest.

It should also be kept in mind that, as darkness dissipates at sunrise, so demonic forces weaken under the influence of the grace of the Lord. Both a priest and a religious doctor can witness it, observing the spiritual state of the patient. A reliable indicator of the action of the word of God supported by a godly lifestyle is the presence of the gifts of the Holy Spirit. According to Apostle Paul, they are: "love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control" (Gal. 5:22-23). If these qualities are present in a patient's behavior, it will undoubtedly indicate a positive change in his spiritual state and minimize the possibility of future demonic influence.

We are convinced that Christianity plays a significant role in healing mental illnesses and maintaining mental health, as God is the source of unity and harmony for all things. The Church of Christ offers its centuries-long experience to help people suffering from mental disorders. Clergy and medical professionals have the opportunity to teach patients to use faith in the help of the true "Doctor of Souls and bodies" – our Lord Jesus Christ to overcome the manifestations of mental illness. Church sacraments, methods and forms of work with mentally ill people have proved their effectiveness and can bring tangible benefits today both in parish settings and medical institutions.

The program for today's conference is very interesting and comprehensive. Over the course of two days, we will hear and discuss approximately 30 presentations. I hope that our meeting will be an important step towards improving the pastoral care of mentally ill people. I wish all participants of this forum God's help and blessed success in their work. May our efforts be fruitful and favorable before the Lord!

*Kaleda V.G.*

**Church and psychiatry: history of cooperation (Russian experience)**

**Abstract:** About 30 years ago, when the question of pastoral psychiatry was first raised in church circles, many did not understand the importance of this issue. However, today the situation has changed, and this discipline is taught in many theological schools, in advanced training courses for clergy and young bishops. Conferences devoted to pastoral psychiatry are held in many regions. Several years ago, a section on “Clinical Psychiatry, Religion and Spirituality” was created within the Russian Society of Psychiatrists. International conferences “The Church's Care for Mentally Ill People” also make an important contribution to the development of this topic. Psychiatrists and clergy still have a long way to go together in understanding the nature of mental illnesses and providing spiritual assistance to ill people.

**Keywords:** church and psychiatry, history of psychiatry, religiosity and mental health.

The history of Russian psychiatry is inextricably linked to the Church, which played a significant role in its development. The Church has also a long history of caring for people with mental illnesses. Churches and monasteries were the first places where people with mental illnesses could find comfort and support. In monasteries, observations of the characteristics of mental illnesses were accumulated. In the Christian manuscripts from Ancient Russia, there are also examples of descriptions of mental illness and advice on how to deal with mentally ill people (for instance, in the Patericon of the Kiev Monastery of the Caves).

Since the 11th century, there has been a differentiated understanding of mental illness in ancient Russian writings. In the "Izbornik (Anthology) of Svyatoslav", human pathology is divided into two main categories: "diseases of the body" (somatic) and "diseases of the mind". The latter are believed to be caused by "damage to the brain", which is seen as the "first and most important" organ in a person, without which there is "nothing left in a human being". With this damage, the patient becomes like an "unburied corpse". It is important to note that the "Izbornik of Svyatoslav" describes, in modern phraseology, a clinical and psychopathological method for diagnosing mental illnesses. This method involves questioning and observing patients. The doctor would call the patient in to talk and "observe" his behavior, posture, gait, and smile during this time.

The care for mentally ill people in monasteries, which emerged spontaneously at one point, was later legalized in Russia through state acts. The first such act dates back to 1551, during the reign of Ivan the Terrible. At the Council of a Hundred Chapters, one chapter was drafted on the need to care for the poor and sick. Among those mentioned were people "possessed by a demon and deprived of reason". They were supposed to be placed in monasteries "so as not to be a hindrance to the healthy" and "to be brought to senses or to the truth".

It is important to note that pre-Petrine Russia did not have a highly organized system of spiritual courts, like those that had been introduced in Western European countries after the end of the 15th century, with the bull of Pope Innocent VIII. For two centuries, these courts continually intervened in the development of the emerging psychiatry, often leading to the extermination of mentally ill people with delusions of self-blame and of diabolic possession. It should be noted that, at this time in Russia, people with mental illnesses in a state of psychosis could freely attribute intercourse with the devil to themselves, without much risk of being burned at the stake.

During the reign of Tsar Fyodor Alekseyevich, a special law (1677) was passed, according to which, in addition to the deaf, blind, and mute, drunkards and "foolish" people also had no right to manage their property. Thus, the legislation of the 17th century was already so advanced that it classified such "stupid" people as "sick".

The care of the mentally ill, which the monasteries provided, undoubtedly required certain material resources. However, the state at that time did not have these resources available. It is known that, in 1681, Tsar Fyodor Alekseevich again proposed to the Council of Bishops the idea of building hospitals and promised to provide funding for this project. However, he did not follow through on his promise.

In 1723, Peter the Great forbade to send "madcaps" to monasteries and tasked the Chief Magistrate with establishing hospitals. However, due to the lack of hospitals in the following decades, the mentally ill were still sent to monasteries.

By a decree of the Senate in 1773, two monasteries (one for men and one for women) were appointed in each province to provide care for the mentally ill. However, the church authorities strongly opposed the transformation of monasteries into tollhaus, i.e. psychiatric hospitals, arguing not only on material grounds, but also on the basis that the care of mentally ill patients is the responsibility of doctors, not clergy.

In 1775, as Russia was divided into provinces, welfare boards were established in the provincial administrations. These boards began to open psychiatric departments in hospitals and build special homes for people with mental illnesses.

In 1834, the first textbook on psychiatry was published in Russia, written by P. A. Butkovsky, the son of a priest from the Kharkov province. The book was titled "Mental Illnesses, Set Out in Accordance with the Principles of the Current Teaching of Psychiatry, Both General and Specific, Theoretical and Practical Aspects." In the theoretical part of his textbook, the author formulates conceptual statements very important for the first half of the XIX century about the nature of human mental life: "The organs of the soul ... are nerves, the brain ... Although the soul and body are different entities in humans, we are not able to determine the exact boundaries between them." At the same time, based on Christian anthropology, the author identifies the spiritual component in humans: "The spirit is the thinking and recognizing principle of the soul, through which we explore and learn about the truth, the Universe, and our own nature." P. A. Butkovsky also noted that in patients with relatively mild forms of mental disorder, "free will and prayer can significantly contribute to healing. Prayer is one of the most powerful means of strengthening mental life."

The end of the 19th century saw the formation of modern psychiatry. In Russia, district hospitals for people with mental illnesses were built in every province, which were comparable to the best clinics in the world at that time. In all hospitals churches were established. The ministry of priests in these churches had its own unique characteristics compared to parish churches and chapels at other hospitals. For example, the priest at the Moscow District Hospital for the Mentally Ill was instructed to conduct a "spiritual conversation with the hospital's patients, who were referred to him by medical staff "[1]. That is, only patients who were mentally stable enough were selected to have a conversation with the priest. Conversations with the priest were not recommended for some patients.

In the 20th century, during the period of the atheistic government, many mentally ill people in our country found shelter in monasteries. In many monasteries,

[1] Instructions for staff of the Moscow District Hospital for the Mentally Ill, M., 1907. Paragraphs 190-194 of this instruction are devoted to the duties of the priest. Currently, this is the Moscow Psychiatric Clinical Hospital No. 5.

after their closure, psychiatric boarding hospitals for severely chronically ill patients were established in in the suburbs. As an example, we can mention the St. Nicholas Peshnosha Monastery, the "Joy and Consolation" monastery and the St. Nicholas of Birlyuk hermitage in the Moscow region, the St. Alexander of Svir' monastery near St. Petersburg, the Assumption at Vysha hermitage, where St. Theophan the Recluse lived, the hermitages of St. Nil of Sora near Vologda, the St.Seraphim and Mother of God of Consolation of All Sorrows at Ponetaevka Monastery near Diveyevo, and one of the brethren's buildings of the Dormition Lavra in Pochaev. [2].

At the end of the 20th century, against the backdrop of significant political events in our country and in connection with the emergence of new opportunities to improve the quality of training for future clergy, there was a pressing need to introduce students of theological schools to the basics of psychiatry, in the same way that students of psychology departments are introduced to the basics of this field. It is important to note a general trend that exists worldwide: often, when mental disorders begin or worsen, patients first seek help from clergy. At the same time, in many cases, the mental health and even the life of a person depend on the behavior of the priest. It is no coincidence that the first specialized guide to psychiatry for clergy was written nearly 100 years ago by the renowned German psychiatrist, Kurt Schneider (1927).

In Orthodox literature, the need to clearly distinguish between pastoral care and psychiatry was first discussed by Archimandrite Cyprian (Kern), a professor at the St. Sergius Institute in Paris and author of a course on pastoral theology (1957). Father Cyprian believed that these two areas were different, although they were adjacent. He wrote that there were mental states that could not be defined by the categories of moral theology, and which were not included in the concepts of good and evil or virtue and sin. These are all those "depths of the soul" that belong to the field of psychopathology, not asceticism." Father Cyprian recommended not to invite a psychiatrist to the analogion, but for the priest himself to study the psychopathology of mental illnesses, "so as not to condemn as a sin in a person what in itself is only a tragic distortion of their mental life, a mystery, not a sin, or the mysterious depths of the soul, not moral depravity." In each specific case, he urged acting "with care," with special attention and imbued with a spirit of compassion and understanding, attention and inner sensitivity. Archimandrite Cyprian emphasized that the subject of "Pastoral Psychiatry" should not be seen as an "additional part of the Breviary or the Nomocanon", as it does not belong to the field of pastoral asceticism. Instead, it is a separate area of pastoral counseling that should not be overlooked by priests.

Later, Metropolitan Anthony (Blum), who has a medical background, wrote: "A priest can not a professional psychiatrist, but he should have… some knowledge of how mental illnesses manifest themselves. When a person with mental illness becomes a believer, their mental state can cast a shadow over everything, including their life in the church. It is important for the priest to be able to differentiate between illness and a genuine mystical experience."

The modern concept of the discipline "pastoral psychiatry", which involves the collaboration between a psychiatrist and a clergyman, was formulated by Professor D.E. Melekhov, one of the leading figures in Russian psychiatry. This concept is discussed in his book "Psychiatry and Questions of Spiritual Life". D. E. Melekhov built on the patristic understanding of the trichotomous human personality, which is divided into three parts: physical, mental, and spiritual. In accordance with this, diseases of the spiritual realm are treated by a priest, mental ones by a psychiatrist,

2 One of the first monasteries that was "transformed" into a psychiatric institution was the St Cyrill Trinity Monastery in Kiev after it was closed in 1786 by order of Catherine II. In its buildings, St. Cyrill's charitable institutions were established, which included a house for people with mental disabilities with 30 beds.

and physical ones by a somatologist (such as a therapist or neurologist). All three aspects of the human personality are closely interconnected, which often requires the combined efforts of a mental health professional and a priest to provide appropriate care for a person with mental illness. At the same time, while a psychiatrist plays a leading role in the treatment of acute psychotic disorders, after the acute phase has been relieved, during the remission stage, when mood instability and states of despair are common, and the patient faces the challenge of finding personal meaning of the disease, the role of a priest becomes more significant. D. E. Melekhov's work was included in the "Clergy Handbook", and later, his concept of the relationship between spiritual, mental, and physical illnesses formed the basis for the respective section in the "Basics of the Social Doctrine of the Russian Orthodox Church" (XI.5), which states the following: “The Church regards mental diseases as manifestations of the general sinful distortion of the human nature. 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 passions. In accordance with this distinction, it is equally unjustifiable to reduce all mental diseases to manifestations of obsession — the conception ensuing in the unjustifiable exorcism of evil spirits, and to treat any mental disorder exclusively by medical means.”

In his practice, a psychiatrist often deals with situations where patients, due to the nature of their mental illness, do not admit that they have an illness and refuse to take medication. This can lead to a rapid worsening of their condition. Such situations can be extremely difficult, both for the doctor and for the patient and his family. The lack of medical care in some cases leads to irreversible consequences. If the patient is an Orthodox Christian, it is very important what position the priest will take in this matter.

"Being sick," writes Archpriest Vladimir Vorobyov[3], "they want to feel healthy and are not aware of their illness. These are the most challenging cases. The priest needs to explain to the individual that mental illness is not something to be ashamed of. This is not a condition that excludes a person from life. It is a cross. Such a person may not be able to do things in the same way as healthy people, but he can and should strive to be more humble himself…"

D. E. Melekhov cautioned priests against attempting to eliminate all instances of mental illness solely through "spiritual treatment ".

An important event in the history of modern Russian psychiatry was the consecration by His Holiness Patriarch Alexy II in 1992 of the hospital church in honor of the icon of the Mother of God the Healer at the Scientific Center for Mental Health of the Russian Academy of Medical Sciences. Since that moment, the staff of this leading scientific center has been closely cooperating with theological schools, synodal institutions, monasteries and parishes of the Russian Orthodox Church. This cooperation has been going on for more than 30 years.

Since the mid-1990s, Moscow Theological Academy has been offering a course on the basics of pastoral psychiatry as part of pastoral theology. This practice continues to the present day. Later, the teaching of this course began at St. Tikhon's Orthodox University, Belgorod, Voronezh, Sretensky theological seminaries. The course in pastoral psychiatry is an interdisciplinary program that covers the main symptoms, patterns, causes, and features of mental illness, as well as the special aspects of pastoral care for individuals suffering from these conditions. The aim of the course is to prepare future priests for the pastoral care of people suffering from mental

3 *Vorobyov V., Archpriest.* Repentance, confession, spiritual guidance. M.: The Light of Orthodoxy, 1997. p. 52.

disorders. The objectives of the course are to provide general information about the symptoms of mental illness, teach students how to recognize the main signs of various mental disorders, outline the features of both pastoral and medical approaches to patients, and explain the principles of pastoral treatment for specific manifestations of mental illness. It is crucial that future priests understand the main symptoms of mental illness, and the course of the disease. They should also be aware of the medications are prescribed, and avoid following their spiritual children's lead in cancelling or reducing medication, which, unfortunately happens quite often.

It should be noted that, in the church and secular society alike, there is a lack of acceptance for psychiatric care. At the same time, it should be clearly understood that people with mental illnesses, deprived of the opportunity to receive medical care, become victims of this approach.

One of the most prominent representatives of the antipsychiatric (and antimedical) trend was Bishop Barnabas (Belyaev, 1887-1963), one of the most mysterious figures in the history of the Russian Orthodox Church of the twentieth century, who in 1922 stopped his episcopal ministry and began to lead the life of "God's fool". In his work "The Fundamentals of the Art of Holiness"[4], the author collected and systematized the teachings of the holy fathers. However, when it comes to medicine, his view is peculiar: "...there should be no medicine in the sense that it is praised by educated people. It does not bring benefits, but only harm; and in those cases when a person recovers, a true miracle happens – the human body fights and overcomes not only the disease itself, but also the damaging effects of the drugs prescribed to it!.. Gout, rheumatism, bladder, liver, kidney, hypochondria, overeating, and various types of nervous disorders all have their origins in digestive system disorders. Leanness, circulatory irregularities, and anemia develop as a result of our excessive consumption and stomach diseases... The number of patients with nervous disorders, such as hysteria, hypochondria, melancholia, and mental illnesses, increases solely due to the consumption of meat, alcoholic drinks, as well as tobacco, tea, coffee and so on."

Bishop Barnabas' anti-medical position is in contradiction with the conciliar decision of the Russian Orthodox Church. Thus, in one of the chapters (XI.1.) of the "Basics of the Social Doctrine of the Russian Orthodox Church", the following is stated:

At all times the Church has been concerned for the human health, both spiritual and physical…The biblical attitude to medicine is expressed most fully in the Book of Jesus the Son of Sirach: «Honour a physician with the honour due unto him for the uses which ye may have of him: for the Lord hath created him… For of the most High cometh healing…Then give place to the physician, for the Lord hath created him: let him not go from thee, for thou hast need of him. There is a time when in their hands there is good success. For they shall also pray unto the Lord, that he would prosper that, which they give for ease and remedy to prolong life» (Sir. 38:1-2, 4, 6-10, 12-14).

Russian Orthodox Church's Inter–Council Presence adopted in 2021 a document prepared by the Commission on Church Education and Diaconia - "Pastoral Care in the Russian Orthodox Church for mentally ill people", which was addressed to the Educational Committee and the Department for Church Charity and Social Service. The document formulates the Church's approach to mental health issues; provides a classification of mental illnesses from the perspective of modern medicine;

4 *Barnabas (Belyaev), Bishop*. The Fundamentals of the Art of Holiness. Nizhny Novgorod: Publishing House of the St. Prince Alexander Nevsky Brotherhood, 1998.

outlines the basic principles of spiritual care for people with mental illness and their families; speaks about the involvement of people with mental illnesses in religious services, church sacraments, and rituals; highlights the issues of training clergy to provide pastoral care to people with mental health needs and their families; offers practical guidance for church-based care for those with mental health needs; and provides recommendations for organizing church-based support for individuals with mental illness.

In recent years, under the blessing of His Holiness Patriarch Kirill of Moscow and All Russia, issues related to pastoral care for people with mental health issues have been discussed during Christmas readings, including those organized at the diocesan level. These discussions have taken place at the annual international conferences "Church Care for Mentally Ill People," which have been held since 2018 within the walls of the Danilov Monastery. The conferences have brought together representatives from the psychiatric community, as well as Orthodox priests and theologians. Representatives of other Christian denominations are also invited to participate in the conferences.

In 2021, a textbook for the Bachelor of Theology program titled "Pastoral Theology" was published. The text states that "…a priest should not only be a confessor but also, in some ways, a psychiatrist. In any case, a priest should master at least the basics of psychiatry". The textbook has a special appendix "Fundamentals of pastoral psychiatry" with a description of the main manifestations and patterns of mental illness. In addition, that same year, the publishing house of the Moscow Patriarchate released a special guide for priests titled "Fundamentals of Pastoral Psychiatry," which was well-received by the Orthodox community. Over the past few years, classes on the basics of pastoral psychiatry have been offered in several dioceses as part of advanced training courses for clergy. A lecture on psychiatry has also been repeatedly given at special courses for newly ordained bishops.

In 2021, the "Clinical Psychiatry, Religiosity, and Spirituality" section was established within the Russian Society of Psychiatrists.

The purpose of the section is to systematize modern ideas on the relationship between clinical psychiatry, spirituality and religion, as well as to disseminate scientific and practical knowledge to a wide range of people involved in helping religious patients with mental pathology.

It should be noted that many publications by modern domestic psychiatrists emphasize the importance of a psychiatrist having an understanding of the religious beliefs and peculiarities of the spiritual practices of patients (Logutinenko R.M. 2014, Kopeyko G.I. 2021). They emphasize the significance of paying attention to patients' religious experiences (Sidorov P.I. 2014) emphasizes the uniqueness and individuality of the spiritual realm, which he sees as expressing the essence of a person's personality. Kondratiev F.V. 2017 also emphasizes the importance of recognizing the unique nature of each individual's spiritual experience.

It should be noted that many publications by modern Russian psychiatrists emphasize that a psychiatrist needs to have an idea about the religious views and peculiarities of the spiritual life of patients, (Logutinenko R.M. 2010, Kopeyko G.I. 2021); that it is essential for psychiatrists to pay close attention to the religious experiences of their patients (Sidorov P.I. 2014). They emphasize that the spiritual sphere is always uniquely individual, and expresses the person's identity (Kondratiev F.V. 2018).

Many psychiatric scientists emphasize the importance of collaboration between a psychiatrist and a priest in the treatment of people with mental illnesses who have a religious worldview ((Polishchuk Yu.I. 2010; Kaleda V. G. 2017; Sidorov P.I., 2014; Voskresensky B.A., 2016; Borisova O.A., 2022). They also note (Savenko Y.S., 2013)

that even their non-direct cooperation greatly enhances the effectiveness of therapy. The religious factor, according to the researchers, should be considered as a potential resource that the patient can use when faced with illness and other life stresses.

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*Archpriest Pavel Velikanov*

**Religion, religiosity, pseudo-religion, toxic faith, false religion: another attempt to agree on concepts**

**Abstract**: In their work, psychiatrists often encounter the need to understand and describe the religiosity of people with mental illnesses, as well as to differentiate between genuine religiousness and pathological conditions that may appear to be religious. This is why an attempt has been made to define such a condition as "pseudoreligiosity", which, however, could lead to a mistaken perception of the religiosity of anyone suffering from mental illness as "pseudoreligious". While religiosity, religion, faith, and the inner world of a person are interconnected and constantly interact with each other. It is impossible to determine exactly what is primary in morbid religiosity: mental disorders, which inevitably impose their "prism" on the entire perception of religion, psychological trauma that throws consciousness onto a long-trodden track, or an imposed image of God that justifies a morbid situation and gives it the status of truth. Of great importance for believers suffering from mental illness is the organic interaction between three key figures in the field of soul therapy: a priest, psychologist, and psychiatrist. Each of these professionals, working in their respective fields, can contribute to the harmonization of religiosity as such.

**Keywords:** religiosity, faith, pseudo-religion, "morbid" religiosity.

"Not everything that is printed in books is sacred [Not every printed word is sacred]," says the abbot of the monastery in the epilogue of Nikolai Dostal's film "The Monk and the Demon." However, our consciousness stubbornly asserts about "spirituality", "religiosity", "faith", "holiness", as soon as something related to the Church, Scripture and other phenomena of religious life comes in sight. The issue of defining concepts becomes particularly important as soon as we move from the field of "norm" into the "borderline" zone – between norm and pathology, where the key question is: "Who are the judges?" How can we draw not even a clear, unambiguous boundary between conditionally "healthy" and conditionally "diseased" faith, but at least outline a certain area in which it is already necessary to use additional tools to determine health or illness?

To begin with, we need to identify the field of our reflection, or rather, some "introductory" concepts, without which we cannot move forward.

**Religion**

A sociocultural phenomenon reflecting the need inherent only in man for existence as the fulfillment of a way of being. We should immediately note that this is not the only way of "being": philosophy, art, ministry and sports are on the same field. However, unlike them, religion always has a specific content, determined not by a sense of beauty (art), not by rationality (philosophy), not by striving to fulfill a moral duty (service) or achievements in sports, but by an authority outside of the person's personality, which in relation to each of the above-mentioned aspects (feeling, reason, will) has an unambiguous and indisputable priority. The willingness to accept the dominance of religious authority is a fundamental attribute of religious faith; if this faith in the unconditionality of authority is absent, then any, even the most harmonious religious system, is destroyed.

Religion is a derivative of the deep demand that lives inside a person; according to N. Berdyaev, it is "an opening into infinity"[1]: religion gives him wholeness, form, completeness. Any religion offers its follower a specific model in which a person receives structured answers to questions: What am I in this world? Where am I going? Why does everything happen this way and not otherwise? What exactly should I do and why? Etc.

Why is religion a "sociocultural" phenomenon? This form is never completely authentic, growing "out of itself": it is born in the context of a specific time, cultural traditions, values and inevitably takes them into account – in a positive or negative way. The religion accommodates itself to the society and culture, it puts on what is visible and sensually perceived, certainly bringing a religious tonality to its "outfit".

Religion is just a space, a "stage" – where a person is more likely to meet God, because all the "decorations" of the "stage" encourage this. But they may not meet, stuck in contemplation of the scenery, carried away by the music coming from the orchestra pit, etc. If we continue the analogy, then meeting God in religion is similar to experiencing catharsis during a theatrical performance; one is related to the other, but is not absolutely necessary and inevitable.

**Religiosity**

The ability of a person to accept religion and put it into practice. Through religiosity, a person "lives" religion, embraces it in his thoughts, values, customs, rituals, in everything that makes up the way of life. Different scholars have seen this concept as broadly about religious orientations and degrees of involvement or commitment[2] (B.Holdcroft, 2006), while noting that there is no agreement among scholars on its criteria. The main aspects are beliefs (doctrine), practice and spirituality, which, as a rule, can be very different from each other.

The range of religiosity is quite wide and is determined by the environment, upbringing, peculiarities of the psychological constitution, character and other factors. The status ranges from "superficially religious", sometimes episodically "remembering" and actualizing one's belonging to religion, to "fanatically religious", who capitulated to religion without a trace and allowed it to enter any, even the most secret, corner of the soul, willing even to lose one's life in the name of religion.

**Faith**

A person's deeply personal response to the "call of religion," which is determined by the correspondence of religious orientations to the deepest attitudes of the individual. Faith is always a response, first of all, free and conscious: "force won't make you a believer." It is impossible to inforce faith, but one can be pushed to it, if there is at least a small groundwork for it.

The range of faith is also wide – from "little faith" to "faith that moves mountains". The ability to endure uncertainty without destruction, anxiety, despondency, and the ability to take significant risks grows in proportion to faith.

Faith is conditioned by the inner world of a person, and therefore has the quality of mobility and instability: for keeping it "in good shape", it is not enough to follow the rules of piety, fidelity to dogmas, regular participation in divine services – all what makes up the "fabric of religiosity": by themselves, all these tools are not able to "create" or "revive" faith, but rather are an auxiliary means for an already accomplished reversal from a lesser faith (or unbelief) to a greater one.

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[1] «The man is interesting and significant because he has an openness drilled in him into infinity» (Berdyaev N.A. The Destiny of Man. Paris. 1931. p. 162).

[2] Holdcroft, Barbara (September 2006). "What is Religiosity?" Catholic Education: A Journal of Inquiry and Practice. 10 (1): 89–103.

Faith "breathes crises"; it does not develop progressively and linearly (see the article " The 'dark night of the soul' and depression: on the issue of disidentification of concepts"). The dynamics of faith can be compared with the focus adjustment of a flashlight: decreasing in width makes the light brighter and stronger, while increasing in width makes it scattered: "O you of little faith, why did you doubt?" Christ asks the apostle Peter, when the "focus of his faith" widened to the point that he began to notice the surrounding element and be horrified by it. Both with a "narrow light ray" and with a "wide" ray the faith is still there, but its quality is very different.

The following analogy can be drawn using the example of a relationship between a man and a woman. The feeling of love between them is close to the concept of "faith". The stamp in the passport with all the consequences in social, moral, and legal terms is religion. The way in which the spouses realize their "legal cohabitation" in practice, the extent to which their modus vivendi contributes to the maintenance and development of love for each other – religiosity.

**"Pseudo"**

How applicable are the categories of "true" and "false" in relation to religiosity? Obviously, these categories are evaluative. But no estimation is possible without a clear frame of reference. What do we have in the case of religiosity?

It is not surprising that it was among practicing psychiatrists, who are constantly faced with manifest mental pathology caused or masked by religiosity, that the idea arose to describe the religiosity of a mentally ill person as false or "pseudo-religion". The frame of reference is very clear here: there is relative mental health and obvious pathology. Health and illness are respectively labeled as "true" and "false" in relation to religiosity. Thus, it is postulated that a mentally ill person, by definition, has "pseudo–religion", and a healthy person has "true religiosity". In our opinion, there is one fundamental mistake here.

If we leave the medical space proper and look at the issue from the point of view of religious studies or theology proper, the attribute "false" cannot be mechanically applied to religiosity as such. The term "pseudo" in relation to religiosity completely negates religiosity itself, instead of carefully understanding this complex and polyphonic phenomenon. If "pseudo-religiosity" is not inherently religiosity as such, then what kind of phenomenon is it? And under what conditions can "true" religiosity emerge from "pseudo-religion"?

Any "reading" by consciousness of religion and/or spiritual (mystical) experience cannot be attributed as "true" or "false", primarily because it is always personal. We cannot talk about a "true" or "false" personality: at the same time, of course, in psychotherapy it is possible and necessary to talk about certain traumas, distortions, underdevelopment, privativeness, inferiority, etc., which with competent therapy can be safely overcome or compensated. Just as a personality can be said to be more or less healthy or, on the contrary, obviously ill, the same should be applied to religiosity – without attribution of "true" – "false". St. Ignatius Bryanchaninov, in his Ascetic Experiences, shows well that "spiritual deception is the wounding of human nature by falsehood... the state of all men without exception, and it has been made possible by the fall of our original parents. All of us are subject to spiritual deception."[3] If the position of the Saint is recognized as correct, then the question of "pseudo-religion" disappears automatically: any person is pseudo-religious until he has reached the state of deification. There was only one period of "healthy", "true" religiosity in the history of mankind – before the fall, when God and man communicated directly, "on the

[3] Complete collection of works and letters: in 8 volumes / St Ignatius Brianchaninov / General editor O.I. Shafranova. – 2nd ed., corrected and supplemented: Letters: in 3 volumes.

same wavelength", without being conditioned by any kind of mediation and inevitable interpretations.

Without any doubt, religiosity, religion, faith and the inner world of man are interdependant and are in constant communication with each other. However, it is hardly possible to say what exactly is primary in morbid religiosity: an organic mental disorder that inevitably imposes its "prism" on the entire perception of religion, psychological trauma that throws consciousness onto a long-trodden track, or an imposed image of God that justifies a diseased situation and gives it the status of truth?

**The fabric of religiosity**

Religiosity has 3 sides:

1. what does a person think, in what images does he see spiritual realities (perceptions);
2. how does he behave (practice);
3. what and how does he experience (mysticism, spirituality).

Ideally, all these sides interact with each other, being turned to the Other – God, indirectly manifested in the world and society. In reality, there will be certain distortions that will determine the specifics of a particular person's religiosity.

All sides of religiosity are balancing each other, thereby creating a certain strain or "tension" of the canvas of religiosity: perceptions correlate with practice and spiritual experience, practice is regulated by perceptions and supported by mysticism, spirituality is verified by perceptions and framed by practice.

Hyper- or hypotrophy of either side leads to distortion, significant deformation of the "canvas" of religiosity. "Sagging", inferiority, insufficiency in perceptions inevitably lead to spiritual unscrupulousness, "hunger" for everything "spiritual". The insufficiency of the mystical side leads to formalism, loss of interest, and lifelessness of religiosity as such. Inferiority of the practice delutes religiosity to a worldview seasoned with vague and chaotic mystical experiences that are unable to direct the "sail of religiosity" anywhere.

The faith as such (see definition above) is not reducible to any of the three "nodes" of religiosity: it is present in perceptions, adding an attribute of truth to statements that are insufficiently articulated and justified; faith also justifies the importance and necessity of practice by the presence of a Divine Addressee, to Whom the activity is addressed; in addition, faith "opens" mystical experiences towards the Divine Object/Subject, acting as a kind of "channel" of interaction between the human and the Divine, the "interface" of God-man communication, bringing a person out of a state of self-sufficiency and isolation.

How can each side of religiosity be described in order to make its measurement possible, without which it is impossible to talk about the "norm" and going beyond it?

**Perceptions**

In the field of perceptions, those images that are directly related to the personality are the most significant for describing the quality of religiosity. Questions of an abstract dogmatic nature that are not identified as "guides to action" or "answers to specific life questions", for all their declared importance, can remain in the most distant storages of consciousness and, in general, have no effect on religiosity.

1. The image of God: strict / merciful, self-willed / predictable, "quick to hearken" / hard to persuade, generous / demanding, etc.
2. The image of the world (doomed / inspired, friendly / hostile, helping / hindering, warm / cold, attentive / indifferent, godless / blessed, etc.

3. The image of the person himself (wonderful / disgusting, sincere / deceitful, smart / stupid, kind / evil, well-intentioned / mean, promising / hopeless, superficial / deep, etc.

**Practice**

Practice, as a rule, includes the following areas:

1. Congruence (proportionality, consistency) with the religious system: observance of fasts, holidays, ecclesiastical rules, regular participation in divine services and other types of religiously oriented activities. This ranges from complete surrender with the sacrifice of all aspects of personal life to religion, up to the destruction of the family, to “noticing out of the corner of the eye.” A classic example of such “ritual belief” is a case described by S.I. Fudel from a police chronicle of the early twentieth century, when a peasant who robbed and killed a girl did not eat eggs from her basket because it was a fast day.

2. Transferring religious references to the sphere of active life; actualization of religious attitudes in everyday life. This ranges from episodic involvement or one-time “breakthroughs” to destructive anxiety and a pervasive fear of doing something not according to the will of God.

3. The active application of the Divine Scripture, its actualization in everyday life. Scripture as a "guide to action" and the main "compass" of faithfulness, constant "checking" oneself with the Word of God is an essential attribute of religiosity. This ranges from episodic remembering to the transformation of Scripture into a "universal potholder". The text of Scripture "dissected" by the mind, taken out of context and tradition, becomes just a set of quotations that can justify any behavior – as it is perfectly shown in the film "The Disciple", where the main character justifies even his most eccentric, immoral actions with the words from the Bible.

**Mysticism, spirituality**

The most difficult area of religiosity to define is the mystical or spiritual, it includes the following aspects:

1. The interiorization of religious ideas; the “descent” of the mind into the heart, understood in the broadest sense as emotional experience and deep acceptance of Divine truths. This ranges from an episodic warm heart response to non-stop self-induced agitation.

2. Turning to God (prayer, ritual, sacraments, etc.) with tracking the "feedback" from Heaven. This ranges from rare, occasional cases to alarming sensitivity to any possible “signs”, “answers from above”, “non-random accidents”, an exaggerated and fundamentally unsatisfiable request “upwards”, a forced “pulling” of Heaven to earth.

3. The presence of the mysterious, miraculous, supernatural in life. This ranges from rare "flashes" to to continuous miracles.

In the above case of the peasant murderer, the selective application of church guidelines is obvious: killing because of hunger is bad, but acceptable, but eating eggs on a fast day is unacceptable under any circumstances. There is a catastrophic predominance of ritualism over the interiorization of the main Christian commandments and the displacement of the image of the punishing God from the spiritual and moral realm into the ritual.

Now let's look at the above sides through the prism of falsity. Can ideas about God be false? No doubt, yes. But here lies an important and, in fact, insoluble problem: most of the dogmatic statements of the Christian religion are antinomian in nature (see "The Pillar and Ground of the Truth" by priest P. Florensky), that is, they require faith to "bridge the gap" between seemingly mutually exclusive statements. Accordingly,

morbid religiosity will strive for simplification and unambiguity: God is either good or strict.

One of the possible signs of morbid religiosity is fragmentation, incompleteness of ideas; clear predominance of selective unambiguity over holistic complexity and antinomy. Instead of accepting as an axiom its own limitations, the incomprehensibility of the Divine Mysteries, accepting all the diversity and polyphony of Revelation as it is, entirely, morbid religiosity "plucks" from this "flower garden" what is close to it and what it “likes” in strict accordance with its damaged nature. Hence the tendency to radicalization and fanaticism, the predominance of literalism over polyphony and symbolism: "for the letter killeth, but the spirit giveth life." (2 Corinthians 3:6) – this is exactly what it means.

The second feature of morbid religiosity is "symbolic insensitivity". This is the desire to reduce symbols to "winking" and "hinting", as if they were signs that clearly indicate and interpret the content, replacing the denotation with their own reality. This reality has nothing to do with what the symbol originally meant. For example, the attitude towards a shrine as being "infected" with grace, akin to a type of "spiritual radiation", with the resulting consequences in terms of disposal of the unusable. Or, the substitution of veneration for the Mother of God with the cult of one of Her icons, which is de jure denied by church teachings, but is widespread in practice (for more information on the stages of the formation of a simulacra on the example of an icon, see J. Baudrillard's "Simulacra and Simulation")[4]. Morbid religiosity, unlike healthy religiosity, can "think up" the signs and absolutize them: for example, an icon that has fallen from a shelf can be a sufficient basis for far-reaching conclusions. Another example is the clear attribution of saints to specific everyday needs, and so on.

The third feature is the ethical and aesthetic "clumsiness" that comes with a lack of empathy and a lack of moral sensitivity development. This "awkwardness" stems from the lack of focus and the disconnection of value priorities from the warm heartfelt experience of the Divine presence. As a result, there is a hyper-compensation for heart deficiency through over-rationalization, with an attempt to "calculate" and "justify" actions based not on the "experience of the heart" but on a rational "matrix of right and wrong".

The fourth feature is the dysfunctional nature of morbid religiosity as a means of maintaining the "burning of the spirit" in the human soul. The "ship" of faith must "fly", driven by the breath of the Divine Spirit, pushing the resisting (!!!) religiosity like a stretched sail. In a sense, this image helps to understand why there is a certain opposition to the Divine in the very nature of religiosity. They are "opposed" to each other: if the "sail" does not resist the wind, it does not "work"! It is from this tension, which can at times reach an acute existential crisis, that movement is born. The sprout of faith grows, constantly overcoming the resistance of religiosity and winning more and more space for itself.

The fifth characteristic feature is stagnation in the development of faith. This faith, which was once a living, ever-changing experience of recognizing the Divine in the everyday realities, freezes in the form of "religious declarations". These declarations

[4] “These would be the successive phases of the image:
1. It is the reflection of a basic reality.
2. It masks and perverts a basic reality.
3. It masks the absence of a basic reality.
4. It bears no relation to any reality whatever: it is its own pure simulacrum.
In the first case, the image is a good appearance: the representation is of the order of sacrament. In the second, it is an evil appearance: of the order of malefice. In the third, it plays at being an appearance: it is of the order of sorcery. In the fourth, it is no longer in the order of appearance at all, but of simulation”. (Jean Baudrillard. Simulacra and Simulations. URL: https://genius.com/Jean-baudrillard-simulacra-and-simulations-annotated)

are primarily in the realm of perceptions and no longer involve the sensory world. One could say that this faith has become "privatized", much like a bride might "privatize" her husband after the long-awaited stamp in the passport, thus laying the inevitable future divorce into the foundation of the marriage.

But this same "sprout of faith" can get stuck, not overcome the "asphalt" of religiosity, wither and die; at the same time, the "heaving" asphalt can be perceived as a full-fledged, healthy religiosity. Religiosity, which has "stuck", stopped, become stuck in familiar forms and has not been able to "break through" them or overcome them, is doomed to decay and death.

Healthy religiosity, accordingly, will have the following minimal signs: adaptability, dynamism, complexity (antinomianism), sensitivity, openness, drama and the ability to stay in uncertainty as a result of living, rather than formally declarative faith.

Accordingly, healthy religiosity will have the following minimal characteristics: adaptability, dynamism, complexity (antinomianism), sensitivity, openness, expressiveness and the ability to stay in uncertainty as a result of living, rather than formally declarative faith.

The problem of morbid religiosity is, first of all, the problem of existential self–determination of the individual, the problem of unwillingness to take on the risk of faith, which is expressed in the desire to hold, grasp, own the Divine – as much as possible. And here it is extremely important to have an organic interaction between the three main figures in the field of soul therapy – a priest, a psychologist and a psychiatrist: each of them, working in his field, is able to contribute to the harmonization of religiosity as such, “tightening” the sails and moving the boat of faith in the right direction.

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**Religious masks of mental disorders**

**Abstract**: This report discusses special forms of mental pathology in which a mental illness imitating traditional forms of religious behavior is hidden behind the facade of religious manifestations and excessive religiosity. The correct assessment of these conditions from both a spiritual and psychiatric point of view is extremely difficult. The choice of adequate tactics of pastoral care depends on the timely recognition of these disorders. Mental disorders hidden under the mask of religiosity are often underestimated by both pastors (priests) and doctors, which leads to failure to provide timely medical care and to the fact that the illness progresses to another, more severe stage. On the other hand, such a person's behavior tends to confuse members of the religious community, cause misunderstandings, and may also result in them receiving inadequate spiritual advice. Often, in order to avoid a tragic outcome, the Church leadership, is forced to limit the presence of such individuals in church community.

**Keywords**: religious anorexia, depressive delusions, paranoid delusions with religious content, possession syndrome, strategy of pastoral counseling.

Psychopathological disorders, which may hide behind manifestations of religiosity, have certain clinical pictures Let us examine some of the most common conditions.

**Anorexia mirabilis** syndrome (holy anorexia) is characterized primarily by delusional food refusal. The intent of such behavior may vary: self-improvement, atonement for past sins, struggle with the passion of gluttony. In severe cases of such conditions, patients often die from starvation. People with such disorders are completely captured by morbid experiences, their behavior cannot be corrected, up to the point that they ignore the advice of a religious spiritual leader to stop fasting (O.A. Borisova, 2019). Historical examples of such states were Maria of Uania (1177-1213), Catherine of Siena (1347-1380), Columba of Rieti (1467-1501). [5]

Next, we will present a clinical case from our practice: a young man until the age of 14 years was cheerful, active, sociable by nature. At the age of 16, he successfully graduated from Theater College, was fond of rock music, and organized his own rock band. At the age of 19, he began to read religious literature, stopped communicating with former friends. At the age of 20, he was baptized and immediately decided to enter a monastery, where he first lived as a pilgrim, and then as a monastery worker. After three years in the monastery, the patient suddenly stopped communicating with his relatives. Due to the lack of communication with their son, the parents decided to visit him. According to them, the young man looked "catastrophically thin." According to his mother, he looked like a "prisoner of Buchenwald." In addition, he not only looked sick, but also had somatic symptoms. Due to suspected pneumonia, the patient was admitted to the district clinical hospital. The anamnesis revealed that in recent months, for the purpose of "spiritual improvement", he had been binge-reading spiritual literature and began to apply ascetic advice to himself, which was intended for mature monks, advanced in monastic life. He adhered to extreme fasting, eating water and bread once a day, devoting many hours to prayer practice, his favorite reading was "Experience in the Ascetic Life of Bishop Ignatius Bryanchaninov."

Doctors at the hospital diagnosed acute bronchitis, alimentary dystrophy, protein-energy deficiency, protein-free edema of the shins and feet, moderate anemia of

[5] Marie of Oignies, Catherine of Siena, Columba of Rieti

mixed origin, sinus bradycardia with episodes of atrial rhythm and mitral valve prolapse of 2nd deg. Due to the severe somatic condition, the patient was transferred to the intensive care unit, where he stayed for a week. The patient's mother took a firm and decisive position and insisted on the inpatient treatment in a psychiatric hospital, which helped to correct the situation and saved the life of this young man. Later, he was treated at the SCMH clinic. He did not consider himself ill, he explained his condition by spiritual reasons, the need for strict asceticism. He was convinced that he was destined for a special mission, that the Lord had called him to a life of faith. The doctors of the department called the spiritual father of the monastery, who tried to persuade the patient to eat according to the recommendations of doctors. The patient categorically refused to follow the advice of his former confessor. In the department, he refused to take hospital food, meat and dairy products, ate only 1-2 spoons of soup per day; the staff saw several times the patient trying to dispose the food in the sink. He avoided communicating with other patients and spent his time passively lying in bed. The examination by the physician revealed severe somatic complications: the skin and visible mucous membranes were pale, the eyelids were edematous; the feet and shins, were swollen up to the middle third; there were trophic changes on the skin of the lower limbs. ECG results also revealed severe trophic disorders: atrial rhythm, bradycardia (heart rate was 40 beats per minute), diffuse decrease in left ventricular myocardial repolarization, prolongation of the QT interval to 550 milliseconds. During the examination, when it was necessary to go up the stairs to the third floor, the patient fell from weakness, and needed help of the medical staff. The necessary treatment was provided, after which he was discharged with significant improvement: his normal eating pattern was restored, he developed a critical attitude towards his previous behavior, and he subsequently returned to his normal life and found a job.

Thus, in this case, we see that mental pathology during the first 3-4 years was hardly noticeable for both relatives and clergy. Religious “problems” and “spiritual search” came to the forefront in the patient’s condition, masking mental pathology. For a long time, the relatives did not understand that their son was ill, and only when severe somatic complications arose - dystrophic phenomena associated with refusal to eat, the patient was given the necessary medical care. The opinion that only spiritual support, staying in a monastery, and participating in liturgical life can solve all mental problems without medical help proved to be incorrect.

**The syndrome of paranoid delusions with religious content ("religious paranoia")**. These conditions are characterized by persistent delusional ideas that are outwardly plausible, psychologically understandable, have a high degree of systematization, and affective tension; they completely take over the consciousness and life of patients. At later stages, delusional ideas of persecution are added, the content of delusions expands with the involvement of new people, and a special way of life and worldview is formed (A.S.Tiganov, 1999; Borisova O.A., 2019). Clinical case: a young man, 11th grade of school, completely immersed in religion, attended church every day. He prayed 5-6 hours a day, went only to those monasteries in which worship was celebrated according to the full statute, without shortages. If he did not have time to fully read the prayer rule, he refused to eat. During the fasts, he drastically limited his food, completely refused to read secular literature and watch TV, calling it "diabolic culture." He was unshakably convince was right and defended his religious views with inappropriate persistence; he completely lacked criticism of his condition and the struggle of motives. This was combined with coldness and indifference to his relatives, friends, whom he called godless and servants of the devil. His behavior gradually acquired features characteristic of a family tyrant: he forced his grandmother to read the prayer rule, observe fast days, turned off the TV at his grandfather’s in the evenings. If his mother cooked him something from dairy products on Wednesday, he could throw

the plate with food in her face. Gradually, he stopped obeying the priests, calling them heretics, and prayed for hours at home, following the requirements of the Typicon. Eventually, he came to the conclusion that he alone preserved true Orthodoxy and, in fact, invented his own religious system. On major religious holidays, he refused to attend school, devoting the whole day to prayer. Later, he developed a whole delusional concept, linking together not only the people of his immediate surrounding, but also a much wider range of strangers and events. His delusions became more complex and systematized, and his delusional activity increased. Delusional ideas of a religious nature expanded, capturing a growing number of people around them, delusional ideas of persecution and self-assessment added up. 7 years later, hallucinatory manifestations developed, which subsequently took on the character of verbal imperative hallucinosis, under the influence of which the patient made a suicidal attempt, that ended in death.

It is important to emphasize that in this case, religious delusions were in sharp contradiction with the objectively existing religious traditions in society. The overvalued ideas with religious content were transformed into a complex delusional system, the entire behavior of the patient was determined by religious delirium. At the same time, the external pseudo-religious form of behavior sharply contradicted the inner virtue of patience, humility, respect for relatives and friends. Delusional ideas revealed a high degree of uncriticism, led to a violation of social relations, to severe and dangerous acts of aggression towards relatives and to autoaggression.

**Depressive delirium syndrome with religious content**

The leading manifestations of this condition against the background of a low mood are the ideas of self-abasement, self-blame, guilt, sinfulness of varying severity, reaching the degree of delirium, followed by suicidal behavior, formation of specific religious phenomena: confessional ambivalence, feelings of abandonment by God, spiritual hypochondria (G.I.Kopeyko, 2021; O.A.Borisova, 2023; E.V.Smirnova, 2023; A.G.Alekseeva, 2023; G.I. Kopeyko, 2023; O.A.Borisova, 2019). In the cases we studied, patients blamed themselves for all sorts of negative events (for example, for the illnesses of relatives), felt guilty towards their relatives and friends, considered themselves "bad Christians", guilty of the shortcomings in raising children, not being able to provide them with proper care and education. The patients blamed themselves for the fact that their behavior did not meet the requirements of religious rules and regulations. There was a depressive interpretation of the present and previous events. Depressive experiences stemmed from previously existing religious ideas and worldviews of patients and corresponded to their cultural level. Everyday content of sinful experiences, ideas of self-abasement, self-accusation, failure were transformed into a total feeling of one’s own guilt, a deserved “punishment by hellish torments” and subsequently developed into a persistent delusional conviction of one’s own sinfulness.

The patients claimed that they did not feel grace from prayer, did not feel a response in their soul from participating in religious rituals, compared their condition with "petrified insensitivity", talked about the lack of a sense of "living faith". They said that God had abandoned them, that they "cannot feel the presence of God in life, do not feel divine grace." They believed that God "did not hear them, turned away, left them," described a feeling of "complete spiritual isolation from the outside world, especially from God, comparing their condition with "being in a vacuum"; they claimed that they had lost the most important thing in life — the meaning of life, faith in God and hope for salvation. Such ideas were accompanied by reflections that "now nothing holds them in life," "they belong in hell."

In more severe cases, depressive symptoms became more complicated: ideas of blame and condemnation developed. Patients noticed a negative attitude towards themselves in the behavior of others, noted signs in the environment confirming their

worthlessness, failure. Delusional ideas of sinfulness were manifested in the patients' conviction that they "deserve God's punishment," that they had committed a "mortal, unforgivable" sin, a "sin against the Holy Spirit." Such patients sought ways to atone for their sins: they continuously attended church services, often confessed, fanatically observed religious traditions, tortured themselves with various exhausting fasts that did not correspond to church traditions, contrary to the advice of confessors, inflicted various self-harm. Being in the company of other believers was also difficult, since it seemed to such patients that others "saw" their sins and condemned them.

In some cases, patients came to the idea that their choice of denomination was wrong. At the same time, the main inner experience was a feeling of guilt for a mistake in choosing faith. In such cases, they had agonizing doubts about the wasted time following the "wrong faith", they were worried about the fear that because of the "untruthfulness" of their faith they "would not be saved." To them it seemed that there was a "flaw" in their faith, and they had an incurable "spiritual illness." Some changed their faith, believing that this way they could earn God's forgiveness, while they could not "find a place for themselves, spiritual peace" anywhere. As the delusional disorders worsened, the belief in a "corrupted" faith appeared, which testifies to the betrayal of God, "the likeness of Judas the traitor." Even though the patients constantly double-checked their religiosity and sought advice from confessors in various monasteries, they did not find peace of mind. Due to the fact that their own condition was interpreted by patients as a sign of sinfulness, they turned to a doctor very late; in addition, some did not agree to seek medical help without the blessing of a spiritual father, which, as a rule, could not be obtained in time. And this led to the rapid development of a vicious circle and the worsening of the mental state. When the condition worsened, patients described their state as "rotting" or "loss of soul." They said that their hearts were "dead to faith", that they were "spiritually damaged", "died alive", "went to hell alive", felt that they were "decomposing mentally". Some patients considered themselves to be the culprits of the coming apocalypse, which they associated with their own sinfulness, they were convinced that they would suffer forever for their sins. Patients not only expressed ideas of self-blame, but also felt condemnation from God, whose image was "punishing". At the height of the morbid condition, such patients had feelings of hopelessness, rejection and despair, accompanied by unwillingness to live, the development of suicide intentions, as well as suicidal attempts.

Thus, due to the specific content of depressive states associated with religious experiences, they are often not regarded as morbid, requiring the help of doctors. This leads to a worsening of symptoms and a late referral to psychiatrists, accompanied by negative consequences, in particular, suicide attempts.

**Religious possession syndrome**

The specific core of such conditions is delusional belief of the patient that he was possessed by a "spiritual being" by embedding into the body or possession from the outside, which leads to total control over his mind, body and soul, up to the formation of a new personality in him over time, and causes great suffering. Most often, this is accompanied by the hallucinatory disorders and respective delusional behavior (G.I.Kopeyko, 2018; G.I.Kopeyko, 2019; I.S. Samsonov, 2019).

In the cases studied, mental disorders began acutely in patients. Patients suddenly felt that a demon had "entered their body." They physically felt the movements of an alien entity inside themselves, which was localized in various parts of the body; they described the penetration of the being into the eyes, ears, and its movement inside the body. They felt that the demon was moving under the ribs, "sucking under the heart, drinking blood and taking away energy", causing all sorts of unpleasant sensations. After patients became convinced of the physical penetration of a

demon into the body, "strange thoughts" appeared, which were "sent by the devil." There appeared previously uncharacteristic offensive phrases addressed to others, forcibly imposed mental dialogues, obscene language. The patients were convinced that the demon inside them forbade them to eat and drink water and showed "mocking dreams" at night. When the manifestations intensified, they felt that the "energy entity" completely captured them, and under the influence of the demon they themselves turned into another being. Some described themselves as "a horned goat", felt that they were "twisted, shrunk", they could not move, felt their limbs like hooves, and themselves "in demonic skin, in animal clothes." At the same time, the demon "forbade" them moving, forced them to be silent, so that they could not talk, swallow food. Some patients heard demons inside their heads, who "screamed and howled in different voices," pointed out their sins, swore obscenely and thereby prevented them from praying; they felt that the demon controlled their speech, visually showed scenes of obscene content. In some cases, it was reported that the demon inside them influenced the people around them, forcing them to yawn, cough, and violate the norms of decent behavior. The patients felt that "demonic energy" emanated from them, which was transmitted to their loved ones, and the latter developed "harmful passions". They tried to combat their demoniacality in all available ways: restrictions in food to kill the demon, refusal of liquids, causing vomiting. Many patients attended exorcism sessions, read the so-called “besogons” (exorcisms), performed magic rituals, and sometimes even made serious suicide attempts.

Interpretations of those around them regarding the condition of patients suffering from delusional possession varied: some considered them to be possessed, others – mentally ill, and some put an equal sign between the two. Thus, these conditions could be mistakenly regarded as manifestations of demonic possession in a religious context, which led to inadequate pastoral advice and methods of managing. A psychiatric assessment of these cases made it possible to establish the formation of a psychotic state within schizophrenia, the key feature of which was the phenomenon of total possession syndrome, referred to in psychiatric literature as the Kandinsky-Clerambault syndrome. It should be emphasized that the main strategy in these conditions was medical treatment by specialists.

Thus, in the described clinical examples, we are talking about manifestations of hyperreligiousness, accompanied by marginal forms of religious behavior.

*Summarizing these cases, the following criteria can be identified that distinguish manifestations of pathological pseudo-religion arising from the clinical psychopathological disorders from religious experiences in mentally healthy individuals:*

- during the examination, it is possible to identify concomitant psychopathological disorders: sleep disorders, cognitive disorders, pathological changes of a somatic nature;
- patients often experience suffering, anxiety, depression in connection with their religious experiences and behavior;
- there may be special type of thinking disorders (echoes, insertion or withdrawal of thoughts, transmission or openness, interruptions of thoughts and other manifestations of ideational automatism), transient or persistent hallucinatory disorders. In some cases patients have suspicion, ideas of reference, persecution, influence;
- religious delusions reveal a high degree of uncriticism, rigidity and form specific delusional behavior that cannot be corrected with the help of advice from relatives or a confessor;
- religious experiences are often of a dominant nature, alien to the former personality. Sometimes it is possible to clearly identify the so-called antinomic character shift that precedes the onset of a morbid condition;

- religious delusions lead to disruption of social and professional relationships and often endanger the life of the patient himself;

- there are more or less pronounced personality changes: emotional coldness and indifference to relatives, absence of relatives and friends.

*The religious and psychological criteria of these states are:*

- the external "pseudo-religious" form of behavior sharply contradicts the deficit of internal virtue (patience, humility, sacrificial love);

- mental disorder has a plot of pseudo-religious concepts, which usually contribute to alienation, both from people who adhere to traditional religious values and from their own family;

- these patients do not have a spiritual father or they refuse to follow his advice;

- the religious experience of an individual contradicts the established cultural or religious tradition, while patients, as a rule, do not maintain contacts with the religious community, often have a negative attitude towards traditional religious institutions, regarding them as "false, corrupt".

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## Normal and pathological religiosity in depressive states in pastoral and psychiatric practice

**Abstract:** The paper discusses the features of pathological religiosity found in some patients with a religious worldview who suffer from depressive disorders. This is relevant for both clinical psychiatry and pastoral care for mentally ill people. It describes the clinical relationship between the content of religious experiences and the structure of depression in which they are observed. It cites the opinion of clergy ministering to people suffering from depressive disorders that common external manifestations are a lack of critical attitude towards one's spiritual state, the inability of the individual for internal development, an obsession with negative thoughts and fears of a religious character, a false belief in the "unforgivability" of committed sins, the inability to accept constructive advice (and even to understand it), lack of peace and joy from repentance, despondency, suicide thoughts. The priest should be guided by the principle: to stretch out his hands to the sinner and bear the burdens of his brother, to support the weak spark of faith, to help, as much as possible, the person to find consolation in his sorrow. Help in resolving doubts whether it is admissible to turn to doctors in such cases.

**Keywords:** religiosity, pathological religiosity, depression, depressive religious phenomena, pastoral care.

Distinguishing between normal and pathological religiosity in depressive states is an important task both in psychiatric practice and in the work of a pastor or psychologist. Such conditions often go unidentified due to the fact that patients are reluctant to report their experiences, regarding them as a purely spiritual (religious) problem; they are characterized by a high risk of suicide (G.I.Kopeiko, 2021; E.V.Gedevani, 2022), since such patients lose basic values and meanings, and faith in this case loses its protective function (K.I.Pargament,2001; F.M.Shankov,2015). As a result specialists underestimate the severity of the condition and are not able to provide qualified timely assistance. The problem of recognizing pathological religiosity in depression is of high relevance due to the need to prevent destructive behavior of patients, sometimes dangerous to themselves or others, as well as to provide assistance at various levels, including pastoral counseling or spiritual guidance, as well as timely medication treatment (G.I.Kopeiko, 2021; E.V.Gedevani, 2022).

Herman M. van Praag, a Dutch psychiatrist, founder of the Section on Religion, Spirituality and Psychiatry at the World Psychiatric Association (WPA), describes normal and abnormal religiosity in his concept of religiosity. The religiosity construct includes three elements:

- Sensitivity – emotional and intellectual – to the concept of God and the transcendent reality it represents.
- Closeness to worship and rituals related to the concept of God.
- Acceptance, at least in general terms, of the concept of man and worldview that a given religion advocates.

He describes normal religiosity as an average statistical norm, which includes the cognitive norm of conceptualizing the need to search for the meaning of life, however, without changing the hierarchy of motives. The structure of religious needs, within which normative and non-normative religiosity develop, according to van Praag, includes a) the search for meaning and spirituality, b) dependency need, c) emotional response need, d) bliss and amazement, e) secularization with preservation of faith. The

author characterizes the normative religiosity as openness to the other, non-isolation, as well as indefinability and awareness that God is unknowable.

The abnormal religiosity, according to van Praag, can be divided into 3 groups: fringe-normal, abnormal, non-pathological manifestations, abnormal, pathological manifestations.

The author divides all abnormal manifestations of religiosity into two groups (so to sayby the degree of severity): hyporeligiosity and hyperreligiosity. In each of them, the author records both borderline normality and abnormal variants without pathology and abnormal variants with pathology. Van Praag classifies agnosticism (variants of the norm), atheism (abnormal, non pathological manifestations), and evangelizing atheism (abnormal, pathological manifestations) as hyporeligiosity. Hyperreligiosity includes: coagulation of religious beliefs (variants of the norm), pathological outgrowths of faith coagulation (abnormal, pathological variant), religious fancy and exaltation (abnormal, non-pathological manifestations), religious psychosis (abnormal, pathological manifestations). Pathological outgrowths of faith coagulation (abnormal, pathological manifestations) and religious psychosis (abnormal, pathological manifestations) are the closest to the phenomenon of pathological religiosity identified in psychiatric practice (H.M. Van Praag, 2009).

In this study, we define **religiosity** – provided that there is faith in God – as the acceptance and internalization of religious beliefs by an individual, the rethinking of one's values and views on life that is implemented in the behavior and lifestyle of an individual. Pathological **religiosity** is understood in this study as the acceptance and assimilation of religious beliefs, altered by mental disorders of religious content, which leads to the religious behavior and lifestyle of patients distorted by these beliefs.

At the FSBSI SCMH, in the Group of Special Forms of Mental Pathology of the Department of Youth Psychiatry, 115 patients (41 men, 74 women) with a religious worldview from 18 to 55 y.o. (average 32±8.5 y.o.) were examined from 2011 to 2023. All patients were undergoing treatment due to the development of a depressive state with religious content, formed as part of an endogenous disease. The study applied clinical-psychopathological and clinical-catamnestic methods. The average follow-up observation period was 9.5 years. The study did not include patients with somatic and neurological diseases in the decompensation stage; with organic CNS lesions; epilepsy; patients with substance abuse. To diagnose a depressive state, the criteria for a "depressive episode" as defined by the ICD-10 were applied. So, the most typical manifestations of a depressive state are low mood, loss of interests, increased fatigue, and decreased activity. Common symptoms of depression include decreased concentration, low self-esteem and a sense of self-doubt, ideas of guilt and self-abasement, a pessimistic view of the past, present and future, and disturbed sleep and appetite. An important feature of the patients included in the study was their religious worldview.

When considering affective pathology (mood disorders) or the affective register of psychopathological disorders, it is important to note that depressive states are quite common both among the general population and among patients with a religious worldview. According to WHO, by 2023, about 280 million people worldwide suffered from depression, which is 5% of the world’s adult population. The depressive state affects both the cognitive and behavioral aspects of mental activity and also has an impact on the religiosity of patients. The study revealed that manifestations of pathological religiosity occur in more than 20% of patients who have a religious worldview and suffer from depressive disorders. In addition to the usual set of symptoms and manifestations of depression mentioned above, the clinical picture of depression in patients with a religious worldview reveals special religious

manifestations and phenomena that are unique and are observed in the structure of such conditions only in this cohort of patients.

The study found that the most common manifestation of pathological religiosity in people with depression were the **ideas of guilt and sin**. The depressed mood came amid feeling of guilt, which was central to the patients' condition. The patients' thinking was dominated by the ideas of self-abasement, self-worthlessness. These ideas were accompanied by a feeling of sadness (such depressions are usually called melancholic). The maximum severity of the dreary effect was felt physically by patients in the precordial area as a painful "heaviness" in the soul, known in religious literature as "mental anguish" (heaviness or sadness). Ideas of guilt had the character of overvalued disorders that arise against the background of existing depressive disorders. Their severity increased simultaneously with the increasing intensity of depressive affect. Reaching the level of delusional thinking, some patients, at the height of their depression, formed ideas not only of guilt towards God, but also self-judgments about their sinfulness. The patients accused themselves of acts they did not commit, considered themselves to be responsible for the misfortunes of others, called themselves "sinners" who should expect just retribution, deserved punishment. Ideas of deserved punishment were added to self-reproaches and ideas of self-accusation. These conditions became clinically distinct, changing the outward behavior of the patients, resulting in a clear need for medical assistance.

Other patients demonstrated a change in religious feelings as depression deepened. The patients said that confession does not bring relief, does not free them from the sin they have committed, and that repentance was inaccessible or that there was no full feeling of repentance. A feeling of being **abandoned by God** arose (A.G. Alekseeva, 2023). This phenomenon is known as the loss of divine grace by man; the apparent withdrawal of God from man, manifested in a formal weakening of divine support (Judges 6:13). Conscientious observance of religious prescriptions by patients (being present at and participating in church sacraments, following the prayer rule, attending and participating in church services, and pilgrimages) did not bring relief. The patients claimed that they were unable to turn to God again through prayer, that they had lost spiritual contact with Him. Due to this condition, patients were unable to share their experiences for fear of being misunderstood, and this affected their previously established way of life. The patients stopped attending religious gatherings, refused to read religious literature and daily prayers, and “found” non-existent sins in themselves. A feeling of hopelessness, futility, and despair developed and reached its maximum manifestation in thoughts about the loss of the meaning of life, its low value, and in the feeling that “it is impossible to return to the life of a believer.”

The formation of the phenomenon of God-abandonment was a unique aspect of depression among Christians. A state of spiritual anesthesia, loss of a sense of "living faith", a state of "petrified insensitivity", alienation of emotions spread to the entire spiritual sphere of human life. These feelings were reinforced by thoughts of self-blame, self-deprecation, guilt, and a sense of guilt before God. A painful feeling of "God's silence" emerged. Thoughts of one's own guilt and sinfulness transformed into ideas of punishment from God, reaching an extreme level of delusion. A special psychopathological phenomenon is being formed – a **psychotic vector of guilt** directed by God at the patient, manifested in the ideas of deserved punishment from God, a cardinal change in the image of God from merciful to cold, silent, punishing Judge. During the most severe depressive episodes, patients with religious guilt and feelings of sin experienced feelings of rejection and condemnation, despair, and hopelessness. These feelings often went along with thoughts about the futility of life, not wanting to live, and suicide intentions. Suicide thoughts would be interpreted by patients in some cases as “demonic attacks”, which led them to seek help in a religious environment and

attended numerous exorcism rituals, which led to a deterioration in their mental state rather than to its improvement. Such conditions were especially dangerous in terms of suicide actions, because the motivation to fight, to avoid suicide as a mortal sin, was leveled against the background of the conviction of sinfulness and unforgiveness, reaching a delusional level (E.V. Smirnova, 2023).

Another common manifestation of depression was anxiety. In religious patients, ideational disorders in depressive states with a predominant anxiety were characterized by difficulties in concentrating, absent-mindedness during prayer, difficulty understanding the words of the Holy Scripture, increased fatigue, and rapid onset of exhaustion during prayer. Motor disorders in such depressive states were visible externally as increased motor activity, reaching a level of anxiety agitation. Disorders in the form of so-called "mental turmoil" played a special role in these patients. They were characterized by **super valuable doubts about the validity of their choice of faith**, which is a form of pathological religiosity among patients who became religious before the onset of their illness; patients with severe anxiety began to question the truth of their Orthodox faith. These feelings began to acquire fundamental significance in the lives of patients and, in some cases, began to determine their behavior, which consisted of searching for evidence that the chosen denomination was “incorrect”. They also had ideas about the need to convert to another confession or even religion, with severe fears that due to the falseness of their faith they would not be able to be saved.

Among the special phenomena typical for depressive pathological religiosity, the **state of** “**spiritual hypochondria**” was characteristic of such patients (E.S. Krylova, 2003; G.I. Kopeyko, 2021). The patients were fixated on the "lack of real faith" and blamed themselves for it. Obsessive doubts about the truth of their faith and convictions about its flaws were based solely on the patients' own spiritual feelings. In these cases, obsessive doubts led to unusual behavior, with frequent consultations with religious experts, respected spiritual fathers, and "specialists". Complaints of depressed mood, apathy, and asthenia were accompanied by painful doubts about the correctness of one's own faith. The patients said they felt a sense of "spiritual hunger." In all areas of faith (the existence of God, the actual truth of Orthodoxy, as well as its individual aspects), blindness seemed to set in, a loss of the ability to recognize the spiritual, which the patients themselves often called “spiritual blindness.” They became convinced of their own spiritual inferiority, insufficiently deep and sincere faith, and incorrect prayer reading. The patients experienced excruciating suffering due to the insufficiency and “poor quality” of their faith, which had previously been different, “alive”, finding signs of its “corruption”. Exaggerated preoccupation with one’s spiritual state and the conviction of the existence of a “flaw of faith” actually led to hypochondriacally stigmatized behavior. Any new information related to faith had an impact on the perception of one’s spiritual illness and confirmed it. The desire to constantly recheck the conformity of their religiosity with newly identified criteria for the sake of returning to their former, true faith prompted patients to seek consultations with spiritual fathers in monasteries on pilgrimage trips specially organized for this purpose. For a while, after the respected spiritual fathers confirmed the correctness of their spiritual development, the patients found peace. However, the newly emerging doubts concerned the assessments of the religiosity of the spiritual fathers themselves and, accordingly, the convictions of their own unidentified spiritual flaw intensified. Turning to even more authoritative priests did not bring the expected resolution of their doubts. Characteristic were suicide thoughts from the position of rational comprehension, reasoning about the meaninglessness of life, without emotional turmoil.

Thus, depressive states in patients with a religious worldview have special manifestations, which certainly require attention not only from a psychiatrist, but also from a priest. In **pastoral practice**, people suffering from depressive disorders are quite

common. As general external criteria that distinguish healthy religiosity from unhealthy, from the point of view of a pastor, the following main parameters can be considered: the presence or absence of critical approach in relation to one's spiritual state; the ability or inability of an individual to develop internally (the ability of a person, independently or with the help of a priest, to build a fruitful spiritual life, to analyze his value system, to change in a positive direction). An unhealthy religious background can be indicated by various manifestations of "stagnation in spiritual life". These include obsession with negative thoughts and fears (religious), inability to believe in the possibility of positive change, inability to accept (and even to understand) constructive advice, lack of faith, despair, unwillingness to live, and a sense of " God-abandonedness", "possession", anxiety, fears, lack of peace and joy from repentance, obsessive negative thoughts, despondency, and suicide thoughts. All the above-described manifestations are very often found precisely in depressive states in people who associate their illness with the sins they have committed. It is important for the priest to maintain a correct, attitude towards the patient from a spiritual perspective. In this regard, the interpretation of the phrase from the Gospel of Matthew 12:20 ("…a bruised reed he will not break, and a smoking flax he will not quench"), which is offered by St. Maximus the Confessor, is helpful: "Whoever, in imitation of the Lord, treats [people] with compassion, does not allow [a person] broken by sin to be completely broken." Or by St. Jerome of Stridon: "He who does not stretch out his hand to a sinner and does not bear the burden of his brother, [he] crushes a broken cane. And he who despises the weak spark of faith in these little ones, [he] extinguishes the smoking flax." Support and assistance in finding consolation in such grief is an important task of the priest. Along with the ability to understand and recognize depression, to provide support and consolation in a state of mental illness, the tasks of a pastor when interacting with such patients include helping a person understand the morbid nature of his condition, recommendations or referral to a medical specialist, support if treatment is needed (D.A.Ivanin, 2023).

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**Content and psychological meaning of mental representations of heaven and hell among Orthodox believers**

**Abstract:** This report discusses the results of an empirical study of the mental representations of the concepts of heaven and hell among Orthodox believers. From a psychological perspective, these concepts can be seen as symbolic tools, or "psychological instruments". Using them in real life practice mediates a Person's life relationship with the World, influencing the psychological mechanisms of behavior regulation. The study involved 62 people aged 18 to 57 years, Orthodox, residents of various regions of the Russian Federation. It was revealed that mental representations of hell at the associative level are more detailed than representations of heaven. Since the degree of detail in an image of an object relates to the subjective feeling of psychological distance from it, this can be seen as evidence of experiencing a greater psychological closeness to hell than paradise (on an unconscious or poorly realized level). The mental representations of heaven and hell among Orthodox believers reflect not only the canonical characteristics of these concepts, but also their cultural patterns. The authors believe that the psychological significance of the mental representations of heaven and hell among Orthodox believers lies in stimulating correct, morally justified behavior from a Christian point of view. This stimulation is presumably carried out by activating the above–mentioned concepts of individual personal experience, mainly emotional as well as bodily. The research methods used were The Centrality of Religiosity Scale of S. Huber and O. Huber, the method of directed associations and mini-essay.

**Keywords:** mental representations, religious beliefs, heaven, hell, Orthodoxy, believers.

**Introduction**

Religious images and concepts are important means of a person mastering his own and other people's behavior. They represent everyday reality in a special way to an individual: when placed in the supernatural context, the reality acquires specific religious meanings and significance. Thus, in the context of supernatural reality, breaking the a social norm can be defined as sin, tolerant behavior as humility, a noble motive as the guidance by the Holy Spirit, insight in the process of solving a life task as Divine revelation, etc. A religious image can serve as a reference model of behavior for a believer, facilitating behavioral decision-making or acting as a component of a worldview, etc.

The general psychological significance of religious images and concepts can be revealed using the cultural-historical or cultural-instrumental approach developed in the psychology of religion (Dvoinin, 2022). Within this approach, which is based on the cultural and historical theory of the development of higher mental functions by L.S. Vygotsky (Vygotsky, 2000a, 2000b), religious images (objectified and subjective), religious concepts are considered as symbolic means - "psychological tools"[1]. Operating with them in real life practice mediates a Person's life relationship with the World, influencing the psychological mechanisms of behavior regulation (Dvoinin, 2022). Along with religious images and concepts, objects (natural and man-made), as well as actions (rituals) can act as such psychological tools (Dvoinin, 2022).

[1] The term "psychological tools" was used by L.S. Vygotsky by analogy with *technical tools*, which, as means of labor, restructure the relationship between man and nature, making labor processes more efficient. – *Authors' note.*

Psychological studies show that when religious concepts are activated, a person's level of tolerance to uncertainty decreases (Sagioglou & Forstmann, 2013). It has been found that this trend varies depending on the level of believers' religiosity: activation of religious concepts somewhat reduces tolerance to uncertainty in deeply religious people and, conversely, slightly increases it in people with low religiosity (Ulybina, Klimova, 2017).

The well-known study by J.L. Barrett and F.C. Keil (1996) revealed that the mental representations of God in people with religious views are dualistic. On the one hand, if these people are trying to describe God, then so-called "theologically correct" attributes are credited to Him: omnipotence, eternity, the ability to know a person's innermost thoughts, being outside spatial limitations, etc. On the other hand, when analyzing specific situations related to God's actions in them, people intuitively discover anthropomorphic ("theologically incorrect") representations: they point out that God can be in a particular place and to be absent from another, spend time doing His deeds, not foresee the consequences of human actions, etc. (Barrett & Keil, 1996). The results of this study, initially conducted on American students, are consistent with more recent studies conducted on a sample of Bhagti Hindus (Barrett, 1998), as well as on Orthodox believers (Kolkunova, Malevich, Kozhevnikov, 2017).

Images (and concepts) of heaven and hell are significant elements of the Christian doctrine, embodying ideas about opposite places and/or states of eternal human life. In Bible, heaven and hell are usually described metaphorically, with varying degree of detail and quite variably. [2]

Paradise is described as both Eden and the Kingdom of Heaven/ Kingdom of God, in various material characteristics and as the spiritual state of a believer. For example, originally, in the Old Testament, paradise was described as an Eden that existed on earth, which was located "in the East" (Gen. 2:8), a river flowed out of it, trees grew in it, including the tree of good and evil, and it was inhabited by animals; God settled man in the garden of Eden (Gen. 2). In the New Testament, paradise is already interpreted somewhat differently. It is described as a place where one can "be with Christ" (Phil. 1:23), as the kingdom of God, which is inside a person, and not outside (Luke 17:20-21). According to Apostle Paul: " For the kingdom of God is not a matter of eating and drinking, but of righteousness, peace and joy in the Holy Spirit" (Rom. 14:17). Along with this, in the Bible we also find the following description of paradise: “I saw the Holy City, the new Jerusalem, coming down out of heaven from God… down the middle of the great street of the city. On each side of the river stood the tree of life, bearing twelve crops of fruit, yielding its fruit every month. And the leaves of the tree are for the healing of the nations. No longer will there be any curse. The throne of God and of the Lamb will be in the city, and his servants will serve him. They will see his face, and his name will be on their foreheads. There will be no more night. They will not need the light of a lamp or the light of the sun, for the Lord God will give them light. And they will reign for ever and ever“ (Rev. 21:2; 22:2-5).

Hell is described as follows: "fire of hell" (Matt. 5:22), "eternal fire" (Matt. 25:41), "eternal punishment" (Matt. 25:46), "lake of fire" (Rev. 20:14), “fiery lake of burning sulfur” (Rev. 21:8), where there will be no rest day or night (Rev. 14:11), " worms never die, and the fire is never put out" (Mk. 9:44), where there is neither working nor planning nor knowledge nor wisdom (Eccl. 9:10). The Gospel of Matthew says that those doomed to stay in hell will experience fear of torment and sorrow in the "outer darkness", where is "weeping and gnashing of teeth" (Matt. 25:30).

[2] The following examples of descriptions of *heaven* and *hell* from the Bible are for illustrative purposes. We do not set ourselves the task of a systematic analysis of the content of these concepts in Christian doctrine. – *Authors' note.*

It seems that in the life of Orthodox believers, images (and concepts) of heaven and hell occupy an important position, serving as some kind of positive (in case of paradise) or negative (in case of hell) incentives for righteous (morally justified, from the Christian doctrine point of view) behavior. In accordance with the cultural-historical (cultural-instrumental) approach in the psychology of religion (Dvoinin, 2022), these concepts can presumably be considered as psychological tools mediating the moral behavior of believers.

Our research was aimed at identifying the content of mental representations of heaven and hell among Orthodox believers.

M.A. Kholodnaya (2023) defines mental representations as experience-based subjective forms of seeing reality. There are several levels in the content of mental representations: associative, evaluative, figurative and verbal (conceptual) (Prokhorov, 2016). Our study was limited to explication of the associative and figurative-conceptual levels of representations of heaven and hell.

**Research methodology**

Orthodox believers, members of various Orthodox online communities and groups, were invited to participate in the study. The sample was formed spontaneously. The level of religiosity was measured for all those who responded to the invitation to participate, after this non-religious persons were excluded from the study sample. The final sample included 62 individuals, residents of various regions of the Russian Federation: 67.74% women and 32.26% men aged 18 to 57 years (M = 34.32; SD = 11.03).

All the individuals were interviewed on the Google Forms platform. The following techniques were applied in the study:

1) "*The Centrality of Religiosity Scale*" by S. Huber and O. Huber (2018), which was used to determine the level of religiosity of the individuals;

2) *The method of directed associations*, with which the associative content of mental representations of heaven and hell was explicated. The respondents were asked to give the first associations that came to mind separately for each concept – heaven and hell. The resulting associations were grouped into semantic categories and then analyzed for frequency and comparison.

3) *Mini-essays* "What do you mean by the term "Paradise"?" and "What do you mean by the term "Hell"?" (the proposed volume was 3-4 sentences each). This technique was used to identify the figurative and conceptual content of mental representations of heaven and hell. Then the content analysis of the received texts was made with the identification of semantic units and subsequent frequency and qualitative analysis.

Methods of mathematical data processing were also used: Kolmogorov-Smirnov criterion, Wilcoxon T-criterion, Cohen's d, Spearman's correlation analysis, Fisher's angular transformation (φ).

**Results and discussion**

The study showed that of all respondents, 80.6% were identified as "highly religious" and 19.4% as "religious". At the same time, according to the 10-point scale, the average religiosity indicator is M = 3.41 (SD = 0.63). The distribution of religiosity indicators is normal.

The total number of associations in the sample: 355 for the concept of heaven and 477 for the concept of hell. On average, each individual had 5.73 associations with the concept of heaven (SD = 3.25) and 7.69 associations with the concept of hell (SD = 3.68). Both distributions differ from the norm. Significant differences were found in the number of associations with the concepts of heaven and hell ($T = -4.606$, $p < 0.001$).

Thus, the level of detail of the concept of hell, determined by the number of association, is higher than in the concept of heaven; the identified effect size was above average: Cohen's d = 0.566.

The most common associations with the concept of *heaven* are the following (in descending order of frequency): **light; happiness; love; peace; joy; angels; God; peace; tranquility; sun; sky; goodness; garden**. The most frequent associations with the concept of *hell* were (in descending order of frequency): **pain; torment; suffering; fire; fear; punishment; darkness; satan; sins; imps; devils; nine circles of hell; hopelessness; demons**.

Considering associative connections as manifestations of deep, poorly realized contents of the psyche, we can say that in this case, the religious concept of hell, which is negative in its meaning (in the context of Christian doctrine), apparently has greater subjective significance in the mental world – it causes more associations than the concept of paradise. In other words, whether the believer is aware of it or not, the threat of going to hell has more psychological meaning for him (for example, an emotional or motivating charge) than the pleasant In other words, whether the believer is aware of it or not, the threat of going to hell has more psychological meaning for him (for example, an emotional or motivating charge) than the pleasant perspective of going to heaven.

Also, based on the Construal level theory by Y. Trope and N. Liberman[3], the greater detail of the associative content of mental representations of hell can be considered as evidence of experiencing (at an unconscious or poorly realized level) a greater **psychological proximity** of hell than paradise.

Correlation analysis has shown that the degree of detail of the concepts of heaven and hell is not related to the level of religiosity of Orthodox believers. Perhaps the degree of detail is related to such a factor as the different cultural complexity of these concepts – it is hell that is widely represented in works of art. In the respondents' mental representations, one of the most common associations was the nine circles of hell, which is undoubtedly a consequence of the cultural influence of Dante Alighieri's "Divine Comedy" on this religious concept.

After the content analysis of the mini essays, the characteristic features of the figurative and conceptual content of the representations of the concepts of heaven and hell were explicated. These features have been grouped into categories (Fig. 1).

[3] This theory suggests that there is a relationship between the subjective experience of psychological distance in relation to a certain object (phenomenon) and the level of its construction in consciousness: *the further* a person subjectively perceives an object, *the more abstract* and less detailed it is represented in consciousness. And vice versa, the closer this object is subjectively imagined, the more detailed and concrete it is in consciousness (Krivosheina, Kotov, 2016; Medvedev, 2022; Trope & Liberman, 2010). – *Authors' note*.

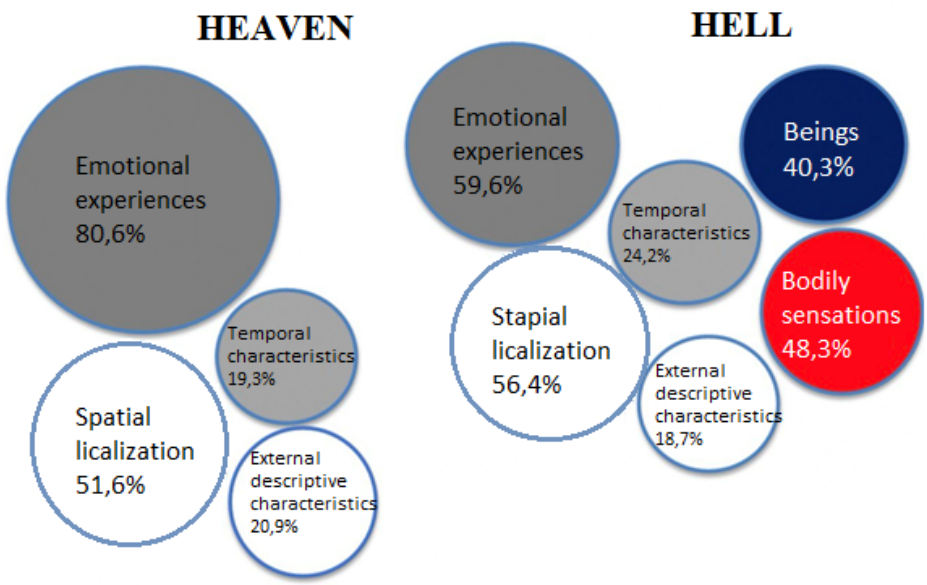


Fig. 1. The figurative and conceptual content of the mental representations of heaven and hell among Orthodox believers

As we can see, the most prominent group of indicators for both the concepts of heaven and hell was "emotional experiences" (found in 80.6% and 59.6% of essays, the difference is statistically significant: $\varphi = 3{,}288$, $p < 0.001$). Let's also take into account the similar frequency of occurrence of groups of features such as "spatial localization" (51.6% of cases for paradise and 56.4% for hell; $\varphi = 0.679$, $p > 0.05$), "temporal characteristics" (19.3% for paradise and 24.2% for hell; $\varphi = 0.841$, $p > 0.05$), "external descriptive characteristics" (20.9% for heaven and 18.7% for hell; $\varphi = 0.396$, $p > 0.05$). At the same time, the following groups of indicators were found only in the content of mental representations of hell: "bodily sensations and manifestations" (48.3% of cases) and "beings" (40.3% of cases).

In the figurative and conceptual content of mental representations of heaven and hell, figurative elements prevail over conceptual ones, which is quite natural, since in the Bible and other Christian sources heaven and hell are described mainly in a figurative, metaphorical form. According to the qualitative analysis, in the figurative and conceptual content of representations, as well as in the associative, there are cultural (non-canonical) patterns of ideas about heaven and hell: swans; nine circles of hell; a cauldron in which sinners are boiled; zombies; archdemon Belphagoras; Valhalla – the heavenly palace from Germanic mythology, etc. Most of these patterns relate specifically to the image of hell.

Using the cultural-historical (cultural-instrumental) approach in the psychology of religion (Dvoinin, 2022), one can assume that mental representations of heaven, through which a person masters his own psyche and behavior, "work" through activation in a certain life situation of the emotional experience of a person associated with experiences of love, happiness, joy, tranquility, pacification, etc . At the same time, mental representations of hell, in addition to activating emotional experiences (experiences of suffering, hopelessness, loneliness, emptiness, etc.) to regulate behavior, also actualize bodily experience associated with a variety of pain sensations. At the same time, the experiences and sensations associated with hell, being more detailed and fueled by cultural patterns, make hell psychologically closer (in the sense of psychological distance) to a person than paradise.

## Conclusion

To summarize the current study, it is important to note that it is exploratory in nature; the data obtained should be further checked and clarified. However, the study of the content of the mental representations of heaven and hell allowed us to get closer to identifying their psychological significance. We believe that this significance lies in the actualization of an individual's own experience, mainly emotional as well as bodily, in order to stimulate a believer to correct, morally justified behavior from a Christian point of view in a wide range of life situations. At the same time, it seems that representations of hell have a greater psychological significance than representations of heaven, among other things because of the greater detail and strong cultural load of the concept of hell in Christian communities.

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*Protoarchimandrite Shage Ananyan*

## Basic principles of counseling in the light of the theological tradition of the Armenian Apostolic Church

**Abstract:** The tradition of spiritual care in the Armenian Apostolic Holy Church, as also in the Oriental Orthodox and Eastern Orthodox Church traditions, is rooted in the Holy Bible and the theoretical and empirical aspects of teachings of the Church Fathers. In this sense, the Armenian Church tradition of spiritual care is very close to the Orthodox Church thinking. This specifically refers to the unique role of the church and the clergy in spiritual healing and in subsequent processes. In my report, I will present three main phenomena that, in my opinion, can best reflect the most important principles of spiritual care in the tradition of the Armenian Church. These are: 1. The perception of the correlation between spiritual and physical illnesses; 2. The role of a priest as a spiritual doctor; and, finally 3. The Church's approach to spiritual healing.

**Keywords:** pastoral care, spiritual illness, spiritual healing, spiritual integrity, Christian spirituality.

### Relationship of spiritual and bodily illnesses

The disease has not only physical, but also spiritual and mental roots. In this sense, Jesus often identifies a sinful person with a sick person. "And when Jesus heard it, he said to them, “Those who are well have no need of a physician, but those who are sick. I came not to call the righteous, but sinners.”" (Mark 2:17). Moreover, overcoming illness, from the New Testament perspective, is maintaining a healthy balance between the body and mental state. Apostle Paul articulated this point of view more clearly: “For I delight in the law of God, in my inner being, 23 but I see in my members another law waging war against the law of my mind and making me captive to the law of sin that dwells in my members. Wretched man that I am! Who will deliver me from this body of death? Thanks be to God through Jesus Christ our Lord!” (Rom. 7:22-25).

With regard to the restoration of mental health, the Bible very often uses physical, bodily images, that is, emotions and thoughts; their impact is associated with one or another part of the body that needs to be healed first. For example, the heart is considered the most important, psychophysical organ and main organ of spiritual depth, i.e., of the relationship to the divine infinity; "The heart is deceitful above all things and beyond cure. Who can understand it?" (Jeremiah 17:9). Kidneys are a rarely mentioned organ through which God explores the inner world of the human psyche and spirituality. "I the LORD search the heart and examine the mind, to reward each person according to their conduct, according to what their deeds deserve" (Jeremiah 17:10). "Test me, LORD, and try me, examine my heart and my mind" (Psalm 26:2)

The physical and spiritual integrity of the body essentially consists of three parts: soul, spirit and body. This important principle of union appears in the Bible as a factor that ensures the person's healthy inner being. God blesses the integrity of man, his 'triunity'. "May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ." (1 Thess. 5:23).

In general, the following important principles of human mental and physical interactions can be identified in the Bible:

1. An organic unity that emphasizes the integrity of the human body, i.e. even when individual organs are indicated, they act as an expression of this integrity.

2. An independent function of organs, when they act as an expression of the whole human body, while also having an independent role that represents one or another aspect of a person's mental and physical world.

3. Synthetic thinking or model. The mention of any human organ does not refer to its physical structure, but rather to its functional properties. For example, in the book of Judges, the phrase "My own hand has saved me" (7:2) does not imply its reading in the literal sense, that is, the hand saved me in the physical sense, but the word “hand” means power, courage, strength, etc.

4. The principle of mental properties, when a reference to a bodily organ is understood to mean the mental properties attributed to that organ (J. Wilkinson, 191; P.Humbert, 1918).

Psychological and mental problems as such, from the point of view of Christian spirituality, are perceived primarily as a disruption of a person's spiritual integrity. This statement is based on the most important principle of the Christian faith, according to which man is created in the image and likeness of God (Gen. 1:26-28), and, accordingly, fidelity to the image and likeness of God, and the commandment to keep ourselves whole and pure in our spiritual inner world, are the most important guarantees of recovery. In this sense, before turning to the basic principles of counseling, it is necessary to consider several important anthropological aspects in context of theology and moral teaching of the Armenian Church.

1. The image and the likeness of God have different functions. The divine image is the ability to achieve the divine in the man and become like God (deification, theosis); this is the power that a person carries throughout all his life. As long as man is a living, intelligent being, he has a divine image. The purpose of man's creation is essentially to become like God (Ps. 82:6). The likeness is closely related to the free will and desire of a person, when a person makes every effort to achieve godlikeness by grace and power given by God’s image, to be a full participant in the plan of God's salvation. In other words, man, as the bearer of the image of God, possesses all the virtues contained in this image, which are manifested in his life through likeness.

2. In the spiritual and mental sense, the disease entered into mankind through sin. From the Christian spirituality perspective, sin is seen as the result of using godlikeness and free will to do evil; a person makes a choice not to maintain the image of God as complete and harmonious, but rather to satisfy their own ego. Moreover, in this sense, not only the full perception of the image and likeness of God is violated, but also man himself as a person (Metropolitan Hierotheos, 1993).

3. This disease manifests itself first at the cognitive level, that is, a person loses the ability to know God, is unable to distinguish and choose right and wrong in spiritual and internal matters. As a result of this lack of knowledge, he is always guided by the wrong choice. Moreover, this disease manifests itself primarily through the human mind, as the most important organ capable of making a choice, then through emotions and feelings. At the same time, essentially the entire mental inner world finds itself in a cognitive crisis.

4. In a pathological sense, sin or evil is not a real phenomenon, the patristic and spiritual tradition of Church clearly states that evil is simply the result of the choice of human mind and will. In other words, sin or evil, as a disease of the soul, is the absence of the right choice, the presence of a pseudo-phenomenon that makes a person want to continue to be in this disease.

**Priest as a spiritual doctor**

In the theological thinking of the Early Church (I-V centuries), the salvific work of Jesus Christ was described as healing (C.H. Grundmann, 2018). One of the first Fathers and theologians of the Church, St. Ignatius of Antioch, formulates this idea as

follows: "...There is no other Healer but the Incarnate God Jesus Christ..." The church thinkers of the first five centuries of Christianity described the cognitive crisis that a person experiences as a result of sin only in pastoral terms: Jesus Christ as a Healer who can treat the soul and the eyes of the heart. According to this image, the first Doctor and Healer is Christ, followed by the anointed servants of the church (clergy). The power or gift of healing is transmitted almost exclusively through the sacraments of the Church. In the priestly ordination rite, the bishop also gives the ordained the gift of healing of "all kinds of diseases and evil ailments" (Big Mashtots (Euchologion), p. 265).

This theological position has played and continues to play an important role in the tradition of the Armenian Church. In the "Book of Canons", which summarizes the canonical thought of the Armenian Church of the V-XII centuries, which also contains many instructions and rules regarding spiritual and pastoral care, there are rules defining the duties of a clergyman as a spiritual doctor. Thus, in the rule 39 "The Second Apostolic Rules", the bishop is defined as the "guardian and protector of human souls. ", the rule 11 of the Second Council of Dvin, convened in the VI century (554-555 y.), obliges not only the clergy, but even princes, to take special care of the poor, orphans, widows and grieving people, both spiritually and materially. The 1st rule of the Council of Partav (768) obliges the bishop, first of all, to take care of the diseases of the people ("pain of mental wounds").

Evidence of unique and particular situations of providing spiritual care can also be found in the "Armenian Book of Canons". It is about restoring the spiritual condition of people, especially military personnel, before and after the war. Here are two examples.

-Under the name of the famous Theologian and Father of the IV century Church, St. Basil of Caesarea (330-379), a special pastoral letter entitled "Canonical Scripture" was translated into Armenian, which obliges persons who shed blood and killed people during the battle to do penance for 3 years in order to restore their own spiritual health (3rd and 8th canons).

-Under the name of St. Basil, the famous theologian and Father of the Church from the IV century (330-379), a special pastoral letter titled "Canonical Epistle" was translated into Armenian. This letter obliges those who have shed blood or killed during battle to perform penance for three years in order to restore their spiritual health (canon 3 and 8).

-In the canons attributed to St. Athanasius of Alexandria and, most probably translated in the VI-VII centuries, there is an interesting rule: "Question: - If in the army, during the war, an unbaptized person approaches a priest and says: "Baptize me," but the priest does not have the necessary ritual attributes (for example, Holy Myrrh) for baptism, and the unbaptized person insists and says: "War and death are ahead. If you don't baptize me, I will die unbaptized, you will be responsible for my soul's salvation." In this case, what should a priest do, if he cannot get the necessary ritual attributes due to the approaching military situation? Answer: - He has to baptize with water and the Holy Spirit, even if there is no holy Myrrh..." (Rule 85). From the examples given it is clear that a priest is obliged, first of all, to take care of the spiritual needs of a person. Moreover, this obligation is not only moral, but also canonical, that is, in case of non-fulfillment, the priest will be punished accordingly. Therefore, spiritual care is seen as following Jesus Christ, the Great Healer, a duty that the clergy take on along with their spiritual vocation. In the Armenian Church tradition, priests are seen as doctors of the soul. What are the necessary prerequisites?

A spiritual father, a doctor, a confessor is necessary for healing and caring for the soul, since a person cannot judge himself and distinguish between his sins and wrong decisions. This is one of the most important principles of spiritual care in the

Armenian Church. Therefore, a spiritual doctor, a priest, in order to properly fulfill his spiritual mission, is obliged to observe the following norms:

- To know the Bible and Biblical moral teachings. This is especially important, since the moral and psychological analysis of biblical characters and their examples are of great importance in organizing confession as a spiritual process (Mxit'ar Sasnec'i's Theological Discourses, 10).

- To have fundamental knowledge about the moral principles of the Christian faith, because, according to St. Grigor Tatevatsi, a priest is an intermediary between God and people; with God's help he must be able to distinguish between His will, that is, good and evil, right and wrong moral realities, and have a certain pastoral and spiritual care experience (Book of Sermons, Summer Volume, p. 189). This last point is important in order to correctly diagnose various sins and spiritual illnesses and put an appropriate 'bandage' on them.

A priest, as a doctor following a Great Healer, has no right to neglect the necessary spiritual 'bandage' and advice to someone who needs spiritual healing. An ancient Christian book translated from Assyrian into Armenian back in the V century, a collection of sermons by the monk Afrakhat, the Persian sage (280-345), describes the following three conditions for healing the soul in his writings, which reflect the oldest spiritual tradition of the Christian East:

A. Whoever shows the priest the wounds of his soul, the latter is obliged to put a bandage of spiritual healing on them.

B. If someone is ashamed to open the wounds of his soul to a priest and tell about the sins that trouble him, then the priest should encourage such a person to confess everything without any reservations.

c. Having received confession of sins and problems, the priest has no right to ridicule them or even make inappropriate hints (La version Arménienne des oeuvres d'aphraate le Syrien, Sermon 7).

**Church model of spiritual healing**

Spiritual counseling, in the sense of restoring spiritual health, is not a simple process, it is part of the Penance sacrament, one of the seven sacraments of the Church. As in the case of all other sacraments, there are certain theological and canonical requirements here.

Firstly, the sacrament is performed by an ordained clergyman, who is also responsible for pastoral care. He has the right to listen to a person’s sins and all questions troubling about this, to give appropriate admonition and healing, and then absolution. Actually in the Armenian Church tradition this process is clearly coordinated. The following two stages are important: first, a person in need of spiritual healing asks the priest all the questions and problems that bother him, later then the priest distinguishes them, clearly separates sins, mistakes and deviations from other mental problems. Finally, through ritual and prayer, he takes care of the soul: the time for spiritual healing is also determined by the priest himself (St. Ovnan Mandakuni, A Call to Repentance, The Book of Canons, vol. II).

As already mentioned, the phenomenon of soul healing or confession is special in two important ways: dialogue and ritual. It shall never be limited to a one-time meeting. St. Grigor Tatevatsi defined clear principles for the proper organization of pastoral care. So the principles of a person’s spiritual restoration process can be presented as follows::

- A spiritual doctor should be able to listen to a confession. The lack of listening can lead to undesirable and irreversible consequences. If a person in need of healing is interrupted and not listened to, this will lead to spiritual death and infertility, because

without a complete picture, one can choose the wrong approach and turn the entire healing process in the wrong direction.

- The process of spiritual recovery is purely individual and, accordingly, the confessor must be able to clearly distinguish the spiritual abilities of a given person. Moreover, many external and internal factors play an important role here. How exactly to assign the correct penance for spiritual healing is largely determined by prevailing social conditions: peace or war, age, gender, physical and mental abilities of a person, social status, etc. It is also important to keep in mind how long a person has been in a spiritual crisis.

- If there is a physical illness, it is not necessary to immediately turn to the process of spiritual healing. It is necessary to study and understand the influence of bodily and physical diseases on the mental state first, and only then begin the process of spiritual healing.

- It is especially important to distinguish sins from mental problems: are they simple or complex, i.e. do they have both external and internal causes, or are related only to the one's mental inner world?

- The work of spiritual recovery should start gradually and be perceived as a process. A person’s readiness should be considered: if they are not yet ready for spiritual healing, they should first bring themselves to a certain level of self-awareness and then move on from discussing small, insignificant issues to more important and challenging topics. At the same time, it is particularly important that a person makes a confession based on their own will and desire. In this regard, any haste could interrupt the dialogue between the priest and the penitent once and for all. The main difficulty here is with people who are in despair due to their mistakes, sins, or imagined irreversible situations. Tatevatsi provides clear guidance on this matter. "If someone is petrified because of sin, then he must be brought to maturity through confession, that is, to soften this stiff state with the hope of God's mercy. It should be said: "Be not afraid, tell your sins not being ashamed or afraid, so they disappear like a spark of fire thrown into the ocean, as the ocean is immeasurable, and the spark is small." And so God's mercy is immeasurable, but your sins are small..." ( St. Grigor Tatevatsi, Summer Volume, pp. 189-192).

This process is strictly confidential, the priest has no right anywhere and under no circumstances to disclose the details received during confession and spiritual healing.

Even after confession, the priest should regularly visit the healed person, try to maintain constant communication after healing until he is sure that the person is already in the full recovery state.

**Concluding remarks**

1. Illness, whether physical, mental or spiritual, according to the Christian understanding, has a clear spiritual and moral cause and a healing mechanism. In the Bible, in the writings of the Church fathers and teachers, it is almost always associated with the spiritual state of a person. If a person's spiritual state is disturbed, he may become ill; when harmony is restored, he recovers.

2. However, Christian thinking also clearly distinguishes between psychophysical, mental and purely spiritual diseases, which respectively have their own special forms of healing. At the same time, while distinguishing them it does not disconnect them, because it considers the unity of the human body, mind and soul as an expression of one integral and whole personality.

3. It is in this context that, during the modern period, it may be possible to apply the achievements of modern psychology, especially psychotherapy, with the Christian

psychological tradition. There are vivid examples of this in the Orthodox and Catholic Church traditions.

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## Religious radicalism and psychopathology

**Abstract**: The report discusses various manifestations of religious radicalism and highlights the main psychosocial factors contributing to its formation. Clinical examples are provided to show that for people with mental health conditions, religious radicalism can be a factor that leads to refusal of medication and contributes to the development of suicidal thoughts and behaviors.

**Keywords**: religiosity, religious radicalism, suicide, suicidal behavior, mental disorders.

Modern researchers pay attention to the influence of the religious factor on the course and prognosis of mental disorders. Particularly in the studies on various aspects of the development of mental pathology, they reveal the religious affiliation of patients, their occult hobbies, their participation in the activities of destructive cults, etc. (Pashkovsky V. E., 2009; Prokopovich G. A., 2015; Popov Yu. V., Pichikov A. A., 2017; Chumakov M. V., Chumakova D. M., 2020; Kleiman E. M., Liu R. T., 2014; Lawrence R. E., Oquendo M. A., Stanley B., 2015; O'Reilly D., Rosato M., 2015, etc.).

Several researchers emphasize the protective antisuicide role of traditional religious beliefs[1]. Data on the protective effect of religiosity related to suicidal behavior are presented in the review by Kopeiko G. I. et al. (2020). The authors note that by now there is a large amount of literature indicating the beneficial influence of the religiosity factor. Most studies note that religiosity correlates with a negative attitude towards suicide. An important role in reducing suicidal activity is played by the meaning-forming role of religion and the support of the religious community.

In the study by M.V. Chumakov et al., dedicated to the problem of the interconnectedness of religiosity and various personal characteristics, the researchers found that individuals with higher levels of religiosity tend to have less pronounced suicidal intentions. The authors also found that "the indirect relationships between suicidal intentions and religiosity are realized through an optimistic outlook on the future and the ability to address oneself in a positive way."

Nevertheless, in practical medicine, doctors often face a situation when a patient who follows a traditional religion (in particular, Orthodoxy), attends divine services, reads religious literature, does not have a sufficiently critical attitude to his mental disorder, refuses to cooperate with a doctor and take medications, in some cases explaining his behavior by religious principles. Quite often, the patient's incompetence is associated with such a widespread phenomenon in the religious environment as religious radicalism.

The concept of "religious radicalism" implies blind adherence to religious principles, rejection of any innovations, even those that are not directly related to religion (in particular, obtaining a new passport, TIN, barcodes, etc.), dividing people into "righteous and false believers" even within the same denomination, intolerance of other opinions. In its extreme manifestations, reaching the point of extremist actions and statements, religious radicalism is close to religious fanaticism.

Religious radicalism as a phenomenon exists in any religious system. In case of destructive cults[2], it is normal, while it applies mainly to ordinary members of the

1 For modern Russia, the traditional religious beliefs are: Orthodox Christianity, Sunni Islam of the Hanafi Madhhab, Lamaist Buddhism and Talmudic Judaism.

2 Destructive cults in religious studies are understood as organizations that practice deception when engaging (anonymity and pseudonymity) and control the consciousness of their adherents (control of information, behavior, thinking, emotions).

organization. Cult leaders do not always follow the radical ideas that they proclaim, allowing themselves a life full of pleasures and excesses (A.L. Dvorkin, 2012). Although in some cases radicalism is also a characteristic of the leader, especially if he suffers from a mental disorder with delusional symptoms, super-valuable ideas or has paranoid personality traits.

One of the determinant psychosocial factors of the spread and persistence of religious radicalism in Russia and CIS is the paternalistic way of perceiving information, including religious information. This is due not only to the general lack of the population's religious education, but also to the post-Soviet mentality issues. Most people who consider themselves believers accept the opinions of their leaders or preachers without proper criticism, i.e. without comparing these opinions with the Holy Scriptures and the fundamental doctrines of their faith. This is directly related to the factor of information overload, when modern man unintentionally isolates the simplest resources from the huge flow of external information. At the same time, often such opinion leaders are chosen who can reduce all the diversity and complexity of religious processes to simple schemes (they are always right - others are always wrong, our failures are the work of enemies of our faith, etc.). In general, in destructive cults, all information for members is intentionally limited and simplified by the leader and/or the doctrine, and any alternative opinions are severely suppressed.

It should also be noted that the occult worldview, which includes religious syncretism, belief in magic, fortune-telling, omens, and other practices, is widespread. This contributes to the confusion of religious views, even for those who identify with a particular religious tradition.

Many studies have been conducted on the manifestations of religious extremism in Islam. Thus, M.Ya. Yahyev (2010) notes that Islamic radicalism is characterized by the adherence to the value-based principles of "pure Islam" in terms of both non-believers and those who do not belong to the world of "true faith" within the Islamic community. The author emphasizes that Islamic radicalism is a deformed and perverted form of Islam. The goal of Islamic radicalism is to change the place and role of Islam in modern society. Radical strata of Muslims allow the use of terror and violence to achieve this "higher goal". Religious, including Islamic, radicalism is characterized by a division into "us" and "strangers", a search for internal enemies who, in the opinion of radicals, cause even greater harm to religion than open enemies.

There are currently many radical Islamist groups operating in Russia that are recognized as terrorist organizations. These include "Taliban Movement", "Islamic Group", "Islamic State (ISIS)", "Muslim Brotherhood", "Al-Jihad", "Al-Qaeda", "Islamic Liberation Party", Hamas, and many others. A pressing issue is the radicalization of migrants who arrive in Russia from CIS countries. Modern sociologists are actively studying the causes of this phenomenon. Thus, some authors identify one of the factors contributing to the radicalization of migrants as the specific features of Internet resources popular among citizens of Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan who have come to work in Russia (N.D.Tregubova, A.A.Ivanova, 2020). One of these features is religious radicalism. The authors note that a significant proportion of the websites with radical rhetoric are related to Azerbaijan and Islamic issues. At the same time, the theme of injustice and oppression is often "actualized". As an example of radicalist rhetoric on the Internet, the authors cite the following poem:

*How many Muslim tears have been shed,*
*Crimea, the Caucasus, Gaza and Tatarstan...*
*Why are the vaults of Islamic temples*
*rob the vaults of Islamic temples???*

According to N.D.Tregubova and A.A.Ivanova, migrants in Russia, including

representatives of diasporas, are the most sensitive to radical criticism of their own government, regional separatism and religious radicalism, and "the latter seems to be the most dangerous for Russia, since the first two are focused on the country of origin, and religious radicalism is of universal value".

However, apart from Islamic radicalism, the radicalization of the Orthodox religion also poses a certain danger to Russia. The Old Believers can be considered an example of such radicalization in the recent past. In the history of the Russian schism, there are numerous descriptions of Old Believers' mass suicides, committed by them for religious reasonsThese were mainly self-immolations, although other methods of suicide were also used, especially in the early period of the schism (A.V. Kartashev, 2007; I.V. Lysak, 2019). At the same time, suicide in Christianity is a mortal sin. Such a paradox is of interest to many researchers. As Lysak I.V. notes, they suggest three main explanations for this behavior of Old Believers. The first position explains the suicidal behavior of Old Believers as a social protest against persecution. Another part of the researchers explains the massive self-burning by the peculiarities of the Old Believers' ideas about the afterlife of man, with their belief in the "cleansing power of fire." And finally, the third group of scientists connects the mass suicides of Old Believers with the peculiarities of their ritual practice. In addition, if in the initial period of the division one of the reasons for the suicides was apocalyptic sentiments, then later mass "burning" largely became a "tradition". According to I.V. Lysak, the main reason for the mass suicides of Old Believers was their so-called "folk religiosity", in which ritualism prevailed over dogmatics. The "folk religiosity" is characterized by the interweaving of pagan beliefs and rituals into the Christian religion, in particular the belief in "purification by fire".

Apocalyptic sentiments are characteristic of a number of radical pseudo-Orthodox groups in our time. In 2007, the events related to the case of the so-called "self-burriers'" group were widely covered in the media. A group of 35 Orthodox Christians, led by Pyotr Kuznetsov (with a chronic mental disorder), went to live in caves that they dug in Penza region, expecting the end of the world to come soon, which, in their opinion, was supposed to happen in 2012 as a result of the fall of comet "Armageddon" to earth; later the date of the end of the world was changed to May 2008. Two women from the group died in the caves from harsh living conditions and diseases. The leader of the Penza sectarians, Pyotr Kuznetsov, tried to commit suicide on April 2, 2007. He was found in a barn on the territory of his own house and taken to the hospital with a head injury. The motive for suicide could be disappointment that the "end of the world" had not come. By May 16, 2008, all the recluses, except for the two who died in the dugout, have left the caves. In December 2012, only one family from the members of this group remained in Nikolskoe village, and a few other families moved to Belarus.

It is not uncommon for people to engage in suicidal behaviors due to misunderstood religious ideas that are promoted by the leaders of radical groups. At the same time, the leader is not always mentally but typically has certain personal characteristics such as rigidity, suspiciousness, intolerance towards other opinions, and a desire for unlimited power.

An example is the case of Nikolai Romanov (former schema-hegumen Sergiy), who was arrested in December 2020 for inciting nuns of the Sredneuralsky convent to commit suicide. In this convent he actually dismissed the mother superior and encouraged his followers to "die for Russia." In addition, Romanov introduced physical punishments to children living there in the convent and inspired his followers to believe in his supernatural abilities - he tried to resurrect a drowned child. Despite such extravagant behavior, Nikolai Romanov was found sane. The court found the former schema-hegumen Sergiy and his former press-secretary Vsevolod Moguchev guilty of inciting hatred as part of an organized criminal group. (par. "c" of part 2 of Article 282

of the Criminal Code of the Russian Federation).

Participation in the activities of such religious groups often leads to various mental disorders that persist even after leaving the organization. This is especially true for children and young people, whose coping mechanisms have not yet been sufficiently developed. In some cases, the group affects the mental state of the relatives of those involved in it. So, we observed a patient who tried to hang himself after long, hopeless attempts to rescue his wife and child from such a religious organization. According to the parents, the patient was Orthodox, but did not show much interest in religion. He received secondary vocational education, worked as a loader driver. The patient's second wife (the first died of leukemia) and her mother were members of a religious (pseudo-Orthodox) organization in the village of Zayanye, Pskov region. This community was headed by Hegumen Roman (Zagrebnev), who was subsequently banned from ministry, and had radical views. The wife and mother-in-law involved the patient's children in this community. On this basis, there were conflicts with his wife. The eldest son from his first marriage lived with the patient's parents, and it was not possible to involve him in the community. His wife and mother-in-law took their youngest (their own) son with them to Zayanye. After numerous visits to the village and attempts to persuade his wife to leave the community, the patient attempted suicide (hanged himself), was taken off the noose, but the consequences of the attempt were severe – acute retrograde and fixation amnesia, manifestations of posthypoxic encephalopathy.

One of the distinctive personality traits peculiar to people who adhere to radical religious views is rigidity, inflexibility, inability to adapt to new conditions and compromise. In our study of suicidal behavior and the post-suicidal period in psychiatric hospital patients, rigidity prevailed among the personality traits in patients who had attempted suicide. Thus, in patients who had committed suicide attempts (81 people), rigidity, isolation, excitability and sensitivity prevailed among personality traits. In the group of patients with suicide statements (80 people) – isolation, sensitivity, anxiety and excitability. At the same time, the differences between the groups reached a significant level in the prevalence of rigidity in patients who had committed suicide attempts compared with patients who had suicide statements (32.1% and 15.0%, respectively, $p < 0.05$). It can be assumed that similar personality traits in supporters of religious radicalism and patients with suicide attempts may contribute to the development of suicidal behavior in individuals who are members of radical religious groups. However, this assumption needs further assessment.

In patients with chronic mental illnesses, radicalistic pseudo-religious ideas (about the need to be afraid of new passports, TIN, barcodes, etc.) are often intertwined with psychopathological symptoms, delusional ideas of persecution and influence. As an illustration, here is a clinical example of a patient with a paranoid form of schizophrenia.

Patient D., 30 years old, native of the Rostov region. Positive family history. The youngest of 3 children. No deviations during the early ears development. He completed 11 years of secondary school and one semester at the Don State Technical University, he left his studies because "it was not interesting." He was drafted into the army, however, almost immediately he was discharged, and was treated in the psychiatric department of a military hospital. He worked in various low-skilled jobs, including sales, advertising, and road sweeper. He is divorced, has a daughter, is deprived of paternity. He lives in a separate apartment with his mother, relations are strained, he put huge crosses at home, littered the rooms. The patient's mother, a former engineer, works at the church. After the army, the patient was registered with the psychoneurologic dispensary, however, he visited the doctor only at the request of his mother, and refused supportive therapy. According to his mother, he has been behaving inappropriately at

home lately, constantly spending time at the cemetery, "talking" there with his deceased grandfather. At times he froze in one position, lay in his clothes in a dry bath. Before confession, he wrote in a note: "I slept with a cat", "I slept with a baby", "I got married in a church." He burned his passport because the priest said it was a "demonic document." He hitchhiked in cars to St. Petersburg to "visit the church." In St. Petersburg, he drew attention to himself with his inappropriate behavior: walking down the street carrying a large wooden cross. He did not respond to the comments of the police, and was hospitalized in a psychiatric hospital. When he was admitted to the hospital, he seemed to be hallucinating, said that he hears the "voice of God", God directs him. He feels the influence of "evil spirits", a wooden cross helps him to fight them. Emotionally inadequate, with pretentious facial expressions. He was found to have severe structural disorders in his thinking, including paralogy and slippage in reasoning. Against the background of neuroleptic therapy, the acute psychotic symptoms were relieved, but there was still no critical attitude towards the illness.

It can be assumed that if this patient had communicated with a competent spiritual father who understands the intricacies of mental illness and the importance of supportive treatment for chronic conditions, rather than a priest who sees a passport as a "demonic document," his religiosity could have helped improve his mental health.

## Conclusion

Thus, for people suffering from mental pathology, religious radicalism is a factor provoking refusal to take medications, as well as contributing, in some cases, to the suicidal behavior. To reduce the influence of the ideas of religious radicalism on religious patients, it is necessary to develop cooperation between psychiatrists and clergy[3], promote spiritual education of patients and medical workers, and develop and apply various methods of spiritually oriented psychotherapy. For mentally healthy people, reducing exposure to radical religious ideas can be achieved through the joint work of clergy and psychologists, aimed primarily at developing such psychological qualities as the ability to take responsibility, counteract psychological manipulation and critically evaluate information coming from various (including religious) sources.

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**The phenomenon of possession in mental disorders: clinical and psychopathological features**

**Abstract:** The problem of studying the phenomenon of possession with religious contents is still relevant, since, on the one hand, it is recognized by almost all religions, while on the other hand it is of particular interest to the scientific community. The views of researchers on this phenomenon differ, this is due to both the structure of the syndrome itself and the psychopathological and clinical manifestations: the phenomenon of possession is considered both within the framework of dissociative disorders and of delusion of possession with religious contents. The results of the study of religious delusions of possession in schizophrenia have shown that its specific feature is the patients' persistent delusional belief that they are possessed by some kind of hostile or powerful spiritual entity, which has entered their body or taken over their mind from the outside. The data obtained is important for the social prognosis, the choice of therapeutic strategies for these patients, as well as pastoral counseling.

**Keywords:** the phenomenon of spiritual possession, religious delirium, schizophrenia.

Descriptions of the phenomenon of spiritual possession can be found in texts of the pre-scientific age (Holy Scripture, Tradition, patericons, hagiography, etc.). Since the advent of psychiatric science (in the XIX century), researchers have been trying to explain these conditions from a medical point of view, which, however, according to their ideas, did not exclude the religious component of this phenomenon. Thus, it was believed that demons can cause many diseases, including mental disorders, such conditions were called "demonomaniac insanity" (W.Griesinger, 1867) or "demonomania" (J.Esquirol, 1838; M.Macario, 1843; J.Séglas, 1888).

In the 20th century, as science continued to develop, these conditions were studied in greater detail. Thus, for the first time, Karl Jaspers suggests that this phenomenon is heterogeneous and identifies several varieties of it, which may fall within the endogenous and schizophrenic spectrum but may also be influenced by dissociative disorders (K.Jaspers, 1923). With the advent of psychoanalysis, which has spread widely around the world, the phenomenon of possession has most often been classified as dissociative disorder. These disorders were usually associated with childhood trauma and abuse (S.Freud, 1923; S.McCormick, D.C.Goff, 1992; N. Tosh, 2002).

Currently, the study of the phenomenon of possession with religious contents is relevant, as there are diverse views in the scientific community regarding this phenomenon. This diversity relates to both the structure of the disorder itself and its psychopathological and clinical manifestations (J.A.Madere, 2023; I.J.Pietkiewicz, 2022; de Menezes A., Moreira-Almeida A., 2009). Thus, in dissociative disorders (previously referred to as "dissociative (conversion) disorders" in ICD-10), the phenomenon of possession is often observed. In ICD-11, this phenomenon is separately presented as possession trance disorder (6B63) (G.M.Reed, 2019).

In addition, the phenomenon of spirit possession, in its most pathological form, is manifested as religious delusion of possession. It is the latter conditions that are the subject of this study, which was conducted from 2015 to 2023 by the group for the study of special forms of mental pathology under the leadership of Academician of the Russian Academy of Sciences A. S. Tiganov (until 2019) on the basis of the Department of Juvenile Psychiatry of the Federal State Budgetary Scientific Institution "Scientific Center for Mental Health" (FSBI SCMH).

The study involved 75 patients with religious delusions of possession as part of their schizophrenia (RDP). The most patients identified themselves as Orthodox (90.7%) or Muslim (5.3%), or considered themselves non-believers at the time of the RDP manifestation (4%).

According to this study, the delusion of religious possession (RDP) is a complex psychopathological and polymorphic formation. The specific core of the religious possession delusion (RDP) is the patient's delusional belief about the possession of his personality by a specific disembodied spiritual entity (hostile or benevolent) that penetrated into the body or captured it from the outside. As a result, according to the patient's delusional conclusions, his soul, mind and body are completely taken over. This, in turn, begins to completely determine his actions and thoughts, leading to the formation of a new personality or identity within him.

In all cases, the patients called the hostile spiritual entity a "demon", "devil", "Satan". Along with the "demonic possession", the patients talked about the possession by a divine spiritual entity - "the holy spirit", "divine light", "the Mother of God". Delusions of affection in these cases were associated with changes in affect (manic).

A clinical and psychopathological study of the religious delusion of possession made it possible to identify certain types, in which hallucinations or delusions are the predominant symptoms:

· hallucinatory type (1) 39 patients (52%)

· delusional type (2) 36 patients (48%)

A characteristic feature of hallucinatory RDP type 1 is the patient's delusional belief that a bodiless spiritual entity has entered their body and is controlling their mind and personality, which leads to a complete loss of control over their somatic condition and soul. Massive hallucinations of general feeling, which developed primarily, retained their fundamental importance as the condition developed, while delusional ideas of influence were secondary. Type 1 RBOs were formed acutely, with the onset of hallucinations of general feeling. Delirium often occurs through the mechanism of "illumination," when patients clearly indicate the circumstances, the specific day, and often the hour, when they experienced a feeling of "a demon entering their physical body." The patient's delusional conviction of being possessed by a demon was an indisputable evidence, not subject to any logical justification or doubt. There was no criticism of the described disorders.

The delusional form of RDP type 2 developed in accordance with the patterns of acute sensory delirium formation, while the source of the impact felt by patients had an external (mental) origin. Such states were accompanied by a feeling of complete spiritual defeat caused by a demon. The physical impact was felt indirectly, through a "spiritual" impact, that is, "secondarily". The characteristic features of type 2 RDP include pronounced polymorphism and the severe disorders presented in the clinical picture of the disease.

**Delusional behavior**

Patients with RDP did not demonstrate behaviors that, according to the Orthodox Christian tradition, is characteristic of possessed individuals (negative reaction to sacred objects and religious services: the Bible, icons, Holy Water, the Cross, participation in the sacraments), which is also confirmed by experts in the field of exorcism (J.M. Vegas, 2019).

Deviations in the social and religious lives of patients became evident immediately during an RDP attack, and in some cases, during the subsequent course of the disease. Being in an acute psychotic state, patients invented specific forms of defense and struggle against demons: some made too frequent pilgrimages to monasteries, churches, sacred sites and springs, others read special non-canonical

religious texts and exorcic prayers. The described manifestations of pathological religiosity (O.A. Borisova, G.I. Kopeiko, 2019) were closely linked to specific psychopathological conditions.

**Religious worldview and lifestyle of patients with RDP**

Clinical observation revealed certain characteristics of the religious worldview and lifestyle of patients with RDP. During the observation period, a qualitative assessment of the dynamics of religiosity was carried out, taking into account the peculiarities of faith formation in these patients. The results showed that there were significant differences between the types.

The religiosity of Type 1 RBD patients began to develop gradually, long before the onset of the disease, had a certain level of maturity and continued to adhere to traditional Orthodox canons (64.1%). As the disease progressed, the external manifestations of religiosity did not change significantly or decreased slightly.

In some cases of type 2 RDP (religious behavior observation), religious conversion occurred several years prior to the manifestation of RDP and, in half of these cases, the conversion was of a more simplified nature, or manifested in the form of rare, formal, and superficial participation in religious rituals. Before the development of RDP, 61.1% of type 2 RDP patients were non-religious, and direct conversion to religion chronologically coincided with the development of the RDP condition. Unlike what was observed in patients with type 1 RDP, the development of a mature religious worldview did not take place.

**Conclusion**

This description of the RBO phenomenon expands our understanding of the psychopathological diversity of these conditions and provides new insights into diagnostic qualification and differentiation, potentially leading to controversy in both psychiatric practice and religious circles. The data obtained may be important for social prognosis, treatment prognosis, as well as psychopharmacological treatment of patients with RDP and for pastoral care. It also requires long-term follow-up to fully resolve the issues raised.

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*Hector de Ezcurra*

## Differentiation of spiritual experiences from mental disorders

**Abstract:** Our team has to deal with people with psychotic disorders (schizophrenia, delusional disorders; sometimes even spouses or relatives simultaneously suffering from delusional disorder) or with people with a neurotic personality type with hysterical, conversion, obsessive or dissociative traits. Others come to us because they are simply misinformed, ignorant, suggestible, or fearful. But this does not mean that supernatural demonic influence does not exist; this means that it is quite rare and it is necessary to distinguish one from the other, particularly by seeking the help of mental health professionals. In this paper, we will discuss the issue of differentiating spiritual experiences from mental disorders and focus on specific experiences generated by spiritual forces – in this case, demons.

**Keywords**: schizophrenia, delusional disorders, dissociative identity disorder, demonic influence, exorcism.

As you might know, demonic action is divided into 2 different categories: **Demonic Ordinary Action** and **Extraordinary Demonic Action** (EDA). The ordinary action is what we experience as temptation, in which demons work every day on each one of us. The second group of actions can be divided into: possession, obsession, vexation and infestation.

Mental health professionals and laymen *who don't work in this field*, often think that those people who are looking for help from an exorcist are all mentally disturbed people, and sometimes that is the case. We can verify that some of those who claim to be under a demonic attack are mentally ill. But not all of them are delusional, nor suffer epilepsy, or have an Identity Dissociative Disorder, as many people think.

We will be talking, specifically about one kind of actions they can do that can be confused with mental pathologies: the Extraordinary Demonic Action. Individuals who suffer from these situations often turn to an exorcist for help. Many of these exorcists work with a team, which hopefully includes Mental Health professionals. It is true that in our team sometimes we receive psychotics, (schizophrenics, delusional individuals or even delusional couples or family members), or people who have a neurotic personality with histrionic, conversive, obsessive or dissociative traits. Others come to consult us only because they are just misinformed, ignorant, suggestible, or fearful people. But all this doesn't mean that Extraordinary Demonic Action doesn't exist, it only means that it is rare and that it must be carefully discerned, sometimes with the help of Mental Health professionals.

In this field we need to have common sense.

If we are in a city and we hear, through the open window, the sound of equine hooves against the sidewalk's cement, could it not be zebras? It could be. But it is much more likely to be horses! This means that we must first, discard the simplest, most logical and frequent answer to a problem, and when there is no other natural explanation, only then think of a preternatural phenomenon.

There is a practical rule, enunciated by Fr. Tanquerey:

How can an exorcist tell the difference between a demonic phenomenon and a psychopathological phenomenon? Observing the people when they meet him or when they receive prayers, he pays special attention to that phenomena that doesn´t have a natural explanation:

• "Why does this person make such a scandal simply for receiving a few drops of water from the tap that were exorcised? Why does this water burn them and that other water which is not blessed does not?"

• “What makes this person able to guess and turn angry because that priest has a reliquary in his coat pocket that contains a consecrated host?”

• “How does this girl struggling on the floor with her relatives and some assistants, whose eyes are closed as the exorcist, standing at a distance, is praying for her, manage to hit his face with an accurate spit?”

• “What makes a person’s abdomen expand like an eight months’ pregnancy only for some minutes of prayer?; and why does her abdomen move and make noises during the whole exorcism, and goes down and calms down when that prayer finishes?”

• “Why, in a few minutes of praying, this person with whom we have been talking, who did not have any bronchial discharges, does now give off a foul-smelling yellowish-white foam, and burps strongly, with a putrid smell, when some minutes ago he did not, and when the prayer finishes, he will not show any of these things?”

• “How can this other person, who does not even know about the existence of the International Association of Exorcists (AIE) know that it’s president had died minutes earlier, even before the press?”

• “Why can this person, of a low cultural level, write cell phone messages which say, in ancient Greek: «On the third day»?,” “And why, this same woman, who had such an ugly aspect at the beginning, with big dark circles under her eyes, and on whose chest inverted crosses appeared spontaneously, came, after three months’ exorcisms, with a big right cross drawn on her chest that lasted for three days, after which she felt delivered, and when she came back she was transfigured into a nice-looking happy woman?

• “Why, in some cases, the manifestations change according to the liturgic moment of the year and the solemnities being celebrated?”

• And, above all: “Why, in different places and in different periods, sequences of similar symptoms and signs occur?”

The answer to all this is the **demonic extraordinary action**, which can sometimes be found besides any psychopathological condition or personality, but must be carefully distinguished from a mental condition. Even if sometimes they can be together, they mustn’t be confused: they are very different things. Sometimes it happens that it is impossible to make a clear distinction between a psychopathological disorder and a disorder caused by demonic extraordinary action, at least, in the beginning.

**The essence of the differential diagnose**

For humans, getting ill, (as happens in psychopathological conditions), is a natural phenomenon. Theologians consider that anything that is not a **natural** phenomenon can only be:

• **supernatural:** that which comes from God, which is “above the natural,” meaning not only what relates to human nature, but also to any created or creatable nature. Only God can, as an efficient cause, perform this type of actions, even when, by his command, a creature his (an angel, for example) intervenes as an instrumental cause.

• **preternatural:** that which is “beyond natural,” where natural means what relates to human nature and everything below it. Demons can do things which seem prodigious in our eyes, because they are beyond human ability, but always only within the natural possibilities of their angelic nature. They are always creatures, not gods.

***“All that is beyond the possibilities of human nature and everything that is below it, if it does not come from God, comes from the devil. There are no other efficient causes, nor are there any intermediate states.”***

This concept is very important in order to be able to clearly distinguish these three situations. For this, we must also avoid using the word “**paranormal**” since it refers to the ideas of a pseudoscience, **Parapsychology**, which tries to explain in natural terms the phenomena that the Church considers **supernatural** or **preternatural** (as if

some persons, things or places *naturally* had certain unnatural capacities).

***All E.D.A. related discernment is based on defining whether a phenomenon or set of phenomena is natural or preternatural.***

If we should come to face a phenomenon that is not natural, (as those examples I mentioned before), then, according to its context, contents, and consequences, it will be necessary for us to discern whether it is a supernatural or preternatural phenomenon. It is worth to make an effort to clearly distinguish these different situations to avoid huge misunderstanding and serious consequences.

**Comorbidity**

It's not strange to find comorbidity, that is, de coexistence of Psychopathology with Demonic Extraordinary Action. The presence of DEA does not exclude psychic disorders (and vice versa). Psychopathology and DEA obviously can coexist but must never be considered the same thing.

**Possession experience**

One situation that often arises the question "Could this be demonic possession?" is the one in which the individual feels controlled by something that is exterior to himself.

We usually experience a "sense of control" ("sense of agency"), which is that subjective conscience that one's own voluntary actions in the world are started, executed, and controlled by oneself. In several psychopathologic conditions this "sense of control" at some point is lost. The individual feels as if "something" that is out of his voluntary control, dominates him and forces him to incur in certain behaviors that they did not intentionally choose. This experience is sometimes called "possession experience", which is a subjective, fantasized emotional experience, that is, a psychologic phenomenon, and should not be confused with true demonic possession (which is a real, objective, spiritual phenomenon, produced by an external spiritual demonic force). Of course, in actual possession, the person will also live a "possession experience", but in this case, from a spiritual, real cause.

In all these cases, there can be conducts that the individual experiments as coming from an external force, independent from himself, and make him feel "possessed" by something. But in these cases, it's not a demonic possession.

**Psychosis**

Another situation commonly confused with possession is psychosis, which as you must know, is the technical name for insanity. To define it simply, we could say it is the inability to distinguish reality (which is external and shared) from fantasy (which is internal), that is a failure of the reality test (objective assessment and judgment of the world outside the individual), and by the creation of a new (psychotic) reality. In psychosis, we can often see: 1) perception disorders, such as hallucinations, and 2) thought disorders, such as delusions.

**Differential diagnosis**

These are some of the psychiatric disorders that could be confused with Extraordinary Demonic Action:

1. Schizophrenia
2. Delusional Disorder
3. Shared Psychotic Disorder ("Folie a deux")
4. Altered States by substance-related disorders (alcohol, caffeine, cannabis, hallucinogens, inhalants, opiates, sedatives, stimulants, etc.).
5. Histrionic Personality Disorder

6. Conversion Personality Disorder
7. Dissociative Identity Disorder ("Multiply Personality")
8. Hypomania or Mania
9. Major Depression
10. Borderline Personality Disorder
11. Obsessive-Compulsive Disorder
12.Gilles de la Tourette's Disorder
13. Panic Disorder
14. Epilepsy
15. Factitious Disorder

I made a guide for discernment with a comparative table for each one of these fifteen clinical conditions. The purpose was to create a tool that was available to aid in the discernment process. The aim of this differential diagnosis is to ensure that no one suffering from extraordinary demonic action is mistakenly sent to a psychiatric hospital, and that no one with a mental illness receives exorcisms by mistake. In both cases, the consequences are serious. If a Mental Health professional wants to help an exorcist in this discernment, I think he should start by discarding the clinical situations we can see in this table.

The Discernment Guide, seeks to answer the following question: «Which are the differences between the signs of a psychopathological disorder and the signs that could be indicative of demonic possession, vexation, obsession or infestation?»

The task of the Mental Health professional is to psychologically assess the person from his own field of knowledge. He will then inform the exorcist if there is any psychological or psychopathological explanation for the symptoms and signs observed. With that information, the exorcist makes a discernment about the presence or absence of extraordinary demonic action and the need for exorcisms or not. The tables in this guide seek to exemplify the process of differential diagnosis that a Mental Health professional makes in his mind when he must answer the above question.

We will use one of those tables as an example of the discernment guide. Let's see the differences between the Dissociative Identity Disorder and Possession.

| *Dissociative Identity Disorder* | *Extraordinary Demonic Action (Possession)* |
|---|---|
| Involuntary intrusions into conscience that alter the integration of physical functions, bring confusion and distortion of body image. A disruption of personality allows, in certain moments, the separate function of different aspects of personality, which are so diverse that there appear to be an identity alien to the original one. | Possessions is not a disruption of personality that gives transient prevalence to another part of their own personality (the "other identity"), but a **temporary substitution of identity**. When not in trance, there is no need for confusion or distortion of the body image. |
| This occurs with persons who have not achieved good integration of their identity due to flows in upbringing and/or traumatic events in their lives. It's a long-standing disorder. | It may occur to any person, even those with **good identity integration**. There may be **a clear date of beginning** (for example, through contact with occultism). |
| **"A. Disruption of identity** characterized by two or more distinct personality states (of any type). That some cultures can | **The emerging identity is special evil in character, filled with hatred towards the sacred, pride and resentment. It is** |

| | |
|---|---|
| describe as an experience of possession. The disruption of identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition and/or sensory-motor functioning." (For example: intense emotions or impulses, including speaking or other actions that arise without a feeling of personal belonging or control (even attempt at suicide).)<br>"These signs and symptoms may be observed by other persons or declared by the sufferers themselves". | **totally alien to the person** ("That is not my daughter"). There can be anything from fury to mutism. Sometimes the person's identity fights the demonic entity to regain control of their body and communicate with the exorcist.<br>This would not be a subjective experience ("a possession experience"), but the **external action of a non-human being, endowed with their own intelligence and will, which momentarily replace those of the person**, causing a transient passive suspension of the intellectual and volitional activities, **exercising a despotic control of the person's body and actions**. There are behaviors that are inexplicable to the affected person. In the cases of E.D.A. authentic testimonies are useful and taken into account. |
| "B. Recurrent gaps in recall of everyday events, important personal information, and/or traumatic events, that are inconsistent with ordinary forgetting. | Sometimes there are gaps in memory about what happened during the trance state. |
| C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. | Outside of trance states, he/she can usually lead a totally normal life. |
| D. The disturbance is not a normal part of a broadly accepted cultural or religious practice".<br>The crises are triggered by and extended due to psycho-social pressure. | The alteration is caused by a spiritual entity.<br>The crises can be triggered and extended in presence of the sacred. |
| Improves with several psychotropic drugs and psychotherapy. | The symptoms are not solved with medication or psychotherapy (they can even aggravate). |
| No preternatural phenomena are observed. | Preternatural phenomena are observed. |

Someone comes to our consulting room (much more commonly a woman) with several emotional and physical issues, who at times seems to be another person, and whose attitudes are different from their usual identity. The person may experience this like something alien that "invades" and "takes over" her. Someone could think she's possessed. Some psychiatrists believe that all patients who undergo exorcism prayers actually suffer from Dissociative Identity Disorder, but obviously, this is not the case.

You can read more in detail about this subject in a book I wrote, called "An enemy has done this -The action of the devil in the eyes of a mental health professional", which is available on Amazon in 4 different languages. Another book that I highly recommend to anyone working with individuals suffering from the demonic extraordinary action is "Guidelines for the Ministry of Exorcism – In light of

the current ritual", published by the International Association of Exorcists. It can also be found in many languages.

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**The spiritual and moral component in rehabilitation after severe psychotrauma**

**Abstract:** The problem of studying, diagnosing and correcting negative mental consequences of stressful factors, caused by various traumatic events (accidents, catastrophes, military operations, violence), is very urgent. An important aspect of the rehabilitation of people with post-traumatic disorders is the restoration of spiritual and personal orientations and meanings of patients. The moral aspect plays an essential role in maintaining the integrity of the personality of people who have experienced severe stress, but mental health professionals are limited in their ability to provide competent advice on these matters. To expand rehabilitation possibilities, it is necessary to involve not only volunteer organizations, organize long-term cooperation with NGOs and charitable foundations, but also establish active interaction with representatives of religious organizations.

**Keywords**: psychotrauma, post-traumatic stress disorder, rehabilitation, spirituality.

The problem of providing assistance to people who have experienced severe mental trauma, primarily related to participation in warfare, is now very relevant. Post-traumatic stress disorder not only manifests itself through a number of symptoms that can make it difficult for people to function, but it also has a negative impact on their relationships with others. Uncontrollable anger, emotional alienation and inability to communicate properly with representatives of various social institutions — all this complicates the relationship between those who have been traumatized and those who come into contact with them in life. Post-traumatic stress disorder (PTSD) can provoke or exacerbate other mental disorders – anxiety-depressive, affective, chemical and non-chemical addictions, eating disorders. Disorders that occur during emotional stress in various structures of neurophysiological regulation of the brain can have a negative impact on somatic health and lead to changes in the functioning of the cardiovascular system, gastrointestinal tract, blood clotting system, and to immune system disorder (Alexandrovsky Y.A., 2009; Semenova N. V., Goncharenko A. Y., Lyashkovskaya S. V. et al., 2023).

The treatment of disorders associated with stress and mental trauma involves consistent efforts to overcome symptoms that interfere with mental functioning. This includes psychopharmacological and psychological interventions (Driga B. V., 2012). The most relevant algorithms for the complex treatment of these conditions are described in clinical guidelines. The main objectives of psychotherapeutic treatment of patients with PTSD are to reduce the intensity of painful memories, reduce sensitivity to external and internal stimuli that trigger the reliving of traumatic experiences, reduce the severity of affective disorders, avoidant behavior and restore interpersonal and social adaptation. Psychotherapeutic treatments for PTSD aim at cognitive reassessment of a traumatic event. Many of these techniques involve viewing, visualizing, and re-living the trauma experienced (exposure therapy), while using methods to reduce the current level of emotional response. This includes the process of rethinking in order to achieve integration and reevaluation of the event (Semenova N. V., Goncharenko A. Y., Lyashkovskaya S. V. et al., 2023).

Despite the accumulated medical experience in treating patients with stress-associated disorders, post-traumatic stress disorder, the number of scientific studies on this topic, available clinical guidelines and clinical recommendations, psychiatrists and psychotherapists face problems of such patients that go beyond the competence of medicine. The treatment of symptoms of post-traumatic stress disorder is often

complicated by the fact that the person's personality, when faced with the circumstances that caused the disorder, is not only in a state of intrapsychic maladjustment, but also in a state of moral and value disorientation. When a person finds themselves in situations of mortal danger, death of their comrades, or when they witness their own cowardice or unfair decisions made by others, they may experience a collapse of their ideals about people, the world, and themselves. This can cause a powerful psychological and emotional crisis.

A mental disorder, whether it is a procedural or psychogenic illness, is a crisis not only for the psychosomatic health, but also for the social and mental organization of an individual, which exposes their spiritual and deep-seated content, distorting or destroying it (Alexandrovsky Y.A., 2009).

V.N. Myasishchev in his article "The psychological significance of military psychopathological experience", providing an analysis of studies of the relationship between the characteristics of psychophysiological disorders with the specifics of the received injuries, including the effects of adverse situational conditions, draws attention to the fact that the consequences depends not only and much on the severity of the injuries, but on the condition of the individual, his system of relations and moral values.

At all times, great importance has been placed on the ability of a person to recover after experiencing difficult situations – values, meanings and spiritual orientations of the person (Voskresensky B.A., 2004). However, it would be difficult and controversial to develop and explain methodologically the category of "spirit", "strength of spirit" within psychology as a science. Turning to the help and experience of other fields of study, such as philosophy, cultural studies, sociology and theology, which reveal the understanding of spirit (Latin: Spiritus) and the spiritual within these disciplines, we can see that it is important and necessary to incorporate this understanding into the process of recovery for individuals who have experienced serious mental trauma. This is because it can ensure the true integrity of the individual's personality and its meaning-making, guiding force. The spirit, according to philosophical and religious understanding, is the highest human ability that allows him to become a source of meaning, personal self–determination, meaningful transformation of reality; It opens up the opportunity to complement the natural basis of individual and social existence with the world of moral, cultural and religious values, playing the role of a guiding and concentrating principle for other abilities of the soul (Trofimov V.K., 2013).

The moral aspect plays an essential role in maintaining the safety of the personality of people involved in military mission. The situation of military operations sharply confronts the concepts of good and evil that exist in peace time with military realities. Moral concepts such as duty (a set of obligations to society and one's country), honor (as belonging to a community united by specific activity, for example, military, officer’s honor), conscience (as internal individual control of moral norms) require special actualization. A conscious understanding of these categories by a person allows one to maintain personal dignity in situations of difficult moral choice, to experience responsibility as awareness of the possible consequences of one’s choice and consent to them (J. Bujenthal, 1998). Captured by painful doubts about “whether I’m doing the right thing”, “how can I forgive myself for what I have to do while fulfilling my military duty”, a person cannot always find support from those around him. Mental health professionals are limited in their ability to provide competent advice on these issues.

Modern rehabilitation programs pay much attention to the processes of physical and mental recovery. However, an equally important aspect of the rehabilitation of people with post-traumatic disorders is the restoration of spiritual and personal orientations and meanings of patients. Expansion of meanings, socio-cultural, and other

boundaries of the meaning space of the personality allows filling, correcting, partially introducing (forming) value and meaning content into the spiritual core of a person, so that the personality is already able to see the landmarks and support points necessary for the restoration process (Vasilyuk F.E., 2005). For this purpose, representatives of religious denominations and NGOs may be involved, paying special attention to the period of training of soldiers and their support. To expand the possibilities of social rehabilitation, it is necessary to involve not only volunteer organizations, organize long-term cooperation with non-profit public organizations and charitable foundations, but also establish active interaction with representatives of religious organizations.

It is equally important that specialists involved in the provision of medical and psychiatric care, at least in general terms, know about the basic relationships between neuropsychiatric and spiritual crises of a person. According to Professor Y.I. Polishchuk, MD: "In recent years, the scientific paradigm in psychiatry has expanded from a biomedical model of mental pathology to a biopsychosocial model. However, holistic, anthropocentric and humanistic approaches in medicine and, especially, in psychiatry necessitates further expansion of this paradigm to include a spiritual dimension. The body-soul-spirit trichotomy must be accepted and assimilated in scientific and practical psychiatry" (Polishchuk Y.I., 2001).

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*Wenceslao Domingo Vial Mena*

## Spiritual maturity and mental health

**Abstract:** Many personality disorders are characterized by the experience of existential emptiness and difficulties in communicating with other people. If a person feels that he is not alone, then this feeling becomes the basis of psychological safety, which allows him to withstand life's difficulties and assert his own worth. Even childhood traumas gain a new perspective when there is someone who cares. By letting a person know that they are not alone, we help them cope with their fears. Self-analysis is important for mental health, aimed at self-understanding and attitudes towards preventing self-destructive behavior, which results in responsibility for one's own behavior and lifestyle. Trust in God leads a person to clearer control over their emotions, a more tolerant perception of disappointments and acceptance of suffering.

**Keywords**: spiritual maturity, meaning, growing up, mental health.

A fundamental difference between human maturity and that of animals or plants is freedom, an exclusive property of the spirit. A bird matures driven by its instincts, which necessarily move it. The bird knows how to get food, how to reproduce and the role it plays within its species and in the world, without learning it. Lower beings, like a fruit, require only sun and time to ripen.

The person, on the other hand, matures spiritually, for which he needs education and the help of others. In this process, he can freely discover and follow a project, see his life as a mission and ask himself what its meaning is; and freely move forward or backward. We will put this process of maturity in relation to mental health.

We will use the image of a boat in the middle of the sea, tossed by the waves and the wind. We take it from the Gospel, in which we see the disciples of Christ overwhelmed, about to drown in the storm. They then ask the Master, who is asleep in the stern of the boat: "Do you not care that we are perishing?" To which the Lord replies: "Why are you afraid, you have no faith yet?" This is followed by Jesus' rebuke to the waters and the wind, which obey him and are instantly calmed, and a new question from the apostles: "Who is this?" (cf. Mk 4:37-41).

These three questions will serve as an outline. Let us remember that the sea in the Bible often represents the forces that only God can dominate, as we read in Psalm 65: "Thou who dost calm the roaring of the seas, the noise of their waves, and the tumult of the peoples".

### 1. Knowing that we are not alone

"Don't you care that we are perishing?" It is a question we all ask ourselves, with perhaps a different formulation, in the face of difficulty and pain: "Is there anyone who cares what happens to me?". In mental illness, particularly depression, the automatic response is so often: "No, there is no one who cares about me."

Psychological suffering includes this type of radical loneliness. This is why it increases in those who have difficulty in loving because they have not been loved.

Many times I have seen the same thing in spiritual accompaniment, as a priest. People who complain, because they say that no one cares about what happens to them. Whether it is an illness, overwork, a family worry or a crisis in marriage. Thinking that no one cares about us goes hand in hand with isolation and self-centeredness.

And it is precisely in these two dangerous traits that mental illness finds fertile ground. There is an underlying egocentrism and a global lack of hope, which prevents finding a goal and the meaning of life. Hence, many personality disorders are characterized by a sense of existential emptiness and difficulty in opening up to others.

Knowing that we are not alone is, on the other hand, the soil where a happy life flourishes. On this conviction rests the psychological security to face life. As Piaget wrote: "the personality is oriented in the opposite direction to the ego: if the ego is naturally egocentric, the personality is the decentered ego" (J.Piaget,1989). In the mature person, there is harmony between one's own individuality and the conviction to live with and for others.

He who has psychological security seeks not only individual balance, but harmony with nature, with others, with God[1] . He strives to give tension to every chord of a good or virtuous life.

If we want to improve mental health, we have to sharpen our ear to catch the dissonant notes. Most of the time it will not be necessary to dig too deeply into the past life or the unconscious, but to notice the conscious flow of thoughts. Meditate on what is felt and perceived, to give it a name and a story.

The notes out of tune can take the form of disproportionate reactions or traits that reflect an exaggerated desire to be valued, to look good. For example, perfectionism that is rooted in experiences of rejection and a more or less conscious thought of wanting to prove one's worth, because no one else cares.

Even the existence of psychological wounds from childhood takes on a new perspective, if there is someone who cares about them. Losses, failures or abuse in childhood do not always spoil future life.

To emerge from these wounds, it is necessary to acquire security, which comes especially from knowing that one is loved and affirmed in one's own value. Young people and adults need positive *feedback*, confirmation of their abilities and validation of their feelings and goals.

An open attitude is proper to the spiritual person: open to other opinions, to the existence of differences, to different ways of doing and saying, to transcendence, to mystery…

From this comes hope, which, in an example of St. John Chrysostom, gives security like the anchor of a ship in a storm, which prevents the ship from drifting, even if it is tossed about by the winds[2] . To which St. Thomas will add: "Man must be bound to hope, as the anchor is bound to the ship. But there is a difference between the anchor and hope, and that is that the anchor clings downward while hope clings upward, that is, to God"[3] .

From the outside, one can damage someone's psychological security with indifference, contempt or hurtful statements; or, on the contrary, positively affirm with the example of a coherent life and words of encouragement.

To improve mental health, it is important to reaffirm the value of each person, with empathy that is not only cognitive. That is, not only realizing the other person's emotions - whether he or she is happy, angry, sad or afraid - but also affective. It is necessary to come to share the feelings of others, to sympathize and console.

It is necessary to be attentive to the needs of others, so that they feel accepted, valued, loved and important. And to unmask possible roots of psychic symptoms in distorted beliefs of the type: "Nobody cares about what I do, how I am, what I feel, what my project is..."; or what is similar: "I am useless, nobody considers me, nobody loves me".

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[1] Cf. FRANCIS, Encyclical Letter *Laudato si`*, May 24, 2015; and Apostolic Exhortation *Laudate Deum*, October 4, 2023.

[2] Cf. ST. JOHN CHRYSOSTOM, *In Hebrews* 11.

[3] ST. THOMAS AQUINAS, *Sup. epist. ad Hebreos*, ch. 1, lectio 4: "ita homo debet alligari isti spei, sicut anchora navi alligatur. Est autem differentia inter anchoram et spem, quia anchora in imo figitur; sed spes in summo, scilicet in Deo".

We have identified a question that overwhelms and disrupts harmony: "Who cares?" Mental health depends in part on the answer. By answering the question well, we will know how to answer another question, "Why am I doing this?", whether it is work, a charity work, family or social duties, an act of religious worship. What we do requires a motive, and if we are guided by love for someone outside ourselves, there is a better chance of stability.

As physicians, psychologists, priests, or simply brothers in the common human nature, we have the possibility of communicating in many ways a sincere: "I believe in you, you are not alone". In this way we reinforce the psychological security of others and lay the foundation for discovering and overcoming fears, which we will see below.

**2. Naming fears**

"Why are you scared? Do you still have no faith?" ". We know that verbalizing symptoms is beneficial for psychic health. This requires a healthy introspection, which seeks self-knowledge and assumes some preventive attitudes: for example, not drinking excessively, doing exercise, not isolating oneself, etc., and striving to follow the medical guidelines for healing.

This is a first sense of the word responsibility, from the Latin *respondo*, to bear the burden of one's decisions and actions. This is not often referred to in mental health. The DSM-5 includes a preliminary note explicitly stating that, with the descriptions of illnesses, there is no intention of entering into arguments of responsibility or imputability[4] .

On the other hand, a patient needs to know that not everything that happens to him or her is the result of chance and hostile forces. When attempts have been made to remove any responsibility from the person for his or her symptoms, the clinical results have been worse (W. Vial, 2019). In the end, if everything was by chance, why make an effort to get better, why listen to health professionals?

Knowing how we are and how others are removes fears. Without labeling, it is good to know what traits can cause problems, so as to discover them and name them. Some of these dangerous traits are well known, such as perfectionism, affective instability, pessimism and sadness, insecurity and scruples, victimhood and idealism in judging ourselves or the world.

As we know, there is no clear boundary between "normal" defects and a personality disorder, because normality is dimensional: not everything is black or white. But in the disorder, according to Kurt Schneider, it is more evident: "They are people who suffer and make people suffer" (K.Schneider, 1980).

Often, the patient is unable to give a name to this suffering, he or she does not know why he or she is afraid or why he or she is empty.

The second part of the question "Do you still have no faith?" sheds new light. In reality, any person has a certain faith, because he asks himself for the meaning of his life and of what he does. He can deny God or believe in Him, but he has to find a reason for living.

When Christ puts fear in relation to lack of faith, he teaches us that the human being craves the supernatural. He is, in a way, naturally supernatural, without being entitled to it or to the grace of God. If this is taken as a valid premise, excluding any supernatural element from existence will be detrimental to mental health.

This brings us to a second meaning of the word responsibility, taken from its other Latin root: *respondere*. To respond to someone, to discover a person or super person, who has given us a mission, who has a project for every human being.

[4] Cf. AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), APA Press, Washington DC 2013.

With this super person in mind, it becomes easier to make sense of or name the pain. "Why is this happening to me… and now too? It's not fair, I haven't done anything wrong." So many times we complain in the face of illness or need to comfort the one who does, and we look for a culprit.

Knowing why we suffer is not a task that can be left aside. Since everyone suffers from illnesses, since there is no life without pain, if we do not find some reason for it, we will have to conclude with the tragic statement that existence is meaningless. In that case, we live only by chance or by the whim of hostile forces.

It is difficult to find answers to the questions of this world, particularly to illness. Faith in God helps to interrupt a continual search for culprits. With faith, fears diminish and it is possible to face life with the humility of not knowing everything, of being imperfect creatures of a God who loves us as the best of fathers.

"The key that gives us back our freedom is ours", wrote Edith Eger (2018), a concentration camp survivor. We cannot decide the past, to have an existence without any pain, but we can decide to look to the future and stop being "our own jailers". In this way, fears are annulled and the inner freedom of the spiritually mature person grows.

### 3. A humble attitude that does not deny God

"Who is this, that even the wind and the sea obey him?" This last point reflects the amazement, which led the apostles to discover that Jesus was God. I think wonder is a very appropriate attitude for mental health, although I have not found it mentioned in medical articles.

The universe has surprising rules of operation. Phenomena such as the orbit of the planets, the speed at which the earth rotates, the temperature, the amount of CO2 in the atmosphere or the melting of ice are interconnected and are reflected in some mathematical formulas.

In the face of the order of the world and of nature, it is possible to continue as if nothing were happening, or to be filled with wonder and ask more questions. From this astonishment can be born the commitment to seek an intelligent author, to recognize him as creator and to thank him for the world he has made, for "the common home" as Pope Francis calls it.

But one can also use all that knowledge to achieve power, without worrying about other persons or peoples. It is possible to leave God aside or act from the affirmation of his death, like Nietzsche.

And if the entire universe has rules, the human mind also seems to have them. There is in the person an integrating mechanism based on the coherence of the elements, alignment and absence of overload. Incoherence disturbs mental processes, can cause alterations of rational judgment and psychic illnesses.

*Anima naturaliter religiosa*, the soul is naturally religious, according to Viktor Frankl[5]. A healthy person effectively seeks the meaning of his life, questions himself about pain, death and the purpose of what he does. In the second century another author, Tertullian, said something similar: *anima naturaliter cristiana*. The soul naturally seeks Christ.

Christianity, unlike any psychotherapy, presents each person, healthy or sick, with a model of maturity. Someone to imitate, who is more than a simple reference figure. Jesus Christ presents himself as true God and true man, "the way, the truth and the life" (John 14:6) (E. Colom, A. Rodríguez Luño, 2001). And this "truth cannot

[5] See *V. Frankl*, *Logotherapy and religion*, at https://www.madurezpsicologica.com/en/logotherapy-and-religion/.

impose itself except by virtue of its own truth, as it makes its entrance into the mind at once quietly and with power"[6]

From this follows the logic of a categorical affirmation: "Man can only understand himself starting from God, and only by living in relationship with God will his life be true. However, God is not someone unknown and distant. He shows us his face in Jesus; in his actions and his will we recognize the thoughts and will of God himself"[7] .

The Christian is in a privileged situation to reach maturity and help others, for having received the revelation of God made man. Looking to Jesus, one sees the goal and receives the means to enrich the spiritual dimension, in the unique and unrepeatable unity of the person.

Jesus suffered physical and psychological pain; he experienced exhaustion, thirst, humiliation, anguish and a dishonorable death. And he was innocent. By faith we believe that through his pain he obtained great good for us, freeing us from sin and opening for us the gates of heaven. And that he rose again.

If Jesus was a perfect man, very clever, very good and generous, but nothing more…, then he was an impostor. A human being does not resurrect by himself, does not ask his followers to take up his cross and follow him, to eat his flesh (in reference to the Eucharist), does not revive the dead, does not heal all kinds of diseases with his word and does not expel demons.

That is why we believe that Jesus was God. God can do all this; God can unite his plans to a mystery like that of sorrow. He can say "blessed are those who mourn, for they shall be comforted" (cf. Matt. 5:4).

The question "who is this?" has important consequences. Recognizing God is life-changing, and it is not unscientific to admit that He may exist: the universe and the human mind give hints of his presence. What is unscientific is to deny God a priori. Technological progress and what is happening in the world do not remove the question, for the wonder remains. People need God.

From a psychological point of view, imagining a person who loves us and accompanies us in any circumstance, Jesus, in every past, present or future event, fills us with peace.

If we want to develop our personality and be happy, we cannot just look at ourselves or just listen to our psyche: " Our lives are involved with one another, through innumerable interactions they are linked together. No one lives alone. No one sins alone. No one is saved alone. The lives of others continually spill over into mine: in what I think, say, do and achieve. And conversely, my life spills over into that of others: for better and for worse"[8] .

The Christian is in relationship with all of creation and can reach maturity in and with nature, without becoming dissolved in it. That is to say, he can achieve a healthy realism in the vision of the world and its historical situations, with the conviction that "Christ our Lord still wants to save men and the whole of creation — this world of ours which is good, for so it came from God's hands"[9].

Spiritual maturity lies also in looking at the reality of death, which marks the end of our personal history on earth, with a sense of responsibility: "Faith in Christ has never looked merely backwards or merely upwards, but always also forwards to the hour of justice that the Lord repeatedly proclaimed"[10].

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[6] VATICAN II, Dignitatis humanae, n. 1.
[7] BENEDICT XVI, *Jesús de Nazaret I*, 161.
[8] BENEDICT XVI, *Spe salvi,* n. 48.
[9] J. ESCRIVÁ DE BALAGUER, *Christ Is Passing By*, n. 183.
[10] BENEDICT XVI, *Spe salvi,* n. 41.

The interior life, our personal relationship with God and other supernatural realities that come from the depths of our being as a manifestation of religion, help us to grow. Trust in God leads human beings to a more precise control of their emotions, to a greater tolerance of frustration and to the acceptance of suffering. It is a source of mental health.

This God can never be an excuse for mistreating other people or looking down on them, perhaps because they do not believe, for, as St. John wrote, "If anyone says, 'I love God,' and hates his brother, he is a liar; for he who does not love his brother, whom he sees, cannot love God, whom he does not see" (cf. 1 John 4:20).

In short, there are two possibilities: to affirm God or at least to seek him, or to find a substitute. When the main source of security ceases to be God, when faced with the question "Who is this," we content ourselves with thinking that he is only a powerful man. This path can lead to putting oneself, or another person or thing, in the place of God, and drowning.

**Conclusions**

The concept of spirituality is very present in psychiatry and general medicine, as a factor that improves prognosis. The references are usually pragmatic, about the comfort given by a religious leader, a reason to go on living provided by religion, or the serenity of believing in a new life after this one (P.W.Sanders, G.K.Allen et al,2015).

Less frequent is the mention of the real existence of a God who is close and father of all. Pastoral theology, with the experience of spiritual accompaniment, shows that faith well lived, which puts love of God first and love of others as oneself second (cf. Matt. 22:37-39), is a preventive factor that improves the prognosis.

In any case, regardless of whether or not one has a faith or religion, one needs to answer the questions that we have asked. Those who suffer need to know "who cares". On the answer depends their capacity to rise from their wounds, or resilience, and their hope. They also need to give a name to their fears, and to be amazed before the world and others.

Focusing on spiritual maturity leads to another conclusion that I consider important for mental health. The need to rediscover the person, to focus on him or her, rather than on his or her personality or way of being. This makes it easier to bring out the positive in each person.

This implies going out of oneself, putting into practice the human capacity for self-transcendence towards God and others. Spiritual maturity leads to discovering that, as Kierkegaard wrote, "the door to happiness does not open inward (...), but outward" (S.Kierkegaard, 1983).

Let us return to the image of the boat in the storm, and see humanity in it. But let us not imagine a ship alone and adrift. Let us listen to the advice of St. Augustine, and let us be filled with the hope and faith that overcome fears: "Christian, Christ sleeps in your ship: wake him up; he will give order to the storms so that all may be calm again. (...) What is it to wake up to Christ? To awaken faith, to remember what you have believed. So remember your faith, awaken to Christ. Your same faith will give orders to the waves that disturb you and to the winds of those who persuade you to evil and they will disappear at once"[11] .

[11] ST. AUGUSTINE, *Sermons* 361, 7.

**Feeling of guilt – normal and pathological – in pastoral practice**

**Abstract:** The feeling of guilt can be both normal, natural, and pathological, which can manifest itself in the development of various mental disorders. In pastoral practice, dealing with guilt is challenging because the line between natural and pathological guilt is very thin. Working with the natural feeling of guilt requires relatively less effort and can be limited to psychocorrectional approaches, and only in some cases is it necessary to refer the person to a spiritual counselor or psychotherapist. Pathological feeling of guilt can usually be addressed through detailed psychotherapeutic interventions, which are the focus of this report.

**Keywords:** types of guilt, normal guilt, pathological guilt, psychotherapeutic treatments of guilt.

Guilt is a complex moral emotion. It is defined as a feeling of worry or unhappiness that a person has because he/she has done something wrong, such as causing harm to another person (Cambridge Dictionary). It is characterized by a feeling of remorse, responsibility of doing something wrong and self-blame. Guilt occurs when somebody does something perceived as wrong, unethical or harmful. When somebody violates his/her own moral or ethical standards, the person can have the feelings of guilt.

Guilt may arise out of real or imaginary situations. For example, if a person has really harmed or hurt another person, the doer can experience guilt. Guilt can also be a natural response to one's own actions or decisions. It can be an imagined or perceived guilt, when a person commits a mistake against his/her own moral or ethical standards. It can also be perceived when the individual is not able to rise up to his/her own standards of expectation. Another occasion of advent of guilt is when the person overestimates one's own role in the situation. Guilt is also seen in various forms in different psychiatric disorders.

Types of Guilt:

- Natural Guilt – if someone genuinely does a mistake and feels bad for that, it is called natural guilt. It is normal and adaptive. It motivates the person for adopting beneficial changes.
- Survivor's Guilt – it develops in someone who has survived a life-threatening situation. There are two major components in survivor's guilt: guilt that he/she survived when others died, and that he/she could have done something more to save the lives of others.
- Personal Guilt – this guilt occurs when a person believes or realizes (accurately or not) that he/she has compromised his/her own standards of conduct, or has violated universal moral standards and bears responsibility for that violation.
- Catholic Guilt – this is a generalized feeling of excessive irrational guilt associated with Catholics, as and when they are not able to follow religious preaching imperatively. It leads to the belief that they are all sinners basically and require repeated correction or religious rituals to attain sanctity.
- Social Guilt – social guilt is induced by social norms and expectations. They are gender based and discriminatory in origin. It varies from culture to culture. Example – role of a mother.
- Compulsive Guilt – persistent excessive experience of guilt leads to compulsive guilt. The people are unable to ignore these thoughts. The thoughts accompanying the emotion of guilt are usually intrusive and discordant with their own moral code.

**Features of Pathological Guilt**

Pathological guilt can be a psychiatric condition. The subjective experience of guilt is excessive and irrational. It affects the overall functioning of the individual and weakens him/her. The situation can become overwhelming and persistent. The feeling of guilt is generally disproportionate to the actions or decisions taken by the individual. The individual starts to give unnecessary importance to minute details and intensify his/her emotions.

Pathological guilt can be a symptom of grief, OCD, severe depression, PTSD, anxiety disorders, borderline personality disorder, dependent personality disorder, delusional disorder/psychosis and so on.

**Difference between Normal Guilt and Pathological Guilt**

| | *Normal Guilt* | *Pathological Guilt* |
|---|---|---|
| 1 | Adaptive emotion | Maladaptive emotion |
| 2 | When a person does something against his/her moral values | Unrelated to any wrong doing |
| 3 | Normal/common or manageable emotional response | Excessive and irrational |
| 4 | Proportionate to situation or outcome | Disproportionate to the situation or outcome |
| 5 | Temporary and diminishes as the individual makes amendments or learns from experience | Triggered by minor or non-existing transgressions |
| 6 | | Chronic and persist for a long period of time |
| 7 | | Interfering with daily life |
| 8 | | Symptom of underlying mental health condition |

**Signs of Guilt**

Guilt is manifested in different forms in the individuals undergoing guilt. Anxiety, crying spells, insomnia, muscle tension, rumination, regret, stomach upset and worries are some of the signs of guilt. He/she may seek reassurance repeatedly and may do activities to reduce the intensity of guilt. Many people find resort in religious/spiritual rituals, while others end up in vicious circle of guilt and other negative emotional states.

**Grades of Guilt**

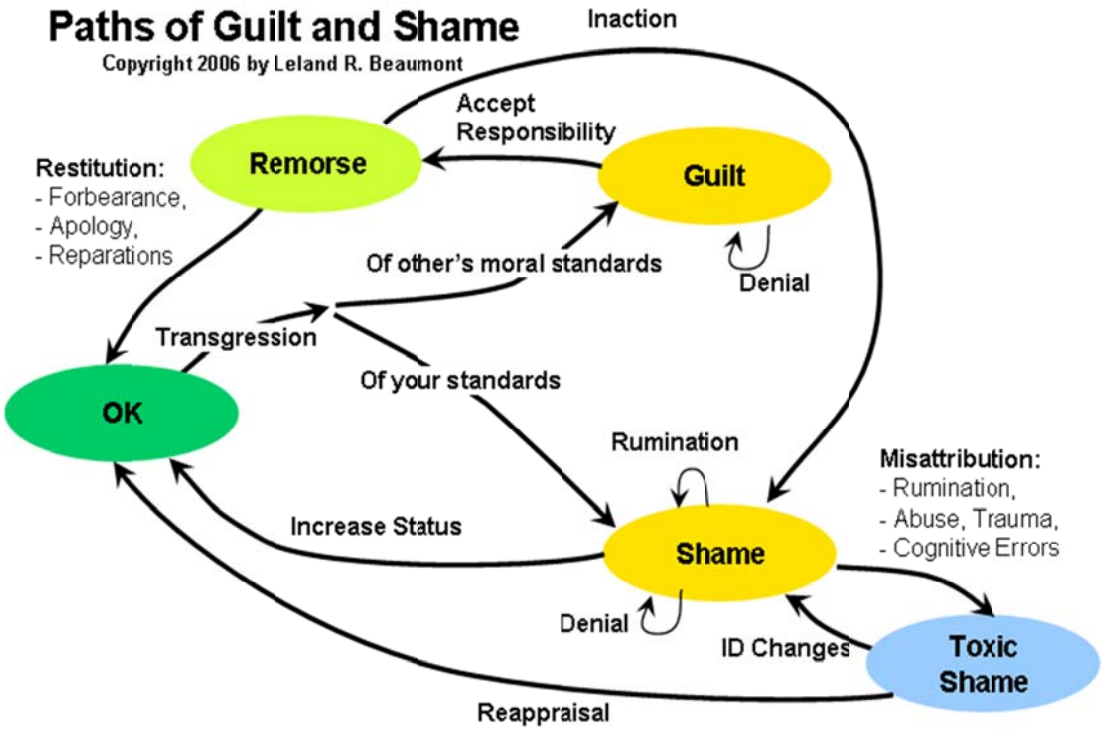
Guilt can be found in varying intensity as in the case of pain. Even though it is difficult to fathom the quantity of pain and guilt, both are quantified on the basis of a graded scale. The continuum of guilt categorizes it into three variants of increasing intensity – helpful guilt, unhelpful guilt and shame. Demarcating the subtle boundaries between the three categories helps us to control self-criticism and reject shame messages.

- Helpful Guilt – this is the feeling of discomfort about something that we have

done objectively wrong. Cause for this guilt is breaking of objective moral standards. This leads to forgiveness seeking and self-correction. Healing occurs when self-correction is achieved. This is regarded as positive as it is beneficial for the future life adjustments.

- Unhelpful Guilt – here, feeling of discomfort is about something we have done against our unrealistic high standards. Origin of this level of guilt is breaking an impractical high standard. This leads to self-punishment and entrapment in guilt. Healing and positive behavioral change does not occur until the person escapes this state of mental block. This condition is observed as negative as it is not favorable for future life adjustments.
- Shame – shame is an intensely painful feeling of being fundamentally wrong, surpassing the actions we do or decisions we take. It arises out of innate sense of worthless or being defective. The person's confidence breaks and he/she refuses trial bringing about a change. This leads to fear of rejection, self-isolation, deeper mental health issues and substance abuse. The person withdraws himself/herself to avoidance of similar circumstances and this state is considered as negative.

**Paths of Guilt and Shame**




The above diagram represents the state-transition diagram, explaining different phases in the development and consolidation/resolution of guilt and shame. Each bubble represents a state of being and labels represent actions or events.

OK: this is the beginning or neutral state when a person is free of guilt.

Transgression: a failure to meet individual's own standards of behavior; a dissatisfaction based on self-assessment or a decrease in stature leads to shame. Failing to meet the moral standards of others leads to guilt.

Rumination: dwelling on the transgression, blaming self, focusing on errors, and replaying mistakes over and over in mind can be carried too far.

Denial: this is the behavior of refusing to take responsibility for one's actions or

decisions.

Misattribution: this is a type of cognitive error in which the individual blames himself/herself for events he/she does not have any control and he/she becomes upset over things he/she cannot change.

Toxic Shame: this is an intense, personal, and private pain based on blaming oneself incorrectly, unjustifiable, or unreasonably.

Reappraisal: during this process, the individual thinks again, more clearly, rationally, and realistically about what he/she is blaming herself/ himself for and derives a new meaning.

Identifying Changes: after the reappraisal, the individual identifies changes he/she wants to make in his/her life.

**Neuropsychology of Guilt and Shame**

While experiencing guilt, neural activity is observed in the limbic system and frontal lobes – more precisely in prefrontal cortex and amygdala. During an event of guilt, the fear response generated by the brain is predominantly fight. Focus is turned towards action as the subject perceives more control on the surroundings. Hormones like cortisol, adrenaline, oxytocin and DHEA come to play and the individual benefits from the experience.

Shame is a more complex emotion, determined by broad cultural and social factors. High neural activity in the right hemisphere is found during the experience of shame. As shame is triggered by the feeling of incompetence, the fear response generated is predominantly submission/fawn, instead of fight. This activates stress hormones leading to overwhelming anxiety.

Repetitive destructive beliefs (faulty belief that I cannot change the situation) lead to repetitive destructive behaviors (such as excessive drinking) in order to block out the overwhelming feelings of shame which in turn culminates in repetitive destructive beliefs. This vicious cycle is called shame cycle.

Excessive chronic guilt and shame result in habitual self-monitoring and self-condemnation which sets stage for depression, anxiety, resentment, anger and suicide.

**Pastoral Care**

Dealing with guilt in pastoral practice is challenging as a delicate line divides the natural and pathological guilt. Managing natural guilt is comparatively less demanding and can be done without any psychotherapeutic treatments. Steps involved in managing natural guilt are active listening, spiritual guidance and directing religious rituals to reduce or resolve guilt. First step should be done in a non-judgmental fashion, facilitating at most expression of feelings. Spiritual guidance is given by helping the individuals to explore spiritual and ethical dimensions of guilt by using religious scriptures, beliefs and tradition. During the next stage, religious rituals such as confession, repentance, Holy Communion, prayer and meditation are suggested to reduce the intensity of guilt or to resolve it. Importance of forgiveness can also be explained. Counseling and psychotherapy referral can be done if the guilt persists for longer duration.

Pathological guilt can be addressed in detailed psychotherapeutic interventions, discussed in presentation.

*Priest Dayavosh Azizyan Ali Komi*

**The role of prayer in supporting people with mental disorders**

**Abstract:** One of the key concepts in the field of mental health is "psychological safety", which implies a state in which a person feels protected, safe at the level of his emotions and thoughts, is not afraid of punishment and humiliation, calm and cheerful. The lack of "psychological security" causes serious damage to psychological health in general. Believers know from the Holy Scriptures that this can be achieved through a sincere connection with God, giving Him their thoughts, feelings and actions. Prayer helps to hear the Lord's instructions and understand His guidance. Prayer, as a means of communication with God and other people, establishes the right relationship between a person and the Creator. A well-directed spirit promotes the development of the ability to control oneself by overcoming one's illnesses.

**Keywords**: psychological safety, prayer, spiritual nature of a person.

"Come to Me, all who are weary and heavy-laden, and I will give you rest. Take My yoke upon you and learn from Me, for I am gentle and humble in heart, and you will find rest for your souls. For My yoke is easy and My burden is light." (Matt. 11:28-30).

One of the key concepts in mental health is the concept of "psychological safety", which basically brings about a good and pleasant sense of life to the person. This simply means to have a tranquil mentality, away from any fear of punishment and humiliation. The lack of this can lead to a loss of meaning and purpose in life, and it can seriously harm one's psychological health overall.

Tranquility and liveliness result from reaching psychological safety and self-confidence. As people of faith, we learn from the Scriptures that one can only reach this point by being truly connected to God, allowing Him to guide our thoughts and allow only Him to judge our emotions, behaviors, and thoughts. "Peace I leave with you; my peace I give to you. Not as the world gives do I give to you. Let not your hearts be troubled, neither let them be afraid", says the Lord. (John 14:27).

The subconscious is the home of one's instincts, motives, fears, drives, taboos, and negative thoughts that one faces, consciously or unconsciously, from their conception. However, as people are unable to face, solve, or answer many life issues, these things get stored in the subconscious and end up controlling most of their actions. This plays an important role in shaping one's personality.

So, in a way, the underlying reason for much of our behavior and actions is beyond our control and awareness. We are surprised again and again by our actions and behaviors in our daily lives, and at times, we can't even explain our behavior. Sometimes, the more we try to understand our behavior, the further we get from finding concrete answers. We often understand our behavior based on our education and life experiences. However, sometimes, in different situations, looking back and introspecting surprises us even more, as we can't find a reason for certain behaviors in our education or life experiences!

So, people often find themselves to be strange, complicated, and quiet unknown. The Gospels demand us to do certain things and observe certain ethical standards. However, in many cases, we don't do what we think is right or want to do, and we do things that we later consider wrong and regret.

Paul, the Apostle, speaks about the same experience in Epistle to the Romans. He writes: "For I do not understand my own actions. For I do not do what I want, but I do the very thing I hate" (Rom. 7:15). Having mentioned this, Paul seeks a theological explanation for this. His answer is rooted in his experience of divine revelation. His solution to this issue is also based on the saving act of God through Jesus Christ.

In his letter to Thessalonians, Paul the Apostle, writes: "Now may the God of peace himself sanctify you completely, and may your whole spirit and soul and body be kept blameless at the coming of our Lord Jesus Christ" (1 Thess. 5:23). The picture that Paul describes in this verse is a picture that has been expressed in different ways in the Scriptures. He talks about the spirit, the soul, and the body.

The human spirit is the foundation of man's spiritual nature, which allows him to connect with God. Through the sacraments of Baptism and in the act of repentance, and the spiritual experience of rebirth the human soul can be born anew, establishing a new relationship with God that was damaged by sin and the Fall. The physical body is another part of a person, which enables them to exist in the world. It is through this body that a person experiences the material dimension of life. And the third part is the self, or ego.

Even though these three parts are studied separately, they influence each other closely and form one whole person. In the Fall, the spiritual bond between man and God was broken, affecting his whole being. His body was plagued with diseases, and sin and evil reigned over him. Through the Holy Baptism, humans experience a new relationship with God. The reign of sin comes to an end, and the Holy Spirit resides in humans, dominating their entire existence.

Thus, one can investigate illnesses and mental problems in Christians, as their bodies and minds can become sick. In fact, if an adult has converted, they might have been affected by certain problems in their childhood or previous stages of life, and therefore may already have mental issues. Not dealing with these problems after conversion can lead to even more mental and emotional issues later on.

Despite this, the Divine Grace is an undeniably active part of the Christian life. If a Christian utilizes the resources that God's Grace provides him in his Christian life, his entire being may be transformed, and this can help him solve his psychological issues.

One can refer to the instincts (or movements) of the Holy Spirit, meditation on the Sacred Scriptures, spiritual reading and spiritual guidance, and, above all, participation in the sacraments of the Church as some of the main divine helpers whose role should never be denied in treating a mentally ill or depressed Christian believer.

Prayer is the essence of the Christian journey with God. Prayer connects us to God. It is also a way to connect with others and to love them. The Scripture says, "pray without ceasing" (1 Thess. 5: 17). In this sense, any activity or thought that blocks our relationship with God and moves us to be self-referential (rather than related to God) is sinful and harmful to human person as it negates his true mening of life as a spiritual being.

1. Adam and Eve's act in the Genesis chapter 3, can be considered a lack of prayer (note that prayer is dialogue and relationship with God). They ate the fruit of the Tree of Knowledge of Good and Evil, and they felt ashamed to speak to God, who had come to the Garden looking for them. Sin separated them from God and prevented them from connecting with Him. Adam and Eve's failure to pray (relationship and dialogue) was sin and the cause of sin and the beginning of the problems in the nature.

Can you imagine a person who claims that he is your best friend but has never talked to you? If yes, it means that your friendship has been very dark and full of tension. In the same sense, relationship with God, without any socialization with him, is weak and meaningless. There is no good relationship with God without prayer. Children of God, by their very nature, are inclined to relate to God: "O Lord, in the morning you hear my voice; in the morning I prepare a sacrifice for you and watch" (Psalm 5:3). The Scriptures encourage us to pray and following this order will lead to many blessings: "The Lord is near to all who call on him, to all who call on him in truth." (Psalm 145:18).

Christ is the example of a person who prays all the time. He prayed a lot (see Luke 3:21, 5:16, 9:18 & 28,11:1), and told his followers to pray (Luke 11:2-4). If Christ needed prayer, then how much more does a faithful Christian need it?

2. Life without prayer ignores the Healing Grace of the Holy Spirit. We have been asked to pray for the Christian brothers and sisters (Jacob 5:16). Paul the Apostle always asked the others to pray for him (Eph. 6: 19, Col. 4: 3, 1 Thess. 5:25), and he also prayed for others (Eph. 1: 16, Col. 1:9). When our life is without prayer, in fact, we ignore and disobey God's commandment to love others: "First of all, then, I urge that supplications, prayers, intercessions, and thanksgivings be made for all people" (1 Tim. 2:1). The Lord says "But I say to you, love your enemies and pray for those who persecute you, ..." (Matt. 5: 44). Jesus' message is that we should show love and support to everyone, even those who may not seem lovable.

3. Prayer makes us hear God's constructive guidance. Life without prayer weakens our hearing sense to Jesus Christ. The letter to the Hebrews 12: 2 reminds us that Christ is the booster and fulfiller of our faith. In the absence of the Holy Spirit, one can easily fall into the trap of self-criticism and self-judgment, focusing on worldly self-improvement. It is when one says" May your Kingdom come, may your will be done on earth as it is in heaven", that he is confronted with the incompatibility and conflict between his sense of healing and Divine healing.

Matthew 26:41 warns us that: "Watch and pray that you may not enter into temptation". Avoiding prayer leaves the heart open to temptation and can lead a person to deeper sin. We can only act wisely when led by the Holy Spirit. Our prayers are only fruitful and effective when we rely on the power of the Holy Spirit to guide us.

"In the same way the Spirit also helps our weakness; for we do not know how to pray as we should, but the Spirit Himself intercedes for us with groanings too deep for words; and He who searches the hearts knows what the mind of the Spirit is, because He intercedes for the saints according to the will of God" (Rom. 8: 26-27).

In this sense, one can see that prayer, as a way to relate to God and the other, weather neighbour or the enemy, puts the human person in the right relationship with the Creator. The relationship that, in Paul's terms, we might call "justification". It allows a person to direct their whole being towards God. This will certainly not be the cure for a psychologically ill person, but will certainly affect him positively. A rightly directed spirit helps the body and mind to direct themselves correctly and heal from illnesses.

*Priest José Antonio Fortea Cucurull*

**Psychiatry and pastoral care: analysis of a complex case**

**Abstract:** This report presents a case from pastoral practice when, following a spiritual vocation, a girl entered a convent, but a few weeks later she developed a depressive state, which gradually worsened and, apparently, required medical intervention. Despite the advice of the confessor to leave the congregation due to fears for her life and health, she, in obedience to the abbess, nevertheless remained in the convent. On Easter Sunday, her mood changed dramatically. She felt a wave of joy and happiness fill her, and it continued throughout the year. From this story, we can conclude that the Lord is the master of the laws of nature, He has the power to heal any illness despite the natural laws.

**Keywords:** monastic life, depression, connection between the natural and the supernatural, the will of God.

I would like to share with you one of the most challenging cases I have encountered in my role as a priest, providing advice, counseling, and spiritual guidance to all those who have asked for my help.

The story of the nun that I'm going to share with you - I have permission to do so, because years later, I asked her: "I think your story at the beginning of your religious life is one of the most interesting stories I've heard. Do you mind if I share it with people at conferences and talks?" And she gave me permission.

This is the story of a nun. At that time, she was a young woman who had just completed her studies at university and had a successful career in the world. I was her spiritual father. We discussed whether she might have a spiritual vocation, specifically a vocation to a contemplative convent.

When she finished her university studies, filled with devotion and a desire to offer herself to Christ, she joined a convent that I knew well. It was a very strict place, where they lived completely separated from the world, in extreme poverty and cold, with simple food and a lot of prayer. She entered the convent, but from the beginning, there was no comfort or joy. Only desert, darkness, and the silence of God. Weeks passed - one, two, four, six…Still no joy, still only desert. She asked me if I thought she had a vocation for this order and this house. I said that I preferred for her to come to her own conclusion. I suggested that she go to her prayer time and she would find out for herself. One month and two weeks after she entered the convent, she said that she thought she didn't have a vocation there.

I agreed. A lot of times I reach to the same conclusion, because to enter a religious order, you need joy and enthusiasm for it to be fulfilling. You can't enter a convent only with darkness, loneliness and lack of joy all the time. Then I said, "The sooner you leave this house, the better." But she spoke with the superior (she was a very good woman with many virtues, lots of prayer and lots of experience due to her age). And superior told her, "No, I assure you that you have a vocation. I assure you that you belong in this house."

The novice obeyed her and time began to pass. I insisted on my position, saying, "It's your choice." But a new problem started to arise - sadness week after week. I became very worried, because I saw clearly that depression was beginning. All the signs of depression were there. I insisted, "You have to leave this house. Depression is beginning in you. This is not about virtue or offering our suffering to the Lord. It's about you having a disease, And it can grow to a level that you cannot manage." She continued to obey her superior, and the depression grew larger and larger every week.

More than two months after she entered the convent, my worries were at their worst. It was not just depression. If she continued to stay there, she would suffer from major depression. I told her that the problem would be that she would not be able to get out of bed. But she continued to obey the superior.

I insisted that if she left the house, she would need professional help and medication because she was in the middle of a depression.

The superior told her to stop talking to me. One day, she told me it would be our last conversation. And it was.

Not only that. The superior also spoke with the bishop. The bishop told me one day that she had spoken with him and he told me: "Stop, let this vocation go to the superior."

What could I do? I couldn't break into the convent by force. I didn't speak with the novice for more or less a year. One day, she called me on the phone and said she wanted to talk to me." She told me that during our previous conversation, she insisted: "I would like to stay, at least until Easter, in this convent. Please let me finish Lent." I said at the time: "You don't have the strength to resist until Easter. You need to leave now."

Our conversations stopped, and then she told me: "The first day of Easter, Easter Sunday, my soul flourished again. I felt filled with joy, spiritual joy, and happiness that completely overwhelmed me. That happiness lasted more than a year, even though there were times of desert and darkness."

I was in the church for the ceremony - she gave temporary vows. I saw her face full of joy, and it was clear that it was a mystical experience.

In the following years, I talked with her at least once a year and we analyzed what had happened. We talked, and I said, "I think I did the right thing. I think my judgment was correct - you were suffering from depression in a very serious form. What happened then?"

After analyzing myself, I came to the conclusion that my intuition was right. We have to obey the laws of psychiatry because there is a relationship between the natural and the supernatural. The supernatural does not violate all the natural laws, but it is in harmony with them.

We, priests, have to submit to those laws. However, in this particular case, I received a lesson: you did well and did the right thing, but I am the Lord, and I can do what I wish. In this case, I pushed her soul beyond the natural limits, even beyond the natural limit. You were her spiritual father, and she had to offer everything, even your help, but her loneliness was complete, isolated even from your counseling.

**Conclusion**

We, priests, have to recognize the connection between natural and spiritual phenomena. Imagine a person who says, "I have received a revelation from God. I can fast for a day, a week, or a month, and the Lord will sustain me." If I knew this person, his spiritual journey, and he is not a fool, his mental health was sound, I would suggest, "OK, let's try it, but when signs start to appear that indicate possible harm to your health, we should stop." There are signs that indicate your health is at risk. "

"Yes, but there is a revelation..." "Yes, right, but we have to submit to the laws of nature. We've tried, but now is the time when we need to intervene."

That's true for the body, and the same could be said for the mind. We do have a spirit, filled with light and treasures from heaven. But the mind works according to the laws of nature. As priests, we need to understand that we can't just say "No, it doesn't matter".

This lesson from heaven was very interesting for me.

The conclusion is - God is law, and He can do anything He wishes. However, at the same time, I understood very clearly that I did wright, my conclusion was wright.

I'm glad to have shared this episode in my life with you. I hope that it can help someone in a very complex case of that kind.

*Nasr Victor Sami Michael*

**Role of the Coptic Orthodox Church in mental health promotion**

**Abstract:** About 5000 years ago, the ancient Egyptian civilization during the time of the Pharaohs, believed in a three-part concept of the human being: the body, the psyche, and the soul; already at that time, they described symptoms of various mental illnesses. The Holy Family found refuge in Egypt after fleeing from King Herod, and Egypt later converted to Christianity. Today, the Coptic Orthodox Church provides various social services, including assisting those suffering from mental illnesses, combating stigmatization of these illnesses, and raising public awareness about their causes and treatments through education and media. The Church maintains rehabilitation centers and hospitals for different categories of people with mental illnesses, nursing homes for patients with Alzheimer's and other diseases, and provides psychiatric services for prisoners. Researchers from the Coptic Church conduct academic work on addiction, behavioral disorders, and mental health issues in children and teenagers.

**Keywords:** Coptic Orthodox Church, the Church as a "therapeutic community", dissemination of information about mental disorders, prevention and treatment of mental illnesses.

I came from Egypt, the land of history – Egypt was even there at the beginning of history. The Pharaonic civilization started 5000 years before Christ. It was at that time that our old grandparents, the Pharaohs, discovered the psyche. They believed in eternal life and saw the person as being composed of three parts (the *Ba*, the *Ka*, and the *Kha*): the body, the psyche, and the soul (*Ka* is a letter in the form of a person with his arms lifted towards heaven). They mummified the body, they symbolized the soul by a great living bird (Eagle), that flies and comes back to visit the body, and the psyche by a person that is standing beside the body raising his two arms upwards, waiting for the time of the last exam – the judgement day.

Our Lord Jesus Christ blessed Egypt when the Holy Family fled from King Herod. “When Israel was a child, I loved him, and out of Egypt I called My Son” (Hosea 11: 1). They returned home to Palestine after three years and two months, and later, Egypt changed its religion to Christianity. “How God anointed Jesus of Nazareth with the Holy Spirit and with power. He went about doing good and healing all who were oppressed by the devil, for God was with him” (Acts 10: 38).

Our Lord Jesus Christ was moving doing good things: “Jesus went throughout Galilee, teaching in their synagogues, proclaiming the good news of the kingdom, and healing every disease and sickness among the people.” (Matt. 4: 23). “The blind receive their sight and the lame walk, lepers are cleansed and the deaf hear, and the dead are raised up” (Matt. 11: 5). “Then they brought him a demon-possessed man who was blind and mute, and Jesus healed him” (Matt. 12: 22). He took care of the insane people (the mentally ill, he freed and healed those who were addicted to sin.

In our liturgy we pray: “As for us also, O Lord the maladies of our souls, heal, and those of our bodies too, do cure. O You, the true Physician of our souls and our bodies, the Bishop of all flesh, visit us with Your salvation” (Liturgy of St. Cyril - St. Kirellos Mass of Coptic Orthodox Church).

In 2022 the World Health Organization stated that

- 1 in every 8 people in the world live with a mental disorder.
- Mental disorders involve significant disturbances in thinking, emotional regulation, or behaviour.
- There are many different types of mental disorders.

- Effective prevention and treatment options exist.
- Most people do not have access to effective care.

The Coptic Orthodox Church pays great attention to the well-being of everyone. We consider the church to be a “therapeutic community“, that takes care of each single individual from all aspects: body, psyche and soul. His Eminence Metropolitan Serapion before being ordinated to be the metropolitan of Los Angeles, was the Bishop of Bishopric of Public, Ecumenical and Social Services (BLESS) (1985- 1995). He initiated different programs that introduced integrated services regarding health education and development, Among them was the first anti-drug program in Egypt and in the Middle East - “The Best Life Anti-Drug Program“ that is dealing with the problems of addiction from all its aspects:

1- Primary prevention, by raising awareness among priests, social leaders, families and target groups working in all dioceses, using pamphlets, booklets, lectures, intensive training courses.

2- Secondary prevention, that means early detection and prompt intervention and treatment, through different outreaches that receive the addicts and their families, preparing the addicts to go through the suitable program.

3- Tertiary prevention, aiming at prevention of complications and deterioration, by providing rehabilitation (physical, psychological, spiritual, vocational and social) to individuals at the first “Therapeutic Community“ in Egypt.

The program was a pioneering one, and it was a great model that was introduced to the community. It helps a lot of families and their children.

Nowadays, most churches in different dioceses replicate local programs, including halfway houses, such as the “Clever Son” program in Alexandria. The Coptic Orthodox Church is helping in fighting the stigma against mental illness by raising awareness about its nature and its treatment, through different institutes i.e. the Institutes of counseling (Maady, Dokki etc.) in different parts of Egypt; the Institute of pastoral care & education. The students of these institutes are mostly priests, Sunday servants, social leaders. They play an important role in changing the wrong concepts of mental illness. Some of these students continue their studies in order to learn how to provide assistance and participate in the management process.

The Church has also developed special places for children with mental health issues. Elfolk ("boat") is an example of this, taking care of children with problems such as mental subnormality and autistic spectrum disorders. The church also has different places for people with conduct disorder, delinquents, and adolescents with psychological issues.

- The Coptic Orthodox Church also pays attention to couples during the engagement period, newlyweds and parents to raise awareness about mental illnesses and their prevention.
- Most local churches today have facilities for the elderly (geriatric homes), which serve seniors with Alzheimer's disease and other forms of dementia and psychological issues.

Special psychiatric services are also offered to prisoners who suffer from various mental illnesses through regular visits from priests and a team of professionals, including a consultant psychiatrist. “I was in prison, and you visited me” (Matt. 25: 36). The Coptic Orthodox Church also plays an important role in raising awareness about mental illness through Christian TV channels.

Regarding the research work at academic institutions, researchers have begun to consider psychological aspects in their studies. This is reflected in the Master's and PhD theses they are writing. Before I came to Moscow, we were preparing a protocol regarding a thesis at one of the institutes that would be in collaboration with the Russian

Orthodox Church. In the future, we plan to expand this collaboration to include other churches, focusing on the psychiatric aspect and mental health.

A significant event was the visit of Professor Ahmed Okasha, former president of the World Psychiatric Association (2002-2005) and advisor to the president of Egypt on community integration, who paid a visit to His Holiness Pop Tawadrous II to discuss the role of the Coptic Church in promoting mental health services.

In conclusion, I would like to emphasize that although a lot of work still needs to be done in this area, a good start has been made and we are committed to continuing our efforts.

**Delusions of guilt and suicidal behavior in depressive-delusional psychoses in patients with a religious worldview**

**Abstract**: The study of depressive-delusional states, which are characterized by delusional thoughts of guilt, sinfulness, and self-blame, remains relevant due to their high prevalence and difficulties in diagnosis. The dynamics of such conditions' development in the form of aggravation of depression often go unnoticed. At the same time, depressive-delusional psychoses can have a significant impact on the life of a believer due to possible changes in behavior and the development of suicidal tendencies. Due to the peculiarities of the clinical pattern and the specificity of these psychopathological disorders, timely recognition of such conditions plays an important role for both doctors and pastors who care for religious patients.

**Keywords**: depression, depressive-delusional psychoses, delusions of guilt, suicidality, religious worldview.

Guilt and sinfulness are two of the most fundamental and closely related experiences for a believer in Christianity, and especially in Orthodoxy (T.P. Gavrilova, 2011; A.V.Lorgus, O.M. Krasnikova, 2010). In many Orthodox prayers and psalms, the awareness of one's sinfulness and the call for mercy are expressed. In the Jesus Prayer, a repentant appeal to God is the main and essential core of the prayer: "Lord Jesus Christ, Son of God, have mercy on me, a sinner" The righteous saints addressed God with similar words. Thus, St John of Kronstadt addressed God: "Lord, I am a sinful man, have mercy on me!"

Guilt and sin are not equal concepts, but in the believer's mind they are inextricably linked. As the priest and Orthodox psychologist A. Lorgus (2010) notes, "three feelings of guilt haunt a person in life - from the first and vague experiences of his "I" to the last breath: a sense of real guilt, irrational guilt and existential guilt ... The feeling of guilt differs from the feeling of sin in its inner intimate essence. When a sense of sin appears in a person's experience, it leads to a change in the personality structure. A special layer of personality is being formed — the attitude to one's own sinfulness, sins; the relationship with one's conscience, with God." "The feeling of guilt and the feeling of sin do not coincide, first of all, in that the feeling of guilt is an attitude to oneself, to one's act and thought as a part of self, and the feeling of sin is an attitude to something else, alien. And the feeling of guilt can either turn into a feeling of sin if it is a genuine feeling of sin, or remain if it is an irrational feeling of guilt, or if the person does not have the practice of repentance."

As depression develops and the condition worsens, the feeling of guilt, which is one of the key experiences, is transformed into delusions of self-accusation - the patient's unshakable conviction that he has broken or is breaking the Church canons, has committed sins for which it is impossible to receive forgiveness. So, back in the XIX century, religious melancholy, described by the German psychiatrist W.Griesinger (1871), included a state of mental depression combined with religious delirium of grave sin, fear of hellish punishments, curses by God. The patient may be convinced that his actions or inactions caused some negative events: the illness of relatives, children, the death of parents, collapse of enterprises, spread of epidemics, wars, approaching death of mankind or the entire universe. The latter experiences are characteristic of the so-called depressive-paraphrenic states, in which delusional disorders acquire a megalomanic character. In religious patients, depressive experiences are often accompanied and manifested by special, qualitatively different than in a healthy person,

experiences of their own sinfulness, a sense of God-abandonment, doubts about their own faith, which are obsessive or even delusional in nature.

Currently, the group for the study of special forms of mental pathology of the SCMH is conducting a study of depressive-delusional states with delusions of sinfulness (85 patients). It was found that religious delusions of sinfulness were registered both in affective disorders (26 people, 30%), and in schizophrenia and schizoaffective psychoses (59 people, 70%).

At the initial stages of the depressive state development, patients were dominated by a dreary affect, ideas of self-abasement, self-accusation often related to domestic matters. The patients felt guilty towards their relatives and friends, guilty of lack of attention to their relatives and in raising children, that they could not provide them with proper support and education. The ideas of self–accusation were combined with religious ideas of sinfulness - the patients considered themselves "bad Christians", were convinced that they had broken the commandments of God, with their thoughts and actions, for example, desecrated shrines by not being able to focus on prayer during the service, "could not resist the temptations of Satan" by thinking badly about a loved one. At the same time, there was a discrepancy between the severity of the "offense" and the feeling of total sinfulness, which did not leave a person after repentance, confession or conversation with a priest and communion. A feeling of despair and a persistent conviction remained that he could have neither leniency nor forgiveness from both people and God himself.

As the depressive state worsened, the ideas of sinfulness developed into a persistent delusional belief that because of patient's sins, loved ones and people around could suffer, i.e., the ideas of sinfulness began to expand, and suicidal thoughts associated with them spread to loved ones. In the future, the ideas became more massive, megalomanic (the patient faces a well-deserved "punishment with hellish torments", humanity may suffer because of the patient's transgressions, etc.). At the same time, delusional ideas of meanings with an alarming affect arose: the patient began to "see" the "signs" around, highlighting his "sins". He noticed from the behavior of others that they were aware of his “sins” and condemned him for them. The patients called themselves "great sinners", said that they "deserve God's punishment", and at the same time sought ways to atone for their sins: they repeatedly attended church services, often, sometimes daily, confessed, fanatically observed various church rules even against the advice of priests. The phenomena of depressive-delusional depersonalization, represented by ideas about irreversible changes in personality, which affected the entire spiritual sphere, could be added to the existing disorders. Patients described such experiences as "rotting" or "loss of soul." They said that their hearts were "dead to faith", they were "spiritually damaged", that they had already "died alive", "went to hell alive", felt as if they were "decomposing mentally", and this was a consequence of their sinfulness. Thus, it was the formation of a religious nihilistic delirium, reaching the level of Cotard's delirium. Some patients considered themselves to be the culprits of the coming apocalypse, which they associated with their own sinfulness, were convinced that they would suffer forever for their sins (Ahasuerus's delusion) (E.V.Smirnova, 2023).

Based on the analysis of the patients' experiences, distinguishing features of delirium of guilt and sinfulness from the normal feelings of guilt and sin in a believer were formulated, which are as follows:

1. Patients feel the absoluteness of their sins, covering their entire existence.
2. All actions of the past are revaluated in context of total guilt and sin.
3. Delusional ideas of guilt and sinfulness can acquire a megalomanic character, allegedly affecting the whole of humanity, the world itself (with worsening depression).
4. The delusion of sinfulness and guilt cannot be dissuaded.

5. Confession and other sacraments often do not improve the condition, sometimes they can lead to its aggravation.
6. The loss of hope for the God's mercy is the most important indicator of a morbid condition (development of delirium).
7. Delusional ideas of guilt are usually followed by other signs of depression, including somatic, vegetative, cognitive and other disorders.

Anti-vital reflections, suicidal thoughts, intentions, deeds and self-harming actions of various degrees of severity were noted in 80% of patients out of 85 people in the group with delusions of sinfulness, however, it was very important that suicidal attempts and severe self-harming behavior were registered only in 7% of patients (6 people), which is significantly lower than the total suicide rate in depression, which is 15%. This confirms the published data on the protective effect of the religiosity factor in relation to suicidal tendencies (V.E.Pashkovsky, 2015). These 6 patients had severe suicide or autodestructive behavior. As punishment for their sins, the patients poured boiling water on themselves, led an ascetic lifestyle, punishing themselves with especially strict fasting, up to severe exhaustion, inflicted physical injuries on themselves, stabbing themselves in the heart area, hoping to atone for their sins. So, one patient "saw himself in hell", felt "the smell of decomposition of human flesh" and felt that "the devil took a place in his heart", called himself a "great sinner" and tried to drown himself in the river. It is important to note that life-threatening self-harming actions were mostly self-punishment; they developed at the height of a depressive-delusional state, often during an acute sensory delirium, imperative hallucinations, acute delusional depersonalization and delirium of metamorphosis, sometimes with elements of oneurism-like disturbed consciousness.

Delusional ideas of sinfulness and self-blame are often not recognized in a timely manner, thereby aggravating the manifestations of a morbid depressive state, and lead to an increased risk of suicide attempts. However, the described cases of autoaggressive and suicide behavior of religious patients were particularly brutal and persistent in comparison with patients of the general population (I.H.Gotlib, S.L.Hammen, 2002; R.Gournellis, 2018).

Modern suicidology considers religious faith as a protective factor against suicide behavior. Although none of the world's traditional religions explicitly encourages suicide, their positions are not absolutely identical. Thus, Judaism, Christianity, and Islam, based on the idea of man as the image of God, have a more definite anti-suiciel position than Eastern religions with concepts of transmigration of souls or rebirth (T.Stompe, K.Ritter, 2011). In the Orthodox tradition, the sin of suicide consists of both the very fact of killing (oneself in this case), and the sins of unbelief and lack of faith, cowardice, sins of despair and despondency, through which one refuses to carry his cross of life, doubting God's saving Providence for each person (M.Stepanenko, 2006).

The attitude of the church and the priest to the problem of suicide and suicidal thoughts of a believer is important, which he may encounter both in conversation with the patient, in confession, and in communication with relatives of the deceased patient. Today a priest most often has to celebrate funeral services for complete strangers.

If the cause of death was suicide, the clergyman has difficulties in the practical application of Canon 14 of Timothy of Alexandria. The relatives of the deceased have the right to provide medical documentation confirming a mental disorder, which will allow the priest to conduct the funeral service.

During the diagnostic process, the psychiatrist must personally talk to the patient, observe him/her both during the interview and his/her behavior in the medical institution. The doctor must collect an objective anamnesis from relatives, friends and neighbors of the sick person, determine hereditary factors, and, if necessary, prescribe a

psychodiagnostic examination, which helps in differentiating the diagnosis. The process of establishing a psychiatric diagnosis, treatment and further psychoneurological observation are strictly regulated by generally recognized international standards and the legislation of the Russian Federation, and all information about the course of the disease is recorded and later stored in a medical institution. Thus, today the result of a medical examination and the respective psychiatric diagnosis established by a psychiatrist correspond to the canonical definition that a person is (or was before committing suicide) in a state of "mindlessness" and "out of mind".

It is obvious that timely identification, treatment and pastoral care of patients with mental illnesses is necessary to build adequate strategies for overcoming depressive disorders with religious guilt delusions, considering the peculiarities of the suicide risk manifestation in these patients, taking into account their religious worldview and changes in religious experiences in a morbid state. Knowledge of the symptoms and syndromes of mental illness may help the priest to understand the situation of incipient suicidal behavior and prevent suicide.

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*Ivanin D.A.*

## Approaches to depression in various Christian confessions in Russia

**Abstract:** This article analyses approaches depression in various Christian denominations in Russia, such as the Russian Orthodox Church, the Roman Catholic Church and Protestant denominations. Based on the analysis of official documents and data from the official websites of religious organizations, we identified common features and differences in theological approaches to understanding depression. The study found that most confessions see depression as a combination of medical and spiritual aspects, emphasizing the importance of the spiritual component in the treatment of depressive states. There is a range of differences in the perception of depression, starting from its definition to the assistance methods, which reflects the theological and pastoral characteristics of each confession.

**Keywords:** depression, despondency, theology of depression, Russian Orthodox Church, Roman Catholic Church, Christianity and psychiatry, pastoral care.

Depression, according to the International Classification of Diseases (ICD-10)[1], is defined as a mental disorder, the main characteristics of which are low mood and loss of pleasure in all, which must last at least two weeks. This condition is often accompanied by a decrease in self-esteem, loss of interest in life, inadequate feelings of guilt and pessimism.

According to the latest World Health Organization study (2017), 5.5% of the population in Russia suffer from depressive disorders (7,815,714 cases) [2].

However, the number of people diagnosed with depression is much smaller than the number of people experiencing symptoms of depression, not having a diagnosis or have not sought help of psychiatriat. According to monitoring data from the Institute of Psychology of the Russian Academy of Sciences, in May-August 2022, the proportion of respondents who noted symptoms of clinical depression was 32-35%[3].

In Russia in 2020, respondents who reported that they "experienced such anxiety or depression that they could not continue their normal daily activities for two weeks or longer", spoke about the following ways to improve their condition: 25% - contacting a professional, 41% – taking medications, 17.5% – religious, spiritual practices[4]. Thus, even though more than 40% of respondents admit using medications in depression, only a quarter consider it possible to seek professional help. The data also show that a relatively large percentage of people with depressive symptoms consider spiritual and religious practices to be a way to improve their health condition, which indicates trust in religious institutions in the treatment of depressive disorders.

At the same time, a study of attitudes towards mental illness among Christians (M.S.Stanford, 2007) has shown that even in countries where psychological and psychiatric care is well developed and accessible[5], after communicating with official representatives of the Church:

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[1] International Classification of Diseases (ICD-10) URL: https://mkb-10.com/ [access date 15.10.2023]

[2] Depression and Other Common Mental Disorders.Global Health Estimates [dataset]. World Health Organization (2017) [original data] URL: https://www.who.int/publications/i/item/depression-global-health-estimates [access date 15.10.2023]

[3] Institute of Economic Forecasting of the Russian Academy of Sciences. Quarterly GDP Forecast. Issue No. 55. URL: https://ecfor.ru/publication/kvartalnyj-prognoz-ekonomiki-vypusk-55/ [access date 17.10.2023]

[4] Wellcome Global Monitor (2021) – processed by Our World in Data. [dataset]. Wellcome Global Monitor (2021) [original data]. URL: https://ourworldindata.org/grapher/dealing-with-anxiety-depression-comparison?tab=table&country=~RUS [access date 02.11.2023]

[5] Human resources for mental health [dataset]. World Health Organization (2019) [original data] URL:

• 31.4% of the respondents had the impression that mental illness is the result of a personal sin.

• 32.4% of respondents said that Church officials said they did not have a mental illness, even when a mental health professional said they did.

• 18.4% of respondents believe that the Church does not recommend the use of psychiatric drugs, and 2.7% believe that it prohibits them.

A content analysis of 15 Christian self-help bestsellers mentioning depression (M.Webb, 2008) showed that 9% of text units state that depression is the result of demonic influence, 5% – that depression is the result of a person sinning or being a bad Christian, and only 2% – that depression has a physiological the basis. As a response to depression, 30% of text units indicate trust in God, 22% – increased religious activity, 8% – personal will or self–discipline, and only 1% - referral to a psychiatrist.

Thus, the analysis of sources about depression shows a lack of understanding among Christian authors and church ministers about the official definition of depression within their denomination. This raises the question of whether ideas about depression are reflected in official documents and websites.

**Methodology**

The aim of this research is to analyze the official views on depression as reflected in official documents and on the official websites of the main Christian denominations in Russia. – the Russian Orthodox Church, the Roman Catholic Church, the Russian Union of Evangelical Christians-Baptists and the Russian United Union of Evangelical Christians (Pentecostals) (the latter two denominations are the most numerous representatives of Protestantism in Russia). Such an analysis, we believe, will allow us to answer the question of what kind of idea an ordinary believer can get about the position to depression in his denomination, as well as what authors and priests should rely on when addressing this topic. The research methodology is based on the principles of PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) [6]. The study was conducted in October-November 2023, both using the search tools of the sites themselves and the Yandex search engine.

The official websites of religious organizations were used to collect information:

• vatican.va (Roman Catholic Church)

• patriarchia.ru (Russian Orthodox Church)

• cef.ru (Russian United Union of Evangelical Christians (Pentecostals))

• baptist.org.ru (Russian Union of Evangelical Christians-Baptists)

Selection criteria:

1. Types of documents: official documents, articles, sermons, statements by officials regarding depression and mental health.
2. Time interval: documents published after 1991
3. Language: Russian.
4. Accessibility: free access through the above official websites.

The search process:

1. Identify keywords and phrases to search for: "depression", "mental health", "despondency" and their alternate word forms.
2. Using search tools on official websites for exact matching of phrases and for relevant results.
3. Filtering of the obtained documents according to the specified selection criteria.

A search using the word “despondency” was performed to test the hypothesis that the concepts of “depression” and “despondency” are identified with each other and

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https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/human-resources [access date 7.11.2023]

[6] https://www.prisma-statement.org/

that the concept of “despondency” inherent in Christian tradition is used, which is similar in the description of symptoms to depressive disorders according to ICD-10. However, this article uses only search results for the word “depression” for generalization and conclusions.

Statistical results of the study:

| "Depression" | Patriarchia.ru | Vatican.va | cef.ru | baptist.org.ru |
|---|---|---|---|---|
| Total mentions | 88 | 98 | 21 | 23 |
| Mentions in official documents | 3 | 8 | 2 | 0 |

**Summary of the research results**

**Roman Catholic Church (website vatican.va )**

The Roman Catholic Church has a single hierarchical center and unified document database on the website vatican.va. In total, 98 mentions of the word "depression" were found, including in official documents of the highest authority: apostolic letters – 4, encyclicals – 4. But the largest number was found in the reflections, particularly, of Pope Francis – 51, Pope Benedict XVI – 9, Pope John Paul II – 28.

The most informative, in our opinion, is the Address of Pope John Paul II to the participants of the 18th international conference on depression organized by the Pontifical Council for the Pastoral Care of Health Care Workers (November 14, 2003) [7]. Here are the most characteristic quotes and some generalizations regarding the concept of depression in the Catholic Church:

1. The concept of depression encompasses various conditions: " Your work, dear participants in the Congress, has revealed the different, complex aspects of depression: they range from chronic sickness, more or less permanent, to a fleeting state linked to difficult events."

2. Depression has a complex, psycho-socio-spiritual character: "The spread of depressive states has become disturbing. They reveal human, psychological and spiritual frailties which, at least in part, are induced by society."

3. Depression has a tight connection with the spiritual state, the spiritual component of depression needs close attention: "You have stressed that depression is always a spiritual trial… This disease is often accompanied by an existential and spiritual crisis that leads to an inability to perceive the meaning of life." and spiritual methods of treatment: " In the spiritual process, reading and meditation on the Psalms, in which the sacred author expresses his joys and anxieties in prayer, can be of great help. The recitation of the Rosary makes it possible to find in Mary a loving Mother who teaches us how to live in Christ". "Participation in the Eucharist is a source of inner peace, because of the effectiveness of the Word and of the Bread of Life, and because of the integration into the ecclesial community that it achieves. Aware of the effort it costs a depressed person to do something which to others appears simple and spontaneous, one must endeavour to help him with patience and sensitivity, remembering the observation of St Theresa of the Child Jesus: "Little ones take little steps".

[7] Address of John Paul II to the participants in the 18th international conference promoted by the Pontifical Council for health pastoral care on the theme of "Depression" (14.11.2003) URL: https://www.vatican.va/content/john-paul-ii/en/speeches/2003/november/documents/hf_jp-ii_spe_20031114_pc-hlthwork.html [access date: 12.11.2023]. Translated by author.

Here, we believe, he offers a theological perspective on depression, which could be described as the position of the Catholic Church: "In his infinite love, God is always close to those who are suffering. Depressive illness can be a way to discover other aspects of oneself and new forms of encounter with God." [8]

In his encyclical Evangelium Vitae, Pope John Paul II also notes the link between depression and suicide, as well as the influence of illness on the degree of guilt of the perpetrator of this mortal sin: " Decisions that go against life sometimes arise from difficult or even tragic situations of profound suffering, loneliness, a total lack of economic prospects, depression and anxiety about the future. Such circumstances can mitigate even to a notable degree subjective responsibility and the consequent culpability of those who make these choices which in themselves are evil."

In part, we can see a confirmation of the position of Pope John Paul II in the apostolic letter of Pope Francis, "Misericordia et Misera"[9]:"In a culture often dominated by technology, sadness and loneliness appear to be on the rise, not least among young people. The future seems prey to an uncertainty that does not make for stability. This often gives rise to depression, sadness and boredom, which can gradually lead to despair. We need witnesses to hope and true joy if we are to dispel the illusions that promise quick and easy happiness through artificial paradises. The profound sense of emptiness felt by so many people can be overcome by the hope we bear in our hearts and by the joy that it gives."

In general, we can say that the Catholic Church views depression as both a medical and a spiritual problem, emphasizing the importance of the spiritual dimension in understanding and approaching the treatment of depression. This position has led to the formation of a large number of associations of religious specialists and non-professional helpers as well as active cooperation with mental health professionals.

An analysis of depression understanding beyond official documents has shown that it is theologically understood in two aspects: as a means of spiritual purification and growth sent by God, or as a consequence of the general fall, which has transformative potential.

In the first case, depression, while a severe condition, is ultimately bestowed by God to advance in personal holiness. The source of depression is beyond the control of people suffering from it – in God himself. Therefore, depression should be faced, like any other challenge, - with a prayer for God to faithfully guide us through it and to use it for our good, even if it involves pain, in order to free us from depression. Mental illness, therefore, is not a sign of a person's sin or lack of faith, but it may involve connivance to demons to tempt him. This is an important stage in approaching holiness and closeness to God. At the same time, the spiritual experience of suffering (for example, by a saint or another spiritual person) is fundamentally different from mental illness, although it has some common manifestations, therefore it is possible to distinguish between spiritual types of depression (part of the way towards unity with God, necessary in a certain period of spiritual development for any ascetic) and pathological types, which do not contribute to spiritual growth and are not supposed to come from God.

In the second case, depression is considered as a natural consequence of general human nature distortion, which can bring spiritual benefits; it can be caused by various reasons (physical illness, character, lifestyle, acceptance of demonic infusions, social, cultural or traumatic factors). Depression is inherently bad and undesirable, but it can

[8] ibid.

[9] FRANCISCI PP. MISERICORDIA ET MISERA. LITTERAE APOSTOLICAE URL: https://www.vatican.va/content/francesco/en/apost_letters/documents/papa-francesco-lettera-ap_20161120_misericordia-et-misera.html [access date: 14.11.2023]. Translated by author.

become a reason for a person's spiritual awakening and growth, if a person reacts to it correctly. It brings us closer to understanding the Sufferings of Christ on the Cross.

**Understanding of depression in Russian Protestantism**

The generalized position of all Protestants in Russia regarding mental illness reflects the Social position of the Protestant Churches in Russia[10], adopted by the Advisory Council of the Heads of Protestant Churches of Russia in 2003. Paragraph 9.6. "Attitude to mental illness and psychiatry" states: "The Churches consider mental illness as one of the manifestations of the general damage to human nature caused by the fall. Some diseases and ailments develop either under demonic influence, or become the result of passions that enslave a person. In the field of psychotherapy, a combination of pastoral and medical care for mentally ill people is most effective, provided that there is proper differentiation between the roles of a doctor and a minister."

The Social concept of the Russian Union of Evangelical Christians-Baptists[11] does not contain the word "depression". On the official website baptist.org.ru this word is mentioned 23 times, however, in the documents – 0. It states that depression is "a serious mental illness taking a lot of sacrifice and impacting humanity in our time," [12] and further it says that "depression most often arises as a result of a dilemma: a passionate desire for something and the inability to achieve it. As a rule, the main problem is an act of distrust of God."

In the section "Pastor's answers", Y.K. Sipko, Chairman of the Russian Union of Evangelical Christians-Baptists (2002-2010), Vice-President of the World Baptist Alliance (2005-2010) also emphasizes the spiritual aspect of overcoming depression: "Therefore, depression can occur in Christians. Loneliness, unfortunately, is also possible. The most important thing is that it is possible for Christians to be freed from such diseases. It is important to prayerfully reflect on your spiritual state before God. Such reflection will lead us to repentance, and this will be the liberation of the spirit and soul from resentment, condemnation, loneliness and depression." [13] Sergey V. Babich, a counselor, staff of the Department of pastoral ministry of the Russian Union of Evangelical Christians-Baptists, based on the Word of God, identifies various types of depression, including "neurotic" (Ps. 101:3-11) and "psychosomatic" (Ps. 38:13-14) [14] types.

The largest Protestant association in Russia is the Russian United Union of Christians of the Evangelical Faith (Pentecostals) in official documents on the website https://www.cef.ru has 2 mentions of the word "depression". However, both references are mentioned in the context of discussing other issues. Thus, the Concept of social rehabilitation of people with chemical dependence[15] (approved by the board of the Centralized Religious Organization Russian United Union of Christians of the Evangelical Faith (Pentecostals) on April 02, 2015) says: "At the same time, a consultant, using the best practices and achievements of psychology, sociology and

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[10] Social position of the Protestant Churches in Russia, adopted by the Advisory Council of the Heads of Protestant Churches of Russia. URl:https://www.cef.ru/documents/docitem/article/1379387 [access date: 16.11.2023].

[11] Social concept of the Russian Union of Evangelical Christians-Baptists / URL: https://baptist.org.ru/faith/faith-copy [access date: 16.11.2023].

[12] Skachkova A., Dorogaya M. Pastoral care in depression.URL: https://baptist.org.ru/read/article/97964 [access date: 16.11.2023].

[13] Sipko Y.K. About Depression. Pastor's Answers. URL:https://baptist.org.ru/read/article/94123?ysclid=lpbavbcqyl837103835 [access date: 16.11.2023].

[14] Skachkova A., Dorogaya M. Pastoral care in depression. URL: https://baptist.org.ru/read/article/97964 [access date: 16.11.2023].

[15] Concept of social rehabilitation of people with chemical dependence. URL:https://www.cef.ru/documents/docitem/article/1378310 [access date: 17.11.2023]

medicine, should help a parishioner overcome psychological problems (depression, despondency, despair, fear, confusion, anger, loneliness, suicide moods, etc.), make informed decisions, identify internal resources necessary for healing. The consultant is obliged to have information about the possibilities of obtaining medical care and assistance in resolving family, legal, social and other issues and, if necessary, provide this information to the parishioner both in person and in correspondence forms of counseling."

Thus, depression is seen as one of the main psychological issues that the consultant can help the patient deal with, using knowledge from psychology, sociology, and medicine. In particular, the consultant should also identify the internal resources needed for healing and provide information about the possibilities of obtaining medical and social assistance.

The total number of mentions of depression on the official website is 21. These mentions are found in articles, sermons and answers from the pastor. In general, they admit the importance of a comprehensive approach to the treatment of depression, which includes both psychological assistance and spiritual support. For example, Matts-Ola Iskhoel, First Deputy Bishop of the Russian United Union of Evangelical Christians (Pentecostals), senior pastor of the "Word of Life" Church in Moscow, in his interview to the website https://wolrus.org /, reposted by the portal https://www.cef.ru /, states that it is unreasonable to see the root of all mental problems in spiritual problems and urges to turn to psychologists' help: "It seems to me that it is important for us to see differences: medicine is medicine, psychology – psychology, spirituality – spirituality. If a person has the flu, we will not say that he is possessed by a demon: the flu is a bacterium, a virus, not a demon. We will pray for healing, but we will not give up medicines. The same applies to mental problems: if a person is depressed, it does not mean that he is possessed. This may be the case, of course, and we as a church should be able to differentiate these. But it is unreasonable to believe that all mental problems have spiritual causes. Our knees may hurt, our emotions may also hurt... Depression, self–rejection, constant competition - I think it's important to contact psychologists who work with these problems today." [16].

In general, based on the analysis of references to depression in unofficial documents, it can be concluded that most people understand depression as a consequence of a person's personal sins (it is caused by sin, its natural consequence or punishment from God, lack of faith or demons, or both). People suffering from depression are often seen as lacking certain spiritual fruits, which are considered evidence of a genuine Christian faith. Psychological disorders and distress are not compatible with a Christian lifestyle. A Christian's life should be filled with joy, and the absence of joy is a sign that one may have not enough faith. Instead, the focus should be on developing willpower and practicing positive thinking. It is assumed that believers can achieve immediate change through respective acts of faith, repentance, and spiritual intervention, such as prayer or exorcism.

**Russian Orthodox Church**

Although of all the denominations we study, it is in the theology of the Russian Orthodox Church that the term "passion of despondency" is still actively used to describe conditions similar in symptoms to depressive disorders from ICD-10, on the official website patriarchia.ru the term "depression" is used quite often – 88 times, and 3 of them are in official documents (there are 5 documents in total), and 7 in the sermons, greetings and addresses of the Patriarch.

[16] Matts-Ola Iskhoel. About Christianity, Psychology and Meditation [Interview].URL: https://www.cef.ru/infoblock/publications/newsitem/article/1593254 [access date: 18.11.2023

The Basis of the Social Concept of the Russian Orthodox Church, adopted by the Bishops' Council of the Russian Orthodox Church in 2000, define the basic provisions of the doctrine on church-state relations and on a number of modern socially significant problems. The document also reflects the official position in the field of relations with the state and secular society and establishes several guiding principles applied in this area by the episcopate, clergy and laity.

The Basis of the Social Concept of the Russian Orthodox Church suggests to combine pastoral and medical care for people with mental illnesses, while clearly distinguishing the areas of expertise between doctors and priests. It states that mental illnesses can also be caused by "nature": “XI. 5. The Church regards mental diseases as manifestations of the general sinful distortion of the human nature. 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 passions. In accordance with this distinction, it is equally unjustifiable to reduce all mental diseases to manifestations of obsession — the conception ensuing in the unjustifiable exorcism of evil spirits, and to treat any mental disorder exclusively by medical means. More fruitful in psychotherapy is the combination of the pastoral and the medical aid with due delimitation made between the jurisdictions of the doctor and the priest”. [17]

So the understanding of depression according to official documents and statements of officials can be formulated as follows:

1. There are various causes of depression, including mental and socio-cultural ones: "These processes are caused primarily by problems in the spiritual, moral and emotional spheres, and, by the resulting prolonged depression. The reason for the latter is the separation of man from God, the disruption of the continuity of generations, the deterioration of national traditions, and the destruction of connections with nature, as well as work, family, and spiritual and cultural bonds."[18]

2. The social concept also directly mentions depression, emphasizing its connection with suicide thoughts and reducing the patient's responsibility for them: "The request of a patient to speed up his death is sometimes conditioned by depression preventing him from assessing his condition correctly."[19]

3. A distinction is made between depression, which can be treated with medication, and despondency, which is perceived solely as a spiritual state: "Sometimes despondency is confused with depression. The external manifestations of both are quite similar. But if depression is the result of mental distress, that is, a consequence of illness, then despondency is not such. The concept of "despondency" can generally be defined and described only in a religious frame of reference. If a person loses faith in God, if he begins to doubt a lot, if he loses some vital coordinates associated with his religious choice, then, as a result, despondency sets in, the most difficult state of mind. Despondency cannot be treated with medication, it is impossible to get out of despondency through suggestion from the outside. This is a condition that only man himself can overcome, relying on the power of God."[20]

4. Various causes of depression are discussed, and the positive impact of the spiritual condition on it is highlighted. "One can list endlessly the reasons why a modern

[17] Basis of the Social Concept of the Russian Orthodox Church. URL: http://www.patriarchia.ru/db/text/419128.html [access date: 27.10.2023]
[18] Statement of the Holy Bishops' Council of the Russian Orthodox Church on the life and problems of indigenous peoples. URL:http://www.patriarchia.ru/db/text/1401214.html [access date: 27.10.2023]
[19] Basis of the Social Concept of the Russian Orthodox Church. URL: http://www.patriarchia.ru/db/text/419128.html [access date: 27.10.2023]
[20] Sermon of His Holiness Patriarch Kirill after Great Compline on Monday of the first week of Great Lent in the Cathedral of Christ the Savior, March 11, 2019 URL:http://www.patriarchia.ru/db/text/5387868.html [access date: 28.10.2023]

person who sincerely considers himself strong and powerful, simply would not be able to live, would fall into the deepest depression. But St. Mary, a simple sinful woman, was able to go through all these trials." [21]

The document of the Commission of the Inter-Council Presence on Church Education and Deaconia "Pastoral care in the Russian Orthodox Church for mentally ill people" (2020) [22] deserves special attention. It defines the important place of priests and parish social workers in identifying believers with symptoms of depression, as well as the need to advise such persons to visit psychiatrists. Mental health is declared to be the area of joint responsibility of priests and mental health professionals (psychiatrists, psychologists and other specialists):

"7.2. Priests, monastics, social workers of parish communities, when communicating with mentally ill people, should pay attention to the following symptoms of mental disorder, in which it is necessary to strongly recommend them to seek advice from psychiatrists:

• depressive states with a strong feeling of longing, hopelessness, despair, loss of life prospects, with ideas of self-blame and humiliation, low value, excessive sinfulness;

• depressive states with reflections on the meaninglessness and aimlessness of life, anti-vital reflections, suicide thoughts and intentions;

• depressive states with a sense of abandonment by God, loss of meaning in life and hope for God's mercy, "petrified insensibility."

The fact that such a document has been developed is evidence of the deep and productive cooperation between theologians and psychiatrists within the Russian Orthodox Church. This also applies to a series of conferences[23] held under the auspices of the SCMH and the Department for External Church Relations of the Moscow Patriarchate, chaired by Metropolitan Sergiy of Voronezh and Liski, the head of the expert group on "Pastoral care of the mentally ill people" of the Inter-Council Commission on Church Education and Deaconia. Significant role in thece conferences was played by the leading Orthodox scientific psychiatrists V.G. Kaleda and G.I. Kopeyko. All this testifies to the Church's interest in the problems of mental illness and the desire to study both spiritual and scientific aspects.

It is also worth noting that in the Orthodox Church, which has the most integral and developed theological anthropology and a huge ascetic heritage, well developed teaching about passions, attempts are being made to understand depression theologically through the lens of passions of despondency and sadness. This can be found in the studies of Orthodox scholars such as J.C. Larcher, Arch. Gabriel Bunge, Rev. Georgy Maksimov, and Orthodox psychiatrist D.A. Avdeev. This once again demonstrates the attention given to the definition of the spiritual aspect of the phenomenon known in psychiatry as depression, however, does not speak about identification of depression and despondency in the official rhetoric of the Russian Orthodox Church. Depression is seen more as a spiritual trial associated with the loss of the meaning of life and distancing from God. The importance of spiritual life and connection with God for overcoming it is emphasized, however, the medical nature of this illness, the variety of its causes, including mental and socio-cultural ones, are not denied.

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[21] Word from His Holiness Patriarch Kirill on the 5th Sunday of Great Lent after the Liturgy in St John the Russian Church in Fili-Davydkovo in Moscow on April 2, 2017URL:http://www.patriarchia.ru/db/text/4850010.html [access date: 28.10.2023]

[22] Pastoral care for mentally ill people in the Russian Orthodox Church. Document of the Commission of the Inter-Council Presence on Church Education and Diaconia.URL:https://www.diaconia.ru/pastyrskoe-popechenie-o-psikhicheski-bolnykh?ysclid=lpbdwqqez3768802629 [access date: 30.10.2023]

[23] The list and materials of the conferences can be found on the website URL:https://psyreligion.ru/archives/event-category/conferences [access date: 30.10.2023]

**Conclusions**

The main Christian denominations officially declare scientific understanding of mental disorders, however, theological models of understanding depression are not clearly fixed in official documents, where a mixture of understandings and discourses can be found.

This gap leads to various interpretations and positions, spread both at the level of the parish clergy and different unofficial publications and self-help manuals.

For the most part, modern concepts of the theological understanding of depression inherit their historical roots laid down in patristic theology, which combines various models of understanding.

Although certain models of understanding depression are more consistent with the accents in the teachings of various Christian denominations, they all are shared by members of these denominations.

Each of the models indicates that depression can be a place of revelation and spiritual growth, however, to achieve true healing, both the spiritual and medical aspects of depression must be taken into account. This understanding will allow the development of pastoral care programs and establish cooperation with mental health professionals for more effective treatment of various types of depression.

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**Religiosity and mental disorders – a norm and a pathology. A clinician's perspective**

**Abstract:** the report develops the concept of mental disorder on the basis of the trichotomy (spirit-soul-body), originating from Christian anthropology. Some basic manifestation forms of mental disorder are indicated, which are compared with non-pathological experiences, including those typical for the religious experience. The norm of mental health is defined apophatically – as the absence of illness

**Keywords**: trichotomy, mental disorder, diagnosis, apophatics.

First and foremost, it's important to clarify that the term "clinician" refers specifically to a psychiatrist who investigates, evaluates, that is, diagnoses the patient's experiences.

The need to compare religiosity and mental disorders comes from the apparent similarity of these experiences. In both cases, unexpected and unusual conditions often arise, and as a result, there is a change in the mental state, which, in some cases, raises disturbing questions about their causes and consequences of these changes. This formal (at a superficial, unprofessional glance) similarity raises questions about understanding the norm and pathology of the psyche, about the essence of psychiatric diagnosis.

The starting point for reflection is the trichotomy – spirit-soul-body, which is self-evident for both church people and medical specialists. (Let's clarify that for the second group, it is currently defined as a bio-psycho-social concept). It has been presented in our reports and publications on many occasions, so we will only remind you that mental disorders unfold in the "mental" sphere; and faith, lifestyle generally reside in the "spiritual" sphere. The spirituality sphere is beyond the competence of a psychiatrist. A psychiatrist is trained and has the right to identify and evaluate disorders, illnesses, and not the moral and legal consequences of an act or behavior in general. The respective aphorism by Viktor Frankl is widely known: a priest saves the soul of a layman seized by sin, and a doctor treats diseases (Frankl V.E., 2000).

I will repeat myself: it is the trichotomy that allows to single out the space in which the mental disorder unfolds. It seems reasonable to define it as psychiatric anthropology (Voskresensky B.A., 2021). In its own way, it reveals substantively the problem of the relationship of mental processes with both somatic pathology and spiritual collisions. It can also be used to address relationship between creativity and mental pathology, crime and mental abnormalities, dissent and psychopathology.

Mental disorder manifests itself through psychopathological experiences, which, being immaterial, can nevertheless be structured, qualified, evaluated. Their most expressive, vivid manifestations are positive symptoms – special experiences that do not occur normally. These are, for example, hallucinations ("voices", "visions", etc.), special mood swings (depression – low mental tonus, mania – the opposite condition - elevated arousal), disturbance of consciousness ("being in another world" - amusive or frightening), jitteriness or "stupor", etc. But the most important thing is that any illness, including mental illness, is a weakening, decay, disappearance of normal mental processes inherent in humans - that's negative symptoms. Let's call this "duo" group one in our discussion.

However, mental disorders are not always so profound, significant. Often they are limited only to the quantitative transformation of normal mental processes: weakening - strengthening, changing their proportional relationships. This is the field of so-called minor or boundary psychiatry - group two.

So, the essence of mental disorders is changes in the mental sphere. The popular, officially declared criteria for mental pathology today - suffering, difficulties in personal growth and functioning, suspension / stagnation in personal growth - are uninformative, too vague, and go beyond the “mental”. But when establishing a diagnosis, a psychiatrist determines by what patterns and in what direction (the starting point here is the causes of the disease) the mental and emotional condition of the patient is changing.

The above two groups also can be found in the “society-faith-mental disorder” space. The first group we define here as the group of productive and deficit disorders. Both can, to a certain extent, resemble healthy experiences. But this comparison with the norm is only theoretical and conventional. These are the pairs: conditions of elevated mood, inspiration and manic excitement; feelings of imperfection, sinfulness and depression with ideas of self-blame, evil power, tormenting immortality; syndrome (ensemble of symptoms) of the psychic automatism (obsession as pathology) and synergistic experience; catatonic-hebephrenic conditions and foolishness for Christ; autistic disorders and asceticism, obedience, hesychia. Pathological fantastic ecstatic states, alteration of consciousness caused by the use of psychoactive substances often have religious content. Experiences that occur during a state of clinical death ("life after death") and those that are deliberately induced through the use of specific psychotechniques ("psychotherapeutic techniques") can also be considered part of this group.

During the diagnostic process, the psychiatrist attempts / tries / strives to transform these spiritual experiences into mental illnesses indicated in the first position of each of the above comparison pairs. If this is not possible, it is impossible to discuss a mental disorder, regardless of how unusual, incomprehensible or exotic the analyzed experiences or actions may be from a generally accepted perspective.

By their pathological ("psychiatric") nature and dynamics, these experiences are not specific to a particular group of believers and can occur in people of various vocations and ministries.

The second group can be described as situationally personal disorders (psychogenic-psychopathic in the traditional psychiatric terminology). Its inherent symptoms can be expressed through obsessive and irresistibly painful experiences (for example, the fear of the Great Exit described by V.M. Bekhterev (Bekhterev V.M., 1902), blasphemous thoughts), super-valuable and paranoid super-valuable (peculiar fanatical), and induced ideas ("mental infection", as they used to say, a hundred and more years ago), conversion and dissociative disorders - specific bodily and psychological "misalignments" as well as other forms of depersonalization that are close to them, with their hysterical mechanisms, shrieking, some ("light") forms of obsession, "hiccups"; from a human perspective very understandable psychogenic (post-stress) depression – the same as "grief reaction"; Explosive (aggressively excited) reactions that are opposite to the previous ones in their manifestation. The "shouting in the crowd", "addiction" (not chemical, but psychological) and other similar phenomena that have emerged in recent decades, are all just behavioral acts. But not every ethically and legally abnormal behavior indicates a mental disorder. To become such, it must be structured in a certain way, take shape into one or another morbid symptom complex. I would like to reiterate that the disorders in this group are rooted in mechanisms that are common to both the norm and the pathology, and in cases of disease, they are largely determined by the individual's characterological traits. In other words, the identification of these disorders does not imply any specific pathogenic effect of religious practice on the mind. Psychologists emphasize that any aggression is contagious. Every crowd is a brutal formation, especially the one that is shouting. The effects of suggestion and dependency are successfully demonstrated in a wide range of advertising and propaganda campaigns. In different historical periods, young people have gone not only

to religious groups but also to revolution, business, virgin lands, and the Baikal-Amur Mainline (BAM). Have living conditions always been optimal in these locations?

So, these conditions are not exclusive to people of faith. They are universal in nature and can occur in any group of patients. They are possible, as we have said before (under certain conditions), also in people who "do not deserve" a psychiatric diagnosis, they may be seen as an episodic reaction. Simplifying and generalizing, it can be assumed that, in the vast majority of cases, the patients in this second group are aware of their condition and have some control over it. The social significance of this kind of pathology is determined primarily by general humanistic and legal, that is, spiritual, and not medical criteria.

But even a seriously mentally ill person, at his core, remains a spiritual being. Morbid experiences are one thing, but his world of values and beliefs is something else entirely. And as for church life, the medical recommendations for this plan are determined by the specific symptoms. Various situations may also arise here.

In the first case (we mean, first of all, the most significant and at the same time the most mysterious and difficult to understand disorders - schizophrenia and affective spectrum) - morbid experiences have a religious and/or mythological and even fantastic content. During this period, there is no actual, canonical church life. The fantastic and cosmic nature of these plots is not a coincidence, not the end of a spiritual (misguided) journey. Rather, it is one of the patterns in the cultural and historical development of humanity. It has been established that, in the early stages of human development, concepts emerged describing the formation of planets, continents, oceans, and then specific regions, areas, settlements, and so on.

And in case of illness, the journey back is made: as they say, from the kitchen (from everyday life, plausibility) to space.

In most cases, patients do not take a critical approach to these morbid experiences. They "take everything that happens to them as the truth, as an experience of growth and knowledge," or they regard it as an "attack from evil forces." So one of the patients with the ideas of diabolic influence claimed that he was given the disease as a temptation. The doctor objected, explaining that the patient had a disease in the form of temptation, but, being in an acute state, he was unable to perceive psychotherapy. Many psychiatrists have noted that in such situations, especially during acute mental disorders, visiting the church, participating in divine services, sacraments does not bring relief, and even this very need is lost. Active church life is not recommended for such patients.

The second option is "mixed": actual religious and psychopathological experiences coexist, intertwine in a unique way. With such situations, it is sometimes possible to trace how the spiritual is directly subordinated to the mental. So a patient, who was in a sad, angry, excited state, demonstrating aggression towards her mother and at that moment partially realizing both her morbid and sinful behavior, later, after the acute condition ended, explains: "I understand that this is a sin, and it makes me want to hit even harder." Here is another observation: the patient is a devout person, attending church; during the next episode, she expresses diseased ideas of self-blame and redemption: she feels like the most sinful person and believes she must bear the sins of others. In an attempt to "cleanse herself" of these sins (as she describes it), she rushes to swim across the Moscow River during the autumn-winter season. One should not see in these experiences the ideals of love for one's neighbor, sacrifice, redemption, and general humanistic aspirations. These are pathological conditions. They do not lead to enlightenment, but rather to a more intense state - the expansion of fantasy to universal proportions, aggression towards others, or self-aggression, suicide. It is important to approach recommendations regarding church life with caution and restraint.

Both in patients and in relatives, we sometimes find a desire for faith, for Baptism as the only and guaranteed means of healing. However, the ministers of the church warn against mixing the spiritual and mental. To clarify their position, they emphasize that there is nothing wrong with having an inner desire for healing. They say that this should not be confused with the purpose and meaning of the sacrament of Baptism. Healing is possible only if there is a clear distinction between these actions. The clinical significance of this "demarcation" is that it indicates a critical approach to painful experiences in patients. The clinical significance of this "demarcation" is the emergence of a critical approach towards morbid experiences in the patient.

If religious church life and morbid experiences are not connected in any way (for example, the patient is a church person, and the symptoms are delusions of jealousy, damage, being robbed by neighbors) – that is, the third option of the discussed relationship between faith and illness, – then there is no need for medical restrictions on church life.

In case of situational personality register disorders (psychogenic-psychotic), the recommendations of the religious psychotherapeutic plan are formed in accordance with religious and common criteria.

Although formally mental health is not related to psychiatry, its definition, its criteria are necessary, both as a starting point for the diagnosis of respectitve disorders, and as a standard for psychohygienic recommendations. Modern criteria are diverse: effective adaptation, personal growth, satisfaction from one's activities, self-criticism, etc. Obviously, these are very general and not all of them fall within the scope of a psychiatrist's expertise. In our opinion, the psychiatric norm of mental health is apophatic, it is the absence of pathology-disorder-disease. If there are no mental experiences (the realm of mental processes) contained in the list of psychiatric illnesses, then, subjectively, from a psychiatric perspective, he is considered healthy, regardless of how incomprehensible, unusual, unconventional, or challenging his statements, actions, or lifestyle (the realm of the spiritual) may be. The concepts of psychiatric, cultural, legal, and religious norms do not coincide. The trichotomous basis and justification for such discrepancies, which in this context demonstrates its humanism (we apologize for using this term in the church context), upholds the spiritual freedom of the individual.

The concept of a harmoniously developed individual, which was a popular ideal several decades ago, is more social than psychiatric or hygienic. The harmony of personality does not lie in the equality or closeness of all its components, but rather in the mastery of the variety of forms of human activity, interests, values, and abilities.[1]

However, a certain relationship between the spiritual and the mental can still be formulated. In the words of a philosopher who is now popular in various ways: "Real health is a creative function of the self–preservation instinct; It immediately manifests itself in both will, art, and the continuous action of an individual's self-doctoring" (Ilyin I.A., 1993)[2]. We believe that a "self-doctor" is a critical and responsible attitude to one's life, including health. And the "creative function" is a value function, spiritual function — the most important in the context of real reflections.

Reflections on the reliability and objectivity of the diagnosis naturally include the question of the diagnostic "tools" and "technology". Modern technical means, a variety of questionnaires and tests significantly enrich our knowledge about the

[1] It is natural to expect a comment on the historical determinacy of the concept and criteria of mental disorder. But we note that in works on the history of psychiatry it is always presented in one way or another. We will limit ourselves to the thesis: mental disorders are transhistorical, but their understanding is changeable. It is trichotomy that allows one to mitigate contradictions and identify certain unshakable foundations (Voskresensky B.A., 2016).

[2] For the sake of accuracy, we note that this (like the phrase below) is not a statement by the philosopher himself. The author quotes a letter from his doctor.

neuropsychiatric activity of a person, but still do not and cannot be decisive for making a psychiatric diagnosis. Mental activity is carried out by the brain, which is not possible without the nervous system. However, human experiences are not inherently material, but rather ideal. In psychiatry, the psyche of the patient is explored through the lens of the doctor's mind. Talking with the patient, observing his behavior, the doctor evaluates the vibrancy and diversity of his emotions, harmony of thinking, authenticity, harmony of motor skills, and so on. We define the diagnostic thinking of a psychiatrist as a figurative process - the mental state of a patient is compared at different stages of their life and illness.

In order to make this definition (figurative) less declarative, we will include it in a number of other "diagnostic techniques". I believe doctors will understand these definitions without further explanation: a neurologist (previously called neuropathologist) has spatial thinking, a surgeon has engineering and design thinking, an obstetrician has mechanistic thinking (not in the derogatory sense, but in reference to the biomechanics of childbirth), a therapist has pathophysiological thinking, and so on.

I apologize for my bold attempt to describe the mindset of a clergyman – it is Christian.

Despite these differences, there is a significant common foundation for the diagnostic work of these professionals: "The diagnosis is carried out through the living, artistic, and loving contemplation of a suffering person," - a quote from the same work by I.A. Ilyin (Ilyin I.A., 1993).

This inherently Christian definition can be given a different cultural and historical interpretation. A renowned Russian psychiatrist, Professor Pyotr Viktorovich Morozov (who spoke in this conference room 2 or 3 years ago), compared the diagnostic approaches of psychiatrists from different countries and emphasized the special - intuitive and deep understanding of the patient's experience, which is characteristic of psychiatrists from Eastern Slavic countries. (The article discussed the issue of diagnosing schizophrenia-spectrum disorders in relation to accusations of arbitrary, or more specifically, politically motivated, expansion of their diagnostic criteria). He explained this technique by the highly developed intuitive and emotional forms of communication characteristic of authoritarian and tyrannical regimes (Morozov P.V., 1991). Thus, the national characteristics of interpersonal communication prove to be a factor that enriches the tools of our professional medical practice.

In conclusion, here is another comparison from the renowned Swiss psychiatrist of the mid-last century, Christian Scharfetter. Considering the fundamental progression of all diseases, including mental disorders, and their potential for aggravation, C. Scharfetter emphasizes the special social significance of these conditions: "... the psychiatrist... is like Simon the Cyrenian carrying the cross – he cannot deliver the Savior from the cross, but at least he can help carry this cross." (Scharfetter C. 2011).

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**Contemporary practice of exorcism in the Catholic Church: discernment of spirits, supernatural manifestations, paranormal phenomena and psychopathology**

**Abstract:** This report will present an approach to the interaction of a psychiatrist and a clergyman in a situation requiring exorcism. Medical care of patients need to take into account the possibility of spiritual influence. At the same time, to perform an exorcism, the assistance of a psychiatrist is necessary in order to identify probable psychiatric causes of the observed phenomena and provide assistance in the event of the possible mental disorders.

**Keywords:** exorcism, possession, pseudo-possession, religiosity, religious experience, demonic influence, spiritual influence.

The modern approach to exorcism in the Catholic Church is clearly described in the "Guidelines for the Ministry of Exorcism"[3], developed by the International Association of Exorcists.

In order to understand the Catholic Church's approach to the relationship between medicine in general (particularly psychiatry) and faith, which invariably underlies any possible spiritual help, the following aspects have to be considered:

a) theological and doctrinal grounds on which the Church believes that higher spiritual powers, such as fallen angels, may intervene in matters of human physical and mental health, which are usually dealt with by medicine;

b) prerequisites and conditions for the interaction of psychiatrists and specialists in the spiritual life of a person;

c) possible types of spiritual manifestations and the need for a differential diagnosis in such cases.

1. Firstly, the Christian faith affirms that God, the Most Holy Trinity - the Father, the Son, and the Holy Spirit - is the Creator of heaven and earth, of everything visible and invisible. This belief recognizes the existence of both the material and spiritual worlds. The material world can be studied and influenced by scientific methods, while the spiritual world consists of spiritual beings, in the church tradition called angels, who cannot be explored with physical tools, but can manifest themselves in the material realm.

God created everything from nothing and made everything good. Of course, God could have created the world in a state of ultimate perfection, but in His infinite wisdom and kindness, God wanted to create the world "in a state of development." [4] This “development” includes the possibility not only of greater, but also of lesser perfection. It also includes the creation and destruction of living beings, and therefore physical evil, until creation reaches perfection.

In the same way, moral evil also arises from this development. Angels and humans, intelligent and free creatures, are called upon by God's plan to strive for their ultimate perfection, which is the fullness of God's presence and love, choosing him with free will. In this process of free development, both angels and humans can go astray. And indeed, they have sinned. This is how moral evil entered the world, incommensurably more serious than physical evil. God, neither directly nor indirectly, is the cause of this. However, He allows it, respecting the free will of His creation, and mysteriously knowing how to extract good from this.[5]

[3] Associazione Internazionale Esorcisti (a cura) Linee guida per il ministero dell’esorcismo, Padova, Edizioni Messagero, 2019 (hereinafter - Linee guida).
[4] Cf. Catechism of the Catholic Church, 4th ed., Moscow, 2001 (hereinafter – CCC), pp. 301-304.
[5] Ibid., pp. 310-311

We firmly believe that God is the Lord of the world and history. But we often remain unaware of the ways of His Providence, because on the way to our perfection we have only partial knowledge. Only when we see God “face to face” (1 Cor. 13:12) can we see and understand the ways in which, even through the dramas of evil and sin, God leads His creation to the rest and fellowship of that final seventh day for which He created heaven and earth. God in His Providence takes care of everything, from the smallest insignificant things to great world and historical events. Revelation insists on the absolute sovereignty of God in the course of events: "Our God in heaven and on earth does whatever He wants," says the Psalmist. Man, created at the same time as a spiritual and corporeal being (God breathed the breath of life into a man molded from the earth), is able to interact with his Creator, as well as with the material and spiritual world. Therefore, God does not leave the entire formation of the world to the fulfillment of the natural laws, but He Himself and through angels enters into spiritual interaction with man. That is how, first of all, we received the Holy Scriptures.[6]

Having been created good, some angels, while retaining their nature, voluntarily became evil and separated from God - the Supreme Good. That is, they would also be kind if they stayed the way they were created. But due to the abuse of the natural perfection not standing in the truth (see John 8:44), they separated themselves from the greatest Good, to which they should have remained faithful. Christian tradition calls these separated angels Satan, the Devil, and others – imps and demons.

These spiritual creatures, having fallen away from their original dignity, oppose the salvific will and action of God, accomplished in Christ, seeking to involve man in their rebellion against God, to "demonize" man, to make him like one of their own, in contrast to deification, conformation with Christ.

Thus, evil in the world, as Church tradition says, is not just a kind of inferiority, but an active, living and spiritual being, the perverted and perverting one. All biblical and ecclesiastical teaching recognizes the existence of Satan and insists that he has no beginning in himself but is a creation of God. This is not a pseudo-reality and not a personification of the reasons for our misfortunes unknown to us.

Based on constant church Teaching, Pope Francis reminds us that we will not be able to realize the existence of the devil if we persisted in perceiving life exclusively from an empirical point of view, ignoring the supernatural perspective. It is the conviction that this evil force is present among us that allows us to understand why evil sometimes has such destructive power. The Devil is present from the first pages of Scripture, and the Scripture ends with a description of God's victory over him. Jesus gave us "The Lord's Prayer" and wanted that we at the end ask the Father Lord to drive away us from the evil – the evil spirit. It means a being that has a personality and is constantly plotting against us. Jesus taught us to ask daily for deliverance from this spirit so that his power would not prevail over us. Thus, we should not perceive the devil as some kind of myth, image, symbol, figure of speech or idea. Such a misconception leads to the fact that we weaken our vigilance, become careless and, as a result, more vulnerable.[7]

Thus, the Church, in accordance with the main source of its teaching – the Lord Jesus Christ – insists that both the Gospel teaching and the experience of faith in life reveal us the existence of the world of demons, that this is an undoubted dogmatic reality. However, it is important not to exaggerate the possibilities of God's fallen creations.

Rebellious angels have forever lost the possibility of eternal bliss and all supernatural gifts, but they have not lost the gifts and qualities inherent in their nature as

[6] Ibid., p. 314
[7] Cf. Francis Gaudete et exsultate, Rome, 2018.

such. So, they completely retained natural knowledge. This knowledge, which in demons can be innate, received and communicated, surpasses any knowledge available to people. They are able to draw conclusions about upcoming events based on any natural causes already in effect. They are better than any lie detector at guessing the inner movements of a person's thoughts based on physical manifestations. But not only demons, but also angels, by their very nature, cannot know the secrets of God and the secrets of the human heart. Moreover, they cannot have precise prior knowledge of free actions, but can only make assumptions that may be wrong.

Although demons can perform actions that seem supernatural to us, because in the created world there is no power comparable to that of the angels, neither individually nor together can they perform genuine miracles, that is, act by suspending the laws of nature or against the laws of nature, the sole author of which is God. The demon can simulate healing, suspending the effect of the disease, but cannot provide healing, resurrect the dead, or reattach an amputated limb. The demon is able to move existing objects from one place to another, connect them in a bizarre way, but not create new ones. The demon is also able to induce visions, but only by using images already existing in a person's memory or creating unnatural combinations of them, but not inspiring new visual images. The demon has knowledge of events that do not depend on the free will of man or God - future earthquakes, hurricanes, breakdowns of mechanisms, just as he knows and can create the impression of prophecy about the results of actions that some people have already taken, about which others know nothing.[8]

Therefore, to emphasize this inequality between Divine and demonic forces, it is truly wrong (in the strict sense of speaking) to talk about "supernatural" (supernaturalis) actions of demons, but only about preternatural (praeternaturalis) actions. Satan's power is not unlimited. He is only a creature – strong, because he is an exclusively spiritual creature – but, nevertheless, only a creature with the limitations of creation, subject to the will and dominion of God. And this subordination expresses itself in the fact that they are incapable of performing supernatural actions, i.e. actions that exceed the capabilities of creation.

The perverted will of demons, seeking to enslave a person, acts in two ways: in the moral, i.e., spiritual sphere of a person and in the psychophysical – the bodily one.

Satan doesn't need to possess us. He poisons us with hatred, despondency, envy and vices. So, while we weaken our vigilance, he uses this to destroy our lives, our families and our communities, because "the devil prowls around like a roaring lion looking for someone to devour" (1 Pet 5:8). It is temptation that is the greatest and deadliest danger, because it directly opposes the salvation plan of God. Temptation gives Satan the opportunity to truly enslave a person, because by succumbing to temptation and sinning, a person by his own free and personal decision gives himself over to Satan's power. Throughout their earthly lives, all people, although to varying degrees, are subject to temptations, so this kind of Satan's action can be called ordinary.

Satan's actions in the psychophysical sphere – such as possession, obsession, harassment or infection - cause a person great suffering, are spectacular, attract attention, but in themselves do not distance him from God and are not as severe as sin. By influencing the psychophysical state, the devil, first of all, seeks to intimidate the person, subjugate his free will, and at the same time to somewhat imitate God's Incarnation. Such actions can be called extraordinary, not because they are spectacular, but because they are rare. The response to Satan's extraordinary actions is exorcism, the prayer of the Church, by which she calls upon Christ, the Son of God, to free man from Satan by His Divine power.

[8] See Linee guide for more details.

2. We have seen the theological reasons why the Church has no doubt about the intervention of spiritual forces in human life. This includes the emergence of the Holy Scriptures, numerous, fairly well-documented miracles, numerous miraculous discoveries of icons and statues. The Christian faith proceeds from the fact that God constantly uses supernatural phenomena to contact a person. At the same time, there are known and documented cases of extreme diabolical influences – unnatural manifestations of his power.

It is important to note that, regardless of what modern science says, for example, about a possible genetic tendency toward religiosity, the very possibility of a "natural scientific explanation" for the tendency does not refute faith as a response to God's revelation about the creation of the world. It is precisely the fundamental impossibility of scientific verification of spiritual phenomena that leads to their denial being postulated a priori. It is impossible to say in a strictly rational manner that phenomena that cannot be reproduced in experience do not exist. Faith, for its part, does not deny the possibility of manifestation of spiritual influences through genetic, hormonal and other mechanisms of human physicality.

At the same time, cases of extreme diabolical influences (usually called possession) from the point of exorcism have always needed the advice of medical specialists. In the practice of exorcism, the Catholic Church has always postulated the need to distinguish between unnatural manifestations (i.e., extreme demonic actions) and possible psychopathologies or neurological disorders. So as far as 1563, the Church Council of Reims: "Many times those who consider themselves the prey of the devil, need a doctor more than the ministry of an exorcist." The first obligatory rite of exorcism for the entire Catholic Church, published in the Roman Ritual in 1614, i.e. long before the formation of psychology and psychiatry as sciences, recalls: "First of all, an exorcist should not easily believe that someone is possessed by demons. Therefore, he must have a good understanding of the symptoms that allow him to distinguish the possessed from those who are susceptible to any illness, especially mental illness."[9]

This consistency in the teaching of the Church is confirmed by the Catechism of the Catholic Church, which in 1673, speaking about the importance of the ministry of exorcism, indicates the need to make sure, before performing an exorcism, that we are talking about the presence of the evil one, and not about illness.

In the practice of exorcism, it is clear that a person who seeks help from an exorcist is more likely to be suffering from delusions or other psychopathological conditions, rather than actual possession by an evil spirit. Various dissociative disorders, such as paranoid delusions and obsessive-compulsive disorder, as well as phobias and histrionic personality disorder, can manifest as pseudo-possessions.

At the same time, it should be borne in mind that exorcism itself as a complex set of prayers and rituals (if carried out without considering the psychiatric situation of the affected person) can provoke imitation of typical possession behavior. Also for a person suffering from certain psychopathologies, such exorcism can actually form dependence on the rite itself, in which exorcism is not perceived as the beginning of a spiritual liberation from the power of a demon but must be repeated simply as a certain exposure. And this is another reason for a thorough differential diagnosis of psychopathology and possible extreme demonic influence. In other words, an exorcist, when faced with a specific situation of possible possession, always needs the help and advice of a psychiatrist.

[9] See Valter Cascioli Esorcistica e psichiatria a confronto. Modalita di dialogo. Problemi interpretativi e di diagnosi differenziale; in Quaderni AIE, No 1, Roma, Marzo 2015, p. 129.

On the other hand, a psychiatrist who can help an exorcist at this moment must have a holistic Christian vision of the world order. It is not enough to assert one's faith in God. Faith also includes confidence in the existence of "invisible" (according to the Creed) forces, invisible also for any scientific instruments, since these forces are immaterial. And these forces, angelic or diabolical, are capable of producing, respectively, supernatural or ab-natural effects. Without this recognition of the objective existence of something that cannot, in principle, be studied by scientific instruments, any actions of spiritual invisible entities will be perceived only as part of a socio-cultural environment that awakens physical and mental manifestations. Often, even those who consider themselves believers see religion and religious experience as a set of mental manifestations, in which religious views and truths of faith turn out to be only projections and objectification of a mental state. Such a rationalistic approach denies the very possibility of having spiritual, rather than mental or physiological problems, therefore it will not allow to see quite clear symptoms of supernatural or unnatural manifestations.[10]

The integral health of a suffering person should include, in addition to the physical, mental and moral aspects indicated by WHO, also a spiritual assessment. And the restoration of such integral health is the joint goal of both the psychiatrist and the exorcist. In some cases, the "mixed" nature of the disease becomes clear. Just as outwardly similar symptoms may indicate a mental or neurological illness, some symptoms may turn out to be a manifestation of the extreme influence of the evil one.

Thus, delusions of obsession will have the usual psychopathological characteristics: distortion of reality, self-centeredness, insensitivity to rational or factual arguments. At the same time, the main signs of possession are also objective in nature: knowledge of languages that a person has never studied, knowledge of facts that one cannot know, physical strength that cannot be explained by the level of physical development, possible levitation, regurgitation of various objects.

Voices and visions can, of course, be caused by hallucinations, in which acoustic or visual images may arise. Someone with a religious bent may believe that they see spirits. Psychiatry will distinguish between the characteristics of such manifestations.[11]

However, if voices and visions, due to their characteristics, are not related to psychopathology or neurology (if they turn out to be quite informative), a psychiatrist may need the help of a spiritual life specialist to identify possible spiritual influences. At the same time, one should not forget that a demon is capable of significantly influencing the psychosomatic state of a person, therefore, cases requiring simultaneous therapeutic intervention, both mental (psychiatric) and spiritual (exorcism), are quite probable and are confirmed in the practice of exorcism. Demonic influence can not only disguise itself as psychopathology, but can also manifest itself in the aggravation of a physical or mental condition, sharply reducing the effectiveness of standard therapy; in addition, psychopathology itself can provoke manifestations of demonic influence. Therefore, the interaction between an exorcist and a psychiatrist will not always result in a determination of which of them should act further in order to restore integral health, but may require long-term joint action.

3. The need to examine, or distinguish, spirits is another important reminder. Because, in addition to the widespread materialistic rationalistic approach, which denies the existence of the spiritual world in general and the partial belonging of a person to it, at the same time the craze for everything spiritually-like is spreading widely. Just look at the shelves of souvenir shops and eco-shops with their talismans, tarot cards, etc. With this approach, on the contrary, it is possible both a gullible willingness to

[10] See ibid., pp. 135-137.
[11] See Linee guida, 215-225.

recognize spiritual manifestations in any psychopathology, and careless “following on the lead” (on a leash) of any spirit, considering them all to be the highest good entities. A holistic Christian perception should again help us remember that any spirits can be only angels created by God, and none other uncreated entities, the souls of the dead, the souls of trees, etc. At the same time, some of the angels are fallen and evil, seeking to destroy man by tearing him away from God. Good angels serve God and can transmit messages from God to a person.

Pope Benedict XIV, in his treatise on Beatification[12], published in 1850, examines mystical manifestations in the lives of saints and insists on the need to distinguish natural, supernatural and ab-natural manifestations, clearly realizing that the sanctity of life itself attracts the attacks of the evil one rather than drives them away[13]. Therefore, Pope Lambertini suggests to recognize the mystical manifestations, since the demon seeks to make an impression by performing pseudo-miracles. Therefore, the holy life of a Christian is revealed not by mystical manifestations – voices, visions, prophecies – but by a moral life of growing in Christian virtues.

The demon is able to excite fantasy, but all images will correspond to the person's own feelings. Unlike God, who can make you see "the very new things" for which there are no words known – as we read in the descriptions of the visions of John the Theologian and St Paul.

A person of a certain mindset (melancholic, according to Pope) is able, taking into account many completely natural reasons, to predict the future in the natural course of events.

The experience of many saints shows that a special connection with God, which allowed them to better understand and see the effect of God's mercy and love in this world through mystical visions, was often followed by other visions aimed at awakening fear and distrust in God. Visions, special messages, including through a voice - which is not clearly recognized as the voice of someone you know or deceased relatives - are possible, but only as a strengthening of the personal path of approaching God, and perhaps also as an example for others of a virtuous and pious life, full of love for one's neighbor.

Demonic messages, on the contrary, can disguise themselves as communication with the souls of the deceased, suggest taking the position of the only true interpreter of divine revelation and the gifts of God, rejecting the authority of the Church, suggesting things contrary to faith and Scripture.

In these reflections of Pope Lambertini - Benedict XIV we see that already in the middle of the 18th century the possibility was recognized that in one and the same person, even if he is a saint, the peculiarities of personal psychology, supernatural revelations of God, and unnatural attacks of the evil one can simultaneously manifest themselves; and they must be distinguished. And it is not the presence of such spectacular phenomena that determines sanctity.

In the Scripture itself, chapter 18 of the Deuteronomy (Deut. 18:21-22) has a warning about false prophets who do not speak from God, predicting things that will not happen.

As for hearing different voices or conversations with the deceased, it is worth recalling that if we are not talking about the already mentioned variants of psychopathology, but of real extraordinary events of a spiritual nature, then firstly,

[12] Benedict XIV, De servorum Dei beatificatione, after Bruxelis, 1840 https://www.miraclehunter.com/marian_apparitions/discernment/Benedicti_Papae_XIV_Doctrina_de_servorum.pdf, accessed 05.03.2024.

[13] For a more detailed analysis, see Francesco Asti, Mist and Diabolic Influenza: Criteria for Detection, in Quaderni AIE, No. 8, Rome, March 2017, pp. 46-132.

God's words are transmitted by angels who do not need to hide behind the "voices of the deceased or the spirits of ancestors".

In the situation of the voices of angels conveying certain messages, one should proceed from the fact that possible manifestations of supernatural divine intervention will be accompanied by the visionary's desire for invisibility, humility and modesty, a readiness only to convey the message, but not to be its owner.

On the contrary, the desire for fame, for all the benefits, to claim a kind of "copyright" for the message will accompany the diabolical deception, which the person himself may not realize, but with which the devil seeks to distract not only himself from God, but also the others.

Quite often we meet with people who claim to experience so-called "paranormal" phenomena that seem beneficial - internal or external voices, foresight, fragrant smells, messages received in various ways, the ability to recognize diseases, to heal by the imposition of hands. These people are called mediums, psychics, etc. We can also mention those who directly claim to be engaged in "white" or "black" magic. When speaking about mediums, it is necessary to know that the evil one has extraordinary powers; it is necessary to distinguish between mediation in communication with the evil one and the gift of supernatural visions.[14] Therefore, it is worth noting that the term "paranormal" itself, which is quite widespread, is acceptable only as one of the translations for the Latin "praeternaturalis" - located outside the limits (but not above) of the natural - unnatural, ab-natural, paranatural. When a medium "talks to spirits," unless this is a manifestation of psychopathology, he turns out to be an intermediary for an evil spirit, even if he sincerely believes that he is in contact with the spirits of his ancestors. Whether he induces such a conversation in himself or receives visions and messages without his own intention, the one who acts in this conversation, called the spirit of the dead or ancestors, is in fact always and only a malicious spirit - a devil, demon, or Satan. As for any magic, faith and Holy Scripture do not deny the very possibility of its existence, but note that any magic is an attempt to control creation contrary to the Creator, and therefore refers to demonic manifestations.

Paranormal phenomena, in the traditional sense of the term, are often associated with so-called psychic abilities. However, it is the belief that these abilities exceed human nature that suggests they come from a higher power - either God or angels, whether good or fallen. At the same time, the desire for sensation, to draw attention to their paranormal abilities, the desire to make money from it indicate their unnatural origin and diabolical deception.

Prophecies, revelations of God, and special gifts are always associated with prayer and develop on the long path of growth in faith.

An individual revelation from God, mediated by an angel, the messenger of God, manifests itself in the conformity of all elements with a holistic faith. These elements are: the correspondence of the alleged message to the faith and morality of the Church, the credibility of the visionary, sincerity, lack of self-interest, humility, submission to Church authorities, sanity, sober lifestyle, clarity. Consistency and constancy in the presentation of facts or messages. Fulfillment of prophecies, healings. But, the most important element is the spiritual fruits - it takes many years for them to develop and to be verified. The humble willingness of the supposed seer to wait for this time, to entrust his message to the Church and never return to it again, becomes an additional argument in favor of supernatural intervention.

[14] See Renzo Lavatori L'identità e le azioni degli angeli nella visione cristiana, in Quaderni AIE, No 18, Roma, Gennaio, 2020, pp. 22-49.

There is one more important criterion of distinction: God always respects a person's free will, so he can suggest the person to convey a message or a fact to others but does not control a person that begins speaking against his will.

From the point of view of spiritual health, it is important to understand that even a sincere desire to help other people using their special abilities, without trying to understand the source of these abilities, can lead a person into a demonic trap. This refers to the transmission of information from spirits and to healing by the power of spirits.

And the general approach of the Church and psychiatry in cases of allegations of any special abilities should not differ from the approach when a person is suspected of being possessed. First, it is necessary to exclude the psychopathological nature of the phenomena, and only then evaluate the events or messages from the point of view of faith.

To summarize, we can state that over the past centuries, the Catholic Church has always resorted to the help of first doctors in general, and then, as the medical field developed, to the help of psychologists and psychiatrists to determine that certain phenomena in the life of a particular person go beyond framework of medical and natural science explanations. Only after this the Church considers itself in the position to make a judgment about the divine or demonic origin of the remaining phenomena.

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**Spiritual meaning as a driving force in overcoming spiritual crisis**

**Abstract**: The problem of overcoming spiritual crisis requires deep and methodologically verified research strategies, which, in turn, can be based on understanding spiritual experience. We can say that when faced with such a state, the individual experiences disintegration and, thanks to the crisis, gets the opportunity to move either towards regression, disintegration and schisis, or towards rebirth and ascent. Meaning-making can be a significant mechanism for resolving a crisis. This has determined the purpose of this study, which is to determine the role of spiritual meaning in the structure of a spiritual crisis.

**Keywords**: spiritual crisis, spiritual health, spirituality, religious faith, religiosity, meaning-making, spiritual meaning.

**Relevance and problem of the study.**

The theme of spiritual crisis is particularly relevant in the post-COVID-19 era and the time of deep socio-political instability that has followed, as many people around the world have faced particular experience of borderline existence (Oakes, 2023). People are experiencing crisis associated with many factors that depend on both the pathogenesis of diseases and traumatic consequences (Lim et al., 2022; Hogg et al., 2023). Following the schisis of mass consciousness in recent years, there has been an increased involvement of the population in major religious denominations (according to the portal for research on the religion future[1]) and interest in faith in the context of experiencing uncertainty and critical events (Kowalczyk, 2020; Shai, 2022).

According to foreign studies, a purely scientific interest in religiosity and spirituality is also growing. At the same time, more attention is paid to the negative aspects of religiosity and spirituality, such as the problems of "spiritual struggle" (K.I.Pargament, & J.J.Exline, 2023), situation of "loss of religion", "de-identification" from religion (McLaughlin et al., 2022), "religious trauma" and the phenomenon of “Christian shame” often associated with it (A.Downie, 2022). It is especially important to emphasize that the widespread dissemination of research focusing on issues of spirituality and religiosity is facilitated by their active funding from foundations and charitable organizations (for example, the John Templeton Foundation[2]).

The main agenda of the ongoing projects is well reflected in one of the articles of the American Psychological Association summarizing various studies on the topic of religiosity and spirituality (Z.Abrams, 2023). This publication highlights the following aspects:

(1) Firstly, the issue of **harm** that religion can cause to individuals, especially members of various minority groups, is actively discussed within the academic community of the United States;

(2) Secondly, the researchers emphasize the increasing demand from clients and patients for their religious and spiritual beliefs to be taken into account when discussing their issues with healthcare professionals (psychologists, psychiatrists, and somatic doctors);

(3) Thirdly, the authors positively assess the tendency existing in psychological society to separate the concepts of religiosity and spirituality. At the same time, spirituality is proposed to be understood as "the process of searching for something sacred", and the term "religion" is used in relation to dogmatics, organized practices, confessional beliefs, etc. (ibid.). The researchers note the lack of competence of psychologists and

[1]see — Annual Table of World Religions, 1900-2025: https://www.wnrf.org/cms/statuswr.shtml

[2] https://www.templeton.org/

psychiatrists in this sphere, and therefore the importance of obtaining special "spiritual/religious competencies" is recognized.

The above ideas formed the basis of a major project, which aims at improving competencies in the field of spiritual health, creating an inclusive environment and expanding the capabilities of specialists by addressing the religious aspects of clients' lives. This project includes research, as well as specialists' training, beginning with higher education and later completing with advanced training courses (currently, education is accessible without cost, provided you do not require a receipt for educational loans).

Thus, significant attention from sponsoring organizations to the topic of spiritual health and the resulting increase in projects on this issue has so far created an area of active academic and practical development in the field of spirituality and religion. In our opinion, the issues under discussion require deep and methodologically verified research strategies that can be based on understanding the spiritual experience of clients, patients, and parishioners who complain of negative conditions associated with the spiritual sphere.

One of the conditions that can also be placed among negative experiences is considered to be a spiritual crisis. The word "crisis" comes from the ancient Greek word κρίσις, which captures two hypostases of this state: on the one hand, "turning point", on the other hand, "trial, judgement". In this regard, we can say that during a crisis, a person's personality may experience disintegration. Thanks to the crisis, it gets the opportunity to either move towards regression, disintegration, and schisis, or towards rebirth and ascension.

Based on the studies of W. James, we assumed that the mechanism of crisis resolution is through meaning-making (James, 1902; 1993, p. 249). Thus, the purpose of this study is to determine the role of spiritual meaning in the structure of a spiritual crisis.

**Methods**

As a research strategy, we have chosen the methodology of qualitative research (Busygina, 2024), which, we believe, allows us to obtain a comprehensive understanding of the processes of transformation of a person's experience and understanding of a spiritual crisis when he finds spiritual meaning. The grounded theory method (Strauss & Corbin, 2001) was chosen as the method of data analysis, which has a highly heuristic potential, since it allows linking previously unrelated scientific concepts and creating new theories based on data.

The study had two stages (2020-2021 and 2022-2023). The respondents who came to the interview at the second stage agreed to repeat sharing about the earlier spiritual crisis and its consequences. The study includes an analysis of the protocols of 18 respondents who experienced a spiritual crisis (14 female, 4 male) aged 21-54 years (average age 29 years).

## Results

### *Stages of spiritual crisis*

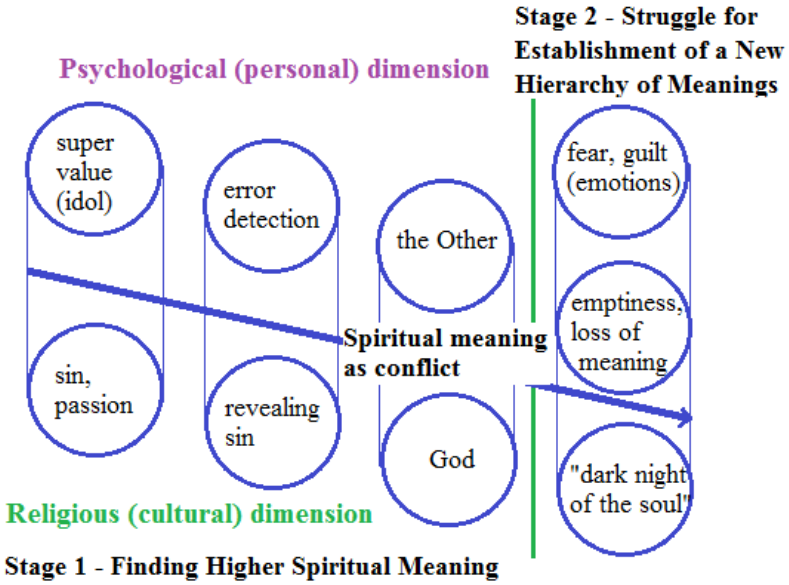


Figure 1. Stages of spiritual crisis (1 and 2).

At the **first stage**, respondents saw the root cause of the spiritual crisis as being the result of a particular sin. Moreover, first they didn't realize or only partially realized this sin. In the next phase, committing the sin did not give the respondents a sense of satisfaction. Sin was revealed as a "candy wrapper" that brings emptiness and suffering. In the subsequent stage, through a painful search, the respondents were revealed the crude essence of the mistake they had made. This was the first time a spiritual meaning was revealed, which first was formulated by the **other** (friend, priest, inner voice, etc.) and therefore, it caused conflict and unwillingness to reconcile.

The **second stage** of spiritual crisis is a spiritual struggle. This stage is full of various thorny experiences: an attempt to "bargain" with God, resentment towards Him or the inability to forgive oneself, fear that God would never accept one back, etc. Some respondents mentioned that they had tried unsuccessfully to deal with their passion on their own. At this point, they were experiencing how their former value system was being destroyed, and the meanings were being lost.

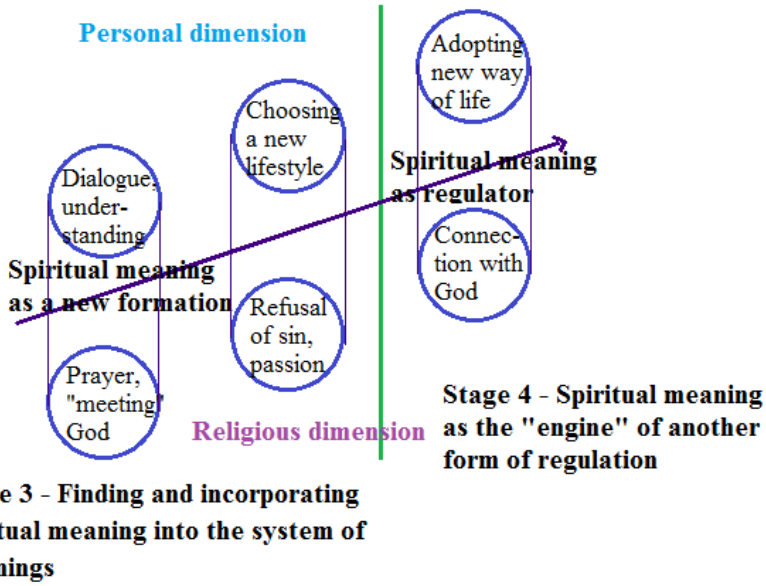


Figure 2. Stages of spiritual crisis (3 and 4).

Respondents who have overcome a spiritual crisis go through the **third stage**. It is characterized by reaching the peak point of despair, in which helplessness is replaced by humility. For the first time, spiritual meaning unfolds in the inner plane of the personality as an understanding, as a fully accepted and illuminating idea. At the same time, when the abyss of despair is still visible, the joy of liberation from sin also arises.

In the future, the respondents strengthen their choice of a new lifestyle and understanding of the world. At this stage, the spiritual meaning became the "motivator" and played the role of a regulator of a person's lifestyle: a person's actions were now correlated with a new spiritual principle of life, obtained by the individual in acts of overcoming himself and his passions.

**Discussion**

Spiritual meaning, thus, is the triumph of meaning over suffering (Vasilyuk, 2021, p. 11). Similar images can be found in the poem "Dark Night of the Soul", when the author describes plunging into the depths of spiritual darkness and a liberating way out to Christ.

*"I remained, lost in oblivion;*
*My face I reclined on the Beloved.*
*All ceased and I abandoned myself,*
*Leaving my cares*
*forgotten among the lilies".*
St. John of the Cross (1577-1579 yy.)

The work of spiritual meaning in a crisis is illustrated by Metropolitan Anthony of Sourozh: "Chaos reigns [in the heart], but not a disorderly and meaningless chaos, but one in the center of which is the word of God, capable of giving it direction, meaning, form, provided that a person responds to this word, provided that we choose the Logos with all our will, choose the meaning, the sense of being and let it act in us as an organizing force — not by submission or taming, but by calling to life —to life in abundance" (Surozhsky, 2019, p. 23).

**Conclusions**

Thus, the spiritual crisis can be understood as a super-existential situation that involves the destruction of previous foundations of existence and challenges meanings. At the same time, the spiritual meaning is imposed in the crisis from the outside — by another person, text, etc. — not truly owned by the individual, however, triggering the subsequent resolution of the crisis. Besides, the spiritual meaning is found inside at the moment of a personal encounter with the manifestation of the Divine (as a new psychological formation). Finally, the spiritual meaning arises in the "transcendental" plane, becoming a consolation, a source of new ideas and meanings, a regulator of the individual's lifestyle, which is now guided not by egoism, egocentricity, but the higher values..

In other words, finding the spiritual meaning of the situation of personality destruction contributes to the resolution of the spiritual crisis. The peculiarity of the acquired spiritual meaning is that it is not directly tied to existence and specific areas of current life, however, it restructures the values and meanings system of the individual, sometimes in a radical way - around higher values, transcendental experience and the experience of communion with God.

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**Epidemics of mental disorders with possession syndrome: historical and clinical aspects**

**Abstract:** The article presents data on epidemics of mental disorders that take the demonopathic forms, called in common terms demonic possession, obsession, hysteria, and hiccups. The causes, clinical forms, models, and stages of their development, as well as therapeutic and preventive strategies, are analyzed. It is noted that there is a similarity between the psychopathological disorders in the structure of these epidemics and the conditions described in the Gospel, and also in the works of psychiatrists of the past – i.e. epidemics of hysteria, as well as in the works of modern psychiatrists – outbreaks of mental disorders with hiccup obsession syndrome, found in northern Russia. It is noted that the clinical interpretation of these conditions is complex and ambiguous, that a spiritually oriented approach to their therapy, rehabilitation, medical and preventive measures is required, as well as the participation of not only a psychiatrist, but also a clergyman.

**Keywords:** mental epidemics, demonic possession, obsession, hysterics, hiccups, suggestion, autosuggestion, hysteria, psychogenic diseases with possession syndrome, induced neuropsychiatric disorders with hiccup symptoms, spiritually oriented approach.

**Introduction**

Evangelists have described numerous cases of healing by the word of God of "all kinds of diseases and infirmities", "sleepwalkers", "lepers", "paralyzed", "suffering from ulcers", "bleeding", "deaf", "blind", "dumb", "tongue-tied", "possessed by seizures" and "evil spirit". We see illustrations of this in the following passages of the holy Gospel:

- "While they were going out, a man who was demon-possessed and could not talk was brought to Jesus. 33 And when the demon was driven out, the man who had been mute spoke. The crowd was amazed and said, "Nothing like this has ever been seen in Israel." (Matt. 9:32-33)
- "Lord, have mercy on my son," he said. "He has seizures and is suffering greatly. He often falls into the fire or into the water. (Matt.17:15)
- "Jesus rebuked the demon, and it came out of the boy, and he was healed at that moment" (Matt. 17:18).
- "Just then a man in their synagogue who was possessed by an impure spirit cried out, "What do you want with us, Jesus of Nazareth? Have you come to destroy us? I know who you are—the Holy One of God!" "Be quiet!" said Jesus sternly. "Come out of him!" The impure spirit shook the man violently and came out of him with a shriek" (Mark 1:23-26).
- "A man in the crowd answered, 'Teacher, I brought you my son, who is possessed by a spirit that has robbed him of speech. Whenever it seizes him, it throws him to the ground. He foams at the mouth, gnashes his teeth and becomes rigid… So they brought him. When the spirit saw Jesus, it immediately threw the boy into a convulsion. He fell to the ground and rolled around, foaming at the mouth… 'It has often thrown him into fire or water to kill him… When Jesus saw that a crowd was running to the scene, he rebuked the impure spirit. 'You deaf and mute spirit,' he said, 'I command you, come out of him and never enter him again.' The spirit shrieked, convulsed him violently and came out. The boy looked so much like a corpse that many said, 'He's

dead.' But Jesus took him by the hand and lifted him to his feet, and he stood up" (Mark 9:17-27).

In common parlance, these states are referred to as demoniac possession, evil eye, hysterics, miryachit (polar hysteria) and hiccups. Their clinical picture includes ideas of possession, witchcraft, messianism, illuminations, revelations, prophecies, religious visions, impairment of consciousness, glossolalia. These conditions often coincide with the descriptions in the Gospel and can be classified under F44.3 "Dissociative mental disorders" in the International Classification of Diseases (ICD-10).

**Mental epidemics of hysteria**

Since the XVI century, epidemics of mental disorders have been observed in Europe and Russia. At the end of the XIX century, psychiatrists V.M. Bekhterev, N.V. Krainsky investigated hysterics, that had become epidemic in Russia. V.M. Bekhterev wrote that the basis of hysteria is suggestion, which helps instill certain mental disorders from one person to another. Penetrating consciousness without active participation of the I-subject, suggestion remains outside the sphere of his personal consciousness. Due to this, all its further consequences occur without adequate delay. The factor that contributes to the suggestion is faith.

He emphasized that the widespread epidemic of demonic possession during the Middle Ages bore all the traces of popular beliefs at that time regarding the extraordinary powers of the devil over human beings. Due to the autosuggestion that the devil could enter the human body, this idea was often the source of great hysteria, which could spread like an epidemic. V.M. Bekhterev regarded hysteria as a reflection of medieval demonopathic disorders.

V.M. Bekhterev argued that epidemics have always developed under the influence of beliefs about evil eye and demonic possession. The clergy played a significant role in this. Separation of hysterians from each other, their isolation from healthy individuals in order to prevent mutual suggestion, is one of the most important therapeutic measures that should be used in epidemics of hysteria, evil eye and demonic possession (V.M. Bekhterev, 1903).

N.V. Krajinsky in 1898-1899 observed an epidemic of hysteria in the Smolensk province. He suggested the original concept of hysteria as a social disorder that is not associated with either epilepsy or hysteria, but is not feigned either. Like V.M. Bekhterev, he, explained the seizures of hysterians by the extreme suggestibility of the psyche. At the same time, he denied that the essence of hysteria is the manifestation of hysterical neurosis, which, due to the suggestibility of patients, is transmitted by analogy with bacteriological epidemics. Based on personal observations, he ranked the hysterians and identified three circles.

- The first circle − the hysterians, that started the epidemic. N.V. Krainsky considered them "not sick, but cunning pretenders," and regarded all their actions and seizures as a simulation, not always controlled.
- The middle circle is real hysterians who fall into uncontrollable seizures consisting of arbitrary muscle contractions. Amnesia, hypnobility and a sharp change in the type of behavior indicated that the patients were really in some kind of altered state of mind and did not control themselves. At the same time, they did not suffer from epilepsy or hysteria.
- The third circle is random people who "imagine they are jinxed."

As a result of the research, he confirmed that hysterics has nothing to do with hysteria. The psychological profile of the patients was not "ostentatiously theatrical, as was usually the case with hysterics," they "sincerely suffered from their condition, without the egoism characteristic of hysterics." The leading role was played by the

social atmosphere and the memorable behavior of the first pretenders, who created a pattern, according to which others then began to behave in the same way (N.V.Krainsky, 1900; P.G.Nosachev, 2023).

**Psychogenic diseases with hiccup obsession syndrome**

For many centuries, the Russian North has been an area where different ethnic groups, cultures, and faiths met. As a result, hysterodemonic diseases - "shyva", "shamanic disease", "hiccups" - have become widespread here.

Archaic forms of neuropsychiatric disorders with hiccup obsession syndrome - "hiccup disease" - are still found in a number of districts of the Arkhangelsk Region and the Perm Territory. Such epidemics were described by psychiatrists M.D. Uryupina (1972) and V.V. Medvedeva (1979).

Associate Professor of Perm Medical University M.D. Uryupina observed a psychic contagion in the 1970s in the Perm Region. The research was done on the basis of the Perm Regional Psychiatric Hospital, the psychiatric department of the Komi-Permyak District Hospital in 1967-1972. Based on its results, in 1972, the PhD theses "Psychogenic diseases with obsession syndrome" was presented.

Over the course of 5 years, M.D. Uryupina studied 110 patients with ideas of hiccup obsession, 90 prs. had psychogenic disorders, 20 had psychoses and neurotic states of other etiologies. Women of working age, who had family and territorial contacts with such patients, prevailed. Patients had high selective suggestibility, were deeply superstitious, believed in the possibility of evil eye, the invasion of hiccups, which contributed to the clinical development of a mental disorder with possession ideas.

In the genesis of the disease, both acute and long-term psychotraumatic situations played a role with typical threats against patients about casting the evil eye, sorcery, witchcraft, inducing hiccups, and predicting the disease on its behalf.

After a period of high attention and self‑observation with hypochondriac fixation, paroxysmal conditions developed - "hiccup attacks", accompanied by speaking on behalf of “hiccup” (psychogenic hysterical speech-motor automatism) in different forms - mute, producing undifferentiated sounds or speaking, - with delusional ideas of possession, sorcery, "bewitching" and senestopathic automatism (constant or paroxysmal sensations in various parts of the body, the feeling of deprivation of certain physiological functions - breathing, swallowing, urination, which were performed by “hiccup”).

M.D. Uryupina noted that paroxysms of motor and senestopathic automatism developed in the context of hysterics narrowed field of consciousness and were violent. Therefore, she attributed the leading syndrome in the structure of the disease to the hysterical-hypochondriacal syndrome of obsession with “hiccups” or the hypochondriacal “Kandinsky-Clerambault” syndrome, which develops psychogenically.

The following disease stages were described:

-· The first stage: evil eye, witches casting hiccups, hiccups intruding the body;

-· The second stage: mental disorders caused by possession, by hiccups settled inside the body.

According to the severity of symptoms, all clinical forms were divided into:

- Psychoses manifested by significant affective tension and varying degrees of disturbed consciousness, by unshakable, delusional belief that hiccups are present not only during paroxysmal periods, but also outside them.

- Neurotic reactions - with hysterical paroxysms, not accompanied by changes in consciousness.

- Progressions - with neurotic and delusional syndromes.

There was a sub-acute course, with recovery and recurrence, with a seizure duration of up to 6-8 months, and a disease duration of 2 to 40 years. The transformations of syndromes were described, when, for example, hysteric symptoms turned into hypochondriacs or speech-motor automatisms became more complex, and the silent form of hiccups was replaced with speaking.

Some patients remained convinced after treatment that the hiccups were still present in their bodies, and the medication only silenced them and stopped them from moving.

Systematic sanitary, educational and atheistic work among the population was proposed as preventive measures, including for the eradication of sorcery.

**Induced neuropsychiatric disorders with hiccup symptoms**

From 1970 to 1979, Associate Professor V.V. Medvedeva from the Northern State Medical University examined 146 patients with hiccup possession syndrome in the Pinezhsky district of the Arkhangelsk region.

Three forms of the disease were identified: mute, roaring and talking hiccups and three stages of the disease.

An aura was described at the beginning of an attack - weakness, unpleasant sensations in various parts of the body, numbness, goosebumps, lump in the throat, esophagus, stomach, irresistible yawning, lacrimation, redness or pallor of the skin, increased breathing and pulse rate, chills, fever, hyperhidrosis, tremor of the hands and eyelids, increased pressure.

The main radical of the attack was hyperkinesis, which was manifested by tics of the respiratory and phonation type, and which had involuntary-obsessive, obsessive-violent and violent character. These attacks cannot be stopped voluntarily; their duration ranges from several minutes to several days.

At the end of the attack, patients experienced weakness, fatigue, muscle weakness, depressed mood, anxiety, and sometimes a feeling of shame and embarrassment.

According to the researcher, the mute form was manifested by simpler, elementary hysterical disorders; the roaring and speaking forms manifested themselves as more complex disorders, with a peculiar change in consciousness (narrowed consciousness, hypnoid state) and increased pathological subordination and suggestibility.

V.V. Medvedeva believed that hiccup attacks were caused by hysterical and inductive mechanisms. Therefore, she called the disease “induced neuropsychiatric disorders with hiccup symptom.”

According to V.V. Medvedeva, the factor contributing to the chronic mental trauma was the archaic, superstitious understanding of the essence and origins of the disease that was prevalent among the indigenous people of the Pinezhsky District in the Arkhangelsk Region. This understanding was based on the idea that hiccups were a material entity that could enter the human body through the ears, eyes, nose or skin. In the body, it takes the form of hair, fly, cockroach, worm, lump or other living creatures and could boss there.

According to her observations, patients explained, interpreted, and expressed archaic ideas about possession, obsession, and witchcraft as superstitious beliefs. These ideas had their own historical and ethnographic roots, "ground", and were nourished by sporadic cases of hiccups and periodic epidemic outbreaks among certain groups of the population.

The following therapeutic measures were proposed: treatment of chronic somatic diseases, psychotherapy, drug therapy with tranquilizers to relieve affective and

autonomic disorders, as well as minor antidepressants and small doses of antipsychotics (etaperazine, triftazine, haloperidol), and injections of aminazine with pipolfen to relieve major attacks.

Spiritual and educational activities were aimed at correcting the moral and psychological climate and fighting superstitions. To prevent religious epidemics of such disorders, it was recommended to "teach the population to wisely observe religious rituals" and "use rituals of prayer as auto-training of the neuropsychic sphere".

According to P.I.Sidorov, V.V. Medvedeva, A.N.Davydov (2014), the implementation of a comprehensive program of care for such patients made it possible to improve the condition and recovery of 82.2% of patients within 5 years. Epidemic outbreaks of hiccups in the Pinezhsky district were not observed until 2014.

**Attitude to possession in Christian anthropology**

In Christian anthropology, personality is considered in the unity of spiritual, mental and physical manifestations, provided that the sphere of the spirit has a transformative influence. Spirituality is defined as the highest level of development and self-regulation of the individual; ignoring it leads to moral dissonance, spiritual conflict and disorder in the spiritual, mental and physical spheres.

It follows from the draft document "The Attitude of the Russian Orthodox Church to modern exorcism practices" (2022)[3] that the Church considers possession not as a mental disorder, but as a "special condition" that can be allowed by God to help a person repent and overcome sin. The healing is the church sacraments: repentance, communion, unction and exorcism. The document notes that leaving such people without spiritual help can lead to despair and even suicide. It states that it is necessary to distinguish possession by evil spirits from mental illness and unhealthy religiosity. To do this, the clergy are recommended to familiarize themselves with the basics of psychiatry.

Signs of such a special condition are "fear of the sacred" (cross, holy water, relics, etc.), a diseased reaction to contact with it. It is recommended to distinguish demonic possession from mental illness, mental disorder and unhealthy religiosity(P.I. Sidorov, V.V. Medvedeva, A.N. Davydov, 2014).

According to "The Bases of the Social Concept of the Russian Orthodox Church" (2000), it is equally unjustifiable both to "reduce all mental diseases to manifestations of obsession" and to try to "treat any mental disorder exclusively by clinical means." A number of disorders of the spiritual sphere, bordering on mental illnesses, need pastoral care and application of special practices.

So, for the organization of interaction between the ROC and the Ministry of Health of Russia, a cooperation agreement has been concluded (2015), under which assistance from the ROC is provided in emergency situations. Methodological recommendations have been developed to establish the procedure for clergy visiting patients in medical organizations (2022).

**Conclusion**

The described epidemics of mental disorders with obsession syndrome have similar psychopathological manifestations, unchanged throughout the entire period of their observation and description, from Evangelical times to the present. Their structure is characterized by ideas of possession, states of disturbed consciousness, and various glossolalia. The clinical interpretation of these conditions is complex and ambiguous, and it does not always match the symptoms of hysteria. When studying mental disorders in such patients, it is necessary to describe not only the mental, but also the spiritual

[3] https://msobor.ru/projects

state. When treating them, psychiatrists should pay attention to identifying the connection between mental disorders and disorders in the spiritual sphere. If such a connection exists, it is necessary to involve experienced priests in psychotherapeutic and psychoprophylactic cooperation.

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**Approaches to overcoming pathological religiosity in a comprehensive program of assistance to mentally ill people based on a religious worldview**

**Abstract**: This article provides an overview of research on spirituality and religiosity in the works of Russian psychiatrists. The methods of religious psychotherapy are discussed in the context of the experience of the comprehensive rehabilitation program for mentally ill people with a religious worldview. The research studies how the value based and religious orientations and religious behavior affect the manifestations of pathological religiosity in a sample of 42 patients undergoing rehabilitation in therapeutic communities in church parishes and in public organizations. The transformation of value-semantic orientations and religious beliefs during rehabilitation is followed by changing religious behavior, which has a beneficial effect for overcoming pathological religiosity.

**Keywords**: pathological religiosity, religious psychotherapy, spiritually oriented approach, rehabilitation of mentally ill people.

**A review of national clinical studies on religious psychiatry**

The religious worldview of mentally ill people and people with behavioral disorders plays an important role in terms of clinical manifestations and course of the disease and should be considered in the treatment and prevention of such disorders, as well as in the development of comprehensive rehabilitation programs.

National and foreign studies indicate that the principles of organizing rehabilitation programs, as well as the necessary components of their implementation, should be based on the general principles of psychosocial rehabilitation, and shall use approaches of spiritually oriented and religious therapy (Kaleda V. G., 2020). The study of the experience of religious psychiatrists and the development of approaches to spiritually oriented programs of assistance to religious patients are the sphere of scientific interests of the working group of special forms of mental pathology of the Federal State Budgetary Scientific Institution "Scientific Center for Mental Health" (SCMH).

In 2021, the section "Clinical Psychiatry, Spirituality and Religiosity" was established in the structure of the Russian Society of Psychiatrists, which was chaired by Vasily G. Kaleda, MD, Professor, Deputy Director for Development and Innovation of the SCMH. The World Psychiatric Association (WPA) has a Section on Religion, Spirituality and Psychiatry for study of the effects of spirituality and religiosity on mental health in mentally ill people. International conferences on various issues of religion and mental health are held annually in Moscow, where Russian and foreign experts in this field meet.

The staff of the SCMH analyzed reviews of world research in the field of religious psychiatry, as well as conducted a number of clinical studies. G.I. Kopeyko and I.S. Samsonov studied the issues of differentiation of normal religious faith and religious psychopathology (Kopeyko G. I., Samsonov I. S., 2020). Based on the analysis of the medical records of 304 patients with schizophrenia, a study of the religious delirium phenomenon has been conducted. The authors describe the development of the psychopathological picture with the expansion of the range of delusional ideas from ideas of reference to overvalued delusional ideas with a complex delusional system; and the capture syndrome with religious content has been described as the most common form of religious delusion. The criteria for distinguishing normal religious faith from religious delusion are also given.

Pathological religiosity occupies an important place in understanding the problems of religiosity and mental health. A group of researchers led by V.G. Kaleda analyzed Russian and foreign sources by keywords: "normal religiosity", "pathological religiosity", "religious delirium", "religious-mystical states", "religious coping" in the databases MEDLINE/PubMed, Scopus, eLibrary, Google scholar, Cyberleninka (Popovich U.O., Romanenko N.V., Kaleda V.G., 2020). An analysis of the results of studies conducted between 1990 and 2020 provided extensive material for understanding the phenomenon of "pathological religiosity". The authors note the beneficial effect of religiosity on mental health, the importance of religious coping in the rehabilitation of patients with schizophrenia and schizophrenic spectrum disorders. At the same time, works devoted to the study of the influence of religiosity that preceded psychotic states of on the formation of religious delirium and the assessment of its prognostic value demonstrate contradictory results; in some cases this is due to a biased attitude towards the patients' religiosity. Scientists emphasize the importance of cooperation between a psychiatrist and a priest in order to provide better and more effective care for religious patients with mental disorders.

Based on the analysis of mental disorders with a religious content, conducted by G.I. Kopeyko and O.A. Borisova, types of pathological religiosity were described, related to various registers of the depth of mental disorders according to E. Kraepelin's classification (Borisova O.A., Kopeiko G.I., 2019). According to the authors, pathological religiosity can be assessed on the basis of several criteria, which include personal patterns, features of social functioning, absence or presence of positive psychotic symptoms, formation mechanism, possible antisocial manifestations. Depending on the severity of the disorders, assistance may include both pastoral counseling (spiritual guidance), psychopharmacological treatment, and supervision and care for severely disabled people if necessary.

G.I. Kopeyko and P.V. Orekhova, in their review of the studies of Russian and foreign scientists, explored the phenomena of religious fanaticism and religious delusion (Kopeiko G.I., Orekhova P.V., 2021). They noted the difference in the mechanisms of formation and clinical manifestations of such conditions. People with religious fanaticism are characterized by an antisocial orientation of their behavior, violation of social norms and a tendency to self-destruction. The authors note that "for a fanatic, blind adherence to religious rules, dogma is more valuable than another person"; in other words, for such people, "the Sabbath is more important than a person."" In cases of religious delirium the affected patient most often loses contact with the religious community, in some cases he is in disagreement with the spiritual father. Religious delusions have a worse prognosis compared to delusional disorders that have a different, non-religious content. A dissertation study of psychopathology and clinical picture of the end of the world delusions with religious content in schizophrenia has been completed at the SCMH in 2023 (Orekhova P.V., 2023).

In another study, the problem of distinguishing true religious visions and a special type of morbid experience (oneiroid-catatonic state) was considered, based on the texts of Holy Scripture and Holy Tradition, as well as the experience of the Christian Church Fathers (Gedevani E. V., Alekseeva A. G., 2020). The description of oneiroid-catatonic states was made the previously conducted dissertation study (Alekseeva A.G., 2016). It was concluded that true religious visions always contribute to spiritual repentance and humility, a change in a person's condition, his conscience; at the same time, the behavior of a person who, "without having deep spiritual experience, being a neophyte, begins to tell the world about his revelations, which were supposedly revealed to him by angels," is extremely suspicious.

There are a number of studies conducted on the topic of religious delusions in individuals with schizophrenia. One of the studies provides a detailed description of

religious delirium based on a review of literature (Kopeyko G.I., 2019). And based on the examination of 36 patients with schizophrenia, the clinical and psychopathological features of the capture syndrome with religious content were described, which develop according to the patterns of paranoid syndrome and are followed by the development of massive psychic automatism (Samsonov I.S. et al., 2020). The results of a long-term study of the clinical and psychopathological properties of the capture syndrome with religious content in schizophrenia are presented in a dissertation study completed in SCMH in 2021 (Samsonov I.S., 2021). E.V. Gedevani and E.V. Smirnova studied in detail the psychopathological features of religious delusions of sinfulness in patients with depression. The authors suggested that such conditions are often not recognized as a mental disorder requiring medical attention, and often lead to a worsening of the condition and late seeking help, which in some cases can lead to suicide attempts (Gedevani E.V., Smirnova E.V., 2021).

A detailed study of the influence of the religiosity factor on depression and suicide behavior revealed the protective role of religiosity in depressive states, manifested by a lower probability of depressive disorders, a decrease in the severity of depression, shortening of depressive phases and a greater rate of remission. It was also found that religious support is especially important for elderly patients and adolescents (Kopeyko G.I. et al., 2020). The authors believe that religiosity contributes to the formation of a negative attitude towards suicide and a decrease in the level of suicide activity.

As part of the research on the clinical characteristics, prognosis, and patient care related to the phenomenon of "God-abandonment", a group of 35 patients with depression was examined. The comparator group included 5 monks who had no clinical manifestations of the disease. It has been established that the central element of this condition is the specific disorders that can be defined as a state of spiritual anesthesia, a kind of religious equivalent of anaesthesia psychica dolorosa [painful mental insensitivity]; also three types of conditions have been identified, including states of spiritual crisis, depression with anesthetic and depersonalization disorders, as well as delusional ideas within acute polymorphic or depressive-delusional psychoses (Alekseeva A. G. et al., 2024).

**Religious support for the mentally ill people in a review of national research**

A significant place in scientific research is taken up by issues related to helping patients with religious worldview and mental health conditions.

The study of the value-semantic orientations of a person is important for both theory and practice, allowing to approach the assessment of the effectiveness of religious psychotherapy methods. The study of value-semantic formations and the description of their structure in mentally ill people with a religious worldview was carried out on 4 groups: "Orthodox patients", "non-believers", "healthy Orthodox" and "healthy non-believers" (Borisova O.A. et al., 2019). The authors present convincing conclusions that mentally ill non-believers have a significant distortion of value-semantic formations caused by the disease; at the same time, these formations are safer in mentally ill people with a religious worldview. The authors believe that, despite the illness, patients can fulfill the meaning of life through striving for God. They are characterized by a special attitude to the disease consistent with the religious worldview.

The experience of the SCMH specialists shows that for the treatment and rehabilitation of mentally ill people with a religious worldview, complex methods should be used, including therapy with psychopharmacological drugs, which reduces the negative manifestations of the schizophrenic process, but also psychocorrective and

psychotherapeutic methods, psychoeducational measures, among which methods of spiritually oriented and religious psychotherapy take an important place.

The study of religious coping strategies has shown the importance of the religious factor in rehabilitation work and the effectiveness of various religious coping strategy types for patients with schizophrenia. In a study on a sample of 68 patients with acute psychotic attacks with hallucinatory-paranoid, affective-delusional, oneiroid-catatonic and affective symptoms, who had a religious worldview (belonging to Christian denominations - Orthodox, Catholics, Protestants), at the first stage, value-semantic formations were studied in them, as well as in control groups of non-religious patients, believers and healthy non-believers. Comparative analysis has shown significantly greater stability of the value-semantic structure in patients with a religious worldview; a spiritually-oriented approach to rehabilitation should be implemented not only taking into account the characteristics of value-semantic orientations, but also rely on the preserved spiritual values of patients. The second part of the study assessed the possibility of using religious coping strategies in rehabilitation work with patients with paroxysmal schizophrenia and religious worldview. Based on the classification of coping strategies (K. Pargament, H. Koenig, L. Perez, 2000), "religious methods of preserving the basic values of life - conservation of traditional values and meanings; strategies of social support through a religious community; methods of religious transformational coping — religious rethinking of the situation, rethinking of one's own personality and the so-called united religious coping; religious coping strategy for achieving an emotionally comfortable state that religious faith provides (comfort, reassurance, forgiveness, reconciliation)." The authors attribute the following observations to the results of the study: patients were able to change behavioral stereotypes and acquire independent living skills. At the personal level, patients experienced a deep value-semantic reorientation with the actualization of the spiritual component and harmonization of personality, which entailed a change in the entire lifestyle of the patients (Kopeyko G.I., Borisova O.A., Kazmina O.Yu., 2016).

Effective religious coping strategies can also be used in comprehensive care for depressed patients (Kopeiko G.I. et al., 2020). The personal involvement of religious patients in religious rites plays an important role. The attitude of specialists towards religious patients should be based on a personal approach, and the clinician needs to assess the importance of religious views and practices in the patient's life. The religious worldview helps the patient preserve the basic values of life, allows them to rethink the situation of their illness and their own personality through a religious lens. Through religious faith, they can find reassurance, comfort, forgiveness, and reconciliation. It also provides access to various forms of social support from the religious community.

In patients with behavioral disorders caused by addictions, the experience of working with a multidisciplinary team of specialists, and use of social therapy based on the principles of a therapeutic community, proved to be successful. Such a community is formed in family sobriety clubs, based on a public organizations and church parishes, where the principles of family therapy are also used, and anti-drug activities are implemented. Religious psychotherapy includes the spiritually oriented dialogue of T.A. Florenskaya and religious coping strategies, while the appeal to the patient's spiritual self contributes to a more positive experience of difficult life situations, value-semantic reorientation in the tradition of religious worldview, the development of new coping behaviors (Baburin A.N. et al., 2016). Monitoring of therapeutic groups' activities is carried out by specialists of the psychiatric and narcological service, and the necessary medical treatment is provided by specialized mental health facilities. The study, which included 53 patients with alcohol addiction, demonstrated the high efficacy of a complex treatment program that included a spiritually oriented component (Magai A.I., Kazmina E.A., 2015). Also, in the system of comprehensive care, psychoeducational

and psychosocial activities, including religious content, play an important role (Kopeyko G.I. et al., 2020).

In religious patients with comorbid pathologies, such as endogenous mental disorders or addictions, the optimal form of rehabilitation is a therapeutic group based on confessional parish communities operating within the system of public organizations in the field of mental health care, under the supervision of leading scientific, practical, and research centers. With such an organization, the therapeutic component of the program is carried out through the outpatient service of a medical institution, where the patient receives medical supervision. The rehabilitation component is implemented through an extra-institutional, spiritually oriented group and various forms of spiritual support (Magai A. I. et al., 2019). In a study of 26 patients with mental pathology and alcoholism, who underwent rehabilitation using religious psychotherapy methods, there was an improvement in their quality of life, an increase in the general meaningfulness of their lives and the formation of an adequate self-esteem a harmonization of their internal and external religiousness, as well as the development of new religious coping behaviors (Kopeyko G. I. et al., 2019).

An important place in the system of measures aimed at assisting the mentally ill people is the integration of these individuals into the religious community life. The implementation of bio-psycho-socio-spiritual approach determines the integration of secular and religious approaches in treatment and psychotherapy, as well as of the patient's natural religiosity, which can be most fully realized in a supportive church environment. In spiritually oriented models of assistance, faith and religious life practice fill religious coping methods with content; and religious teaching can be used to discuss irrational beliefs and challenge negative knowledge (Magai A. I., Solokhina T. A., 2021). The principles of the program of patient care in a religious parish are as follows: 1) an individual approach and the work of a multidisciplinary team of specialists; 2) assistance in restoring social status; 3) voluntary participation of the patient and family members in the life of the religious community; 4) actualization of the family type of communication and social support; 5) a wide range of socio-therapeutic activities, including those of spiritual nature.

**A comprehensive program for mentally ill people based on a religious worldview**

The above analysis of sources allows us to formulate the main provisions of a comprehensive assistance program for mentally ill people based on a religious worldview:

1. The program should be based on the bio-psycho-socio-spiritual concept of mental illness therapy, including the integration of biomedical, psychosocial, sociotherapeutic and spiritually oriented approaches in helping the mentally ill.

2. The therapeutic component of the program should be provided by specialists and organizations from the mental health sector using modern, scientifically-based technologies and techniques for psychopharmacological treatment, psychological correction, and multimodal individual and group psychotherapy.

3. The rehabilitation component of the program is provided by outpatient services in the structure of mental health institutions and of non-institutionalized formations related to the work of public and religious organizations. The principles of rehabilitation include the creation of a therapeutic community where spiritually-oriented forms of support are provided together with various types of psychosocial and socio-therapeutic assistance, as well as family therapy.

4. Within the spiritually-oriented approach, the program has a positive impact on value and meaning orientations based on religious worldview; adaptive styles of

religious behavior are developed, which favorably influences coping with phenomena of pathological religiosity.

An analysis of some components of the program has been previously presented in scientific publications (Magai A.I., 2023, 2022). In this study I would like to elaborate on the description of the spiritually oriented component of the program.

The structure of spiritually oriented activities can be diverse and is determined by the capabilities of specialists and by practices implemented in a specific situation.

The general principle of this stage of assistance, in its ultimate goal, can be described as the correction of pathological religious behavior. The return to normal (true) religiosity, and in some cases the replenishment of deficient religiosity, is achieved as a result of the activities of the rehabilitation program and the patient's natural religious life in faith. Overcoming spiritual deficiency has a positive effect on the mental health of the patient (Kirilyuk M.I., Nemtsev A.V., 2023).

According to Priest Pavel Velikanov, manifestations of pathological religiosity can be influenced at two main levels:

1) Beliefs and doctrines based on distorted value (religious) ideas;

2) The practice of religious life, in which non-adaptive styles of religious behavior are implemented.

Based on the proposed model, two main targets of spiritually oriented therapy can be identified in the patient care program based on a religious worldview: spiritual values and meanings, as well as religious behavior.

*The first target* is value–semantic orientations, morbid beliefs and distorted religious judgments. Earlier, as part of the pathological religiosity study, cases were described when special value orientations and morbid judgments caused conflicts between the patient and his own personality, people around him, including the spiritual father and representatives of the religious community. A negative attitude of the patient towards God may also be formed (Bussema K.E., Bussema E.F., 2000).

The religious psychotherapy describes approaches used in different religious denominations. In the Christian tradition, experts focus on forgiveness strategies (REACH model) (Worthington Jr E.L., Lin Y., Ho M.Y., 2012). Russian studies have proven the effectiveness of spiritually oriented dialogue according to T.A. Florenskaya (Magai A. I., Ryazanova T. B., 2023), as well as methods of religious cognitive psychotherapy (Utrobina V.G., Sterligova O.P., 2022). Attempts to comprehend religious approaches have been made in the Islamic tradition (Yakhin F.F., 2018). Foreign studies describe the successful application of cognitive religious psychotherapy within the context of a spiritually-oriented approach to coping with anxiety and depression, as it is practiced in various faith traditions (Anderson N. et al., 2015). The main mechanisms that can be used in achieving the therapeutic objectives of this stage include transformational religious coping and religious rethinking of the situation, as well as rethinking one's own personality.

*The second target* is maladaptive styles of religious behavior, as well as behaviors induced by diseased religious attitudes. Participation in religious life contributes to a natural correction of negative behavioral patterns (Polishchuk Yu.I., 2006). At the same time, the persistent maladaptive religious behaviors necessitate the creation of a therapeutic environment where behavioral manifestations of pathological religiosity are replaced by new, adaptive religious behaviors in the course of special structured activity (Baburin A.N. 2017). Among a large set of techniques, methods and tools, the following are described and successfully used in practice: pilgrimages, art therapy, film lectures, cultural and mass events with a spiritual and moral focus, sports activities in a religious community, rehabilitation camps, psychoeducational and psychoeducational events with a spiritual and moral focus (Borisova O.A. et al., 2010, Kopeyko G.I., 2020). The analysis of religious coping strategies allows us to identify

the main mechanisms of such therapy: social support through a religious community, religious coping through finding an emotionally comfortable state, acquisition of new social functions through participation in religious life.

It is worth noting that such manifestations of religious life as participation in divine services, the sacraments of Confession and Communion, observance of religious fasting within the rehabilitation program are considered as a natural manifestation of religious feeling and are not the target of psychotherapeutic work. However, they can be considered in aspects of the "spiritual records" of the patient.

## Research

### Purpose of the study

To determine the impact of a comprehensive rehabilitation program based on a religious worldview, value-semantic orientations and methods of religious coping in patients with mental and behavioral disorders.

### Hypotheses

In the process of rehabilitation, patients with a religious worldview experience qualitative changes in the spiritual sphere and value-semantic orientations, the adaptive skills of religious coping behavior are learned, which positively affects the pathological religiosity.

### Materials

The study was conducted of a sample of 42 patients, 22 men and 20 women aged 25 to 60 years with diagnoses of endogenous mental illness (diagnosed according to ICD-10 – F20.x, F25.x, F21.3-21.4, F 33.4, F31.7, F32.2) and behavioral disorders (according to ICD-10 – F10.x).

As part of the therapeutic module, patients had outpatient observation in psychiatric clinics in Moscow, and the activities of the program rehabilitation module were carried out in spiritually oriented therapeutic communities based on public organizations (Interregional public movement in support of family sobriety clubs, Russian Charity "Family and Mental Health") and Moscow churches (Church of All Saints in Sokol, St. Euphrosyne Church, All-Merciful Savior church (Monastery to the Mother of God icon Joy of All Who Sorrow).

In the context of the therapeutic community, methods of social therapy, spiritually oriented dialogue according to T.A. Florenskaya, cognitive religious psychotherapy and other multimodal psycho- and sociotherapeutic approaches (art therapy, film therapy, leisure activities) were used.

### Research methods

Clinical and statistical methods, psychometric scales and questionnaires were used as research methods: the self-assessment scale of C.D. Spielberger and Y.L. Khanin (State-Trait Anxiety Inventory, STAI), the SF-36 quality of life questionnaire, the test of life orientations (LOT) by D. A. Leontiev (adapted version of "Purpose-in-Life Test", PIL), a questionnaire of value orientations by S. Schwartz, a scale of religiosity (adapted version by O.Yu. Kazmin), a short questionnaire of religious coping B-RCOPE (adapted version by F. M. Shankov, A. A. Zolotareva), a self-evaluation questionnaire.

### Results

42 patients with diagnosed of mental disorders participated in the rehabilitation program. 13 stopped rehabilitation before to the scheduled date, out of 29 people, 10 attended the program activities regularly, and 19 – irregularly. In the group of

rehabilitation participants, the level of quality and meaning of life increased, as well as a transformation of value orientations, with a focus on the values of "safety", "kindness", and "tradition". There was also an increase in the coherence of values between groups of normative ideals and personal priorities (according to Schwartz). There was a harmonization of the structure of religiosity, accompanied by an increase in the values of internal religious orientation and a change in religious behavior among patients. This was accompanied by a sense of fullness in religious experiences and an improvement in the quality of their religious lives. According to the self-evaluation questionnaire analysis and clinical observation, patients stated the importance of religious psychotherapy in coping with mental disorders. The specialists of the program noted that the patients demonstrated more adaptive religious coping behaviors, indicating positive changes in the course of correction of pathological religiosity. The change in the value-semantic sphere and religious behavior was accompanied by the transformation of the entire lifestyle of patients, the establishment of constructive relations with family and friends, in the religious community.

**Conclusions**

The study confirmed the hypothesis that, in the context of the rehabilitation program for religious patients, a change in lifestyle leads to a transformation of their religious orientation, with a decrease in pathological religiosity manifestations and an increase in normative religiosity. The use of various forms of religious support helped to improve mental health and psychological well-being. At the same time, the methods of religious psychotherapy did not become an alternative to the natural religious life, but complemented it taking into account the existing disorders.

The effectiveness of a rehabilitation program based on a religious worldview is determined, in our opinion, by the following factors:

1. Participation in the activities of the religious rehabilitation program contributes to the creation of conditions in which the natural process of spiritual and moral development and correction of psychopathological manifestations takes place.

2. Positive changes also arise as a result of the acquisition of new knowledge and skills in the course of psychoeducation and psychosocial activities, the use of religious coping strategies.

3. The implementation of a spiritually oriented component is not an alternative to religious life, but complements it in the view of existing disorders. It is important to remember that the inchurching is not a method of psychotherapeutic help, but rather the result of an individual's personal encounter with Christ.

4. The religious rehabilitation program does not bind the life of patients on its events, but helps them to acquire the meanings and skills of religious life, taking into account their mental illness..

5. The activities of the religious rehabilitation program allow patients to adaptively fulfill their needs, including spiritual ones. For this purpose, various professional psychotherapeutic technologies and methods are used, including those of a religious orientation: family counseling, spiritually oriented dialogue by T.A. Florenskaya, various forms of psychotherapeutic and sociotherapeutic support.

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**Features of the spiritual life of psychically ill people**

**Abstract:** Many years of working with mentally ill people in the hospital have shown that there are believers among them. The "hidden man of the heart" is still in them (1 Pet. 3, 4). When treating mentally ill believers, medical methods alone, as well as a set of rehabilitation measures carried out by a psychologist, are not enough; they need also spiritual help: Confession and Communion. This is especially true in compulsory treatment facilities. In order to provide comprehensive assistance to people with mental health illness, it is essential that priests have not only spiritual training, but also expertise in the field of psychiatry. Fortunately, today there is real hope for mutual understanding and cooperation in providing assistance to mentally ill believers. During my many years of work I have noted that in patients who began attending church and participating in the sacraments, the course of the disease acquired a more favorable character: they were much less likely to require hospitalization, and outpatient care in a neuropsychiatric clinic was often sufficient for them. Our common task is to do everything possible to alleviate the suffering of mentally ill people so that they can carry their burden with God's help.

**Keywords**: mentally ill, soul, psychology, psychiatry, symptoms and syndromes, drug therapy, rehabilitation, psychocorrection, mentally ill person, Christian group, spiritual help, the word of God, repentance, Communion.

In my contribution I would like to refer not to theoretical reasoning, but to many years of work experience (more than 40 years) as medical psychologist in psychiatric hospitals in Leningrad and St. Petersburg. The last 4 years in the I. I. Skvortsov-Stepanov State Psychiatric Hospital. The conclusion I came to may sound paradoxical to you, but this is the fruit of my observations and reflections: among mentally ill people, there are spiritually healthy individuals who believe in God! The "hidden man of the heart" lives in them (1 Peter 3:4). Their "Spirit indeed is willing, but the flesh is weak" (Matt. 26:41). Such people are in especially dire need of spiritual help; their soul responds to the healing word of God.

Despite the fact that in Soviet times atheism dominated, which seemed to leave no room for the soul, nevertheless, the following expressions were preserved and continued to live in colloquial speech: "the soul is not at peace", "one's soul sank into one's boots ", they called people "soulful" or "soulless", "kind soul", "pure soul". We read about the soul in the classics, heard in old Russian romantic and folk songs, etc. And since psychology is the science of the soul, I decided to study at the Faculty of Psychology.

We received an excellent basic education at the Faculty of Psychology of Leningrad State University. But we trained to look at man from a materialistic perspective. Scientific psychology considers a person as an object of study, research, and diagnosis. It divides the soul into various mental processes. In the 1970s, the V. M. Bekhterev Psychoneurological Institute, one of the leading institutions in our country, began to collaborate with the Faculty of Psychology to train specialists for work in psychiatry. As students of the medical psychology specialization, we have had the opportunity to undergo a three-year training in small, big, child, adolescent and adult psychiatry, neuropsychology, rehabilitation and psychocorrection. We were provided with all the latest theoretical and practical developments.

During our studies, we attended clinical examinations at the institute. There I heard some patients answering the question: "What is bothering you?": "My soul hurts." So these were not mentally ill, but spiritually ill people. With the knowledge I have

acquired, I have come to the hospital to work in psychodiagnostics and rehabilitation. Previously, drug therapy was the main focus in the treatment of mental illnesses. But now, after the acute condition of the patient was relieved, he was transferred to a general department. There, he became part of the life of the department, participating in activities such as occupational therapy, reading, playing board games, watching TV, and working individually and in groups with a psychologist. In personal communication, patients often shared their secrets. They talked about themselves, their lives, the things that hurt their souls, what they felt guilty about, and what prevented them from sleeping peacefully at night. Sometimes it was a real confession. They thanked for being listened to and understood. I had a keen interest in each of them, a desire to understand and, if possible, help. I liked to implement and carry out rehabilitation activities, to participate in the process of returning patients to a full life. At the same time, I felt that this was not enough. What else were our patients missing? I received the answer to my question in the summer of 1986 in Zelenogorsk. Flyers with a story about the church as a hospital and about the Sacrament of Confession were placed on the stand near the Church of the Kazan Mother of God. Leaflets explaining that the Church was a hospital and describing the Sacrament of Confession were placed near the stand outside the church of the Mother of God icon of Kazan.

At that time there were only 4 active churches in Leningrad. On Sunday, I went to the worship service at the Transfiguration Cathedral, and later I continued attending services. Attending the Sacraments nourished my soul. Now, if necessary, I could tell the faithful patients about the possibility of receiving spiritual help from the Orthodox Church. For example, I will tell you the story of a patient who first arrived at our hospital in an acute condition. She got sick after she graduated from the university. Her parents tried to hide from everyone that their daughter was mentally ill. For many years, they simply locked their daughter at home and went to work. But all the secrets become clear. The disease progressed. The patient started opening windows, screaming, throwing things out. The neighbors called an ambulance. She was treated in the hospital for several months, the acute condition has been resolved, however, the patient obviously had a problem. I needed to see the patient before I let her go on a trial vacation for the weekend. During the conversation, she began to talk with regret and pain about her life and what she had "messed up". It was a real confession. "Do you regret what you did?" I asked the patient. "Yes," she replied. "Do you believe in God?" "I do", she replied. It turned out that the patient was secretly baptized by her grandmother, since her parents were communist party members and held high positions in our city. That's why they didn't go to psychiatrists. Then I told the patient about the opportunity to go to church for confession to ask God for forgiveness for sins and receive Holy Communion. After the weekend, the patient returned to the hospital. I invited her to my office and that's what she told me. On Sunday, accompanied by her mother, she went to church for a worship service. Her mother stayed outside. The patient entered the church and asked where she could confess, went up to the priest. Here I quote her words: "I came and told everything. Then the priest covered me with something. And when I took it off, for the first time in many years I felt so good and easy, as if a heavy load had been lifted from my shoulders." I looked at the patient and saw on her face no longer a mask, but a grateful smile. Now I had no doubt that our faithful patients needed spiritual help: Confession and Communion. Later on, I saw a lot of evidence of this. In patients who began to attend church and participate in the sacraments, the course of the disease acquired a more favorable character: they were much less likely to be hospitalized; outpatient care within a psychiatric clinic was enough for them. Later, when it became possible, I invited priests to the hospital. And before that, I sometimes took patients from other cities to church, which was next to the

hospital. The doctors of the hospital also noticed the beneficial effect of the sacraments on the sick and even asked when the priests would come.

At the beginning of the 2000s, a chapel has been opened in the psychologists' office. Confession, Communion and individual baptisms of the patients took place there. After discharge, some of our patients went to work in monasteries, and sometimes stayed there if they took supporting therapy. This was possible when the head of the monastery considered and took into account patient's diagnosis while providing spiritual care, and gave his blessing for taking medicines. Unfortunately, sometimes the priests canceled the medicines, and then the patients returned to the hospital very soon. The priests had a spiritual education, but they lacked knowledge and understanding in the field of psychiatry. This is why, also at the beginning of the 2000s, the rector of the St. Petersburg Theological Academy, Archbishop Konstantin, introduced an elective course in psychiatry for students of all classes of the Seminary and Academy. Fortunately, doctors are now becoming more interested in attending church services, and priests are learning more about psychiatry. We turned around to face each other, and there is a real hope for mutual understanding and cooperation in helping mentally ill believers. This is clearly demonstrated by our conference.

Due to the above and to illustrate the real request from the mentally ill people for spiritual assistance, I want to focus on the experience of working in the department of compulsory treatment at the Skvortsov-Stepanov Psychiatric Hospital. At the end of 2017, the hospital administration mobilized a psychological service for active group work at this department. In addition, a separate request was received to form a Christian group to use the faith of patients as a resource in the treatment and rehabilitation process. Patients had to attend all group meetings (cognitive training, art therapy, psychoeducation, etc.) compulsorily as prescribed by a doctor. They signed up for the Christian Group on their own and came voluntarily. We introduced ourselves at the first meeting. Everyone shared what brought them to the group, their knowledge of their faith, and their hopes and dreams. Those attending the group were baptized, but not active believers. They wanted to learn more about God, read and understand the Holy Scriptures, and learn to live a Christian life. They had a spiritual thirst.

After the session, I went to the doctors' office to find out about my patients and get acquainted with their clinical record. From a conversation with doctors, I learned that most of the group's members are "incurable patients with a severe defect" who have committed serious crimes: brutal murders and violence. That many of them have been in compulsory treatment for more than 10-20 years. Their medical records were so thick that they resembled ancient folios. I tried to start reading those of them that are a little thinner, and realized that it was better for me not to know all the details of their deeds. Let them be ordinary mentally ill people for me. If they voluntarily joined a Christian group, then their soul is still alive, so there is a spark of faith in it. For many years they have been carrying the heavy burden of their sin and no medications could relieve their mental pain and silence the voice of conscience. Therefore, spiritual therapy is especially recommended for them. My task is to do everything possible for them to alleviate their suffering.

Our Christian group was heterogeneous in age, diagnosis, intellectual and educational level, and social status; they were people with academic education and without education, aged 18 to 70 years, with various forms of schizophrenia, schizotypal, personal and organic disorders, with a mild degree of mental retardation and with a mild degree of dementia. The group was open. When a new person joins us, we ask him to say a few words about himself. The rules of working in a Christian group did not differ from the rules in other groups. We started each session with prayer. At the end, according to tradition, everyone was invited to say in a circle what he had gained that was useful for the soul, in what mood he was leaving the session. As a rule,

everyone's mood got better, the patients sincerely thanked for the session, asked the leader to come back again, and asked about the time of the next meeting. Some patients left in the same depressed state in which they came to the group, but said they did not regret being with us.

It is important to note that due to the limited number of available rooms, we were allocated residually daytime sleep hours for our sessions. At that time, when all the patients took medicines after lunch and went to sleep in their rooms, the faithful patients went to the group. Working in a group required great inner concentration and tension from them, despite this, most patients continued to attend our sessions. This was especially true for those patients who have been on treatment for decades (9 people) – they were the core of the Christian group and attended it regularly. However, some patients were forced to skip sessions. Alone, because they could not overcome day somnolence and participate in group work. Others, because their mental state was deteriorating, and then the doctors would not allow them to go to the group. During the session, we prayed for everyone who couldn't come. Sometimes the patient stopped coming on his own, because he thought that he had "enough", and after a few months he could return. Patients with religious delusions also came to our group. After drug therapy, their mental state improved, while at the same time they lost interest in spiritual issues. They would leave our group forever. Fortunately, a little later, the time of our meetings was changed: we started meeting at 12 o'clock.

For 4 years we have been practicing for 1 hour 2 times a week. From 10 to 15 people came to sessions, sometimes more. Each patient had a Bible or a New Testament with him. What did we do at the Christian group? Literally "Bibliotherapy". First, we learned about the commandments of God, and only then we began to read one chapter from the Gospel in a circle. After that, the patients could ask questions. Next, I suggested recalling the contents of the chapter: what events are described in it, who participated in them, what teachings were useful for the soul in it. It was important for me that each patient tried to feel that the Lord Jesus Christ loves him, that the word of God is addressed to him personally, and it is important for us to try to hear and, if possible, understand Him. The discussion in the group was always meaningful, deep, and serious: the patients communicated with each other not as patients of a psychiatric hospital, but as brothers in Christ. We talked about living faith, the opportunity to make friends with God, build personal relationships with Him, and what needs to be done for this. Now our patients have the opportunity to see their lives in the light of Christ's truth and love, to compare it with what our Lord and Savior, Jesus Christ, teaches us. Their soul responded to the Lord's call: "Repent!" Gradually, the patients came to a conscious desire to confess their sins to God and ask for His forgiveness. They needed spiritual help. There is a church of the Great Martyr and healer Panteleimon on the territory of the hospital. With the permission of the head of the department, I arranged with the rector of the church, Fr. Alexy, to visit patients at the department. We were preparing for this event together. The patients were afraid and asked to talk about the sacraments of Confession and Holy Communion. And finally, the priest came, and we prayed together. And after the Confession, the patients received the Holy Communion. For our patients, it was the first Confession and the first Holy Communion in their lives. Late the priest regularly visited our department. The patients began to prepare more consciously and participate in the sacraments in order to ask the merciful Lord for forgiveness, to reconcile with Him in their hearts. Other patients of the department followed our patients to Confession.

Attending the Christian group has become an urgent need for the patients. It became apparent when I have left for vacation. Despite my absence, on the appointed day and hour the patients gathered together on their own. The staff was surprised and met their wish, because staff usually has to make an effort to gather patients into groups.

The group continued to work. Doctors began to treat religious patients with respect. It remained a mystery to them what gives strength to patients with a pronounced emotional, volitional and intellectual defect to get up on their own and go to work in a group. They shared their bewilderment with me, and were interested in what we were doing; I told them. Many of the doctors were baptized, nominally Orthodox, sympathizers. They became motivated to read the New Testament. Some of the doctors, watching our patients, put on a cross. Icons appeared in the department.

In my work, I relied primarily on God's help and applied all my accumulated professional experience and knowledge, as well as experience in helping religious patients, including those who had never attended church before. I also tried to take into account the requests of patients and their condition, church calendar feasts, name days of the group members. In a difficult situation, patients could ask for support and prayer help. For example: at the beginning of the meeting, each person in a circle called his name, said in what mood he came, what worries him. When the patient was depressed and bleak, we all prayed for him. Or, for example, when he was outraged or angry at the medical staff, we clarified what happened to him, together we tried to look at the situation from a Christian perspective, as the Lord Jesus Christ teaches. The patients were particularly worried about waiting for the commission to lift compulsory treatment, and asked to pray for them. After the commission, if their treatment was extended, they had a question: "Why?" It was necessary to help the patient to accept the decision of the commission as the will of God. It was hard to do this, but the patients understood what they were being punished for and learned to accept it. They were helped in this by the leaflet "This was from Me" (the spiritual testament of St. Seraphim of Vyritsa). Sometimes we read it as a group. Some patients had their own copy in the hospital.

In group sessions, we not only read, narrated, and discussed the Bible, but also listened to spiritual chants, we sang prayers before and at the end of group work, painted, watched feature films and documentaries and discussed them. Among them: "Pilgrimage to the Eternal City", "In the footsteps of Christ", "The Forgiven Resurrection", "Ben Hur" and others. Also, at the request of the patients, we talked in detail about sins and Christian virtues, and read spiritual literature on this topic. As a result of this work, the patients designed a poster and called it "The Tree of knowledge of Good and Evil" and, with the permission of the administration, put it on the wall of the hospital department.

Each patient in the hospital department had a New Testament, short prayers and icons. They took spiritual literature from me for independent reading. All this contributed to the formation of patients' Christian worldview and understanding of how truly religious people lived and live. They began to pray for each other. At Easter and Christmas, we were allowed to have a festive tea party. Patients prepared for these holidays in advance, made postcards with their own hands and congratulated their relatives and staff. For Christmas, those who wanted to, learned poetry.

From the outside, it may seem that there is nothing surprising here. This is so, if we do not take into account that all of the above happened to deeply defective patients who committed serious crimes. Now they were not serving their time, but consciously and patiently, with God's help, they tried to carry their burden. Being "jailed" for many years, they got a chance to gain inner freedom, freedom in Christ.

**Conclusion**

Thus, spiritual therapy is especially indicated for mentally ill patients. Their soul responds to the healing word of God. Mentally ill people need to receive not only medical but also spiritual help, attend the church services, resort to the sacraments of Confession and Communion. Experience shows that this approach in the treatment of

mental illness has a beneficial effect on the course of the disease. The task of a psychiatrist, psychologist and priest is to do everything possible to alleviate the suffering of the mentally ill people so that they could, with God's help, carry their burden.

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**Psychological resources in pastoral care in working with pathological and true feeling of guilt**

**Abstract:** The pastor is faced with a person's feeling of guilt when the latter experiences shame for a sin committed as a consequence of awareness of his individual sinfulness. Shame is an emotional reaction of the soul when it recognizes its sinfulness as a personal spiritual and moral "badness." Culpability is an emotionally constructive transformation of the feeling of shame into personal responsibility for what was done, it is the acceptance that retribution is fair, atonement and correction are necessary. Guilt is a reaction to a sin committed as a misdemeanor, which is converted into acceptance of the trajectory of correction. The feeling of guilt is always directed at the person's personality. This is the important difference between guilt and the feeling of guilt.

The pastor should differentiate between the feeling of guilt and true guilt in the light of God's commandments and; when recognizing the feeling of guilt, work, first of all, with guilt. A psychologist or psychotherapist works with the feeling of guilt, and, if the spiritual and moral causes of this feeling are determined, delegates the client to the pastor. It is important for the pastor to understand that the person can have feeling of guilt without having committed sin, as a form of neurotic or religiously rationalized self-esteem. True feeling of guilt is always a reaction to shame as a result of awareness of personal sinfulness, which is actualized in the light of clear, spiritual and moral values and God's commandments, in which, by definition, the pastor is an expert.

**Keywords**: true feeling of guilt, culpability, pathological guilt, pastoral care resources.

**Guilt and culpability**

Three feelings of guilt can haunt a person throughout his life:

• feeling real guilt,

• irrational feeling of guilt (imaginary)

• and existential feeling of guilt.

A priest most often comes into contact with people who are burdened by guilt as a result of feeling they have committed a sin. Real guilt leads a person to turn to a representative of the Church as a guide to God. A psychologist most often has to work with an irrational feeling of guilt. A Christian psychologist and psychiatrist in their practice deal with both feelings of guilt and a feeling of sin.

**Culpability and true feeling of guilt** arise as a result of awareness of the intrapersonal conflict of one's moral principle with the Divine rules of life. It is often perceived as a conflict or inconsistency with the internal moral law of conscience, society, faith, conscience. It is important for clergymen to approach the states of culpability and feeling of guilt in a differentiated way.

Guilt is a fault, misdemeanor, crime, transgression, sin (meaning misconduct).

A clergyman is an expert in understanding the states of sinfulness, guilt, and forgiveness.

Feeling of guilt is a psycho-emotional reaction to both true and pathological feelings of guilt.

Both priests and psychologists and, in cases of pathology, psychiatrists work with feelings of guilt.

**Feelings of guilt and shame are interrelated.**

Shame is the first reaction of a sinful soul to sin, the awareness of "badness". The example of Adam and Eve. " And the man and his wife were both naked and were not ashamed" (Gen. 2:25) and hid, being afraid (Gen. 3:10).

Guilt is acceptance of the need for retribution. An example is the expulsion of Adam and Eve from paradise.

Shame is an awareness of one's "sinfulness" or spiritual and moral inadequacy, causing moral regret. Unlike feeling of guilt, shame does not seek retribution or redemption; in shame, the human soul lives through its spiritual insufficiency and moral inferiority.

The feeling of guilt, unlike shame, seeks retribution as a form of atonement, accepting punishment "for the sake of correction."

Whether a **feeling of guilt is true** is determined, first of all, by the reaction to the impact of truth in the forms of God's Word, Divine church practices.

True culpability is lived in the feeling of guilt and under the influence of the gracious resources of the church. It transforms the state and feeling of guilt into resources and states of forgiveness and spiritual and moral recovery.

Prayer of repentance, sacraments, sacred rites, rituals of church practices are intended to restore the soul from guilt to forgiveness and sanctification of the soul.

Feeling of guilt is a psycho-emotional reflection of a person's culpability.

The culpability is directed at a sinful state, a misdemeanor and acknowledges that correction or punishment is fair.

Feelings of guilt are an emotional form of a person's internal self-esteem.

True feeling of guilt indicates specific states.

**The pathological feeling of guilt** manifests itself as a stable emotional self-esteem, which is not converted into beneficial states under the influence of church sacraments and sacred practices, and requires constant correction by an external assessment of a socially and psychologically significant person: a priest, a spiritual father.

If such relationships do not exist, then the pathological feeling of guilt and the accompanying feeling of shame breaks through in the form of auto-aggression, both psychological and physical, and is often projected onto others in the form of persistent condemnation and rationalized aggression.

A clergyman does not have to diagnose the truth and pathology of guilt. The priest has the meaning of God's law of life and knows how to help with the resources of sacred rites and church sacraments; compliance or resistance towards them will indicate the presence or absence of pathology in the experience of guilt or shame. Under the influence of the admonishing words of the pastor and the sacred rites of the church, a person experiences an internal transformation of feelings of guilt into a feeling of "forgiveness," "sanctification," and peace.

Therefore, first of all, in spiritual pastoral practice, it is important to interact with a person's soul from the position of a clergyman, as an expert who can explain compliance with God's laws of life and help the person's soul determine the degree of guilt before God and his conscience.

This is a kind of spiritual rationalization that allows a person to separate his guilt before God and understand his feeling of guilt as a personal reflection or as an irrational, sometimes neurotically determined self-esteem.

In practical pastoral work, this can be done in a personal, pastoral conversation, in which the pastor, asking a question about the feelings of the person, turns his inner gaze to the meanings that fuel this feeling. From the irrationally experienced to the rationally comprehended.

**Questions about feelings of guilt and shame:**

What do you feel? What does it look like in your case? When have you felt this before? How would you like to feel? Has this happened in your life?

**Questions about meanings:**

Why do you feel that way? What or who is it related to? What do you think are the reasons for such an internal state?

True feelings of guilt, shame and sinfulness are neutralized and converted under the influence of the Divine meanings of Holy Scripture, sacraments and sacred rites.

Pathological feeling of guilt resists and turns off neurotic defenses.

In this case, the pastor has the opportunity to try a "psychologist" in himself and, if these attempts bother the pastor or fail to have a spiritual and therapeutic effect, connect a Christian psychologist or psychiatrist who shares the spiritual meanings of the church and Christian life and knows the techniques of converting neurotic complexes into therapeutic resourceful states.

What can a pastor do before referring a person to a Christian specialist?

Analyze the case from the position of the hypothesis of pathological feelings of guilt and shame, testing the hypothesis of fixation, transference and projection.

**Emotional transference of feeling of guilt.**

***The transference of the feeling of guilt,*** *once experienced with a parent, to the pastor, to the rector, to God the Father* occurs as a result of the transfer of a chronic feeling of guilt, formed under the influence of a parental figure in childhood, to a clergyman, God, a servant of the Church in the present. The person feels guilty, just like he did before his father or mother in his childhood. This happens if the parents used an authoritarian parenting strategy and manipulated the child's feeling of guilt.

**Transference strategies.**

1. A positive transfer of the true feeling of guilt, redemption, and forgiveness.

It is formed as a result of an educational strategy in which parents explained to the child in a language he understands:

• criteria of guilt,

• defined clear boundaries of right and wrong,

• feeling of guilt arose as an emotional reaction to understanding parental values of life and behavior,

• the child experienced a feeling of guilt during the process of explanation,

• the child accepted that redemptive and corrective actions were fair,

• after that his parents forgave him, and this was reinforced verbally, tactilely, emotionally.

2. Transference of pathological experience of guilt, shame and punishment.

It is formed as a result of an educational strategy in which parents:

• did not explain the criteria of guilt, but simply punished,

• the boundaries of right and wrong changed situationally depending on the emotional state of the parents,

• the child's feeling of guilt developed as an emotional reaction to punishment,

• the child regained the favor of his parents as a result of redemptive actions,

• forgiveness by parents was not always or not at all supported verbally, tactilely, emotionally,

• the parents took the stress out on the child, assigning him the blame,

• the child experienced the feeling of guilt as a threat of inevitable punishment, and therefore the guilt was rationalized and repressed, forming neurotic strategies to minimize or avoid the threat, subsequently leading to the projection of one's guilt onto others.

**Pastoral resources**

In a person's mind, a pastor can be associated with a significant figure to whom respect or fear, inherited from parents, is emotionally transferred. If a pastor feels a similar attitude towards himself, then he can accept this emotional transfer and complete a constructive parental scenario in contact with the person, taking on the short-term educational function of a spiritual father, mother, mentor and helping the person to live a constructive scenario of true culpability, guilt, shame and forgiveness, within which the spiritual mentor:

• explains the criteria of guilt,

• defines the understandable framework of the righteous and sinful,

• feeling of guilt develops as an emotional reaction to an understanding of the spiritually and socially significant values of life and behavior,

• the feeling of guilt is experienced in the process of clarification,

• the person accepts that redemptive and corrective actions are fair

• after that, in contact with a spiritually significant figure of the pastor, forgiveness is lived through, which is positively supported by verbal and emotional feedback.

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*Lazko N. V.*

**The role of a psychiatrist in helping patients with chronic mental disorders realize opportunities for participation in church and parish life**

**Abstract:** The report is dedicated to one of the aspects of the problem of adaptation of patients with chronic mental disorders in the society. The important role of fully integrating such individuals into Eucharistic and parish life was emphasized. The tasks that psychiatrists face in relation to patients with mental disorders and the typical contingent of patients, are identified: tasks that have both similarities and differences. The importance of church formation in cases where it is impossible to carry out pharmacotherapy due to somatic burden. Specific options for adaptation measures in the situation of parish life for persons suffering from endogenous mental disorders, neurotic pathology, and cognitive deficits are proposed. The presented material confirms the thesis about the need for cooperative efforts of a psychiatrist, psychologist and priest to solve this problem.

**Keywords:** chronic mental disorders, adaptation, Eucharistic life, psychopharmacotherapy, psychocorrection.

The issue of adaptation in the society for patients with chronic mental health disorders remains relevant, as it must be addressed on an individual basis for each such person. At the same time, those who correlate their worldview with one or another religious confession have the advantage of "consciously allowing" the Creator into the structure of their lives. According to the Russian scientist and theologian, outstanding church and public figure A.V. Kartashev (cited from the 1996 edition), "the church must have fundamental answers to absolutely all the questions of life"; he also points out that "our pastorate must, as an institution, as an estate, be trained in its theological school to provide laypeople with spiritual guidance not only on matters related to soul salvation... but also on social issues." The prominent Russian psychiatrist S.S. Korsakov paid special attention to the treatment of mentally ill patients, where "everything must be harmonious, everything must be done punctually, accurately in time and in quality, but at the same time must be conscious." He emphasized that "the living soul must be visible in everything, and above all in the individualization of each patient." In his opinion, psychiatry, due to its closeness to psychology and philosophical sciences, greatly contributes to improving the general worldview of the doctor, gives him a more correct understanding of the most important manifestations of individual and social life, and increases the educational influence of the doctor on the environment (cited from the 2003 edition). Our famous elder Archimandrite Ioann (Krestyankin), and not only him, repeatedly reminded ill people, especially those with mental disorders, of the need for Confession, Unction and frequent Holy Communion (2004). Therefore, it is extremely important to fully include such people, our brothers and sisters, in full-fledged Eucharistic and parish life, which once again confirms the thesis about the need for the cooperative efforts of a psychiatrist, psychologist and priest. Of course, the "ideal" supervisor in this situation is a priest with training in medicine and in pastoral psychiatry and psychology. But, since such cases are rare, each specialist helps in accordance with his competence. It is assumed that both the psychiatrist and the psychologist, as members of the Church, have their own personal experience of the Eucharistic life (or experience of spiritual life in accordance with their confessional affiliation). Of great interest is the practical experience of Fr. Cyprian (Burkov), a monk and Orthodox psychologist, who offers his clients with mental disorders to learn the skill of constant prayer with minimal use of psychopharmacotherapeutic drugs.

The tasks that psychiatrists face in relation to parishioners with mental disorders and the regular patient population have both some common features, but also certain differences. All patients: a) require necessary and adequate psychopharmacotherapy and metabolic correction; b) need the timely inclusion of psychotherapeutic and psychocorrectional assistance upon achieving a stable mental state (which is recommended by a psychiatrist when assessing the dynamic mental state); c) need adequate recommendations on daily routine and employment (professional and (or) domestic) depending on the characteristics of the mental disorder and predicted adaptation capabilities.

When supervising patients with mental disorders in a parish community, their individual religious experience should be taken into account, including the skill of constant prayer in some of them, and the ability to assess their condition from the point of view of "discerning spirits." Regarding the idea of Professor F.V. Kondratiev about "removing protection" for reasons unknown to us, when patients begin to feel the "invisible world", it should be noted that a number of patients have empirically come to a similar conclusion and are trying to resist this with prayer. He also points out that the ability of mentally ill people to resist tendencies to ridiculous, dangerous acts as a result of the "psychotic chaos" that has washed over them has been repeatedly noted in the specialized literature (Breiz A., Strauss T.S., 1983). According to him, since in most psychopathological syndromes connections with the outside world are not completely lost, this leaves open the possibility for a more or less adequate reflection of external realities and the use of premorbid personal experience, which can manifest itself in quite psychologically understandable actions (1987). In some cases, it is almost impossible for patients with somatic complications to receive not only adequate, but also minimal pharmacotherapy, which determines the need for inchurching due to "life-threatening conditions." Therefore, a psychiatrist, in addition to the above, can: a) actively assist in the arrangement of pastoral care for the individual Eucharistic life; b) help the priest determine ascetic practices (fasts, prayers, etc.); c) recommend in a sensitive manner to the hierarchy and community leaders that they be included in the available employment opportunities in the parish (attending classes to studying the Holy Scriptures, folk choir singing, Church duties, palliative assistance, etc.).

For a more complete presentation of the psychiatrist's role in helping patients with mental disorders in the parish, we will outline the main nosological forms and the problems and potential opportunities associated with them. Thus, when interacting with patients with mental disorders of the schizophrenia spectrum and other endogenous pathologies, one should take into account, first of all, the tendency to distorted perception of information and its subjective interpretation due to ideational disorders, affective instability, even during therapeutic remission. Such persons, provided they have sufficient intellectual integrity, are capable, in their mental state, of choir duties, for example, reading the Psalter, which, according to St. Basil the Great, is "serenity of Soul; it is the author of peace,… city of refuge from the demons; a means of inducing help from the angels, a weapon in fears by night, a rest from the toils of the day". Dynamic interaction with other people and organizational assignments (pilgrimages, etc.), can be associated with increased mental stress. This can lead to worsening health. However, specific tasks related to finding information for Sunday school classes or about the location of a pilgrimage site are generally adequate and do not usually deplete individual resources.

Cognitive deficits and the slowness of mental processes (in organic mental disorders, mental retardation as well as genetic pathology) determine, mainly, the possibility of "applied" participation in parish life, including "imitating" activities, such as cleaning and decorating a Church in preparation for services, serving as a candlestick holder, preparing drinks after Holy Communion, etc. Certain difficulties arise when

cognitive and behavioral disorders are combined. The latter, as a rule, can be controlled by therapy in general, although they may occasionally spontaneously resume, albeit for a short period, with routine household activities, being “provoked” by everyday routine. Therefore, parish staff and parishioners who directly interact with such individuals need a “short training course” to avoid such escalations.

Neurotic disorders, which often have a prolonged course, can be particularly concerning due to the challenges of realizing the full potential of such individuals. In these cases, it can often be difficult to select an adequate therapy due to organic defects (consequences of early illness, infections, and intoxications) and various somatic pathologies. For such patients, who are personally and intellectually intact, the psychotherapeutic work of both a doctor and a psychologist is of great importance, aimed at developing the skill of switching from one’s own troubles to helping in solving the problems of other people (nursing, training parishioners using professional knowledge, specialized counseling).

Conclusion. Thus, a psychiatrist, in collaboration with a psychologist and a priest, can greatly improve the adaptation of patients with various forms of psychopathology both in everyday life and in parish life, and also provides an opportunity for other members of the parish community to actively demonstrate their Christian attitude towards those suffering.

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**Studies of the non-pathological etiology of hallucinatory experience in the light of the intentionality of religious consciousness**

**Abstract:** The question of the etiology of hallucinatory experiences is still unclear, and the available data does not allow us to develop a single, generally applicable theory regarding the causes of these experiences or the process of experiencing them outside the analysis of a specific personal experience. Many parallel existing and influencing factors form an individual picture each time.

When analyzing, it is important to consider that in each specific case, both autocommunication in internal speech during a failure to identify one's "I" and pathological psychophysiological changes in the human body can be relevant as a basis for experience. Such caution allows us to overcome the initially set positions of predestination regarding the ontological status of experiences, which are accepted in psychiatry and theology.

**Keywords:** hallucinatory experience, spiritual experiences, psychopathology, belief in the supernatural.

In the Christian tradition, religious experience often takes the form of a person's dialogue with God. And although Christianity is quite suspicious of unusual, mystical experiences such as ecstasy, glossolalia, etc., it is less resistant to spiritual visions and voices if they come from God. However, outside of theological reflection, the understanding of these phenomena has undergone significant changes over the past few centuries.

Up until the 19th century, visions and voices were generally understood to be spiritual experiences. But by the beginning of the 20th century, as E. Underhill notes, a stable confrontation between two extreme positions in their interpretation was taking shape, each of which attributed to its interpretations the status of the only convincing ones [Underhill, 1912, 319–356]. On one side of the debate, psychologists and psychiatrists discussed the psychopathological classification of both phenomena, which were referred to as *melancholia religiosa, paranoia religiosa, and mania religiosa*, etc. Within the pathographic research, confidence was strengthened that it was possible to make and justify psychopathological diagnoses for the most prominent figures in history and, in particular, the history of religion. A confidence that has been questioned over time, continues to persist to this day [Murray, Cunningham, Price, 2012, 410-426]. The opposing view was held by supporters of the "supernatural", who argued that many mental phenomena represented a miraculous interference with the "laws of nature". Although changes in science and culture over the past fifty years have reduced the intensity of this confrontation, this disposition remains largely relevant to this day, perhaps due to the fact that religion and psychiatry represent two self-sufficient systems that often do not need a mutual explanation of subjective religious experience.

However, in order to avoid one-sided judgments, the possibility of interdisciplinary analysis involving psychological, clinical psychopathological, and philosophical concepts is extremely important for the religious studies of the experiences that constantly arose in the lives of mystics such as Anthony of Padua, Margaret Mary Alacoque, Henry Suso, Teresa of Avila, Catherine of Siena, Ignatius Loyola and others. Such an approach when considering issues common to these disciplines inevitably leads to their transformation. Thus, the question of the etiology of the mental disorder pathogenesis, as accepted in psychiatry, is transformed within the context of philosophy into a question about the existential context of experience and its ontological status. This allows us to shift the focus of research interest from

psychopathological labeling towards explaining the mechanisms of thinking that underlie experiences.

The starting point in understanding the etiology of spiritual voices and visions can be the study of auditory verbal hallucinations (hereinafter referred to as AVH) over the past 35 years. However, is it the same psychological basis in relation to visions experienced by mystics, which are expressed through a different spectrum of perception? At the same time, an important question arises whether it is correct to categorize both types of experiences as hallucinations in the strict sense?

The history of active research into the phenomenon of AVH begins with the works of E. Kraepelin [Kraepelin, 1913] and E. Bleuler [Bleuler, 1911] on psychopathology, in which both emphasized the almost unlimited diversity of this symptom in schizophrenia. After the publication of the book "Beiträge zur Psychiatrie" (Contributions to Psychiatry) by the German psychiatrist and psychopathologist K. Schneider [Schneider, 1946], the AVH has firmly established itself as one of the key diagnostic elements in the research field. In Chapter VI of this work ("Cyclothymia and Schizophrenia") K. Schneider characterizes AVH as "first-rank symptoms" [Schneider, 1950]. This classification was required not because he considered them to be the main symptoms of this psychosis, but because they are of particular importance for diagnosis. Despite this clarification, as experiments by D.L. Rosenhan [Rosenhan, 1973] showed, already by the 1970s the fact of experiencing an AVH often determined a psychopathological diagnosis. The "first-rank symptoms" began to be definitely understood as diagnostic criteria for a positive diagnosis of schizophrenia in the third classification of mental disorders, adopted in 1980 by the American Psychiatric Association, after the World Psychiatric Association at the VI Congress in Honolulu in 1977 recommended that national societies use classifications compatible with the WHO International Classification of Diseases, Ninth Revision. According to the definition in the latest, Fifth Revised Edition of the Diagnostic and Statistical Manual of Mental Disorders: "Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts" [American Psychiatric Association, 2022, p. 102].

However, the accumulated research material shows that AVH can manifest itself both in pathological conditions: schizophrenia, Alzheimer's disease, dementia, depression, etc. [Woodset et al., 2015], and in healthy people [McCarthy-Jones, 2012; Alderson-Day et al., 2017]. At the same time, changes in psychiatry, psychology and neurobiology have contributed to a rethinking of the pathogenesis of AVH. First, the transition to the Crepelean, symptom-based approach towards psychopathology of schizophrenia [Bentall, 2003] led to a focus on AVH as an independent phenomenon within normal experience. This blurred the stable labeling of AVH as a specific symptom of psychopathology [Feelgood, Rantzen, 1994; Johns, van Os J., 2001; de Leede-Smith, Barkus, 2013]. Secondly, the development of interdisciplinary research at the intersection of psychology, neurophysiology, and neuroimaging has led to several models for understanding the phenomenon of AVH being proposed over the past 30 years.

One of the first studies that identified a number of key questions and offered possible answers to them was R. Hoffman's study [Hoffman, 1986]. Based on the assumption that AVHs are examples of auditory images phonetically organized into words, Hoffmann proposed that the primary material of AVHs is *internal speech*. This assumption has been supported by many psychologists [Bentall, 2003; McCarthy-Jones, 2012] and has been validated in empirical studies [McGuire et al., 1995; Shergill et al., 2000; Langdon et al., 2009]. Based on the works of L.S. Vygotsky (1982), A.R. Luria (1958), A.N. Sokolov (1968), G. Zivin (1979) and others, who have shown that verbal images are a normal part of consciousness, he explained the paradox of the "alienity" of

one's own inner speech by the fact that it is unintentional. R. Hoffman suggested that disruption of a subject's normal reasoning processes may lead to perceiving some internal speech utterances as unintentional, resulting in them being attributed to an external source. Despite criticism [Akins, Dennett, 1986; Stephens, Graham, 2000], Hoffman's work pointed the way to a possible understanding of the essence of AVH. It took more than 15 years of research to develop a AVH model that provides both experimental confirmation and a phenomenological explanation to address this criticism.

In 2004, a team of researchers led by M. Seal published a study critically analyzing the available data on specific neurocognitive disorders linked to the phenomenon of AVH in schizophrenia. It proposed a new multidimensional model of the AVH formation process [Seal, Aleman, McGuire, 2004]. It is based on the model of passivity experiences developed by K. Frith et al. [Frith, Blakemore, Wolpert, 2000], which were found in people with schizophrenia. By modeling the predictability mechanism of the consequences of actions, the work of Frith and his colleagues explained why an action performed by a person can be actively perceived as performed by oneself or passively experienced as performed by *Another*. Further research by Sarah-Jane Blakemore showed that if predicted sensory feedback does not match and override actual feedback, this results in increased activity in the parietal cortex, causing movement to feel "externally controlled" [Blakemore, 2003, p. 651]. Frith's model also indicated [Frith, 2002, p. 481–487] that the feeling of authorship depends on the execution of the D. Wegner's mechanism of "apparent mental causation" [Wegner, 2002, p. 64]: due to the temporal proximity (about 50–100 ms) of the thought of what should happen and the actual action, a feeling of personal authorship of the completed action is formed [Wegner, Wheatley, 1999].

Using this model, M. Seal and his colleagues started from the proposition that any neurocognitive model of AVH must take into account the following: one's own thought, misinterpreted as speech, is perceived as unintentional. Seal et al. next proposed that, "once some *trigger event* brings about the generation of the AVHs motor commands are issued and *inner speech* is produced" [Seal, Aleman, McGuire, 2004, p. 65], - therefore, inner speech can be conceptualized as an action, making the application of Frith's model to it valid. However, this application of Frith's model to inner speech had a significant drawback. Contrary to the claims of Seal and his colleagues, Frith's model does not suggest that the distortion of the predicted state leads to an experience of unintentionality, which then becomes a sense of self- or other-authorship through preconscious attributions. Instead, the analysis of Frith's model showed that there is a two-part mechanism in which the sensations of authorship of the action are determined by the mechanisms of D. Wegner and S.-J. Blackmore. Based on this, an alternative concept was proposed, developed by S.R. Jones and C. Fernyhough: the problem of perceiving what is heard as "alien" stems from a failure in *identifying* inner speech [Jones, Fernyhough, 2007].

S.R. Jones and C. Ferneyhough point out that if the mechanism of "apparent mental causation" of D. Wegner does not work, then a person does not feel the emotion of authorship, although he himself initiated the action. Instead, Blackmore's mechanism for rejecting predicted and actual feedback, which results in increased activity in the parietal cortex and hence a sense of external control, will operate, leading to the connection of the event with an external cause. This approach provided a resolution to the paradox in which AVHs are perceived as alien and at the same time recognized as one's own [Fernyhough, 2004].

A similar point of view is expressed by D. Stangellini and D. Cutting, who argue that AVHs are a disorder of self-regulation, leading to a disruption of internal dialogue awareness [Stangellini, Cutting, 2003].

The development of these models formed the basis for rethinking both the pathogenesis of AVH and understanding the essence of the phenomenon. Combining the obtained data, we can say the following:

1. In some cases, AVH may be a normal experience, and only when combined with other clinical data, it becomes a manifestation of psychopathology.

2. AVHs can be a person's inner speech, experienced as the speech of *Another*.

3. The cause of AVH may be due to a failure in the process of self-determining one's internal speech, which has neurophysiological correlates in the mechanisms proposed by Wegner and Blackmore.

4. This failure can be caused by an experience related to a "triggering" event.

Further studies of AVH have shown that the “trigger” event can be grief, spiritual insight, or voluntarily dissociated states: meditation, traumatic events, memory impairment, prolonged stress, sensory deprivation, etc. [Waugh, 2015, e54–e55]. An analysis of the specificity of these trigger and background factors showed that they can be classified in three areas: biological; psychological; social [de LeedeSmith, Barkus, 2013, 1–25]. These interacting factors may be mechanisms or triggers, the first of which facilitates maintenance and the second initiates the onset. However, the relationships between these variables are not discrete but create a complex picture because they are multifaceted and not mutually exclusive.

As for the context of the experience of spiritual voices, in which AVHs acquire a clear religious connotation in the mind, research in this area made it possible to include in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders classifier an indication that AVHs are experienced not only as voices perceived as distinct from the individual’s own thoughts, but "may be a *normal (ordinary) part of religious experience* in certain cultural contexts" [American Psychiatric Association, 2022, 102].

In other words, when analyzing AVH, there are several contexts in which the phenomenon of this experience may be influenced by religious practices. In this sense, the initial data about the prerequisites for having such a religious experience could be considered a marker.

A. Deikman, who studied the psychological characteristics of religious experience, proposed to group such experience in three divisions: “untrained-sensate”, “trained-sensate”, and “trained-transcendent” [Deikman, 1966, 324–338].Typical of the first of them is the ability to have the experience without an internal desire for it, when it is spontaneous and unexpected for a person. The "trained-sensate" category refers to the experience of people who have deliberately sought "grace," "enlightenment," or "union" by means of long practice in concentration and renunciation. However, when the active phase of contemplation concentration, in which a person is captured and absorbed by the process, passes into the stage of a spontaneous and effortless internal process, a transition to “trained-transcendent” experience occurs. It requires passivity and self-surrender, open receptivity, which resulting from the banishment of thoughts and sensations that fill one, and the renunciation of goals and desires directed toward the world. And the experience of spiritual voices according to the first type can differ strikingly from those induced according to the third type. The picture of trigger factors in this case will differ strikingly.

Therefore, from the point of view of the disposition of opinions mentioned at the very beginning, the experience of spiritual voices (as AVH) does not determine a psychopathological status. Religiosity and psychopathological symptoms are often intertwined and coexist simultaneously, but they can also be independent phenomena. History of psychiatry of the 20th – early 21st centuries. shows a gradual transition from a total definition of religious-mystical experience as psychopathology to doubts about the obviousness and irrevocability of such labeling, since mystical experience itself is

not a sign of psychosis [Dein, Loewenthal, 1999, 101–104]. And the intrapsychiatric history of research on hallucinations, and in particular auditory-verbal ones, confirms this.

And yet, this distinction is only possible when working with the specific experience of a specific individual, in the perspective of personal history, cultural background and other influencing factors. In other words, a hermeneutic and phenomenological analysis of the individual's life world is necessary. Applied to a specific situation, they can shed light on the reconstruction of the genesis of a specific experience, acting as factors influencing the actual work of psychological mechanisms of thinking [Muskhelishvili, Bazlev, 2018, 128–139].

It would be wrong to say that this concept is the only one. However, the AVH hypotheses not related to inner speech [Kapur, 2003, 13–23; Behrendt, Young, 2004, 771–787], which give affirmative results when analyzing the pictures of acute psychoses and schizophrenia, often do not consider the array of data that is collected among persons who do not have a psychopathological diagnosis - among those who do not have any other grounds for marking psychopathology, except for the fact of experiencing AVH. Also, a number of researchers point to the "weak point" of the concept of inner speech as the basis of AVH, namely, data on non-verbal hallucinations, such as music, animal cries, the sound of water heard in the head, etc. Such contents of this experience, in their opinion, cannot be derived from inner speech [Baklushev, Ivanitsky, Ivanitsky, 40]. And this criticism highlights three significant aspects of the issue under investigation: the question of the communicative structure of inner speech, its coding, and its functional significance.

The phenomenon of inner speech has been an object of interest since the early period of philosophy, beginning with Plato and Aristotle. [Duncombe, 2016, 105-125]. We can find reflections on it in the works of Marcus Aurelius, Augustine and many others. However, it would be wrong to claim that inner speech in these works became an independent object of study. Rather, it's about weaving it into discussions about human thought and the soul, as an idea of the soul's inner dialogue. The semiotic analysis of this dialogue shows that, although the subject does not learn anything new about the world through his inner speech that he would not have already known, it does not mean that communication does not take place during inner speech [Lotman, 1973, 227–243]. So, based on the two possible directions of message transmission, there are two communication models in culture that are used for two different channels of information transmission.

The first model is the "Other – Me" channel, in which the "Other" is the sender (the author of the message), and "I" is the addressee (the recipient). In this model, there is a fundamental separation between the addressee and the addresser who sends him the message [Muskhelishvili, Shreider, 1997, 3].

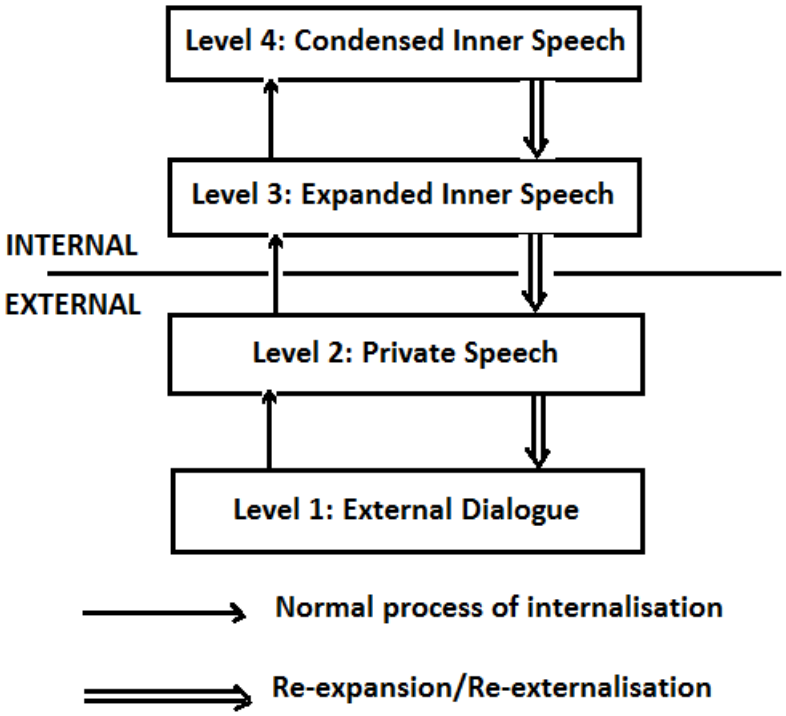
The second model is the "I – I" channel, which implies the inseparability of the addresser and the addressee, which forms autocommunication. In this model, the perception of a message from an external source consists of its assimilation as internal speech, in which the external source initiating autocommunication "acts not as a message," but "as a stimulator of the development of thought" [Lotman, 1973, 231]. Due to this, there is no increase in information in autocommunication; instead, there is a change in the personal horizon, in which the already available information is comprehended and appropriated, and ultimately the individual himself changes.

In the 20th century, due to the rapid development of related fields such as philosophy, psychology, and semiotics, inner speech began to attract the attention of researchers. Since the end of the 19th century, systematic study of this phenomenon has revealed its complexity. So, the code of inner speech uses the same languages as external speech, such as acoustic, graphic and body movement, and intonation codes.

But it also includes characters from other code systems: these are images – visual, auditory, olfactory; images, concepts, schemes, etc., which are proportionally combined with each other depending on the degree of "depth" of inner speech [Lvov, 2000, 42-45]. Together, this complex is referred to as the code of thought or the mental code.

The formation of this code was described in the first half of the 20th century by L.S. Vygotsky. According to his theory, each mental function appears twice in development: first, on the interpsychological plane (as a function distributed among several individuals) and, second, on the intrapsychological plane (as an internalized version of this previously external function). Internalization, therefore, is more than simply copying external speech onto the intrapsychological plane. Rather, interpersonal dialogue, initially built in external speech, undergoes a number of important transformations in the process of internalization, forming internal speech.

Of particular importance for ARTICLE IN PRESS Level 4: Condensed Inner Speech Level 3: Expanded Inner Speech Level 2: Private Speech Level 1: External Dialogue Normal process of internalisation Re-expansion/Re-externalisation EXTERNAL INTERNAL Fig. 1. Stages of internalisation. C. Fernyhough / New Ideas in Psychology 22 (2004) 49–68 55 present




Developing this idea, C. Fernyhough [Fernyhough, 2004, 49–68] schematically depicted the process of internalization in the form of a stepped four-level model, in which level 1 means external dialogue, level 2 – private speech, level 3 – expanded inner speech, level 4 – condensed inner speech. At level 1children and caregivers engage in overt verbal dialogue. At level 2 they conduct these dialogues in their own overt (and then gradually subvocalised) private speech. At level 3 private speech is fully internalised and covert, but the character of normal conversation is still manifested internally as the process of talking silently to oneself. At level 4 the syntactic and semantic transformations of internalisation ensure that inner speech no longer resembles the external dialogue it was based on. According to Vygotsky, the main characteristic of inner speech is its fragmentary and abbreviated nature compared to external speech. According to Vygotsky, the main feature of inner speech is its fragmentariness, abbreviation and abbreviation in comparison with external speech. It is “purely predicative,” “idiomatic,” “maximally condensed” [Vygotsky, 1982, 239–240]. Inner

speech, losing most of the acoustic and structural characteristics of external speech, significantly reducing and acquiring personal fields of meaning, is to a large extent thinking in pure meanings [Vygotsky, 1982, 353], in which without reference to a specific situation it turns out to be incomprehensible.

In complex cognitive conditions, as exemplified by AVH, as Fernyhough notes (Fernyhough 2004, 55–56), there may be a transition from level 4 (condensed inner speech) inner speech to level 3 (expanded) inner speech, and even a return to level 2 (private speech). At the same time, according to Vygotsky's theory of the social origins of thought, inner speech maintains its dialogical nature, so thinking is naturally influenced by other voices, through which a person assimilates perceptions of the world within an external dialogue. Thus, the voices in the inner dialogue are semantic expressions of views of reality – just as the voices in the external dialogue represent different views of the world. Mature inner speech is a constant dialogue between these internal, simultaneously held views. Due to this, inner speech initially includes the coordination of several voices, which gives us an understanding of the problem of the "alien, but own" voice in AVH.

However, the approach of Western researchers of AVH does not fully take into account that inner speech, due to its autocommunicative structure, is in a certain sense identical to the process of thinking itself.The interaction of internal (subjective) language and natural (objective) language forms the process of thinking, in which, quoting Vygotsky, "external speech is the process of transforming thought into word, its materialization Inner speech moves in the reverse direction, from without to within. It is a process that involves the evaporation of speech in thought" [Vygotsky, 1982, 316].

As F.V. Bassin: "... a number of theoretical and experimental arguments can be given in favor of the fact that the possibilities, ease and breadth of linking "pure meanings" are not only not inferior to the similar possibilities of verbalized knowledge, but even, apparently, significantly exceed them" [Bassin, 1978, 739–740].

This is confirmed by the fact that the code of inner speech is free from the redundancy characteristic of all natural languages. The connections between the elements in it are objective, i.e. are meaningful, not formal, and the conventional rule is compiled specifically for this case, only for the time necessary for a given mental operation [Zhinkin, 1964, 36]. Experimental studies by N.I. Zhinkin have shown that, in the dynamics of the thinking process, the code of internal speech is not pronounceable. The thought is born in a subject-pictorial code. The image, as well as the object it represents, can be the subject of an infinite number of statements, providing unlimited possibilities for natural language, which is constantly revived in inner speech. This makes speech difficult, but it encourages utterance. As a result, the mechanism of human thinking is realized through two opposing dynamic units: the subject-visual code (inner speech) and the speech-motor code (expressive speech). In the first unit, a thought is generated, and in the second unit, it is expressed and transmitted back to the first unit. In this way, the process of understanding in thinking can be seen as a translation from natural language to an inner language, while the opposite process forms the act of speaking.

Due to this code transition, M.S. Bonfeld argues that it is fair to discuss the polymorphism of human thinking. In this context, non-verbal forms of thought are closely related to verbal forms, and vice versa [Bonfeld, 2006]. Such types of non-verbal thinking are "visual thinking" (R. Arnheim), "illustrative" (S.L. Rubinstein), "practical" (Vygotsky), "mathematical" (J. Hadamard), "musical" (Bonfeld), etc. These types of thinking are based on inner speech, which ceases to serve as a direct means of communication and instead becomes a form of internal thought process. [Rubinstein, 1946, 414-415].

Thus, the criterion of polymorphism of thinking, which was not previously taken into account, indicates the possibility of non-verbal hallucinations being based on inner speech. In the context of our discussion, this suggests that this principle may also hold true for the visions experienced by mystics, understood in this instance as a non-verbal form of thought. In other words, both types of experiences can be understood within the framework of a single thinking mechanism, which expresses itself in different forms depending on the situation. Indeed, in the Christian mystical tradition, experiences of spiritual voices and visions often occur together, providing the mystic with an explanation for what is revealed through the inner eye or ear of the individual. They can also provide answers to deep questions about life or satisfy unconscious spiritual aspirations, evoking feelings of feelings of deepest pleasure or, conversely, regret for experiences such as sin and suffering [van Merrelo, 1993].

The uniqueness of the religious interpretation of such experiences by mystics lies in their integration into the cultural framework, which allows individuals to achieve a sense of inner harmony. [Waugh, 2015, E54-E55]

It is also true that, in each culture and at different historical periods, experiencing such a setback acquired the meaning of a connection to the heavenly world, expressed in the language and traditions of that particular culture. An example of a work that considers the history of religion from this perspective is the book " Hearing voices, demonic and divine: scientific and theological reflections " by K. Cook [Cook, 2018]. In this book, the author analyzes biblical, historical, and scientific accounts of experiences with spiritual voices within the Christian tradition, exploring them through the lens of 35 years of AVH research.

And yet, studies of AVH generally do not take into account the differences between the phenomenological characteristics of true hallucinations and those that are typical of descriptions of spiritual voices and visions within the Christian tradition.

1) Firstly, spiritual visions and voices do not have the characteristics of objective reality that are inherent in true hallucinations. Instead, they are recognized as being directly related to another spiritual realm.

2) Secondly, mystics perceive them as a kind of revelation that is sent down from God as a sign of his special favor. In other words, they experience them as a "gift" that is received passively.

3) Thirdly, the source of voices and visions often comes from within the mystics themselves. They describe their perceptions not through their bodily senses, but through "inner sight", "inner hearing", or "hearing and seeing with the spirit", etc..

4) Fourth, there is a clear intentional connection to the personality of the one who gives the experience. In other words, the mystic knows who the "Other One" is who is giving them the experience. This could be God, an angel, a demon, or intermediaries such as the Virgin Mary or saints.

These phenomenological characteristics suggest that, in the case of spiritual experiences such as visions and voices, it may be more appropriate to talk about pseudo-hallucinations rather than true hallucinations. This term was first introduced by F.V. Hagen in his work "Zur Theorie, der Hallucinationen" [Hagen, 1868] and was later developed by V.H. Kandinsky in "On Pseudohallucinations" [Kandinsky, 1890]. Unlike E. Kraepelin and E. Bleuler, Kandinsky argued that such an experience occurs not only in cases of psychopathology, which is of great significance, but also among mentally healthy individuals, as confirmed by current research. Based on the work of Kandinsky, K. Jaspers introduced this distinction into the global practice of clinical diagnosis at the beginning of the XX century [Jaspers, 1913]. However, over several decades, terminological confusion and the overloading of the concept have led to the situation where by the end of the 20th century, there was a dispute about the possibility of clearly differentiating between pseudo-hallucinations and true hallucinations in clinical practice

[Slade and Bentall, 1988]. This has led to the gradual abandonment of the term "pseudo-hallucination" in English-language literature, especially.

And yet, although the term "pseudo-hallucination" may seem misleading, this phenomenon appears to be related to the process of thinking, rather than the perceptual disorder under which it has been classified. This has led to confusion. At the same time, there is an increasing amount of data suggesting that there are several intermediate phenomena located between the extremes of "normal" and "abnormal", "thinking disorders" and "perceptual disorders", which suggests that the binary classification of human experience is not always accurate. As a result, several researchers have introduced the concepts of "non-psychotic hallucinations", "partial", and "transient" [van der Zwaard, Polak, 2001]. The phenomenological characteristics for diagnosis were: the modality of hallucination (visual, auditory, tactile, olfactory, gustatory), complexity, localization (external or internal), degree of sensory brightness, degree of reality check, degree of controllability, continuity, trigger factors, etc. Based on the correspondence with these characteristics, the experiences of spiritual voices and visions reported by Christian mystics are most closely aligned with the definition of non-psychotic hallucinations.

The differentiation between non-psychotic and true hallucinations indicates that more attention should be paid to the issue of critical evaluation of the basis for spiritual voices and visions based on inner speech. Phenomenological analysis suggests that, in non-pathological cases, such an experience requires an explanation that is unrelated to a disruption in psychophysiological processes. Their spontaneity, short duration, and intentional orientation indicate the nature of the failure, which was caused by a number of trigger factors. At the same time, the concept of polymorphic thinking suggests that the code for inner speech includes both verbal and non-verbal elements that explain the unified process of thought in cases of both "inner voices" and "inner visions".

The internalization of this code from the personal experiences, which provide the context for the formation of meaning, explains the differences in the content of experiences among individuals. The metaphorical nature of this code indicates that this content is understood by a person based on those intentional attitudes that are typical of that person.

To summarize, these remarks on the etiology of hallucinatory experiences do not allow us to identify a single, universally applicable theory about their causes and the process by which they occur, outside of analyzing a specific personal experience. Many factors exist and influence at the same time, creating a unique picture each time. When analyzing, it is important to take into account the possibility that the basis for such an experience could be an autocommunicative dialogue in inner speech, which occurs in a situation where one fails to identify their own "I". This can also be a result of pathological psychophysiological changes in the human body's functioning. Such caution allows us to overcome the original assumptions about the predetermined ontological status of experience, which are accepted in psychiatry and theology.

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**Phenomena associated with religious experience in the structure of affective disorders**

**Abstract:** The paper discusses the issue of emotional disorders in somatic medicine and the role of phenomena related to religious experience in shaping the clinical picture of these conditions. The results of a clinical study are presented, which show that the assessment of religious experience can help differentiate between clinical and psychopathological symptoms and spiritual ailments. This interdisciplinary approach, based on a bio-psycho-socio-spiritual model, can help increase the effectiveness of treatment for neurotic affective disorders in patients with somatic profiles.

**Keywords:** religious experience, phenomena of religious experience, affective pathology.

The relationship between religious experience and mental health is currently a topic of scientific research. Along with the protective role of religiosity in relation to mental health, there is also an inducing, masking effect, aggravating the course of the disease and making it difficult to diagnose. In the research conducted by the FSBI "Scientific Center for Mental Health", five types of endogenous depressive states were identified, and the contents of religious experiences associated with each type has been described in detail (Kopeyko G.I., 2021). The main categories, conceptual models and results of empirical studies of spiritual and religious coping have been presented (Vasilyuk F.E., 2014, Shankov F.M., 2015.). The issue of affective disorders in somatic medicine and the involvement of phenomena related to religious experience in the development of these disorders' clinical picture remains poorly understood.

Purpose of the study: to identify phenomena associated with religious experience in the structure of affective pathology in patients of a multidisciplinary clinic.

The study has been conducted on the basis of a university clinic. The specifics of the consulting work of a psychiatrist in a somatic clinic using high-tech treatment methods include: a short hospital stay for patients, organizing consultations mostly at the request of the treating physician, limited time available for making diagnostic decisions, patients' alertness towards psychiatric care, and lack of follow-up monitoring after discharge from the hospital. A significant number of primary patients with no previous experience of psychiatric treatment come to the attention of a consultant physician. In the overall structure of revealed psychopathology, most of the nosological forms can be classified as neurotic disorders. A significant part of a consulting psychiatrist's work involves motivational activities and providing problem-based information.

Outpatient charts, medical histories (including conclusions and diary entries), and protocols of clinical and diagnostic interviews conducted on inpatient and outpatient patients at the multidisciplinary university clinic from November 2022 to November 2023 were reviewed.

The study included cases (N=111) with psychiatric diagnoses that meet the criteria for disorders: F06.3 Organic affective disorders; F06.4 Organic anxiety disorder; F31 Bipolar affective disorder; F32 Depressive episode; F33 Recurrent depressive disorder; F34.0 Cyclothymia; F34.1 Dysthymia; F41.0 Panic disorder; F41.2 Mixed anxiety-depressive disorder; F43.2 Adjustment disorders; F45.3 Somatoform autonomic dysfunction (Table 1).

The study did not include cases of patients with psychotic disorders, dementia and severe somatic diseases in the decompensation stage.

**The structure of the identified emotional disorders**

Table 1

| *Diagnosis* | *Hospital* | *Outpatient unit* |
|---|---|---|
| F06.3 Organic affective disorders | 7 | 3 |
| F06.4 Organic anxiety disorder | 18 | 2 |
| F31 Bipolar affective disorder | 2 | 3 |
| F32 Depressive episode | 4 | 5 |
| F33 Recurrent depressive disorder | 3 | 3 |
| F34.0 Cyclothymia | 4 | 3 |
| F34.1 Dysthymia | 2 | 0 |
| F41.0 Panic disorder | 4 | 0 |
| F41.23 Mixed anxiety-depressive disorder | 5 | 4 |
| F43.2 Adjustment disorders | 15 | 5 |
| F45.3 Somatoform autonomic dysfunction | 16 | 1 |
| Total: | 82 | 29 |

The assessment recorded the clinical and psychopathological features of mental illness, as well as statements related to direct religious experience and the assessment of the patient's or their family members' religious experience.

Regarding the definition of "religious experience", there are various points of view on its essence, nature and significance for individuals. The most common definition is based on a broad philosophical understanding. This understanding encompasses a wide variety of phenomena and experiences, ranging from mystical rituals to altered states of consciousness. (E. V. Chelnokova, 2013).

Archpriest Alexander Men: "Religious experience can be defined as an experience associated with a sense of the real presence in our lives of some Divine Principle that directs and makes our existence meaningful" (Alexander Men', 2012)

By religious experience, we also understood the experience of participating in the religious life of the Church and family. In most cases, these were patients and families of patients of Orthodox faith, in several cases they were Muslims.

The study of religious experience was conducted through a clinical diagnostic interview, with the addition of the following questions: "What is your attitude to faith in God?", " What experience do you have of participating in religious life?", "How does faith in God affect your life?", "Are there (were) believers in your family?", " What impact does the religious experience of family members have on you?". The answers to these open-ended questions contained not only factual information, but also reflections, assessments, analysis, and a subjective attitude to the topic under discussion. The answers were recorded in the interview transcript, partially (if they related to psychopathological phenomena), in the description of the history and mental status section of the psychiatric report.

In the formation of a sample set of text messages, materials from 26 cases (23.4%) of patients with emotional disorders involving religious experiences or analysis of religious experiences were used. The cases examined included 10 men and 16 women aged 18 to 72 years.

In the study of textual units, content analysis was applied using the following categories: religious coping, trust and unity with God, transformation of life in the process of religious experience (positive religiosity); ideas of sinfulness, violated identity and loss of meaning, resistance to the imposition of faith, religious doubts, distrust of God and disbelief in one's own strength, enmity toward God (negative religiosity).

In most patients with anxiety symptoms before seeking psychiatric help, symptoms such as anxiety, sleep disorders, irritability, resentment leading to conflicts at home and work, obsessive thoughts about health concerns, and phobic experiences (fears of getting cancer) were the reasons for "seeking God's help". We considered these to be manifestations of religious coping mechanisms. Patients with mild neurotic symptoms noted the positive impact of religious experience. Thus, feasible prayer can help regulate the flow of negative thoughts in patients with obsessions, promote neuromuscular relaxation, and calm down with alarming symptoms. It also allows for the possibility of “sharing responsibility for one's life with God”, which can lead to a greater sense of “trust in God”, “receiving God's grace”, and not having to “rely solely on oneself”.

Phenomena reflecting "unity with God" are formulated as the realization that a person feels "protected" and "loved", "humility comes".

Positive transformations in life were described in such formulations: religion "helped to straighten out my life", everything is happening "right", "as it should be". In our opinion, the positive influence of religious experience generally contributes to the alleviation of clinical symptoms.

Attending church, participating in divine services, regularly reading the morning and evening prayers, reading the Psalms require a certain mental resource, with mild affective manifestations these resources are sufficient for religious activities, which in turn strengthens this resource and contributes to the improvement of the condition. At the same time, difficulties with concentration, mental and physical exhaustion, memory loss, anxiety, asthenia, sleep disorders, and other cognitive and cerebro-asthenic manifestations (vascular and post-cortical) can make it harder to perform rituals and lead to feelings of weakness, sin, abandonment by God, and a lack of "divine help". In our opinion, it is necessary to take into account the feasibility of observing religious rituals. Similar experiences are recorded in the statements of patients with adaptation disorders in situations of increased stress (codependents, mothers and wives of the participants of the SMO), who sometimes "do not really assess their capabilities", "grab a lot of things", do not understand the "feasibility" factor due to the orientation towards approval, success, the desire to "save". Behind this lies the desire to please God in order to help or save a loved one. Prolonged exposure to such situations can lead to a lack of trust in God, a loss of faith in oneself and one's own abilities. The ritualized practice of faith can actually lead to emptiness, rather than humility.

Excessive preoccupation with one's own perceived sinfulness and the belief that suffering is deserved can contribute to the exacerbation of depressive symptoms and the risk of developing psychotic symptoms, (delusions of sinfulness, hypochondriacal delusions). The content of depressive experiences can include feelings of despair, identity crisis, apathy, and a loss of meaning. These feelings may be accompanied by a fear of "betraying God" or not “recognizing Divine providence”, as well as a “discrepancy between one's real self and an idealized image of saints”. A patient who has stopped using drugs describes his experience of sobriety as a "miracle". However, he is afraid of relapsing, as he believes that "it's not just a relapse - it's a betrayal of God", which is "a much scarier thought".

Doubts, contradictions, and struggle occupy a special place among the manifestations of negative religiosity. Patients describe a "difficult relationship with

God," an "inability to trust." Young patients associate their doubts, distrust and God-fighting with negative experiences in their own parental families. According to the approximate scheme: "Mother did not love – I cannot feel the love of God", "Father offended, was rude, deceived – I cannot trust him and I do not trust God." Struggle is used as a means to defend one's independence, freedom, if faith was settled in the family, the child was forced to participate in religious life. Independent spiritual searches at a young age can lead to destructive behavior. "When I read spiritual literature, I found myself in a contradiction. Should I be with God or without him? I was searching for the Absolute, scientific truth, a substitute for God! …I 'sold the cross' …and started using drugs." A patient with obsessive-compulsive manifestations in the structure of bipolar affective disorder describes his experiences as follows: "I set a goal: to sin as little as possible. Searched for sins and corrected them with the help of God... Stopped sinning, there was nothing to conquer in myself, I was bored... . Decided to continue sinning in order to work with God on this, a feeling of guilt appeared, a feeling of the extraordinary gravity of the act. I hurt myself, punished myself."

The experience of counseling of believers and clergy shows a more conscious attitude to their experiences, which contributes to the awareness of the morbidity of psychopathological symptoms, the difference from spiritual ailments, when "prayer can no longer help" and it is necessary to consult with a doctor.

**Conclusions**

Neurotic affective disorders in somatic patients:

Neurotic affective disorders in somatic patients:

• it is advisable to approach them from a bio-psycho-socio-spiritual perspective;

• the study of religious experience can help distinguish between clinical symptoms and manifestations of spiritual ailments.

• dialogue with the doctor helps the patient in forming holistic ideas about the mechanisms of mental pathology, promotes reflection of experience and a more attentive attitude to one's own spiritual life.

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