

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:
AGE-RELATED ASPECTS OF MENTAL HEALTH
DISORDERS AND PASTORAL CARE**

*International Conference
Reports*

22-23 November 2024

Moscow
2025

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This book presents reports of the VI International Conference “Church care for mentally ill people: age-related aspects of mental health disorders and pastoral care”, 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, India, USA, Switzerland, Ethiopia, Germany and Armenia.

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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REPORTS

Metropolitan Sergiy (Fomin)

Church care in the field of mental health

Dear participants of the conference!

According to the World Health Organization, more than 450 million people worldwide suffer from mental disorders. Today, there are more than 200 forms of mental illnesses in which people may experience impaired thinking, behavior, and inability to cope with everyday tasks.

With such a significant prevalence of mental illness, there is an acute shortage of mental health professionals everywhere. In this regard, the Church is faced with the need to fully support and accompany people with mental problems, as well as their family members. Following the Word of the Lord, who gave the clergy the grace to heal the sick, the Church, too, is grappling with a significant mental health crisis affecting the entire society. Many neuropsychiatric hospitals in the Russian Federation have churches and prayer rooms.

The Church's commitment to supporting individuals with mental illness includes raising awareness among parishioners about the issues, hardships, and positive experiences of those affected by mental health conditions. Furthermore, training for the clergy in psychopathology is necessary, without which priests may fail to recognize the signs of mental illness and mistake them for manifestations of spiritual imperfection, such as insufficient prayer or demonic possession.

Today's conference, focused on age-related aspects of mental well-being, aims to ensure that the professional psychiatric community understands the religiosity of its patients and that mental health care becomes an integral part of church service, available in every parish. The dialogue between priests and psychiatrists helps to see in a person suffering from a mental illness the Image and Likeness of God, who can offer a lot to the Church and society, because living with a mental illness gives a unique understanding of suffering, humility, compassion, friendship and love. Individuals experiencing mental health challenges may gain profound insight into suffering, drawing nearer to God and leading a virtuous existence.

Our Lord Jesus Christ has taken upon Himself all the burdens of human nature.

The Savior is surely close to those who are experiencing mental pain and suffering from psychiatric symptoms, and He calls us, as members of the Church, to love, support and protect brothers and sisters in Christ suffering from mental illnesses. In the words of the Holy Apostle Paul: "Carry each other's burdens, and in this way you will fulfill the law of Christ" (Galatians 6:2).

The family undeniably plays a crucial role in laying the foundation for mental health. For an Orthodox person, the Holy Family is an example of intra-family relations, which reveals us the beauty and unity of family life, including support for each other in suffering, and gives us an example of love during difficult trials. Research suggests that healthy family relationships contribute positively to mental well-being. Love and

nurturing relationships with loved ones are demonstrated in numerous ways, including supporting each other's mental health.

Medical statistics and daily life show that mental health problems, including depression and anxiety, are becoming more common in childhood. Children may not express their inner world the way adults do, but they will show their mental problems in the emotional sphere. Regrettably, adults frequently adopt and perpetuate a child's heightened emotional responses, serving as detrimental role models.

When a child experiences strong feelings, regardless of whether he suffers from a mental illness or not, our task is to show him what the world of Christ is. To foster mentally healthy children, it's essential to equip them with the ability to cope with strong emotions and to develop emotional self-regulation. The earlier children witness and learn a healthy, peace-oriented approach to everyday challenges, the more advantageous it will be for everyone.

A strong sense of loneliness is common among young people today, largely influenced by the extensive use of computers, gadgets, and the rise of artificial intelligence. Psychiatrists warn of a youth loneliness epidemic, a driver of mental health issues. Specialists of the World Health Organization note that mental health disorders associated with loneliness, such as depression, anxiety, behavioral problems, and suicide, are increasingly affecting adolescents.

We will not be able to cope with this problem if we do not take into account that in addition to seeking professional medical resources in the field of mental health it is necessary to pay attention to the spiritual needs of young people, spiritual and moral education, as well as the participation of young people in the life of the Church. Especially since, as researchers have frequently pointed out, attending religious services is beneficial for mental well-being. This can best be done through the personal example of parents and other family members involved in liturgical and parish life.

Mental health problems are even more common in the elderly and older adults than in younger people. Aging affects almost every aspect of a person's life. Physical frailty, illness, and disability can worsen a person's mental health. The most significant problems for older adults are depressive disorders and dementia.

Globally, over 55 million individuals are currently affected by dementia. This figure grows by nearly 10 million new cases annually. Dementia ranks as the seventh leading cause of death worldwide and is a major contributor to disability and the need for external support among the elderly.

Dementia has become one of the priority issues of the healthcare system and an important topic discussed at our conferences. One of the tasks of pastoral counseling is to raise awareness of dementia among clergy and parishioners, to create favorable social conditions for people with this pathology, support caregivers of people with dementia and conduct scientific research on the impact of religiosity on the prevention and course of mental illness in the elderly.

Despite the fact that mental illnesses are a widespread phenomenon of human life, they are still often associated in the public consciousness with something shameful and humiliating, which can prevent people from seeking medical help. Common stereotypes include the notion that people with poor mental health are dangerous and are to blame for their illnesses, cannot take care of themselves, and are unlikely to ever recover. People living with symptoms of a mental disorder, in addition to suffering from the disease, still face an additional burden of stigma, which can lead to social difficulties, for example, when looking for housing, work, or medical care. Such an attitude towards the mentally ill does not align with what Jesus Christ called us to, nor with the Basics of the Social Concept of the Russian Orthodox Church, which attest that no one and nothing can alter or diminish the dignity of a person, bestowed upon them by God at birth. Patients suffering from mental disorders remain the beloved children of

God. The medical community and the clergy should jointly ensure that mentally ill people are not stigmatized in secular society and in the Church.

I would like to thank all the participants of this conference who, through their professional efforts, provide medical care and support to people living with mental illnesses and facing mental health problems. I trust our meeting will bear significant results during this critical and transformative period for Russian history and culture. May the Lord, the true Doctor, offer comfort to all who are suffering, encourage the clergy and medical professionals to maintain their dialogue, and grant us the wisdom so that, through our combined efforts, all those in need of spiritual support can receive it.

Age and mental disorders

Abstract: The article highlights the peculiarities of the onset and course of certain types of mental disorders, as well as specific psychopathological syndromes characteristic of different age periods. For example, autistic spectrum disorders can develop in childhood, while depression, often accompanied by suicidal behavior and non-suicidal forms of self-destructive behavior, can occur in adolescence and youth. In old age and advanced age, the risk of diseases with predominant memory impairment, leading to dementia, increases, but disorders of the psychotic and affective registers are also encountered.

Keywords: age-related factor, autistic spectrum disorders, pubertal period, youth age, dementia, somatized depressions, pastoral care.

In their development, humans sequentially pass through various age periods. Russian psychiatrists have highlighted the influence of age on the clinical manifestations and progression of various mental disorders. Age exerts both pathogenetic and pathoplastic effects. As a result, certain mental conditions exclusively manifest during specific age periods. In some cases, the clinical presentation of mental disorders may alter with age. Additionally, particular age phases are characterized by unique psychopathological syndromes.

One of the most prevalent and incompletely understood developmental disorders affecting early childhood is childhood autism, which encompasses a diverse range of conditions characterized by varying degrees of symptom severity and distinct manifestations. Consequently, it is currently a standard practice to categorize these conditions under the umbrella term of autism spectrum disorders (ASD). These disorders manifest through a spectrum of symptoms, including challenges in establishing and maintaining social interactions, communication deficits, and severe impairments in speech and motor development. Typically, the initial signs of autism spectrum disorder emerge during infancy and become evident before the age of three. Among children, males are more frequently diagnosed with this condition compared to females. There exist multiple variants of early childhood autism, which differ in their severity and specific clinical presentations. Nevertheless, despite this variability, there are persistent features that are characteristic of most autism spectrum disorder syndromes.

Children with autism spectrum disorder (ASD) typically exhibit significant challenges in the development of verbal communication skills. Instead of using conventional words, they may resort to non-verbal forms of communication such as murmuring, echolalia, or repetition of stereotyped sounds or syllables. Importantly, these alternative modes of communication are generally not intended for social interaction or to facilitate communication but rather occur in isolation. From an early age, children with ASD often display aversion to physical contact with their caregivers, including avoidance of touch with mother, hugs, or eye contact. Children with autism frequently exhibit stereotyped motor movements, repeating basic object manipulations over and over. These behaviors can persist for extended periods and include movements like rocking, body twisting, or circling. Children with ASD tend to exhibit heightened sensitivity to environmental changes. This hypersensitivity can manifest as intense anxiety or fear in response to the presence of strangers, loud noises, or deviations from their routine. They may seek solitude by retreating to secluded areas, such as closets, drawers, or under furniture, where they may remain for prolonged periods, often concealing themselves with clothing and adopting a fetal

position. Any alterations to their daily schedule, meal times, or the placement of familiar objects and toys can elicit a strong reaction of distress and behavioral disorganization.

Children with ASD often display a strong interest in collecting items that others might consider unusual or without practical use. This can include bottle caps, flasks, wire fragments, and various other unconventional objects. This intense focus often overshadows more typical activities for their age group. A notable portion of individuals with ASD show some degree of cognitive impairment. However, when the condition is milder, cognitive abilities can be within the normal range, and in some cases, exceptional talents may emerge. These talents can manifest in specialized skills such as mathematics, chess, music, or visual arts. The exact cause of childhood autism is still under investigation. While genetic predisposition and abnormalities in brain development are well-established factors, the precise mechanism underlying the disorder remains unclear.

It is necessary to emphasize the significance of early intervention for this condition, which should incorporate both pharmacological and psychocorrectional approaches aimed at addressing emotional deficits and promoting social skills development.

The situation is further complicated by the fact that parents of children with autism frequently lack a comprehensive understanding of the disorder's characteristics and may either underestimate or deny the presence of significant mental health issues, attributing their child's behavior to their "unique" or "special" nature. As a result, it is crucial for a clergyman to tactfully convey the necessity of seeking consultation and treatment for the child from qualified child psychiatrists, while acknowledging parental distress. This pastoral task can be even more challenging than persuading an adult to pursue psychiatric assistance.

Adolescence, also referred to as puberty, represents a crucial phase in the development of an individual's identity formation. This developmental stage is characterized by significant psychological and physiological transformations, the emergence of an individual's personal worldview, and the establishment of foundational social, spiritual, and moral principles. Adolescence is widely acknowledged as a critical period for the maturation of an individual's moral and ethical framework. This phase is often characterized as one of the most demanding and complex stages of human development. Some psychologists and psychiatrists liken puberty to an explosion that erupts after a peaceful (or relatively peaceful) childhood, calling it an age of expectation, bewilderment, and exploration. Others describe it as a time of "turbulence and upheaval," "romanticism and disorder," or simply "storm and stress." During adolescence, individuals often display a striking dichotomy of sensitivity and insensitivity, shyness and bravado, a rejection of societal norms, and an idolization of random individuals. St. John Chrysostom noted that youth is like a unstrained horse and a wild beast.¹

Adolescence can be divided into two stages: early adolescence (ages eleven to fifteen), characterized by negativism, stubbornness, and a tendency to rebel against authority, particularly fathers; and late adolescence (ages sixteen to twenty-five), marked by maturation, self-awareness, and a growing understanding of the world.

Early adolescence is often described as the "age of moods" or the "period of uncontrollable emotions." A volatile mood, marked by rapid swings between emotional extremes, is a key feature of a developing person. This is due to significant hormonal changes and the ongoing development of different brain regions, which can

¹ The Works of our Holy Father John Chrysostom, Archbishop of Constantinople. Vol. 8. In Russian. St. Petersburg: Publishing House of the St. Petersburg Theological Academy, 1902. pp. 925-926.

sometimes be uneven, leading to delays in the formation of inhibitory processes. Teenagers react strongly to events, whether they are personally relevant or not. They can be highly sensitive and vulnerable, often masking their emotions with indifference, arrogance, or rudeness. Mood swings can occur for seemingly trivial reasons, as perceived by adults. It is during adolescence and young adulthood that a particularly high incidence of suicide attempts and completed suicides is observed.

This period is marked by an extreme outlook and a strong desire for independence. Adolescents often exhibit a propensity for rebellion, resistance to authority, and a disregard for the counsel of elders. They insist on being recognized as equals to adults, despite lacking the necessary physical, intellectual, or social maturity to justify such a stance. They crave freedom from external control and aspire to complete autonomy. Their judgments tend to be one-sided, absolute, and intolerant. This perspective frequently leads to feelings of pessimism, despair, and a withdrawal from routine activities.

During this phase, individuals undergo a heightened awareness of their physical and spiritual identities. They critically evaluate their physical appearance, as well as their mental, moral, and volitional attributes. This stage is characterized by an intense preoccupation with physical appearance and any perceived physical limitations, coupled with rigorous self-assessment and introspective analysis. Doubts concerning adherence to societal age norms and apprehensions regarding physical and mental health are also prevalent.

The significant hormonal reorganization of the body often results in a disparity between the physical and psychological manifestations that a young individual projects onto the external environment. Puberty brings about a desire for approval and a heightened focus on personal appearance. Consequently, issues pertaining to height, hairstyle, physique, and attire become more pronounced and salient.

The most significant characteristic of this developmental stage is the emergence of an interest in the problem of existential meaning, encompassing both individual purpose and the broader significance of human existence. This period is marked by profound contemplation of moral concepts such as good and evil, as well as reflections on mortality and the possibility of eternal life. It is a time of intense introspection and the active pursuit of one's vocation, accompanied by deep engagement with the texts of Scripture and a fervent desire to integrate their teachings into daily life. For individuals born into a religious family, this stage often involves the appropriation or rejection of their parents' faith as a personal conviction. In certain cases, this process may be protracted over many years. The quest for answers to these existential questions is characterized by a systematic study of religious, philosophical, and psychological literature.

Adolescence often brings a heightened awareness of one's individuality and uniqueness, which can lead to feelings of isolation and internal conflict. It's precisely at this age that, beneath a facade of bravado and defiant actions, one feels most insecure. Consequently, there is a growing need for recognition, security, and empathy. Peer relationships become particularly crucial, often standing in stark contrast to interactions with adults. These relationships are marked by a special level of trust and confiding, fostering a sense of closeness and intimacy. Consequently, the experience of communication breakdowns is especially poignant. Friendship evolves to a more selective and profoundly emotional level, with individuals assimilating new roles and statuses while honing their communication skills and styles. They also develop a sense of belonging to social groups.

In the later stages of adolescence, as opposed to the earlier stages, there is an increased necessity for interaction with a significant adult figure, particularly in situations characterized by uncertainty where independent decision-making is

challenging. Conversely, the absence of such interpersonal connections with both peers and adults may suggest the existence of specific issues.

During adolescence, the process of sexual self-identification concludes, and a strong desire emerges to form relationships with members of the opposite sex. Any setbacks in these relationships cause intense emotional distress and sometimes lead to the belief that the situation is catastrophic. Adults frequently express frustration with the perceived cynicism and boastfulness exhibited by teenagers in their interactions with the opposite sex. However, it is essential to recognize that these behaviors may reflect not just a negative attitude but also the struggles and insecurities of a young person who is still learning to navigate their own challenges.

A distinctive characteristic of youth is the formulation of life objectives, career selection, completion of educational programs, and initiation into professional activities. It is noteworthy that the commencement of professional careers for contemporary youth occurs at a later stage than in previous generations. For instance, at the outset of the previous century in Russia, approximately one-third of young individuals were already engaged in employment by the age of sixteen. The remaining population initiated their careers at the age of twenty.

The puberty can manifest in various ways: for some individuals, it is marked by intense emotional and behavioral challenges, characterized by conflicts and emotional outbursts; for others, it progresses more smoothly, without such sudden shifts in mood. The differences in how this stage unfolds are influenced by numerous factors, with the specifics of upbringing not being the most significant among them. Consider, for instance, Orthodox families with multiple children, where siblings raised under similar conditions may experience puberty quite differently. Nevertheless, their later achievements in life did not appear to be directly related to the peculiarities of this developmental phase.

In the formative years of adolescence, individuals require special attention and care from their parents and spiritual guides. The words of St. John Chrysostom are particularly relevant here: "For as untilled land, such is also youth neglected, bringing forth many thorns from many quarters".² ... "youth is an age of difficulty; ... and requires an exceedingly strong bridle. It is indeed a sort of combustible pile easily catching anything from without, and quickly kindled".³

It is important to note that numerous diseases, including psychiatric conditions, can manifest during adolescence. In practice, it can be challenging to distinguish the "turbulent" puberty phase from the initial stages of various mental disorders.

Another complex and significant life stage is old age, which typically begins at the age of 60. In the WHO's classification, old age is considered to start after sixty years, while senescence (or advanced old age) begins after seventy-five years.

In numerous parishes of our Church, particularly in rural regions and small towns, the senior and aged population constitutes more than half of the congregation. Clergy members frequently encounter both age-associated psychological changes and various pathological conditions. To distinguish between normal aging processes and mental illness within this demographic, a general framework can be applied. Most mental disorders tend to significantly alter an individual's personality traits. While age-related personality changes, such as heightened frugality, callousness, mistrust, social withdrawal, and suspicion, may be a natural part of the aging process, they often exacerbate pre-existing negative characteristics. Conversely, any substantial alterations in personality traits should prompt concerns regarding potential mental pathology.

² St. John Chrysostom, Homilies on the Gospel of Matthew, Homily 49.

³ St. John Chrysostom, Homilies on the statues, Homily 1.

In old age and senility, there is an increased susceptibility to diseases characterized by significant memory loss, leading to dementia. These conditions can also be accompanied by psychoses that manifest as delusions and hallucinations while maintaining clear consciousness. Additionally, affective disorders such as depression, and to a lesser extent mania, are also more prevalent.

Senile depression is a prevalent yet frequently overlooked condition among the elderly population. It is accurate to characterize depression as an epidemic among older adults. Society often attributes the pessimistic outlook of the elderly to external factors, particularly social issues. The complexity of diagnosis stems from the diverse "masks" of depression, which are highly characteristic of the elderly. How often do people of this age complain about everything except their mood! One common form of depression in the elderly is somaticized (hypochondriacal) depression, in which psychological distress manifests as a wide range of real or perceived physical discomforts, health anxiety, and an unrelenting pursuit of medical diagnoses. Certain studies indicate that up to a quarter of elderly patients visiting clinics require psychiatric intervention primarily.

There are several important indicators that can help identify depression as a clinical condition that requires specific treatment. These include sleep disturbances such as frequent awakenings during the night or early in the morning, a reduced appetite leading to weight loss, and a worsening mood in the morning. Suicidal thoughts are a clear sign that medical intervention is necessary, particularly in elderly individuals, as they often lead to serious suicide attempts. Fortunately, in most cases, depressive disorders in elderly and senile individuals can be effectively managed with low doses of modern medications. The difference in the quality of life for the patient and their family members before and after appropriate treatment can be significantly improved.

Senile psychosis is a prevalent condition. One of the most common delusional syndromes is what is known as "housing paranoia," characterized by "small-scale" or "staircase" delusions. The core of these delusions revolves around the fear of losing one's property. Patients often believe that their neighbors are spying on them, entering their homes, stealing small items, or using special devices to irradiate or gas them in an attempt to seize their apartments. A common element in psychoses is the notion of enemies, whom sufferers characteristically label "they." These delusions are often accompanied by illusory or hallucinatory experiences. For example, a person might initially report that a flashlight is shining through their window at night, intentionally making noise to disrupt their sleep and drive them mad. Subsequently, they may begin to "hear" their neighbors discussing, insulting, and threatening them. Almost every residential building has elderly individuals with these types of disorders. They rarely seek medical help; instead, they assert their rights, contact the police, and engage in disputes with imagined adversaries. It is impossible to reason with a patient experiencing paranoid home delusions, and their unfortunate neighbors should avoid interacting with them to prevent the escalation of the delusional narrative. In some cases, such patients may become physically aggressive and pose a risk. In these situations, it is advisable to involve their relatives, persuading them of the need and feasibility of medical intervention. If this approach is unsuccessful, persistent complaints should be made to the police and local psychiatric facilities, advocating for a psychiatric assessment of the "persecuted persecutor."

It is important to note that psychotic, delusional, and hallucinatory disorders generally respond well to treatment. Modern pharmacological interventions effectively mitigate most of the adverse effects that have historically contributed to a negative perception of psychotropic therapy over the past several decades.

Of all the ailments associated with old age, dementia, also termed senile dementia or dotage, is unequivocally the most profound and challenging. Among its various manifestations, vascular dementia and Alzheimer's disease are the most frequently encountered forms. Although these conditions may present challenges in differential diagnosis for the untrained observer, vascular dementia typically exhibits a more favorable response to therapeutic interventions. The risk of developing dementia increases with advancing age, and its prevalence is on the rise due to extended life expectancies facilitated by medical advancements. Emotional flattening, sexual disinhibition, exaggerated egocentrism, and hoarding tendencies create a shared character profile in individuals with early-stage dementia. The ability to memorize new things is impaired first, making it impossible to learn new household appliances or memorize a poem. Then forgetfulness sets in, affecting more current events: patients lose things (and often accuse others of theft), confuse dates, can get lost outdoors, forget words, especially nouns, make mistakes in calculations, and stop managing household tasks like cleaning and cooking. The emergence of false memories becomes more frequent, and a lack of awareness regarding their condition is a prevalent characteristic. In the absence of treatment, dementia can give rise to severe behavioral disturbances, including aggression, delusions, and hallucinations. Additionally, there may be complications related to urinary incontinence, dysphagia, and impaired mobility. As the disease progresses, patients necessitate constant care.

Dementia currently lacks a definitive cure, but early intervention can significantly delay the progression of the disease for extended periods. Therefore, it is crucial to identify the onset of dementia as promptly as possible. At the first signs of potential cognitive impairment, family members are advised to administer a standardized, online cognitive assessment tool known as the MMSE. This brief, five-minute test provides a reliable method for preliminary diagnosis of dementia. In the middle and advanced stages of the disease, treatment is primarily symptomatic and focuses on managing behavioral manifestations. It is essential to emphasize the significance of therapeutic interventions during these phases, as it is often the aberrant behavior, rather than the underlying memory deficits, that most severely impedes the patient's ability to function within a family environment.

In cases of advanced dementia, there is a significant deterioration of the personality, affecting all facets of cognitive function. In contrast, partial dementia allows certain personality traits and cognitive abilities, such as critical thinking, to persist. This condition is marked by an uneven impairment of mental processes, with symptoms manifesting intermittently and briefly. For individuals with severe dementia, it may be permissible to administer the Holy Communion without prior Confession. In less severe cases, Confession should be conducted similarly to that of a child, focusing on essential matters.

The immediate family members of individuals with mental health disorders, who are significantly impacted by the illness of their loved ones, require specialized pastoral support and assistance from the church community.

Inner peace of the person in the technological society

Introduction

Aldous Huxley, in his novel “Brave New World”¹, written in 1931, describes a highly technological society in which everyone is permanently happy. No one lacks what is necessary to satisfy all the senses: they have sex hormones, sprays of good aromas, pleasant noises, cinemas that make them experience images sensually, etc.

The biggest breakthrough is a wonderful substance, distributed free of charge by the state, called Soma, with hallucinogenic and euphoriant effects. If someone goes through a second of difficulty, he takes Soma and immediately finds himself in a happy world. Wars and diseases no longer exist. There are no strong individualities or great loves, so there are no conflicts. Each person is for the use and pleasure of all. When he dies, impregnated with Soma, there is no sadness or pain, but he returns his carbon to the universe.

This “social advancement” has been achieved by eliminating freedom and the family; the state controls everything, from reproduction to death. There is no father or mother, but all are conceived by in vitro fertilization and are born or “decanted”, as it is said in the novel, from glass jars. Culture, art, science, literature, philosophy, and of course God and religion are not accepted either.

In that happy and peaceful world God is not necessary. If God exists, he is silent, he neither speaks nor hears. Prayer is obviously meaningless.

It is easy to see similarities with some social environments today, where the parental figure is missing and the emptiness, which many experience, is filled with alcohol, drugs or the internet, which are used as an emotional regulator, a new Soma. Little space is left for reflective silence or prayer.

But what is peace? There are many synonyms for the word peace: concord, agreement, tranquility, calm, serenity, silence, harmony. Of these, concord and harmony have a special depth.

Is there real peace in Huxley's brave new world? We said there are no wars, and that is what we call concord. Where there is peace there is concord, but not always when there is concord there is peace². Peace in its proper sense refers to the heart of the human being, to a serene and coherent coexistence of the desires and appetites of the flesh and the spirit towards the good.

Peace is an abstract concept that reflects the spirituality of the human being, and is not linked to matter: «Peace is neither white nor dove-shaped»³.

Inner peace is not an emotion, which lasts only a short time, but a state, a positive feeling, maintained over time, deeply rooted in the person. Therefore, peace can be independent of emotions or other feelings. One can be sad and have peace, one can be suffering and have peace, bored and have peace, tired and have peace. And without inner peace, outer peace or concord cannot last. St. Augustine defines peace as the tranquility of order⁴.

¹ ALDOUS HUXLEY, *Brave New World*, first edition in 1932.

² Cf. THOMAS AQUINAS, *Summa Theologiae*. II-II, q. 29, a. 1. The study of concord or lack of concord, with its known mental effects, especially in the form of Post Traumatic Syndrome, does not fall within our objectives.

³ CARLOS LLANO, *Dilemas Éticos de la empresa contemporánea*, Fondo de Cultura Económica de España, México 1998, 50.

⁴ «Pax omnium rerum tranquillitas ordinis» (the peace of all things is the tranquility of order): St. Augustine, *The City of God*, XIX, 13, 1. For a deeper understanding of peace as self-mastery and a sign of maturity of the personality, with the importance of cultivating a good and wise

That tranquility, St. Thomas comments, would be to have appeased the appetites in oneself, and one's own appetites with those of others. In both cases, in internal and external peace, the principal cause is the love of God, which orders all the affections to Him; and the love of others, which leads us to love them as ourselves. It is shown that the ultimate cause of peace is charity⁵, and that «the perfection of joy is peace»⁶.

Jesus said: «Blessed are the peacemakers, for they shall be called children of God» (Mat. 5:9). This does not refer to any human concord or peace, but to being at peace with God, to seeking his friendship and desiring to unite our will to his⁷. It is a central longing of the human being, who is called to promote peace within himself and to transmit it to others.

In psychology, peace is often spoken of, without a clear definition⁸. There is a psychology of peace, which studies the elements necessary to avoid wars, terrorism, conflicts and other forms of violence⁹. It is noted, however, that the peace that everyone desires is not reduced to the absence of conflict, but to a diverse state of mind, without fear, with a reaffirmation of one's own value, security about the future and a perception of unity with other people¹⁰. It can be seen as the polar opposite of anguish, caused by the lack of hope and love, and by the certain possibility of not being¹¹.

The concept of tranquility also lends itself to numerous interpretations, depending on the cultural context, and it is difficult to clearly delimit its differences from peace¹².

The impact on peace has been explored at different levels: on positive emotions, on the capacity for engagement, on the meaning of life, personal well-being and resilience¹³. The principles of positive psychology, of a pleasant, engaged and meaningful life, were found to affect peace.

Lobna Chérif et al. in 2022 showed that inner peace is related to 3 of the 24 character strengths identified by Seligman and Peterson¹⁴: hope, enthusiasm and gratitude; and that it manifests itself in harmony and serenity, associated in turn with well-being (happiness) and life satisfaction¹⁵.

heart, capable of discerning good and evil, see: JOSÉ BENITO CABANIÑA & CARLOS AYOXELÀ, *Building interior order*, in: https://opusdei.org/en/article/building-interior-order/#_ftnref8.

⁵ Cf. THOMAS AQUINAS, *Summa Theolog.* II-II, q. 29, a. 3.

⁶ ID, *Summa Theolog.* I-II, q. 70, a. 3, c.

⁷ Cf. SAINT LEO THE GREAT, *Sermon De beatitudinibus*, 95, 8-9.

⁸ Cf. DANIEL J. CHRISTIE, *What is Peace Psychology the Psychology of?*, in «Journal of Social Issues», Vol. 62, No. 1, 2006, 1-17.

⁹ On this topic see: HERBERT H. BLUMBERG, et al, *Peace Psychology: A Comprehensive Introduction*, Cambridge University Press, 2006.

¹⁰ Even children crave more than the absence of conflict; cf. JEROME A. ESQUIBEL; HARYCANE L. CANLAS, et al, *What is peace? exploring the experiences of children living in a war-torn area*, in *European Journal of Social Sciences Studies* 10, n. 2, 2024, 32-56.

¹¹ Cf. V. V. VON GEBSEL, *Antropología médica, (Prolegomena einer medizinischen Anthropologie)*, Rialp, Madrid 1966, 468-482.

¹² Cf. VINCENT CHRISTOFFERSEN, ŠKODLAR RINGGAARD, *Exploring tranquility: Eastern and Western perspectives*, *Frontiers in psychology*, 2022-08, Vol.13, 931827-931827.

¹³ Cf. J. CHRISTOPHER COHRS JACOBS, DANIEL J. CHRISTIE, et al, *Contributions of Positive Psychology to Peace. Toward Global Well-Being and Resilience*, in «American Psychological Association», Vol. 68, No. 7, 590 - 600, DOI: 10.1037/a0032089.

¹⁴ Seligman and Peterson in their 24 character strengths do not mention peace. Nor does the concept of peace appear in the analytical index of their main work. The concept they use on some occasions is that of peace of mind, especially in relation to hope, although they do not define it: cf. PETERSON, C., & SELIGMAN, M. E. P., *Character strengths and virtues: A handbook and classification*, *American Psychological Association*, Washington DC, 2004.

¹⁵ Cfr. LOBNA CHÉRIF, RYAN NIEMIEC, VALERIE WOOD, *Character strengths and inner peace in International Journal of*

On this basis, I will show some challenges of peace in our interconnected world. We will then look at two common and widespread ways of seeking peace as inner balance: Yoga and Mindfulness. Finally, I will refer to Christian meditation as a source of harmony and lasting peace.

1. Challenges of peace in an interconnected world

The Internet plays a key role. That is why it will be the first point we will deal with. The Internet was born at the end of the 1960s. Today it is likened to a neural network. The brain has about 100 billion neurons and about 15,000 connections between them or synapses. The Internet, for its part, has about 1.2 billion PCs, plus 27 million servers and many millions of connected devices and cell phones, 44 million webcams, etc... In other words, an impressive and growing power.

This great Internet tool presents several challenges for peace and mental health, due to its peculiar characteristics, which Cooper described in 1998 with 3 “A's”: easy access, affordability, and anonymity, conducive to addictive use and disordered sexuality¹⁶. From here we have identified 6 challenges.

First, anonymity, which underlies the other drawbacks. Screens tend to cover the real identity, which facilitates misuse. It can produce an existential void, generating faceless people, without personality. Let us remember that the face is precisely the icon of personality.

Anonymity also fosters isolation and leads to a decrease in personal responsibility. An extreme case is that of the *hikikomori*, in Japan, which has spread to many countries. These are young people who isolate themselves in order to continually use the Internet.

Then, interpersonal relationships can arise from the misuse of the web. Toxic emotions are produced by fragile virtual relationships, in which there is a tendency to confuse the real with the virtual. Bullying is frequent and causes more serious damage to children.

It also facilitates addictions to gambling, drugs or social networks. Children between the ages of 5 and 11 spend about 2 hours a day in front of screens; between the ages of 11 and 18, this figure rises to 3.5 hours. It is estimated that teenagers, who use the Internet the most¹⁷, spend an average of 1,560 hours a year on social networks, which is equivalent to time spent at school.

The last challenge is criminality, not only on the Dark Web, such as the illegal sale of weapons, drug use and sex trafficking. The network itself does not cause the problems, but contributes to make explicit some personal deficiencies and favors the satisfaction of tendencies that, in real life, would not be accepted by the person or by society. In particular, the impulses of sexuality find an easy outlet in the anonymous protection of the screen. It also facilitates the radicalization of ideas and thus can diminish peace at the family and world level.

Huxley's Brave New World dystopian motto of «Community, Identity, Stability», where identity meant uniformity, is reflected in the misused networks. In that world, hundreds of twins and different castes were produced in vitro, to function without freedom, like machines. The Internet and networks can standardize in anonymity.

Wellbeing, 12(3), 16-34. <https://doi.org/10.5502/ijw.v12i3.2195>.

¹⁶ cf. A. COOPER, *Sexuality and the Internet: Surfing into the new millennium*, in «Cyber Psychology and Behavior», 1 (1998), 181-187.

¹⁷ Cf. CASALÓ, LUIS V., et al, *Tiempo Destinado a Internet Por Los Adolescentes Españoles - Time Devoted to Internet Activities by Spanish Adolescents: Diferencias Según La Práctica de Deporte y El Afecto Recibido* in «Reis: Revista Española de Investigaciones Sociológicas», no. 177, 2022, 3-20. JSTOR, <https://www.jstor.org/stable/27116851>.

In short, the excessive stimuli of technological society can clutter the inner world: it leads to a failure of harmony and therefore of peace.

2. The longing for balance: Yoga and Mindfulness

Technological society is hyperactive. People run and rush, looking at their phones and listening to music at the same time, without communicating with each other. The internet is full of information, but lacking in certainty. The need for peace continues to be pressing and various techniques that present themselves as emotional regulators and spiritual tools to achieve balance and peace have increased. Two widespread examples are Yoga and Mindfulness.

Yoga and Mindfulness have a religious origin or base, without a personal God to relate to. Hinduism in the case of Yoga, and Buddhism in the case of Mindfulness. They have had a great impact in the West since the 80's, with greater or lesser secularization or loss of religious foundations¹⁸.

They are presented as the art and science of governing the mind. They use concentration on the body, in particular the breath.

Let's first look at the serenity that Yoga offers. Yoga is a word that comes from Sanskrit. There are traces of its use 3000 years before Christ. It is one of the 6 doctrines of Hinduism, which considers the human being with a soul enclosed in a body, which has 4 parts: physical body, mind, intelligence and false ego. According to the Hindu religion, yoga is a spiritual path to experience the contact with the divine: the integration of the individual soul with God, Brahman, or with its deity or avatar; and the liberation from material bonds.

It presents 8 steps of a self-realization with three bases: suppressing the modifications of the mind, silence; non-attachment: non-self or nullity; and thirdly, abandonment to reach Samadhi, which is the full realization of oneself, an inner awakening or spiritual force to enter into communication with the divine being.

As a form of meditation, Yoga uses various postures, called Asana, to act on the body and mind. The keys to its practice are: slowness of movement, slow, conscious and directed breathing, and mental attention in a receptive state to what is happening. It can be accompanied by the mental repetition of a mantra, to concentrate on breathing in and out regularly and slowly.

From the biological point of view, Yoga reduces stress, improves concentration and promotes mental clarity. In the body, it increases flexibility, coordination and resistance.

Let us now look at the type of peace or well-being associated with Mindfulness¹⁹. It is the modern English translation of the Buddhist term Sati, a type of meditation described in the 5th century collection of Buddhist writings, the Digha nikaya (DN 22), which reads: «the path with a single goal, o monks, comes from the four pillars to achieve purification, to overcome weeping and lamentation, to turn away from pain and suffering: observing the body, sensation, mind and the elements». It is performed with crossed legs and full attention on the inhalation and exhalation, experiencing the body.

The main disseminators in the West are the Vietnamese Buddhist monk Thích Nhất Hạnh and his American disciple of Hebrew tradition, the biologist John Kabat-Zinn.

¹⁸ The increase in these practices can be seen, at times, as a reflection of secularized societies, in which a world without God is sought. In these societies, various forms of religiosity multiply without a personal relationship with a God of love: cf. FRANCIS, Encyclical *Dilexit nos*, 24 October 2024, n. 87.

¹⁹ For more information: cf. IACOPO IADAROLA, *Mindfulness Un'opportunità per I cristiani?*, Ares, Milano, 2020.

Thích Nhất Hạnh describes an example of Mindfulness as follows: «When you are washing the dishes, washing the dishes should be the most important thing in your life, whether you are drinking tea or in the bathroom... living in the present moment is the miracle».

A key question of Mindfulness is: «Your body is present, what about your mind?» It means total attention in the present moment, recognizing our thoughts and accepting them without judgment, with the aim of observing them with perspective, without immersing oneself in the content. Concentrating on one's own breath and thoughts in an impersonal way, so as not to identify with them or be drawn into them. It would be a state of mind that everyone can achieve: «Particular attention to the present, with an attitude of acceptance»²⁰.

By concentrating on the body, thoughts and feelings, one aspires to Nirvana, a state of perfect peace or tranquility.

It was introduced in medicine as a Mindfulness-Based Stress Reduction (MBSR) technique. It is used in depression, anxiety, obsessive-compulsive disorder and many other symptoms, with moderate usefulness in healthy people²¹. However, adverse effects have been described due to excessive concentration on one's own thoughts.

There is no doubt that these techniques, such as Yoga, Mindfulness and others, have many positive elements, but also some more negative ones, as highlighted in a document from the Congregation for the Doctrine of the Faith of the Catholic Church²².

The main positive factors are that they manifest a thirst for spirituality, can serve as a remedy to the dispersion in our technological society, give space to the body and its energies with clear health benefits, and help to better control the interiority: emotions and feelings, one's own ideas and reasoning.

The negative aspects would be: confusing these practices with Christian prayer; putting balance as the only goal, not wanting to experience emotions, and therefore perhaps not fully loving others; a possible hyper-reflection or excess of attention on oneself, which is one of the adverse effects also considered by medicine; a certain cult of the body, identifying its pleasurable sensations with spiritual experiences; and that they can promote egocentrism, giving priority only to individual well-being.

And if we ask ourselves: do these techniques achieve true peace? Are they a remedy to the anxious activism of the technological world? Do they reach the heart?

It is clear that many methods succeed in introducing a certain inner order which, as we have seen, is at the root of peace; but the very name of techniques sounds artificial, like an external addition, like the Soma of Huxley's world. The experience of peace that is achieved seems largely caused by physiological factors and the suppression of the emotional world.

From a physiological point of view, the key is in the control of breathing, similar to diaphragmatic breathing²³, which lowers heart rate, blood pressure and stress, and

²⁰ NATALIE ZOE TAYLOR, PRUDENCE MARJORIE ROBINA MILLEAR, *The contribution of mindfulness to predicting burnout in the workplace*, in «Personality and Individual Differences», 89 (2016) 123-128.

²¹ BASSAM KHOURY et al, *Mindfulness-based stress reduction for healthy individuals: A meta-analysis* in «Journal of psychosomatic research», 2015-06, Vol.78 (6), 519-528.

²² CONGREGATION FOR THE DOCTRINE OF THE FAITH, *Letter on some aspects of Christian meditation*, October 15, 1989.

²³ Cf. MA, XIAO; YUE, ZI Q, et al, *The effect of diaphragmatic breathing on attention, negative affect and stress in healthy adults*, in «Frontiers in psychology», 2017-06, Vol.8, 874-874. The authors studied diaphragmatic breathing independently of classical aspects of yoga or other spiritual tools. They found a decrease in negative emotions, improved attention and a significant decrease in saliva cortisol.

improves depressive symptoms²⁴. In a sense it is like a brain reset, facilitating new ways of thinking and feeling. From the spiritual point of view, a kind of immersion in divinity is sought, reducing in some way one's own identity.

3. Christian meditation, source of harmony and peace.

Christian meditation, unlike methods of inner control that seek balance, is not a technique, but places a person, Jesus Christ, at the center of a relationship of dialogue. It does not consist in diluting or immersing oneself in divinity, losing personality and denying emotions and the earthly, but in illuminating existence with the life of Jesus of Nazareth, the incarnate Word, who promised: «Peace I leave with you, my peace I give to you; not as the world gives do I give to you» (John. 14:27).

Christian prayer is a gift of God that comes from the heart. It is a privileged path to inner peace. In this regard, the great scientist Blaise Pascal wrote: «I have discovered that all the misfortune of men comes from one thing: not knowing how to remain quiet in a room»²⁵. The context of this statement is when he speaks of the misery of man without God, who seeks to distract or amuse himself in many things, such as gambling, war or vain conversations, which prevent him from focusing on what is most important and from knowing the reality of his limited condition.

If Mindfulness is awareness focused on what is important, we can say that Christian Mindfulness would be to be constantly aware of the presence of a God who is close to us, who loves each person and calls us to speak with Him. For a Christian, each practice of piety, the moments in which he prays or goes to the temple, are transformed into moments of peace. And it is especially prayer, or dialogue with a God who listens and speaks, that permeates his thought and action. We will quote, among many, two authors who express this idea very well.

The first is St. Basil, who describes Christian prayer in this way: «It is beautiful prayer that makes God more present in the soul. In this consists the presence of God: in having God within oneself, reinforced by memory. (...) We become a temple of God: when the continuity of memory is not interrupted by earthly concerns, when the mind is not disturbed by fleeting feelings, when he who loves the Lord is detached from everything and takes refuge in God alone, when he rejects everything that incites to evil and spends his life in the fulfillment of virtuous works»²⁶.

The second, many centuries later, but in the same vein, is St. Seraphim of Sarov, who refers to the joy of seeing Christ with the inner eye; a joy greater than that of seeing the sun with the eyes of the flesh. To maintain this peace, St. Seraphim will tell us that it is important to ward off melancholy with a joyful spirit, and also by knowing how to hold one's tongue, and avoid judging others: «Nothing contributes to inner peace as much as silence (...). We must concentrate our thoughts, our desires and our actions on acquiring God's peace and cry out unceasingly with the Church: Lord give us

²⁴ Cf. A.V. RAVINDRAN; M.S. MCKAY, et al, *Breathing-focused Yoga as Augmentation for Unipolar and Bipolar Depression: A Randomized Controlled Trial: Le yoga axé sur la respiration comme traitement d'appointement pour la dépression unipolaire et bipolaire: Un essai randomisé contrôlé*, in «The Canadian Journal of Psychiatry», 2021 Feb;66(2):159-169.

²⁵ BLAISE PASCAL, *Pensées*, n. 138: «Divertissement. Quand je m'y suis mis quelquefois à considérer les diverses agitations des hommes et les périls et les peines où ils s'exposent, dans la cour, dans la guerre, d'où naissent tant de querelles, de passions, d'entreprises hardies et souvent mauvaises, etc., j'ai découvert que tout le malheur des hommes vient d'une seule chose, qui est de ne savoir pas demeurer en repos, dans une chambre».

²⁶ ST. BASIL, *Epistle 2*, 2-4.

peace!»²⁷. «The gifts of grace belong only to those who pray and take care of their own souls»²⁸.

In summary, as great as technological progress is, it fails to quench the yearning for infinity or God, which is the foundation of peace. In *Brave New World*, Huxley illustrates this tension with a dialogue between the World Controller, called Mustafa Mod, and John, known as the Savage, because he comes from a village where people are still born in a natural way, and is on the fringes of the happy society. And so says Mustafa: «The fact is that at present we can retain youth and prosperity to the end. What follows from this? Evidently, that we can be independent of God».

But can we be independent of God? I think not. The more we orient ourselves towards God, the more inner peace we will have and the more we will be able to bring it to others, by understanding and feeling the divine truth, moving away from egocentrism²⁹. The Christian life is not only a search for balance, but also healthy tension. Peace is order, and that order or harmony requires effort and the help of the Holy Spirit. The human will, moreover, is wounded by sin and is fragile. For this reason, peace requires us to be vigilant over ourselves and our passions³⁰.

Conclusions

There is no drug or technology that can replace God and ensure peace. Neither can techniques focused on the balance of the self, such as Yoga or Mindfulness, do so. To achieve peace, we need a different attitude, related to charity: to love others as brothers and sisters, to believe in a universal fraternity. Peace is the fruit of love, which goes beyond justice. Only on this path is lasting inner peace possible, which is the «perfection of joy», as St. Thomas Aquinas described it.

Inner peace, therefore, is related to an inner attitude. It depends on virtue, a force that pushes us to be better, and on a solidarity as a type of friendship or social benevolence, of which Aristotle speaks, that moves us to love all human beings as brothers and sisters.

This attitude is possible only if we give space to silence, if we learn to disconnect from the excesses of internal and external stimuli. The Christian's prayer follows a very good itinerary: to seek Christ, to find him, and to love him³¹. Prayer is a source of Human flourishing and peace.

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²⁸ *Ibidem*, 198.

²⁹ Cf. FULTON SHEEN: *Way to inner peace*, Alba House; First Edition: 11 January 1995.

³⁰ Cf. SECOND VATICAN COUNCIL, *Gaudium et spes*, n. 78.

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Characteristics of late-life depression. The role and importance of spiritual care

Abstract: The article addresses issues of prevalence, etiology, and clinical features of late-life depression, describing biopsychosocial and spiritual factors as causes. It presents the results of a clinical study identifying markers of poor prognosis for late-life depression and describes the peculiarities of psychopathological symptoms in religious and spiritual patients with depression. Based on an analysis of Russian Orthodox Church documents, clergy opinions, and psychiatrist recommendations, the article examines the boundaries of interaction between psychiatrists and clergy, and the role and significance of pastoral care in late-life depression.

Keywords: late-life depression, bio-psycho-social-spiritual causes of depression, boundaries of interaction between psychiatrist and clergy, role and significance of pastoral care.

According to WHO estimates, 280 million people worldwide suffer from depression, including 5.7% of those over 60. People over 60 account for about 25% of suicide mortality. There is a problem of insufficient diagnosis of depression all over the world, because the symptoms of depression coincide with other socio-psychological problems of the elderly.³²

An analysis of the dynamics of the general and primary incidence of mental disorders in the population of the Russian Federation over 60 years of age showed that over the period 2000-2016, the prevalence of affective disorders among patients over 60 years of age increased by 60.8% in absolute numbers (Demcheva N.K., Kekelidze Z.I., Kazakovtsev B.A., Makushkin E.V., 2017).

Depression is a risk factor for dementia. Cognitive impairments, closely linked to depression, develop during depressive episodes and can reach the level of dementia in late age. Dementia is significantly more common in patients with prolonged and chronic depression. Pathological grief reactions and pathological loneliness are also risk factors for dementia. In patients with depression, cognitive impairments may reflect not only the impact of depressive affect on cognition but also a concurrently developing organic brain lesion. Thus, depression can be an early stage of a degenerative disease, and its prevention and active treatment can be a method of preventing late-life dementias (Polishchuk Yu.I., Pishchikova L.E., Smirnov O.R., Letnikova Z.V., 2021).

Yu.I. Polishchuk (2017) identified the following characteristics of late depressions: anxious affect, atypicality, tendency towards chronic subsyndromal course, prevalence of masked and somatized forms, hypochondriacal and somatoform symptoms, and a high risk of completed suicides (Polishchuk Yu.I., Kalinichenko T.P., Letnikova Z.V., 2017).

S.G. Zhislin (1965) viewed the tendency towards depressive states and their prolonged course as common for the involutional period. In his opinion, the psychogenic factor – loss of life positions – plays a significant role in the exacerbation of the pathological process in old age; situations that contain not actualized factors, but only their possibility in the future, possess the greatest pathogenic influence (Zhislin S.G., 1965).

O.P. Vertogradova (1986) noted that with advancing age, depression simplifies and "cleanses," progressing from a full-blown depressive state in adulthood to a simplified structure with vitalization and somatization of all syndrome components in old age (Vertogradova O.P., Voitsekh V.F., Krasnov V.N., 1986). In the genesis of

³² Mental Health and Older Adults, WHO Fact sheet, 2017

psychopathological formations in late age, endogenous factors are replaced by others, caused by associated somatic pathology, increasing psychorganic disorders, and a decline in social status.

Yu.I. Polishchuk (2019), analyzing the causes of late-life depressive and anxiety disorders, identified biological, psychological, and social factors. Biological factors included age, age-related brain involution, physical and mental decline, reduced adaptive capacity, polymorbidity, predisposition to anxious and depressive reactions, emotional lability, and susceptibility to psychotraumatic circumstances. Psychological factors included mental and moral trauma, family problems, worsening well-being, losses, and loss of meaning. Social factors included retirement, job loss, ageism, abuse and violence, loneliness, and the collapse of previous ideals and worldviews. He emphasized that depressive and anxiety disorders in the elderly arise from the simultaneous or sequential action of several factors in their integral combination and interaction (Polishchuk Y.I., Letnikova Z.V., 2019).

Analysis of clinical features of late-life depression revealed unfavorable prognostic signs such as recurrence, treatment resistance, and incomplete remissions. Increasing polymorbid pathology, associated hypochondriacal fixation on somatic distress with anxious affect and various pathological sensations (cenesthesias), became significant factors for both the development of depression and its unfavorable recurrent course (Pishchikova L.E., Smirnov O.R., Letnikova Z.V., Egorova D.A., 2023).

In Christian anthropology, personality is viewed as a unity of spiritual, psychological, and physical manifestations under the transformative influence of the spiritual realm. Spirituality is defined as the highest level of development and self-regulation of the personality, the neglect of which leads to moral dissonance, spiritual conflict, and disturbances in the spiritual, psychological, and physical spheres.³³

According to researchers, religious spirituality positively correlates with mental health, the risk of developing major depression decreases linearly with the use of religious coping methods, religious faith modifies depressive symptoms with partial reduction, and church sacraments have a psychotherapeutic effect. Prolonged depressive reactions develop as a result of the destruction and loss of higher personal meanings in individuals whose meaning sphere was dominated by spiritual and prosocial values prior to the illness.

It is noted that a religious worldview can help in coping with a mental disorder, but it can be a ground for the development of ideas of religious and mystical content within the framework of a depressive state, and it can be a reactive factor for the occurrence or deepening of the severity of depression in religious and spiritual patients. Dominant and super-valuable ideas and thoughts about imaginary and real sins committed by religious and spiritual patients in the past can contribute to the consolidation and prolongation of the ideatory component of the depressive symptom complex, in particular, the ideas of guilt, sinfulness, self-abasement and self-blame (Polishchuk Yu.I., Pishchikova L.E., Letnikova Z.V., 2020).

Religious worldview, on one hand, is a psychotherapeutic factor and a coping mechanism for morbid states, and on the other, can contribute to its development, exacerbating depressive experiences and guilt.

In the clinic of the Moscow Research Institute of Psychiatry, a branch of the V.P. Serbsky National Medical Research Center of Psychiatry and Narcology of the Ministry of Health of Russia, we observed diverse psychopathological conditions with ideas of religious and mystical content in older religious and spiritual patients with depression, including:

³³ [Electronic resource]. URL: <https://totmir.com/wp-content/uploads/2021/09/Osnovy-sotsialnoj-kontseptsii-Russkoj-Pravoslavnoj-TSerkvi.pdf> (Accessed 05.05.25).

- obsessive religious rituals;
- religious ideas of sinfulness, combined at a height with a sense of abandonment by God, a weakening or loss of a sense of grace, encounters with the Lord, lack of relief from church sacraments, prayers; manifested as conviction of having violated the commandments of God, desecration of sacred objects, breaking previously taken vows, certainty that illness is punishment for an improper lifestyle, sins, that they could not resist the temptations of the devil; with thoughts of the worthlessness of further existence, unwillingness to live, suicidal intentions;
- states with ideas of obsession with religious and mystical content;
- a depressive-paranoid condition that arose as part of the Jerusalem Syndrome.

All these mental disorders required analysis not only of psychopathological symptoms but also of the patient's spiritual sphere, identifying the causes of its disruption. This necessitated close collaboration between the psychiatrist and the clergy to analyze the spiritual basis of the illness and provide pastoral care.

From the document of the Commission of the Inter-Council Presence on Church Education and Diaconia (2020) "Pastoral Care in the Russian Orthodox Church for the Mentally Ill," it follows that the Church views mental illnesses as one of the manifestations of the general sinful corruption of human nature³⁴. By distinguishing the spirit, soul, and body levels of personal structure, the Church Fathers differentiated between diseases arising "from nature" and ailments caused by demonic influence or resulting from enslaving passions. Accordingly, it is equally unjustified to reduce all mental illnesses to manifestations of possession and to attempt to treat any spiritual disorders solely with clinical methods. It is noted that existing societal prejudices, myths, and superstitions regarding psychiatry and the mentally ill lead to patients not seeking medical help in a timely manner. At the same time, patients themselves and their relatives try to substitute a psychiatrist with a priest, and consider all mental illnesses as a form of demonic possession.

According to the authors, the tasks of the pastor in relation to mentally ill people are:

- Teach the person to accept the very fact of having a disease and strive for healing;
- Help understand that mental illness is not a sign of being forsaken by God, closing off the Kingdom of God or participation in the life of the Church, but rather a cross given for one's salvation;
- Facilitate the patient's referral to a psychiatrist, examination, and, if necessary, systematic treatment;
- Promote church involvement and participation in the sacraments of the Church to improve mental well-being;
- Be able to recognize acute forms of mental disorders that threaten the life of the patient or others, and understand when to provide emergency assistance, including involuntary hospitalization.

According to Archpriest Ilya Odyakov and Nikolai Martinkevich (2024), a spiritual advisor should not become the cause of suicidal thoughts by resorting to harsh judgments, reprimands, and punishments, which can be the last straw for a person feeling trapped in their life. One should not intimidate a penitent with threats or "predictions" about the possible consequences of sins associated with depression. It is wrong to link any mistakes and transgressions in a person's spiritual life with illness or

³⁴ [Electronic resource]. URL: https://diaconia.ru/wp-content/uploads/2024/12/2020_3d5e994d.pdf (Accessed 05.05.25).

to find a causal relationship. On the contrary, it should be emphasized that illness is not a result of personal sin. The priest should reassure the sick person that they can trust the doctor and that the prescribed medications and other treatment methods are effective.

A priest unable to recognize mental illness (e.g., depression) can make significant errors during Confession. These include: misunderstanding the penitent's words about powerlessness, "petrified insensitivity," or "emptiness within the soul"; treating a depressed person as healthy; imposing common spiritual advice; attempting to force the patient to live like a healthy person; reproaches, humiliation, and efforts to "humble" them by any means, which can intensify feelings of inferiority, guilt, and loneliness (Archpriest Ilya Odyakov, Archpriest Nikolai Martinkevich, 2024).

According to V.G. Kaleda (2021), a high level of specialization for clergy in psychiatry is required. Clergy should uphold the doctor's authority in the patient's eyes. By providing explanations, they should reduce anxiety, understanding the nature of panic disorder. They must be able to distinguish between a person's thoughts and obsessions of a pathological origin. When depression is identified, instead of condemning or supporting self-condemnation, clergy should seek the origins of depression in the patient's behavior and character. It is important to explain the pathological nature of the condition and the need to postpone life decisions until recovery. In a state of depression, besides encouragement and emotional support, gentle activation, feasible work, or obedience at the church are necessary. Thus, the priest's task becomes to urge the patient to fully trust God and bless him to accept supportive therapy (Kaleda V.G., 2021).

In his report at the Moscow Diocesan Assembly (December 20, 2023), Patriarch Kirill outlined a stricter stance on pastoral care³⁵. He deems unacceptable the use of psychotherapy methods based on suppressing the patient's personality, altered states of consciousness, and behavioral manipulation by both doctors and clergy. He stated, "Confession should serve solely the reconciliation of the sinful person with God, and it is unacceptable to make it a means of inquiry or supervision, psychotherapy, conflict resolution, or anything else." He considers it unacceptable for clerics to be overly involved in psychological practices, which can harm the pastoral approach, lead to shifts in conceptual systems, re-encoding of patristic terms into psychological ones, and the exclusion of turning to God! He also deems unacceptable the avoidance of discussing sin and passions to avoid upsetting parishioners, "stigmatizing," or "devaluing" them, which leads to the abandonment of penitential labor and inner self-work. He critically assesses Confession and pastoral care that turn into therapeutic conversations between parishioners and priests, and humility is interpreted as "accepting oneself as I am." The Patriarch calls for pastors to be able to listen compassionately to those coming to the Lord. However, compassion does not imply verbosity filled with many pieces of advice, but, firstly, a respectful and serious attitude towards another's sorrow, another's misfortune, understanding that for a grieving person, nothing is more dramatic than their current sorrow. And secondly, compassion implies sincere prayer for the person. Priests should not become psychologists or "coaches." Clergy should also not interfere with the therapeutic prescriptions of psychiatrists.

Conclusion

D.E. Melekhov's (2011) position about the boundaries of interaction between a psychiatrist and a clergyman regarding a mentally ill person remains relevant. He wrote that the primary task for a spiritual father, as well as for a psychiatrist who is a religious person, is to establish a "spiritual diagnosis," i.e., to determine what in a person's suffering has a directly spiritual cause and is subject to spiritual treatment. At the same

³⁵ [Electronic resource]. URL: <https://www.patriarchia.ru/db/text/6085672.html> (Accessed 05.05.25).

time, it must be established that exactly in his experiences is a manifestation of mental illness, which has a cause in disorders of brain activity or the entire body, and therefore requires medical competence, equipped with modern knowledge of the laws of psychological life, the laws of biological, emotional mental life and medical effects. Finally, if a person has psychophysical impairments resulting from personal or family sins, then he needs spiritual and psychiatric methods of treatment at the same time. In such cases, spiritual recovery can lead to mental and physical healing (D.E. Melekhov, 2011).

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Depression in elderly

Abstract: Depression in older adults is often wrongly perceived as a natural consequence of aging or a understandable psychological response to age-related hardships. However, it is a condition defined by persistent low mood, anhedonia (inability to feel pleasure), and unexplained fatigue, not attributable to somatic pathology. Moreover, depression in the elderly can present with symptoms that appear similar to dementia. When offering spiritual pastoral care to depressed elderly parishioners, the priest should observe signs such as fear of death, complaints about insufficient attention from children, and a disinclination to join parish events or services.

Keywords: Depression in the elderly, symptoms of late-life depression, pastoral assistance for elderly patients with depression.

Depressive disorders significantly impair the quality of life of elderly individuals. 15% of older persons (over the age of 65) show signs of depression. For people living in long-term care facilities, this could reach 50%. They are frequently misdiagnosed and underdiagnosed due to their unique clinical presentation and the coexistence of a variety of physical and cognitive disorders. Hence the treatment gap is very wide.

What is depression?

Depression is not just a feeling of sadness in response to life events or disappointing situations. It is a persistent low mood, lack of energy (fatigue) and inability to feel happy (anhedonia). Depression affects both mental and physical function.

Common misconceptions about depression in older adults

1. It is a part of normal aging.
2. It is simply a reaction to environmental factors and does not require specific treatment.

How is "depression in older adults" different from depression in the general adult population?

1. Symptoms are different – somatic/ physical symptoms may predominate the clinical picture. Symptoms such as constipation, forgetfulness, agitation/ restlessness, fatigue, intolerance / sensitivity to noise, irritability etc. can lead to misdiagnosis.
2. Assessment is different - Sensory deficits, such as visual impairment and hearing loss, should be taken into account during assessment. A cognitive assessment should be carried out in every case, both clinically and through appropriate testing batteries. (Literacy, including digital technology literacy, should also be considered when interpreting the results of formal cognitive tests.) MoCA, Dementia Screening Test, and Mini-Mental State Examination are some of the commonly used bedside tests in India.
3. Treatment is a bit different - both psychosocial interventions and pharmacological treatment should be used. The choice and dosage of medications should be tailored to the patient's medical conditions and organ function levels.
4. Outcomes may be different - the treatment outcome may not be as good as for adult depression.

What causes “depression in the elderly”?

Depression in older adults is not always caused by environmental or psychosocial factors alone. It is often a complex issue with multiple factors involved. Genetic factors play a lesser role when depression begins in childhood.

Vascular and degenerative changes in the brain that occur with advancing age can contribute to symptoms of depression, such as persistent low mood, slowed psychomotor activity, fatigue, and anhedonia. Cerebral atrophy, deep white matter changes, and lacunar infarcts are common on brain imaging (Magnetic Resonance Imaging or MRI) in older adults with depression, but these findings are not specific to the condition.

Depression and neurological disorders in the elderly

Studies have shown that 40% - 60% of stroke survivors, 30% - 40% of patients with Parkinson's disease, and 20% - 40% with Alzheimer's meet the criteria for Major Depressive Disorders. The terms "vascular depression" and "multi-infarct dementia" are used to describe depression resulting from strokes - both major and minor - which may go unrecognized because the symptoms of depression are considered part of the more visible neurological disorder. These types of depression can be more difficult to treat, and underlying factors such as hypertension, heart disease, and diabetes mellitus should be actively addressed.

Medical conditions comorbid with depression

Depression in older adults often occurs in conjunction with other medical conditions. These conditions include cardiovascular disorders, chronic obstructive respiratory disorders, cancers, chronic pain conditions, musculoskeletal disorders, renal and liver disorders. Symptoms of depression may be mistaken for those resulting from these medical conditions, leading to missed diagnoses. Some medications used to treat these conditions can also contribute to depression. For example, medications such as beta blockers, reserpine-containing agents, clonidine, and methyl dopa, which are used to treat systemic hypertension, are known to cause symptoms of depression. The list of medications that can cause depression is quite extensive. Anti-arrhythmics, anabolic steroids, anticonvulsants, barbiturates, digitalis, glucocorticoids, H2 blockers, and metaclopramide are some examples. It is important to carefully evaluate all medications a patient is taking, both those prescribed by a doctor and those purchased over the counter, including the ones from alternative systems. In India, the use of herbal Ayurvedic preparations and Sidha system medicines, which may contain heavy metals, is specifically addressed.

Psychosocial factors contributing to depression in old age

Bereavement (demise of a spouse, siblings or friends), limitations on mobility and travel which disconnects a person from social interactions, role transitions in family, loneliness (“rather than solitude”), dependency on others, whether financial or physical, attitudes of family and society towards older adults (“ageism stereotypes”), frustrations with decline in memory etc. can contribute to low mood, helplessness and worthlessness.

Diagnosis of depression in older adults

The same criteria used for diagnosing depression in the general adult population (DSM-5 or ICD-11) are also used for older adults. However, it is important to take into account atypical features (cognitive impairment, sensory problems, psychomotor agitation, and physical symptoms etc.) when making a diagnosis.

Although the main features of the condition are persistent low mood and anhedonia, impairment of vegetative functions such as sleep disturbances, appetite loss, and physical symptoms like fatigue may also be present in most cases.

Patient Health Questionnaire (PHQ9), Geriatric Depression Scale and Beck Depression Inventory (BDI) are used in India for the screening of geriatric depression.

Assessment of risk of suicide

Suicide or self-harm risk assessment should never be ignored in the assessment of elderly persons with depression. The Beck Suicide Inventory can be useful when used in conjunction with a sensitive clinical evaluation.

Treatment of depression in Elderly

The treatment of depression in older adults should be a thoughtful combination of pharmacotherapy and psychosocial interventions.

Response to pharmacotherapy for geriatric depression is relatively low, especially when there is a significant vascular component. Elderly patients are more likely to experience adverse effects from antidepressants, such as anticholinergic effects (e.g., constipation, dry mouth, urinary retention, blurred vision etc.), and cardiovascular adverse effects (conduction defects and orthostatic hypotension), particularly with drugs in the tricyclic class. Selective serotonin reuptake inhibitors are generally considered safe, but caution should be taken to monitor for the risk of hyponatremia in elderly patients.

The use of benzodiazepines among the elderly is common in general practice for treating symptoms of anxiety and depression. However, the costs associated with these medications (cognitive impairment, ataxia, falls, and injuries) outweigh the potential benefits.

Psychosocial interventions should be planned individually and involve the family for every individual. Health care professionals in the community can provide simple supportive therapy with basic training. Outdoors activities and involvement in group meetings can be useful at the community level. Initiatives by neighborhood groups such as the Vayomithra project (befriending the elderly), supported by the Ministry of Social Justice, are implementing these innovative programs at the community level in Kerala.

A structured individual cognitive behavior therapy may not be feasible in the Indian setting, but group therapy can be attempted for milder cases. Existential and spiritual-oriented therapies may also have a place in psychosocial interventions.

Involving family members in the care of an elderly person has been shown to improve their quality of life and reduce their expressed emotions.

Conclusion

Depression among older adults is a significant area of concern in mental health care. There is a wide treatment gap. To address this, the health care system needs to adapt and provide early recognition and prompt treatment. This includes a combination of pharmacological treatment with antidepressants and psychosocial interventions, such as spiritual support. These interventions have been shown to reduce suicide rates and improve quality of life for those suffering from depression.

The church and its members have a responsibility to work with mental health professionals to recognize and manage depression among the elderly.

Attention deficit disorder in children and adolescents

Abstract: Attention-deficit/hyperactivity disorder (ADHD) is the most common neurodevelopmental disorder in children. It is characterized by inattention during tasks requiring sustained concentration, restlessness, hyperactivity, and an inability to control impulsive verbal and behavioral responses. Late identification of the syndrome heightens the likelihood of oppositional behavior in adolescence, antisocial behavior in adulthood, and the potential for drug addiction. Two-thirds of children with ADHD also experience co-occurring developmental and learning disorders, such as dyslexia. Clergy who minister to families with children experiencing poor academic performance or behavioral issues should remember that these disorders are treatable and encourage parents to seek professional help. At the parish or diocesan level, educational seminars can be organized for parents and teachers, including Sunday school instructors, with the participation of psychiatrists and psychologists who share Christian values. Children and parents are in need of spiritual and psychological support due to the high levels of frustration, low self-esteem, and guilt they are experiencing.

Keywords: Attention-Deficit/Hyperactivity Disorder (ADHD), behavioral disorders in children and adolescents, pastoral care for children with behavioral disorders.

Attention Deficit Hyperactivity Disorder (ADHD) is a common disorder in children which impacts domains of academic performance, emotional regulation and social development in a significant manner. It is estimated that 5-7% of school age children are suffering from this disorder. However, only a small number of these children are diagnosed to have this disorder and even a much smaller number are getting proper and timely interventions. The treatment gap is estimated to be 75-80%.

What is ADHD?

ADHD is a neurodevelopmental disorder that typically manifests in childhood and affects three areas of brain function: attention, motor activity and impulse control. Child's ability to focus and sustain attention is significantly impaired resulting in distractibility, forgetfulness, frequent losing of belongings and poor academic performance. Inability to control motor activity results in fidgetiness, running about when expected to sit down quietly and restlessness. Diminished ability to inhibit impulses may result from lack of reflection about the consequences of a behavior. This is clinically manifested as talkativeness, inability to wait for one's turn, intruding into conversation and blurting out answers before the question is completed. Child's ability to plan, organize, execute and monitor goal-directed complex behaviors can be impaired significantly. From the above description it is very clear that ADHD not only affects the academic performance, but also impairs the development of behavior self-regulation which is so important in his / her development.

Case Scenario:

A 8 year old boy is referred to Child and Adolescent Services by the school counsellor. The concern by the teachers and family is that he has "poor academic performance despite being smart and good in many other things". The boy's behavior was described as naughty and careless. He frequently fights with peers for silly reasons and yells and swears at them. He forgets his home works and doesn't convey messages from teachers to home. His notebooks are incomplete and messy. Lot of spelling mistakes are noticed in his notes. Though mathematics is his favorite subject, he is not

getting expected grades because of careless mistakes. He doesn't like reading and forces mother to read out for him. Mother was a bit guilty as the kinship blamed her for spoiling the child by sparing the rod! On examination he was initially angry and resentful for the long wait at the clinic. Later after tactfully establishing the rapport he appeared playful to the extent of bit disinhibited. His developmental history was normal except for a mild delay in speech which caught up after pre-school placement. He did not have any significant medical problems. Intelligence appeared average on clinical evaluation.

Child appeared very distracted and uninterested as the session progressed and had to be discontinued after 20 minutes as he demanded to go out for a cola drink. Mother had to yield to his pressure tactics to continue the interview. He was reluctant to read and on repeated requests he read without fluency and with lot of hesitation. He said he wants to be a Chef and for that reading is not needed! Though he was cheerful mostly he expressed his anger towards mother who brought him to the "crazy doctors" quite unnecessarily.

How to diagnose ADHD?

Carefully elicited history and clinical examination are the key to accurate diagnosis. Errors of diagnosis can happen in both sides – the error of under diagnosis by attributing normalcy ("everything will be alright as he grows up") or the error of over diagnosis by attributing pathology (to normal childhood exuberance).

These issues have been taken care of by the developers of DSM 5 and ICD 11.

Rather than making impressionistic assumptions, using statistically valid diagnostic criteria are recommended using the above guidelines. 9 objective criteria each from two domains – the domain of inattention & the domain of hyperactivity-inputs – have been codified to help clinicians more objectivity. Based on the presence of the items in these two domains, if the required criteria are met the syndromal diagnosis, its sub typing (into combined or predominantly inattentive) and severity can be made.

Using rating scales like Connors Comprehensive Behavior Rating Scale (parent, child, self) are helpful in quantifying and domain identification.

What else to look for?

ADHD is seldom a single diagnosis. It comes with comorbidities from among other neuro developmental disorders like specific learning disorders (like SLD – developmental dyslexia, dysgraphia, acalculia, developmental coordination disorders), obsessive compulsive disorders, anxiety disorders, mood disorders and so on. When left unintervened children with ADHD can run more into substance use disorder and disruptive behavior disorders (oppositional defiant disorders & conduct disorders) in adolescence. So at the end of the work, having multiple diagnoses is quite common.

We need to look for comorbid medical conditions also in children with symptoms of ADHD. Epilepsy, migraine, bronchial asthma, allergies, thyroid disorders, iron deficiency, lead poisoning, sleep disorders etc. can mimic symptoms of ADHD. Many medications used in treatment of these disorders, for example barbiturates, anti histaminergics etc. can contribute to inattention and hyperactivity.

What causes ADHD?

There is no single cause for ADHD. Genetic factors (inheritance and expression of DAT genes, DAR4 genes) can increase vulnerability. Antenatal and perinatal factors like low birth weight, birth asphyxia, maternal alcoholism and smoking can be a second hit. These factors lead to malfunction of key brain circuits determining functions like sustained focus and shifting of attention, rewarding of pleasurable experiences, inhibition of impulsive responses and motor activities and organization and execution of

complex goal directed activities. Among the several brain circuits identified the most important ones are cortico-striatal pathways and cerebellum. The key neurotransmitters identified are Dopamine and Nor-epinephrine.

Under-stimulating and chaotic environment at home and inadequate parenting strategies may worsen the problem.

Do children overgrow ADHD as they grow up to adolescence?

Previously it was believed that by the time children “mature” into adolescence and early adulthood the symptoms of ADHD naturally resolve. But follow up studies and retrospective recollection from early adulthood suggest that it is not the case. Though hyperactivity (the more visible part of ADHD) subsides, inattention, impulsivity and impairments in carrying out complex goal oriented long term tasks continue to be impaired in nearly two third of children with ADHD through their adolescence and perhaps life long! This can have a profound influence on the life of a person who lives with it, and that too being unaware of it. This can lead to academic underachievement, an unstable career, poor quality marital relationships, and poor parenting. So it is very important to follow up children beyond their school age.

How ADHD is treated?

1. Early identification.
2. Comprehensive evaluation – including developmental and educational assessment.
3. Making a formulation for comprehensive management.
4. Parent & teacher education.
5. Medications.

Medications do have a definite role in the treatment of ADHD. Stimulants (Methylphenidate, Amphetamine salts) are the first choices. Non-stimulant medications like Atomoxetine, Clonidine, Guanfacine, Bupropion, Desipramine are used as second line agents. The parents and children should be properly educated about the possible benefits, limitations and adverse effects of the medications before they are initiated.

6. Behavioural strategies – parents and school authorities should be trained in implementing these strategies in a firm and consistent manner.

7. Remediation and accommodation – school authorities and educational system should be ready to provide an individually tailored training program, especially when these children have comorbid learning disorders.

8. Career planning & life coaching – the statement made by the child in the anecdote: “I don’t have to read much to become a Chef” need serious consideration. The natural skills and endowment in non-academic areas can be capitalised in planning their career and future lives.

Role of Church

Traditionally, Church’s emphasis on bringing up children was confined to training them in spiritual paths of Christianity and Orthodoxy. But in the light of newer developments, church has to take up scientific training of parents as a priority in its ministry. The priests and the leaders of religious communities in the local areas should take the lead and collaborate with professionals.

Prevention of dementia: the perspective of a doctor and priest

Abstract: Dementia prevention underscores the need for a comprehensive approach that combines medical, social, and spiritual aspects. A balanced and active lifestyle, addressing health issues, strengthening social relationships, and engaging in spiritual practices contribute to reducing the risk of dementia. The church plays a vital role by creating a supportive community, encouraging fasting, and fostering a culture of communication that promotes mental health. These practices are essential not only for dementia prevention but also for maintaining overall well-being.

Keywords: dementia prevention, dementia risk factors, the role of the Church in dementia prevention.

Introduction

Approximately 50 million people worldwide are currently affected by dementia, a figure expected to triple by 2050. This projection underscores the urgency of understanding preventive measures, as 40% of dementia cases are deemed preventable. To address this, a holistic approach combining medical, social, and spiritual perspectives can help identify effective prevention strategies.

In the first part of this paper, I will present the 12 protective factors against dementia, as identified in an article published earlier this year in the German scientific journal *Der Nervenarzt*. In the second part, I will explore how these protective factors are embodied in an active spiritual life.

Risk factors for dementia

Age remains the primary risk factor for dementia. Data shows that while the incidence rate is 0.4% in the 60-65 age group, it rises dramatically to over 10% among those over 90. Despite the global increase in dementia cases, the incidence in industrialized nations appears to be on a downward trend, likely linked to enhanced living conditions, including access to education, improved nutrition, and better healthcare.

However, there are also modifiable factors that increase the risk of developing dementia. These include limited educational background, high blood pressure, hearing loss, smoking, obesity, depression, low physical activity, diabetes, social isolation, excessive alcohol consumption, traumatic brain injury, and air pollution.

Cognitive education and stimulation during youth play a pivotal role in preventing cognitive decline. This is due to the increased brain plasticity in youth, a period of maximum cognitive development potential. Education initiated in middle or later stages of life does not yield the same preventive benefits. Therefore, to reduce dementia risk, it is crucial to foster educational experiences in childhood and adolescence. Lifelong cognitive training through consistent mental engagement also helps prevent dementia, regardless of formal education level. This aligns with the well-known "use-it-or-lose-it" principle, which posits that mental abilities reinforce brain structures, whereas disuse leads to the loss of neurons and the brain networks involved in those activities. Although computerized cognitive training programs enhance specific cognitive skills, they do not contribute to dementia prevention.

Hearing loss is another significant risk factor. A reduction of just 10dB in hearing can increase dementia risk by 30%, and hearing impairments in midlife double the likelihood of dementia in later years. This is especially concerning, as one in three people over the age of 55 already experiences hearing difficulties. Reduced hearing is believed to diminish cognitive stimulation, leading to social isolation and depression –

each a risk factor for dementia. When hearing impairment coincides with vision impairment, dementia risk surges by 160%. Correcting hearing loss with hearing aids mitigates dementia risk and slows the progression of cognitive decline.

Traumatic brain injuries (TBIs) from falls, accidents, or contact sports like boxing also heighten dementia risk, with the likelihood of dementia increasing fourfold within six months of such an injury. Simple preventive measures, such as wearing helmets during recreational activities like cycling or implementing fall-prevention strategies for older adults, can help reduce the risk of dementia associated with TBIs.

Blood pressure is a particularly critical factor in dementia risk. Individuals with systolic blood pressure exceeding 140 mmHg at age 55 face a 60-fold increase in the likelihood of developing dementia. Notably, antihypertensive therapy is the only drug treatment proven to prevent dementia, while other drugs like statins or aspirin have shown no preventive effect.

Engaging in moderate to intensive physical activity weekly during midlife lowers dementia risk by 20% over the following 25 years. Conversely, studies indicate that individuals diagnosed with dementia were 40 times more likely to develop the condition if they had been physically inactive in the decade preceding their diagnosis. Thus, engaging in regular physical activity – as defined by the World Health Organization as 150 to 300 minutes of moderate-intensity activity weekly, 75 to 150 minutes of vigorous-intensity aerobic activity, or an equivalent combination of both per week – not only helps reduce the risk of heart attack, stroke, and diabetes, but also significantly lowers the likelihood of developing dementia.

In diabetes, the risk of dementia increases proportionally with the duration and severity of the condition, making hyperglycaemia a key risk factor for dementia development. Preventive strategies for diabetes, including regular exercise and a balanced diet, can consequently help reduce dementia risk.

Smoking, including passive exposure, is another risk factor, though the evidence for passive smoking is less conclusive. Importantly, quitting smoking—even in advanced age—significantly lowers dementia risk, making smoking cessation advisable and beneficial at any age.

Excessive alcohol consumption is strongly associated with dementia, particularly with early-onset cases. The risk of developing dementia rises when alcohol intake exceeds 168 grams per week (equivalent to more than two units per day, where one unit is a 300 ml beer or a 125 ml glass of wine). To mitigate this risk, moderate alcohol consumption should remain within one unit per day for women and two for men, with at least two alcohol-free days per week recommended.

Depression is both a prodromal stage and a risk factor for developing dementia. One in 8 people living at home alone have clinically relevant depressive symptoms.

Obesity, i.e. a body mass index greater than 30 kg/m², also increases the risk of dementia. Even a minor reduction of 2 kg helps to improve cognitive abilities.

Social isolation is associated with an increased risk of dementia. People who have lived alone all their lives or are widowed have a higher risk of dementia. In fact the most important protective factor against dementia is good social contacts. These protects against dementia through several mechanisms. Conversely, social isolation increases the risk of developing dementia. Geriatric syndromes, which involve reduced hearing or vision, decreased mobility, and incontinence, lead secondarily to reduced social contacts and social isolation. An increase in social contacts should therefore be an important goal in geriatric treatment and dementia prevention.

Air pollution is one of the important factors that exacerbate neuro-degenerative processes. A significant association between increased risk of dementia and exposure to nitrogen dioxide, carbon monoxide and fine particles has been observed. Avoiding air

pollution and improving air purity is of paramount importance for the prevention of dementia.

The role of spiritual and community practices

In the second part of this paper, we will see that in addition to lifestyle adjustments, community and spiritual practices, such as fasting, physical activities, and social connections within the church, offer unique benefits that support mental resilience and reduce dementia risk.

While some of mechanisms previously discussed involve social or legislative measures such as improving educational processes and preventing or reducing air pollution, others involve medical measures such as treating hearing impairment, blood pressure, diabetes and preventing brain injuries. But almost all factors are more likely to involve a healthy lifestyle. In this sense, psychosomatic and spiritual processes in the church play a crucial role not only in overcoming the passions, but also in bodily health, in this case in the prevention of dementia. In this second part of this presentation, we will explore how the spiritual life in the Church, specifically the Orthodox Church, can have a preventive effect on the development of dementia.

At the outset, it should be noted the essential role of the body in Orthodox worship and Christian asceticism in general. From the beginning, the Church opposed the heresy of Docetism, which preached an apparent incarnation of the Savior, pointing to the essential role of the body in the work of the Savior and in the salvation of each individual person. Man is unitary, the division into body and soul is rather a didactic tool, useful in some situations. However, it is important to remember the psychosomatic unity of the human being. The body is not only the manifestation of the soul, but also an integral part of human reality and of interpersonal interhuman or divine-human interaction. Therefore, the body, an integral part of the human being, has equal value in relation to the soul in spiritual life.

Fasting is a foundational element of Orthodox Christian life, widely preached yet often neglected or misunderstood by many Christians. While the benefits of a Mediterranean diet – rich in fruits, vegetables, seeds, fish, wine, and olive oil, and low in meat and dairy – are well recognized, fasting transcends dietary habits. Here, we set aside its profound spiritual purpose as a hunger and thirst for God to focus instead on its role in managing and controlling impulses. Psychology reveals that we cannot control the initial emergence of thoughts or impulses; rather, our role lies in choosing whether to accept or reject them and whether to act upon them. In concise terms, this decision-making process unfolds in the interplay between the nucleus accumbens, where impulses arise; the prefrontal cortex, crucial for decision-making; and the basal ganglia, responsible for habitual, reflexive actions.

Training the prefrontal cortex strengthens our ability to act freely, voluntarily respond, and shape emerging impulses before they become ingrained reflexes – or to reshape them even if they have become such behaviours. Just as the famous "marshmallow test" highlighted the importance of delayed gratification, fasting can be seen as a disciplined postponement of gratification that reinforces willpower and breaks the hold of impulses. The goal is to master the brain's instinct to consume freely, making it easier to adopt mindful, healthful eating habits essential for managing hypertension, diabetes, and obesity. Through this practice of delayed gratification, individuals can also break free more effectively from the grip of harmful habits, such as alcohol or smoking – known risk factors in dementia development, as mentioned earlier.

While physical activity may not seem integrated to Christian practice, this is far from true. The daily practice of metania (with sets of 30, as recommended by St. Isaac the Syrian), standing during services, and participating in religious processions or walking pilgrimages are all forms of physical activity within the spiritual life. Though

often overlooked, these activities carry both a deep spiritual significance and a vital physical benefit. For example, engaging the large muscles of the legs stimulates the release of Brain-Derived Neurotrophic Factor (BDNF), a hormone crucial for neuroplasticity. This occurs because movement signals to the brain that something significant is happening – prompting heightened awareness and alertness, both to potential opportunities and possible dangers. Thus, physical movement within spiritual practices places the brain in a state of enhanced attentiveness, opening it to a deeper perception of spiritual reality.

An often-overlooked aspect is the Church as the body of Christ. While much is said about the mystical body of Christ, it also physically encompasses each individual Christian, highlighting the communal nature of the Church and the relationships that must exist among its members. This means that no one should be left out, no one should feel alone, and everyone has their unique place and responsibility within the body of Christ. The social bonds fostered within the Church can be essential for maintaining or regaining mental and spiritual health, thereby playing a preventive role against conditions like depression and dementia, as explored earlier.

Dogmatic discussions, and discussions of faith more broadly, can sometimes be highly charged and polarizing. They are often either politely avoided or used combatively by individuals with antisocial or schizoid tendencies, who may interpret any opposing view as a personal attack. The culture of dialogue, however, involves conversations where others' beliefs are genuinely listened to and respected, even if they are not shared. This approach requires mental maturity, stability in one's own faith, and flexibility of thought, as well as deep spiritual maturity. Such maturity includes an awareness of the human susceptibility to deception until one reaches a personal vision of God, as St. Ignatius Brianchaninov explains in his work on spiritual delusion. When approached in this way, open and constructive discussions on Church teachings – without dogmatic laxity or compromise – contribute to brain health, as evidenced by neurotheological studies mentioned by Andrew Newberg.

Thus, we can see how the Church's somatic, psychological, and spiritual practices are essential to human health and in the prevention of diseases like dementia.

Conclusion

In conclusion, preventing dementia requires a holistic approach that weaves together medical, social, and spiritual aspects. A balanced approach – encompassing healthy lifestyle choices, community engagement, and spiritual practices – plays a crucial role in reducing the risk of dementia and promoting overall well-being. Maintaining an active lifestyle, addressing health issues, fostering social relationships, and engaging in spiritual practices all contribute to reducing dementia risk. The Church plays a vital role by building a supportive community, encouraging fasting and moderate physical activity, and nurturing a culture of dialogue that supports mental health. These practices are not only essential for dementia prevention but also for maintaining a state of well-being that encompasses both the physical and spiritual aspects of human life.

Age-related comparative aspects of delusional disorders in endogenous psychoses

Abstract: This article discusses the significance of various factors influencing the structure of psychopathological syndromes. It elaborates on the key clinical and psychopathological features of delusional disorders across childhood, adolescence, young adulthood, elderly, and senile age periods, based on the results of long-term research conducted at the Institute of Clinical Psychiatry of the Russian Academy of Medical Sciences and, subsequently, at the Scientific Center for Mental Health.

Keywords: delusional disorders, childhood, adolescence, elderly age, clinical-psychopathological features, syndrome structure.

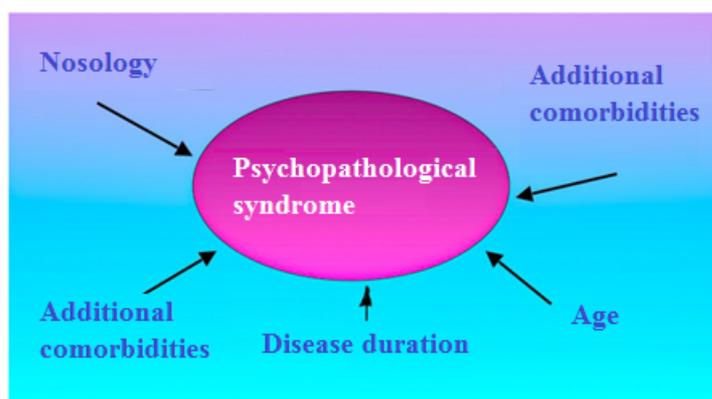
When beginning to outline the features of delusional and hallucinatory disorders from a comparative age perspective, it is necessary to emphasize that 'psychopathology is currently experiencing a period of stagnation' (Tiganov A.S., 2016). In this regard, the present report focuses primarily on research published in the 20th century in the works of clinicians from the Russian clinical school, who meticulously described the psychopathological characteristics of mental disorders.

The influence of the age factor, leading to the transformation of psychopathological symptoms and syndromes, was also characterized by Karl Jaspers (1965). In his seminal work, "Allgemeine Psychopathologie," he wrote: "Every mental illness modifies with age. Some illnesses appear only at a certain biological age... Age leaves its mark on any pathological condition."

It is currently a well-established fact that various clinical factors influence the formation of the psychopathological picture of the syndrome (Tiganov A. S., 2016).

Fig. 1 provides a generalized overview of how age influences psychopathology and the clinical manifestations of mental disorders.

FACTORS DETERMINING SYNDROME STRUCTURE



The degree of personality changes certainly is of primary importance, as it affects the characteristics of the disease's course and significantly determines the deformation of psychopathological syndromes. At the same time, not only the degree of personality changes plays a significant role, but also the nosological features of the disease. The preceding course of the illness has a considerable impact on the psychopathological structure of the syndrome. A crucial factor influencing the specific features of the syndrome, in addition to the above, is the detrimental exposure preceding the onset of the disease, which modifies the initial presentation or determines a range of characteristics throughout its course. Finally, among the most important factors

affecting the syndrome's structure, age should be mentioned. It is well known that the same condition, developing in different age groups, manifests differently, which in some cases significantly complicates the diagnosis of the disease.

Fig. 2 illustrates how age influences the clinical and psychopathological presentation of mental disorders.

INFLUENCE OF AGE FACTOR

- **Age-related changes in psychopathological syndromes and symptoms (referred to as syndrome atypia)**
- **Specific psychopathological syndromes characteristic of a given age (age-specific syndromes).**
- **Changes in the clinical picture (progression) of endogenous diseases and their outcomes (final stages).**
- **Specific response patterns in psychopharmacotherapy (tolerability, side effects, complications)**

We will examine the **principal features of delusional and hallucinatory syndromes in children.**

It is important to note that many authors dispute the possibility of delusional and hallucinatory syndromes occurring in childhood, arguing that the emergence of such syndromes requires a certain level of mental maturity. From this perspective, delusional disorders can only arise in children after puberty, while before that age, only fears, fragmented "absurd ideas," and delusion-like fantasies are observed. Extreme proponents of such views do not even allow for the possibility of equating psychopathological disorders in children and adults, and consider child psychopathology as an independent field, unrelated to adult psychopathology.

Conversely, studies carried out by many Soviet, Russian, and international child psychiatrists suggest an alternative viewpoint on this matter. While clinical presentations may not entirely overlap, it is still feasible to identify psychopathological syndromes in both children and adults (Kozlova I. A., 1967, Snezhnevsky A.V., 1983). It should be emphasized that the age-related characteristics of psychopathological disorders in children are more pronounced the younger the child. In adolescents, manifestations of hallucinatory and delusional disorders are greater than in children and resemble the clinical picture in adults. Nevertheless, during periods of developmental crises, especially puberty, psychopathological syndromes may occur that are not typically observed in adults. Considering the age-related modification of symptomatology, it is possible to create a kind of "age scale" for each syndrome, as pointed out by H. Maudsley (1868), and later by G. E. Sukhareva (1967), M. Sh. Vrono (1971), V. M. Bashina (1980), et al. All syndromes typical of endogenous psychoses in childhood are characterized by fragmentation, rudimentariness, immaturity, and incompleteness of individual components and the entire syndrome as a whole, as well as transience and variability. The previously held view of the poverty and monotony of productive disorders in childhood has not been confirmed by more careful observation and thorough examination of patients (M. Sh. Vrono, 1971). Overall, however, N. Bürger-Prinz's (1950) remark that everything atypical is typical for the psychopathology of childhood remains valid.

T. P. Simson and her colleagues (1948, 1959) have written extensively on the specific manifestations of delusional and hallucinatory disorders in children with endogenous psychoses. In these cases, the pathological process affects an organism that

is in a period of intensified and incomplete development. Therefore, a complex combination of symptoms of the pathological process with ongoing physiological development arises (T. I. Yudin, 1921). The younger the child, the more the manifestations of ontogenesis tend to mask the clinical picture of a disease. G.E. Sukhareva (1933, 1937, 1967) emphasized that the interaction between normal physiological growth and the destructive schizophrenic process leads to a modification of both. Consequently, the dynamics of delusional and hallucinatory disturbances in children become more complex and convoluted than in adults. The significance of the age factor was also clearly articulated in the works of G. Clerambaut (1924, 1926), who indicated that the severity of the disease outcome is directly dependent on the age at its onset and the massiveness of the brain lesion (the earlier the lesion occurred and the more massive it was, the more severe the consequences).

In childhood, delusional disorders often manifest as unmotivated, diffuse fear. This disrupts all of the child's behavior ("disruption of behavioral patterns," according to Kothe). In adolescence, a characteristic feature is the predominance of delusional ideas that are characterized by imagery and concreteness, and naivety of judgment, indicating immature thinking. Typical delusional themes considered "predominant" for this age group include: the "alien parents" delusion, delusions of "other (high) origin," delusional dysmorphic, and hypochondriacal ideas. In prepubescent children, a hostile attitude towards parents, stemming from a paranoid stance with a tendency towards delusional interpretation, is observed in some cases.

Fig. 3 illustrates the characteristics of delusional disorders in childhood.

CHILDHOOD DELUSIONAL DISORDERS

- **Unmotivated, diffuse fear, hostile attitude towards parents, delusions of "alien parents" or "other" (high) origin**
- **Pathological Fantasy Syndrome, transforming into Delusion-like Fantasizing (manifesting as depersonalization, parapraxes, and self-recrimination)**
- **Overvalued ideas with one-sided interests, characterized by obsession (immature reasoning on abstract topics, a tendency to "philosophize"), and marked by unproductiveness.**
- **During puberty, the onset of delusional dysmorphic and hypochondriacal ideation.**

We will now examine in more detail the *age-related progression of overvalued and paranoid disorders* in children and adolescents.

Very early in the course of the illness, as early as 2-4 years of age, children begin to exhibit persistent, one-sided interests of a cognitive nature. Initially, this manifests as a tendency to ask peculiar "inquisitive," "philosophical" questions, engage in special stereotypical games with schematic representations of play objects, and a propensity for stereotypical collecting of specific items. Among the initial symptoms of early childhood schizophrenia, T. P. Simson (1959) describes the symptom of "getting stuck" at the stage of asking questions. Stereotypical questions manifest in the tendency to repeat the same phrase, the same question, without interest in the content of the answer. They differ from the "stages" of questions of a healthy child by an age-inappropriate excessive interest in the abstract and, most importantly, they are associated with persistent, monotonous ideas, reflecting thought disorders. Systematized paranoid delusions, expressed verbal hallucinations, are very rare. In contrast, overvalued ideas are encountered quite frequently. These include one-sided interests

with a character of obsession, which in older children manifest as immature reasoning on abstract topics and a tendency to "philosophize" ("philosophical intoxication").

In children of pubertal age, the formation of a syndrome of pathological fantasizing (V. N. Mamceva, 1973, 1977) occurs. Over time, this syndrome becomes more complex, with visual pseudohallucinations joining the fantasy images. Subsequently, these patients develop forced thinking, a feeling of being controlled, and other manifestations of the Kandinsky-Clérambault syndrome. Delusions of a fantastic nature are often observed, differing little from delusional fantasies. A characteristic feature is the "outgrowing" of pathological fantasizing into paraphrastic delusions with manifestations of the Kandinsky-Clérambault syndrome (V. N. Mamceva, 1973, 1977).

Let's explore in more detail the manifestations of *pathological fantasizing and the syndrome of delusion-like fantasies* in children (Rudneva I. K., 1984, 1986).

Pathological fantasies with role-playing transformations (Rudneva I. K., 1984). By 3-4 years of age, an interest emerged in peculiar, stereotyped games in which patients identified themselves with imagined characters: animals or people, as well as inanimate objects.

This regression was accompanied by specific behaviors indicative of their chosen personas: for example, they would lap from a saucer on all fours, mimic "claw deployment" by tucking a belt into their tights and identifying it as their "tail," vocalize with meows, solicit calls of "kitty-kitty," desire tactile stimulation akin to petting fur or ear tickles, and request "food for hedgehogs," and so forth.

The ability to distinguish between game and reality was sometimes lost, and the patients were obsessed with the game. They demanded to be called by fictional names, imitated the heroes of their fantasies, who often did not correspond to their gender and age, and dressed in the same way as the characters they invented.

Between the ages of 3 and 7, transformations into inanimate objects may occur. Children may portray themselves as a "clockwork mechanism," a "trolleybus," or an "electric train," and behave according to their experiences. Criticism is impaired but not entirely absent.

Pathological fantasies as a manifestation of pathological drives (Rudneva I. K., 1984). In most patients, pathologically perverted drives were identified as early as one year of age, which manifested in manipulation of feces, peculiarities of defecation and urination acts, accompanied by stereotypical actions and autoaggression. Between the ages of 6 and 7, signs of dromomania, pyromania, and kleptomania emerged, and instincts (self-preservation and feeding) diminished. Cruelty and aggression towards insects and small animals, as well as weaker and more defenseless peers, were evident very early on. The pathology of these patients' urges often manifested in their desire to spend time in dumps, dirty courtyards, abandoned houses, and attics, soiling their clothes and shoes, deriving particular pleasure from it. The peak of pathological fantasizing, which is a manifestation of the pathology of urges, occurs after the age of 5-7. The patients vividly imagine scenes of violence, the destruction of people by dinosaurs, the devouring of some animals by others, Crusader wars, partisan executions, and the torture of prisoners of war. With apparent enjoyment, they recounted their "hunts," involving the flaying of live and dead animals, the scalping of people, their burning in gas chambers, and their extermination using laser beams. Pathognomonic are the "grave" games, fantasies accompanied by the visualization of themselves being hanged or buried. During pre-puberty and puberty (ages 11-13), some of them experienced an irresistible urge to realize their fantasies in real life, which was carried out by two patients (one of them committed an act of hanging, while the other kidnapped a child from a stroller and threw it from the sixth floor). At the moment of committing these acts, the patients identified themselves with the object of their fantasies and, for a brief period, seemed to lose awareness of their own 'self'

Pathological fantasies such as misstatements and self-accusations (Rudneva I. K., 1984). Around the age of 3-4, statements attributing non-existent qualities to themselves and their close relatives began to appear. At times, they spoke of "unrelated parents." During the second age crisis (7-8 years) and pre-puberty (11-12 years), misstatements and self-accusations occupied a dominant position in the clinical picture of the illness. They accused their closest individuals, most notably their parents, of neglect and mistreatment (claiming they weren't fed or provided with new clothes), of physical abuse, of intentions to "drown" them, and ultimately, of sexual harassment and assault ("rape by father"). There developed a negative attitude towards those around, marked by suspicion, cruelty, a particular interpretation of one's deeds, and a reassessment of one's life perspectives. During the ages of 10 to 12, pathological fantasies such as accusations and self-accusations manifested as feelings of being persecuted by a supposed "admirer," along with self-accusations concerning "sexual interactions with him." During the transformation of neurotic pathological fantasies to a delusional level, patients developed a conviction that what had happened to them was real ("attempted rape by a peer"). Simultaneously, they assumed the role of a "victim of sexual harassment."

Pathological fantasies linked to games and hobbies characterized by overvalued ideas are the most common manifestation of pathological fantasizing. (Rudneva I. K., 1984). Pathological fantasizing was clearly evident by 2-3 years, initially appearing as pathological interests and play. These were "daydreams" with imaginative representations, in which some patients would as if "transport themselves to another planet," while others would "swing on swings built in the clouds," and so on. Some children made up fairy tales, while others showed an interest in a range of subjects and phenomena unusual for their age (for example, the structure of microbes, jet engines, capacitors, electrical circuits); they drew diagrams of traffic flow with stops, to which they gave fantastic names; they drew geographical maps and plans of non-existent countries and cities; they created their own calendars; they played with "imaginary friends." Between the ages of 7-10, a preoccupation with fantasies characterized by vivid imagery was observed. Thus, the patients would invent their own countries, devising descriptions of cities, continents, and modes of transport, crafting their own "language," and occasionally bestowing an unusual appearance upon the country's inhabitants, with these sometimes being cities populated by robots or animals. In these pathological fantasies, the patients occupied dominant positions (transforming into the ruler of their country, a "warlord," a "space alien," or "the greatest robot"). The patients transformed themselves into fictional characters (sometimes of a different gender and much older than themselves), living two lives simultaneously (in "the past century and 16 years ahead of the present"). This imaginary theme was also evident in their actions: they would draw beards and mustaches on themselves; wander the streets with bows and arrows, wrapped in cloaks.

When pathological fantasies transitioned to a *delusion-like level*, these patients exhibited preoccupation and obsession with their "dreams"; complete "immersion in the world of their fantasies" and difficulty shifting attention to real events; the emergence of a belief that their fabrications actually exist, the appearance of vivid visualized representations that, at the peak of the psychotic state, took on the character of imagination hallucinations; and a drive to realize their fantastic ideas. Delusional fantasies encompass both the reincarnation into fantasy heroes and the conviction of alleged "actions" against the sick by imaginary "persecutors" or real individuals, expressed pathology of drives, inventive ideas, and so on. Many patients at the height of a psychotic state can implement their pathological drives in reality, reincarnating into the object of their fantasy (Rudneva I. K., 1984, 1986).

When considering **delusional disorders common in adolescence**, we must note

the specific psychobiological processes occurring in puberty: significant neurobiological changes entailing both the restructuring of the hypothalamic-pituitary-gonadal-adrenal axis function and neuroplastic changes in the synaptic structures of the brain, the completion of the reorganization of neuronal connections in cortical areas, the limbic system, and other brain regions. The plastic alterations taking place in the neuronal structures of the brain due to a sudden surge in the secretion of sex steroid hormones are so significant that the literature has coined a specific term to describe the characteristics of pubertal changes in the brain — 'adolescent brain.' Neuroplastic changes in brain tissue also largely determine the specific manifestations of the "pubertal psyche," which are expressed in a particular adolescent style of cognitive functions, heightened sexual motivation, increased sensitivity to social stimuli, adolescent aggression, sensation-seeking, particular psychological vulnerability to external psychotraumatic factors, impaired control over impulsive desires, and insufficient critical evaluation of one's actions, as well as in the specific biological sensitivity of adolescents to medications and narcotic substances. The maturing cognitive sphere provides the ability to think abstractly, to care about the future, and also leads to the development of complex and associative memory, logical and critical thinking. At the same time, during puberty, a restructuring of the sphere of thinking occurs, characterized as a "cognitive revolution" (Piaget J., 1975), when not only maturation takes place, but also higher forms of cognitive thought processes are revealed, a transition to formal-logical and hypothetical-deductive thinking occurs, and combinatorial and propositional operations with abstract concepts are developed. The aforementioned psychobiological characteristics of adolescence facilitate the development of formed delusional constructions and specific symptom complexes — dysmorphophobic delusion and sensitive delusion of reference (Kopeiko G. I., Oleychik I. V., 2007).

Adolescent sensitive delusion of reference is characterized by a range of phenomenological features associated with the pathoplastic and pathogenetic influence of the age factor (Kopeiko G.I., 1987).

Fig. 4 illustrates the characteristics of adolescent delusional disorders.

ADOLESCENT DELUSIONAL DISORDERS

Adolescent sensitive delusion of reference

- **A distinct fabula in delusional disorders, characterized by pubertal experiences manifested as delusions of a sexual, dysmorphophobic, and hypochondriacal type, alongside a conviction of one's own moral-ethical deficiency.**
- **Sensitive delusion of reference in adolescence and young adulthood is characterized by a low degree of systematization and a low level of development of delusional ideas.**
- **Another characteristic feature of delusional constructs in these cases is the combination, within the structure of delusional disorders, of elements of sensory and interpretative delusions, expressed to a greater or lesser degree.**

In such cases, a particular delusional pattern emerges, mirroring specific pubertal experiences through delusional ideas related to sexuality, body dysmorphia, and feelings of personal moral inferiority. Delusional symptoms exhibit a degree of uniformity, monothematicity, and a fixed narrative, with persistent assertions. Sensitive delusions of reference in adolescence and youth are notable for their lack of systematization and the rudimentary nature of their delusional beliefs. A further distinguishing characteristic of the delusional formations observed here is the

integration, to varying degrees, of both sensual and interpretative delusional elements within their structure. The development and persistence of these delusions were significantly influenced by affective (depressive) disorders and catathymic experiences. Furthermore, in patients with adolescent sensitive delusion of reference, defensive forms of delusional behavior predominated, with the direction of delusional actions towards themselves rather than others (e.g., flight, avoidance of confrontation, passive defense, persistent suicidal intentions and actions).

The dynamics of the delusional syndrome in the studied patients also possessed certain peculiar characteristics. In the first stage, an affectively charged complex of ideas was formed, the content of which was psychologically understandable, as if stemming from the patients' unique personalities and developing during an exceptionally significant crisis period for them. In these cases, depressive ideas of worthlessness were primarily concentrated in the sexual sphere, reflecting disease-modified and exaggerated characteristics of adolescence. They were closely intertwined with sensitive ideas of reference and ideas of guilt into a single overvalued complex, forming the basis of adolescent sensitive delusion of reference.

In the second stage of development, morbid manifestations reached a delusional level, and a genuine sensitive delusion of reference emerged. This involved the formation of a poorly developed delusional system, thematically linked to the preceding overvalued idea. The patients' delusional judgments and conclusions were scarcely rooted in interpretive elements, while their delusions of reference preserved a distinct affective charge and relevance throughout.

In the third stage of the development of adolescent erotomania, in some cases, there was a generalization of delusional ideas of reference with a further expansion of the circle of "ill-wishers" and the involvement of new individuals. In other cases, delusional ideas of an hypochondriacal nature were added, or the delusion of reference with a shade of condemnation or neglect was replaced by a delusion of persecution, which retained a sexual theme and was combined with elements of delusion of recognition, verbal illusions, and other disorders. The period of detection of the described delusional disorders coincided with adolescence. Although the course of the illness was episodic, with exacerbations, after adolescence, the pathological disorders generally completely receded, leading to a state of practical recovery, or the illness continued but with a significant alteration in the narrative of delusional ideas and the appearance of other productive disorders alongside them.

Beyond adolescence, **old age** marks another significant surge in the prevalence of mental health conditions. The development of psychoses during this period of life is caused by a complex interplay of various biological, psychological, social, and environmental factors. Primary psychotic disorders encompass illnesses in which productive symptoms serve as the main characteristic.

Fig. 5 presents epidemiological data on the prevalence of psychosis in late life.

LATE-LIFE PSYCHOSIS

- **Late-life psychosis is strikingly prevalent in older adults:**
- **presenting in 5–15 % of elderly geropsychiatric inpatients,**
- **10 to 62 % of nursing home patients, and**
- **as high as 27 % of community-dwelling psychiatric outpatients.**
- **The lifetime risk for psychotic symptoms in the elderly is up to 23 %, with dementia being the main contributing factor**

Delusional disorders in old age are marked by their limited scope, concreteness, and everyday nature of content (Kolykhalov I.V., 2020). The condition is characterized by delusional ideas of jealousy, poisoning, material and moral damage, and impoverishment, as well as "partition" delusions, hypochondriacal (nihilistic) delusions, and delusions of poisoning. Alongside verbal hallucinations, tactile and olfactory hallucinations are often observed (Sternberg E.Ya., 1981, 1983). Hallucinatory disturbances in schizophrenia are characterized by greater complexity and heterogeneity. A relationship between tactile hallucinations and cenesthesias has been reported. In old age, the syndrome of mental automatism is less distinct, rudimentary in nature, and more often limited to senestopathic automatisms. Old age is characterized by the emergence of small-scale interpretative delusions with a specific, impaired theme, which exist as if isolated from the content of major delusional disorders. Delusional disorders are characterized by a specific 'age-related coloring' in the form of ideas of material and moral damage, jealousy, poisoning, domestic persecution, and petty sabotage, directed at individuals in the patient's immediate environment (neighbors, relatives). Hallucinatory disorders, on the other hand, are abortive in nature and are primarily represented by acoasms in the form of the sound of water, knocks in the neighboring apartment, and calls, which also receive a delusional interpretation. These features of delusional constructions, as well as the presence of "small-scale delusions" such as "apartment paranoia" within the structure of delusional disorders, have been described as "involutional paranoia" (Zhislin S. G., 1965, Pyatnitsky A. N., 1980).

Psychopathological characteristics of late-life paranoiacs (Fig. 6).

LATE-LIFE PARANOIA

- **Delusional disorders thematically solely linked to the patient's residential context**
- **Chronic paranoid interpretative delusion, a "delusion of limited scope" (or "delusion of circumscribed scope"), affecting those in the patient's immediate environment.**
- **Hallucinatory disorders primarily manifest as elementary perceptual illusions (acoasms, olfactory, tactile, thermal hallucinations), which are also characterized by the ordinariness of their content.**
- **Patients typically maintain satisfactory social adjustment and show no significant mental abnormalities outside the delusional sphere, which makes diagnosing the illness difficult.**

Kolykhalov I.V. Chapter 2. Late-life psychoses. In: Handbook of Geriatric Psychiatry / ed. by Prof. S.I. Gavrilova. Moscow: MEDpress-inform. 2020: 188-232.

Age-related alterations in delusion are directly linked to a specific dynamic in hallucinatory disorders. Isolated predominance of verbal hallucinosis, even within the hallucinatory variant of paranoid schizophrenia, is rarely observed (Sternberg E.Ya., 1981). Sensory distortions, including olfactory, gustatory, and general sensations (visceral, thermal, etc.), hold a significant place and are sometimes hard to differentiate from illusions and delusional interpretations. There is a growing prevalence of sensory disturbances, characterized by their predominantly peripheral localization (Zhislin S. G., 1965; Sternberg E. Ya., 1977). True auditory hallucinations, which, as research by S. G. Zhislina and E. K. Molchanova has shown, are typically more persistent, predominate

over pseudohallucinations. Sometimes auditory hallucinations persisted only in the form of noises (knocking, stomping, ringing, rustling), which were also difficult to differentiate from illusory disorders and delusional interpretations of real existing sounds. In some cases, auditory hallucinations became functional, meaning they occurred only simultaneously with the appearance of specific real sounds and ceased with their disappearance. Even when the verbal hallucinations retained their threatening or abusive nature, patients spoke of them with greater composure, as if they were something external, remarking that they had "grown accustomed to the voices" and that they "didn't interfere with them anymore." At the same time, a dual attitude towards hallucinatory disorders was often observed: while recognizing their alien nature and labeling them as "hallucinations," patients simultaneously did not consider hallucinations to be a manifestation of illness (Sternberg E.Ya., 1981).

Patients often report hearing the voices of old acquaintances, childhood friends, villagers, or long-deceased relatives. The line between hallucinatory disorders and confabulations is gradually blurring, and patients' statements when questioned about hallucinatory experiences resemble fantasizing. With the reduction of hallucinatory disorders, a type where imagination plays a significant role (so-called imagination hallucinations) was often observed. Following the doctor's instructions, the patients experienced hallucinatory dialogues, posing questions and reporting "heard" responses in detail, under the influence of a specific suggestion (Sternberg E.Ya., 1981).

While the scale and fantastical nature of delirium in old age tend to increase, the actual creative and intellectual substance of this delirious production gradually diminishes. The level of synthetic, integrating work on delusions, which consists in establishing "logical" connections between individual phenomena, is gradually decreasing. The level of analysis of phenomena, i.e., their delusional interpretation, was also decreasing. As a result, the search for new evidence also declined. Delusional statements increasingly assumed the nature of unmotivated, "naked" assertions, and fantasizing on themes of previous delusions occupied an ever-larger part of the patients' discourse (Sternberg E.Ya., 1983).

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Comparative age-related aspects of affective disorders

Abstract: Affective disorders constitute a significant proportion of the global disease burden, being among the most prevalent mental health conditions. Their clinical manifestations are directly dependent on age, as each age group possesses a unique combination of biological, psychological, and social factors. This explains the significant differences in symptoms of depression, mania, and mixed states observed in patients of different ages. This report presents data from scientific research on age-specific features of affective disorders conducted at the SCMH, provides general characteristics of affective disorders, and outlines their specific features for different age groups. Understanding the age-specific features of the clinical presentation of mood disorders is crucial for accurate diagnosis, selection of appropriate pharmacotherapy, and the provision of individualized psychological support and pastoral care.

Keywords: affective disorders, depression, mania, affective-mixed states, age-related features, age factor, psychopathological features, tactics of pastoral counseling.

Affective disorders hold a central place among mental pathology. These are diseases caused and driven by disturbances in internal biological and physiological processes (notably neurotransmission and other mechanisms). Experts first recognized affective disorders as a distinct condition in the 19th century. The primary symptom of affective disorders is mood disturbance. Mood disturbances are considered pathological when they interfere with social and work activities, affecting all aspects of functioning, and necessitate medical intervention (Tiganov, 2022). According to current clinical guidelines, the duration of symptoms is also a crucial factor: the symptoms must persist for at least two weeks.¹

Affective disorder is characterized by a constellation of symptoms, which can be classified into two categories: obligatory and optional. The *obligatory* symptoms constitute the affective triad, while the *optional* symptoms include somatic and vegetative manifestations.

The affective triad, characterized by depressive and manic states, encompasses the following components:

- Emotional inhibition or arousal;
- Motor inhibition or excitation;
- Associative (ideational) inhibition or arousal.

Current classifications identify acute affective psychoses (manic-depressive or bipolar affective disorder) and non-psychotic chronic affective disorders (cyclothymia, dysthymia).

Age as a pathoplastic determinant

The age factor significantly influences the clinical manifestation of affective disorders, as each age period is characterized by distinct biological, psychological, and social predictors that impact the manifestation, development and prognosis of these conditions (Tiganov A.S., Panteleeva G.P., 1998).

Next, we will examine the clinical features of affective disorders across early childhood, adolescence, and old age.

According to various authors, including foreign child mental health specialists, it has been established that mood disorders in young children and schoolchildren remain

¹ International Classification of Diseases, 10th Revision (ICD-10). Mood disorders [affective disorders] (F30-F39). – URL: <https://mkb-10.com/index.php?pid=4193>

one of the most underdiagnosed problems (Lack C.W., Green A.L., 2009). According to international literature, such conditions account for up to 25% of childhood mental pathology, and later recurrences are also found in adults (Lee H.J., Kim S.H., Lee M.S., 2019).

The alteration of the clinical presentation of emotional disorders in children is a consequence of the immaturity of both cognitive abilities and all morphofunctional systems of the brain. The developmental process in childhood is uneven, and children are unable to adequately express their experiences verbally. Additionally, their personality and self-awareness are still developing, which contributes to the atypical clinical presentation of emotional disorders. Affective symptoms in children often appear in a subtle and fragmented manner. Biological factors, such as genetic, infectious, immunological, toxic, metabolic, and others, play a significant role in the development of affective disorders in children. This age group is particularly susceptible to reactive states in response to traumatic events, and their symptoms can be easily influenced by external factors. Affective presentations in childhood are often "masked," with somatic complaints, manifestations of somatoautonomic dysfunction, and neurological disturbances emerging as primary concerns. (Bashina V.M., 1999; Sukhareva G.E., 1974; Kovalev V.V., 1995; Shevchenko Yu.S., 2017).

During adolescence, neurohormonal processes exert a significant influence, leading to profound changes within the body. This period is characterized by a rapid morphofunctional transformation across various organ systems, with particular emphasis on the brain. The brain undergoes further maturation, involving an increase in the number of glial cells, active growth of neural connections between cells, and an elevation in their density. Concurrently, complex psychological responses emerge, including shifts in cognitive patterns and behavior, as well as emotional lability, which are typical of adolescents. These factors contribute to the development of specific clinical forms of affective states, which are quite common in adolescence and are accompanied by a high risk of suicidal behavior - the most dangerous complication of affective disorders (Tsutsulkovskaya, 2003; Oleychik, 2010; Kopeyko, 2011).

In the old age, the aging process becomes more pronounced, characterized by specific biological changes such as hormonal and metabolic alterations within the body. The coexistence of various physical and organic conditions, including cerebral and vascular diseases, further deteriorates the patient's health status and contributes to the development of secondary mental disorders. The extensive use of medications to manage chronic conditions in older adults, combined with the experiences of loss and bereavement associated with this life stage, as well as social isolation, can lead to the manifestation of concealed forms of affective disorders. These conditions are commonly encountered in outpatient and general medical settings and may not be adequately recognized by psychiatrists. All these factors are prerequisites for the development of mood disorders in late adulthood (Konstevoy V.A., Medvedev A.V., Yakovleva O.B., 1997).

Depressive states in childhood

Depression in children can manifest from infancy. The clinical picture is most often dominated by symptoms of anxiety. These can range from protracted, chronic states extending up to a year or longer, to transient episodes (10-14 days) featuring pronounced, well-defined psychomotor agitation, accompanied by inexplicable fears or domestic phobias.

Depressive states characterized by prominent somatovegetative and/or pain symptoms are the second most prevalent mental health issues among children. These symptoms often mask affective disorders. Frequent episodes of "colds," non-localized pain across the body or in specific organs without identifiable medical causes,

dysfunction of somatic systems, herpetic infections, and vegetative disturbances such as vomiting and fever of unknown origin are common "masks" of depression in children. Tearful depressions, states of discontent, capriciousness, and pronounced dysphoric reactions – irritability, malice, and disruption of social contacts – are also typical manifestations in younger children.

A particular form of childhood depressive disorders is characterized by motor disturbances. Subcortical, adynamic depressions are described, where children exhibit apathy, lethargy, loss of motivation, and diminished interests. Pediatric specialists have identified conditions of pseudoregression, which involve temporary suspension in psychomotor development or delayed acquisition of speech functions, among other symptoms. These conditions are equivalent to depression and can diminish over time and with appropriate therapy.

Behavioral manifestations of mood pathology in children are often not identified promptly, being attributed instead to poor character or inadequate child-rearing practices. All these conditions can lead to developmental disorders, social maladjustment, a decline in academic performance, and difficulties in peer relationships. Therefore, timely diagnosis, comprehensive assessment, and specialized treatment by psychiatrists are essential Bashina, V.M. (1999); Golubeva, N.I. (2016); Iovchuk, N.M. (1976); Kalinina, M.A., Kozlovskaya, G.V., Koroleva, T.N. (1997); Severny, A.A., Iovchuk, N.M. (2018); Shushpanova, O.V., Golubeva, N.I., Balakireva, E.E., Nikitina, S.G., Blinova, T.E., Shalina, N.S. (2024).

Depressive states in adolescence

A significant proportion of patients diagnosed with depression are adolescents. In this age group, the clinical presentation of depression is characterized by the absence of the classical triad of symptoms. Predominant complaints include feelings of indifference, apathy, or sullenness and irritability. Common symptoms also encompass fatigue, a lack of energy, and an increased desire for sleeping all day. Instead of experiencing longing, adolescents often report a sense of boredom, discomfort, and an inability to derive pleasure from activities. Instead of ideational inhibition, concentration difficulties are observed, leading to impaired learning, a decline in academic performance, problems with focus, heightened distractibility, learning difficulties, and academic backlogs. This developmental stage is marked by the emergence of super values, which may be of a religious, philosophical, or abstract nature. These ideas can lead to the development of a distinctive depressive worldview. Behavioral changes in adolescents are also notable, characterized by a desire for independence, disregard for authority figures, exaggerated opposition to elders, parents, and teachers, rejection of traditional societal values, uneven and contradictory maturation, a propensity towards delinquent behavior, substance abuse, and potential violations of social norms, resulting in legal and criminal issues (Meleshko T.K., Kritskaya V.P., Oleychik I.V., Kopeyko G.I., 2007).

Adolescence is marked by a protracted period of depressive disorders. This is not a matter of weeks or months, but rather of years, with frequent relapses and, of course, a significant number of deliberate suicidal inclinations among adolescents (Kaleda V.G., Omelchenko M.A., 2023; Migalina V.V., 2023).

Late-life depression

In the context of general depression, a loss of drive and initiative, a sense of guilt, sleep disturbances, decreased appetite, and weight loss, among other symptoms, a complex of symptoms that are characteristic of late age emerges — anxiety and hypochondria. Anxiety is often accompanied by motor disturbances, manifesting as agitation. These individuals experience heightened anxiety for various reasons, sleep

disturbances, difficulty falling asleep, frequent nighttime awakenings, and early morning awakenings. Anxiety can be triggered by simple everyday issues and can impact various aspects of an older person's life. For elderly individuals, somatized, hypochondriacal states are characteristic, associated with concerns about their own health, which are based on objectively existing poly-morbid somatic pathology. The patients' attention is focused on the manifestations of the depressive syndrome, such as gastrointestinal dysfunction, changes in appetite, and weight loss (Safarova, T.P., 2019, 2020).

Senile depression is a condition characterized by the development of delusional thoughts, which encompass a wide array of themes specific to this age group: feelings of guilt, harm, impoverishment, sinfulness, and punishment. In some instances, the severity of these delusions can escalate to the point of experiencing megalomania or nihilism. In the context of the elderly, there are specific conditions known as "depressive pseudodementia" or "reversible dementia." These conditions manifest as memory loss, diminished speech, difficulties in orientation, a partial comprehension of the situation, a sense of helplessness, and episodes of confusion at night, which are subsequently forgotten. In most cases, these disorders are reversible and can be alleviated through appropriate treatment and a reduction in the intensity of depressive symptoms (Kontsevov V.A., Medvedev A.V., Yakovleva O.B., 1997).

Manic disorders

The diagnosis of manic or hypomanic states in children presents a significant challenge due to the atypical clinical presentation of these conditions. Such conditions are atypical in their clinical manifestations and are often not recognized or diagnosed based on historical data from the patient's medical history. These conditions are characterized by a disproportionate affective triad, which includes affective disorders in conjunction with other psychopathological symptoms, and a prolonged or chronic course. The clinical picture of manic conditions in children exhibits a reduced thymic component, with motor agitation and somatovegetative manifestations predominating. Descriptions of mania in children include symptoms such as restlessness, monotonous activity, fussiness, motor disinhibition, foolishness, and pathological fantasizing (Iovchuk N.M., 1985; Burelomova I.V., 1986).

Manic states in adolescence also exhibit differences from classic manias. They are characterized as "atypical." Joyful and cheerful moods are rarely observed in adolescents. The shade of mood takes on a distinct character, while the ideational component prevails over the motor one. Common manifestations include irritability and agitation, devoid of genuine cheerfulness. This state often resembles a non-productive, talkative condition characterized by youthful idiomatic expressions and cynical humor. There is a notable absence of tact, frequent unprovoked conflicts, derision, aggression, and outbursts of anger. Conditions marked by uninhibited impulsivity, aberrant behavior, and loss of self-control are frequently observed. Additionally, there is a proliferation of various super-valuable formations associated with a specific age-related disorder, as well as pronounced psychopathic traits. The coexistence of multiple types of manic affect or rapid transitions between different types of manic affect within the same phase are also characteristic features (Panteleeva, G.P., Tsutsulkovskaya, M.Ya., 1998).

The clinical picture of late-life mania is characterized by atypical manifestations, which are caused by age-related modification of symptoms (Shulman K.I., Herrmann N., 1999). In elderly patients, such conditions are tinged with psycho-organic and amnesic disorders. Among manic states in the elderly, cheerful manias are distinguished, characterized by the absence of accelerated speech tempo, excessive circumstantiality, and a combination of hypermnesia for the past with mnemonic

weakness for current events. Anger mania is described, in which manic arousal is combined with a persistent irritable-angry mood background. A special type of late-age mania is "senile mania", which, in accordance with its clinical features, requires differential diagnosis with the condition of dementia (Andrusenko M. P., 1986).

Affective-mixed states

In certain phases of affective disorders, affective mixed states can be observed, wherein depressive and manic triads are blended together. In foreign literature, these states are referred to as "a mixed state" (Janiri D., Conte E., De Luca I. et al., 2021). At the same time, the clinical presentation of the affective phase includes isolated features that are typical of affective disorders from opposing spectrums. According to various authors, mixed conditions are quite prevalent, occurring in 30-60% of cases. The presence of such conditions indicates a more severe course of the affective disorder and necessitates a different treatment approach for patients. According to the ICD-10 classification, an affective-mixed episode is characterized by a combination or rapid alternation (typically within a few hours) of hypomanic and depressive symptoms, lasting for at least two weeks. These conditions are diagnosed under distinct rubrics ("Mixed Affective Episode").

In children, these conditions are often misidentified as attention deficit hyperactivity disorder (ADHD). In medical terms, these conditions present as anxiety disorders characterized by sudden outbursts of agitation, as well as behavioral disorders, disobedience, and defiant behavior towards authority figures. They are classified under the diagnostic category «F 91».

The volatility of emotions, their frequent fluctuations, and instability are typical of adolescence. Among the emotionally mixed states, there are those characterized by a depressive mood, accompanied by accelerated thinking and motor agitation (the depressive type of affective mixed states). States of agitation without a sense of joy, accompanied by discontent and dysphoria (manic type); the alternating type is also distinguished – with rapid shifts from a manic affect to a depressive one and vice versa (Kopeiko G.I., 2011).

In old age, affective mixed states are characterized by a combination of irritability, gloomy displeasure, and an inclination towards excessive talkativeness and pressured speech (dysphoric). These states may also be accompanied by external hyperactivity, with feelings of anxiety and restlessness. Also noted are cases where hypochondriacal concerns (belief in somatic illness) are paired with increased activity, acceleration, and mood swings. Mixed affective states in late adulthood are often caused by somatic and vascular pathology, and are characterized by polymorphism and variability.

Conclusion.

Recognizing the clinical characteristics of emotional disorders across various age groups is crucial for their timely identification, prompt treatment initiation, and provision of effective psychological and pastoral assistance to patients. The prevalence of these conditions among individuals of all ages highlights the significance of their study not only within the medical field but also among psychologists and clergy.

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Existential crisis and auto-aggressive behavior in adolescents

Abstract: This paper explores the connection between the existential crisis that occurs during adolescence and the emergence of auto-aggressive behavior in teenagers. The paper examines the components and issues of existential crisis, as well as the mechanisms behind the development of auto-aggression during adolescence. It also discusses the significance of religion in addressing existential issues and preventing auto-aggressive behavior in developing individuals. Finally, it presents key approaches for assisting adolescents with auto-aggression, including those provided by religious figures.

Keywords: existential crisis, period of adolescence, auto-aggressive behavior, adolescents, risk factors.

Adolescent existential crisis (from Latin «*existentia*» meaning «*existence*» and Greek «*κρίσις*» meaning «*decision*» or «*turning point*»), is a transition from childhood to adulthood, a stage of personality development characterized by a sense of deprivation of higher values, a search for answers to questions about the meaning of existence, one's place, and path in the world. The specific age-related characteristics of adolescence, such as the desire for separation and the ongoing process of self-discovery, contribute to the formation and exacerbation of mental health issues during this period. These issues can manifest as neurotic disorders, depression, adjustment disorders, or addictive behaviors as well as various forms of auto-aggressive behavior.

The elements of the existential crisis in teenagers can be broadly categorized into:

- Emotional: encompassing feelings of fear, unease, a decline in mood, a loss of joy in life, emotional distress, longing, and despair.
- Cognitive: a sense of aimlessness and a lack of purpose in life.
- Behavioral: withdrawal from social interactions, conflict, hostility, episodes of aggression, and various forms of auto-aggression / self-destruction, including suicide.

The fundamental **concerns of the existential crisis during adolescence** encompass the recognition of the disparity between idealized conceptions of the world order and the reality; the clash between the desire for life and the comprehension of the inevitability of death, the dread of it, and the future; as well as the tension between the pursuit of freedom and the realization of it as a loss of fundamental meanings and values, landmarks in one's existence; the sense of boundaries between oneself and others, the contradiction between the feeling of isolation and the need for emotional connection with others. During this phase of life, individuals contemplate the purpose of life, their position in the world, and the choice of their own destiny and path within it. This period is particularly challenging for adolescents, yet without undergoing it and finding answers to these questions for themselves, individuals cannot achieve psychological maturity.

During the teenage years, auto-aggressive behavior is a common manifestation of unresolved issues and challenges during an existential crisis, a sign of mental distress, and a symptom of various mental health conditions. It encompasses a pattern of behavior that disregards the real or potential danger / harm / risk to one's health or life, while focusing on self-destruction, either directly or indirectly. **Auto-aggressive behavior** can be divided into two categories: *self-destructive behavior*, which involves harming oneself without directly recognizing or acknowledging the danger, and *self-injurious behavior*, which involves intentionally causing physical harm to one's own body. Within the latter category, there are two subtypes:

1. Suicidal self-harm is a deliberate act aimed at ending one's own life, including thoughts, intentions, and actions.
2. Non-suicidal self-harm is a complex pattern of self-destructive behavior that does not have the intention of ending one's life.

The significance of the issue of auto-aggressive behavior during adolescence is determined by a variety of factors. These include the high incidence of non-suicidal (NAB) and suicidal auto-aggressive behavior, as well as the steady increase in the frequency and decrease in the age of onset for all forms of self-harm. The prevalence of NAB ranges from 6.7% to 17.8% in the general population of adolescents, and can reach up to 60% in clinical samples (M.Zetterqvist, 2015; M. Kaess et al., 2013). As for suicidal behavior, it is the third leading cause of death among adolescents. It is estimated that 8% of adolescents in the United States have attempted suicide (B.Shain, 2016), and the suicide rate in the Russian Federation among individuals aged 15-19 is on average 16.1 per 100,000, which is 2 and 1.6 times higher than the global average, respectively (B.S. Polozhiy et al., 2016).

Its significance is also underscored by its profound social impact, encompassing the severity of its consequences (including the potential for harm to health, life, and the possibility of disability or death); the multifaceted nature of these consequences; the ambiguity of obtained data on auto-aggressive behavior; inaccuracy of information on the effects of precipitating (clinical and socio-stressful) factors in the development of auto-aggressive behavior and protective effects; and the limited availability of preventive measures and multidisciplinary approaches to assistance.

It is essential to acknowledge that auto-aggressive behavior is a heterogeneous continuum, with phenomena observed in adolescents in the general population at one pole, and disorders found in their peers with various psychiatric disorders at the opposite pole.

To summarize, the main factors that contribute to auto-aggressive behavior in adolescence can be categorized into several groups.

Firstly, we are talking about *mental health issues* (affective disorders, anxiety personality disorders, schizophrenia spectrum disorders). Environmental factors also play a significant role. This includes the family environment, particularly when relatives have mental health problems or substance abuse issues. The peer group and the influence of various social groups and subcultures are also important. *Stressful experiences*, such as information overload and traumatic events like bullying, conflicts, or academic setbacks, can also contribute to auto-aggression. *Adolescence itself and the existential crisis of adolescence* are risk factors, as are *pathochacterological traits* (including emerging personality disorders) predisposing to auto-aggression.

We have identified the following patterns of auto-aggressive behavior in adolescents: *dissociative, related to disorders in impulse control, juvenile*, and affective.

1) *Dissociative* — this pattern was based on the separation of normally integrated personality properties. It encompassed two subtypes:

A) *Depersonalization* — this subtype was marked by a sense of loss/estrangement from one's self and associated with patients' attempts to regain vivid emotions and perceptual sensations.

B) *Demonstrative* — this subtype emerged in the structure of intrapersonal conflict with others, aimed at attracting attention, "validating" the suffering experienced, and was often openly manipulative.

2) *Associated with impulse-control disorders* – arose from an individual's difficulty resisting the urge/impulse for a specific activity. It included:

A) *Addictive* – was developed due to the existence of impaired drives.

B) *Obsessive-compulsive* – realized an obsessive desire to perform manipulations that do not bring pleasure, while understanding their unacceptability.

C) *Impulsive* – based on sudden impulses to a certain activity with a feeling of relief after they were completed.

D) *Pathological substitutional activity* – appeared as an unconstructive behavior option when negative emotions arose, allowing the individual to switch attention.

3) Juvenile – occurred at the stage of maturation with a combination of lack of life experience, lack of probabilistic forecasting and age-related impulsivity. It was divided into:

A) *Imitative* – this subtype emerges as a consequence of communicative insufficiencies. Adolescents engage in this behavior in an attempt to organize social interactions within their peer reference group and to establish their position within this social framework.

B) *“Experimental”* – this subtype arises in the structure of experience acquisition as a peculiar test by an adolescent of the boundaries of his capabilities.

4) Affective (self-torturing, according to the classification by E.S. Krylova et al. (2019)), based on feelings of guilt and a desire for self-punishment, arising against the background of depressive disorders.

The mechanisms were initially identified in patients with personality pathology but were later found with varying frequency in adolescents with a range of mental health conditions and their healthy peers.

The above necessitates developing multidisciplinary prevention and intervention strategies for these adolescents, not limited to the work of psychiatrists and psychologists.

Research conducted by the World Psychiatric Association has demonstrated the significant role of religion as a source of spiritual well-being in preventing mental health issues, reducing their incidence, enhancing the efficacy of treatment, and improving treatment outcomes (H.E. Koenig, 2012; A. Moreira-Almeida et al., 2021). Drawing on evidence regarding the impact of spirituality and religion on enhancing the overall well-being and mental health of the general population, the World Health Organization has incorporated these factors as indicators for evaluating an individual's quality of life (P.D. Verhagen, 2021).

At the same time, it is obvious that the impact of clergy on adolescents with auto-aggressive behavior or those at risk cannot be overstated, especially considering the Church's centuries-long experience of assisting in addressing and resolution of existential issues.

It is crucial to develop main strategies to assist adolescents with auto-aggressive behavior.

1. Identifying mental health issues (particularly signs of anxiety and depression) in adolescents at the earliest possible point in their development.
2. Implementing a multidisciplinary pharmaco- and psychotherapy for disorders with adolescent auto-aggressive behavior.
3. Involving religious leaders in preventive efforts to prevent mental health issues and auto-aggressive behavior in adulthood.
4. Including clergy in rehabilitation programs aimed at addressing auto-aggressive behavior in adolescent patients, as part of a multidisciplinary approach.
5. Providing educational and psychological support to adolescents and their families, as well as their social environment.

Conclusions

Recent scientific research has corroborated longstanding empirical evidence indicating the positive impact of religious beliefs and associated spiritual experiences on the psychological well-being of most people. Spiritual development is widely acknowledged as a fundamental human necessity. Interactions with clergy and individuals who share similar beliefs positively correlates with lower levels of depression, anxiety, suicidal ideation and attempts, substance abuse, and higher self-esteem, crucial for adolescent development (C. Vieten et al., 2023). Communication with Church representatives can serve as an important resource for a teenager, providing emotional well-being, giving an incentive to form a system of values, ideas about the meaning of life, and its significance. Effective programs for preventing and rehabilitating adolescent auto-aggressive behavior must rely on a multidisciplinary approach. Considering positive experiences in Russian psychiatry with adult patients (Kopeyko et al., 2016), collaboration with clergy is advisable for developing and implementing constructive coping strategies for adolescents.

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Characteristics of destructive behavior in middle-aged patients with delusions of the end of the world in schizophrenia

Abstract: A psychopathological analysis of the end of the world delusion with religious content (EWDRC) identified two distinct types, each with unique clinical and phenomenological characteristics as well as different mechanisms of delusional formation. *Type I (Apocalyptic)* is associated with an acute sense of impending global catastrophe. This subtype typically manifests within a time-limited delirious episode in the context of paroxysmal schizophrenia. *Type II (Eschatological)* involves an expectation of the world's end in the foreseeable future, occurring as part of a continuous chronic schizophrenia. Notably, subtype I demonstrates a prevalence of antisocial and self-destructive behaviors, with minimal instances of antisocial or immoral conduct. In contrast, subtype II is marked by a higher incidence of antisocial and immoral behaviors, often including potentially harmful actions such as inducing delirium in others.

Keywords: end-of-the-world delusions, apocalyptic delusions, eschatological delusions, destructive delusional behavior, early detection.

Introduction

At the current stage of psychiatric development, one of the most pressing issues remains the prevention of socially harmful behavioral deviations in patients with schizophrenia spectrum disorders. Despite their high incidence, delusional disorders with religious content delusions remain understudied clinically and therapeutically (S.Dein, 2021; A.Dudek, 2019; V.Kovess-Masfety, 2018). Addressing this challenge requires not only identifying the types of endogenous mental disorders associated with such behavior but also delineating the stages of schizophrenia during which different forms of destructive conduct can manifest. Moreover, no effective strategies for preventing such behavior have been developed to date.

Religious delusions are often characterized by specific forms of destructive behavior determined by the psychopathological picture of religious and mystical disorders (Waldfogel S., 1995; Kraya N., Patrick C., 1997; Field H., Mohr S., Huguélet P., 2004). International literature documents cases involving delusions of reincarnation into the Antichrist, which have been associated with either violent actions against others (Silva J.A. et al., 1997) or suicidal acts (Reeves R.R., Liberto V., 2006). Several authors have reported instances of non-suicidal self-destructive actions driven by religious and delusional motives, including self-castration (Waugh A.C., 1986) and severe eye injuries (Gamulescu M.A., Serguhn S., Aigner J.M. et al., 2001; Martiniuc G., Trifina A., Trifina L., 2007). The Russian media has extensively covered cases of particularly dangerous social behavior exhibited by patients with schizophrenia under the influence of delusional and hallucinatory-paranoid disorders: the murder of three monks in Optina Monastery in April 1993 and of the Priest Pavel Adelheim in August 2013, both

According to Pashkovsky V.E. (2006), the delusional actions of patients with religious delusions exhibit a broad spectrum of manifestations, ranging from disordered affiliations with diverse pseudo-religious and occult groups during the initial stages of illness to gross brutal behaviors under the influence of psychotic disorders, including physical aggression, homicidal, and suicidal acts. Pashkovsky V.E. identifies the most prevalent forms of delusional behavior: disorganized conduct during church services (6.2%), unruly behavior in public spaces (16.2%), disorderly actions at home (27.8%), cruelty to animals (3.2%), vagrancy (9.4%), sexual deviations (4.5%), suicidal acts aimed at merging with the deity or the "cosmos" (2.6%), suicide driven by feelings of

sinfulness (9.7%), physical aggression (16.2%), and homicidal actions (4.2%). The most severe forms—physical aggression (23.4%) and homicidal behavior (6.4%)—are frequently observed in delusions related to witchcraft; suicidal behaviors are more common in messianic delusions (5.0%), while suicidal behavior driven by guilt is often associated with delusions of sinfulness (21.8%).

A significant correlation was identified between the prevalence of religious delusions and various types of behavioral disorders. The most frequent forms of disorganized behavior were associated with the following delusions: public disorganized behavior – with delusions of reformism (28.6%), domestic disorganized behavior – with delusions of sinfulness (34.9%), vagrancy – with delusions of obsession (14.9%), guilt-driven suicidal behavior – with delusions of sinfulness (21.8%), physical aggression and homicidal behavior – with delusions of witchcraft (23.4%).

Objective of the Research: to develop a clinical and pathopsychological methodology for the early identification of destructive behavior in patients with religious and mystical delusions and for potential prevention of the manifestation of such behavior. It is assumed that this technology will allow for timely diagnosis and monitoring of patients with various forms of schizophrenia.

The subject of the Research: A representative sample (39 cases) of patients diagnosed with schizophrenia exhibiting religious delusions and destructive behavioral patterns.

Research methods: Clinical-psychopathological, psychometric, clinical-catamnestic, experimental-psychological. Statistical processing of the obtained results was carried out using the Statistica-7 package (for Windows, StatSoft, Inc., USA). The statistical significance of the differences was determined by the Mann-Whitney U—test for independent groups.

Patients and research methods

A catamnestic cohort of patients suffering from endogenous mental illnesses, having a religious worldview and being treated at the SCMH and under dynamic supervision at the department for study of special forms of mental pathology.

The research involved a sample of 39 patients, comprising 18 women (46.2%) and 21 men (53.8%). The age range at the time of the initial assessment was from 18 to 55 years ($M=37,6$ $SD=12,2$). All participants in the study had been diagnosed with schizophrenia. The diagnoses were established in accordance with the International Classification of Diseases, 10th Revision (ICD-10; codes F20.00, F20.01, F20.02), the International Classification of Diseases, 11th Revision (ICD-11; codes 6a20.0, 6a20.1, 6a20.2), and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; code 295.90). Additionally, the classifications were based on the approaches employed by German and Russian psychiatric schools in the typology of psychopathological disorders.

The patients were examined by clinical-psychopathological, clinical-catamnestic methods. Statistical analysis of the results was conducted using the Statistica-7 software (for Windows, StatSoft, Inc., USA). The significance of differences between groups was assessed using the Mann-Whitney U test for independent groups.

Research results:

Psychopathological types of the end of the world delusion with religious content

The psychopathological analysis of EWDRC identified two distinct types of this symptom complex, characterized by different clinical, phenomenological features, and varying mechanisms of delusional genesis: *Type I (Apocalyptic)* and *Type II (Eschatological)*.

Type I (Apocalyptic) is marked by the feeling of the immediate onset of the end of the world. The delusion unfolded within a time-limited attack of paroxysmal schizophrenia.

Type II (Eschatological) is characterized by the expectation of the end of the world in the foreseeable future within the context of a chronic, continuous course of schizophrenia.

I Apocalyptic type of Delusional Disorder (28 patients)

Two subtypes of the apocalyptic variant of the EWDRD were identified. The first subtype, characterized by a predominant perceptual delusions in the clinical picture, was observed in 57.1% (16) of patients. The second subtype, featuring a predominance of visual-imaginative delusions, was detected in 42.9% (12) of patients. These subtypes exhibited differences in the severity of symptoms, psychopathological manifestations, duration, and intensity of delusional disorders at various stages of the end of the world delusion's development. Additionally, they varied in terms of monothematic or polythematic delusional structures and the predominant polarity of affective disorders.

A distinctive phenomenological characteristic of acute sensory delusions, particularly those characterized by perceptual delusions in EWDRD, was that the patients only anticipated the threat of the impending end of the world, agonizingly awaiting the upcoming events with anxiety and tension. Visual hallucinations of the imagination portrayed patients as direct participants and witnesses to the unfolding apocalyptic scenarios currently occurring around them.

I.1. The first subtype of the apocalyptic variant of the EWDRD was observed in 16 patients. This subtype predominantly manifested within the context of recurrent seizures in 75% (12) of the cases. The average duration of the disorder from the onset of symptoms was 10 ± 1.5 years. Patients developed this condition at an average age of 37.1 years. The delirium progression was characterized by the following stages:

- The stage of delusional mood, characterized by a premonition of impending catastrophic events and isolated ideas of reference, accompanied by a sense of the impending end of life.
- The stage of delusional interpretation with persecutory ideas.
- The stage of delusion of pretence, involving short-term elements of mental automatisms.
- A brief stage of antagonistic delirium.

I.2 The second subtype of the apocalyptic variant of EWDRD, characterized by a predominance of visual hallucinations (42.9%, 12 patients), was primarily observed within the context of an acute attack (9 patients). The average age of these patients was 28.1 ± 1.3 years. Apocalyptic delusions with religious content emerged during the peak of transient oneiroid-catatonic states, often recurring over several days or weeks. This has been previously described in the context of oneiroid-catatonic attacks in recurrent (periodic) schizophrenia. This pattern of development and dynamics of acute delusional states caused an increased total duration of the episode and affected the overall treatability of the condition. The EWDRD did not exhibit systematic or persistent delusional structures. In 16% of cases (2 patients), febrile-catatonic states developed.

The eschatological type II of delusional disorders is characterized by a chronic clinical course, a high level of systematization in delusional constructions, and a predominant interpretive mechanism of delusional formation. This mechanism involves the analysis and interpretation of global events, leading to the emergence of "delusional insight" regarding the impending apocalypse. Patients also develop their own

conceptual frameworks concerning the end of the world and their role within these eschatological scenarios.

At the core of the delusional constructions was a particular interpretation of the meanings of signs of the apocalypse found in religious texts, subsequently leading to the discovery of corroborating evidence for these signs in current events and the behavior of others. The following developmental stages of this type of delusion were observed:

- The stage of forming an overvalued religious worldview with an increased interest in apocalyptic themes, as well as the formation of a specific delusional mood dominated by anxiety and fear.
- Stage of formation of overvalued delusional disorders.
- The stage of paranoid delusion characterized by the development of delusional behavior, and in some instances, the emergence of intermittent psychotic states.

Destructive behavior

As a generalization of different typologies of behavioral deviations (Ts. P. Korolenko and T. A. Donskikh, 1990; A. A. Krylov, 2001; E. V. Zmanovskaya, 2004; G. Ya. Pilyagina, 2002, p. 208), the following classification of behavioral deviations (deviations) was proposed (Fig. 1, 2).

Fig.1. Classification of behavioral deviations

NON-STANDARD BEHAVIOR	DESTRUCTIVE BEHAVIOR
Actions that go beyond social stereotypes of behavior, but play a positive role in the development of society	Actions that cause harm, damage; destructive behavior

Fig.2. Destructive behavior

Antisocial (delinquent) behavior	Autodestructive (self-destructive) behavior	Antisocial (immoral) behavior
- behavior that threatens social order and the physical well-being of others; - behavior that violates legal norms; - behavior that results in property damage and financial losses	- conduct that poses a risk to one's own physical integrity, including self-aggressive behaviors; - actions with potential for self-harm; - behaviors that may result in victimization or exposure to risks, without deliberate self-destructive intent; - dissociative behaviors, which aim to fragment or disintegrate the individual's personality structure.	- behavior that deviates from moral and ethical norms, disrupts social order and well-being of others, and negatively impacts interpersonal relationships.

1. Antisocial (delinquent) behavior

1.1 Behavior that poses a threat to social order and the physical well-being of others; behavior that contravenes legal norms.

For instance, the patient believed the abbot of their monastery was a "second beast," the Antichrist, based on their delusional beliefs about the end-time scenario. Wishing to arrange a meeting with the abbot to 'sort things out with him,' the patient engaged in a brawl with the guards, scaled the monastery wall, and confronted the abbot physically when they met.

1.2 Behavior leading to damage to material objects, causing financial losses. The patients believed that with the arrival of the end of the world, the necessity for material wealth diminished. They started giving away their belongings, valuables, family treasures, and money.

So, the patient was handing out large amounts of money to strangers on the street and even taking loans to give money to others, convinced that he wouldn't have to pay back the loans since the end of the world was coming.

Other patients, rejecting the TIN as the devil's seal and waiting for the end of the world, not only lost their jobs, salaries, and pensions, but also sold their apartments, took their children out of school, and left for remote villages that were unsuitable for life. They did not depart from that place even when their confessors and members of the community returned to their habitable places. They suffered great financial difficulties.

2. Autodestructive (self-destructive) behavior.

2.1. Behavior that threatens one's own physical well-being (including auto-aggressive behavior).

At the height of his distress, following recurrent oneiric-catatonic states in which the patient perceived himself as the Antichrist destined to bring about the end of the world, the patient decided to commit suicide in order to "save the world". He made a longitudinal cut on his right forearm and used the blood to draw a circle on the floor, encircled by the numeral "6."

In the surrounding environment, the patient began to notice "signs" indicating the "imminent end of the world" and came to the conviction that he was the cause of the impending apocalypse. In the church, he heard a "voice" that commanded him to "kill himself to save the world." Under the influence of this "voice," he went to a department store, stripped off his clothes, and attempted to jump out of a window while naked. He resisted the police and doctors who arrived.

2.2. Potentially self-harming behavior: victimized and risky behavior, without self-destructive intentions.

Patients have no intentions of destructive behavior, but the consequences of their delusional behavior turn out to be destructive. Here are some examples.

The patient believed that since water is a natural environment for birth, the end of the world should be met in water. Therefore, in November, she began to swim across the Moskva River near the Rechnoy Vokzal in demi-season clothes.

The patient was sure that the apocalypse was coming and that she had to save the world from the impending catastrophe. To do this, she had to build a church, throw away her denture, stop taking blood pressure pills, and as a result, caused damage to her health.

The patients, who'd renounced their TIN and expected the apocalypse, lived deep in the woods, completely cut off. They refused pensions, medical services, check-ups, and assistance. Consequently, individuals with cancer did not seek medical examinations or treatment until the final stages of their illness, when excruciating pain became unbearable. At this point, they attempted to acquire painkillers illegally, thereby placing those who, out of compassion, helped them at risk of criminal prosecution.

3. Immoral behavior: actions deviating from moral and ethical norms that

threaten to disrupt interpersonal relationships (including fanatical and autistic behavior)

Individuals exhibiting this behavior often refuse to engage in marital relationships, eschew family formation, and decline to procreate. They may attempt to dissuade their relatives and acquaintances from initiating familial bonds, employing coercive tactics to instill fear of impending suffering and deploying various strategies to obstruct marriages.

In some instances, affected individuals relocate with their offspring to remote rural areas, where they lead a reclusive lifestyle. This seclusion deprives their children of educational opportunities and inhibits their socialization and interaction with peers.

Results

Delirious destructive behavior was observed in patients with both types of EWDRD, although comparative analysis revealed differences in the prevalence of specific types of destructive behavior. It should be noted that a single patient may exhibit multiple types of destructive behavior.

1.1 The first subtype of the apocalyptic variant of EWDRD occurred mainly in the structure of recurrent seizures in 75% (12) of patients. The average duration of the disease from the moment of manifestation was 10 ± 1.5 years. The average age of development was 37.1 years.

Destructive behavior of this type was frequently observed in patients (75% of cases, 12 patients) and predominantly occurred during the pre-hospital phase. In 58% of instances (9 patients), such behavior was deemed inappropriate to the circumstances: patients engaged in actions that posed potential or actual risk to others and themselves. Specifically, in anticipation of the impending apocalypse, patients initiated efforts to "save people." They attempted to halt vehicles on highways and guide individuals to a supposed safe location at red traffic lights or unidentified sites. In 12.5% of cases (2 patients), during the acute exacerbation of psychotic symptoms and with fully developed delusional beliefs regarding apocalyptic scenarios, suicidal behavior was observed as a means to "avert the impending end of the world."

1.2 Second subtype of the apocalyptic form of EWDRD is characterized by visual-imaginative delusions.

Patients exhibited auto- and heteroaggressive tendencies, as well as impulsive behavior, often stemming from catatonic excitement or inadequate actions with impaired consciousness (44% of cases). A smaller percentage of patients (8%) were less inclined to harm themselves or attempt suicide for delusional reasons, believing that their death would prevent the apocalypse and save the world from their sinful thoughts.

2. The eschatological type.

Antisocial and potentially destructive behavior for patients and others was predominant (48% of cases), mainly in the form of inducing delirium in others, which can lead to destructive behavior in induced patients.

Conclusion and findings

The data obtained confirm the existence of significant correlations between delusional behavior and various clinical subtypes of EWDRD.

In subtype I, antisocial and self-harm behaviors were predominant, with minimal manifestations of antisocial and immoral conduct. In contrast, subtype II exhibited a higher prevalence of antisocial and immoral behaviors, as well as potentially harmful actions, primarily manifested as inducing psychotic episodes in others.

These findings provide a foundation for the development of individualized

treatment strategies for endogenous disorders and the prevention of detrimental behaviors. The approach should be based on a comprehensive assessment of the patient's psychological state, incorporating clinical, psychometric, and pathopsychological indicators.

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Comparative age approach as a diagnostic tool

Abstract: The human psyche undergoes a complex evolutionary process, both at the individual level and in the context of collective human development. A comprehensive understanding of these developmental trends and patterns is crucial for accurate psychiatric diagnosis. This paper outlines the stages of formation of various mental processes and structures, including motor and sensorimotor functions, affective responses, cognitive processes, consciousness, temperament, character, and personality. Additionally, it addresses the issue of age-related crises and the diagnostic significance of particular clinical manifestations, arising from the specificities of age-related psychological development. The issue is examined holistically through the lens of a tripartite framework: the biopsychosocial model of the person and disease, which is essentially congruent with the Christian anthropological perspective (spirit, soul, body).

Keywords: psyche, trichotomy, ontogenesis, developmental stages, crises, disorders.

«We instinctively recoil from seeing an object to which our emotions and affections are committed handled by the intellect as any other object is handled»

W. James

This epigraph, taken from "The Varieties of Religious Experience," serves to remind us of the perennial and pressing issue of the relationship between creationism and evolution, a topic we will not delve into here. Instead, we simply acknowledge that there is no doubt that the interplay between faith and reason holds the potential for fruitful and innovative insights for both sides.

Below, we will endeavor to present the information amassed by psychiatry and related disciplines of knowledge, stressing that these are not merely theoretical constructs but rather facts and phenomena that correspond to clinical reality, specifically the diagnostic and therapeutic practices of a psychiatrist.

The development of the psyche occurs through distinct stages, each characterized by its own unique processes. Pierre Janet, a distinguished figure in the field of French psychology and psychiatry, posited that "life is the product of organization" (P. Janet, 1992). Karl Marx, in a related vein, asserted that "What is any illness except life that is hampered in its freedom?" (K. Marx, 1955). In exploring the formation of the psyche, we, to some degree, gain understanding and reclaim aspects of this freedom.

It is important to first clarify the primary categories that define a mental disorder. Contemporary psychiatry, like medicine in general, is founded on a tripartite biopsychosocial model of human nature, which can be traced back to Christian anthropology: mind-spirit-body. A mental disorder, in its broadest sense, refers to a transformation of mental processes such as perception, cognition, emotion, volition, and consciousness. The transformation is "bipolar," characterized by the potential for novel, atypical, and non-normative experiences, including "visions," "voices," and significant mood fluctuations (productive symptomatology). And, regrettably, the almost inevitable weakening-impoverishment, the disappearance of the normal, natural experiences described in the previous sentence (negative symptomatology). "The clinical picture is determined by causal factors, the peculiarities of the individual's mental makeup (the patient's character), and the level (stage) of psychological development."

Let us proceed to an analysis of this complex and multifaceted concept in its structural aspects. The genesis of the psyche has been meticulously examined by

psychiatrists, psychologists, and educators. We will present a consolidated model based on the research conducted by the eminent Soviet psychiatrist Professor G.K. Ushakov (1973). The initial stage, commencing at birth, encompasses somato-vegetative reactions, which include cardiovascular, respiratory, and gastrointestinal processes. In the context of illness, the interplay of "internal" pathologies – namely, therapeutic, neurological, and psychological – is not always clearly delineated.

Motor functions undergo progressive development and maturation, enabling the infant to perceive and respond to both external stimuli and internal sensations through motor activity, which may manifest as agitation or calmness. In the context of diagnosing mental disorders in adults, the presence of marked motor symptoms often indicates a more severe condition, suggesting that the disorder has progressed to a deeper stage. The motor stage is succeeded by the sensorimotor stage, marked by the development of sensory systems (vision, hearing, etc.) and their associated experiences. In mental illness, this can lead to the appearance of illusions and hallucinations. The next stage is the formation of affects, emotional experiences. It becomes clear that elaborate, vivid depressions and manias become possible from adolescence onwards.

In younger children, these mood fluctuations are often manifested through motor sluggishness or uncontrollable behavior. The final stage involves the development of ideational processes, or cognition. The most difficult sections of mathematics, physics, and chemistry are studied in the senior years of high school. Complex logical constructions – both sound and delusional – also emerge from adolescence and youth.

The development of consciousness warrants separate consideration. However, it is crucial to highlight that the psychiatric interpretation of consciousness diverges from the common understanding, which frequently equates it with cognition, beliefs, comprehension, and critical faculties. For a psychiatrist, consciousness is the experience of oneself ("I am Ivan Ivanov"), in the present moment ("November 22, 2024"), and in a specific place ("in this conference room").

Initially, consciousness simply exists—it manifests as a state of being awake (or asleep). Subsequently, the perception of the external world becomes segmented, breaking down into individual stimuli and objects, with the child being one of these objects. From everyday observations, it is well-known that infants often refer to themselves using the third person (for example, "Vasya wants to eat" or "Petya will go for a walk"). Father Sergiy Bulgakov (1999), in his work "The Philosophy of the Name," provides compelling examples of such "self-experience."

At this point, consciousness concentrates (crystallizes) into self-awareness, as exemplified by a six-year-old girl who exclaimed, "I am not nature, I am a human being," during a particularly significant moment for her. Alternatively, one can view it from a different angle. Ernst Kretschmer, a prominent psychiatrist of the twentieth century, offered a somewhat rephrased definition: "The I is the world as lived experience" (1927, p. 119). His original statement was: "... the main complexes of our psychological experience — the 'I' and the external world — disintegrate and transform into each other in such a way that we no longer distinguish them from each other."

These forms of consciousness organization allow for, in cases of disease development, various degrees of its reduction or clouding, corresponding to a specific stage of natural consciousness complexity.

The final stage of development is reflective consciousness, which involves both the experience of one's own "self" and the evaluation of that experience. To elucidate this stage, it is useful to conceptualize it as a square divided by a vertical line. The left side of the square represents the "self," encompassing thoughts, emotions, actions, and other subjective phenomena. The right side is dedicated to "self-assessment," including judgments about the accuracy of perceptions, the thoroughness of understanding, and the refinement of behavior, among other qualities. Throughout cultural and historical

evolution, at both the individual and collective levels, this reflective capacity has manifested as a juxtaposition of various dichotomies, such as piety and sinfulness, truth and fallacy, beauty and ugliness, and lawfulness and transgression. However, these correlations pertain to the spiritual realm and are therefore not within the scope of this current discussion.

As a form of "critique," "evaluation," or "correction," reflection to a certain extent proves to be a burdensome experience; yet, psychologists, psychotherapists, and psychoanalysts alike perceive significant creative resources within it. In a Christian context, an individual's critical self-assessment serves as a motivating force for following Christ: "Lord Jesus Christ, Son of God, have mercy on me, a sinner." Theological scholars, psychologists, and eminent thinkers from various fields underscore the Christian essence of reflection. Tertullian observes that "the soul is Christian by nature." Additionally, Carl Gustav Jung posits that "the psychological process of development which we call specifically *Christian...*," as noted in his 1995 work.

In psychopathology, reflexivity undergoes a transformation, leading to depersonalization. The diagnostic significance of this experience can vary widely.

When examining the development and various manifestations of consciousness, it is pertinent to consider an aspect that might seem unexpected but is, unfortunately, highly relevant. Profanity, which is increasingly audible in diverse settings today, is not merely impoliteness, a lack of cultural refinement, or rudeness. It represents a unique form of lowering the level of consciousness.

It is well-known that in the early stages of human development, the psyche—the soul—was thought to be located in the stomach, often referred to as the "belly of life." This concept is even encapsulated in a specific term: omphalopsychism, derived from the Greek word "omphalon," meaning navel. Over time, this perception shifted upward, eventually settling in the heart and ultimately the head. Scholars of culture and art history observe that in ancient sculptures, particularly of stone women, the lower abdomen and genitalia are meticulously detailed, while the face is merely sketched. When individuals use profanity, their consciousness—or psyche—reverts to a more primitive, bodily state. This reflects the early, fundamentally biological organization of the psyche.

In practical terms, this indicates that this individual may exhibit aggressive behavior towards others. The emotional environment created by such language is antithetical to compassion. The destructive nature of profanity has been linked to clinical manifestations. Psychiatric professionals have observed that when patients with depression request to be assigned to tasks involving cleaning toilets ("to atone for sins")¹, the prognosis for their condition is generally unfavorable.

While not explicitly stated, some apologists of profanity find justification for its active use in the framework of orthodox psychoanalysis, particularly Freudianism. This perspective posits that libido is fundamental to the development of the human psyche. Indeed, sexual desire forms one of the cornerstones of existence, both in its narrow biological sense and its broader cultural and historical context. Humanity has devised ways to transform this raw energy into a creative force rather than a destructive one. The renowned philosopher of the 20th century, Martin Buber (1995), advocated for not deifying instincts but rather elevating them through faith.

However physiology, physicality, and vitality are not to be considered inherently base. They can also manifest in exalted spiritual experiences or ordinary sentimental

¹ A) Quotation marks indicate that the statement belongs to the patient.

B) During her episodes of anxious delirium, our patient heard "profanity invading her mind (at the height of these episodes), perceived as a structural blow." As a devout individual, these experiences were especially burdensome for her.

encounters. In venues such as theaters, concert halls, and museums, one often hears a question: "What defines true artistry?" The common response is that it evokes a physical reaction, such as goosebumps, signifying that the aesthetic experience penetrates deeply. This timeless answer was recently articulated by a prominent figure in the arts, conductor Theodor Currentzis, during a discussion.

The juxtaposition of pejorative terminology and aesthetic appreciation is intended to illustrate that "physiology" can serve as a source of inspiration². The distinguished Russian sex therapist of the mid-20th century, Professor G.S. Vasilchenko, frequently emphasized during clinical trials: "An individual does not possess superior or inferior boundaries; everything is human."³

The development of mental processes does not always proceed smoothly. Natural periods of "Sturm und Drang," in a cultural-historical sense, are possible. These phases are known as age-related crises. Psychiatric professionals pay particular attention to these periods because they can pose challenges for both the individual and their environment, and they may create favorable conditions for the manifestation or recurrence of mental disorders. Here are some examples of states and experiences that that might, or even ought to warrant the attention of loved ones: during the age range of 2-3 years, there may be a loss of self-care skills; during puberty, there may be intensified, "hypertrophied" hobbies, pronounced mood swings, behavioral anomalies, and excessive, unjustified concerns about appearance; at the age range of 45-55 years, there may be an unusual, unfounded preoccupation with health (hypochondria), expressed anxiety, and distrust or suspicion.

Dysontogenesis refers to a deviation from the typical trajectory of mental development. It can manifest in various forms, including developmental delays, accelerated maturation, or temporary irregularities in the progression of psychological faculties.

Mental developmental delays are unequivocally considered a negative phenomenon. However, they can present themselves in different forms. Total developmental delay, affecting all mental processes (evolutionary, in classical terminology), ultimately manifests as mental underdevelopment. Another type of developmental delay, so to speak, with disproportion, elements of internal disharmony, particularly situations where a child appears to be intellectually advanced for their age, can be a precursor to a serious mental disorder. So, one of the patients (a young adult male), as a child, would get angry when he was read fairy tales, but demanded that the intercity bus schedule be read to him before bed. He would sniff completely inappropriate objects, such as railway tracks. He did not interact with his peers. "He developed in parallel with society," his mother described his childhood. But in his youth, this man became a chess champion throughout the entire Soviet Baltics.

In a text by Metropolitan Anthony of Sourozh, dated 2002, he mentions St. John of Kronstadt, who discussed individuals on whom the Lord places a special protective veil from an early age. These people then go on to achieve the fullness of life. Lines from M.Yu. Lermontov also come to mind here:

«The Creator of the best ether
Wove their living strings,
They are not made for the world,
And the world was not made for them!»

² One of the forms of such cultural and historical understanding is considered (probably somewhat unexpectedly for our time) in the book "The Taming of Everyday Life" (2020, pp. 110-154). The subject of discussion is so specific that we will refrain from naming it here, but we will point out that the entire collection is the materials of a scientific conference, and the book itself is defined in the output as a "scientific appendix".

³ Verbal message.

The fundamental nature, operational principles, and temporal sequence of the various manifestations of the observed deviations in psychological development, as elucidated above, exhibit disparities. However, upon synthesis, it is reasonable to infer that *"the characteristics of the syndrome are attributable to the preexisting insufficiency of specific functional brain systems.**"* (G.K. Ushakov, 1973, p. 187, emphasis added by the author)⁴. Conversely, the earlier the pathogenic influence manifests (in relation to developmental stage), the more pronounced the adverse symptoms (degeneration of mental processes). A summarizing and unifying statement for these provisions can be found in the aphoristic saying of the outstanding medical theorist, Academician of the USSR Academy of Medical Sciences I. V. Davydovsky (1960s): "Everyone has their own calendar."⁵

The development of mental activity should also be considered from another perspective – the levels of psychic individuality: temperament, character, personality. Temperament is the dynamics of neurophysiological processes: strength, balance, and mobility, expressed in the perhaps somewhat outdated, but still reliable, language of the world-renowned Soviet physiologist I.P. Pavlov.

There is often no clear distinction made between character and personality. The phrase from the article by the remarkable literary scholar, writer, and reader Irakli Andronikov (1981): "The main qualities of my character since childhood have been shyness and a love for music," illustrates this identification. A love for music is about personality and values, it is what a person places above themselves, for which they live. And although modern psychiatry discusses "personality disorders," it essentially examines the mental makeup, character – an ensemble of mental processes, the development of which is presented at the beginning of this publication, rather than the cultural and social ideals of the patient. And personality pertains to an individual as both the bearer and creator of values.

These psychological constructs develop in a specific sequence: temperament, character, and personality. Personality typically matures during adolescence, a period when an individual attains legal adulthood, selects a life trajectory, and establishes personal relationships. Only after the subject has achieved these milestones can one accurately assess whether their character traits and cognitive processes contribute to life challenges or function relatively smoothly. In cases where life difficulties arise, a psychiatric and psychotherapeutic evaluation is necessary to determine the nature of the issues, formulate appropriate assistance, and implement corrective or therapeutic measures.

In various everyday situations and contexts, different personality types (ranging from healthy and well-balanced individuals to those with vivid and exaggerated traits—a psychiatric term, but still within the spectrum of normal variation—and even pathological psychopathic manifestations) exhibit distinct behaviors. The following are generalized personality types, which have been correlated (to the extent possible) with corresponding behavioral patterns: : psychasthenic (anxious-suspicious) – "purely reflexive," cycloid (syntonic) – "empathetic," excitable (paranoid) – "categorical," hysterical (egocentric) – "artistic."

The classifications types of piety proposed by Mother Maria Skobtsova in her work (2006), namely synodal, aesthetical, ascetical, and evangelical, can be correlated (with a certain degree of caution due to the inherent limitations of categorization) with the aforementioned types of characters.

⁴ Syndrome refers to a complex of symptoms and subjective morbid experiences. Preformedness denotes a specific characteristic of the organization of certain mental processes, which may manifest as painful peculiarities. In the context of our deliberations, it appears reasonable to conflate and even equate "functional systems" with subjective experiences.

⁵ Verbal message.

History is experienced not just by individuals, but by humanity as a whole. Understanding this journey can also be helpful in the diagnostic process. This idea is vividly illustrated in a passage from C.G. Jung's "Memories, Dreams, Reflections" (1994). In one of his dreams, Jung explores his home from the top floor downwards. The house, dating back about 200 years, transitions from a modern setting to increasingly ancient epochs: the 18th century, the Middle Ages, ancient Rome, and finally, a prehistoric cave. Within these rooms, he encounters human skulls, bones, and artifacts from "some primitive culture," as Jung describes them. For a psychiatrist, the significance of these elements lies in their nature and context. It is crucial to recognize that these artifacts are remnants of living beings, with several items of the same type (such as skulls) exhibiting unusual characteristics like being unnaturally large or small. These features are indicative of delirious clouding of consciousness, characterized by zoopsia (hallucinations of living beings), polyopia (multiplicity of images), and macro- and micropsia (changes in perceived size). Of course, this isn't Jung's diagnosis; it's just a dream for him. However, it effectively demonstrates the diagnostic process in psychiatry. The approach begins with the present (the patient's current experiences) and delves into the past (earlier perceptions, memories, and understandings). The goal is to interpret and evaluate these experiences, identifying them as hallucinations, delusions, or other cognitive disorders. Particular attention is paid to the unique aspects of these experiences, such as the nature of hallucinations, the mechanisms of delusions, and any disturbances in consciousness. It is essential to note that this diagnostic process cannot be fully understood without considering the broader history of humanity.

Conclusion

Clinical psychiatry – that is, the discipline that examines the diseased experiences and suffering of patients, which is not quite the same thing – is not only a medical but also an anthropological discipline in the broadest sense of the word.

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Age-related aspects of crisis states under normal conditions and in patients with mental illnesses

Abstract: This report examines certain age-related dimensions of crisis states, which are of interest to medical practitioners, psychologists, and clergy. The spectrum of experiences associated with these states is extremely broad, ranging from phenomena related to spiritual exploration to conditions associated with the development of severe mental disorders. Only a multidisciplinary assessment of the crisis state can provide an objective view of this complex phenomenon and facilitate the most appropriate support, implying the involvement not only of a physician and/or psychologist, but also spiritual guidance.

Keywords: age-related crisis, existential crisis, spiritual crisis, psychopathological disorders, hypochondriac disorders, eating disorders.

The term «crisis» (from the Greek κρίσις) can be interpreted as «judgment, decision, crucial moment» in ancient Greek and as «turning point», «decision», «outcome» in modern Greek, clearly indicating the process of transition from one state to another, a pivotal point. Currently, various forms of crisis are distinguished in the field of psychology, such as «existential crisis», «life crisis», «age crisis», «crisis of meaning», «spiritual crisis», and more. Given the multifaceted and complex nature of these conditions, affecting various aspects of human life, it is essential to examine them from several perspectives — clinical, psychological, and theological.

In general, age-related crises represent a natural component of the transition between different life stages. They are an inherent part of the human developmental process, yet they can also manifest with a “wide spectrum of individual characteristics, determined by the social developmental situation, morphofunctional parameters, and other individual traits” (Zvereva, 2013) and are accompanied by various outcomes. These periods can lead to a wide spectrum of outcomes and may pose particular challenges for individuals exhibiting pre-existing negative behavioral patterns. Developmental crises are especially susceptible to the manifestation of negative behavioral reactions, as they are characterized by an accumulation of various deviations, which can contribute to the development of borderline disorders and the manifestation of mental illnesses (Zvereva, 2015). In this context, certain researchers distinguish between a “crisis period,” which refers to a transitional stage between life stages, and a “crisis,” which denotes the occurrence of mental disorders during a crisis period (Koval & Goryachev, 2012).

In his work “The Will to Meaning,”¹ Viktor Frankl introduces the concept of the “existential vacuum.” This state is characterized by the loss of life purpose, resulting in an existential or spiritual crisis. However Frankl does not classify this condition as pathological; rather, he posits that it is a potential experience for all individuals.

Adolescent crises

Vygotsky L. S. (1984) speaking about the crises of adolescence, noted that along with some changes, which are usually negatively assessed, there are undoubtedly “constructive development processes” during this age period. He also noted that the demarcation between the initiation and conclusion of crisis phases is frequently indistinct. Kashchuk Ya. N. (2011) emphasized the “distinctive features of this developmental stage, including the necessity for professional self-exploration, the

¹ First published in 1969.

formation of personal values and ideals, and the establishment of a consistent worldview”.

This stage of life is marked by a search for life's purpose, self-discovery, and the establishment of personal values. It is also characterized by creative, religious and mystical exploration, and in some cases, it may be accompanied by a state known as "pubertal angst" (E. Kasin, 1971). The most significant experiences in these cases are often linked to a kind of inner spiritual revolution that upends one's worldview, triggered by the emergence of profound existential questions.

The hormonal fluctuations that occur during this crisis period can lead to sudden shifts in mood, ranging from elation and euphoria to depression and deep despair. During these times, the risk of mental disorders manifestation is particularly high. The most frequently observed development of affective pathology involves somatic equivalents, depersonalization, dissociation, dysmorphia, or hypochondria. The most threatening clinical manifestations include eating disorders, various forms of autoaggressive, antisocial and psychopathic (heboid) behavior. The danger of these conditions lies in the fact that the external facade of spiritual, mystical, or philosophical pursuits can mask the severity of underlying psychopathological disorders. This can make it difficult to recognize the true nature of the problem and delay seeking appropriate medical help.

For example, we can cite cases from the Department of Cross-Cultural Psychiatry at the FSBI NCMH where adolescent crises with a spiritual component appeared as spiritual hypochondria, characterized by an excessive preoccupation with the absence of genuine religious belief, self-criticism for this absence, a conviction of own spiritual inadequacy, doubts about the sincerity of one's faith, misconceptions regarding proper prayer practices or so-called "defects in faith."

There were also cases of so-called “holy anorexia”, associated with eating disorders. These conditions were characterized by a refusal to consume food and non-canonical fasting practices. The belief that salvation could be attained only through complete abstinence from food, and in some instances, from water, proved to be uncorrectable. The medical condition of these patients often necessitated involuntary psychiatric intervention, and in certain cases, treatment in an intensive care unit.

Furthermore, the crisis could have been accompanied by rejection reactions, including dissociative disorders, a shift in self-perception, and the emergence of a subjective desire for an «alternative (fictional) life» (J.Vie, 1935) and the so-called «escape into religion» (E.Sands, 1956). At an earlier conference, the case of a patient whose adolescence crisis was marked by depression, social failure, and failure to master the curriculum was presented. In response to the crisis, she sought to find a new social role by leaving the world behind and joining a convent. This decision had severe consequences for both her family and the community of the convent.

The "mid-life" crisis

After the crisis of adolescence, the so-called "midlife" crisis is regarded as the most significant, serving as “a necessary component of the mental development of the individual” and being mediated by “a number of subjective and objective factors” (Fofanova G. A., Bondareva E. A., 2020). During this time, existing values and beliefs are reassessed, and the relationships with the outside world are reevaluated. There is a desire to leave a lasting impact, to create something enduring (E. Jaques, 1965). Such intrapersonal transformation can be accompanied by a sense of dissatisfaction with material possessions and a search for spiritual guidance. The "midlife" crisis is often described as a "values and meanings" crisis. In some cases, this period is characterized by the emergence of so-called "self-transcendent" values, which “reflect supraindividual interests” and direct a person's attention towards “serving a common cause, even if it

means sacrificing personal interests” (K.V. Karpinsky, 2011).

During this age-related crisis, some individuals may experience psychopathological symptoms. In case of religious patients, we frequently observed depressive episodes characterized by feelings of guilt, sinfulness, and God-abandonment. In our research on crisis states that led to the onset of mental illness, we have identified a strong correlation between a person's value-based worldview and his mental well-being (Borisova O.A., Gusev V.V., Dvoinin A.M., Kopeyko G.I., 2019).

Late-life crisis

The crisis of old age can be characterized as the ultimate existential turning point, marked by the acceptance of life's limitations and the search for a deeper purpose in the face of inevitable decline as well as by the final summing up of life. It is a time of painful reflection on the past, contemplating the themes of mortality and solitude. Yet, the range of transformations that occur during this period of crisis can be vast: "the notion of 'old age' in one case means “enduring” suffering, total dependence on the conditions of existence and one’s own deteriorating condition, and in another case – a continuation of personal growth, productivity, and spiritual fulfillment." (Ermolaeva, 2016).

The most prevalent psychiatric conditions accompanying this age-related transition are depressive disorders and cognitive impairments, particularly dementia. However, it is in the old age that individuals often experience a profound spiritual growth, which may manifest as a deepening of their faith or a conversion to it. According to some authors, "at a later stage of life, turning to spirituality and religiosity can help alleviate the symptoms of mental disorders, serve as an effective coping mechanism for overcoming them, and contribute to the development of favorable aging patterns and the ongoing spiritual evolution of an elderly person's personality in the face of biological decline" (Yu.I. Polishchuk, L.E. Pischikova, Z.V. Letnikova, 2020).

It is essential to recognize that for a believer, spiritual growth is a crucial aspect of navigating through a crisis, regardless of the age at which it occurs. A **spiritual crisis** can result in the development of faith, which serves as a foundation for life, a bridge across the existential “abyss”. This experience can lead to the discovery of a new spiritual purpose. To illustrate this, let me share some insights from Archimandrite Sophronius (Sakharov) (1896-1993) about his personal journey. Despite witnessing significant global socio-political upheavals, he did not prioritize these external events over the inner spiritual challenges he faced.

In his book "Seeing God as He Is," he writes: "A strange feeling has settled in my deep heart – the meaninglessness of all the gains on earth. There was something completely new and different about it... Outwardly, however, I was calm; I often laughed merrily; I lived like everyone else does. In a peaceful way, something was happening in the heart, and the mind, putting everything aside, turned its attention inward. A giant plow was ploughing through the vast expanses of my country, tearing out the roots of the past. Everyone was on their feet; there was tension everywhere that exceeded human strength. Moreover, there were events all over the world that marked the beginning of a new era in the history of mankind, but my spirit did not stop at them. A lot of things were collapsing around me, but my inner collapse was more intense, not to say more important to me.

Reality of a different order, unearthly, incomprehensible, possessed me, despite my attempts to evade it. I remember myself very well: in everyday life I was no different from all other people, but at times I did not feel the ground under my feet. I saw it with my eyes as usual, while in spirit I was moving over a bottomless abyss. This phenomenon was then joined by another, no less painful one: an obstacle appeared in front of me in my mind, which I felt like a thick leaden wall. Not a single ray of light,

intelligent light, not physical, just as the wall was not material, did not penetrate through it. For a long time it stood before me, oppressing me...The Lord, ignoring my protests, took me in His strong arms and as if with anger threw me into the boundlessness of the world He had created. In a harsh way, but He opened up the horizons of a different Being for me.

Oh, I suffered so much, but there was no way out, except for a prayer that was revived in me; a prayer to something still Unknown, or rather Forgotten by me. The fervent prayer captured me in its depths and for many years did not leave me either awake or in my dreams. My torment was prolonged. I was driven to the point of exhausting all my strength. Then, quite unexpectedly for me, a thin needle seemed to pierce the thickness of the lead wall, and a ray of Light penetrated through the created channel."

In conclusion, I would like to emphasize that age-related crises are the most crucial periods in a person's life, as they mark the transition from one stage of life to another and are accompanied by substantial changes that affect all aspects of human existence — physical, mental, and spiritual. Therefore, only a holistic approach to understanding this phenomenon can provide an accurate picture of such a complex state as a crisis. Addressing these conditions requires not only the clinician and psychologist, but also the spiritual support that is essential for navigating through these challenging times.

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Psychopathological problems of religious identity in young people at the stage of separation from the parental family

Abstract: this article addresses the development of psychopathological symptoms in young individuals in the context of religious identity crisis, age-related developmental transition, and separation crisis. The findings of the author's theoretical analysis and clinical experience are presented, demonstrating the expediency of verifying crisis phenomena based on a bio-psycho-socio-spiritual model. This approach allows for an increase in the effectiveness of comprehensive care for patients in navigating ontogenetic crises and in the treatment of mental disorders.

Keywords: crisis of religious identity at a young age, violations of separation from the parental family, pathological phenomena of psychological and spiritual crisis.

The progression of the modern global order highlights the complexities associated with developmental crises and identity-formation processes. Issues pertaining to religious identity are particularly salient within the context of individual and familial system development. At younger ages, the manifestations of these crises significantly influence the ontogenetic developmental tasks, the nature of familial relationships, and the characteristics of religious experiences. The phenomenology of identity crises often encompasses both normative and psychopathological symptomatology, necessitating a comprehensive assessment and supportive intervention grounded in a bio-psycho-socio-spiritual framework.

Identity, in its broadest sense, encompasses responses to the questions "Who am I?", "What am I like?", "What is important to me?", and an individual's conception of belonging to specific value systems (professional, social, religious). The concept of "identity crisis" was introduced into psychology through the works of Erik Erikson, who posited that individuals undergo eight stages of identity development, each characterized by the resolution of choice dilemmas. These stages provide opportunities for the formation of contrasting personality traits with which individuals identify. The identified problematic corresponds to the fifth and sixth stages and collectively covers the age range of approximately 14 to 25 years. During the fifth stage, which is associated with the formation of a teenager's sense of identity, an ineffective resolution can lead to a significant identity crisis or role confusion, as well as an impaired ability to make personal choices. This can result in feelings of uncertainty, emptiness, self-worthlessness, and aimlessness. The sixth stage culminates in the achievement of personal maturity, independence, and the capacity to recognize and internalize one's beliefs, norms, and values.

Russian developmental psychology, significantly influenced by the contributions of Lev Semenovich Vygotsky and Daniil Borisovich Elkonin, focuses on the emergence of age-specific qualities as a consequence of successfully navigating developmental crises. These crises are instrumental in fostering an awareness of one's individuality and uniqueness and in developing an understanding of one's personal life trajectory. The formation of an individual worldview is also a critical component of this process. This developmental journey is essential for achieving social maturity, assuming responsibility for one's life, and demonstrating a readiness to make choices.

Ivan Alexandrovich Ilyin highlighted the family as the fundamental "cradle of human culture," which significantly influences the formation of personal identity. He posited that freedom and service are the primary avenues for the development of one's identity. Freedom enables an individual to gain a deeper understanding of themselves, while service facilitates the realization of their purpose. In the process of self-discovery, individuals are encouraged to begin "from the depths – by comprehending and

accepting love, drawing from the enigmatic spirituality of instinct." As noted by Vasily Vasilyevich Zenkovsky, this phase can be likened to the parable of the "prodigal son," wherein "the family should above all focus on ensuring that the teenager feels comfortable and free within it, so that nothing drives them away from home."

Separation is a critical prerequisite for the development of individual identity, manifesting as both emotional and physical disengagement of an adolescent from their parents. This process constitutes a primary developmental challenge during adolescence, necessitating the acquisition of self-sufficiency, emotional maturity, and the capacity to maintain stable interpersonal relationships with the parental family. Effective differentiation from the parental unit is instrumental in fostering an adolescent's autonomy in personal relationships, life decision-making, career development, and even religious convictions. The separation process is a systemic phenomenon that requires the collective preparedness of the family unit. This developmental trajectory spans three generations, with each generation assuming distinct developmental tasks and transitioning through age-appropriate stages in a timely manner. This involves the acquisition of new roles while relinquishing older ones. The successful completion of this separation process in early adulthood results in a transformation of the relationship dynamic with parents, characterized by a nuanced understanding of their strengths and limitations. This understanding fosters a realistic acceptance and the establishment of respectful intergenerational relationships.

The biblical precepts concerning familial relationships exhibit a certain degree of tension. On the one hand, in building a new moral system, Christ calls for leaving one's loved ones for his sake. Conversely, he also emphasizes the necessity of adhering to the commandment: "Honor your father and your mother."

The concepts of separation and individuation are intricately interconnected throughout the process of individual development. Murray Bowen, the originator of family systems theory, delineates two distinct states: an individual who is "isolated, independent, differentiated from the family," and an individual who is "subordinate, dependent, fused with the family." Differentiation, in this context, can be conceptualized as the ability to distinguish between emotional responses and cognitive reasoning. An individual with low differentiation is predominantly influenced by their emotional states, is fused within the family system, and is incapable of achieving separation. Conversely, an individual with high differentiation makes decisions based on rational thought and independent judgment, with minimal influence from the family system. Greater differentiation among family members leads to healthier relationships within the family.

In this coordinate system, the genesis of religious identity during the adolescent phase constitutes a multifaceted spiritual process, whose primary concerns pertain to religious convictions, faith in God, and the existential purpose of life. The attained Religious Identity Integration (RII) signifies the ability to autonomously evaluate culturally influenced religious beliefs and to construct a personal worldview and religious system grounded in individual perspectives and emotions, free from reliance on the social environment (Marcia J.E., 1966).

According to the family systems theory developed by M. Bowen and the psychodynamic concepts proposed by O. Kernberg regarding the fundamental mechanisms of mental pathology, the primary stages of structural and functional organization within a family can be identified. These stages encompass the monadic, dyadic, and triadic levels, which significantly influence the structural organization of individual personalities and the psychopathological profile of emerging symptoms. At the undifferentiated monadic level, the mother and child form a cohesive unit characterized by a symbiotic relationship. This type of organization is associated with elevated levels of anxiety, a deficit in "basic trust in the world," and unfavorable

conditions for the holistic development of family members' personalities. Consequently, the formation of a cohesive self-identity is impaired. The dyadic stage of structural and functional organization results in a fragmented "self-concept," where polar components do not coalesce into a unified structure. This corresponds to immature forms of separation, manifesting as conflicts and disruptions. Only under conditions of a fully-developed triadic system does an integrated, holistic self-identity emerge, enabling the acceptance of contradictory aspects of one's personality. This involves the ability to differentiate emotions, engage in self-reflection, and adjust cognitive perspectives, ultimately leading to the formation of stable internal representations of the self and significant others. The development of a mature 'We' and the capacity for dialogue are emerging. This is a necessary condition for both personal maturity and the attainment of religious identity.

The phenomenon of blurred self-perception, frequently articulated as "without you I do not exist" from a monadic perspective, encompasses a broad spectrum of identity-related issues, including those pertaining to social roles and gender. This condition is marked by an excessive dependence on external models for identity formation. The figures of significant others serve as external models. In today's technologically driven world, characters from video games and anime are increasingly taking on this role. When confronted with the prospect of separation, individuals experiencing this blurred self-concept often exhibit heightened levels of anxiety, which may escalate to the manifestation of psychotic symptoms. This can lead to depersonalization disorders, sometimes progressing to delusional depersonalization, which function as a compensatory mechanism. Those struggling with this issue face challenges in comprehending their own emotions, needs, and self-perception, and may adopt the characteristics of these external models, resulting in the development of fantasy complexes. The psychopathological symptoms observed in this context are fundamentally rooted in the process of identification. By immersing themselves in a delusional model of reality, individuals attempt to compensate for their inability to establish authentic relationships with the external world.

The confrontational ("I'm not you" – dyadic) model. During the identity crisis, the unpreparedness for autonomous existence, and the risk of losing integrity and security, the growing need for independence leads to anger reactions (anger of separation, according to K. Fopel). These anger manifestations reflect the anxiety associated with separation and simultaneously serve as mechanisms for achieving this separation, as they allow for the devaluation of a significant object, thereby reducing dependence on it. Such reactions are typical for teenagers and take various forms, helping them to navigate the challenges of separating from their parents in a timely manner. Anger can also be directed towards God and religious symbols, with young people discarding crosses, icons, and engaging in critical or insulting behavior towards clergy, often troubled by "blasphemous" thoughts. When direct expression of anger towards the recipient is impossible due to the fear of damaging the relationship, whether through physical separation or death, this anger may then be channeled towards others or internalized. Self-harming behavior can be viewed as a strategy to cope with an identity crisis. For instance, the act of self-harm might be interpreted as "filling the void," addressing identity issues stemming from personal immaturity or existential turmoil. There is also an identification type of self-harm that is prevalent in informal subcultures, influencing the development of a person's sense of self. In adolescence, incomplete separation and identity crisis are often accompanied by obsessions and psychosomatic symptoms, reflecting themes of struggle and suppressed anger. In the formation of religious identity, the process of confrontation is replicated, directed towards significant religious objects, while there is a deficit of accepting, loving, and warm attitudes towards oneself and others. In psychotherapeutic practice, it is crucial to

acknowledge the presence of anger, understand its meaning, and facilitate the development of appropriate ways to express it. It is essential to grasp the significance of the symptom and its role in the separation process and identity formation.

A triadic personality structure, characterized by an "I" identity within a cohesive "we", emerges within a well-differentiated functional family system. This structure demonstrates the capacity to accept the inherent heterogeneity and inconsistencies of its nature, thereby mitigating identity crises. During periods of crisis, transient neurotic symptoms may manifest, typically serving as compensatory mechanisms aimed at alleviating tension.

Today, we cannot fully endorse the viewpoint of E. Erikson, who underscored the significance of maintaining the individual's integrity and cautioned against the detrimental effects of internal conflicts. Instead, it is crucial to acknowledge the multifaceted and contradictory nature of personality, focusing on the goal of enhancing mental well-being by developing the capacity to identify and reconcile these internal, interpersonal, and systemic contradictions, including conflicts of a religious nature.

The process of identity formation during early stages of development is intricately linked with the process of individuation and occurs within the context of the family system. It is crucial to assess the functionality of the system, the effectiveness of individuation, the feasibility of dialogue, and the potential for reconciliation of contradictions. The sacrosanct nature of *faith and religiosity* necessitates their special protection. Consequently, a *psychopathological* symptom can serve an identification, individuation, communicative, or compensatory function. From a systemic perspective, it is essential to comprehend this function within a bio-psycho-socio-spiritual framework and to assist the young individual and their family in developing constructive strategies to navigate developmental crises.

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The impact of family conflicts on the mental health of family members, especially children

Abstract: The family is a complex system where the interactions of its members can lead to conflicts that negatively affect mental health, particularly that of children. In the context of modern societal changes, there is an observed increase in divorces and dysfunctional families, which highlights the importance of understanding the causes of conflicts and their consequences. Conflicts often arise due to differences in values and expectations, which can lead to crisis situations and emotional exhaustion. Family conflicts can be both constructive and destructive. Constructive conflicts can foster the growth and development of relationships, while destructive ones can lead to stress and the development of mental health disorders in children. Psychological support and pastoral care can play a significant role in restoring harmony within the family, helping its members cope with conflicts and rebuild mutual trust.

Keywords: Family conflicts, pathological consequences of family conflicts, pastoral care for families in conflict.

'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbor as yourself.' (Matt. 22:37-39)

Family is a system where different personalities interact, and all members influence each other. Conflicts within the family can significantly disrupt harmony and create a negative atmosphere, which is dangerous for the mental health of family members, especially children.

Conflict as a cause of family breakdown

Numerous studies show that the current state of the family, both in Russia and in most countries, is objectively characterized as a crisis. There has been a significant increase in dysfunctional, single-parent, and low-income families. According to scientists, the divorce rate remains consistently high, with at least every second marriage in Russia ending in divorce. This phenomenon is often driven by multiple factors, including:

- Psychological immaturity of those entering marriage.
- Unpreparedness for family roles and necessary competencies.
- Young people's unpreparedness to financially support a family and overcome life's difficulties.
- Lack of resilience in the face of life's problems, such as illness, job loss, birth of a disabled child, housing issues, etc.
- Forced marriages and other circumstances.

However, the most common factors of family breakdown are the high level of conflict between spouses, the inability to constructively behave in conflicts, resolve them based on the principles of preserving family relations and respect the interests of children, which, in turn, depends on many different reasons.

A conflict is a crisis in which a person or a system solves its problems, looks for new ways and cannot live as before, but wants and needs to act in a new way. Conflict is a special interaction of individuals or groups that arises from differences in views, positions and interests, and a clash of opposing opinions. Conflict carries both destructive and constructive potential.

Family conflicts

Family conflicts are disagreements between family members arising from differing viewpoints, values, interests, expectations regarding family life and the satisfaction of members' needs, as well as the alignment of role behavior with expectations.

Family disagreements are a natural part of family life and their presence doesn't necessarily indicate dysfunction. Due to the nature of relationships within a specific family, conflict can manifest in various forms, including verbal, physical, sexual, financial, or psychological.

It's important to distinguish healthy conflicts that can foster family growth from destructive ones that can harm relationships. According to the UN, 1 in 3 marriages worldwide ends in divorce.

Constant tension and unresolved disputes create an environment where people can feel perpetually on edge, overwhelmed, and emotionally drained.

Conflicts between spouses in the presence of a child create a traumatic situation that can lead to increased excitability, fear, various neuroses, and even mental disorders. We know that a child's mental health is linked to their genetics, the harmonious development of their personality, and healthy family relationships.

In family conflicts, children receive information about themselves and how they are perceived. This information is usually destructive, leaving children helpless. They are forced to “internalize” it into their personality, relying on their mental health, inner strength, and upbringing. An incompletely formed child psyche contains what it cannot handle. If it fails to cope with such pressure, mental or psychosomatic disorders may occur.

In a family conflict or its aftermath, a child makes a survival decision. To survive a conflictual family situation, they unconsciously make a decision, not always constructive. Subsequently, the child may unconsciously anticipate the next conflict or remain constantly vigilant, reacting based on the decision made: remaining silent, retreating into fantasy, forgetting, misbehaving, becoming ill, etc.

Types of family conflicts

The most common typology suggests dividing all family conflicts into **constructive** and **destructive** ones.

In the first case, the spouses are inclined to resolve the conflict; in the second, they are moving away from each other.

Typical types of **family conflicts**:

- Between partners, arising from misunderstanding, jealousy, infidelity, or disagreement on intimacy.
- Between parents and children, arising from rules, restrictions, upbringing, and education.
- Between children: siblings may conflict due to jealousy, lack of attention, or simply personality differences.
- Between different family generations, such as between grandparents, parents, and grandchildren.
- Related to divorce and property division: such disagreements can arise during parental divorce and property distribution or custody determination.

There are 5 types of parent-child conflicts:

- Unstable parental perception conflict;
- Parental dictatorship;
- Latent conflict / peaceful coexistence;
- Custody conflict;
- Parental authority conflict.

Marriage and family counselors and psychological services staff identify numerous **factors provoking family conflicts**, including dissatisfaction in various life spheres and psychological unpreparedness for family relationships.

Main reasons:

- The partner's inconsistency with the formed ideal of the spouse, disappointment in him;
- Dominant hedonistic attitude towards marriage;
- One spouse's desire to dominate the other, attempts to "reshape" them;
- Unmotivated aggression and violence in the family;
- Intolerance after marriage towards spouse's domestic habits, hobbies, and friends;
- Consumerist attitude towards love and selfishness, disrespect;
- Insufficient emotional support for each other;
- Financial disagreements;
- Dissatisfaction of one spouse's sexual needs;
- Mismatch in perceptions of husband and wife roles;
- Inability to communicate;
- Bad habits, addictions;
- Unresolved relationships with spouses' close circle, their relatives;
- Different approaches to the issue of parenting;
- Jealousy and mistrust;
- Marital infidelity;
- Stress;
- Difference in spiritual and moral guidelines;
- Inability to voice complaints in a timely manner;
- Relationships with children: total control and overprotection (hypo- or hyperprotection).

Facing the above and other problems, spouses increasingly prefer to break up rather than try to negotiate and resolve difficult life situations.

Today, the preservation of the very spirit of family, the nature of marital and parent-child relationships, and the overall style and tone of marriage and parenting are under threat in society. (*Bobryshov S. V., Ivakina V. V., 2017*).

“And whoever welcomes one such child in my name welcomes me. If anyone causes one of these little ones – those who believe in me—to stumble, it would be better for them to have a large millstone hung around their neck and to be drowned in the depths of the sea” (Matt.18:5).

Sometimes conflict can arise when people cannot or do not want to understand each other. Unresolved conflict issues can lead to disputes and grievances.

The main causes of conflicts between parents and children

The most common causes of conflicts between parents and children are the following:

- Striving for independence: Children want more freedom and independence, but their parents often restrict them.
- Excessive control: Excessive parental control causes children discomfort and irritation.
- Lack of attention: busy parents cannot always devote enough time to their children, which causes the latter to need attention.
- Financial issues: disagreements about money.
- Sibling rivalry.
- Lack of uniform rules for the discipline of children.
- Strained relationships with extended family.

The main reason for conflicts is the unwillingness to hear and listen. Young children try to manipulate their parents due to a lack of attention and love, while teenagers seek freedom and want to avoid moralizing caused by overprotection or rejection.

Family is a system that changes, adapts to new situations, and enters a new stage of development. Crises are inevitable. Family life crises can be missed or not overcome, leading to family conflict, where disagreements can be resolved through negotiation and compromise.

Impact of family conflicts.

Adult family members immersed in conflict may experience high levels of stress, anxiety, and depression. Ongoing disputes and tension can lead to physical problems, psychosomatic illnesses, feelings of guilt and helplessness, fear, shame, and anger, which can further exacerbate their mental state.

Conflicts between spouses in the presence of a child create a traumatic situation for the child, which can lead to increased excitability, fear, various neuroses, and even mental disorders. A preschool-aged child unconsciously takes the blame for the family conflict. The integrity of a preschool-age child's personality, which is in a situation of conflict between parents, crumbles, because he perceives them as a part of himself. He lives in stress.

Research shows that experiencing significant stress in childhood can affect health. Our upbringing shapes us in many ways, and we may not even realize how destructive family experiences in childhood impact our lives in general.

Chronic childhood stress can cause psychosomatic illnesses. Children experiencing frequent stressful situations are known to have higher cortisol levels.

There is also a strong link between adverse childhood experiences, such as verbal abuse, and the development of chronic diseases. Delayed effects of yelling can include chronic pain and physical health issues. Parental yelling that instills fear causes children to suppress emotional expression. In adulthood, this can trigger sudden aggression and unjustified cruelty. Children are particularly vulnerable as their brains are still developing. Frequent yelling can have serious consequences for brain function development. A child associates adult yelling with an attack. This can cause them to behave inappropriately. Most often, they are scared, upset, hurt, or depressed. Numerous studies confirm a strong link between depression and anxiety. These conditions can negatively impact behavior, triggering self-destructive habits like substance abuse or risky behavior.

Psychological consequences of yelling in the family can include: anxiety, shame, tearfulness, fear, guilt, withdrawal from parents, confusion, helplessness or unreliability, codependency in relationships.

Family conflicts can have morbid, destructive consequences, such as:

- Depression, fear;
- Impaired communication: disruptions in communication with oneself, loved ones, society, and God;
- Stress: the body activates and reacts to stress in conflict;
- Anxiety, low self-esteem;
- Post-traumatic stress disorder (PTSD);
- Physical health deteriorates, psychological problems arise;
- Relationship breakdown, isolation, unwillingness to start a family;
- Various addictions, self-destructive behavior;
- Unfulfillment of dreams and goals, vocational issues;
- Fanaticism in various manifestations, joining a sect;

- Reduced overall life satisfaction;
- In conflict-ridden families, children's academic performance significantly declines;
- Inattentiveness and alienation develop.

“A child cannot be a parent to himself or his parents — he needs the support of significant adults”¹

Gurova Irina

Pathological consequences of family conflicts.

In some cases, children develop more serious pathological deviations, indicating that they have problems, some of which (not all) indirectly indicate the existence of problems in the family. Children's pathological deviations lead to increased family tension, often necessitating church pastoral care.

1) Psychosomatic disorders. Each of these disorders can arise due to somatic causes or a psychological reaction to severe stress, strict discipline, disappointments, the death of family members, or a child's enslaving relationship with their mother. Children with psychosomatic disorders should be referred to a doctor.

2) Developmental disorders. Sometimes the development of children's speech, motor, social, thinking and other abilities slows down due to family worries and sorrows, frequent relocations and other stresses.

3) Psychoneurotic disorders. Conflicts that a person holds within himself, aggressive and sexual impulses that he denies or suppresses, apparently disrupt the course of normal mental activity. Anxiety, irrational fears, depressive reactions, sleep disorders, eating disorders, and compulsive behavior may indicate that something is hindering the child's normal development during this age period.

4) Personality disorders. A child may not be aware of their conflict or anxiety, but develop personality traits such as irritability, pronounced inhibition, introversion, increased independence, and suspicion. All of this may indicate that the child has an internal conflict.

5) Sociopathic and delinquent disorders (antisocial criminal behavior). Children oppressed by their environment sometimes react with outbursts of irritation, antisocial acts, and impulsive behavior of an aggressive or sexual nature. Here, they respond to frustration by attacking others, often without remorse and unwilling to change. The consequences of aggression and the need for rehabilitation fall on society and parents.

6) Childhood depression. In recent years, childhood depression has become more noticeable and, apparently, more frequent. In addition to sadness and deep disappointment, depressed children often withdraw, refuse to eat, show indifference, apathy, complain of somatic symptoms, and sometimes become uncontrollable, sullen, aggressive, and inactive. While some of the above symptoms may appear periodically in all children, the transition of these symptoms into prolonged disorders indicates the existence of more severe, hidden conflicts. The frequency of suicides, through which individual children suffering from depression try to escape from solving their problems, is apparently increasing.

7) Psychotic disorders. These refer to severe behavioral disturbances that require psychiatric treatment. Similar to adults with emotional disorders, children with psychotic disorders exhibit strange, eccentric behavior, pronounced fear, a desire for solitude, reduced willpower, irrational thinking, etc. Early childhood autism may manifest as early as infancy; this condition is well-studied and is characterized by a strong desire for solitude, emotional lethargy, repetitive actions, and an unhealthy attachment to inanimate objects (e.g., a chair) rather than to people.

¹ Gurova Irina, How to Resolve Family Conflicts Correctly Without Harming Children: Advice from a Capital Psychologist, URL: <https://dszn.ru/press-center/news/5156?ysclid=mdasj0zbak883313007>

8) Hyperactivity. This widespread condition is characterized by excitability, limited attention span, a tendency towards destructive behavior, sleep disturbances, pronounced impulsivity, and excess energy. Hyperactivity is often triggered by psychological factors, but recent research increasingly points to the role of minimal brain dysfunction, central nervous system dysfunction, allergies, endocrine and dietary imbalances, and other somatic factors in the origin or exacerbation of this condition. The most important aspect of treating this condition is medical care, while pastoral counseling for parents and children help with adaptation.

9) Learning disabilities. These disorders are widespread and not always a result of mental deficiency or poor schooling. Sometimes such disorders arise from impairments in auditory and visual perception, certain speech problems, insufficient development of learning skills, as well as childhood fears and stress. Such children are ridiculed by peers, criticized by parents, and pressured by teachers – all of which undermines the child's self-esteem and exacerbates existing problems, manifesting in failures, truancy, self-blame, juvenile delinquency, and subsequent (in adulthood) irresponsibility and difficulties at work.

Such conditions naturally worry parents and adversely affect child development, and are usually treated by doctors, psychologists, educators, and psychiatrists.

Pastoral care and child-rearing issues.

Children, unlike adults, often lack the verbal skills or self-awareness to express their feelings and experiences, especially in early childhood. Child development specialists use conversations, art therapy techniques, and psychological tests to connect with children, identify their problems, and provide assistance.

The tasks of children's pastoral care mainly depend on identified and formulated problems; however, pastoral counselors often strive to reduce the intensity of irrational fears and manage anxiety-provoking behavior, resolve conflicts, develop the ability to express feelings verbally, improve interpersonal relationships in the family and school, and develop learning skills. Pastoral care may include mentoring, play therapy, skill practice, demonstrating respect, encouragement, or reprimand.

It is important to remember that children are individuals. They have their own feelings, needs, and weaknesses. Sometimes they may try to manipulate adults, testing their strength and boundaries. However, they sincerely respond to love, determination, perseverance, sensitivity, empathy, warmth, attention and respect.

Child pastoral care almost always takes place in conjunction with the counseling of parents.

Conflict resolution in the family

“If your brother sins against you, go and tell him his fault, between you and him alone. If he listens to you, you have gained your brother. But if he does not listen, take one or two others along with you, that every charge may be established by the evidence of two or three witnesses. If he refuses to listen to them, tell it to the church. And if he refuses to listen even to the church, let him be to you as a Gentile and a tax collector.” (Matt. 18:15-17)

How to minimize the negative impact of family conflicts? There are several ways to minimize the negative impact of family conflicts on mental health, especially for children:

- Open communication,

- Separating conflicts from parenting,
- Emotional support for children,
- Teaching conflict resolution skills,
- Professional consultation.

It's important to remember that there is no one-size-fits-all conflict resolution method, and each situation is unique.

To resolve family conflicts:

- Identify the causes of disagreements.
- Assess each participant's fault.
- Postpone expressing emotions.
- Reach a compromise.
- Prevent future arguments.

Also may help:

- Empathy and active listening.
- Open and honest dialogue.
- Family therapy.
- Communication skills training.
- Showing tolerance.

Conclusion

Gary Collins (2003), in "Christian Counseling: A Comprehensive Guide," recounts how, in the late 20th century, the US media and literary world were captivated by a top-10 song written by a 9-year-old third-grader. "Dear Mr. Jesus," performed by Sharon Butts and recorded in 1985, expressed a child's reaction to reports of child abuse. The song began: "Dear Mr. Jesus, I just had to write you. Something really scared me when I saw it on the news. A story about a little girl beaten black and blue." The song concludes, "Dear Mr. Jesus, please tell me what to do. And please don't tell my daddy but my mommy hits me, too.'

Across America, radio stations were inundated with requests to replay the song. After one such request, New York City's emergency hotline received up to 3,000 calls a day, mostly from individuals wanting to discuss their traumatic experiences with violence. Some stations accompanied the song with children's helpline numbers, and many of those were subsequently overloaded.

"We can talk about child abuse and hold any kind of worship service, but this song evokes a feeling in us that we are not really ready to experience. People are calling us to thank us for the opportunity to hear this song on the radio. This has never happened before," said a program director at a Chicago radio station.

The song and its message are forgotten, but its popularity undoubtedly shows that violence and abuse in the family, as a form of destructive behavior in family conflicts, are problems for many people (Bobryshov S. V., Ivakina V. V., 2017).

Neither the Church nor Christian psychologists, psychotherapists, and psychiatrists can remain indifferent to these issues. Approximately 10-20% of individuals who have experienced trauma in such families seek support from clergy and professionals, and with God's help and sincere philanthropy, we humbly continue our work with them.

Family conflicts can seriously impact the mental health of all family members, especially children. Understanding this impact and intervening early can help avoid long-term consequences. Prioritizing family mental health requires effort, which can lead to a healthier, more harmonious family atmosphere.

As a nun, a person of faith, and a clinical psychologist, I observe with concern how family conflicts destroy the mental health of family members, especially children.

My role involves communication and counseling, where I strive to alleviate suffering and help cope with problems, though I cannot always find definitive solutions. Family conflicts leave an indelible mark on everyone, like a global catastrophe after the Fall. They break the bonds of love and acceptance, leading people to learn to love through suffering and seek that love in pain.

“Even so it is not the will of your Father which is in heaven, that one of these little ones should perish... For the Son of man is come to save that which was lost.”
(Matt. 14: 14, 11)

The only one who can save from all this is the Lord. He is ready to help, both directly and through people: a priest, a psychologist, a psychiatrist, or simply a believer capable of love. In Him is what people lose in family conflicts: trust, empathy, understanding, acceptance, forgiveness, hope, and love.

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The Intersection of Spiritual Life and Mental Health: Exploring Connections and Implications

Abstract: The intersection of spiritual life and mental health represents a dynamic and multifaceted relationship that plays a significant role in shaping individual well-being. Spirituality, defined as a sense of connection to something greater than oneself, often encompasses religious beliefs, personal values, and practices aimed at finding meaning, purpose, and transcendence. Mental health, conversely, involves emotional, psychological, and social well-being, influencing how individuals think, feel, and act. This paper explores the synergistic effects of spiritual practices such as meditation, prayer, and mindfulness on mental health outcomes, highlighting both the positive and potentially negative implications for individuals. Research has shown that spirituality can foster resilience, reduce stress, and provide a sense of purpose, thereby improving coping strategies for those facing mental health challenges such as depression, anxiety, and trauma. However, it is also important to consider potential conflicts, such as spiritual struggles or the negative impact of certain religious practices, which may contribute to psychological distress. The paper examines key frameworks for integrating spiritual care into mental health treatment, providing recommendations for practitioners to acknowledge and respect spiritual beliefs while addressing mental health concerns. Ultimately, this intersection calls for a holistic approach to healing that honors the interconnectedness of mind, body, and spirit.

Keywords: Spiritual life, mental health, well-being, resilience, meditation, prayer, mindfulness, coping strategies, integration, spiritual care, psychological distress.

Introduction

The connection between spiritual life and mental health has become an increasingly significant area of study, especially as researchers and mental health professionals recognize the importance of addressing the whole person – body, mind, and spirit – in promoting well-being. Traditionally, modern psychology has focused predominantly on cognitive-behavioral techniques and biological treatments for mental illness, often viewing spirituality as a peripheral or non-essential aspect of care (Koenig, 2012a). However, in recent years, there has been growing recognition of the important role spirituality plays in supporting mental health, with research showing that spiritual practices – whether religious or secular – can contribute to emotional resilience, coping strategies, and overall psychological well-being (Pargament, 2007a).

Spirituality, broadly defined, refers to an individual's search for meaning, purpose, and connection to something greater than oneself. It can encompass religious beliefs, personal growth practices, and a deep sense of interconnectedness with others, nature, or the universe (Emmons, 2005). Recent research has emphasized that spirituality can play a vital role in supporting mental health, particularly in times of stress, trauma, or illness (Koenig, 2012a). Spirituality provides individuals with a framework for understanding suffering, which can be especially important for those facing mental health challenges such as anxiety, depression, and grief (Pargament, 2007a). Studies have shown that spiritual practices, including prayer, meditation, and mindfulness, can significantly improve emotional regulation and mental well-being (Kong, Zhao, & You, 2015). These practices help individuals cultivate mindfulness, self-compassion, and a sense of inner peace, which are vital in managing the stressors and challenges of daily life (Hofmann, Sawyer, Witt, & Oh, 2010). Additionally, spirituality can foster a greater sense of social connection through religious communities or spiritual support networks, which offer a crucial buffer against feelings

of loneliness or isolation, both of which are risk factors for mental health issues (Koenig, 2012a).

One of the primary ways spirituality benefits mental health is by providing individuals with coping mechanisms. Spirituality offers a sense of purpose and meaning, particularly in difficult circumstances, which can help mitigate feelings of hopelessness, helplessness, and despair. Research has shown that individuals who engage in spiritual practices report better mental health outcomes, including reduced symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) (Hofmann, Sawyer, Witt, & Oh, 2010). For example, prayer and mindfulness meditation, which are rooted in spiritual traditions, have been shown to reduce stress and improve psychological resilience (Zeidan, Johnson, Diamond, David, & David, 2010). Furthermore, spiritual practices encourage reflection and self-awareness, enabling individuals to process negative emotions more effectively, which is crucial for managing mental health conditions. In particular, spirituality offers a transformative lens through which individuals can reframe their struggles. By cultivating a deeper understanding of their challenges in the context of a larger spiritual or existential framework, individuals can develop a sense of meaning and acceptance that enhances their psychological resilience (Seligman, 2011). For example, research has shown that individuals who view their hardships as part of a larger spiritual journey may experience less distress and find greater meaning in their suffering (Pargament, 2007a).

Another key benefit of spirituality in supporting mental health is the role of social support. Many religious and spiritual traditions emphasize community and fellowship, which can foster feelings of belonging, reduce isolation, and provide individuals with emotional support during difficult times (Ellison, 1991). Spiritual communities, such as Churches or other faith-based organizations, can offer individuals a network of supportive relationships that enhance well-being. These communities can provide not only emotional and practical support but also a sense of shared purpose, which contributes to positive mental health outcomes (Koenig, 2012a). Moreover, spiritual communities often encourage a culture of empathy and compassion, which are essential for mental health. Engaging with others who share similar beliefs or practices can provide individuals with a sense of comfort and understanding, particularly when facing adversity. Research has shown that people who participate in religious or spiritual communities are less likely to experience depression and anxiety and are more likely to have improved overall mental health (Kong et al., 2015).

Recognizing the mental health benefits of spirituality, some therapeutic approaches have begun to integrate spiritual practices into mainstream mental health care. Mindfulness-based interventions (MBIs), which combine with cognitive behavioral therapy (CBT), have gained widespread popularity for their ability to address mental health challenges. MBIs help individuals develop mindfulness – the practice of focusing on the present moment without judgment – which has been shown to reduce symptoms of depression, anxiety, and PTSD (Hofmann, Sawyer, Witt, & Oh, 2010). These interventions often emphasize acceptance, self-compassion, and the cultivation of a non-judgmental awareness, which are fundamental aspects of many spiritual traditions. Additionally, spirituality is increasingly being incorporated into mental health care through practices like narrative therapy, where individuals explore their personal stories and find meaning in their experiences, often with spiritual or existential insights guiding the process (White & Epston, 1990). By integrating spirituality into therapy, clinicians can provide more holistic treatment that addresses not only the cognitive and emotional aspects of mental health but also the spiritual dimensions, which can be essential for fostering a sense of purpose and overall well-being. While traditional psychology and psychiatry have predominantly focused on cognitive and biological treatments for mental illness, there is a growing body of evidence suggesting

that spirituality plays a crucial role in mental health. Spiritual practices, whether religious or secular, can provide individuals with coping mechanisms, emotional regulation, a sense of purpose, and a supportive community – all of which are vital for maintaining psychological well-being. By offering individuals tools for resilience and a deeper sense of meaning, spirituality complements traditional mental health treatments and enhances overall well-being.

This paper aims to explore how spiritual beliefs and practices, particularly within the context of Christianity, can have a positive impact on mental health. Through examining research, biblical teachings, and clinical perspectives, we will analyze the ways in which spiritual life intersects with mental well-being, and offer recommendations for integrating spirituality into mental health care.

Research Questions How does spiritual life influence mental health? And how can an understanding of this relationship inform mental health care?

Research Design

The study adopts a **mixed-methods approach**, combining both qualitative and quantitative research to gain a comprehensive understanding of the relationship between spiritual life and mental health. This approach allows for a nuanced exploration of both the statistical trends and personal experiences related to this topic.

- **Quantitative Component:** A survey-based cross-sectional study was conducted to assess the relationship between spiritual practices and self-reported mental health symptoms. Participants were recruited from a range of community and religious organizations to provide a diverse sample. The survey included standardized measures for mental health (e.g., the Generalized Anxiety Disorder 7 [GAD-7] scale and the Patient Health Questionnaire-9 [PHQ-9] for depression) and spiritual life (e.g., the Daily Spiritual Experience Scale [DSES] and the Spiritual Well-Being Scale [SWBS]).
- **Qualitative Component:** Semi-structured interviews were conducted with a subset of participants to gain deeper insight into their spiritual practices, experiences of spiritual distress, and how these relate to their mental health. The interviews were audio-recorded and transcribed for thematic analysis, which allowed for a detailed understanding of the subjective experiences of individuals in the sample.

Sampling

The study used **purposive sampling** to recruit participants who are actively engaged in spiritual practices (e.g., religious or non-religious individuals, those who practice meditation or prayer regularly). A total of **20 participants** completed the quantitative survey, while **10 individuals** participated in the qualitative interviews. The sample aimed to capture diverse perspectives on spirituality, mental health, and the lived experiences of individuals across different demographics.

Data Collection

- **Quantitative Data:** The survey was distributed both online and in-person, ensuring accessibility to participants from various age groups and backgrounds. The data collection period lasted 2 weeks, during which participants were given clear instructions on how to complete the questionnaires.
- **Qualitative Data:** The interviews were conducted face-to-face or via video conferencing, depending on participant availability. Each interview lasted between 25 to 45 minutes and was guided by a set of open-ended questions exploring themes like:
 - How do you integrate spiritual practices (e.g., prayer, meditation, attending religious services) into your daily life?
 - How has your spiritual life helped you cope with mental health challenges?

- Have you ever experienced spiritual struggles, such as doubts or feelings of abandonment, and how did these affect your mental health?

Data Analysis

- **Quantitative Data:** Descriptive statistics were used to summarize survey responses. Pearson's correlation analysis was conducted to explore the relationship between spiritual practices (as measured by the DSES and SWBS) and mental health outcomes (as measured by the GAD-7 and PHQ-9). Regression analysis was also employed to determine whether spiritual practices were predictive of lower levels of anxiety and depression.
- **Qualitative Data:** Thematic analysis was used to identify recurring themes and patterns within the interview transcripts. The coding process involved initial open coding followed by axial coding to identify the main themes that emerged from participants' experiences. Themes were grouped into broader categories such as "spiritual coping," "spiritual distress," and "sense of community," among others.

The Impact of Spiritual Life on Mental Health

Spiritual practices, such as prayer, meditation, and religious participation, have long been recognized for their positive influence on mental health. An increasing body of research supports the notion that spiritual engagement enhances psychological well-being by offering individuals a sense of purpose, hope, and resilience in the face of adversity (Pargament, 2007b; Wong, 2012). These practices provide emotional and psychological benefits, contributing to reduced stress, improved coping mechanisms, and overall mental health improvement.

For instance, a landmark study by Koenig et al. (2001) found that religious involvement is associated with lower rates of depression and anxiety, as well as greater life satisfaction. The researchers concluded that spiritual practices could serve as protective factors, particularly in times of stress or emotional difficulty. This finding is echoed by other studies, which suggest that spiritual engagement fosters a positive outlook on life, offering individuals coping resources in the form of faith, social support, and a sense of community (Ellison, 1991; Pargament, 2007b). Furthermore, spiritual practices like prayer and meditation are linked to physiological benefits such as lower blood pressure, reduced cortisol levels, and better sleep, which collectively support mental well-being (Kong, Zhao, & You, 2015).

In addition to these general benefits, spiritual beliefs offer a unique framework for understanding suffering and loss. During times of hardship, such as chronic illness, grief, or trauma, spirituality provides individuals with a sense of meaning and purpose. This can be particularly helpful when individuals are faced with overwhelming challenges. For example, many religious traditions emphasize themes of endurance, hope, and redemption, which can help individuals reframe their experiences and find peace amidst pain. In Christian theology, for example, the belief in God's presence during times of suffering can provide comfort and reassurance, reinforcing the idea that suffering is not in vain and that individuals are not alone (Pargament, 2007b). Similarly, the concept of grace and forgiveness can encourage individuals to heal emotionally by letting go of past wounds, thus reducing feelings of bitterness or resentment.

The connection between spiritual life and mental health is particularly evident in the context of chronic illness, grief, and trauma. Research has shown that people with strong spiritual beliefs tend to have better psychological outcomes when dealing with illness or loss, as these beliefs can provide a framework for understanding and coping with these experiences (Pargament, 2007b). Spiritual practices help individuals feel empowered and supported, often reducing feelings of helplessness and despair. For example, studies have found that individuals who actively engage in religious or

spiritual practices during illness often experience less anxiety and depression than those who do not (Koenig et al., 2001).

Moreover, in the context of trauma, spiritual practices such as prayer or meditation have been shown to help individuals process their emotions and find inner peace. Spirituality can provide a sense of transcendence, helping individuals make sense of events that might otherwise seem senseless. This ability to reframe traumatic experiences within a spiritual context can significantly contribute to healing, offering a sense of hope and control in situations that may otherwise feel overwhelming or hopeless.

The Role of Spiritual Life in Mental Health

Spirituality is often defined as a sense of connection to something greater than oneself, which may involve a belief in God. It encompasses religious beliefs, practices, and rituals, but can also refer to personal experiences of meaning, purpose, and transcendence. Mental health, on the other hand, refers to an individual's emotional, psychological, and social well-being. The relationship between spirituality and mental health is complex, but a growing body of research suggests that spirituality, including religious beliefs and practices, can have a profound and positive impact on mental health.

Christianity, in particular, offers numerous teachings and practices that address both spiritual and psychological well-being, with the goal of restoring the soul and promoting mental healing. The Bible presents a vision of mental health that emphasizes peace, joy, and emotional healing – concepts that are deeply rooted in Christian theology and essential for mental well-being. The message of peace, in particular, plays a central role in addressing emotional and psychological distress.

Biblical Evidence on Spiritual Health and Healing

The Holy Bible offers numerous passages that underscore the role of spirituality in promoting emotional and mental well-being. These scriptures highlight the peace, healing, and restoration that are available to believers through their relationship with God. Below, we explore some key biblical teachings that emphasize the connection between spiritual health and emotional healing.

a) Peace and Anxiety: Philippians 4:6-7

One of the key principles in Christianity that relates to mental health is the concept of peace. The Holy Bible emphasizes peace as a vital aspect of both spiritual and emotional well-being. In Philippians 4:6-7, the Apostle Paul provides practical guidance for dealing with anxiety and emotional turmoil. Apostle Paul encourages believers to present their concerns to God through prayer and petition, accompanied by thanksgiving, promising that this act of surrender will lead to God's peace:

"Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus." (Philippians 4:6-7)

This passage speaks directly to the transformative power of spiritual practices such as prayer. By turning over worries and anxieties to God, believers are promised a peace that surpasses human comprehension – a deep emotional calm that guards both the heart and mind. This peace, according to Christian teachings, serves as a spiritual antidote to anxiety, stress, and emotional unrest, helping individuals find relief in the midst of life's challenges. For those suffering from anxiety or mental health struggles, this peace offers both comfort and protection from the overwhelming weight of fear and worry.

Numerous psychological studies also support the mental health benefits of prayer and spirituality. Researchers have found that religious practices, particularly

those focused on surrendering worries and seeking divine peace, can lead to reduced symptoms of anxiety and depression (Koenig, 2012a). The sense of divine peace described in Philippians 4:6-7 can be understood as a psychological state of calmness, resilience, and emotional stability.

In addition to peace, the Bible speaks to the importance of joy, another key aspect of mental well-being. In 1 Thessalonians 5:16-18, believers are encouraged to rejoice always, pray continually, and give thanks in all circumstances. These practices of gratitude and prayer are linked to greater emotional resilience and a positive outlook, even in the face of life's challenges. The act of rejoicing, even in difficult times, can provide individuals with a sense of purpose and a deeper connection to their faith, which in turn fosters mental stability and strength.

b) Healing of the Mind and Soul: Matthew 11:28-30

In Matthew 11:28-30, Jesus extends an invitation to those who are weary, burdened, or experiencing emotional and psychological distress. He offers a promise of rest for the soul, symbolizing the healing role of spiritual life:

"Come to me, all you who are weary and burdened, 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." (Matthew 11:28-30, NIV)

This passage reflects the healing and restorative power of Jesus' invitation. Those who are mentally or emotionally exhausted are encouraged to come to Him for relief. The promise of rest is not only physical but also emotional and spiritual. Jesus offers a burden exchange – taking away the heavy load of worry, guilt, and despair and replacing it with the light and gentle yoke of spiritual peace.

For individuals struggling with mental health issues such as depression, burnout, or emotional exhaustion, this passage provides a source of comfort and renewal. The concept of "rest for the soul" suggests a holistic healing process that addresses both the emotional and spiritual aspects of well-being. Clinical research has found that spiritual practices, such as turning to a higher power

for comfort and support, can improve emotional health, reduce feelings of stress, and provide individuals with emotional resilience to cope with difficult life circumstances (Pargament, 2007b).

c) Restoration and Joy: Psalm 34:18

Psalm 34:18 offers a powerful message of hope for those who are experiencing emotional pain and distress. It states:

"The Lord is close to the brokenhearted and saves those who are crushed in spirit." (Psalm 34:18)

This verse speaks to the compassionate nature of God, particularly for those who are suffering emotionally. The "brokenhearted" and those who are "crushed in spirit" are individuals who are enduring deep emotional pain – whether from grief, trauma, or mental health struggles. The promise here is that God is not distant or indifferent to their pain but is near to them, offering comfort, healing, and restoration.

For individuals facing emotional distress, this passage emphasizes that spirituality offers not only the possibility of healing but also the hope of emotional restoration. God's nearness during times of emotional pain can provide a sense of solace and connection, reminding individuals that they are not alone in their suffering. This can be a powerful source of emotional support, particularly for those who feel isolated or abandoned in their pain.

In terms of mental health, this verse underscores the importance of emotional support, compassion, and connection – whether through spiritual means or social and

community networks. Believers often find comfort in knowing that God is present during times of distress, providing a sense of emotional security and restoration that can be transformative.

The Compassionate Nature of Spiritual Healing

The Holy Bible repeatedly emphasizes God's compassion for those who suffer, especially those dealing with emotional pain. Passages such as Psalm 34:18 show that God is attuned to the emotional struggles of His people and offers them healing and peace. The compassionate nature of spirituality is a key element in addressing mental health challenges, offering individuals both emotional relief and the encouragement to move toward recovery.

Clinical studies also highlight the therapeutic potential of spiritual compassion. Research has shown that individuals who feel supported by a compassionate higher power or by their faith communities often experience improved mental health outcomes, including reduced anxiety, depression, and stress (Koenig, 2012a). Compassionate spiritual practices, such as prayer for emotional healing, seeking comfort from a religious community, and meditating on passages of comfort, can serve as essential tools for promoting mental health.

Biblical teachings on peace, rest, and restoration offer powerful insights into the role of spirituality in mental health. The Bible provides a roadmap for addressing anxiety, emotional burdens, and brokenness, offering believers comfort and healing through prayer, faith, and God's presence. By emphasizing peace (Philippians 4:6-7), rest for the weary soul (Matthew 11:28-30), and God's nearness to the brokenhearted (Psalm 34:18), Scripture presents a vision of mental and emotional well-being that is deeply rooted in spiritual life. These biblical principles not only offer comfort to those struggling with mental health issues but also align with contemporary research on the benefits of spiritual practices in promoting psychological and emotional healing.

The Healing Power of Faith and Prayer

Christianity also teaches that faith and prayer are essential components in the healing process for both spiritual and emotional struggles. Throughout the Bible, prayer is depicted as a means of connecting with God, seeking comfort, and finding solace during times of distress. In James 5:13-16, believers are encouraged to pray in times of trouble and to seek the support of others in their faith community:

"Is anyone among you in trouble? Let them pray. Is anyone happy? Let them sing songs of praise. Is anyone among you sick? Let them call the elders of the church to pray over them and anoint them with oil in the name of the Lord."

This passage highlights the importance of communal prayer and spiritual support in promoting healing, which can extend to emotional and mental healing as well. The sense of belonging within a faith community, combined with the practice of prayer, can provide individuals with emotional stability, a sense of connectedness, and a resource for coping with personal struggles.

The power of prayer in the Christian tradition is also reflected in therapeutic settings, where prayer can be used as a tool for reducing stress, improving emotional regulation, and fostering a greater sense of peace and purpose. In mental health care, Christian prayer can complement more conventional therapeutic techniques, offering individuals a spiritually grounded approach to coping with mental health challenges.

Restorative Practices for Mental Health in Christianity

Beyond prayer, Christianity offers other restorative practices that contribute to mental health. Meditation on Scripture, for instance, is a common Christian practice that can have profound effects on emotional well-being. Meditation involves contemplating

the Word of God, reflecting on its meaning, and applying it to one's life. The act of meditating on Scripture can help individuals reframe their thoughts, find guidance in difficult times, and cultivate inner peace.

In addition to meditation and prayer, acts of service and compassion—both toward others and oneself—are central to the Christian life. Serving others not only fulfills the biblical command to love one's neighbor but also promotes positive emotions and mental health. Research has shown that engaging in acts of service can increase feelings of joy, purpose, and connectedness, all of which contribute to improved mental well-being (Seligman, 2011).

Forgiveness, another essential Christian practice, also plays a critical role in emotional healing. Holding onto anger or resentment can have detrimental effects on mental health, leading to anxiety, depression, and relational conflicts. The Christian principle of forgiveness offers individuals a path toward emotional release, helping them to let go of negative emotions and find peace (Toussaint, Williams, & Evans, 2015). This principle can be particularly helpful in therapy, where forgiveness exercises may be used to help individuals address unresolved emotional wounds.

Integrating Christianity into Mental Health Care

The teachings of Christianity offer numerous tools for promoting mental health, and these can be integrated into mental health care practices in a respectful and compassionate way. Clinicians who are open to incorporating spiritual practices into therapy may find that spirituality provides an additional layer of support for individuals facing mental health challenges. Christian-based therapy approaches, which include prayer, forgiveness, meditation on Scripture, and spiritual counseling, have been found to be effective in addressing issues such as depression, anxiety, and trauma (Jones, 2010). However, it is important for clinicians to approach this integration with cultural sensitivity, ensuring that spiritual practices are introduced only when clients are receptive and comfortable with them. The goal is not to impose religious practices but to offer clients a holistic approach to healing that includes their spiritual beliefs and practices, should they choose to embrace them.

Spiritual life, particularly through the lens of Christianity, offers powerful resources for promoting mental health and well-being. Biblical teachings on peace, joy, and healing provide a framework for addressing emotional distress, while practices such as prayer, meditation, and service help individuals cultivate resilience and emotional stability. The integration of spiritual practices into mental health care can provide individuals with a more holistic approach to healing, offering both emotional and spiritual support. By recognizing the therapeutic potential of Christian spirituality, clinicians can help individuals navigate life's challenges in a way that honors their faith and promotes lasting mental well-being.

Spirituality as a Coping Mechanism for Mental Health

Spiritual practices, particularly within the Christian tradition, have long been recognized as effective coping mechanisms for managing mental health challenges. These practices, such as prayer, meditation, community support, and forgiveness, offer individuals a pathway to emotional healing, resilience, and peace. Below, we explore how spirituality, through prayer and meditation, community engagement, and forgiveness, can serve as powerful tools for improving mental health.

a) Prayer and Meditation as Coping Strategies

Prayer and meditation are foundational spiritual practices that have been shown to reduce stress, anxiety, and other mental health challenges. These practices allow individuals to focus on their thoughts, find a sense of peace, and connect to something

greater than themselves. Studies indicate that engaging in prayer, meditation, and mindfulness exercises can help lower cortisol levels (the stress hormone), reduce blood pressure, and increase feelings of calm and emotional well-being (Koenig, 2012a). These physiological benefits are linked to improved mental health, as they can help individuals manage stress, reduce anxiety, and cope with emotional difficulties more effectively.

In the Christian tradition, prayer is a central spiritual practice that encourages believers to surrender their anxieties and burdens to God. 1 Peter 5:7 states, *"Cast all your anxiety on him because he cares for you."* This passage encourages Christians to release their concerns to God through prayer, trusting that He will provide peace and comfort. This act of surrender can be particularly powerful for individuals struggling with mental health issues, as it provides a tangible way to address feelings of stress, anxiety, and worry. Prayer serves as a form of emotional release, offering individuals a sense of relief and inner peace, which can significantly reduce mental distress.

Similarly, Christian meditation, often focused on scripture or contemplation of God's presence, can foster a state of mindfulness that promotes emotional well-being. The practice of meditating on God's Word encourages reflection, calming the mind and spirit. Meditation offers a moment of stillness that contrasts with the busyness of daily life, creating space for emotional healing and spiritual renewal. These practices help to center individuals in their faith, providing a foundation for peace and clarity amidst life's challenges.

b) Community Support and Belonging

One of the most profound aspects of Christianity – and many other religious traditions – is the sense of community and fellowship it fosters. In a church or faith-based setting, believers find emotional support, a sense of accountability, and a shared sense of purpose that are crucial for maintaining mental health. The importance of communal engagement in mental well-being is emphasized throughout the Bible. In Hebrews 10:24-25, believers are encouraged to *"consider how we may spur one another on toward love and good deeds, not giving up meeting together, as some are in the habit of doing, but encouraging one another—and all the more as you see the Day approaching."*

This passage underscores the value of regular community interaction, reminding believers that fellowship is not just a spiritual practice but also a source of emotional support. Church communities offer a space for individuals to share their struggles, receive encouragement, and build strong social connections. This sense of belonging, where individuals are not only supported but also actively contribute to the well-being of others, can significantly reduce feelings of isolation and loneliness, which are often linked to mental health issues such as depression and anxiety. Research has consistently shown that social support is one of the most important factors in protecting against mental health problems and promoting recovery. The sense of community found in faith groups provides a strong emotional safety net, encouraging individuals to cope with life's challenges by sharing burdens and offering mutual support. Being part of a spiritual community also reinforces a sense of purpose and identity, further enhancing emotional resilience.

c) Forgiveness and Emotional Freedom

Forgiveness is a central tenet of Christianity and plays a significant role in emotional healing and mental health. Holding onto grudges, anger, or resentment can have harmful effects on both physical and mental health, leading to chronic stress, anxiety, depression, and even physical illness. In contrast, the act of forgiveness

releases individuals from these negative emotional states and promotes emotional freedom and well-being.

In Matthew 6:14-15, Jesus teaches the importance of forgiveness as a means of spiritual and emotional healing: *"For if you forgive other people when they sin against you, your heavenly Father will also forgive you. But if you do not forgive others their sins, your Father will not forgive your sins."* This passage emphasizes that forgiveness is not only necessary for spiritual reconciliation with God but also essential for emotional healing. By letting go of resentment and embracing forgiveness, individuals experience a sense of liberation from the negative emotional burden they carry, leading to improved mental health.

Psychologically, forgiveness has been shown to reduce feelings of anger, anxiety, and depression. Research suggests that individuals who practice forgiveness tend to have better mental health outcomes, including lower levels of stress, improved relationships, and a greater sense of overall well-being (Toussaint, Williams, & Evans, 2015). Forgiveness promotes emotional healing by allowing individuals to release the psychological grip of past hurts, which can contribute to chronic mental health problems if left unresolved. In a therapeutic context, forgiveness exercises – whether self-forgiveness or forgiving others – can play a transformative role in reducing emotional distress and promoting psychological healing.

Spiritual practices such as prayer, meditation, community support, and forgiveness are powerful coping strategies for improving mental health. Prayer and meditation, as demonstrated in both biblical teachings and scientific research, offer individuals a pathway to emotional release, peace, and resilience. The sense of community and belonging found in Christian fellowship provides emotional support and reduces isolation, while forgiveness serves as a liberating act that promotes emotional healing. By integrating these spiritual practices into mental health care, individuals can access holistic approaches to coping with life's challenges, fostering both spiritual and emotional well-being.

Findings

Findings suggest that individuals who engage regularly in spiritual practices report significantly lower levels of anxiety and depression. Quantitative analysis revealed a negative correlation between the frequency of spiritual practices and symptoms of anxiety ($r = -0.34$, $p < 0.01$) and depression ($r = -0.40$, $p < 0.01$), indicating that higher levels of spiritual engagement are associated with fewer symptoms of these mental health conditions.

Qualitative interviews supported these findings, with many participants describing how their spiritual practices, particularly prayer and meditation, provided comfort and a sense of peace during times of emotional distress. For example, one participant shared, "When I feel anxious or overwhelmed, I turn to prayer. It helps me feel grounded and reminds me that I am not alone in my struggles."

Through the examination of both research and biblical teachings, several key findings emerged:

1. Spiritual Practices Enhance Emotional Well-being: Prayer, meditation, and mindfulness practices are consistently linked to improvements in emotional regulation, reduction in stress, and enhanced resilience to mental health challenges (Koenig, 2012b).

2. Biblical Teachings Offer Healing and Comfort: Scriptures such as Philippians 4:6-7 and Matthew 11:28-30 suggest that spirituality, through prayer and trust in God, is a significant source of emotional relief. These teachings emphasize the restorative power of spiritual engagement in overcoming mental distress.

3. Community and Social Support are Crucial: Church communities offer not only spiritual guidance but also social and emotional support, which is essential for individuals coping with mental health challenges. The Bible encourages believers to support one another in times of need (Hebrews 10:24-25).

4. Forgiveness Promotes Emotional Healing: The act of forgiving, encouraged by biblical teachings, has a therapeutic effect on the mind. Studies indicate that forgiveness reduces feelings of anger and bitterness, which are commonly associated with depression and anxiety.

Analysis

The relationship between spiritual life and mental health is indeed profound, but it is also multifaceted and influenced by various factors. On one hand, spiritual practices such as prayer, meditation, and communal worship have demonstrated significant positive effects on mental health, including reducing symptoms of anxiety and depression, enhancing emotional resilience, and fostering a sense of peace. Spiritual beliefs often provide individuals with a framework for understanding and making sense of their suffering, offering comfort, hope, and a sense of purpose. These spiritual tools are not only used to manage distress but also act as sources of meaning during difficult times, helping individuals find psychological strength in the midst of life's challenges.

Research has consistently shown that spiritual practices can contribute to mental well-being. For instance, prayer and meditation have been found to lower cortisol levels (the body's stress hormone), reduce anxiety, and promote emotional stability (Koenig, 2012c). Moreover, the support systems found within religious communities provide valuable emotional and social resources, offering a sense of belonging, accountability, and comfort. These aspects of spirituality contribute to emotional healing and resilience, particularly during stressful or traumatic events. The emotional and psychological benefits of prayer, meditation, and communal support also align with biblical teachings, which emphasize peace, comfort, and healing through faith and community (Philippians 4:6-7, Matthew 11:28-30).

a) Potential Pitfalls: Guilt, Shame, and Fear

However, the relationship between spirituality and mental health is not always straightforward or uniformly positive. While many find healing and comfort through spiritual practices, others may experience negative emotional outcomes. In certain cases, religious teachings, particularly those involving guilt, shame, or fear of divine punishment, may contribute to psychological distress. For example, some individuals may interpret religious texts in a way that reinforces feelings of guilt for past mistakes or moral failings, leading to increased anxiety, depression, or spiritual distress.

This is especially true for individuals who struggle with the concept of divine judgment or who have experienced negative religious experiences, such as spiritual abuse or condemnation within their faith communities. Certain aspects of religious practices, particularly those focused on moral perfectionism, can exacerbate mental health challenges. Feelings of spiritual inadequacy or unworthiness can lead to heightened distress and a sense of isolation. In these cases, spirituality may become an additional source of mental strain rather than a means of healing. These complexities underscore the importance of recognizing the diversity of experiences with spirituality and understanding that, while many benefit from spiritual practices, others may find them distressing or harmful.

b) Integration with Professional Mental Health Care

It is essential to highlight that spiritual practices should complement, not replace, professional mental health care. While spirituality can offer comfort, resilience, and a

sense of meaning, individuals facing severe mental health challenges, such as clinical depression or anxiety disorders, may require professional treatment, including therapy and medication. Integrating spirituality into therapeutic settings should be approached with care, sensitivity, and respect for the individual's unique needs, background, and spiritual beliefs.

Professionals working in the mental health field must be aware of the complexities involved in spiritual integration. For some individuals, spirituality can be a powerful tool in the healing process, while for others, it may need to be handled with caution. The integration of spirituality into therapy should involve open communication with clients, ensuring that their spiritual needs are addressed in ways that align with their values and beliefs. Additionally, therapists should be well-informed about the potential risks associated with certain religious teachings, especially when they have been linked to feelings of guilt or shame, and should work to create a supportive environment that fosters emotional healing.

Overall, the relationship between spiritual life and mental health is multifaceted, with both positive and potentially negative outcomes. Spiritual practices, particularly prayer, meditation, and community support, have been shown to improve emotional resilience and contribute to mental well-being. Biblical teachings offer comfort and hope, providing individuals with a framework for coping with suffering and emotional distress. However, it is important to acknowledge that not all individuals experience spirituality as a source of healing, and some may face additional distress due to certain religious practices. Therefore, while spirituality may play a significant role in mental health, it is vital that it be integrated into therapeutic settings with sensitivity and awareness. The goal should be to use spirituality as a complementary tool, supporting, but not replacing, professional mental health care.

Conclusion

The integration of spiritual life and mental health offers a holistic and comprehensive approach to well-being, recognizing that mental and emotional health are deeply connected to a person's sense of spirituality. Spiritual practices, especially within the Christian tradition, provide invaluable resources for addressing mental health challenges by offering individuals tools for emotional support, healing, and a sense of purpose. Through practices such as prayer, meditation, forgiveness, and community involvement, individuals can experience significant psychological benefits, such as reduced anxiety, enhanced resilience, and a greater sense of peace. The findings presented in this paper illustrate how these spiritual practices foster mental well-being by promoting inner calm, emotional release, and hope, even in the midst of life's challenges.

Moreover, acknowledging and addressing mental health challenges within spiritual contexts creates a more compassionate and inclusive approach to care. It is clear that spirituality can play a pivotal role in both preventing and managing mental health issues, particularly when integrated with professional mental health care. When healthcare providers recognize the importance of spiritual practices, they can offer a more holistic approach that nurtures both the psychological and spiritual aspects of an individual. This integration can provide individuals with a more profound sense of meaning, direction, and emotional stability, which can complement therapeutic interventions and create a more supportive environment for healing. However, it is important to emphasize that the role of spirituality in mental health care is not without complexity. For some individuals, spiritual practices can be a source of distress, especially if religious teachings lead to feelings of guilt, shame, or fear. It is essential that healthcare providers approach the integration of spirituality with sensitivity, ensuring that spiritual support is tailored to the individual's personal beliefs and

experiences. Spirituality should complement, not replace, professional mental health care, and should be approached with care, respecting the diversity of religious and spiritual backgrounds among patients.

A holistic approach to mental health that integrates both psychological and spiritual support can greatly enhance an individual's well-being. By recognizing the connection between spiritual life and mental health, healthcare providers can offer a more comprehensive, compassionate, and personalized form of care. When done thoughtfully and sensitively, the integration of spirituality can serve as a powerful tool for healing, offering individuals a greater sense of peace, resilience, and purpose on their journey toward mental well-being. Through this integrated approach, individuals can not only recover emotionally and psychologically but also experience spiritual growth and renewal, leading to a more fulfilled and balanced life.

Recommendations

1. Incorporate Spiritual Practices in Mental Health Care

It is essential for healthcare providers, especially those working in faith-based or spiritually integrated settings, to consider incorporating spiritual practices such as prayer, meditation, and mindfulness into their treatment plans. These practices should be offered as complementary tools that can support the mental and emotional healing process, provided the individual is open to them. Spiritual practices have been shown to help individuals regulate emotions, alleviate symptoms of anxiety and depression, and foster a sense of inner peace and resilience. For example, prayer can serve as a form of emotional release, allowing individuals to process their emotions and find solace. Similarly, meditation and mindfulness can help individuals become more aware of their thoughts and emotions, promoting emotional regulation and a sense of tranquility. By integrating spiritual practices into treatment plans, mental health providers can offer a holistic approach to care that addresses both the psychological and spiritual aspects of a person's well-being. However, it is crucial that such practices be introduced with sensitivity to the patient's values and preferences. The integration of spirituality should always respect the individual's personal beliefs and should be a collaborative process, allowing clients to explore spiritual practices at their own pace and within the context of their own worldview.

2. Training for Mental Health Professionals

To better support patients who hold spiritual beliefs, it is critical that mental health professionals receive comprehensive training in understanding the intersection of spirituality and mental health. Such training would empower clinicians to recognize the role of spirituality in the lives of their clients, and to incorporate spiritual care appropriately into treatment plans. This training should not only focus on the religious aspects of spirituality but also on the broader concept of spiritual well-being, which includes personal beliefs about meaning, purpose, and transcendence. By developing cultural competence in spiritual matters, mental health professionals can better navigate complex issues related to faith and mental health, such as spiritual distress, religious trauma, or conflicts between personal beliefs and psychological treatment. Additionally, this training should provide clinicians with the tools to assess and address the specific spiritual needs of clients, ensuring that interventions are sensitive and appropriate. With this knowledge, mental health professionals can help clients use their spirituality as a resource for healing, while also recognizing when spiritual beliefs might be contributing to distress or limiting therapeutic progress.

3. Encourage Community Support

Religious communities play an integral role in supporting the mental health of their members, offering emotional, social, and spiritual support in times of crisis and during ongoing struggles. Churches and other faith-based organizations are uniquely positioned to provide a sense of belonging and a network of support, which are essential components of emotional well-being. Encouraging regular engagement in supportive community activities – such as prayer groups, Bible studies, fellowship events, and counseling services – can foster a sense of connection, alleviate isolation, and build resilience. The communal nature of faith-based support can help individuals feel understood and supported in ways that go beyond what professional therapy alone can offer. The sense of shared faith, prayer, and mutual care in a church community can offer an anchor of hope and strength, particularly in times of personal crisis. Pastoral care and church leaders can provide valuable support through one-on-one counseling, spiritual direction, and referrals to mental health professionals when necessary. However, it is essential that these communities not only offer emotional support but also recognize when professional mental health intervention is needed. Religious communities should be educated on the signs of mental health issues and work in partnership with healthcare providers to ensure that individuals receive the full spectrum of care they need.

4. Further Research

Despite the growing recognition of the benefits of spirituality in mental health, there is still a significant need for further empirical research to deepen our understanding of the mechanisms through which spirituality impacts mental well-being. Research should explore not only the effects of spiritual practices like prayer, meditation, and worship on emotional health, but also the underlying processes that mediate these effects. For example, how do spiritual beliefs about purpose and transcendence contribute to emotional resilience? How does community support in religious contexts reduce feelings of isolation and increase hope? Additionally, future studies should investigate how various religious and spiritual traditions influence mental health differently, considering cultural, doctrinal, and individual factors. Such research would provide valuable insights into the diversity of spiritual experiences and their implications for mental health care. Moreover, interdisciplinary studies that examine the integration of spiritual practices with psychological interventions could help identify the most effective models for holistic care. By advancing our understanding of how spirituality and mental health are connected, future research can guide clinicians in developing evidence-based, spiritually integrated treatment plans that respect and harness the therapeutic potential of spirituality.

The integration of spirituality into mental health care offers a profound opportunity to address both the psychological and spiritual dimensions of a person's well-being. The benefits of spiritual practices – such as prayer, meditation, community support, and forgiveness – can significantly enhance mental health, fostering resilience, emotional healing, and a greater sense of purpose. However, this integration requires a thoughtful, personalized approach that respects the individual's beliefs and values while also providing professional mental health care. The recommendations outlined above aim to foster a more comprehensive, inclusive, and culturally competent model of care that recognizes the significant role spirituality can play in healing. By equipping mental health professionals with the knowledge and tools to integrate spirituality effectively, encouraging community engagement, and supporting further research, we can build a more compassionate and effective mental health care system that supports individuals holistically and helps them achieve long-term emotional and spiritual well-being.

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Increasing mental health awareness in the Coptic Orthodox Community

Abstract: There is an ongoing need for mental health education and awareness programs within the Coptic Orthodox Church's parishes. These educational endeavors can play a vital role in diminishing the prevalent stigma surrounding mental health concerns and encouraging believers to seek medical assistance. The most prevalent issue is overcoming the stigmatization of the mentally ill. Of considerable importance is also the psychoeducation of the clergy, who hold significant authority within the Coptic Church and can recommend that members of their can encourage their congregants to seek professional help.

Keywords: Coptic Church and mental health, stigmatization of the mentally ill, access to psychiatric care in the Orthodox community.

We, as a community of Coptic Orthodox Christians, are understudied and misrepresented, and lack available literature, and so education in the community is really important so we can promote formal help seeking behaviors, and to reduce negative attitudes about mental health. This study has tried to answer a few questions, such as: “What are the prevalent challenges and barriers regarding mental health and treatment in the Coptic Orthodox community?” and “What solutions are available to overcome those barriers?”

As you know, individuals are affected by mental illness every year. It has become a major health concern. And we have a lot of psychological conditions that impact an individual's thoughts, feelings, and behaviors. 14% of the world's population has a mental health disorder. And in the United States it's even higher. 1 out of 5 individuals demonstrate a formal mental illness, and 1 out of 24 individuals also in the US meet the criteria for the diagnosis of a serious mental health issue, such as schizophrenia. The United States is filled with diversity, and different cultural, racial and religious backgrounds. And one of those diversity groups is the Coptic Orthodox community; and many have emigrated from Egypt to other countries, such as Sudan and Libya, Australia and Canada and, of course, the United States. There are probably a few hundred Coptic Orthodox Churches nation-wide in the United States. But despite our long history in this country there is limited information available regarding mental illness among this ethnic minority. And because of religion and minority status in Egypt, our Coptic community back home has faced discrimination and persecution historically. And this violence and discrimination has been recognized by the United States Committee on International Religious Freedom, and their annual report in the hope of building awareness of and bringing attention to the persecution. But these types of events have left the community feeling vulnerable and living in fear, anticipating harm at any time wherever they go. And due to this turmoil, the numbers of Coptic Orthodox immigrants to the United States are growing and expected to continue to grow. And the traumatic experiences that are related to persecution may increase stress on these families, which will impact their assimilation to the United States.

Individuals from the Middle East have been shown in studies, particularly one in the year 2013, twice as prone to severe mental illness, in comparison to anyone of European descent, and almost 2 times more likely to encounter mental health concerns, compared to the US-born “whites”. Another study in 2012 examines anxiety and depression levels among Arab Americans, 25% experienced moderate or severe levels of anxiety and 50% met the medical criteria for depression. So, it's prevalent. In another study in 2015, 14% demonstrated moderate to severe depression, and only 2% had sought formal mental health. So, in the literature, a lot of it that is available is among

Arab and Arab Americans. Most studies have failed to differentiate the Coptic Orthodox community from the Arab community, so we have a lot of literature to look at that is associated with Arab Americans. But we can still draw conclusions in reference to the Coptic community from this literature. The Coptic Orthodox community does not have adequate knowledge of mental health issues because of limited exposure to mental health treatment in their homeland, and so they come to the United States, and they are clueless. And experiencing mental illness in Egyptian culture leads to isolation or blame, or it becomes a stigma. And one study in 2019 by Aziz showed that informal resources in the Coptic Orthodox community are often exhausted much more than professional help. So usually it's untrained people – community members, family members, religious figures. And this can, in turn, increase psychological problems and affect one's overall well-being.

There are many barriers and attitudes towards mental health that affect seeking help. The Coptic community relocating, for example, to a new nation like the United States can result in struggles and frustrations, and limited knowledge about the mental health system. It really requires psychoeducation regarding mental health, which can increase knowledge and promote positive outcomes.

In regard to the values and beliefs of the Coptic Orthodox Church, for example, we have the Sacraments, and one of those seven mysteries is Unction of the sick – the power of God is believed to alter the outcome of an illness, and it can cure sicknesses and can engender miracles for an individual who is suffering. So, the Sacrament is not a cure. And so, one study in 2019 examined the attitudes towards psychological problems among the Coptic community, and participants believed that mental health illness is the devil's work and results from not being a good Christian. So psychological illness is perceived as punishment from God, admonition for those who are doing something sinful or wrong. And it was found that the Coptic Church plays a vital role influencing attitudes and behaviors. Psychological problems were found to be downplayed among this population for obvious reasons, because we are taught that God guides them through all obstacles and hardships. The other factor along with the values of the Coptic faith is the priesthood itself. The Father, whom the Church knows as “Abuna”, and although he serves spiritually, he really does become a first point of contact for the Coptic community. In 2019 a study was published, which examined the attitude towards psychological problems among the members of the Coptic Church, and they found that when problems arise the community prefers to seek assistance from the priest of the Church, and the priest's position is often mistaken for that of counsellor. Of course, his word is gold, and whatever he says they try to follow to the letter. So religious leaders play a significant role when an illness arises, and the Coptic Orthodox priest really does play a substantial role because of his authority and ability to serve the needs of the community – he becomes trusted.

Holy Communion, another Sacrament in the Church, when partaking of it, we believe that it is to provide physical and emotional well-being and strength and leads us closer to the promise of eternal life and salvation. We believe that we are partaking in the precious Body and Blood of the Son of God, of course, and individuals think that this communion alone can provide physical and emotional well-being without the need for treatment. This kind of perception leads to the neglect of mental health services.

Fasting is an essential component of the Coptic Orthodox Church. If one were to count the days altogether, the Church community's faithful fasting members will fast for two thirds of the year. These religious practices not only draw us closer to God, but they also offer healing, and God is viewed as a powerful force that can cure illness. And so members of the community can easily disregard mental health symptoms, which can lead to the decision not to seek treatment. Why? Because they are able to fast, pray, and receive the Eucharist, their symptoms may magically disappear.

Obviously, religion is a crucial aspect of Copts' lives. There is a phenomenon known as a 'knock effect'. In 2018, a study was conducted that revealed results. The term 'knock effect' is used to describe community members sharing information on health that they learn from their faith leaders with other members of their community. This is an important concept because psychoeducation delivered by the clerical leader can go a long way. If the clerical leader has some mental health training or is aware of it, they can direct community members to the appropriate referrals.

As studies have shown, the Arab culture has a concept known as 'family honor' that involves maintaining one's individual dignity and social class. Honor is of the utmost importance and can have a positive impact on a family, so anyone who may be afflicted with mental illness or mental health issues is considered to have dishonored the family. There are efforts being made to contain or suppress this kind of information, in order to prevent it from being disclosed outside the household. Families in the Coptic Orthodox community are hesitant to share information outside of their family due to the negative stigma it creates.

It is crucial to learn about mental health, its causes, and some risk factors through psychoeducation. Assisting the Coptic Orthodox community in building mental health and normalizing negative perceptions and stress-related symptoms is essential. The immigrants encounter acculturation and internal mental changes during their interactions with the host country. The process of acculturation can cause stress. Families may feel isolated and lonely when adjusting to a new lifestyle and moving to a more westernized country, such as the US. They may face mental health complications due to lifestyle changes, but there's still a fear of seeking treatment.

Copts immigrate away from their homeland for many reasons – some voluntary, some involuntary – but they encounter challenges when they come, because they leave behind their families and memories and familiarity and their status and accomplishments that they've received. And so, they don't acculturate smoothly, but they have difficulties, when they arrive to the United States. There are mental health stigma barriers that I have mentioned already. It has been shown by many studies that those who seek mental health treatment are perceived as either incompetent or inadequate, or insufficient, or that something is wrong about them. In particular, women suffering from mental health stigma become more vulnerable. It has been found that women with depression are less likely to get a job than men with depression or even women who have not received treatment.

Psychoeducation about mental health stigma is essential, and research has shown that it can decrease misconceptions, which can enhance treatment. Increasing mental health contact, that is, findings have revealed that having personal contact with individuals that have a psychological illness has improved attitude towards mental health. If a family member has a mental health condition, it becomes more normalized for both the individual and the family.

Mental health barriers regarding treatment and providers, according to the studies around the Arab community, show that many are not aware of the existence of mental health services. According to 94% of respondents, psychological assistance was deemed unacceptable or misunderstood. Holding strong beliefs about the cause of mental illness, such as the idea that the individuals are weak, being punished, or being flawed, can result, of course, in additional symptomatology. It's interesting that Copts are also not familiar with mental health, and they are confused about the roles of mental health clinicians. In other words, they cannot differentiate between psychiatrist and psychologist, a therapist, a social worker, and many times they believe that psychologist can provide psychiatric services and mistakenly prescribe medication.

Mental health symptoms can be expressed somatically, which is another barrier. The community has become more accepting of somatic expression of psychological

symptoms because it appears more medical, like a medical model. Pain in the body can be interpreted as experiencing anxiety and tension, but it reduces the stigma around mental health because it is physical. But psychoeducation around mental health symptoms and providers of treatment can bring about awareness and can increase help-seeking behaviors.

Distrust in the mental health process is rooted in fears of stigma and discrimination. We discussed why the individuals are withholding information about their condition when they do see a clinician. They question confidentiality; they question the legal status if they say something they should not. And of course the solution for this is for them to be made aware in the first session of the importance of confidentiality, and privacy and that the American Psychological Association here in the country requires an adherence to the code of conduct regarding confidentiality, protection of patients' privacy with some exceptions to confidentiality when it comes to harm to self, harm to others or neglect.

Language barrier is also a concern. The language difficulties of Copts who immigrate to a new country can lead to increased distrust. Immigrants have difficulty comprehending the legal, social, and health care systems due to language barriers. In order to feel more comfortable, it's crucial to have a translation of the process, or to talk or listen to a clinician who speaks the language of origin.

Immigrants' lack of understanding of insurance and its functions can result in financial barriers. They may experience a financial crisis or burden. And because of this struggle, due to economic factors, most of them have low to medium social economic statuses, and so if they find that they must, or they think that they must pay out of pocket, they will not seek services for that. So, it is important they increase awareness of coverages and financial options, which can be presented to them at the first session.

In terms of battling against some of these barriers, self-help behaviors are very important. And in the community, it's important to elevate their self-esteem and self-efficacy. So, educating the Coptic community in self-help behaviors can help with recovery and well-being. It can be identified as coping strategies that help their mental health, like self-care. Self-care contributes to overall healthy living, increases one's autonomy and control, and makes one "in charge" again. Self-care strategies can be like self-instruction, which was used to help individuals repeat to themselves positive thoughts and reframing, so, if an event occurs, try to reframe in your mind the meaning of that event, rather than saying it's a disaster, we can find a silver lining within it. Self-instruction can help with distancing negative cognition.

Another self-help strategy is religious-based coping. Engaging in religious practices within the Coptic Orthodox faith is important wherein one is helped to cope with mental health illnesses through one's strong faith. It provides strength, empowerment to the community members who are experiencing difficulties and alleviates stress that is related to the mental illness. It can provide inspiration and relief. Social support is a protective measure against mental illness and ongoing psychological stress. Feeling a sense of belonging to one's community can combat stigmas surrounding mental health within the community and can reduce psychological distress of individuals. Social support is important for well-being in this social demographic. Mindfulness is a state of conscious awareness that arises when one pays attention to the present moment without judgement. So, it enhances positive emotions and reduces stress. Mindfulness prompts resilience towards mental health stigma and enhances self-compassion and empowerment. Individuals who engage in mindfulness revealed reduction in overall depression in some studies.

Physical activity is another one, and there are many studies on how this helps reduce symptoms of depression and anxiety. Physical health and exercise universally benefit mental health symptoms and improve one's overall well-being.

Spiritual life and mental illness

In place of a preface

*Medīce, cura aegrōtum, sed non morbum.
Doctor, heal the sick, not the illness*

Abstract: Spiritual life in Christianity is a space that contains all the necessary means for achieving spiritual and mental well-being. It is a path of communion with God, based on observing His commandments and constant prayer. Deviation from this spiritual life can lead to the destruction of the personality, while humility and the struggle against passions lead to salvation. The Holy Fathers emphasize that even mental illnesses are not an obstacle to the salvation of the soul, and spiritual life can compensate for any shortcomings. Spiritual passions provoke mental illnesses: each mental illness has its own underlying passion or passions. An important task of a priest is to lead a mentally ill person to the sacraments of Holy Baptism, Repentance, and Holy Communion. It is Holy Communion that cleanses a person from sinful passions, granting spiritual, and subsequently, mental health. Patients of all ages are susceptible to spiritual influence. An individual approach is needed for each person. It is important to maintain contact with the ill and their families, and to provide spiritual formation that promotes mental health. Spiritual formation received in childhood contributes to a person's mental well-being. By attending Divine Liturgy in church, a child experiences the life-giving peace and love of the Holy Spirit, and through the partaking of Holy Communion, gains spiritual health. By freeing himself from sin, he becomes spiritually more protected and capable of thinking, speaking, and doing good independently. The ultimate goal of Christian pedagogy is to cultivate in children love for God and for their neighbor. This creates fertile ground for the child's independent overcoming of every psychogenic impulse that disrupts their mental health.

Keywords: spiritual life and mental health, spiritual upbringing, Christian pedagogy.

Mkhitar Geratsi (mid-12th – early 13th century), whose name graces Yerevan State Medical University, is widely regarded as the founding father of medieval Armenian medicine. His approach to disease treatment was comprehensive, extending to psychotherapeutic methods. "Entertain the sick with games and jokes, and by every means possible, bring them delight. Let them listen as much as they can to the lyre, the sounds of strings, and agreeable tunes," recommended Geratsi for one-day fevers arising "from cares and sorrows."¹

The Armenian Church did not obstruct the work of medieval doctors. Instead, religion and medicine were intertwined, particularly in ethical considerations and Christian values like mercy, compassion, and neighborly love.

"A physician must possess a rational mind and a strong sense of duty, demonstrating patience and a readiness to provide counsel. <...> He should love the poor, be merciful, faithful, God-fearing, and morally pure," wrote Amirdovlat Amasiatsi (XV c.). This applies to healers of the body, and especially to healers of the mind and soul.

¹ From the book "Consolation for Fevers" (1184), in which Mkhitar Heratsi summarized the works of ancient and Arab doctors, methods of Armenian folk medicine, and most importantly, his empirical observations.

"All Divine Scripture, Old and New, guides naturally sick human nature to Jesus Christ, Who is the only Physician of our souls and bodies" (St. Symeon the New Theologian).

Spiritual life as the fullness of our existence

From a Christian perspective, spiritual life is the experience of the joy of the Kingdom of God, which is attained through the sacraments of Holy Baptism, Penance, and Holy Communion. It involves living in communion with God, adhering to His commandments, and engaging with Him through prayer and the reading or listening to the Holy Scriptures.

Spirituality is communion with the Holy Spirit. It is an inherent aspect of human existence. A deliberate and conscious departure from the spiritual life, focused on God, inevitably leads to the erosion of one's identity. Spiritual life, on the other hand, is a journey marked by humility and the ongoing struggle against one's passions, culminating in salvation.

The Holy Fathers explicitly state that the Lord will never burden a person with a trial that exceeds their capacity (1 Cor. 10:13). Mental illness constitutes a heavy burden for the afflicted individual, but it does not obstruct the possibility of their soul's salvation.

Any physical or mental defect, any incompleteness in our existence, can be filled by a spiritual life in Christ, "For in Christ all the fullness of the Deity lives in bodily form" (Colossians 2:9), and through Eucharistic communion with Him: "and He put all things in subjection under His feet, and gave Him as head over all things to the church, which is His body, the fullness of Him who fills all in all." (Ephesians 1:22-23).

Spiritual life as a way to overcome a mental disorder

A person's spiritual journey commences with the acceptance of faith. Following this, an extended period of learning ensues, during which one engages with the practice of prayer and delves into the understanding of the Holy Scriptures through the insights of the Holy Fathers or sermons delivered in the church. To navigate this path correctly, it is imperative for a believer to maintain continuous interaction with a spiritual guide. In the case of individuals suffering from mental illness, medical interventions aim to facilitate a state of mind that allows for effective communication with the confessor. This enables the patient to attentively receive guidance, absorb information, and process it mentally.

Despite the mental limitations that people with mental illness may face, they are still capable of experiencing the fruits of faith to some extent, undergoing spiritual growth, and being drawn towards light and goodness.

Spiritual service is a noble act that brings about spiritual freedom and well-being, first and foremost for the priest, and then for the congregation being served. In my firm belief, spiritual health is the ultimate objective of Christianity, and spiritual service is intended to remove obstacles on the path to this sacred goal.

One of the major challenges to achieving spiritual well-being is mental illness. This report aims to demonstrate that spiritual yearnings often serve as catalysts for mental health issues, while church services and the sacraments administered by clergy can have a therapeutic impact on those suffering from mental disorders. The sacraments of the Church can be seen as divine interventions facilitated by faith and prayer through the hands of a priest. Sacraments such as Holy Baptism, Penance, and Holy Communion are known to have a revitalizing effect on believers.

The central duty of the priest is to guide the patient toward confession through moral teachings and exhortations. Their aim is to help the patient deeply understand and experience the mercy of a Forgiving Lord, as expressed by the prophet: "I, even I, am

He who blots out your transgressions for My own sake, and I will not remember your sins" (Isaiah 43:25).

Upon embarking on the spiritual journey, the path to perfect well-being of the soul is paved through the sacrament of Communion. This sacred rite is preceded by the sacrament of Repentance, which involves confessing one's sins and receiving absolution from God through the absolution (sacramental) prayer of the priest. To undertake this process, the penitent requires both repentance and courage. Repentance illuminates the realization of one's sinfulness, while courage empowers one to confess these transgressions and seek forgiveness. According to the teachings of the Holy Fathers, this journey of repentance is facilitated through prayer, fasting, and acts of charity.

In order for a mentally ill person to reach this life-giving sacrament, it is necessary, alongside appropriate psychiatric care, to provide them with proper spiritual upbringing, teaching them the Word of God by word and deed, and instilling in them love for God. It is meticulous and frequently unrewarding labor, requiring the clergy to undertake a true act of devotion.

St. Catholicos John I Mandakuni (478 – 490) advises the clergy: "Since divine love has the power to accomplish the impossible and is concerned with the salvation of all, it strives to reach those who listen through even the smallest and narrowest openings. The priest, filled with divine love and trusting in the power of the Holy Word, which says: 'Go and convert your brother so that your own sins may be forgiven,' and: 'whoever turns a sinner from the error of their way will save them from death and cover over a multitude of sins ' (James 5:20), should not be idle in caring for the flock entrusted to him by God. For to seek and care for the salvation of others is a great and significant benefit..."

The clergyman must connect with the patient's innermost self. Regular visits, casual conversations, and genuine understanding pave the way for a mentally ill individual to approach the church. The unwavering prayerful, moral, and practical assistance from family and a confessor, coupled with their constant presence, achieves miraculous results. Encouraging discussions with the patient and reminders of Words of God are essential for the patient's well-being and offer hope to their family members.

The purpose of all these meetings and encouraging conversations is to bring the patient into the Church and to guide them towards the Sacraments of Confession and Holy Communion.

A significant barrier exists between us and God – sin. Each of us must critically assess our own character to morally evaluate it and achieve repentance. However, for someone with mental illness, there is an additional obstacle on this journey: an unreflective attitude towards their mental symptoms. Spiritual life requires self-examination and a repentant spirit. Through the sacrament of Repentance, a person with mental illness can free themselves from sin and thereby overcome their illness.

St. Grigor Tatevatsi (14th – early 15th cc.), elucidates that "sin entails a deviation from the unchanging Good, which is God, and a shift towards mutable goods, the beasts as they are".² In essence, sin is the act of turning away from goodness and straying from it. According to Sacred Scriptures, God created humanity in His own good image and likeness; however, humans voluntarily distanced themselves from this goodness, transforming their original good image into an evil one. Ever since, evil has become an inherent part of human existence. This transformation did not occur externally, under specific circumstances related to individuals, but within the individuals themselves.

²From the "Book of Questions" by St. Grigor Tatevatsi (1397), which is a comprehensive interpretation of the Holy Scriptures.

Archimandrite Grigor Skevratsi (XII c.) posited that evil is the corruption of human benevolence, transforming virtues into sins. This perversion disrupted the natural harmony of humanity, causing our inherent inclinations to degenerate into sinful desires and severing our essential bond with the divine. Consequently, our sinful inclinations are essentially perverted virtues, functioning as forces that ought to propel us towards the Unspeakable Good and God, but instead, they drive us in the opposite direction. The human senses serve as the portals to the soul, through which impressions nourish either virtuous or sinful tendencies. Therefore, individuals must intentionally open these portals to virtues and close them to evils.

Sin is a state of mind that runs counter to God's will, often linked with evil or even being evil itself. It should not be viewed solely through a moral lens. This condition inherently causes suffering for an individual, a profound wound to the soul, and is the root of various physical and mental ailments.

This also applies to mental illnesses. A mental illness is a severe suffering, not morally reprehensible, but capable of causing grave crimes against people, against oneself, and against God.

Mental illness can be defined by the presence of emotional disorders, impaired thinking, and altered perception. I will use an example of one such condition to illustrate how passions can impact mental health.

Emotional disorders involve extreme and contrasting mood swings, ranging from intensely negative to overwhelmingly positive and vice versa. These fluctuations can be rooted in various mental states, including anger, lethargy, melancholy, avarice, and a craving for recognition.

St. Nile of Sinai describes sadness as a human emotion characterized by anger stemming from a lack of desired things or dissatisfaction of one's passions. He further elucidates that despondency is a state of "soul exhaustion," "where the soul lacks its natural vigor and is unable to bravely resist temptations".³

Laziness and despondency make life unproductive and unpromising, which is an internal spiritual experience of depression as a serious mental illness. According to Academician Snezhnevsky, individuals experiencing depression often harbor unjustified animosity towards their family and friends, accompanied by persistent discontent and irritability.⁴ These symptoms, which can also manifest in manic phases, are exacerbated by a spiritual condition marked by an inflated sense of glory-seeking.

Passion can be viewed as a malady of the soul, a form of spiritual distress. In my view, every mental condition or ailment appears to be accompanied by its corresponding passionate drive.

The core of repentance lies not in remorse for our actions but in acknowledging and regretting the inherent evil within ourselves, with a resolute determination to cease from sinning. By aligning oneself in this manner and countering these passions, the individual can extinguish their ardor and prevent it from inflicting severe emotional torment.

And a few more words about the care of patients of various age groups.

Children. Children deserve the most profound love. Their innocence and emotional vulnerability often lead them to see a priest and exclaim, "Look, that's Grandpa Jesus!"

Mothers (or grandmothers) usually bring children to the priest when they face issues. The crucial task for the priest is not to make the child feel like you're aware of their problem, but rather to engage in play and build a friendship. This approach yields

³From the work of St. Nile of Sinai "About the Eight Evil Spirits."

⁴Handbook on Psychiatry/ Ed. by A.V. Snezhnevsky. – 2nd ed. – M.: Meditsina, 1985, p. 56.

remarkable results. The child will naturally want to return to the church, allowing for prayers and figuring out what's going on with the family.

Teenagers and youth. They should be approached in a manner akin to children. Often, they are also brought by someone. They don't typically seek out the priest on their own.

You can't start talking to a teenager about a problem right away. First, you need to become friends with them and build a trusting relationship. You can invite him to our home, talk about him, about God, about science, about children's and teenagers' interests, and show interest in his life. In a word, become an authority for him. Then you will be able to help him.

Adults. Empathy and patience, along with the ability to listen to patients attentively until the end, are qualities that can win the trust of adults and make them open to the guidance of a spiritual father. Knowledge of psychopathological symptoms is especially helpful here, as it allows for the identification of the illness. Of course, it is essential to tell the patient the truth, albeit tactfully and without causing offense, and to refer them to a doctor. If the patient is chronically ill and aware of their condition, it is advisable to encourage them to participate in the sacraments of Repentance and Holy Communion.

Elderly patients particularly require empathy, seeking a warm and understanding approach from others. A priest can be very effective by treating the patient with the same care and respect they would show to their own parent.

Example from my practice. I recall a specific incident when I was summoned to assist an elderly woman. She was a widow and had not seen her son for an extended period, living alone. Upon his return, he discovered the following situation: the woman's sleep had been disturbed; she would often see the image of her husband standing nearby, either looking at her or not, and these visions greatly unsettled her.

At her son's request, I visited the elderly woman. I gave her a warm embrace, took a seat beside her, and engaged in conversation – not about her illness, but on other matters. She then shared her own feelings, and we prayed together. Following this, we remained silent. She just took my hand, kissed it, and gently stroked it for a while.

Mistakes of a priest when working with the mentally ill

The first mistake involves an unprofessional approach, characterized by either ignorance or denial of psychiatric principles. As a consequence, the patient is deprived of competent assistance in both cases.

The second mistake is when a priest treats a patient solely in the capacity of their duty: if the patient comes, they pray; if they don't, the priest moves on, forgetting of the one. This approach leaves the patient feeling abandoned, which can lead to a sense of being left to fend for themselves against their illness. In such circumstances, there is a risk of suicide attempts.

Example from my practice: young man, approximately 20-23 years old, believer and known for his kind nature, sought help at the church. He was affected by a mental illness and was fully aware of it. We frequently discussed his condition. He participated in the Confession. During prayers, he often voiced his frustration towards God, asking, "Why are You doing this to me?" One day, he confessed to me that he couldn't bear these blasphemous thoughts about God. I felt deeply sorry for him, but I reassured him by explaining that these thoughts were not his own, but a manifestation of his illness. I also prayed for him. One day he returned to ask for another prayer, and after the session, he left. About two hours afterward, he called me, but I was occupied and couldn't answer right away. When I returned his call later, he was no longer reachable. It later came to light that he had tragically jumped off a bridge and died.

It is essential to show genuine interest in the patient, maintain a friendly and open relationship with the patient's family. The illness itself may prevent the patient from attending, so the intervention of a priest can be crucial in ensuring that medication is started or resumed on time.

Spiritual formation and mental health

Spiritual education during childhood significantly impacts a person's mental well-being.

In every diocese of the Armenian Apostolic Holy Church, there is a school of Christian formation operating within each church. Children attending these schools not only acquire Christian knowledge but also participate in the Divine Liturgy. My firm belief is that by attending the Divine Liturgy in church, children experience the life-giving peace and love of the Holy Spirit, thereby achieving spiritual health through the Holy Communion. This spiritual purification renders them more resilient to sin and empowers them to think independently, speak truthfully, and act virtuously.

The ultimate goal of Christian pedagogy is to nurture children's love for God and their fellow human beings. This fosters an environment where children can autonomously overcome any psychogenic impulses that threaten their mental well-being. Consequently, virtues such as forgiveness, patience, compassion, and humility counteract feelings of despair, anger, doubt, vanity, and any spiritual maladies.

Conclusion

Viam supervadet vadens.

The road will be conquered by walking

The path to our Heavenly Fatherland is the essence of spiritual life. No one can hinder a person from embarking on this journey. It is about moving forward, not remaining stagnant. Spiritual life is all about progress and growth, continually drawing closer to God, who is "The Way, the Truth, and the Life."

Mental illness is a cross to bear, often an exceedingly heavy one, so burdensome that the individual carrying it needs support. The Lord provides help to those in need, whether it's through psychiatrists, spiritual leaders, or simply compassionate individuals. The Bible instructs us, "Bear one another's burdens, and so fulfill the law of Christ" (Galatians 6:2). To bear one another's burdens is to render both physical assistance and spiritual succor, through pastoral oversight and intercessory prayer, for those whom the Lord has joined us with.

Specifics of mental health and spiritually-oriented psychotherapy for patients of various age groups with suicidal statements

Abstract: The aim of this research was to investigate the characteristics of mental health and social adaptation among various age groups of patients presenting with suicidal ideation, as well as to examine the efficacy of spiritually oriented psychotherapy and spiritual support for this population. Comparative analysis of different age groups revealed the following patterns: a higher prevalence of young patients (aged 35 and under) among individuals with suicidal ideation, a tendency for an increase in the severity of depressive symptoms with advancing age, and a decline in social adaptation and overall social functioning, particularly in the domains of interpersonal relationships, leisure activities, and general life attitude. Among patients who actively participated in spiritual activities at the psychiatric clinic of the Military Medical Academy and underwent spiritually oriented psychotherapy, a predominance of neurotic, stress-related, and somatoform disorders was observed. It is crucial for clergy to empathize with the pathological manifestations of individuals experiencing suffering, recognizing that these manifestations of human frailty can be diverse and necessitate the intervention of a true Healer of both body and soul. Thus, the hospital clergy, in collaboration with medical staff, assume the role of "fellow workers for the kingdom of God" (Colossians 4:11) in the care and treatment of patients. The fostering of cooperation between psychiatric services and church organizations contributes to the spiritual growth of patients and the enhancement of their mental well-being.

Keywords: suicide, suicidal statements, age-related characteristics, spiritually oriented psychotherapy.

Depression and related mental health conditions, which have become prevalent in psychiatric practice during the twentieth century, remain a significant concern in contemporary medical discourse. These disorders frequently manifest with suicidal ideation.

Suicidal statements and attempts are frequently a primary justification for admitting patients to psychiatric institutions. However, unlike suicide attempts, the attributes of this patient cohort are rarely subjected to systematic scrutiny; instead, a greater emphasis is placed on studies of completed suicides, attempted suicides, and self-injurious behaviors. Therefore, the objective of our research was to examine the mental health and social adaptation of patients from various age groups exhibiting suicidal ideation, as well as to investigate the unique facets of spiritually oriented psychotherapy and spiritual support for this particular demographic.

We surveyed 110 patients at Saint Petersburg City Psychiatric Hospital No. 1 who, upon admission, made suicidal statements. The sample was stratified into three age cohorts: the first group consisted of young adults aged 18 to 35 years, the second group included middle-aged individuals aged 36 to 59 years, and the third group comprised elderly patients aged 60 years and older. The distribution of patients across these age groups was as follows: 46 patients (41.8%) fell into the first group, 37 patients (33.6%) were in the second group, and 27 patients (24.5%) were in the third group. Consequently, the young adult group was the largest, while the elderly group was the smallest.

Numerous researchers have observed that women are more prone than men to express suicidal ideation and attempt suicide, whereas the incidence of completed suicides is higher among men. In our patient cohort exhibiting suicidal tendencies,

women constituted a slight majority (55.5%). However, among younger patient group, men demonstrated a slight predominance (56.5%).

Heredity exacerbated by mental disorders was identified in 26.1% of the young patient group, 24.3% of the middle-aged group, and 11.1% of the elderly. Similarly, heredity aggravated by alcohol use disorder was observed in 23.9% of the young patients, 24.3% of those in the middle-aged group, and 11.1% of the elderly group. Suicidal behavior among relatives was documented in 6.5% of the young patient group, 2.7% of the middle-aged, and 3.7% of the elderly.

The structure of mental disorders in patients of various age groups is presented in Table 1.

Table 1. The structure of mental disorders in patients of various age groups with suicidal statements¹.

<i>Age /ICD</i>	<i>18-35 y. o.</i>	<i>36-59 y. o.</i>	<i>60 or older</i>	<i>Total</i>
F01-F09 Organic, including symptomatic, mental disorders	8 (17,4 %)	10 (27,0 %)	23 (85,2 %)	41 (37,3 %)
F10 Mental and behavioural disorders due to use of alcohol	3 (6,5 %)	6 (16,2 %)	0	9 (8,2 %)
F11-F19 Mental and behavioural disorders due to psychoactive substance use	11 (23,9 %)	1 (2,7 %)	0	12 (10,9 %)
F20-F29 Schizophrenia, schizotypal and delusional disorders	8 (17,4 %)	7 (18,9 %)	0	15 (13,6 %)
F30-F39 Mood [affective] disorders	3 (6,5 %)	4 (10,8 %)	2 (7,4 %)	9 (8,2 %)
F40-F48 Neurotic, stress-related and somatoform disorders	3 (6,5 %)	6 (16,2 %)	1 (3,7 %)	10 (9,1 %)
F60-F69 Disorders of adult personality and behaviour	8 (17,4 %)	2 (5,4 %)	1 (3,7 %)	11 (10,0 %)
F70-F79 Mental retardation	2 (4,3 %)	1 (2,7 %)	0	3 (2,7 %)

Among the group of young patients, the most prevalent diagnoses were those falling within the F11-F19 categories of the ICD, which encompass substance use disorders (23.9%). Diagnoses of organic disorders, schizophrenia spectrum disorders, and personality disorders were each identified with similar frequency (17.4% each). In the middle-aged patient group, organic disorders emerged as the most frequently diagnosed category (27.0%). Patients with alcoholism and neurotic disorders were observed with somewhat lower prevalence (16.2% each). Among elderly patients, there

¹ As classified under "Mental disorders and behavioral disorders" in the ICD-10

was a significant predominance of diagnoses categorized as organic disorders (85.2%). Additionally, among all patients with suicidal ideation, organic disorders were the most commonly recorded (37.3%).

The hospitalization in a psychiatric facility was the first for 41.3% of younger patients, the second for 32.6%, and the third or subsequent for 26.1%. Among middle-aged patients, 54.1% experienced their first hospitalization, 18.9% their second, and 27.0% their third or subsequent. In the elderly patient group, 62.9% were admitted to a psychiatric hospital for the first time, 22.2% for the second time, and 14.8% for the third or subsequent time.

Suicidal ideation is frequently observed in patients presenting with depressive symptoms. In the evaluated cohort, the level of depression at admission was quantified using the Hamilton Depression Rating Scale (HDRS). The analysis revealed that the mean HDRS score for young patients was 11.4 ± 6.2 points, for middle-aged patients 12.9 ± 6.4 points, and for elderly patients 14.4 ± 6.8 points. Consequently, there is a discernible trend towards an escalation in the severity of depressive symptoms with advancing age. While the average HDRS scores for young and middle-aged patients generally aligned with the criteria for mild depressive disorder, older patients exhibited scores indicative of moderate depression.

The social functioning of the patients was evaluated using the Global Assessment of Functioning Scale (GAFS). In the cohort of younger patients, the mean score for social functioning at the time of hospital admission was 30.5 ± 13.1 . For middle-aged patients, the mean score was 25.6 ± 10.1 , and for elderly patients, it was 21.4 ± 11.9 . Consequently, there is an observable trend for the level of social functioning to decline with advancing age. Overall, the social functioning level within this patient group is notably low, primarily attributed to suicidal ideation and, in some cases, the presence of hallucinatory-delusional symptoms. Specifically, in the younger patient group, a psychotic state was present at the time of suicidal ideation in 21.7% of patients. Among middle-aged patients, this percentage was 21.6%, while in elderly patients, it was 7.4%.

The social adaptation of patients was evaluated on a point basis using the Social Adaptation Assessment Scale (Rustanovich A.V., 2000). This scale consists of six criteria: educational attainment, employment or educational status, family relationships, interpersonal interactions, leisure activities, and overall life attitude. The collected data on the social adaptation status of the examined patients is shown in Table 2.

Table 2: Social adaptation of patients from different age groups with suicidal statements (scores).

Social adaptation age	Education	Work (study) in progress	Family relationships	Interpersonal interactions	Leisure	General attitude towards life
Young	$2,2 \pm 1,1$	$2,1 \pm 1,3$	$1,8 \pm 0,8$	$3,1 \pm 0,7$	$2,6 \pm 0,8$	$2,3 \pm 0,8$
Middle-aged	$2,5 \pm 1,1$	$1,9 \pm 1,2$	$2,1 \pm 1,2$	$3,2 \pm 0,8$	$2,7 \pm 1,0$	$2,1 \pm 0,9$
Late-aged	$1,8 \pm 1,2$	$1,2 \pm 0,6$	$2,5 \pm 1,1$	$2,9 \pm 0,7$	$2,5 \pm 0,8$	$2,0 \pm 0,9$

The educational attainment of patients can be characterized as generally low, with a slightly higher level of education observed in the middle-aged patient cohort (mean score: 2.5 ± 1.1). Regarding social adaptation in relation to employment or education, elderly patients exhibited the lowest scores (mean score: 1.2 ± 0.6). Only 29.1% of the patients were actively employed or engaged in educational pursuits at the time of assessment. Notably, 3.6% of patients were retired due to age, 20.9% had mental disabilities, and 22.7% had somatic disabilities. The lowest level of adaptation in family relationships was observed among young patients (mean score: 1.8 ± 0.8). In terms of interpersonal relationships and leisure activities, elderly patients demonstrated lower average scores (mean scores: 2.9 ± 0.7 and 2.5 ± 0.8 , respectively). Concerning the general attitude towards life, elderly patients also displayed lower average scores (mean score: 2.0 ± 0.9).

Thus, the comparative analysis of age groups among patients with suicidal ideation reveals several notable characteristics: a preponderance of younger patients (under 35 years of age) within this patient population, an increasing trend in the severity of depressive symptoms with advancing age, and a decline in social adaptation and functioning, particularly in interpersonal relationships, leisure activities, and general attitude towards life. Additionally, organic disorders are conspicuously prevalent among this patient cohort, with a more pronounced manifestation in the elderly patient group.

The following features primarily pertain to "civilian" patients who are undergoing examination and treatment at the city psychiatric hospital. In contrast, the patients at the psychiatric clinic of the Military Medical Academy present a somewhat different demographic profile. This clinic primarily serves military personnel, including active-duty participants in Special Military Operation. Additionally, the clinic provides medical services to retired military personnel, family members of service members, cadets enrolled in military educational institutions, conscripted personnel, and patients who have opted for contracted, fee-based treatment. Historically, these various categories of patients collectively comprised the majority of the clinic's patient population. However, in recent times, participants in Special Military Operation have come to constitute approximately 80-90% of the patients receiving examination and treatment at the clinic.

Due to the structure of mental disorders observed in patients of the clinic who have participated in a Special Military Operation, stress-related disorders are predominant, including acute stress reactions and post-traumatic stress disorder. Anxiety and depressive disorders, some of which may escalate to a psychotic level, are also prevalent. Acute polymorphic psychotic disorders, with or without symptoms of schizophrenia, and conversion and dissociative disorders are also noted. Many patients suffer from the consequences of traumatic brain injuries and blast wounds, which result in various health complications, including difficulties in mobility and attendance at long religious services due to physical pain and unstable somatic condition. Despite these challenges, a significant number of patients continue to attend church and participate in religious services. The primary motivations for their attendance, as reported by the patients themselves, include the desire to pray for their fallen comrades, seek spiritual guidance from a priest, and confess their sins. Many patients, having experienced the trauma of war, report a significant increase in their religious faith and for the first time engage in the practice of confession. Their attitude towards death, including violent death in wartime, can vary significantly due to their personality traits and worldview, as well as the influence of any mental disorders they may have.

Of the total patient cohort at the psychiatric clinic in 2024, 50 individuals actively participated in services at the clinic's chapel. Among these patients, 15 (30%) had suicidal ideation in their clinical presentation of mental disorder. It is important to note that these patients also displayed other forms of suicidal behavior, including

suicide attempts and self-harm, which are not detailed in this report. Patients with suicidal tendencies require specialized attention from both psychiatric professionals and clergy. Participation in religious services is particularly beneficial for these patients, but they also necessitate heightened supervision to mitigate the risk of suicidal actions during their absence from the hospital setting. Consequently, all patients attending religious services are under the constant supervision of a qualified medical professional.

Among patients with suicidal statements who actively participated in religious activities and received spiritually oriented psychotherapeutic interventions, a predominance of neurotic, stress-related, and somatoform disorders was observed, accounting for 60% of the total patient population. Additionally, schizophrenia spectrum disorders were diagnosed in 20% of the patients, substance use disorders in 13.3%, and personality disorders in 6.6%. Organic disorders were not identified in this patient group, although a significant proportion had suffered contusions, suggesting a potential "organic background" that may deteriorate with age. It is noteworthy that, similar to civilian patients with suicidal ideation, the majority of military personnel in this group were young (60% were youths), while elderly patients were significantly less represented (6.6%), reflecting the predominantly young and middle-aged demographic of military personnel.

Providing spiritual guidance to such patients demands that the priest, above all else, focus on the inner world of the suffering individual. Patients who come for confession frequently have little to no church experience, and as a result, they don't readily open up about their "pain points." In such instances, it is imperative not to dismiss them on the ostensible grounds of "unpreparedness," but rather to endeavor to establish a personal rapport and encourage an introspective examination of conscience and collective prayer. Subsequently, the dialogue may evolve into a discourse centered on inquiries regarding the significance of human existence and its relevance to the individual's ailment. Our experience with this group of parishioners indicates that these questions are usually not consciously articulated by them or are simply not a primary focus of their attention. As the discourse progresses, teleological frameworks derived from the interlocutor's personal experiences and the axioms of Christian doctrine can be employed to demonstrate the incoherence of pathological impulses directed towards self-destruction. In any case, it is important for the priest to approach the pathological manifestations of a suffering person with empathy, understanding that these manifestations of fallen human nature can be diverse and require the intervention of the true Healer of souls and bodies. In this regard, hospital chaplains, together with the attending physicians, become "fellow workers for the Kingdom of God" (Col. 4:11) in the ministry of caring for and healing the clinic's patients.

Not all military personnel who undergo psychiatric assessment and treatment in specialized medical facilities exhibit suicidal ideation related to mental trauma or specific challenges inherent in military service. As an example, we will present a clinical case of a young patient, a second-year cadet at a military educational institution, who has actively expressed suicidal thoughts.

Patient B., 20 y.o., originates from a family without an anamnesis of psychopathology. He attended school on time and, from the 5th grade, studied at the branch of Nakhimov College. After completing the 11th grade, he entered a military educational institution. Patient B. was characterized as introverted, reserved, and inclined to social withdrawal. During his time at Nakhimov College, he avoided interaction with his peers. When assigned a roommate, he approached the teachers with a request for reassignment or engaged in behaviors aimed at facilitating the roommate's departure. Upon entering the military institute, he struggled to establish a rapport with the commanding officer. Patient B. first noted changes in his mental state in 2022, specifically difficulty speaking in the presence of cadets. He described this as a sudden

awareness of the power emanating from them. Initially, he displayed academic interest during his first year of study, but subsequently experienced psychological discomfort and difficulty forming relationships with fellow students. He perceived them as psychologically superior and unable to connect with them. To address this, he altered his speaking voice to a lower tone. This change was accompanied by a decrease in mood and the emergence of suicidal ideation. He reported fantasizing about shooting himself in the head while carrying a firearm, imagining the act of self-harm. The choice of firearm was justified by its perceived efficiency as a method of ending life. His intentions were thwarted due to the absence of cartridges in the weapon. Patient B. experienced voice-related difficulties, leading to feelings of inadequacy and social isolation. He did not seek professional help and attempted to manage these issues independently. He described a sense of unreality, a narrowing of his social circle, and a preference for solitude. His emotional state deteriorated, and he reported becoming emotionally detached and fixated on his voice problems. Over time, he ceased verbal communication and resorted to non-verbal noises during conversations. Patient B. underwent outpatient examination and private treatment at a medical center. He was prescribed aripiprazole, which demonstrated positive effects on his mood. However, voice-related issues persisted. He did not disclose his psychiatric treatment to the command. Despite regular medication intake, his supply of pills eventually ran out, leading to a recurrence of suicidal thoughts, feelings of unreality, and emotional detachment. Subsequently, he was admitted to a psychiatric clinic upon his consent.

Upon admission, the patient's clinical presentation was primarily characterized by a diminished mood, suicidal ideation, a sense of vocal impoverishment, and an absence of emotional responses, accompanied by distressing preoccupations with these symptoms. Additionally, the patient exhibited allopsychic derealization, emotional blunting, aberrant and indistinct thinking, sleep disturbances, and a lack of motivation. Following the initiation of neuroleptic and antidepressant medication, the patient demonstrated increased activity and improved sleep patterns. However, residual symptoms persisted, including vocal apathy, signs of allopsychic derealization, a persistent low mood, suicidal thoughts, disorganized thought processes, and emotional dullness. Following a comprehensive psychiatric evaluation, the patient was diagnosed with schizoaffective disorder, depressive subtype. Upon stabilization of the general mental state, the patient engaged in religious activities and participated in spiritually oriented psychotherapeutic interventions. The patient was subsequently discharged with an overall improvement in his mental condition but was declared medically unfit for military service based on their psychiatric diagnosis and residual symptoms.

Patients who attend the church participate in the sacrament of Unction, the consecration of Easter foods, and may optionally attend parish gatherings and other events organized by the parish community. This fosters informal, amicable relationships between parishioners and clinic patients, mitigates the stigmatization associated with mental illness, and enables community members to demonstrate empathy and provide comprehensive support to patients. The establishment of collaboration between the psychiatric service and church institutions promotes the spiritual well-being of patients and enhances their psychological condition.

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Faith as a psychological phenomenon

Abstract: Faith, beyond its religious and philosophical interpretations, can be considered a psychological phenomenon. The precise role and location of this phenomenon within the psyche remain subjects of ongoing scholarly debate. Drawing upon a review of existing concepts, we propose examining faith on three psychological levels: the cognitive (conscious), the activity-based, and the personal.

Keywords: faith, psychology, consciousness, activity, personality, pathology of faith.

Traditionally, "faith" has been understood as a religious phenomenon. It is so central to religion that it is often used as a synonym for "faith as a religious practice." In Christianity, faith is seen as a spiritual gift (for ex., 1 Corinthians 12:13). The gift is related to personal achievement ("earnestly desire the best gifts" (1 Corinthians 12:31), but it is not necessarily a consequence of it, but depends on the will of God ("I will have mercy on whom I have mercy, and I will have compassion on whom I have compassion", Rom. 9:15). As a gift, faith can help a person in life's trials and be an inner support.

Furthermore, in everyday language, "faith" and "believe" are also applied to non-religious contexts, ranging from the children's game "I believe – I don't believe" to motivational speakers urging belief in one's own capabilities.

The extensive penetration of the phenomenon of faith into various spheres serves as a reason for interest in it from philosophy and science. While the philosophical discourse on faith dates back several millennia, originating in antiquity (Dvoinin A.M., Danilova G.I., 2013), the psychological exploration of this concept is relatively more recent, having emerged approximately one and a half centuries ago. Contemporary researchers note that there remains a lack of consensus within the psychological community regarding the precise mental construct denoted by the term "faith" (Dvoinin A.M., Danilova G.I., 2013, p. 122). Efforts are underway to delineate the phenomena associated with the term "faith" across multiple psychological dimensions. For instance, Dvoinin A.M. (2014) posits that faith can be conceptualized at two levels: as a cognitive verification mechanism and as an individual's intrinsic worldview, encompassing deep-seated personal convictions. From our perspective, there are at least three such levels.

W. James, one of the first psychologists to study faith as a psychological phenomenon, noted the activity of faith at the cognitive level.¹ [1]. According to James, "faith constitutes a mental state or cognitive function of reality, encompassing any degree of confidence, including the highest level of conviction" (James W., 2010, p. 29). In this cognitive context, faith is distinguished from disbelief, while in its cognitive aspect, it is juxtaposed with doubt and skepticism. Every object, thought, or feeling can be either credible to an individual or subject to scrutiny. James identifies similar concepts in the work of F. Brentano: "Every object comes into consciousness in a twofold way, as simply thought of [vorgestellt] and as admitted [anerkannt] or denied... In every proposition, then, so far as it is believed, questioned, or disbelieved, four elements are to be distinguished, the subject, the predicate, and their relation (of whatever sort it be) – these form the *object* of belief – and finally the psychic attitude in which our mind stands towards the proposition taken as a whole-and this is the belief itself" (James W., 2010, p. 33).

¹ This level can be correlated with the first level in the classification of A.M. Dvoinin.

The pathology of the cognitive dimension of faith as a psychological construct can manifest, according to William James, in both excessive confidence and pathological doubt, or the mania of doubt (Grübelucht). The latter condition was examined by early 20th-century psychiatrists as a type of abstract obsession, characterized by a persistent urge to ponder the causes of phenomena. Individuals exhibiting this condition, upon encountering any information through auditory, visual, or written means, engage in an unrelenting inquiry into the question of "why," despite being cognizant of the futility of such contemplation.

For James, the second instance of the pathology of faith in relation to the cognition of reality manifested as a derealization experience characterized by a sense of unreality, void, and lifelessness. This phenomenon is typically associated with certain forms of melancholy distortion.

The concept of faith as a psychological phenomenon is explored further by B.S. Bratus, who posits that faith in the attainability of ideal goals and projects is an essential component of any human endeavor. According to Bratus, "A creative solution to any life task requires selecting from various possible options, many of which may seem equally likely. Consequently, to act, an individual not only makes a choice but also (often unconsciously) relies on the belief that their chosen path is the most appropriate and necessary" (Bratus B.S., 2019, p.41). It is particularly important to maintain this faith when making decisions to achieve ideal goals and long-term objectives, and to strengthen it. Although Bratus does not explicitly discuss the pathological aspects of activity levels, any manifestations of an inadequate (either excessive or minimal) discrepancy between ideal and reality in activities, such as personality disorders, can be considered within this context.

Finally, the highest psychological level of considering faith – as a personal trait² – appears in the works of several contemporary authors. J. Fowler defines faith as "the orientation of a comprehensive individual, providing direction and purpose to their hopes, aspirations, thoughts, and actions" (quoted by I. A. Dzhidaryan, 2013, p. 201). Dzhidaryan, an expert in the psychology of optimism, considers faith to be a spiritual perception of the future: "The interrelated components forming the optimistic triad – faith, hope, and love – belong to a category of higher, albeit not clearly delineated, feelings that are structurally complex to differentiate, expressing the spiritual dimension within an individual and their relationship with transcendent, meta-empirical aspects of reality. They are intrinsic to the individual and their overall life" (Dzhidaryan I. A., 2013, p. 191). According to this author, faith possesses not only an emotional and sensual foundation but also a philosophical dimension, endowed with the capacity to transcend the boundaries of "current existence" (S. L. Rubinstein) into the realm of the future. It is worth noting that faith, hope, and love are conceptualized by the author within a spiritual rather than religious context, thereby possessing a non-denominational character.

Fanaticism can manifest as a pathological manifestation of religious belief at the individual level. While sharing certain mechanisms with genuine faith, fanaticism is not faith itself but rather a spiritually distorted form of it. This distorted form is characterized by a disconnection from the values of love and hope, resulting in a state of blindness and uncontrollability. In this state, fanaticism disregards rational arguments, practical considerations, and life experience, exhibiting a propensity to overpower and obliterate any opposing viewpoints (Dzhidaryan I. A., 2013, p. 196).

Accordingly, we propose that belief as a psychological phenomenon operates on at least three levels: cognitive (conscious), active, and personal. The questions of their interrelation and their connection to religious belief remain open for further research.

² This level corresponds to the second level in the classification of A.M. Dvoinin.

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Prayer, mental health and well-being

Abstract: the relationship between prayer and mental well-being has been the subject of study for some researchers, but additional data is needed for a comprehensive understanding of its impact. Research has identified various types of prayer, including adoration, confession, thanksgiving, supplication, obligatory prayers, and receptive prayer. These different aspects of prayer can have varying effects on psychological well-being, with some forms providing a sense of peace, while others foster a deeper connection with God. Deeper insight into this issue requires close engagement between mental health practitioners and faith-based organization. By prioritizing education and collaboration, we can enhance mental well-being and build safe spaces for people to understand their spiritual needs without stigma or discrimination.

Keywords: prayer and mental health, psychological well-being, spiritual needs.

Prayer, mental well-being and health

Prayer is a core practice and central to all faiths and plays a vital role in promoting mental well-being and health globally. However, in my presentation, I will focus on the Christian perspective.

There is compelling and abundant evidence to show the positive impact of prayer and following religious practices on mental and physical well-being. An extensive study published in 2017 with sample sizes ranging from 5,681 to 7,458 youth with a mean baseline age of 14.74 years showed that compared with no attendance, at least weekly attendance of religious services was associated with greater life satisfaction and positive affect, several character strengths, lower probabilities of marijuana use and early sexual initiation, and fewer lifetime sexual partners. Analyses of prayer or meditation yielded similar results (Y.Chen, T.J.VanderWeele, 2018).

A 2016 article which reviewed 41 observational clinical studies that evaluated the relationship between private prayer and health conditions reported that frequent private prayer is associated with a significant benefit for depression, optimism, coping, and other mental health conditions such as anxiety (J.W.Anderson, P.A.Nunnelley, 2016).

Prayer is part of the broader spectrum of spiritual disciplines, which include reading and studying the Scripture, fasting, fellowship, serving and giving.

Before delving deeper into the topic, I acknowledge the wealth of knowledge and experience of those in this room, with lived experiences, witnessing the impact prayer and spirituality have on the physical and mental well-being of people in our communities and congregations.

What is prayer?

Prayer, according to the Bible, is a heartfelt and earnest communication with God to express our love, gratitude, and dependence on God. A dialogue where we pour out our hearts and also listen for God's guidance and wisdom. Seeking God's will, finding comfort in times of distress, and experiencing God's presence in our lives.

In Philippians 4:6, we are encouraged by the words- "*Do not be anxious about anything, but in everything by prayer and supplication with thanksgiving let your requests be made known to God.*" This verse underscores the idea that prayer is a way to cast our cares and concerns upon God, trusting that God hears and responds.

In Prof. Friedrich Heiler's comprehensive Christian study into the phenomenology of prayer in 1932, he described:

"There are three elements which form the inner structure of the prayer-experience: faith in a living personal God, faith in His real, immediate presence, and a

realistic fellowship into which man enters with a God conceived as present." (H.Friedrich,1932).

The early Church leaders collectively taught that prayer is more than an activity; it is a way of life, a means of aligning one's heart, mind, and soul with God, and a pathway to spiritual maturity.

Prayer as conversation with God

St. John Chrysostom described prayer as "a conversation with God." He emphasised that it is not about mere words but the attitude of the heart, urging Christians to pray with sincerity, humility, and love. For Chrysostom, prayer is the bridge between humanity and God.

Prayer as a transformative process

St. Gregory of Nyssa saw prayer as a means of ascending to God, likening it to a journey of the soul toward divine likeness. He emphasised that prayer transforms the person into the image of Christ, drawing them closer to divine perfection.

Prayer as worship and thanksgiving

St. Ignatius of Antioch viewed prayer primarily as an act of worship and thanksgiving, an expression of dependence on God and gratitude for His grace. St. Clement of Alexandria emphasised that true prayer is marked by thanksgiving and praise, reflecting a life lived in constant awareness of God's goodness.

Insights from the life and teaching of Lord Jesus Christ

Jesus lived by example: "*Meanwhile, he would slip away to deserted places and pray.*" (Luke 5:16) "*Now during those days he went out to the mountain to pray, and he spent the night in prayer to God.*" (Luke 6:12). Through his teachings and life Jesus revealed prayer as a vital, personal, and transformative practice rooted in faith, love, and submission to God's will.

1. Pray with sincerity, not for show (Matthew 6:5).
2. Pray in private (Matthew 6:6).
3. Use simple and heartfelt words. (Matthew 6:7-8).
4. Gave the Lord's Prayer as a model for prayer, covering adoration, submission to God's will, provision, forgiveness, and guidance. (Matthew 6:9-13).
5. Be persistent in prayer (Matthew 7:7, Luke 18:1).
6. Pray with faith: "*Whatever you ask for in prayer with faith, you will receive*" (Matthew 21:22).
7. Pray for forgiveness and reconciliation: "*And when you stand praying, if you hold anything against anyone, forgive them, so that your Father in heaven may forgive you your sins.*" (Mark 11:25).
8. Pray for God's will, not just your own: "*Father, if you are willing, remove this cup from me, yet not my will but yours be done.*" (Luke 22:42).
9. Pray for others: "*But I tell you, love your enemies and pray for those who persecute you.*" (Matthew 5:44).
10. The power of united prayer: "For where two or three are gathered in my name, I am there among them." (Matthew 18:20).

The taxonomy of prayer

It is essential to analyse the different types of prayer and study their relationship and impact on mental wellbeing. The taxonomy of prayer includes different dimensions and levels of experience. These dimensions vary across religious contexts and can be conceptually distinct. McKinney and McKinney (1999) measured four types of prayer

common in many denominations of Christianity that can be represented by the acronym ACTS—adoration, confession, thanksgiving, and supplication. Researchers added new dimensions to these taxonomies, such as reception and obligatory prayer (S.P.Laird, C.R.Snyder, M.A.Rapoff, S.Green, 2004).

Adoration is defined as worshipping God without reference to external circumstances. Confession is the admission of harmful, sinful, or negative actions, along with a petition for forgiveness. Thanksgiving is the expression of gratitude to God for external circumstances. Supplications are requests to God regarding external life circumstances related to the individual or others (intercession).

Obligatory prayers are required prayers that consist primarily of fixed prayers repeated at each worship time. Orthodox Christian, Catholic and Anglican traditions have components of Obligatory prayer. These prayers also represent an essential component of Judaism and Islam, where followers are required to pray three and five times a day, respectively.

With prayers of reception, one awaits divine wisdom, understanding, or guidance. Baesler (2002) described receptive prayer as "characterised by a contemplative attitude of openness, receptivity, and surrender, resulting in experiences ranging from peaceful/quiet to rapture/ecstasy" (p. 59). Baesler further describes that this form of prayer focuses less on ego-centred active types of prayer (e.g., prayers of petition) and more on God-centered receptive types of prayer (e.g., prayers of surrender). Meditation, receiving the Eucharist, blessings/ gifts, and the Holy Spirit could be considered prayers of reception.

The evidence of the influence of the various types of prayers on wellbeing

Various studies have examined the relationship of these six prayer types with psychological wellbeing, confirming the established finding that prayer can positively affect psychological wellbeing.

Whittington et al. (B.L.Whittington, S.J.Scher, 2010) studied a group of 430 individuals. They found that three forms of prayer (adoration, thanksgiving, reception) had consistently positive relations with wellbeing measures. In contrast, the other three forms of prayer (Confession, Supplication and Obligatory prayers) had negative or null relations with the wellbeing measures. The prayer types that have positive effects appear to be less ego-focused and more focused on God.

A recent study by Newman et al. on the Dynamics of Prayer in Daily Life and Implications for Well-Being involving 350 individuals who completed questionnaires once a day for two weeks (4,437 daily reports) clarifies some of the complexities. Moving beyond distinctions between factor structures of prayer content, first, they examined the antecedents (i.e., the types of daily events, feelings, and states of well-being) that influence specific prayer content. Second, they considered the consequences of prayer on well-being on the following day through lagged analyses. Third, to understand the mechanism explaining the lagged relationships from prayer to well-being, they also examined the moderating effects of individual differences in prayer frequency. They found that thanksgiving and adoration were more prominent in prayers on days when positive events were reported and wellbeing was high. In contrast, supplication was more prominent on days when negative events were reported and wellbeing was low. Relationships between daily events, states of well-being, and prayers of confession were mixed. Some of the negative effects of prayer on wellbeing were attenuated or even reversed among people who prayed consistently (D.B.Newman, J.B.Nezlek, T.M.Thrash, 2023).

Receptive prayers continue to show excellent results. A recent study involving 1,861 senior citizens showed that meditation can alleviate symptoms of depression and anxiety by enhancing one's capacity to experience compassionate love. Incorporating

meditation into mental health treatment plans could be a promising approach to enhancing feelings of love, which may help in reducing depressive symptoms and anxiety. (D.B.Newman, J.B.Nezlek, T.M.Thrash, 2023).

In my experience and reflections, all six types of prayers need to be practised regularly in a disciplined and holistic manner for our physical, mental and spiritual wellbeing.

1. Adoration - praise and worship - we put ourselves in the big picture, disregarding our situation/ condition while ensuring adherence to justice and mercy.
2. Confession - we identify our flaws and mistakes, seek forgiveness and set out to mend broken relationships.
3. Thanksgiving - we count our blessings and rejoice with gratitude.
4. Supplication - we reflect on the needs of others and intercede for them. We also identify our needs, and we pray specifically for assistance.
5. Obligatory prayers - provide a framework for our prayer life to strengthen our spiritual disciplines.
6. Receptive prayers and meditations - give us the space for a contemplative attitude of openness, deep listening, receptivity, and surrender.

Conclusion

There is much need to broaden the research to dig deeper and gather more evidence regarding the relationship between prayer and mental health. We can achieve this by promoting closer relationships between Mental Health Professionals and Faith communities. We need to invest in the faith communities becoming more informed and committed to being effective co-workers and promoting mental wellbeing. Let us foster supportive, safe spaces in our congregations and strive to maintain confidentiality and respect. May we constantly battle against misinformation, obscurantism, stigma, and discrimination.

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Family burden and quality of life in major mental illness

Abstract: "Family intervention" is an approach involving active family member participation in the treatment of a patient with mental pathology, encompassing both education and the creation of supportive interaction environments for all involved.

It's important that families feel in control of the situation, receive emotional support, and utilize effective coping strategies, which in turn reduces their emotional burden. The intervention aims to alleviate negative emotions, such as guilt and anxiety that often arise in family members when they are dealing with the mental health challenges of their relatives. The program promotes a better understanding of the nature of the illness, its symptoms, and the risks of relapse, as well as the role of medication. It helps individuals cope with critical situations and includes training in assertive communication skills and problem-solving related to the illness of a relative. It is important for families to recognize their significance in the treatment process and to be able to adapt to changes, which contributes to more effective interaction and the maintenance of the entire family's mental health.

Keywords: Prayer and mental health, psychological well-being, spiritual needs

Interaction with patients' relatives is certainly one of the most pressing and consistently relevant issues for those working in the field of mental health, also because of the consequences this may have on treatment outcomes, which will be discussed in detail in my presentation.

"Family burden" refers to the practical and psychological consequences of living with and caring for a relative with a mental illness, both subjectively and objectively. In particular, I would like to focus on the early stages of mental disorder, as it is during this period that the chances of effective intervention are highest. The prolonged course of the disorder significantly reduces the likelihood of restoring the patient's previous skills and abilities. Scientific studies show that even intervention two to three years after the onset of the disease significantly limits the possibilities for effective care. Moreover, some data indicate that after one year, and according to others – after a few months from the onset of the disease, the return of the patient and his family to a normal life becomes an extremely difficult task (G.Corrao,2015).

Early intervention in the treatment of severe mental disorders like psychosis develops in four main directions:

- 1) Psychopharmacological treatment: often a necessary component of therapy.
- 2) Competent and timely psychotherapeutic support. Cognitive Behavioral Therapy (CBT) is considered the most effective model.
- 3) The whole range of interventions, which are numerous, aimed at preserving the social role of a teenager during treatment. By "teenager," I mean that the onset of most serious mental disorders, including schizophrenia, psychotic disorders, mood disorders, bipolar disorder, even serious personality disorders and addictions, occurs in adolescence and young adulthood (up to 25-30 years). Therefore, interventions should be targeted at young people and be comprehensive.
- 4) Family support: this is the last aspect to be discussed in this report. In recent years, the term "psychoeducation" has been replaced by "family intervention." This concept has expanded its practice from simple information and education about the disorder to active problem solving and, importantly, targeted treatment. The goal of such intervention is to improve the well-being of each family member, including siblings, as well as anyone who, even if not a blood relative, cares for the young person in the early stages of the illness. The satisfaction of family members providing care for

the patient in their role as caregivers, influenced by a sense of control over the course of the illness, the presence of social support, and the use of effective coping strategies, correlates with a reduction in their emotional distress. In the context of the patient's first episode of illness, interventions should aim to prevent and reduce feelings of guilt, loss, and shame among family members, as well as to mitigate negative emotional reactions such as anxiety, anger, and depression, often associated with distorted and irrational interpretations of symptoms and the disorder.

By "expressed emotion," we mean the expression of emotions by family members towards their ill relative; it is assessed using the "Camberwell Family Interview" (A.Meneghelli, 2011).

It assesses several parameters, such as:

Criticism (C): defined by the sum of critical comments made about the patient; both content and tone of criticism are assessed;

Hostility (H): refers to critical observation of the patient as a whole, rather than in specific situations or aspects.

Emotional overinvolvement (EOI): an exaggerated emotional response to a patient and everything related to them, coupled with pronounced overprotective behavior.

Warmth and Positive Remarks (W/PR): Warmth expressed towards the patient (praise, approval, and high regard for the patient). A high correlation has been found between expressed emotionality and the frequency of relapses in patients with psychoses. At the same time, more adequate expression of emotions within the family transforms it into a protective factor. The results of our study, published a few years ago, demonstrate that reducing the level of expressed emotionality in the family system at early stages of the illness in patients can lead to significant improvements in the family's quality of life and a decrease in the risk of relapse for the patient.

Family members of young people in the early stages of illness or at high risk primarily experience fear and anxiety in response to the traumatic event of the illness or a period of increased risk. These reactions are classified as manifestations of emotional over-involvement (EOI). It is important to note that such families do not yet exhibit the critical and hostile behavior typical of families where the illness is chronic and accompanied by long-term negative symptoms/

Research shows that families with poor awareness of mental disorders often face two negative consequences. Lack of information can trigger dysfunctional, catastrophizing interpretations. This means the family begins to expect extremely negative disease progression and worsening life conditions. Such expectations generate anxiety and fear, which in turn create difficulties in problem-solving and lead to stressful situations.

On the other hand, a lack of information can provoke dysfunctional interpretations, but in a non-catastrophic, minimizing way ("it will pass, he's young, we've all been through this, he'll get better later"). Such judgments reduce the level of concern and proper attention to early symptoms, hindering or completely excluding the timely initiation of necessary treatment.

At the same time, providing accurate information allows us to effectively respond to problems, manage emotions, reduce emotional tension, and decrease stress.

How do we assess a family that has approached our service? The assessment includes the following stages and methods:

- Clinical interview,
- Self-monitoring at home using monitoring diaries,
- Report,
- Problem solving (problem definition),
- Assessment of expressed emotionality,

- Assessment of knowledge about disorders,
- Collecting the patient's medical history prior to the onset of the disease,
- Family members' reaction to events,
- Use of tools (tests/interviews, etc.),
- Use of case formulation,
- Explanatory models of disorders (e.g., vulnerability-stress model, cognitive model of positive symptoms of psychosis, anxiety vicious cycle, etc.).

Intervention plan with the patient's family and significant others is built considering the current phase of the illness and its progression:

First episode and crisis,
Symptomatic remission after the first episode,
Treatment phase and maintaining well-being.

Phase 1. General Psychoeducation: First Episode and Crisis Management.

GOALS: Establish contact with family members by collecting medical history and events that led to hospitalization or a request for treatment.

Actions:

1. Obtain patient's medical history.
2. Inquire about events leading to hospitalization or request for help.
3. find out which stages preceded the onset of the disease.
4. Explore family members' motivation to participate in the treatment process.
5. Instill confidence and acknowledge that the person is facing a complex but manageable situation.

At this stage, the treatment process and therapy options should be disclosed. It is important to provide general but clear information about medicines, postponing more detailed information to stage 2 unless it is urgent. It is also necessary to explain the essence of therapy and its current purpose, as well as to present a general treatment plan and goals, including medication, psychotherapy and social support (individual plan).

Phase 2. Symptom Remission: Psychoeducation phase specific to primary treatment, and Problem Solving.

In the second phase, the intervention aims to create and maintain the well-being of both the patient and his family. For the patient, this implies sharing knowledge about the disorder with family members and teaching effective problem-solving and assertive communication skills. For the family, the goal is to reframe erroneous attributions, reduce guilt, confusion, and stress, and correct underestimation of the disorder's severity. It is important to consider each family member's individual reactions to the new situation, identify emerging needs or changes (e.g., self-blame, stigmatization, common misconceptions, irrational fears), and apply the Problem Solving (PS) method to overcome them.

Actions:

1. Identify irrational beliefs and self- or other-blame attitudes in each family member.
2. Clarify changes within the family since the onset of the illness.
3. Ascertain each family member's perceptions of the current situation.

To effectively assist patients and their families, it is necessary to:

Clarify the illness picture, including positive and negative symptoms, risk signs, and typical disorder progression; provide specialized psychoeducation on psychosis, detailing the nature of positive and negative symptoms; explain the role of medication in recovery and address mistrust or common misconceptions about it (specific psychoeducation); present a model of illness maintenance (vulnerability/stress); adjust unrealistic expectations regarding recovery and timelines; assess the impact of the

illness on family members and relationships, dispelling misconceptions, myths about mental disorders, and feelings of guilt (self and other-blame); assess the need for individual treatment for family members suffering from personal disorders or relationship difficulties (anxiety disorders, depression, loss, separation, family changes); refer family members with mental pathologies requiring specialized care for appropriate treatment; introduce the concept of relapse and train in recognizing its early signs and risk factors; improve family communication skills, emphasizing: increasing expression of positive feelings, reducing negative emotions and their appropriate expression (when necessary), developing the ability to say "no."

Phase 3. Well-being Maintenance: Advanced Psychoeducation

The third and final phase involves various interventions depending on the stage of the disorder. Unfortunately, relapses are observed in some cases. In other cases, the lengthy recovery process allows for medium- and long-term monitoring with family involvement. Key at this stage remain encouraging problem-solving skills and teaching the recognition of risk signs or the impact of stressful situations to prevent relapses.

For effective support, it's important to review perceptions and expectations regarding the illness's course. It is necessary to actively emphasize the patient's strengths and personality, to document changes and successes, while remembering that family members may not always notice them. Skills for coping should be purposefully developed, and if necessary, individual treatment should be offered to family members experiencing personal or relational disorders and difficulties (e.g., anxiety disorders, depression, severe loss, separation, intra-family changes).

In psychoeducation for relapse prevention, it's crucial to openly discuss with the family not only the possibility of relapse but, importantly, how to prevent it. This involves teaching family members and the patient to recognize "risk signals." A relapse action plan involving family members is recommended. Maximum flexibility and accessibility of medical staff for prompt assistance are important. It should also be clarified that while relapses are possible, they are preventable. They are often preceded by symptoms similar to those before the first episode: increased irritability, anxiety, withdrawal, sleep and concentration disturbances, strange behavior, unprovoked excitement, or low mood.

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Comprehensive medical rehabilitation care for patients with severe mental illnesses and their family members: a biopsychosociospiritual approach

Abstract: This report investigates the theoretical underpinnings of integrated medical rehabilitation services for patients suffering from severe mental disorders and their family members. It introduces psychosocial rehabilitation models developed based on these principles and evaluates their effectiveness. The findings indicate a significant reduction in the frequency of relapses and hospitalizations among patients participating in these programs. Additionally, there is an increase in compliance with treatment, enhanced disease awareness, heightened motivation to maintain positive outcomes, the emergence of constructive coping strategies, and the development of resilience. The assessment of the family therapy model reveals improvements in the quality of life for relatives, an increase in familial awareness of the mental illness, a more positive attitude towards psychopharmacological treatment, and a decrease in distress related to interpersonal communication and social functioning.

Keywords: schizophrenia, family of a patient with schizophrenia, psychosocial rehabilitation, types of psychosocial interventions, models of comprehensive care, effectiveness assessment.

Over the past two decades, there have been substantial advancements in the field of medical rehabilitation in psychiatry, particularly in the domains of psychosocial therapy and psychosocial rehabilitation (PSR). Presently, PSR represents the most significant and rapidly evolving branch within psychiatry. Contemporary search engines offer an extensive array of resources in this area, which include scientific and methodological publications, diverse informational materials on psychosocial therapy and rehabilitation, as well as comprehensive practical experience.

For several years, the Federal State Budgetary Institution "Scientific Center for Mental Health" has been engaged in the development and evaluation of contemporary, effective models of medical rehabilitation services for patients with severe mental disorders, such as schizophrenia, schizophrenia spectrum disorders, and bipolar affective disorders (BAD), as well as for their family members.

The objective of this report is to discuss the conceptual frameworks underlying the medical rehabilitation care models and to present the findings of their effectiveness evaluation.

Materials and methods. The report is based on a comprehensive compilation of scientific research conducted by the staff of the Department of Psychiatric Services at the SCMH. Additionally, it incorporates findings from studies by both Russian and international authors. The research methodology includes the application of clinical and psychopathological assessment techniques, psychometric instruments, psychological evaluation methods, hierarchical analysis algorithms for assessing the performance of psychiatric services, scientifically validated methods and algorithms for data collection and processing, and in-depth factor analysis.

Results. In discussing conceptual approaches, it is crucial to emphasize that medical rehabilitation services are viewed as a complex and multidimensional phenomenon. The development and enhancement of these services must be undertaken at various organizational levels, including patients and their families, mental health institutions providing care, and the state and society at large (see Figure 1). For each of these levels, it is imperative to establish specific goals, objectives, features, criteria, and priorities in order to ensure effective and feasible assistance within contemporary socio-economic conditions, which would meet the needs of all participants in the provision

process (V.S. Yastrebov, V.G. Mitikhin, T.A. Solokhina et al., 2008). A schematic representation of a *systematic approach to the provision of medical rehabilitation services* is depicted in Figure 1.

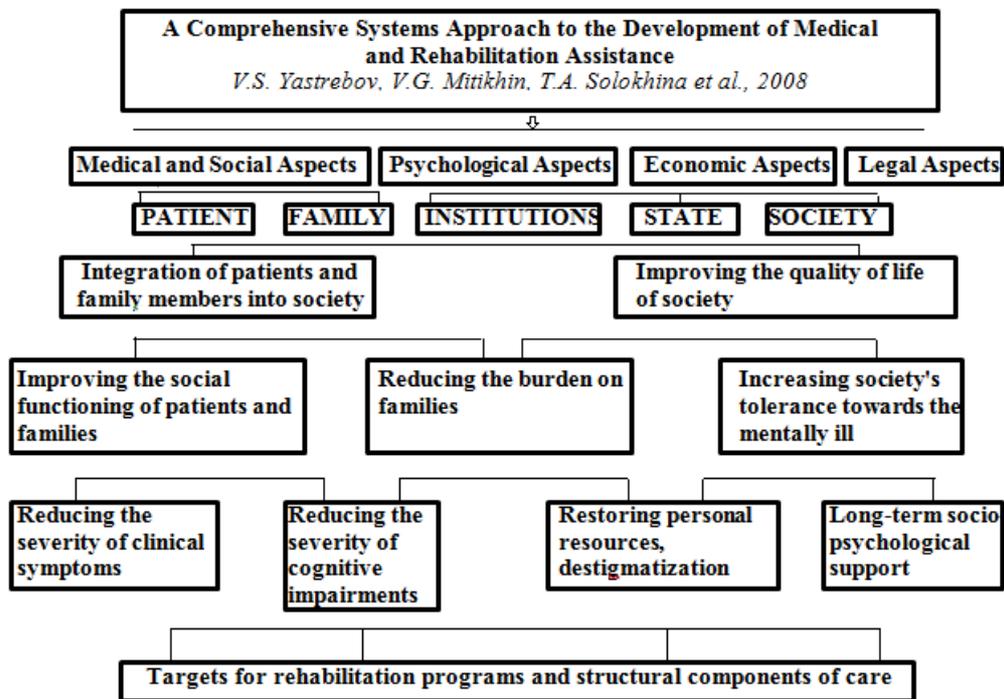


Fig. 1. A systems approach to psychosocial rehabilitation.

In the process of examining the conceptual frameworks required for the advancement of contemporary psychosocial therapy and rehabilitation, it is essential to acknowledge several other crucial prerequisites. At present, the theoretical and methodological foundation of medical rehabilitation services is anchored in the *biopsychosocial paradigm* of mental disorders (Engel 1977). This paradigm underscores the significance of biological, psychological, and social factors in the etiology of mental illnesses, as well as their influence on the patient's resource potential. Additionally, it is founded on a diathesis-stress model, which conceptualizes the mechanisms of mental disorders as involving multiple interacting subsystems at biological, behavioral, and psychological levels. This necessitates a comprehensive assessment of the patient's overall condition.

The *biopsychosocial paradigm* serves as a comprehensive framework for the provision of psychiatric care, encompassing psychopharmacological interventions, psychosocial therapies, psychotherapeutic approaches, and sociotherapeutic measures (Oshevsky, D.S., Solokhina, T.A., 2023). Nevertheless, this model does not fully capture the holistic nature of the individual, including its spiritual dimension and value sphere.

Biopsychosociospiritual approach. The World Health Organization has endorsed a multifaceted biopsychosociospiritual framework for the management of addiction disorders. This comprehensive model incorporates biological, psychological, social, and spiritual dimensions, recognizing the interconnected nature of these factors in addiction. Recent empirical evidence underscores the efficacy of integrating spiritual components into rehabilitation programs. This integration offers substantial resources for overcoming the challenges posed by mental illness, benefiting not only the patient but also their family members. Consequently, it is imperative to consider the spiritual

dimension when designing and implementing rehabilitation strategies (Kopeyko G.I. et al., 2020; Kopeyko G.I., Borisova O.A., Gedeveni E.V., 2022).

Family-oriented approach. In the context of developing a contemporary model for medical rehabilitation services, it is essential to emphasize the role of the family in the care of individuals with mental disorders. Within the biopsychosocial framework, *family relationships* have transitioned from being considered a direct cause of the disease (as previously posited in psychoanalytic theories) to being recognized as one of multiple factors influencing the progression of the disorder and the likelihood of relapse (Kuzminova M.V., Solokhina T.A., 2023). Research indicates that the emotional expressions of patients' relatives, such as excessive emotional involvement, hostility, or critical remarks, along with other familial factors including interparental conflict, social isolation, contradictory approaches to managing the ill family member, heightened fear of psychiatric stigma, miscomprehension of the patient's condition, unrealistic expectations, and a lack of willingness to collaborate with healthcare providers, are identified as risk factors for relapse among patients (Brown G.W. et al., 1972; Lutova N.B., Makarevich O.V., 2020).

In the context of medical rehabilitation services, the family unit should be regarded as a system characterized by dynamic interactions among its members. When a mental disorder affects one member, it inevitably impacts the entire family system. Consequently, the focus of study and intervention should be on the family system as a whole, rather than individual family members as isolated elements (L. Bertalanffy, 1973; M. Bowen, 1978).

In recent decades, there has been a significant shift in the conceptualization of the role of families in the management of mental health conditions (Falloon I.R.H. et al., 1985). Family members are now recognized as integral participants and natural support systems at all stages of the treatment process for individuals with mental disorders. They are provided with education and counseling to understand that their attitudes and behaviors can significantly influence the recovery trajectory of their loved ones. Emphasis is placed on the strengths and resources inherent within each family unit. Concurrently, the burdens experienced by families have been acknowledged, including the challenges associated with caregiving, the unmet need for assistance, diminished quality of life, difficulty in accepting the illness, and the necessity for long-term or even lifelong treatment interventions (Solokhina et al., 1998; Korman et al., 2012). These factors underscore the importance of family-centered care and the development of effective strategies to support family members in their caregiving roles.

The development of neuroscience and the shift of the vector of scientific research into the field of cognitive functions, social cognition, motivation has provided new targets for psychosocial rehabilitation.

It has been established that the decline in social functioning among patients with severe mental disorders is more closely linked to neurocognitive and social-cognitive deficits compared to productive and negative symptoms, as well as low social competence (Gurovich I.Ya., Papsuev O.O., 2015; Dziwota E. et al., 2018; Horan W. P. et al., 2023). Consequently, research in the domain of cognitive functions and social cognition is a prerequisite for the substantiation of pathogenetic psychosocial therapy and psychosocial rehabilitation. This form of psychosocial therapy encompasses cognitive remediation, which involves training in social and cognitive skills through two approaches: compensatory and restorative, as well as metacognitive training that fosters the development of social cognition, responsible for social intelligence and the ability to accurately perceive the emotions and intentions of others (Moritz S. et al., 2023).

The *implementation of psychosocial interventions* that have been empirically validated as effective, as evidenced by systematic reviews employing meta-analysis.

Furthermore, the author's methodologies are incorporated, having undergone comprehensive efficacy assessments and demonstrating robust evidence of their effectiveness.

Examples of psychosocial interventions that have demonstrated efficacy:

- Individual psychotherapeutic interventions for patients.
- Family-based interventions, including psychoeducation.
- Social cognitive trainings, cognitive remediation therapy, and meta-cognitive therapy.
- Vocational training programs and supportive employment initiatives.
- Cognitive behavioral therapy aimed at mitigating the elevated risk of psychosis development.
- Patient support groups.
- Training programs designed to reduce stigmatization and self-stigmatization.
- Religious and spiritual interventions that enhance quality of life, decrease the risk of suicide, alleviate depression, and influence biological, psychological, and social factors.

The transition from methods with general effects to psychosocial interventions aimed at restoring impaired areas of functioning (I.Ya. Gurovich, 2015).

The logical evolution of PSR involves moving from general rehabilitation approaches, employed by specialists (*including cultural activities, diverse employment opportunities, collaborative relationships, therapeutic communities, drama therapy, and literature therapy*), towards methods specifically designed to restore impaired functional areas. The areas of concern/intervention include: neurocognitive deficits, social cognition, motivation, emotional functioning, compliance and illness awareness, role and family functioning, social functioning, coping strategies, skills, knowledge, abilities, and other affected domains.

The proposed conceptual frameworks facilitated the development of a foundational model for psychosocial and psychotherapeutic interventions for patients with severe mental disorders, including schizophrenia, schizophrenic spectrum disorders, and BAD. The model's structural components are illustrated in Figure 2. This model has been implemented in psychiatric hospitals No. 1, 4, and 14 in Moscow, as well as in the NGO "Family and Mental Health," which operates in community settings outside traditional psychiatric institutions. Over 400 patients have participated in psychosocial interventions under this model.

The patient model encompasses 8 modules, each designed to address various aspects of patient care. These modules include psychopharmacological interventions, psychoeducation and adherence therapy, specialized training programs, support groups, psychological counseling, psychotherapeutic services (both individual and group-based, with an emphasis on creative modalities), spiritual support (which may involve psychotherapeutic groups, pilgrimage-based activities, visits to religious sites, consultations with clergy, and viewing films with spiritual and psychological content), and a structured leisure program. This comprehensive framework can be tailored to meet the specific needs of patients by incorporating additional psychosocial interventions and advanced technological applications as required.

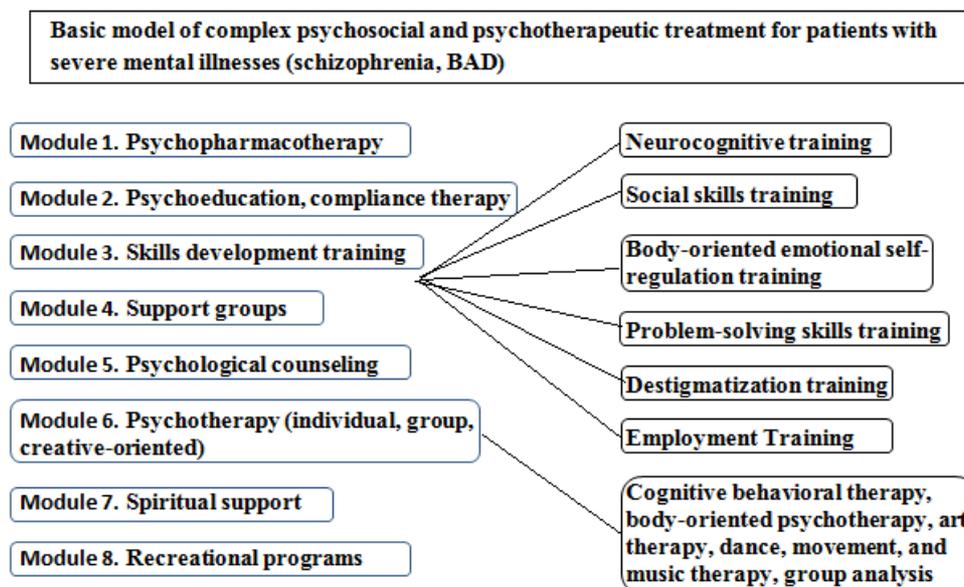


Fig. 2. The basic model of complex psychosocial and psychotherapeutic treatment for patients with severe mental illnesses.

Evaluation of the efficacy of a comprehensive psychosocial rehabilitation program for patients

The assessment of the efficacy of medical rehabilitation interventions was conducted by the staff of the Department of Psychiatric Services of the FSBI SCMH in various patient populations, across diverse forms of care, and with varying durations of psychosocial treatment. This report focuses on a key indicator: the reduction in hospitalizations among patients participating in a long-term comprehensive psychosocial rehabilitation program within the framework of a developed model of medical rehabilitation services provided directly in the community, facilitated by the NGO "Family and Mental Health." The average duration of this program was 3.5 years. The study demonstrated a statistically significant decrease in the hospitalization rate from 0.22 to 0.14 admissions per year among participants (Yastrebova V.V., Solokhina T.A., 2018).

The following factors may be considered among the reasons for the reduction in hospitalizations:

- Achievement of high-quality remission and its maintenance through enhanced collaboration and recognition of the necessity for continuous supportive treatment.
- Heightened awareness of the disease and the acquisition of skills to identify symptoms as manifestations of mental illness.
- Increased motivation to improvement and sustained positive outcomes.
- Development of life-saving coping skills and adaptive strategies to manage illness, as well as improvements in social competence.
- Achievement of a high level of stress tolerance (resilience) comparable to that of a control group of healthy individuals, as a result of the comprehensive rehabilitation program.

Dynamic immunological surveillance of patients during long-term multicomponent psychosocial treatment (in collaboration with the staff of the Neuroimmunology Laboratory of the SCMH)

The effectiveness of psychosocial rehabilitation was assessed using markers of systemic inflammation that correlate with the acuity and severity of the pathological

process in the brain. The concentration of inflammatory and autoimmune markers in the patients' blood was assessed: leukocyte elastase (LE) activity and the functional activity of alpha-1 protein inhibitor (a-1-PI), as well as the levels of autoantibodies to the S-100B protein and myelin basic protein (MBP). Neuroimmunological observation was also carried out among patients involved in the long-term comprehensive psychosocial rehabilitation program at the "Family and Mental Health" NGO.

The results of the study demonstrated that at the initial examination, the participants exhibited a significant increase in the activity of the investigated inflammatory markers, specifically LE and a1-PI, compared to the control group ($p < 0.05$). However, there was no change observed in the autoimmune markers, specifically the levels of autoantibodies against the astrocytic protein S-100B and the myelin protein (MBP), indicating the degree of the pathological process in the brain. Subsequent re-examination during the follow-up period, conducted 12 months after the initial assessment, revealed no alterations in immune parameters, while psychometric indicators improved. Despite the ongoing pathological process in the brain, patients maintained clinical stability and did not require hospitalization, which underscores the efficacy of a long-term comprehensive rehabilitation program. This program enhances stress tolerance, compliance, and the development of adaptive strategies to manage the disease (Zozulya S.A., Solokhina T.A., and Klyushnik T.P. 2022).

Following a period of three months during which patients underwent neurocognitive training, a reduction in the levels of antibodies targeting neuroantigens, specifically the *astrocytic protein S-100B and the MBP*, was observed. This finding suggests that the training intervention exerts a modulatory influence on neuroplasticity and neuroinflammatory processes, purposively through epigenetic mechanisms.

An assessment of the efficacy of psychosocial rehabilitation through immunological markers has demonstrated that comprehensive, long-term psychosocial interventions exert a pronounced inhibitory influence on the ongoing pathological processes within the brain. This conclusion is corroborated by the level of functional recovery observed in patients, in conjunction with the attenuation of the pathological process's intensity following neurocognitive training interventions. The utilization of immunological indicators as objective criteria for evaluating the efficacy of psychosocial rehabilitation in patients diagnosed with schizophrenia and related disorders holds significant promise.

The basic model of support for families of patients with mental disorders comprises six distinct modules. This family therapy model has been successfully implemented in psychiatric institutions No. 1, 4, and 14 in Moscow. Over 500 family members have received psychosocial support through this program (Fig. 3). The structure of the family therapy model encompasses the following six modules: psychoeducation, skills training, psychological counseling (individual and family), group-analytic psychotherapy (duration: two years), an online support group based on spiritual therapy, and efforts to expand social networks (formation of support groups, involvement in public organization's activities).

Basic Model of Support for Families of Patients with Mental Disorders
(V.S. Yastrebov, T.A. Solokhina, V.G. Mitikhin, L.M. Alieva, V.V. Yastrebova et al., 2003 – 2023)

- Module 1. Psychoeducation**
- Module 2. Skills training**
- Module 3. Psychological counseling (individual, family)**
- Module 4. Group-analytic psychotherapy (2 years)**
- Module 5. Spiritual support group (online)**
- Module 6. Enhancing social connectivity through support groups and community organization involvement**

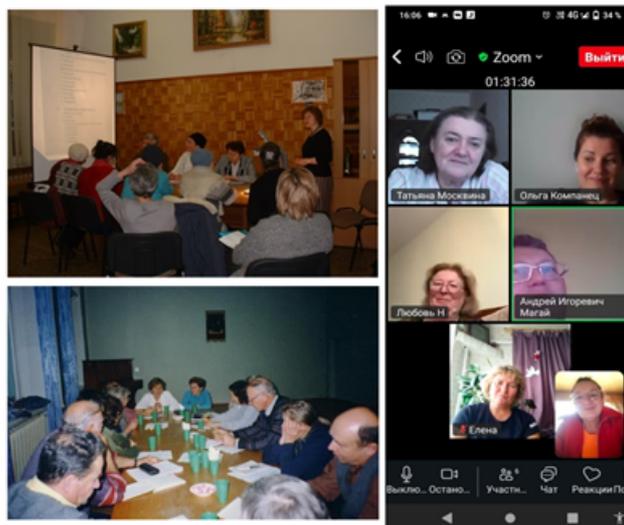


Fig. 3 Basic model of family therapy.

In the context of *assessing the efficacy of working with patients' families*, the following statistically significant outcomes were identified: an enhancement in the quality of life of patients' relatives, an increment in the number of family members who are informed about a family member's mental health condition, an improvement in relatives' perception of pharmacological treatment, an amelioration of psychological well-being, the emergence of adaptive strategies for coping with the disease, and a reduction in distress associated with interpersonal communication difficulties and social dysfunctions (Solokhina T.A., Kuzminova M.V., Mitikhin V.G., 2021).

To sum up, the implemented models of medical rehabilitation services for patients with severe mental disorders and their families have demonstrated their efficacy and potential. The treatment protocol should incorporate psychopharmacological interventions, psychosocial interventions, psychotherapeutic approaches, and spiritual support as integral components.

The significance of psychosocial treatment and psychosocial rehabilitation is underscored by a quote from the academic article by Prosser A., Helfer B., and Leucht S., titled "Biological vs. Psychosocial Treatments: A Myth about Pharmacotherapy v. Psychotherapy" (2016): "Modern cognitive neuroscience demonstrates that the understanding of psychopharmacotherapy as a biological treatment, and psychosocial treatment as a tactic aimed solely at social adaptation, is a myth... The goal of both approaches is pathological neuronal functioning. The only difference is in the method of achieving therapeutic and neurobiological changes."

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Self-stigmatization of patients with endogenous mental disorders: biopsychosocial studies

Abstract: This report presents an analysis of the adverse consequences of self-stigmatization among individuals with mental disorders, utilizing a biopsychosocial framework. The article discusses the findings of a comparative study examining self-stigmatization in patients with endogenous mental disorders, considering the influence of disease form and duration. Based on the study's results, the conceptual framework of an integrated program for the prevention and reduction of self-stigmatization among patients with endogenous mental disorders, developed by the Department of Psychiatric Services at the *FSBSI Scientific Center of Mental Health*, is detailed. Quantitative data assessing the program's effectiveness are provided, and potential avenues for future research and intervention strategies are outlined.

Keywords: biopsychosocial model, self-stigmatization, endogenous mental disorders, schizophrenic spectrum disorders, bipolar affective disorder.

Introduction

Patients with mental disorders constitute one of the most vulnerable populations globally. The impact of the disease itself, coupled with societal stigmatization, can lead to self-stigmatization among these individuals. In contemporary psychiatry, self-stigmatization is characterized as "the entirety of a patient's negative responses to their illness and the societal status of being labeled 'mentally ill'" (Yastrebov V.S., Gonzhal O.A., Tyumenkova G.V., Mikhailova I.I., 2009).

From a biopsychosocial perspective, self-stigmatization has numerous adverse effects. These include the deterioration of patients' clinical condition, undermining their trust in mental health services, and reducing treatment adherence (compliance). Consequently, at the social level, it leads to challenges in obtaining education, securing employment, narrowing social circles, and reducing overall social functioning and quality of life. At the socio-psychological and psychological levels, intrapersonal and interpersonal changes occur, exacerbating the disease. This creates a vicious cycle where negative factors amplify one another, perpetuating and intensifying the initial issues (Solokhina T., Oshevsky D., Barkhatova A., Kuzminova M., Tyumenkova G., Alieva L., Steinberg A., Churkina A., 2024).

Self-stigmatization represents a complex, multidimensional, and dynamic psychological phenomenon that impacts individuals with diverse mental disorders. Nevertheless, some authors point out that, in comparison to other mental disorders, individuals with endogenous mental illnesses (schizophrenia spectrum disorders, bipolar affective disorder (BAD)) experience the highest levels of self-stigma (Latalova et al., 2014; Rayan & Aldaieflih, 2019). Notably, between 55% and 70% of patients with these conditions exhibit a pronounced degree of self-stigmatization.

The scientific literature demonstrates that the incorporation of programs aimed at reducing self-stigmatization into psychosocial rehabilitation, particularly at the initial stages of the disease, leads to an improvement in the condition of 40-60% of patients with endogenous mental disorders and an enhancement in their level of social functioning (Yanos P.T. et al., 2019; Rüscher N., Kösters M., 2021). It is important to note that individuals with long-term mental illness also require such support. Effective, evidence-based programs have been designed internationally to overcome self-stigmatization. However, these programs have not been adapted for implementation in the Russian Federation. Consequently, the development and implementation of such programs represents an urgent and critical task.

The objective of the research was to substantiate and develop organizational and methodological strategies for the implementation of a comprehensive psychosocial intervention technology aimed at mitigating self-stigmatization among patients with endogenous disorders.

The research objectives were as follows:

1. To determine the characteristics of self-stigma in patients with endogenous mental disorders at various stages of the disease.
2. To develop and implement a technology aimed at reducing self-stigmatization, taking into account the specific conditions of the Russian healthcare system, for patients with endogenous mental disorders.
3. To evaluate the effectiveness of the developed technology in mitigating self-stigma.

Materials and methods

A cohort of 86 patients was assessed and categorized into groups according to the nature of their mental disorder and its duration.

The initial cohort, designated as SSD <5 years, comprised patients diagnosed with first-episode psychotic conditions associated with schizophrenic spectrum disorders according to the International Classification of Diseases, Tenth Revision (ICD-10) codes F23.xxx, F20.xxx, and F25.xxx, with a disease duration of less than five years. The second cohort, identified as BAD <5 years, consisted of patients diagnosed with bipolar affective disorder (ICD-10 codes F31.xxx), also at the early stages of the illness, with a sample size of seventeen participants. The third cohort, labeled SSD in Psychosocial Rehabilitation >5 years, included patients with schizophrenic spectrum disorders (ICD-10 codes F20.xxx and F25.xxx) who were in advanced stages of the disease, characterized by a duration of more than five years. These patients were members of the Regional Charitable Public Organization "Family and Mental Health" and were participants in a comprehensive long-term psychosocial rehabilitation program conducted by the organization.

Along with the clinical and psychopathological examination, an assessment was carried out using clinical psychometric scales and psychological questionnaires: "Positive and Negative Syndrome Scale" (PANSS) (Kay S.R., et al.; 1987; Mosolov S.N., et al., 2021); "Questionnaire for the Assessment of the Phenomenon of Self-Stigmatization in Mentally Ill Patients" (Mikhailova I.I., 2004); "Questionnaire 'Method for Assessing Internal Stigma in Patients with Mental Disorders'" (MAIS, Lutova N.B., et al., 2022); "Insight Scale for Psychosis" (ISP, Birchwood M. et al., 1994); "Drug Attitude Inventory" (DAI, Hogan T.P., Awad A.G., Eastwood R., 1983); "Symptom Checklist-90" (SCL-90, Derogatis L.R., et al., 1976; Tarabrina N.V., 2001); "Questionnaire 'Self-Regulation of Behavior Style'" (SRBS, Morosanova V.I., 2004); "Questionnaire 'Coping Strategies Indicator'" (CSI, Amirkhan J., 1990; adaptation by Sirota N.A., 1994; Yaltonsky V.M., 1995).

Research findings

A clinical and psychometric analysis of patients with schizophrenia spectrum disorders, conducted using the Positive and Negative Syndrome Scale (PANSS), revealed that residual positive symptoms were predominant in patients at the initial stages of the disease. These symptoms included incompletely diminished delusional ideation, judgment impairments, isolated hallucinatory phenomena, hyperarousal, mild grandiosity, suspiciousness, and hostility (PANSS subscales: P1=2.08±0.87, P2=2.26±1.02, P3=1.69±0.69; P4=1.64±0.78; P5=1.51±0.64; P6=2.08±1.01; P7=1.46±0.60). In patients with advanced stages of the disease, negative symptoms emerged as the primary clinical manifestation. Reduced social interaction was observed

($N3=3.00\pm0.88$), impairment in abstract thinking ($N5=3.25\pm1.29$), emotional and verbal blunting ($N6=2.95\pm1.42$), and stereotypical thought processes ($N7=3.20\pm1.47$). Regarding general psychopathological symptoms, attention deficits were noted ($G11=2.91\pm0.83$), a decrease in critical self-appraisal ($G12=3.21\pm1.06$), substantial impairments in volitional regulation ($G13=3.37\pm0.76$), and diminished control over impulses ($G14=2.87\pm0.89$).

The study of the structure and values of the level of self-stigmatization components revealed specificity in the studied groups (Fig. 1).

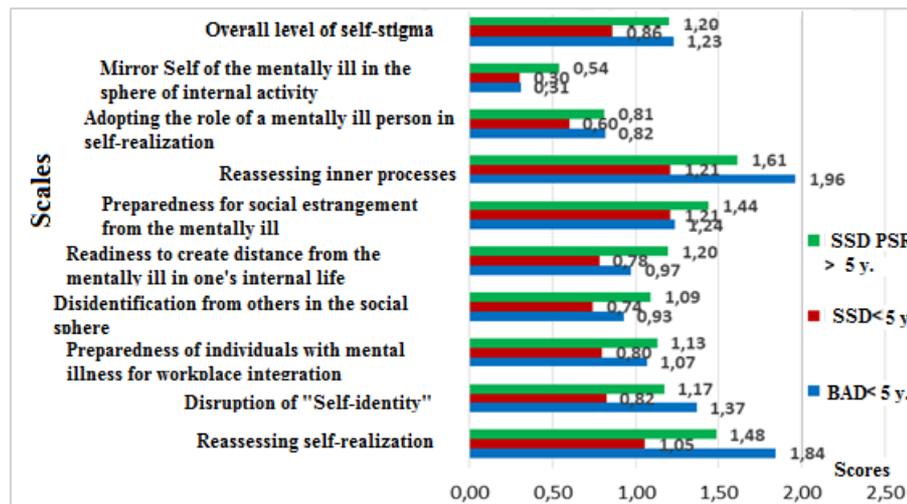


Fig. 1. Comparison of the severity of the structural components of self-stigmatization in patients in the groups of SSD <5 years, BSD <5 years and SSD in Psychosocial Rehabilitation >5 years (according to the "Questionnaire for the Assessment of the Phenomenon of Self-Stigmatization in Mentally Ill Patients").

Patients with bipolar affective disorder exhibited the highest level of self-stigmatization, with an average score of 1.23 ± 0.73 . In their perception, various potential issues such as reduced activity levels, limited self-realization, failures in professional, leisure, and creative activities, as well as difficulties in interpersonal relationships, were attributed to their mental disorder. Idealization of their pre-morbid life and underestimation of their current capabilities led to a pessimistic outlook on their future, a decline in self-esteem, and a subsequent reduction in activity that was not directly related to their affective condition. Patients with schizophrenic spectrum disorders, particularly in the advanced stages of the illness, despite ongoing long-term comprehensive treatment, also demonstrated a high level of self-stigmatization, with an average score of 1.20 ± 0.57 . The predominant component of this stigmatization was the "overestimation of their previous activity". There was a tendency to attribute shortcomings in various life aspects to the influence of their mental disorder, necessitating targeted destigmatization efforts for this group. In the early stages of the disease, patients with schizophrenic disorders displayed a relatively low level of self-stigmatization, with an average score of 0.86 ± 0.53 . This was accompanied by reduced criticality towards their condition, an underestimation of potential social and interpersonal problems, and a desire to distance themselves from individuals with mental disorders. They believed that their mental condition and associated changes would not significantly impact their daily activities.

One of the key components of successful treatment and rehabilitation is the accurate perception of one's mental illness and a strong commitment to the therapeutic process. The analysis, utilizing the ISP and DAI (Fig.2), revealed that patients with

schizophrenic spectrum disorders, particularly in the early stages of the disease, often express a need for treatment while simultaneously exhibiting a negative attitude towards medication. This is accompanied by a limited awareness of the disease and a diminished understanding of the changes associated with it, as well as a propensity towards anosognosia.

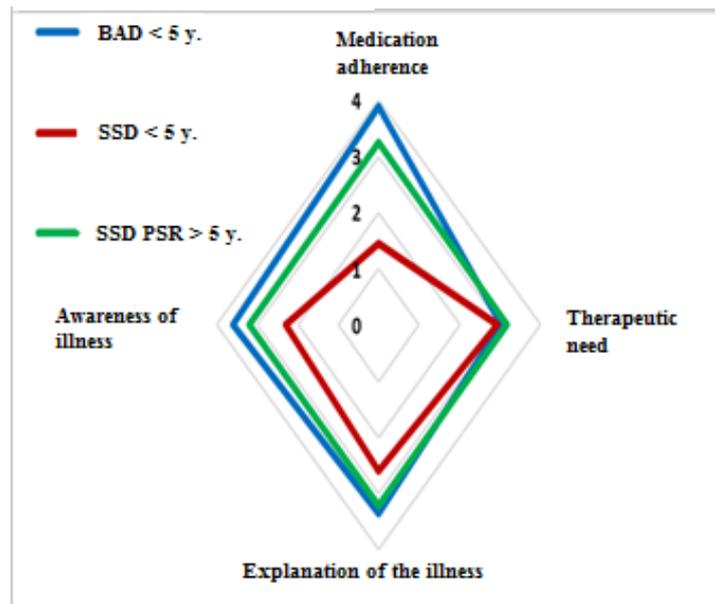


Fig. 2. Attitude to disease and medications in patients in the SSD <5 years, BAD <5 years, and SSD Psychosocial Rehabilitation >5 years groups (according to the ISP and DAI questionnaires).

Patients with bipolar affective disorder and patients with schizophrenia spectrum disorders in the advanced stages of the disease exhibited a high degree of adherence to treatment and awareness of their condition. However, this understanding was unstable and insufficient

These data, as well as a study conducted using psychological techniques (questionnaires SCL-90, SRBS, ICS), allowed us to identify the targets and directions of destigmatization measures with patients with endogenous disorders.

The limited comprehension of the disease, inadequate identification of mental disorders and their therapeutic approaches, and insufficient recognition of the consequences of self-stigmatization underscore the necessity for augmenting patients' understanding of their mental health conditions. It is imperative to cultivate a favorable disposition towards these conditions and devise strategies to mitigate self-stigmatization. The lack of skills for accurately reporting mental health issues highlights the significance of training individuals to enhance these competencies. Diminished self-regulation, feelings of pervasive physical and emotional distress, and the idealization of a pre-morbid past indicate the need to foster a positive self-image and bolster self-confidence through increased self-reflection and the identification of personal strengths. The propensity towards social withdrawal, heightened sensitivity, and limited activity underscore the importance of enhancing communication skills and reducing social tension.

A comprehensive technology has been designed to address self-stigmatization among patients with endogenous mental disorders, aligning with specific objectives. This intervention comprises three modules. The initial module, focused on psychoeducation, aims to assist patients in accepting their condition and recognizing the

necessity for treatment and a healthy lifestyle. In addition to traditional psychoeducational methods, discussions with patients include information on stigmatization, self-stigmatization, and strategies to counter their detrimental effects.

The second component is a multimodal, short-term intervention intended to facilitate safe disclosure of mental disorder information. This approach is grounded in cognitive-behavioral therapy, enhanced by elements of psychoeducation, emotive-reflexive therapy, and narrative therapy. The efficacy of this intervention has been substantiated through multiple studies across various age, cultural, and syndromic groups of patients with mental disorders (Corrigan P.W., et al., 2015).

The third structural element of the developed technology is the training program titled "A Photographic Exploration of Self and the World" (Russinova et al., 2014; Solokhina et al., 2023). In this program, participants took photos of objects and daily occurrences that elicit feelings of anxiety, construct narratives based on their personal experiences, and engage in an analysis of their emotions and associated psychological states. Subsequently, they receive feedback on their observations and reflections. Empirical evidence has been collected to substantiate the efficacy of this intervention approach.

The study encompassed a total of twenty patients diagnosed with schizophrenia spectrum disorders at advanced stages of the disease process.

The comprehensive clinical and psychometric assessment, utilizing the Positive and Negative Syndrome Scale (PANSS), revealed a statistically significant reduction in negative symptoms, specifically within the "Stereotypical thinking" subscale (subscale N-7), which decreased from an average score of 2.00 ± 0.97 to 1.45 ± 0.61 . Additionally, there were significant ($p < 0.05$) changes observed in several subscales reflecting general psychopathological symptoms. Specifically, the level of anxiety (subscale G-2) decreased from 2.60 ± 1.19 to 1.50 ± 0.69 ; mental tension (subscale G-4) from 2.25 ± 0.91 to 1.65 ± 0.59 ; and depression (subscale G-6) from 2.00 ± 0.92 to 1.30 ± 0.57 . Hypochondriacal ideation (subscale G-1) also demonstrated a decrease in manifestation. Furthermore, there was an observed improvement in cognitive processes (subscale G-1) and interpersonal communication skills (subscales G-15, G-15).

An empirical study investigating changes in self-stigmatization among patients demonstrated a decrease in their apprehensions regarding the potential loss of aesthetic perception due to their mental illness, as well as a diminished fear of being unable to establish and maintain interpersonal relationships and healthy emotional connections within their families. Additionally, there was a notable reduction in the compensatory inclination to attribute personal failures to their mental illness and a corresponding decrease in self-bias, as measured by the "De-identification from others in the society" subscale of the "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients". Specifically, the mean scores before the intervention were 0.99 ± 0.46 (1.05 points), whereas post-intervention scores were 0.78 ± 0.42 (0.66 points), with a statistically significant difference ($p < 0.04$). Furthermore, patients exhibited an enhancement in protective factors that enabled them to resist stigmatizing influences, as evidenced by the "Stigma resistance" subscale of the IAIS questionnaire. The mean scores increased from 1.81 ± 0.44 points to 2.36 ± 0.58 points, also demonstrating a statistically significant difference ($p < 0.01$).

The assessment of the dynamics of psychological parameters showed that the patients' interpersonal sensitivity in social interaction decreased (the INT index of the SCL-90-R questionnaire from 1.38 ± 0.66 points to 1.00 ± 0.70 points, with $p < 0.02$), the overall level of distress (the GSI index of the SCL-90-R questionnaire from 1.07 ± 0.52 points to 0.82 ± 0.51 points, at $p < 0.01$). Positive changes in various levels of self-regulation were noted. Adequacy and awareness in decision-making increased (indicators on the "Modeling" scale of the SSRB questionnaire increased from

3.65±1.41 points to 4.30±1.14 points, with $p < 0.02$). Goal setting, planning, and goal retention have become more stable (the SRBS "Planning" scale scores have increased from 5.65±1.49 points to 6.45±1.70 points).

Consequently, a comprehensive strategy for reducing self-stigmatization among individuals suffering from endogenous mental disorders has demonstrated efficacy. It is advisable to incorporate this approach into the psychosocial rehabilitation process.

Conclusion

Stigma and self-stigma and their effects persist as critical biopsychosocial challenges in contemporary psychiatry, hindering treatment and severely limiting the cognitive and social capacities of individuals with mental health conditions. Efforts to combat stigma must be sustained, systematic, and inclusive, targeting all affected populations and implemented across all relevant sectors where stigma is encountered. A pressing objective is to develop effective destigmatization strategies that encompass a diverse array of approaches, eschewing the limitation of a single-method solution. Educational and legislative interventions can play a crucial role in mitigating stigma.

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Development of skills for safe communication about the illness in patients with endogenous mental disorders and their families

Abstract: The report provides a theoretical basis for training technology aimed at reducing self-stigmatization in individuals with mental disorders. It presents the structure of an adapted and tested version based on P.W. Corrigan's "With Pride" training (2013), which aims to teach patients skills for safely disclosing their mental disorder. Attention is paid to the main components of a multimodal approach in conducting the training, and important components for each thematic training session are also considered.

Keywords: endogenous mental disorders, schizophrenia spectrum disorders, safe disclosure skills, self-stigmatisation.

Relevance

Treatment and rehabilitation work in psychiatry, both with patients and their families, continues to face the problems of stigma and stigmatization, despite a significant set of measures carried out in recent years in domestic psychiatry, in particular in Moscow, and aimed at combating stigma and self-stigmatization (psychoeducation, art festivals, programs for psychoeducation of the population and providing them with psychiatric and psychological assistance, publications in the media, and much more). Currently, there is an increase in the number of domestic and foreign publications devoted to the problem of stigma in relation to mental health issues and the search for ways to reduce it.

When faced with an illness, patients encounter a dilemma: "If I accept it, what can I say about myself?" And this is a significant question for them. Lack of knowledge and skills - who, what, how, and to what extent to communicate - leads patients to develop a range of defensive strategies (denial of illness, avoidance, withdrawal, ignoring, etc.), which in turn results in self-limitation and self-stigmatization.

Therefore, at the initial stages of the illness, it is advisable to teach patients the skills to safely communicate information about their mental disorder, including its nature and extent, as well as various methods and choices of individuals and situations for providing this information. Patients with a long-term course of the illness also require active rehabilitation work to maintain a high level of psychosocial adaptation in the family and society (Solokhina T., Oshevsky D., Barkhatova A., Kuzminova M., Tyumenkova G., Alieva L., Steinberg A., Churkina A., 2024).

A multimodal comprehensive training for developing skills in safely disclosing one's mental illness effectively addresses this task. Its technology is based on P.W. Corrigan, B.A. Buchholz's "Coming Out Proud" (2013) training.

From the perspective of evidence-based medicine, convincing data on the effectiveness of training has been obtained for various age, cultural, and syndromic groups of patients with mental disorders (*Rüsch N. et al, 2014; Corrigan P.W., Larson J.E., Michaels P.J., et al., 2015; Tsang H.W., Ching S.C., Tang K.H. et al, 2016; Quinn D.M., 2018; Alonso M., Guillén A.I., Muñoz M., 2019; Setti V.P.C., Loch A.A., Modelli A., de Almeida Rocca C.C., Hungerbuehler I., van de Bilt M.T., Gattaz W.F., Rössler W., 2019; Rüsch N., Kösters M., 2022*).

Method

The training is a multimodal, short-term intervention based on a cognitive-behavioral approach with elements of psychoeducation, emotive-reflective, and narrative approaches (*Corrigan P.W., et al., 2015*).

The training's **goal** is the prevention and reduction of self-stigma in individuals with mental disorders.

Training **objectives** include:

- Developing an adequate attitude towards one's capabilities and limitations related to mental disorder.
- Expanding the possibilities of going beyond one's limitations.
- Teaching the basics of emotional literacy and reflectivity.
- Expanding opportunities for conscious and responsible choice in differentiated and safe disclosure of information about one's mental disorder.
- Minimizing the process of forming a negative identity associated with self-stigmatization.
- Developing skills to model potential reactions of others to disclosure of an existing mental disorder.
- Developing skills for creating and narrating a personal story about one's mental disorder.

The facilitators also aim to convey to participants the importance of choice in decision-making.

“Our destiny is determined by our choices, not our luck”.

Omar Khayyam

Training format: Information sharing, discussions, debates, individual and group work. Closed group, 4-12 participants. Weekly 2-hour sessions (*120 minutes*). The training is conducted by two facilitators (specialists with higher education: a psychiatrist-psychotherapist and a medical psychologist). Participants are given assignments related to the session topics and mini-questionnaires from the Workbook.

Inclusion criteria: patients with various mental disorders in remission, without severe cognitive impairments, who consented to participate.

The key rule for training (for facilitators and participants) is to create a safe therapeutic environment, including: confidentiality ("what's said in the room, stays in the room"); everyone's opinion matters; respect ("we respect each other"). During discussions and feedback, participants learn to express their feelings and thoughts towards others in a non-judgmental and positive way.

The training **structure** includes 2-5 psychoeducational sessions and 3-5 thematic classes. Psychoeducational sessions provide information about the illness, including symptoms, course, and therapy; address emotional distress in patients and their families caused by the illness and its manifestations; and discuss stigma and ways to overcome it. Thematic classes cover: "Weighing the pros and cons of disclosure," "Discussing different ways of disclosure," and "Telling your story." Our experience shows that increasing the number of sessions is related to participants' request for a deeper discussion of experiences that trigger dynamic group processes.

The content of each meeting is voluminous, and the main aspects of the lesson topic are discussed in detail. In addition to discussions, participants complete assignments. Below are the main (key) components of each session.

Session 1: "Exploring the Pros and Cons of Disclosure."

Session goal: to help participants model and justify their most acceptable decision for them. Discussion focuses on three areas:

1. Patient's self-perception and attitude towards their illness, focusing on self-stigmatization as a factor in negative identity formation.
2. The topic of "Secrets and Mysteries in Human Life." Secrets are a part of everyone's life, so participants can choose whether or not to disclose their experiences with mental illness.

3. Through a group "Socratic dialogue," participants weigh arguments for and against disclosure to make their own decision about revealing information.

Important! During the training, the facilitator should maintain a supportive stance in all situations, not insisting or forcing participants to any answer or decision. The basis of the training is the participant's right to CHOOSE!

During the session, participants learn that disclosing their experience with mental illness is a difficult decision that each person must make for themselves, guided by two rules:

Rule 1. Caution. Poorly delivered information can have serious negative long-term consequences.

Rule 2. "A delayed decision is a missed opportunity." This rule suggests that excessive caution leads to unjustified delays.

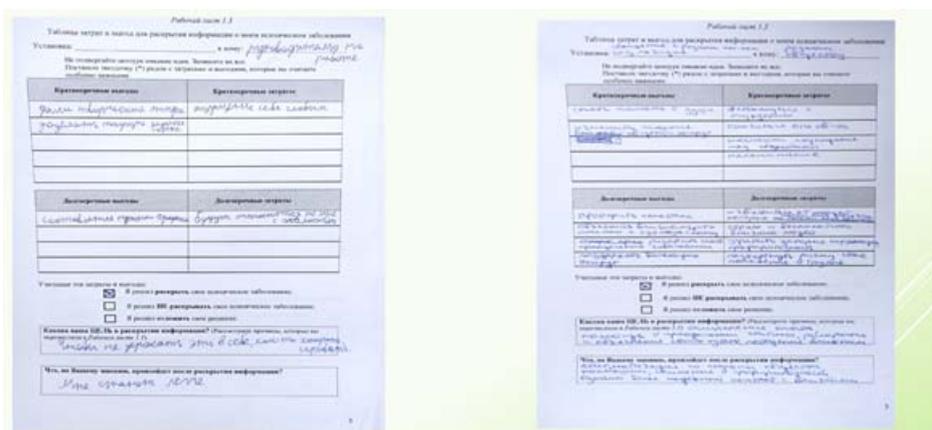
When discussing "Mysteries and Secrets," we examine existing prejudices and misconceptions, articulate the feelings that can arise from keeping a secret, and discuss what to do with secrets when we have them.

Participants discuss: reasons for disclosing mental health conditions; "costs" and "benefits" of disclosure. They are given the opportunity to decide whether to disclose information about their mental disorder or not.

The question "Can anyone help...?" raises not only the topic of help but also the participant's responsibility in making decisions to themselves and their loved ones. Furthermore, participants are informed that disclosure is a difficult and not one-time decision that may change depending on life circumstances.

"What is your decision?" – this question is asked to group participants at the end of the first session. The answer is simple: "Yes, I want..." or "No, I don't want people to know about my mental illness."

Figure 1 shows the responses regarding the decision to disclose information about their mental disorder from two training participants.



Disclosure purpose: not to keep it to myself, to be cunning, to hide.

What will happen: It will make me feel better.

Disclosure purpose: to make sense of experience, to help overcome stigma, to reveal and explain my feelings and behavior to loved ones.

What will happen: stigmatization from society, mockery, doubts about the correctness of what I did. However, a more reliable connection with loved ones.

Fig. 1. Examples of training participants' responses when deciding on information disclosure (patients with bipolar affective disorder).

As seen from the provided responses, in the first example, disclosure allows the participant not to keep it to themselves, to avoid deceit, and not to hide, which will bring them relief. For another participant, the goal of disclosure is to reflect on his experience, get help to overcome stigma, and explain his feelings and behavior to loved ones. Although the participant does not rule out stigmatization and mockery from society and doubts the correctness of their decision, he believes that disclosure will strengthen his connection with loved ones.

Session 2: "There are different ways of disclosure."

Session goal: to develop optimal strategies for disclosing an existing mental health condition.

During the session, five methods of disclosure are described (avoidance of communication, secrecy, selective disclosure, indiscriminate disclosure, sharing personal experiences); the "costs" and "benefits" associated with each strategy are discussed; questions of a differentiated approach to choosing whom to trust with personal information are considered; and possible reactions of people to receiving disclosure information are discussed.

Depending on the decision, there are many ways a participant can disclose or not disclose his mental illness treatment experience. During the session several approaches are explored, one of which a participant can choose depending on the situation, such as: selectively disclosing information in certain situations (*to those he trusts*), keeping it secret in other situations (*telling no one*), or generally avoiding situations unsafe for himself.

Participants discuss important issues related to their personal safety, specifically concerning the recognition of individuals to whom they should not disclose information about their mental disorder.

Also, strategies for keeping information about the illness confidential are discussed with the participants.

There are two strategies for keeping one's experience of dealing with mental illness secret: not telling anyone, which requires a lot of effort and constant control, which increases anxiety levels, and it's an act of inaction! A more active approach is to say what is comfortable and won't cause discomfort.

The session also discusses types of relationships and important characteristics of a person to whom one can open up. Participants are presented with key questions they should ask themselves before opening up: To whom? For what purpose? What will I reveal? What will happen to me afterward?

Facilitators emphasize to participants: the purpose of disclosure is to provide some insight into mental health challenges (*"This is not a confession! You are not obligated to share!"*); do not share past experiences that make you feel uncomfortable or ashamed; disclosure is a process, not a one-time action (*"As you get to know the person you've shared with, only you can decide whether or not to provide information about yourself"*).

Other people's reactions to disclosure are discussed with the participants. Reactions can vary, but they are all combined by two factors:

Factor 1. Emotional Reaction. "People's emotional reaction to you can be positive or negative."

Factor 2. Behavioral response. "People may accept you and show concern, or they may distance themselves and try to avoid you."

The main thing is that the participants are shown that the experience of disclosure can be both positive and negative, and this is normal!

Session 3: "Telling your story."

Session goal: to personalize situations, information volume, and disclosure methods regarding an existing mental disorder.

1. For those who chose to disclose, it's important to learn how to share their story in a personally meaningful and maximally safe way.

2. The circle of individuals who could assist the participant in going beyond their existing experience is being discussed.

3. Feelings and thoughts arising in the participant during the storytelling process are analyzed.

4. The acquired knowledge and skills are summarized, and their usefulness/uselessness and potential for further use are discussed.

Participants are offered strategies for maximally effective disclosure. They are given a plan to construct a personal narrative about themselves and their illness: the story should be personal, first-person; include specific people, places, and times; incorporate professional terminology; avoid extremes (overly positive/negative framing); and prioritize personal safety ("*Respect your own sense of privacy*").

Participants are told that the aim of their disclosure is to give listeners a brief overview of the life of a person with a mental illness who acts differently from stereotypes. The main thing is to learn to tell your story naturally and "from the heart."

Results

The training "Developing Skills for Safely Disclosing Mental Illness" was conducted with three groups of patients with endogenous mental disorders (affective and schizophrenic spectrums) at the initial stage of illness (duration from 6 months to 3 years), and with a group of long-term ill patients (duration over 5 years). Our observations showed that during the training, participants' attitudes (from cautious-skeptical and indifferent to interested, benevolent) and positions (from passively detached to active participation) towards what was happening in the group changed.

Participating in the training allowed participants to overcome their limitations and begin to talk about themselves, their experiences, and share feelings, past and present experiences at their own pace. Participants showed a decrease in anxiety levels and an increase in self-worth.

Conclusion

The training equips participants with knowledge of safe disclosure of mental illness, self-care, mindful choice, emotional literacy, and taking responsibility for their lives. This knowledge can be a valuable tool for developing coping skills. Furthermore, the training initiates group processes and can serve as a basic element in long-term psychotherapy.

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Psychological features of the development of family relationships, family roles. Psychotherapeutic and religious aspects

Abstract: The article addresses the issue of family formation and intra-family role models. The child-adult-parent family model is examined using the example of transactional analysis. A comparison is made between concepts used in the psychotherapeutic process and in religious literature. Conclusions are drawn about the common ideological vector of these concepts and the possibility of increasing the compliance of religious patients in psychotherapeutic work.

Keywords: family, religion, science, psychotherapy, role models, child ego state, adult ego state, parent ego state, spirituality, therapeutic process, compliance.

The family is a socio-cultural and structural unit of society, defined by voluntary marriage, shared living, and common values. It performs a crucial value-based function, serving as a foundation and a source of personal growth.

Legally speaking, a family constitutes a group of individuals connected by rights and duties stemming from marriage, blood relation, in-law relationship, adoption, or any other form of foster care.

From a psychological perspective, a family is a small group united by common goals and forming a single system. In turn, the family system includes role models: man – woman (adult – adult), parent – child, child – child.

The functions of a family can vary depending on the socio-cultural characteristics of a region, but in general, the following functions can be identified: educational, household, spiritual-emotional, sexual, communicative, reproductive, recreational, and social-status functions.

From the perspective of Christianity, the family is seen as a "little church" – a part and image of the Universal Church. The task of the Conciliar Church is the salvation of its members: we have gathered in the Church to save our souls and help others to be saved. In the family, as in a little Church, people also gather to love each other and to be saved [1]. The family is not only an image of the Church, but also an image of a parish community, where the husband, the father, is the priest of the little church, the wife, the mother, is his assistant, an image of a deacon, and their children are the flock, the parishioners of this church.

Role models for the family are present in both psychological and religious paradigms. For comparative purposes, we will examine the schema of transactional analysis alongside the Christian role model of the family.

In Christianity, a child is valued for their own sake, not because they are being prepared to become an adult. This is evidenced by the Gospel: "... unless you change and become like little children, you will never enter the kingdom of heaven" (Matthew 18:3), "... let the little children come to me, and do not hinder them, for the kingdom of heaven belongs to such as these" (Matthew 19:14); "I praise you, Father, Lord of heaven and earth, because you have hidden these things from the wise and learned, and revealed them to little children. Yes, Father, for this is what you were pleased to do" (Matthew 11:25-26). With these words, Christ, firstly, rejects the dismissive attitude towards children and childhood as something insignificant and unimportant. Secondly, he presents children as an example, a role model, calling to learn from them a humble acceptance of the Kingdom of God. Thirdly, he places children above the wise men of this world as confidants of God's revelations. Fourthly, he proclaims a loving attitude towards children (their acceptance) as a condition for salvation. One confirmation of the unconditional value of a child is the tradition of communion from infancy. The

Orthodox Church has not interrupted this tradition, while the Catholic Church moved away from it from the 13th century. Twice the Lord addresses his apostles with the word "children," and both addresses are found in the Gospel of John. The first time Christ calls his closest disciples children at the Last Supper, after Judas' departure, before His betrayal, condemnation, and suffering on the cross (see: John 13:33); the second time – after His Resurrection, during His appearance to the disciples on the Sea of Tiberias (see: John 21:5).

In Transactional Analysis, the Child is an ego state in which a person experiences emotions characteristic of children and behaves accordingly. Two child ego states are distinguished: The Natural Child is the part of the personality that holds onto the feelings a person experienced in childhood. The Adapted Child, for the most part, complies with the demands of others and does not express its emotions and desires. The Adapted Child represents a pattern of suppression and the inability to feel free, and consequently, happy. Thus, we see an overall unified position on the necessity and importance of preserving the natural childlike state, from which an adequate, adaptive, loving adult subsequently develops.

In Christianity, adulthood signifies a stage of maturity, thoughtfulness, knowledge, education, enlightenment, wisdom, preparedness, and perfection in the knowledge of God.

An adult is responsible for themselves and free in their choices. Freedom of choice is the defining moment of the religious idea. From a Christian perspective, freedom of choice lies in the possibility of a choice that is neither predetermined nor imposed. A person can equally say "yes" or "no." The choice concerns one's life path, attitude towards God and people, as well as specific situations where one needs to decide whether to sin or remain faithful to God.

An adult consciously arrives at the understanding, awareness, and desire to be a parent. An adult filled with the love of God is capable of supporting, preserving, and developing this love in a child, i.e., becoming a parent.

In psychology, the concept of "adulthood" is used very broadly. In transactional analysis, the Adult ego state is oriented towards perceiving current reality and obtaining objective information. The Adult lives in the present, "here and now," and accepts their responsibility and their desires. They possess flexibility in decision-making, which is expressed in adaptability.

Consequently, we find highly comparable viewpoints on both freedom of choice and responsibility [3]. Broadly speaking, concepts like "adulthood," "consciousness," and the acceptance of responsibility are fundamental elements within the framework of most psychotherapeutic techniques.

Speaking of the parent's role in a religious aspect, it should be noted that it primarily includes setting a personal example for the child. Children see their parents praying, hear the content of their conversations, and feel the atmosphere in the home.

The Holy Apostle Paul writes: "Anyone who does not provide for their relatives, and especially for their own household, has denied the faith and is worse than an unbeliever" (1 Timothy 5:8). Children are taught that a reasonable person should be afraid of offending God – the Heavenly Father – with a bad deed. From the earliest age, children read books on biblical themes, presented in an understandable language, possibly with pictures.

"Fathers, do not embitter your children, or they will become discouraged" (Colossians 3:21). This verse implies that words and actions should build up and encourage children, rather than tear them down.

"These words, which I am commanding you today, shall be on your heart. You shall teach them diligently to your sons and shall talk of them when you sit in your

house and when you walk by the way and when you lie down and when you rise up." (Deuteronomy 6:6-7)

The task of Christian upbringing is to instill the seeds of faith in hearts, to unfold it, and to prepare children for life.

In Transactional Analysis, the Parent is an ego state that reflects a preserved image of a significant adult from childhood. In this state, a person feels and behaves as their parent or caregiver behaved towards them in childhood. The Parent ego state is formed based on an individual's personal observations of their own parents. It concentrates the behavioral norms, life principles, and values that were customary in the family in which the child grew up.

Two "Parent" states are identified: the Critical Parent and the Nurturing Parent. In Transactional Analysis, the Critical Parent is an ego state that shapes a person's social behavior, prohibits immoral actions, and compels them to fulfill their promises.

The Nurturing Parent in Transactional Analysis embodies love, kindness, and a caring attitude. It's a representation of someone from one's childhood. In this state, an individual feels relaxed, rests, and takes care of others.

The parental state implies resourcefulness, the capacity for care, control, and love, both for oneself and for another person – a child. When in the "Caregiver Parent" ego state, one can, for example:

- Find warm, supportive words for a friend.
- Cook with love for family members.
- Help colleagues and employees grow and develop.
- Empathize and sympathize, showing warmth and acceptance.

A nurturing parent instills self-confidence, allows for self-compassion, and encourages listening to one's feelings.

We see that the positions of parenthood in Christianity and psychotherapy imply a resourceful opportunity and a duty to raise children by personal example, the ability to transmit love.

Conclusion

Thus, it can be concluded that the vectors of formation and development of family role models in the psychotherapeutic process and religion have a similar or identical direction, and the factor of religiosity can contribute to greater therapist and patient compliance [4].

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Youth orientations towards family formation and childbearing: field study results¹

Abstract: A comprehensive socio-psychological study of the value and moral development of contemporary secondary school students was conducted. An integral part of this research involved the identification of demographic attitudes among the younger generation. The survey included 600 secondary school students aged 14-17, with 441 attending public schools and 159 attending Orthodox gymnasiums, located in urban and rural areas of the Upper Volga region, specifically in the Yaroslavl and Tver regions. The analysis of the results was conducted within the framework of V.E. Semenov's concept of polymentality in Russian society, which distinguishes three fundamental mentalities: Orthodox, collectivist-socialist, and individualist-capitalist. A comparative analysis of responses from the two samples revealed that students attending Orthodox gymnasiums (representing the Orthodox mentality) exhibited more favorable characteristics of familial consciousness, manifested in healthier attitudes towards family formation and childbearing, as well as more positive attributes of religious identity, particularly regarding the presence of what are known as "occult elements" of religiosity. Consequently, the Orthodox mentality, which serves as the foundational and core of the three studied mentalities, can be considered a significant factor in psychological and spiritual well-being, as well as in fostering prospects for overcoming demographic decline.

Keywords: psychological and spiritual well-being of youth, high school students, demographic attitudes, religious identity, mentality.

For several years, demographers, medical professionals, and sociologists have been engaged in a discussion about the issue of population decline in Russia. In the past ten years, this topic has increasingly taken center stage in the speeches of leading political figures. The phenomenon of "population decline" in our country is characterized by an increase in mortality rates and a decrease in birth rates, often referred to by experts as the "demographic cross" (with its "intersection" occurring in 1992). This issue is now assuming alarming proportions. A protracted and concerning decline in the Russian population is unfolding, which cannot be solely attributed to poverty, alcoholism, or economic shocks. While these factors undoubtedly contribute, they do not appear to be the primary drivers upon closer examination.

Experts attribute the underlying causes to socio-psychological factors, often referred to as the "Russian disease," and spiritual issues. Western demographers, such as N. Eberstadt, also seek to understand and explain this demographic decline, attributing it to the failure of the socialist project and a shift in public sentiment from optimism to pessimism regarding the country's future. Many Russian psychologists, sociologists, and politicians have also engaged in this exploration. Consequently, the high mortality rate in Russia is related, in addition to economic factors, to a change in worldview, a negative emotional and moral climate in society, and the introduction of culturally foreign values and spiritual forms (T.V. Karsaevskaya, 2002).

Over the past several decades, the Institute of Psychology of the Russian Academy of Sciences has been systematically developing approaches to assessing the macropsychological state of Russian society (Yurevich, A.V., Ushakov, D.V., Tsapenko, I.P., 2007; Yurevich, A.V., 2014). As key integral indicators, the

¹The research was carried out under a grant from the Moscow State Pedagogical University "Spiritual and Moral education and patriotic education of youth — a guarantee of sustainable development in Russia" (No. 1-0049/22).

psychological stability of the Russian personality and socio-psychological well-being have been identified. To quantify the dynamics of the macropsychological state, a composite indicator has been proposed, which, in addition to indices such as mortality from diseases of the nervous system, suicide mortality, morbidity from mental disorders, social orphanhood, and homicide mortality, also includes the index of family stability. This index is considered one of the most significant foundations of society. The stability of the personality, with its values and moral pillars, as well as the foundations of its socio-psychological competence, are indeed laid within the family.

The decline of the Russian family has been a subject of discussion and analysis since the Soviet era, primarily due to the escalation of divorce rates. In recent decades, this topic has gained renewed relevance. The phenomenon of sustained population decline is linked, in part, to long-standing familial norms favoring small families and single-parent households, as well as contemporary global challenges to traditional family structures (Antonov A.I., 2014; Sinelnikov A.B., 2015).

Orthodox psychologist E.A. Morozova (2023) has developed a comprehensive psychological model of family consciousness, which she defines as "an integral, multilevel phenomenon encompassing a system of ideas, expectations, attitudes, images, and ideals of the family, embodied in a individual's activity-oriented moral stance" (Morozova E.A., 2023, p. 83). Her diagnostic study among university students revealed that "the formation of indicators of family consciousness is at moderate and low levels (p. 84).

A team of scholars from STOU, under the guidance of Professor A.B. Yefimov, Head of the Missiology Department at the Faculty of Theology, conducted a study on the value and moral attitudes of a younger demographic – modern high school students. A key component of this research focused on the significance of establishing a family and having children within it.

To investigate the impact of spiritual factors on the value and moral attitudes of young people, the concept of polymentality in Russian society, proposed by V.E. Semenov in the late 1990s, was selected as the foundation for research and data analysis. This concept delineates the fundamental Orthodox Russian, collectivist-socialist, and individualist-capitalist (or liberal Westernist) mentalities, which differ in their historical origins, value systems, and moral foundations. Among these, the Orthodox Russian mentality is considered pivotal, with a millennial history of development in the consciousness of the Russian ethnic group (Semenov, 1997; Semenov, 2015).

To compare the characteristics of individuals from various cultural backgrounds, a survey was administered to high school students aged 14 to 17. A total of 600 participants were included, with 441 attending public schools and 159 attending Orthodox gymnasiums. These students resided in towns and villages within the Yaroslavl and Tver regions, which are historically significant Russian areas. The samples were nearly balanced in terms of gender, with 48% being male and 52% female. Additionally, 95% of both groups identified as ethnically Russian.

It was hypothesized that the responses from high school students attending Orthodox gymnasiums, considered as representatives of the Orthodox Russian mindset according to the theoretical framework proposed by V.E. Semenov, would present a more favorable picture.

Table 1 presents a summary of the responses of our participants to the question regarding their intentions to establish a family in the future. The data are organized in a comparative format, juxtaposing the responses of participants from two distinct samples: "schoolchildren," which includes students from public schools, and "high gymnasium students," who attend Orthodox gymnasiums. The final two columns of the

table display the outcomes of a statistical analysis conducted using the nonparametric Mann-Whitney Z test for comparing independent samples.

Table 1. Respondents' demographic attitudes towards family formation.

Answers to the question: "Would you like to start a family in the future?"	Public school student response rate	Orthodox gymnasiums student response rate	Statistics of the Mann-Whitney Z test	The level of statistical significance P
Yes	69	73	-6,2	0,00000 (statistically relevant)
No	12	8		
Uncertain	3	4		
Other	7	8		
Not answered	8	7		

An examination of the responses to the inquiry regarding future family planning reveals that the majority of participants (a total of 81% in each sample) were capable of providing a specific answer to the posed question at the time. Among the respondents, the proportion expressing a determination to establish a family ranged from two-thirds (in public schools) to three-quarters (in Orthodox gymnasiums). Notably, 12% of the surveyed "schoolchildren" and 8% of the surveyed "high school students" indicated no intention to form a family in the future. Further statistical analysis of the data indicates that the attitudes towards family formation among "gymnasium students" are significantly more favorable compared to those enrolled in public schools. In the open-ended responses provided by the "schoolchildren", arguments against family formation included the following:

- "a lot of trouble",
- "hinders career",
- "too much responsibility",
- "lack of privacy",
- "possible only with full financial security",
- "I don't like children", etc.

Arguments that are more characteristic of the liberal individualistic, Western-oriented mentality and its corresponding values were also evident in the responses from the "gymnasium" group, albeit to a significantly lesser extent.

Interestingly, when processing the initial data, we observed that 9.8% of respondents in the "schoolchildren" sample either left the gender question blank or provided conflicting information (the gender implied by their written answers didn't match the gender they selected). This issue was not present in the gymnasiums students sample. Additionally, among the clarifications provided by "schoolchildren," there were unique responses such as "my gender is not binary," which might be indicative of the influence of contemporary gender propaganda.

Table 2 presents the average data from the responses to the inquiry regarding the desired number of children within a family that the respondents intend to establish in the future. These data provide insights into the evolving family consciousness among adolescents, including their attitudes, expectations, and ideals. Table 2 has the same structure as Table 1.

Table 2. Respondent Answers Regarding Desired Number of Children.

Answers to the question: "How many children would you like to have in the future?"	Public school student response rate	Orthodox gymnasiums student response rate	Statistics of the Mann-Whitney Z test	The level of statistical significance P
None	10	8	-15,6	0,00000 (statistically relevant)
One	22	7		
One or two	8	8		
Two	28	26		
Two or three	3	6		
Three	6	19		
Many	2	8		
Uncertain	3	3		
Other	3	6		
Not answered	14	9		

One of the most challenging aspects of addressing the question about the ideal number of children in a future family is the significant proportion of respondents who express a preference for childlessness. This viewpoint is notably less prevalent among gymnasium students. A majority of public school students (68%) believe that a family should ideally have no more than two children, while 48% of those attending Orthodox schools share this opinion. In contrast, only 27% of respondents express a desire for three or more children. Among public school students, the percentage of those who favor having three or more children is significantly lower, at just 8%.

Thus, the family and child-rearing attitudes of the "school-aged" respondents offer a clear perspective on the continuation of depopulation in our country (an assumed "fertility rate" of 1.6 – a figure within the estimates of contemporary demographers: 1.3 – 1.7 (Sinelnikov A.B., 2015)). Conversely, the outlook among individuals with an Orthodox mindset is considerably more positive, projecting a hypothetical "fertility rate" of 2.4 (marginally exceeding the replacement level of 2.1). These differences, derived from the average figures provided by respondents, are statistically highly significant.

In October 2024, the IX International Scientific Conference "Psychological Problems of the Modern Family" took place at the Faculty of Psychology of Lomonosov Moscow State University. The event delved into a wide array of issues, including demographic challenges. One of the key insights presented was that the modern world's emphasis on bodily pleasure, personal freedom, and career ambitions has contributed significantly to the current state of family problems and a dire demographic situation. These findings align with the data we have collected. Notably, the conference highlighted a concerning trend: the absolutization of humanistic traditions in psychology and psychotherapy, which has led to the **infantilization of youth**. This, in turn, is influencing decisions regarding childbearing and family formation. The humanistic approach, which focuses on self-actualization, is widely taught in the training of professional psychologists and psychotherapists.

Another crucial observation made at the conference was the disparity between the scientific sophistication of psychological approaches and the lack of effective organizational frameworks for their implementation. Indeed, practice-oriented

developmental psychology and developmental psychology are still underdeveloped areas. Psychological counseling for children and adolescents is available but primarily operates on a reactive basis, responding to specific individuals who have identified or are in the process of identifying their issues. The conference underscored the need for a comprehensive and preventive approach to family and child development. This approach should involve all institutions that play a role in the development of children and adolescents – Including families, preschool institutions, secondary schools, and higher education institutions.

With regard to the outcomes of our field research, it is pertinent to highlight certain issues pertaining to the **spiritual health of adolescent populations**. Among the inquiries concerning religious identity in the survey instrument, there was a specific question addressing the respondents' beliefs in the efficacy of psychics, astrologers, and clairvoyants. The data analysis revealed that 20% of elementary school students and 12% of gymnasium students express belief in these practitioners. Conversely, 53% of elementary school students and 72% of gymnasium students categorically disavow such beliefs (the differences being statistically significant). Additionally, 26% of elementary school students (and 14% of gymnasium students) found it challenging to provide a definitive response. This particular survey question, in our professional assessment, addresses what we have defined as the "occult dimensions" of religious identity.

In our assessment, a positive response to the question of belief in psychics, astrologers, and clairvoyants may be interpreted as an indicator of spiritual distress. Priest Valery Dukhanin observes that "... the general ideological confusion evokes sorrow: in the minds of modern individuals, the tenets of Christianity are intermingled with overtly occult perspectives" (2017, p. 5). Through the calculation of correlations between these "occult" components of religious identity and metrics of the development of respondents' value and moral frameworks, including family and parental perspectives, significant negative correlations were identified. Specifically, there was a notable negative correlation between the "occult" aspects of religious identity and the inclination to have children in the future, as well as the valuation of family. Conversely, identifying oneself as a believer in God exhibits a significant positive correlation with the value placed on family, the desire to establish a family, and the intention to have children in the future.

Furthermore, it is noteworthy that the presence of "occult" components of religious identity exhibits a significant negative correlation with age, indicating a tendency for a decline in the prevalence of these elements as individual's transition from early adolescence to late adolescence. In contrast, the identification of oneself as a believer in God does not demonstrate any correlation with age (the correlation coefficient is zero), suggesting that this aspect of personal identity has been established to some degree during the developmental stage of 14-17 years and remains relatively stable. Additionally, there is no correlation with age in responses concerning the desire to establish a family and have children in the future. This observation underscores the importance of initiating the cultivation of pro-family attitudes at an age preceding adolescence, a fact that has been well-known.

It is also noteworthy that faith in psychics, clairvoyants, and astrologers is positively correlated with a liberal individualistic mentality and the value of money. Conversely, when identifying with the statement "I believe in God," these correlations are significantly negative. This observation aligns well with the perspective articulated by Priest Valery Dukhanin, who posits that "in occultism, the spiritual realm is viewed as a means to facilitate personal material well-being – egoism serves as one of the primary motivations for those engaged in occult practices" (2017, pp. 8-9).

The results of the field study underscore the significance of the Orthodox worldview in fostering the development of family consciousness and enhancing the

psychological and spiritual well-being of young individuals. These results are pertinent to the formulation of practical solutions. Regarding the identification of strategies to address the current socio-demographic challenges, it is crucial to consider Toynbee's perspective that nations and civilizations should derive responses to global issues from their historical and cultural heritage. The foundations of Russian culture, in particular, are undoubtedly rooted in Orthodoxy.

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Religious coping in mentally ill individuals: age-specific considerations

Abstract: The main research on religious coping primarily focuses on middle-aged individuals, with less attention paid to other age groups. Even less studied is religious coping and its impact on the mental state of individuals with mental illnesses. At the same time, religious patients often resort to using religious methods to cope with their illness. Therefore, the issues of religious coping among the mentally ill are of interest from both theoretical and practical perspectives.

Keywords: religious coping, age-related coping, coping in mentally ill individuals.

In recent decades, the development of modern psychosocial rehabilitation and treatment technologies has become particularly relevant, ensuring the adaptation of patients and their families with their integration into society (T.A. Solokhina, 2025). An important direction in mental health research is the study of the role of religious coping strategies (H.G. Koenig, K.I. Pargament, 1998). The religious factor serves as an internal support and a potential resource that helps to cope with illness and life challenges (G.I. Kopeiko, O.A. Borisova, O.Yu. Kazmina, 2016; L. Borrás et al., 2007), but at the same time, it can significantly influence the development of mental pathology, particularly depressive disorders (V.G. Kaleda, 2023).

According to some data, religious beliefs play a protective role against suicidal behavior (E.V. Gedeveni et al., 2022), form the basis of spiritually oriented rehabilitation (A.I. Magay, T.A. Solokhina, 2023; A.I. Magay, A.V. Nemtsev, 2021), and are a significant component of therapeutic strategies, alongside pharmacotherapy (A.I. Magay, 2024). Furthermore, the assessment of religious experience phenomena can contribute to the selection of further therapeutic tactics, utilizing personalized coping strategies (I.Yu. Mashkova, N.N. Osipova, 2025).

Religious coping is most often understood as approaches and methods that are substantively based on beliefs in a transcendent, Divine reality.¹ H.G. Koenig et al. (1998) identified the semantic, transformational, and behavioral aspects of religious coping. The value sphere and the specific type of coping are of great importance in the process of coping with mental illness (A.I. Magay, A.N. Baburin, A.V. Nemtsev, T.B. Ryazanova, 2025). The differentiation between intrinsic and extrinsic religiosity is also significant. According to Huber, S., Huber, O.W. (2012), intrinsic, or central, religiosity is associated with true religiosity, while manifestations of extrinsic religiosity may only formally indicate affiliation with a particular denomination and do not contribute to the coping process.

In our opinion, the religious coping of mentally ill individuals with a religious worldview across different age periods should be particularly highlighted. The scientific literature is characterized by a prevalence of articles on middle-aged (adult) patients, while fewer works are dedicated to the religious coping of elderly and adolescent/young adult patients.

In old age, 'the use of spiritually-religious person-centered psychotherapy is particularly relevant; recourse to religiosity and spirituality can mitigate the manifestations of mental disorders and serve as an effective coping mechanism for overcoming them' (Yu.I. Polishchuk, L.E. Pishchikova, Z.V. Letnikova, 2020). It is also important to identify coping types, which can vary significantly in old age (R.D.

¹ In accordance with Christian religious tradition

Hayward, N. Krause, 2015). In one case, religious coping strategies help overcome mental disorders; in another case, the weakening or cessation of religious coping leads to an exacerbation of mental disorders and can result in depression. In terms of preserving mental health, support from church community members is necessary for the elderly to overcome internal doubts in faith and increase efforts to utilize religious coping (P.G. Coleman, 2011).

Children and adolescents utilize religious coping strategies to a lesser extent. However, in cases of positive experience, religious support has a beneficial impact on mental health (J.E. Yonker et al., 2012; Moodley T., Esterhuyse K., Beukes R., 2012; I.M. Shmelev, 2011).

The appeal to religious engagement is associated with the time of activation of religious searching and the individual's ability to internalize religious norms and rules. Research on the characteristics of religiosity indicates that the peak of religious searching occurs during adolescence, while the level of internal religiosity is higher in older age groups (R.S. Titov, 2013). Results from a Russian study on the religiosity of Orthodox youth showed that both young men and women predominantly exhibit consistent internal and mixed religiosity. In some cases, the appeal to religion among young men is linked to situations of disappointment with the past, a lack of meaning in the future, and an inability to manage their own lives, suggesting a connection between religious engagement and mental disorders in these cases (A.M. Dvoinin, G.I. Danilova, 2012).

The study of the relationship between religious coping and depression with anxiety in the research by B. Francis et al. (2019) showed that positive religious coping had no significant association with anxiety and depression. At the same time, negative religious coping had a detrimental effect on mental health levels and was linked to maladaptive emotional regulation styles, leading to dysphoric and anxious affective disorders.

Conclusion

Religious coping is most frequently utilized by middle-aged patients, which is associated with the formation of new religious meanings and value orientations during this age period. In elderly patients, religious coping becomes an important strategy for preserving mental health and overcoming manifestations of mental disorders. The characteristics of the semantic sphere and the difficulties in mastering new adaptive forms of behavior can lead to the insufficient effectiveness of certain methods of psychotherapeutic assistance, which is why additional support from the religious community and helping professionals is necessary. For young individuals and adolescents suffering from mental disorders, the appeal to religious coping is culturally conditioned and is usually associated with the specifics of religious upbringing. When mental disorders emerge or intensify, this support approach is insufficient for this age group, and the creation of specific intervention strategies is necessary. Psychoeducation and religious enlightenment can be beneficial for mental well-being and encourage young patients to seek religious forms of support.

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