

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
Russian Scientific Center for Mental Health

**Church care for mentally ill people:
mental health concepts and intervention
strategies in dialogue between
clergy and psychiatrists**

***International Conference
Reports***

28-29 November 2025

Moscow, 2026

Church care for mentally ill people: mental health concepts and intervention strategies in dialogue between clergy and psychiatrists. International conference. Reports. 28-29 November 2025: – M., 2026. – 176 p.

This book presents reports of the VII International Conference “Church care for mentally ill people: mental health concepts and intervention strategies in dialogue between clergy and psychiatrists”, 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, Iraq, Switzerland, Ethiopia, Egypt, Belarus 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 Russian 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)

Ministering to the suffering soul: the collaborative synergy of Church and psychiatry

Reverend fathers, brothers, and sisters,
dear participants and guests of our conference!

I warmly welcome you all to this hall. I would like to extend a special greeting to our participants from other cities and international guests who have traveled so far to share with us the joy of fraternal fellowship. A special thank you goes to the members of the organizing committee, whose tireless efforts made our meeting possible for the seventh time, which demonstrates not just a formal communication, but a real need for our dialogue.

Today we have all gathered together – clergy, scientists, mental health professionals and practicing psychologists from Russia and countries near and far abroad – to jointly search for a common way of service to mentally ill people.

The importance of the topic we will be discussing over the next two days is obvious. We are seeing an increase in mental health problems and a growing mental distress. According to the World Health Organization, more than one billion people around the world suffer from some form of mental health disorder¹.

Hidden behind the dry statistics is a profound spiritual crisis of humankind. At its very foundation lies an all-encompassing **loneliness**, whose origin is not found in incidental external circumstances, but in an internal affliction: the loss of divine communion, self-centeredness, and the weakening of that sacrificial love which alone possesses the power to unite individuals not only with each other but also with the Creator. Theophan the Recluse's vivid comparison states that a person without God is like a wood shaving coiling around its own void. Becoming self-absorbed, they are trapped by their own fears and thoughts, which undermine mental health.

Furthermore, we are observing a profound **crisis of human identity**. Having rejected the humanistic traditions rooted in the Church of Christ, people are increasingly allowing themselves to be defined by the consumerist society, where an individual's value is not based on their intrinsic dignity as the Image and Likeness of God, but on external markers of success and productive efficiency. This culminates in an existential void, a sense of meaninglessness in life, and professional burnout. These then underpin mental ill-health, manifesting as fatigue, anxiety, and depressive symptoms.

Furthermore, over the past decade and a half, a new, truly extraordinary threat to mental health has emerged. We are witnessing a dangerous **rise in distorted worldviews**, directly linked to deficiencies in upbringing, the degradation of the education system, and the digitalization of consciousness. Extensive gadget usage contributes to a catastrophic deterioration of memory and attention, instilling the idea that the labor of memorization and profound understanding of reality is no longer

¹ <https://www.who.int/ru/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

required. The universal introduction of testing as a knowledge assessment tool methodically undermines the capacity for abstract-logical thinking and a comprehensive view of the world. The "transcendental unity of apperception", as described by Immanuel Kant, has been compromised. Consequently, we are witnessing a widespread inability among young people to analyze and synthesize a variety of facts and sensory input into a coherent, unified experience of the world and a comprehensive worldview. This puts us at risk of raising a generation that thinks in fragments and cannot discern truth from deception.

The global surge in mental health **disorders in our country is aggravated by grave trials**. The social stress that contemporary society is undergoing is magnified by the challenges linked to the Special Military Operation and economic instability. This creates an unprecedented load on the psyches of our fellow citizens, revealing old traumas and generating fresh anxieties.

Frequent psychologically traumatic situations also trigger mental disorders, and this has become a primary focus in mental health worldwide. A psychologically traumatic event is defined as an incident where individuals witness death or the threat of death. Instances of traumatic experience include sexual and physical abuse, exposure to war, terrorism, kidnapping, incurable illness, and forced displacement. Mass psychological traumas, recurring over time, lead to mental wounds that breed distrust, anger, divisions between people and hinder efforts for peace and reconciliation. Research indicates that even when war or hostility between people ceases, negative interpersonal attitudes often persist, which can contribute to the manifestation of violence in new forms, as well as the transmission of psychological trauma through survivors to future generations².

The living human is suffering within the tempest of spiritual, social, and technological storms. This is why our dialogue today is not an academic discourse, but a crucial practical necessity. Clergy and mental health professionals, despite their differing methods and languages, are meant to be collaborators, not opponents, in the endeavor to heal the suffering human essence. The Church and psychiatry stand on the front lines of this battle for the human soul. They are not detached from modern challenges but see their spiritual roots and are ready to speak about them openly. Our meeting today, dedicated to various concepts of mental illness, is a dialogue not for the sake of developing medical and theological theories, but for the salvation of a specific person seeking deliverance from mental suffering.

The theme for this year's conference was chosen with the intention of collectively working to transcend outdated and unproductive historical concepts of mental illness, and to establish a new, holistic approach that fosters authentic synergy between the Church and psychiatry.

In the Late Middle Ages and, particularly, during the era of the Western Enlightenment, against the backdrop of a general societal conflict between faith and reason, a **mistaken and tragic notion emerged that mental illness was solely a consequence of demonic possession or grave personal sin**. This led to the afflicted individual encountering misunderstanding, rejection, and isolation instead of treatment and solace. Today's legacy of misunderstanding the nature of mental illness is profound stigmatization – a brand of shame and fear that still weighs heavily upon those with mental illness, both in society and, regrettably, sometimes even within the Church. Our dialogue seeks to provide a powerful answer to this mischaracterization of illness as sin. Realizing this historical misconception is not a weakness, but a sign of spiritual

² Lev-Wiesel, R. (2007). Transmission of trauma from generation to generation: a preliminary study. *Qualitative Social Work*, 6 (1), 75-94. DOI: 10.1177/1473325007074167

maturity, opening the way to healing not only the sick, but also our own erroneous perceptions. Mental illness or demonic possession is far from always a consequence of moral transgression, not a sign of "special sinfulness" or lack of faith. It is a cross given to man through the inscrutable ways of God's Providence. Our common task is to help individuals bear this cross, replacing the stigma of fear and judgment with compassion, and isolation with fraternal support.

Another concept – "mental illness as a biological dysfunction" – emerged from within the medical discipline. Psychiatry fundamentally interprets mental disorder as an impairment of neurophysiology, biochemistry, and cognitive functions. We recognize the legitimacy and great importance of this approach for the therapy of mental illnesses. However, from the Church's perspective, it is incomplete. After all, when answering the question "How does the body work?", it is impossible to answer the questions "Why am I suffering?" and "What is the purpose of living with this illness?". A psychiatrist cannot treat a certain biological substrate of the illness without addressing the person living in a state of suffering.

Modern psychiatry operates with several core approaches to mental illness: biological, psychoanalytic, behavioral, and systemic. A shared drawback, however, is their exclusion of the personal dimension of human freedom, instead prioritizing biological mechanisms and depicting behavior as a response to external stimuli. Over the past few decades, efforts have been made to overcome the existing boundaries between different schools and to develop what's known as a bio-psycho-socio-spiritual approach to illness. Nevertheless, **the mere mechanical aggregation of simplified, reductionist models of reality is insufficient to construct an integral perspective.** Such a perspective emerges solely upon the acknowledgment of humanity's spiritual core, which, despite being susceptible to diverse external influences, retains the capacity for free and responsible choice.

In our earthly life, humans present themselves as an inseparable, dynamic unity of spirit, soul, and body. Saint Theophan the Recluse teaches: the spirit is drawn to God and the eternal, the soul thinks and feels, and the body acts in the world. These foundational aspects are not isolated "pieces," "levels," or "sections" of human nature; they interpenetrate, existing from the outset as a vibrant, unified, God-oriented person. And when illness afflicts the soul, it inevitably distorts both a person's spiritual life and their physical condition. It is this integrity that makes a person the object of joint care. The pastor is called to heal the spirit by strengthening the connection with God. The doctor is called to heal both the soul and the body, restoring lost harmony. These ministries are not opposing, but rather addressing different aspects of the same, suffering human personality.

A mental disorder is a complex issue that affects the whole person and cannot be fully understood or treated within the confines of either a "medical-biological" or "spiritual" approach alone. Instead, dialogue and collaboration are needed, where each party respects the expertise of the other and works within its own area of expertise, aiming towards a common goal - healing and recovery for the individual. In front of our eyes, **a new and holistic approach to mental illness and behavioral disorders is emerging** in the communication between Christians, doctors, and clergy. This approach sees mental illness as a suffering that affects the whole person.

The care of the mentally ill has a single and undeniable source - the person and ministry of our Lord Jesus Christ. He came into the world not as an indifferent to condemn sinners, but as a compassionate healer of souls and bodies. The Gospel clearly shows this truth: Jesus' preaching of the Kingdom of Heaven was inseparable from his active healing of every affliction in fallen human nature. The Savior's eyes embrace all those who suffer, with love and divine power, including those experiencing mental distress. (Mat. 4:24) To follow Christ's example in relation to those with mental

illnesses means to show the same compassion and dedication for those whose souls are enveloped in darkness due to mental illness. Through his teachings, the Savior encourages every Christian to "go and do the same." (Luke. 10:37)

The Gospel places special emphasis on the ministry of Jesus Christ, which focused on healing the sick. However, this story is not just a historical account. After all, his love and healing ministry continues today. We should always ask for healing from the Lord, whether it be physical, emotional, mental, or spiritual. We should teach this to our patients. In response to our prayers, some people receive instant and miraculous healing. However, the Lord may choose to heal us gradually, or even allow suffering for the sake of our spiritual growth. No matter what happens, we can trust that He has our best interests at heart.

In the era of so-called "personalized medicine", people often talk about individual counseling and personalized treatment for the mentally ill as the best approach to therapy. However, approaches that involve patients in community life are also recognized as important tools for the prevention, treatment, and rehabilitation of patients with mental illnesses. Church communities and religious organizations are places where people can find support and assistance during difficult times. These communities can play a significant role in helping people through certain periods of their lives, providing emotional and spiritual support.

The suffering of the soul before God is just as real and deserves our compassionate attention as physical suffering. Therefore, doctors and clergy should see in every person suffering from mental illness not just a "problem" or "burden," but a person created in God's image who needs healing, dignity, and the chance for eternal life. Through following the Gospel's commandment of mercy, we can not only help our neighbors but also grow closer to Christ, who said, "I was sick and you visited me" (Mat. 25:36).

I sincerely wish us all a deep and productive work. May our work be filled with the spirit of love and mutual trust, and may our discussions be guided by mutual respect.

May God's blessings be with all of you who bring light and hope to those in spiritual suffering, and may the Lord strengthen us as we work together to promote truth and compassion.

Modern concepts of mental illnesses and challenges in training clergy in pastoral psychiatry

Abstract: This report focuses on modern concepts of mental health disorders and the role of pastoral care in interdisciplinary treatment. It argues for a holistic approach to patients, considering biological, psychological, social, and spiritual factors that contribute to mental suffering. The report also emphasizes the importance of not reducing psychopathology to medical diagnosis or spiritual causes alone.

The article discusses the differentiation between mental disorders, spiritual crises, and unhealthy forms of religiosity, as well as phenomena traditionally associated with the sphere of religious care. Special attention is given to biopsychosocial and biopsychosociospiritual models of mental health, as well as schizophrenia, a multifactorial condition formed under the influence of genetic, neurobiological, psychological, and environmental factors.

It is emphasized that religion can act as a source of resilience, meaning-making, and support, but it should not replace professional diagnosis and treatment. The need for training clergy in the field of pastoral psychiatry is explained, since they are often the first to be contacted by people with mental issues. It is concluded that mental health is the shared responsibility of professionals, clergy, families, and the church community.

Keywords: mental disorder, spiritual crisis, pastoral care, biopsychosocial model, biopsychosociospiritual model, multifactorial disease, social inclusion, interdisciplinary training, family dysfunction.

A holistic approach to human beings in psychiatry and pastoral care

The modern understanding of mental illness requires a holistic approach to a person, considering biological, psychological, social, and spiritual aspects of their life. A one-sided view of the patient as merely a "diagnosis carrier" turns out to be methodologically insufficient. Similarly, an approach that interprets mental suffering solely in terms of sin, spiritual decline, or demonic influence is also limited. In both cases, the individual is reduced to a single aspect of their condition, preventing adequate assistance.

The aim of medical and pastoral care is not to oppose psychiatric and spiritual approaches, but rather to differentiate between them and interact responsibly. Mental illness should not diminish a person's dignity or their spiritual status. From the perspective of Christian anthropology, a person with a mental illness remains a bearer of God's image and requires not only treatment but also compassion, support, and respect.

The church tradition emphasizes the spiritual nature of human beings, encompassing their physical, mental, and spiritual dimensions. However, modern pastoral care must take into account the distinction between mental illness, unhealthy forms of religious practice, spiritual crises, and rare instances of conditions that may be interpreted as demonic influences within the church's tradition. Misinterpreting these dimensions can lead to delays in seeking psychiatric assistance, increased suffering, and a higher risk of severe consequences, including suicidal thoughts and actions.

Differentiating between psychopathology and spiritual experiences

In pastoral and clinical practice, it is essential to differentiate between the religious content of experiences and their psychological structure. Patients may talk

about demons, their exceptional mission, being chosen by God, or belonging to sacred figures, but the religious content alone is not sufficient to interpret their condition as spiritual. In some cases, these statements may be a part of delusional thoughts, hallucinations, or other psychotic symptoms.

In this regard, pastoral prudence requires recognizing the limits of the clergy's competence. Exorcism and other forms of spiritual intervention cannot be considered a universal response to mental suffering. On the contrary, a distinction is necessary between mental disorder, spiritual crisis, pathological forms of religiosity, and the Church's own understanding of possession. In modern ecclesiastical and medical practice, such a distinction is of fundamental importance, as it prevents both the medicalization of spiritual life and the spiritualization of psychopathology.

Main groups of mental disorders

Mental disorders are heterogeneous in origin, clinical picture and development mechanisms. Several major groups can be identified, each requiring a specific diagnostic and therapeutic approach.

Firstly, such conditions include mental development disorders, including intellectual disability and other forms of impaired ontogenesis. Their occurrence is primarily associated with congenital, genetic, perinatal, and early biological factors.

Secondly, a significant group is made up of addictive disorders. These include not only chemical dependencies such as alcoholism and drug addiction, but also non-chemical forms of addiction, including gambling, internet addiction, and gadget addiction. The prevalence of these conditions in modern society significantly expands the scope of responsibility of psychiatry, psychotherapy, families, schools, and the religious community.

Third, there are organic mental disorders associated with damage or dysfunction of the brain. These may include dementia, epilepsy, the consequences of traumatic brain injury, intoxication, and other organic processes. In these cases, the biological basis of the disease can often be confirmed by objective research methods.

Fourth, personality disorders and borderline states occupy a special place. Their development is determined by a complex interaction of hereditary factors, temperamental characteristics, family upbringing, early experience, and social environment.

Fifth, a significant group of reactive states includes anxiety, depressive, and stress-related disorders. Their occurrence is associated not only with the intensity of the external stressor but also with the individual's personality traits, coping skills, worldview, value system, and the availability of social support.

Religiosity, resilience and meaning-regulation

Religious tradition can be an important resource for psychological resilience. For a believer, suffering, stress, and life crises are often embedded in a broader context of meanings. A religious worldview allows an individual to perceive difficult circumstances not only as random adversity but also as a time of spiritual testing, moral choice, repentance, inner growth, or drawing closer to God.

This doesn't mean that religious people don't experience anxiety, depression, grief, or mental stress. However, a religious system of meaning can alter the way stress is experienced, promote inner mobilization, and support hope. In this regard, religiosity can serve a protective function, especially when coupled with a mature spiritual life, involvement in a supportive community, and maintaining a realistic attitude toward illness.

However, religiosity should not be seen as an absolute protection against mental disorders. Endogenous diseases, including schizophrenia, have a clear

biological basis, and spiritual life does not eliminate the need for medical diagnosis and treatment. The correct approach requires recognizing both the individual's spiritual resources and the objective reality of psychopathological processes.

Biopsychosocial and biopsychosociospiritual models

In the latter half of the 20th century, the biopsychosocial model, which was proposed as an alternative to the reductionist biomedical approach, acquired substantial importance in psychiatry. According to this model, mental illness develops under the influence of biological factors, psychological personality traits, and social context. Biological factors include genetic predisposition, somatic condition, infections, intoxications, and neurochemical and neuroanatomical changes. Psychological factors include temperament, character, early experiences, emotional regulation, and personality structure. Social factors are represented by family environment, upbringing conditions, stressful events, social support, isolation, poverty, and cultural expectations.

Later, the biopsychosocio-spiritual model emerged and evolved in psychiatry, psychotherapy, and pastoral care. This model highlights that achieving mental health recovery necessitates addressing not only biological, psychological, and social determinants, but also the person's spiritual and value-based dimension. Spiritual factors comprise the existential framework of meaning, moral values, religious identification, coping mechanisms for suffering, the experience of guilt, hopes, the process of forgiveness, accountability, and the perception of a calling.

This model is particularly significant in the context of pastoral psychiatry, as it helps to prevent both biological reductionism and a unilateral spiritual interpretation of illness. In various clinical situations, the contribution of each factor varies: for some disorders, the biological mechanism is predominant, while for others, a stressful situation, traumatic experience, family dysfunction, or a crisis of values takes the lead. Therefore, assistance should be structured individually and interdisciplinarily.

Schizophrenia as a multifactorial disorder

Schizophrenia represents one of the most complex mental disorders, as its development is linked to a multi-level interaction of biological, genetic, neurodevelopmental, psychological, and environmental factors. The disease is not based on a single isolated mechanism, but rather on a complex interplay of predispositions and precipitating conditions.

The genetic component is of significant importance; however, genetic predisposition is not a fatal determinant of the illness. Even with a high hereditary burden, the manifestation of the disorder depends on additional factors, including peculiarities of the prenatal and perinatal periods, early development, traumatic experiences, psychoactive substance use, urbanized environment, stressful events, and social maladjustment.

Concordance rates for schizophrenia in monozygotic twins demonstrate that despite identical genetic material, the disorder does not manifest in every instance. This highlights the substantial influence of epigenetic, environmental, and psychological factors. Therefore, schizophrenia must be viewed as a polygenic and multifactorial illness, where biological susceptibility is expressed only in the presence of specific environmental factors.

Contemporary neurobiological studies reveal structural and functional alterations in the brain associated with schizophrenia, encompassing changes in gray matter and dysregulation of neurotransmitter systems. However, the biological substrate of the disease does not preclude the significance of psychological and social factors. Childhood trauma, chronic stress, an unfavorable family situation, lack of

support, and substance abuse can contribute to the manifestation of psychosis in predisposed individuals.

From a preventive perspective, protective factors play a significant role: a stable and supportive family environment, reduced chronic stress, proper nutrition, regular work and rest patterns, abstention from psychoactive substances, timely medical care, and a supportive spiritual life. While these conditions cannot guarantee complete prevention of the condition, they can lower the risk of its occurrence and contribute to a more favorable course.

Pastoral psychiatry as an interdisciplinary field of study

The purpose of pastoral psychiatry is not for clergy to independently establish psychiatric diagnoses or to substitute for medical professionals. Its objective is to cultivate the skill of identifying situations where a spiritual issue might co-occur with a mental health condition, and to ensure timely referral to a specialist. Clergy should be adept at differentiating a spiritual crisis from depression, psychosis, suicidal ideation, addiction, organic brain damage, or personality disorders.

The experience of church and clinical practice shows that many people in a state of mental suffering initially turn to a priest rather than a psychiatrist. This is due to trust in the Church, fear of stigma, lack of knowledge about psychiatric care, and a desire to understand suffering in spiritual terms. In these circumstances, a priest can play an important role in early identification of problems and encouragement for treatment.

The development of pastoral psychiatric courses in theological education is an important aspect of training for future clergy. These courses should cover the basics of psychopathology, including depression, suicidal behavior, addiction, psychosis, personality disorders, and dementia. They should also address issues related to spiritual support for patients and their families. Special attention should be given to the boundaries of the pastoral professional's competence and their interaction with medical professionals. It is also important to prevent harmful interpretations of mental illness through spiritual means.

Church community as a support resource

The church and the parish community can be a valuable resource for individuals with severe mental illness and their families. The parish can provide not only spiritual support, but also acceptance, social integration, reduced isolation, and assistance in coping with chronic suffering. It is crucial that mentally ill individuals are not viewed as alien, dangerous, or inferior.

Families of patients also need support. The illness of a loved one can be a challenging experience, both emotionally and spiritually, accompanied by feelings of guilt, anxiety, shame, confusion, and isolation. In these situations, the parish community can help maintain the dignity of families, provide hope, and help them overcome stigma.

Thus, mental health should be seen as a joint responsibility of mental health professionals, religious leaders, families, and religious communities. Effective care can be provided if professional boundaries are respected, the dignity of patients is recognized, interdisciplinary collaboration is embraced, and simple explanations are avoided. Modern pastoral psychiatry should aim to create such a holistic, responsible, and scientifically grounded approach.

Strength in hope: psychological resilience and Christian spirituality

Abstract: Resilience, or the ability to recover from psychological wounds, is associated with the virtue of fortitude. Its relationship to hope, which moves us toward a future outcome or reward, is also clear and proven. Christian hope, as a longing for eternal life based on truth, has been little studied in psychology. This virtue, sustained by faith and animated by charity, constitutes a basic structure of resilience. We will study the evolution of the concept of resilience and its classical forms. Then, we will delve into what we have called transformative resilience in hope and how to strengthen it in others.

Keywords: resilience, transformative resilience, Christian hope, strength, psychology and spirituality, psychological wounds

Introduction

Resilience is the ability to cope positively with adversity and psychological wounds. Its current relevance responds to the increase in trauma and low tolerance for suffering. Factors such as family conflicts, absence of parental figures, and lack of social peace hinder balanced development. In addition, many mental health problems in adulthood are linked to adverse experiences in childhood, such as *bullying*, abuse, neglect, and maltreatment¹. Fifty percent or more cases of depression in adults are associated with psychological wounds in early life².

Studies on resilience in psychology and medicine are common³. It has been found that virtually all character strengths in adults promote resilience, in this order of importance: hope, zest, creativity, kindness, humor, curiosity, and bravery⁴. Hope, as a character strength included in the variables of transcendence, is presented as the number one factor in resilience.

From a moral point of view, resilience has been associated with the strength to cope with difficulties and with God's grace as the ability to go beyond what is humanly possible⁵.

¹ Cf. MCKAY, M.T., CANNON, M., et al., «Childhood trauma and adult mental disorder: A systematic review and meta-analysis of longitudinal cohort studies», *Acta Psychiatrica Scandinavica* 2021 Mar;143(3):189-205. doi: 10.1111/acps.13268. Epub 2021 Jan 18. PMID: 33315268.

² Cf. LANOUE, M., GRAEBER, D., DE HERNANDEZ, B.U., et al., «Direct and indirect effects of childhood adversity on adult depression», *Community Mental Health Journal*, 2012 Apr;48(2):187-92. doi: 10.1007/s10597-010-9369-2. Epub 2010 Dec 3. PMID: 21127974. Adverse experiences during childhood can cause functional and structural alterations, observable in the brains of adult patients with major depressive episodes or chronic pain, which are not found in those who have not suffered such injuries in childhood: cf. ANTONIOU, G., LAMBOURG, E., STEELE, J.D., COLVIN, L.A., «The effect of adverse childhood experiences on chronic pain and major depression in adulthood: a systematic review and meta-analysis», *British Journal of Anaesthesia*, 2023 Jun;130(6):729-746. doi: 10.1016/j.bja.2023.03.008. Epub 2023 Apr 21. PMID: 37087334; PMCID: PMC10251130.

³ A search in *PubMed* for the terms "resiliency and hope" yielded 36 results in 2014 and 297 in 2024. The most widely used resilience measurement scale includes 25 different items and is known as the *Connor-Davidson Resilience Scale* (CD-RISC-25); it does not directly assess hope, which can be integrated into the categories of optimism, confidence in the future, and sense of purpose.

⁴ Most character strengths correlate positively with resilience in adults (20 out of 23; there is no correlation with humility, prudence, and the desire to learn): cf. LAPIERRE, S., CHAUVETTE, S., BOLDUC, L., et al., «Character Strengths and Resilience in Older Adults during the COVID-19 Pandemic», *Canadian Journal on Aging / La Revue canadienne du vieillissement*, 2023;42(3):455-465. doi:10.1017/S0714980823000089

⁵ Cf. ROSZAK, P., «Not Only Coping: Resilience and Its Sources from a Thomistic Perspective», *Journal of Religion and Health*, 2023 Aug;62(4):2734-2745. doi: 10.1007/s10943-022-01711-5. Epub 2022 Dec 1. PMID: 36454332; PMCID: PMC10366280.

Resilience, from the perspective of positive psychology, is understood as a dynamic process of transformation influenced by personal, social, and spiritual factors, where hope acts as protection⁶. This hope is usually studied only as something natural, which can also be found in animals. It is equivalent to what St. Thomas called natural passion, which reinforces desire and lifts the spirit to overcome adversity⁷. But it can also be considered a Christian virtue, which is a gift, and guides us toward an arduous but attainable good⁸.

Resilience is a multidimensional concept that encompasses body, mind, and spirit. It involves not only resisting, but also adapting, improving, and transforming. Over time, its meaning has evolved toward a more transcendent vision. Resilience is experienced as a relational process: we need support and a hopeful horizon. Human strength alone is not enough; God's grace, Christian virtues, and the help of others are pillars for rebuilding life after misfortune and facing daily difficulties.

After trauma, initial resilience is fragile, like a newly sprouted plant: it requires care and a favorable environment to grow stronger. Boris Cyrulnik, in *The Ugly Ducklings*, illustrates that overcoming pain does not erase the traces of the past⁹. The swan chick, saddened by seeing itself as weaker and uglier than its supposed duck siblings, is happy to find its true swan family; but that does not solve everything. The memory and representation of humiliation and abandonment remain. There are two options: to lament and seek revenge, or to learn to live a new life, that of the swans.

The key lies in the process of transforming the mental representation of the wound, accepting the aftermath and learning to live again. If there was security before the trauma and support afterwards, the memory evolves and the memories are reorganized¹⁰.

Resilience is a force that allows us to find life and beauty in the midst of adversity, like flowers in the desert. It is not instantaneous, but a lifelong journey. We will see how the concept has evolved, the forms of resilience, resilience in hope, and how to strengthen it.

1. Evolution of the concept

In the early years of the 21st century, after several cases of suicide among students at New York University, a prevention course called *Road to Resilience*¹¹ was

⁶ Cf. SUN YAJING, YU HAIBO, et al., «Sense of hope affects secondary school students' mental health: A moderated mediation model», *Frontiers in Psychology*, 2023, Vol. 14, <https://doi.org/10.3389/fpsyg.2023.1097894>. This and other psychological studies often use the *Adult Dispositional Hope Scale* (ADHS), developed by Snyder and colleagues, which defines hope as a cognitive construct composed of two main dimensions: *Agency*, or internal motivation to initiate and maintain actions aimed at achieving goals; and *Pathways*, or perceived ability to generate plans and alternatives that enable those goals to be achieved, even when obstacles arise: cf. SNYDER, C. R., HARRIS, C., et al., (1991), «The will and the ways: Development and validation of an individual-differences measure of hope», *Journal of Personality and Social Psychology*, 60(4), 570–585. <https://doi.org/10.1037/0022-3514.60.4.570>.

⁷ To see hope as a passion of the irascible appetite, also present in animals, cf. THOMAS AQUINAS, *Summa Theol.*, I-II, q. 40.

⁸ Cf. THOMAS AQUINAS, *Summa Theol.* II-II, q. 17 – q. 22. The virtue of hope is rooted in the will, looks to the future, and has as its object the eternal bliss of heaven, a good that is difficult to attain; it is preceded by faith and precedes charity.

⁹ Cf. CYRULNIK, B., *Los patitos feos. La resiliencia. Una infancia infeliz no determina la vida*, Barcelona: Debolsillo, 2013 (15th reprint 2024). It takes its name from Christian Andersen's well-known tale, *The Ugly Duckling*, from 1843.

¹⁰ See CYRULINK, B., *Sálvate, la vida te espera*, Barcelona: Debolsillo, 2022, 55-57.

¹¹ See SHATKIN, J. P., DIAMOND, U., et al (2016). «Effects of a risk and resilience course on stress, coping skills, and cognitive strategies in college students», *Teaching of Psychology*, 43(3), 204–210. <https://doi.org/10.1177/0098628316649457> (The Power of Resilience).

launched. The results have been good, and the course continues to be offered. The concept of resilience, like the reality it represents, follows an evolving path.

Many authors mention resilience, without entirely agreeing on what they mean by it. The main proponent is Boris Cyrulnik (born in 1937), a French neurologist and psychiatrist who is an expert on John Bowlby's attachment theory. His own personal history serves as inspiration, as he had to struggle to overcome the loss of his parents when he was a young child during the persecution by the Nazis who invaded France. He was saved by a nurse who hid him under the mattress of a dying woman being transported in an ambulance. He sums up his story with these words: «Look at what happened to me. I know who I am because I know what I am capable of in the face of adversity»¹².

The term resilience comes from physics. It refers to the resistance of materials, which allows them to return to their original shape after significant stress that has deformed them. From the Latin *resilire*, which is formed from *re* (backward) and *salire* (to jump). *Resiliens* would be translated as one who jumps backward, retreats, or bounces back.

In the 1960s, it was adopted by psychology, and since then its meaning has changed. Initially, its origin in physics was emphasized as an innate force, similar to that of materials; later, it came to include family, community, and cultural elements that are essential for starting over after trauma.

There has been growing interest in healthy lifestyles, body care, nutrition, contact with nature, and more transcendental elements such as the meaning of life and religiosity. Some emphasize its relatively stable, consistent, and measurable nature. Others study it as a dynamic process that can be modified according to context and developed throughout the life cycle¹³.

It was two doctoral students, Jack (1924-2010) and Jeanne H. Block (1923-1981), who introduced a precursor concept to resilience as it is understood today, which they called *ego-resiliency*, understood as the ability to adapt and respond flexibly to changing situations. They compared it to another construct, *ego-control*, or the ability to react to behavioral and attentional impulses¹⁴.

This was followed by Norman Garmezy's (1918-2009) studies on vulnerable children and competence, as the ability to adapt socially without psychopathology¹⁵. During those same years, Emmy Werner (1929-2017) of the University of California led a prospective study of 698 children born in 1955 on the Hawaiian island of Kauai. It would last 40 years and later become known as *the Kauai Longitudinal Study*¹⁶.

This was a disadvantaged population with numerous biological risk factors, problems during pregnancy and childbirth, coupled with an environment of poverty, family instability, parental mental illness, and substance abuse. They predicted that these children would have more learning, behavioral, and mental health problems, but found that one-third did not have these problems, but rather good health and social integration, and were therefore called resilient.

¹² CYRULNIK, B., *Salvate, la vida te espera*, 40.

¹³ Cf. CABANYES TRUFFINO, J., «Resiliencia: una aproximación al concepto», *Revista de psiquiatría y salud mental*, Vol. 3, No. 4, 145-151; DOI: 10.1016/j.rpsm.2010.09.003

¹⁴ The initial work of the Blocks dates to the 1950s. For a more in-depth look at the concepts, see JACK BLOCK, JEANNE H. BLOCK, «Venturing a 30-Year Longitudinal Study», *American Psychologist*, May-June 2006, Vol. 61, No. 4, 315-327, DOI: 10.1037/0003-066X.61.4.315. Jeanne Block had already passed away.

¹⁵ Cf. GARMEZY, N., «Competence and adaptation in adult schizophrenic patients and children at risk», in DEAN, S.R. (ed.), *Schizophrenia. The first ten Dean Award Lectures*, New York: Ardent Media, 1973, 163-204.

¹⁶ Cf. WERNER, E.E., «Vulnerable but invincible: high-risk children from birth to adulthood», *Acta Paediatrica*, 1997-07, Vol.86 (S422), 103-105.

Various resilience factors were identified, giving rise to a concept more closely linked to the environment and not just to characteristics of the self. In addition to a temperamental basis, aptitudes and values, education, supportive family figures, and even trust in faith and prayer will have an influence. Michael Rutter (1933-2021)¹⁷ played an important role in identifying protective mechanisms for resilience. He highlighted those that reduce the impact of the initial adverse event and the likelihood of negative chain reactions, along with those that promote self-esteem and self-efficacy, with secure, supportive interpersonal relationships and openness to new opportunities.

Resilience has evolved from being understood as a personality trait¹⁸ to a dynamic process of adaptation, influenced by individual and social factors. The spiritual perspective has become more relevant, and it has been found that, to recover from adversity, it is key to find meaning in pain, a purpose for existence, and companionship.

2. Forms of resilience

Resilience can be understood as a personal trait or as an external protective factor. It is comparable to a network that is strengthened over time and by the environment. It affects all dimensions of the human being:

- Physical resilience: good health and recovery capacity, promoted by healthy habits.
- Cognitive resilience: maintaining concentration, understanding the inner world and what is happening around us; it allows us to make good decisions even in times of stress.
- Emotional resilience: knowing and managing emotions, fostering positive feelings and quickly overcoming negative ones, such as fear. When intelligence and willpower guide the emotional world, there is no repression, and disturbing emotions do not persist as if “buried alive”¹⁹.
- Spiritual resilience: includes a clear sense of existence and purpose, establishing strong interpersonal relationships with appropriate intimacy, opening to others with self-transcendence, stepping outside of oneself, and pursuing lofty ideals.

For any form of resilience, several factors must be considered, the first of which is finding a significant person who allows you to know and feel loved.

Next is the regeneration of social and community ties, which are often broken after significant psychological trauma. In today’s society, so interconnected by social media, there are many lonely people who feel anonymous and focus on themselves with growing narcissism. There are too much interconnection and too little connection; and contact replaces true relationship²⁰.

Two fundamental elements follow, which are scarce today: attention and silence. Without stopping to think and contemplate, it is difficult to deploy mental strength and find meaning in adversity.

The fourth is good humor, which is not simply mocking laughter, irony, denial of aggression, or turning pain into pleasure. It is the ability to distance ourselves from us, from our suffering, to give it a name, a meaning, and transform it into a story. A story that is represented in a new way.

It is possible to construct a new feeling about past traumas, but it is always necessary to have someone to help us: a spectator who is interested in our story. In this

¹⁷ Cf. RUTTER, M., «Psychosocial resilience and protective mechanisms», *American journal of orthopsychiatry*, 1987-07, Vol.57 (3), 316-331.

¹⁸ Articles by many authors can be found in LUTHAR, S.S. (ed.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities*, Cambridge University Press: 2003, <https://doi.org/10.1017/CBO9780511615788>

¹⁹ Cf. TERRUWE, A., BAARS, C., *Amare e curare i nevrotici. Terapia delle nevrosi per carenza affettiva*, (Psychic Wholeness and healing; Healing the unaffirmed) Asís: Cittadella, 1984, 51.

²⁰ Cf. HAN, B-C., *El espíritu de la Esperanza (The Spirit of Hope)* (Original title: *Der Geist der Hoffnung*), Barcelona: Herder, 2024, 28-29.

way, «the past becomes coherent thanks to our forgetfulness and our emotional remodeling»; and we try to «understand what happened, to put an end to the confusion, to control the representation. The tragic event is inscribed in a narrative of oneself to give it meaning and embark on a new way of life»²¹.

Logically, there are situations in which laughter is not possible, such as in the case of a child who has seen his parents tortured or humiliated²². It is also possible that supposed good humor can become rigid or take the form of a mask that prevents authentic relationships with others.

But even when there seems to be no way out, when the path appears to be closed, there is one possible strategy: changing one's attitude²³. From a practical point of view, we find four ways to change to a positive attitude to increase psychological resilience.

The first is to train our attention, guarding the gateway to our mind so that it is not contaminated with negative thoughts. It means being in the present and where I should be. Healthy, joyful, and kind attention has these characteristics: it is directed primarily toward the world, not toward one's own mind; it focuses on novelty, not on the experience of a threat or an uncertain future; it delays judgment of others, which tends to be positive. It is the capacity for wonder at the ordinary.

The second way to change your attitude is to cultivate emotional resilience: to better understand and control your emotions. This includes fostering positive feelings of gratitude, compassion, acceptance, and forgiveness. It also means filling your heart with grace, bearing in mind that «if suffering makes us bitter or evil, it is because our hearts are empty: empty of faith, hope, and love»²⁴.

Gratitude allows us to see the good despite the wounds or evils we have suffered; we are grateful to those who love us and to God who cares for us and keeps us in existence. Compassion leads us to understand others and their pain; it allows us to understand that when someone does not express love, they may be asking for help.

Then, accepting limitations and a history of wounds can awaken creativity: accepting deficiencies in oneself, in others, and in situations. Acceptance is closely linked to hope.

Finally, forgiveness, which is easier when we understand that the person who hurt us may have acted out of ignorance or misunderstanding. Even those who cause harm may be more unhappy, as they carry the burden of their actions.

Forgiveness does not happen in an instant, but the decision does²⁵: by choosing to forgive, negative emotions such as anger and hostility are dispelled, and the door to hope is opened. This choice can be made before the other person asks for forgiveness, even if they never do.

In addition to strengthening emotional resilience, it is a good idea to engage in activities that promote physical and spiritual well-being: reading, music, art, exercise, and reflection on the meaning of life. It is important to avoid activism, slow down, and promote peaceful family spaces, reducing excessive demands at school.

Healthy habits also boost resilience: watching your weight, quitting smoking, avoiding a sedentary lifestyle, and learning to relax with activities that allow you to enjoy beauty.

²¹ CYRULNIK, B. *Salvate, la vida te espera*, 77.

²² Cf. CYRULNIK, B. *Los patitos feos*, 112-117; 241-244.

²³ Cf. FRANKL, V., *La voluntad de sentido, Conferencias escogidas sobre logoterapia*, Barcelona: Herder, 1991 (2nd), 36-37.

²⁴ PHILIPPE, J., *La libertad interior. La fuerza de la fe, de la esperanza y del amor* (original title: *La liberté intérieure*), Madrid: Rialp, 2005 (7th), 85.

²⁵ Cf. ENRIGHT, R., *Forgiveness Is a Choice: A Step-by-Step Process for Resolving Anger and Restoring Hope*, Washington: Apa Life Tools, 2019.

Another aspect is the use of psychological defense mechanisms. Those who have suffered need to distance themselves from what has happened, although defenses can be positive or harmful. The more conscious and adaptive they are, the better. Cyrulnik gives some examples, associating them with a person's particular way of thinking²⁶.

- o Denial: this is the most common and manifests itself in expressions such as: «don't think I've suffered». It can be good and necessary at certain stages, so as not to keep going back over what happened.
- o Isolation: this can be accompanied by the statement: «I remember an event that is stripped of its emotional impact».
- o Flight forward: involves constant vigilance: «I am constantly on guard to prevent my anguish from recurring».
- o Intellectualization: «The more I try to understand, the more I control the unbearable emotion».
- o Creativity: Cyrulnik attaches particular importance to this: «I express the inexpressible through the medium of art»²⁷.

There are also ineffective resilience strategies:

- o Forgetting and indifference: painful events are relegated without giving them meaning or a name, and the wound somehow remains open or becomes "infected".
- o Revenge: excludes forgiveness and focuses on the temporary well-being of having a mission—revenge—and a goal that will supposedly erase the wound. It does not achieve well-being but leaves the person a prisoner of their past: they experience the bitterness of the wound and the illusion of alleviating it with revenge. Hate can initially have a protective effect, distancing the aggressor; but when prolonged, it prevents empathy and can end up transforming the victim into the aggressor.
- o Victimhood: provides a false sense of meaning to what has happened. These are people who struggle for recognition, with an excessive focus on the self. Considering oneself a victim for life is harmful, promoting low self-esteem, an inability to love and respect oneself, and an inability to face one's own pain to grow. It can be conditioned by external circumstances that are sometimes unavoidable, such as the legal resources that a victim must resort to²⁸.
- o Compensation: attempts are made to fill the void and drown out false and harmful feelings of guilt with addictions and other harmful behaviors. In adolescence, traumatized young people are more likely to engage in inappropriate and high-risk behaviors: drug or alcohol abuse, promiscuity, dropping out of school, reckless and dangerous behaviors, bullying, violence, and delinquency²⁹.
- o Resignation: this translates into "just gritting your teeth", without any attempt at understanding, forgiveness, or searching for meaning.

²⁶ Cf. CYRULNIK, B., *Los patitos feos*, 32-35. As is well known, the defense mechanisms of *the ego* in general were systematized by Anna Freud.

²⁷ *Ibid.*, 33.

²⁸ Cf. BERMEJO, J. C., RUIZ-ARAGONESES, R., PÉREZ-MIGUEL, E., (2024). «El crecimiento postraumático y la resiliencia en las víctimas de abuso sexual infantil», *Anuario de Psicología Educativa Aplicada*, 1, Article e1. <https://doi.org/10.5093/apea2024a1>.

²⁹ This is demonstrated by numerous studies of Adverse Childhood Experiences, on the consequences of traumatic events up to the age of 18. The first was conducted in 1998: FELITTI, V.J., ANDA, R.F., et al., «Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study», *American Journal of Preventive Medicine*, 14 (1998), 245-258, [http://dx.doi.org/10.1016/S0749-3797\(98\)00017-8](http://dx.doi.org/10.1016/S0749-3797(98)00017-8). See also: SÁNCHEZ-VÁZQUEZ, A.R., «Experiencias adversas en la infancia (EAI): ¿la base del iceberg del sufrimiento emocional de la población infantil y adolescente?», *Anales de Pediatría*, 2024, Vol. 101. No. 5. 299-302. DOI: 10.1016/j.anpedi.2024.10.001.

3. Transformative resilience in hope

Every psychological wound that heals is transformed, but the deepest transformation comes from the grace of God. Trusting in it turns pain into treasure and elevates human nature to a higher dimension: supernatural life. The biblical story can be understood in terms of resilience: after original sin, God guides humanity until he sends his Son. Through his passion, death, and resurrection, Christ lifts human beings, and his resurrection is a sign of our own transformation.

The Old Testament contains numerous references to this resurgence from adversity, with divine intervention, which conveys hope in the face of trials. For example, Psalm 30: «For his anger lasts but a moment, his favor lasts a lifetime. Weeping may stay for the night, but rejoicing comes in the morning» (Ps. 30:5).

Many prophets recall this destiny. Isaiah tells us: «Even youths grow tired and weary, and young men stumble and fall; but those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint» (Is. 40:30-31). It is the greatest confidence, called hope, that overcomes fatigue and difficulty.

Other prophets, such as Micah, also emphasize hope, to rise after falling: «But I trust in the Lord, I hope in God, my savior, confident that my God will hear me. Do not rejoice over my fate, my enemy; if I have fallen, I will rise again; if I am in darkness, the Lord is my light» (Mic. 7:7-8).

When the destruction of Jerusalem came, around 587 BC, Jeremiah announced the calamities that awaited the chosen people. He looks to the future with realism, with truth, for what he announces comes from God. His mission is to tell the truth, and at the beginning of his ministry he receives the most hopeful proof. He laments that he is too young, that he has no skills, but the Lord strengthens him with these words: «Do not be afraid of them, for I am with you to deliver you» (Jer. 1:8).

The fall of Jerusalem and the exile of Israel to Babylon become reality. The recipients of God's promises, the descendants of the 12 most famous tribes in the world, have been left without freedom, without a temple, without an altar, without worship, without anything. In this situation of anguish and desolation, the wisdom books and the book of Job emerge, the latter being an example of resilience.

In the story, the righteous Job loses his material possessions, his family, his honor, and his health, and must endure the mockery and reproaches of his friends and his wife. He accepts what has happened in an exemplary manner and strives to find meaning in it³⁰. Little by little, a hopeful transformation takes place within him, but his attempt remains futile. In the end, in his final dialogue with the Lord, he realizes that while he was trying to explain what was happening, he was unable to do so. He gives up trying to understand and addresses these words to him: «My ears had heard of you, but now my eyes have seen you» (Job. 42:5). This is the greatest transformative resilience: seeing God.

After this humble acknowledgment, God gives Job an abundance of all the goods he once possessed (cf. Job. 42:10). Christian hope is the hope of eternal life. Only that gaze beyond this limited existence allows for the greatest resilience.

The New Testament contains many passages on resilience and hope. St. Paul wrote to the Romans: «We know that all things work together for good for those who love God, who are called according to his purpose» (Rom. 8:28). His message of hope and mission in life is clear, even amid difficulty. In his letter to the Philippians, the Apostle expresses his famous phrase: «I can do all things in him who strengthens me» (Phil. 4:13).

³⁰ For a deeper understanding of the meaning of pain, following the book of Job, see: JOHN PAUL II, Apostolic Letter *Salvifici doloris*, February 11, 1984.

Our future or destiny is not the result of chance. God is very present in our lives. Everything falls within his saving plan. From this comes the realization that we are children of God, which fills us with hope and peace, and makes the saints say: «We've got to be convinced that God is always near us. We live as though he were far away, in the heavens high above, and we forget that he is also continually by our side. He is there like a loving Father. He loves each one of us more than all the mothers in the world can love their children – helping us, inspiring us, blessing... and forgiving. (...) We've got to be filled, to be imbued with the idea that our Father, and very much our Father, is God who is both near us and in heaven»³¹.

Human beings are called to a supernatural life. Looking at Christ walking with us, thinking that there is a God who loves us and accompanies us is the positive thought par excellence of a Christian. And that thought can transform each person and the whole world.

Virtues help us to give the best of ourselves, to recover and move forward. They help us overcome fears, understand the ups and downs, hopes and despair, the mountains and valleys. St. John of the Cross expresses it poetically: «Seeking my loves, I will go through those mountains and rivers; I will not pick the flowers nor fear the wild beasts, and I will pass through the forts and borders»³².

4. Strengthen others

Fostering resilience means giving hope: only those who hope can move forward and face adversity.

Interpersonal relationships are key to creating networks of support and self-esteem. It begins with the ability to listen with empathy, to grasp feelings and understand others. In these networks, the wounded person can feel valued and secure. That security allows them to talk about their trauma and not remain isolated. In children, the family and school environment is fundamental. Overcoming climates of fear opens the door to hope, which drives us toward the possible and the new³³.

We must not confuse hope with optimism. Optimism always sees the future as positive; hope, on the other hand, accepts the uncertainty and the invisible, opens the soul to new possibilities, and gives the world a renewed splendor. It is the virtue that allows us to start over and transform ourselves: «Those who do not dream ahead, with their minds set on the future, do not dare to start over»³⁴.

Hope involves taking the risk of a new life, which is characteristic of resilience. Even the unconscious mind marked by trauma is illuminated by this virtue. By trusting in grace and Christian virtues, it is easier to focus on the present to overcome crises.

It opens us up to a better world, to others, and distances us from our own selves; it marks «the direction of man's existence toward the perfection of his nature, the satisfaction of his essence, his ultimate fulfillment, the fullness of being, which therefore also corresponds to the fullness of luck, or rather, of happiness»³⁵.

True Christian hope does not consist in expecting that everything will turn out well, but in trusting that God is present here and now, even during shipwreck. It is not naive optimism or escapism in the future, but a way of living in the present with meaning, renouncing false securities and learning to love more in adversity³⁶.

³¹ ESCRIVÁ DE BALAGUER, J. *The Way*, no. 267.

³² JOHN OF THE CROSS, *Cántico espiritual*, 3ª estrofa, en *Obras completas*, Madrid: BAC, 1982 (11th), 567.

³³ Cf. HAN, B-C., *El espíritu de la esperanza*, 16-17.

³⁴ *Ibid.*, 64.

³⁵ PIEPER, J., *Las virtudes fundamentales*, Rialp, Madrid 1980 (3rd), 29.

³⁶ Cf. CANDIARD, A., *Esperanza para naufragos. Manual de usuarios para el siglo XXI* (Original title: *Veilleur, où en est la nuit?*), Madrid: Rialp, 2024.

Christian hope also illuminates the past, giving a new vision of what has been experienced and strengthening the memory to look to the future. St. John of the Cross understands it as a desire for God, the infinite source of love and peace: «And for such a great good, it is very fitting to endure and suffer with patience and hope»³⁷.

With his experience, the saint explains: «Hope empties and removes the memory of all creaturely possession, because, as St. Paul says, “hope is for what is not possessed” (Rom. 8:24), and thus removes the memory of what can be possessed and places it in what is hoped for, and for this reason the hope of God alone disposes the memory purely to unite it with God»³⁸.

Hope, even in its human dimension, drives strategies for coping with adversity: it promotes conflict resolution, positive thinking, healthy repentance, and recognition of trauma. It also inspires activities such as sports and artistic creativity.

It will be a priority to ensure, as «a map of hope»³⁹, an education open to contemplation, art, beauty, transcendent meaning, and others; one that teaches how to interpret signs and listen to the heart. And this education begins in the family, where character is forged, an indispensable basis for resilience: «With love, support, and an intact character, a human being can be more resilient than one can imagine»⁴⁰.

The key is to find meaning in what we experience, not to accumulate purposeless activities⁴¹, but to discover their value and open ourselves to others and to God. This certainty allows us to look to the future, leaving the past in His hands.

Benedict XVI affirms: «Only when the future is certain as a positive reality does the present become bearable»⁴². Christian faith and encounter with Christ transform life, sustain us in suffering, and open us to the hope of eternal life.

Providing security boils down to giving hope: even with a past full of wounds, we can look to the future with new eyes. Many psychological problems arise from erroneous thoughts that take root, as cognitive psychology explains and Edith Eger graphically recounts: «Memory is sacred ground. But it is also haunted. It is the place where my anger, my guilt, and my grief circle like hungry birds searching for the same old bones»⁴³. We must convince ourselves, she adds, that so often we are our own jailers and that the key that sets us free is ours; that «the greatest prison is in your own mind, and you already have the key in your pocket»⁴⁴.

But we must go beyond natural hope, which could be misguided because it lacks what is proper to virtue, and aspire to the best of human beings⁴⁵. What gives security comes from heaven, as St. Thomas wrote: «Man must be bound to hope, as the anchor is bound to the ship. But there is a difference between the anchor and hope, and that is that the anchor clings downward while hope clings upward, that is, to God»⁴⁶.

³⁷ JOHN OF THE CROSS, *Subida al Monte Carmelo, Libro III, cap. 2, 15, en Obras completas*, 241; cf. GONZÁLEZ, L. J., *San Juan de la Cruz, México*: Duruelo, 2017.

³⁸ JOHN OF THE CROSS, *Noche oscura, Libro II, chap. 21, 11, in Obras completas*, 411.

³⁹ Cf. LEO XIV, Apostolic Letter: *Designing New Maps of Hope*, October 27, 2025. The Pope recalls how the Desert Fathers «transmitted a pedagogy of the gaze that recognizes God everywhere» (n. 2. 2); and that «educating is an act of hope and a passion that is renewed because it manifests the promise we see in the future of humanity» (n. 3. 2).

⁴⁰ PETERSON, J.B., *12 Rules for Life: An Antidote to Chaos*, Great Britain: Penguin Books, 2018, 217.

⁴¹ As happens to Sisyphus, who does nothing but push a rock up a hill only to let it roll back down again, thinking that in doing so he has conquered fate: cf. CAMUS, A., *El mito de Sísifo*, Madrid: Alianza, 1985.

⁴² BENEDICT XVI, Encyclical *Spe salvi*, November 30, 2007, n. 2.

⁴³ EGER, E., *La Bailarina de Auschwitz (Título original: The Choice. Embrace the Possible)*, Barcelona: Booket, 2019 (18th printing, 2024), 34.

⁴⁴ *Ibid.*, 406.

⁴⁵ PIEPER, J., *Las virtudes fundamentales*, 377.

⁴⁶ THOMAS AQUINAS, Sup. epist. ad Heb. in loc.

Not all hope is enough to rebuild us; we need certain hope. St. Bonaventure compares it to flying, which requires the effort of love, spreading one's wings, «Lifting up one's head, turning one's thoughts upward, that is, toward God»⁴⁷.

In this vein, a useful tool for resilience is *mindfulness* or focused awareness on what is important⁴⁸; for a Christian, this will consist of knowing that they are accompanied by a God who loves them.

This is based on self-transcendence, as an essential capacity that allows one to go beyond oneself, towards others and towards God, in the search for a unique meaning to life and adversity. This idea underpins Nietzsche's phrase, popularized by Frankl: «He who has a why to live for can bear almost any how»⁴⁹.

Frankl also coined what he called a Copernican revolution in psychology: «It doesn't matter that we expect nothing from life, but whether life expects something from us»⁵⁰.

Exercises in gratitude, towards God and people, and realistic planning, always open to hope, are useful.

Conclusions

Resilience is not just about resisting but transforming. As doctors, psychologists, priests, or spiritual companions, we can be catalysts for that change. It is a capacity that varies according to temperament, but it can be cultivated and is related to all virtues, especially fortitude. Its fullness is achieved with the supernatural virtues: faith, hope, and charity, highlighting the hope of eternal life, which we must guard and transmit, «because hope for heaven achieves as much as it hopes for»⁵¹.

Every human being needs hope for a worthwhile future; without it, life comes to a standstill. St. Zeno of Verona (300-371) sums it up this way: «What does the child do with the teacher if he does not expect to reap the fruits of those letters? In what boat will the sailor venture among the waves of the sea if he does not expect a profit or trust that he will reach the desired port? What soldier will despise, not only the insults of the cruel winter or the torrid summer, but himself, if he does not cherish the hope of future glory? What farmer will sow the seed if he does not think he will reap the harvest as a reward for his sweat?». To which he adds, as a conclusion, the essence of supernatural hope: «What Christian will adhere to Christ by faith if he does not believe that the time of eternal happiness promised to him will come?»⁵².

Natural hope wanes with age, for as we grow older, the “not yet” becomes “no longer”; but supernatural hope keeps the longing alive and grants “eternal youth”, as Pieper points out⁵³.

We also conclude that resilience is not innate but is learned and strengthened through accompaniment and practice. We can all help others to make their journey more

⁴⁷ BONAVENTURE, Sermo XVI, Dominica I Adv., Opera omnia, IX, 40a, cited in BENEDICT XVI, *Address in Bagnoreggio*, September 6, 2009.

⁴⁸ JOYCE, S., SHAND, F., TIGHE, J., et al., «Road to resilience: a systematic review and meta-analysis of resilience training programs and interventions», *British Medical Journal Open*. 2018 Jun 14;8(6):e017858. doi: 10.1136/bmjopen-2017-017858. PMID: 29903782; PMCID: PMC6009510.

⁴⁹ NIETZSCHE F., «Götzen-Dämmerung oder Wie man mit dem Hammer philosophirt», in *Nietzsche Werke*, VI 3, Sprüche und Pfeile 12, 54-55: «Hat man sein warum? des Lebens, so verträgt man sich fast mit jedem wie? —Der Mensch strebt nicht nach Glück; nur der Engländer thut das». This corresponds to aphorism 12 of Nietzsche's 1889 work *The Twilight of the Idols*.

⁵⁰ FRANKL, V., *El hombre en busca de sentido*, Barcelona: Herder 1993 (15th), 78.

⁵¹ JUAN DE LA CRUZ, *Tras un amoroso lance*, 4th stanza, in *Obras completas*, 34.

⁵² ZENO OF VERONA, *Treatise on Faith, Hope, and Charity*, I-IV.

⁵³ Cf. PIEPER, J., *The Fundamental Virtues*, 386-387. Pieper comments here on St. Thomas Aquinas, *Summa Theol.* I-II, q. 40, a. 6.

pleasant. As in the story of the Ugly Duckling, transformation is possible: resilience is hope lived through love, which renews us.

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Psychologization of personal boundaries as a challenge to humanity

Abstract: This paper explores the phenomenon of psychologization—the mass adoption and everyday application of psychological concepts and therapeutic approaches by individuals without professional training. The article argues that the use of the "psy-vocabulary" can lead to a distorted perception of reality. It suggests that this "psy-glasses" approach promises clarity and control over life, but in reality, it reduces complex situations to simple labels and reduces the living world to a "transparent" object of dissection.

In this perspective, the issue of personal boundaries becomes the central focus of psychologization: from a concern for delicacy and respect, it easily drifts toward a culture of alienation and self-isolation, where "safety" (including emotional) is sacralized (safetyism), and boundaries are transformed into an instrument of control, justification, and the cessation of dialogue.

The paper analyzes how boundary discourse can function as an unconscious defense (rationalization): terms ("abuse," "narcissism," "depression," "boundary violation") become a "shield and sword," concealing deeper motives, guilt, fear, shame, and a reluctance to encounter. From a theological-anthropological perspective, two models of boundaries are contrasted: one autolegitimate (self-established) and one rooted in a transcendent criterion (Divine law), where "crossing" a boundary is conceived as a sinful transgression, and human dignity is upheld not by self-affirmation but by love, delicacy, and kenotic humility.

The final thesis: the psychologization of boundaries, with the loss of an external standard, blurs the distinctions between norm and pathology, good and evil, and thus becomes a challenge to humanity; the solution is seen as a return to the "living water", cleansing the mind and restoring the ability to be present, to love and to be responsible.

Keywords: psychologization; therapeutic attitude; personal boundaries; privacy; safetyism; rationalization; defense mechanisms; digital transparency; egocentrism; alienation; religious anthropology; sin as transgression; kenosis; delicacy; dehumanization.

Soul: O my father! It is difficult to tear the heart from the sticky elemental mud... Ah, it is difficult! I saw a painted image of a winged youth. He strives to fly to the heights, but his leg, chained to the globe, hinders him. This image is my image. I can't, I just wish.
G. S. Skovoroda¹

All doctors know what kind of patient is the most unbearable: the "healthy lifestyle" follower, who has read the recipes of "alternative medicine healers" and devoutly professes his belief in the total harmfulness of "official medicine." And almost every priest, with a heavy sigh, will tell you how difficult it is to provide spiritual guidance to someone who has read too many holy fathers indiscriminately and without proper understanding and who, at the priest's every word, is ready to unleash a tirade of patristic quotations, thereby devaluing any living word of the pastor. But psychologists

¹ Collected works of G.S.Skovoroda. Vol. 1. St. Petersburg, 1812. p. 499.

also know how hard it is to work with "experienced clients" whose heads are filled with a whole bunch of psychological terms, each of which in their minds often turns into something very far from the classical understanding.

The phenomenon of "psychologization" emerged not so long ago due to the widespread adoption of psychological concepts, approaches, and methods, and the general emphasis on the importance of "mental well-being". The increasing presence of psychology in various spheres of public life gives the impression of its "universalism", "omniscience", and "effectiveness", which is the origin of psychologization.

If we try to define "psychologization", I would suggest that it is the process of applying and adapting popular, often simplified knowledge from the fields of psychology, psychotherapy, and psychiatry to the everyday life of individuals who do not have specialized training in these areas. To better understand this, we can use the "Lego" analogy: a person fascinated by the many colorful and diverse aspects of mental health begins to build his own "structure" - in his own "image and likeness". The main difference with Lego is that this is not an external structure being built, but rather his own "lens" through which he will see everything: the world around him, other people, and himself. Sometimes, a person does not realize that he has constructed "psychological glasses" in front of his "inner eye", through which he can only see. However, more often than not, these thoughts do not occur to him. After all, the glasses create a convincing illusion that many previously unsolvable problems seem quite simple, understandable, and - most importantly! - solvable. This phenomenon of "psychologization" gives researchers reason to refer to modern society as a "psychological society" per se.

"Psy-glasses", which initially give the illusion of greater clarity, can actually alter the perception beyond recognition. In C.S. Lewis' book "The Pilgrim's Regress", there is an image that helps us understand exactly what changes occur when we psychologize. The protagonist of the story finds himself in a dungeon of a giant, from whose gaze he cannot escape. "Now I dreamed that the giant's eyes had this property, that whatever they looked on became transparent. Consequently, when John looked round into the dungeon, he retreated from his fellow prisoners in terror, for the place seemed to be thronged with demons. A woman was seated near him, but he did not know it was a woman, because, through the face, he saw the skull and through that the brains and the passages of the nose, and the larynx, and the saliva moving in the glands and the blood in the veins: and lower down the lungs panting like sponges, and the liver, and the intestines like a coil of snakes. And when he averted his eyes from her they fell on an old man, and this was worse for the old man had a cancer. And when John sat down and drooped his head, not to see the horrors, he saw only the working of his own inwards. Then I dreamed of all these creatures living in that hole under the giant's eye for many days and nights. And John looked round on it all and suddenly he fell on his face and thrust his hands into his eyes and cried out, 'It is the black hole. There may be no Landlord, but it is true about the black hole.'"² [2]

The Landlord – that is, the Lord God, – is not there, but the "black hole" of the human "inwards" is there; and the inside of this hole is just the ugly, cynical nudity, the naked quasi truth. The scalpel of an unloving gaze knows no tact or boundaries - it cuts into something that has been tabooed for thousands of years. As a rule, this is an area of the sacred, in the broadest sense, which includes everything that is heart-pounding to a person, touching the deepest, most delicate, resonant strings of the soul: religiosity, love (including everything related to gender), family, self-awareness, and more.

Much of what psychology began to examine intently, searchingly, and, most

² C.S. Lewis, *The Pilgrim's Regress*. M.: Publishing House of Belles Lettres, 2024. p. 73

importantly, aloofly, without reverence and love, has been deformed beyond recognition under this gaze. The mystery of the sanctity of sex has been reduced to "the physiology and psychology of sex" or even just "technology", which has led to an increasing movement of incels - consciously asexual young people with a hypertrophied sense of self, so much so that we can already speak of a sexual counter-revolution. The dissecting scalpel of rationalism, devoid of any religious bias, has torn the delicate skin of religious belief, effectively diminishing the value of former sacred sites. This process of "eroding" faith was well described by Ivan Ilyin: "It started with a rational mockery..., which perpetuated spiritual blindness and religious infirmity in the souls. This was not just a rejection of the sacred, it was a rejection of a serious and reverent approach to it. This irony cut off the religious wings of people and cauterized their wounds with its caustic poison, so that they could not grow back in the future. It emptied their souls and showed them an empty world, making them accustomed to considering revelation as fiction, dogma as prejudiced, and prayer as childish or hypocritical. People became ashamed of praying, and then they mocked themselves, who had prayed before but no longer did, and the very Subject of their former prayers"³.

But, as Lewis has shown, the "giant of the naked truth" is a fraud and a deceiver. "He showed you by a trick what our inwards would look like if they were visible. That is, he showed you something that is not, but something that would be if the world were made all other than it is. But in the real world our inwards are invisible. They are not coloured shapes at all, they are feelings. The warmth in your limbs at this moment, the sweetness of your breath as you draw it in, the comfort in your belly because we breakfasted well, and your hunger for the next meal—these are the reality: all the sponges and tubes that you saw in the dungeon are the lie"⁴.

Psychologization leads not only to a "deformation of the gaze", but also to the use of "glasses" that allows people to hide themselves as they create an image of a "modern", "advanced" and "mentally skilled" individual. The reliance on these glasses can become so ingrained that without them, a person may feel exposed, stripped bare, and defenseless in their vulnerability. Consequently, they will strive to maintain their use, even in the face of attempts by psychologists, clergy, or even close loved ones to persuade them otherwise. Is psychologizing a form of unconscious defense mechanism, rationalization, that obscures and confuses direct access to a person's inner world, creating a protective barrier that effectively prevents any form of entry? "I'm depressed!" "I won't talk to him, he's a narcissist!" "This is abuse, trespassing my boundaries, how dare you?!" Often, there is no clear understanding of the terms used in these and similar phrases, only a "psychological shield and sword" concealing underlying motives and intentions.

"If then the light within you is darkness, how great is that darkness!" – says Jesus in the Gospel (Mat. 6:23). However, the light emanating from the eyes of someone who is self-absorbed through the lens of «Ψ-glasses» is akin to the blinding light of a UV lamp, sterilizing anything potentially dangerous or uncomfortable. A «spiritual ozone» surrounds such an individual, serving as a warning: stay at a safe distance, for it is lethal!

Furthermore, we now even have a name for this "ozone" - "safetism" as a cultural and psychological mindset in which safety (including "emotional safety") is elevated to a "sacred value", often at the expense of freedom of expression, learning through difficulty, intellectual risks, and so on. The term was coined by Haidt and Lukianov in their book "The Coddling of the American Mind" (2015-2018). They described safetism as a culture where individuals are overprotected from potentially

³ Ilyin I.A. Axioms of Religious Experience. M., 1993, p. 62

⁴ C.S. Lewis, The Pilgrim's Regress. M.: Khudozhestvennaya Literatura, 2024.

distressing ideas or experiences, which paradoxically makes them more vulnerable.

One of the most widespread elements of psychologization has become the theme of personal boundaries. What once amazed Russian tourists upon their arrival in the United States was the physical, measured in decimeters, inviolable space that individuals reserve for themselves — privacy. This notion of personal space, which encompasses concepts such as "personal life," "solitude," and "intimacy," is increasingly becoming more deeply ingrained in the lives of people living in megacities, first, and then everywhere.

In the early 2000s, when I first visited in America and entered a nearby supermarket, I was perplexed by the sight that greeted me at the cashier area. There was a single person standing at each cash register, and then, at a distance of about three meters, there were individuals standing alone. In the large hall, these isolated figures appeared to be part of a staged scene, yet they felt quite ordinary. I thought that you never know what happens in this country and quickly approached the checkout counter and immediately noticed a swift negative response from others: they were in line — yes, in line! — standing there! And the distance between them was several meters! Privacy in action, indeed...

The article "The Right to Privacy" by Samuel D. Warren & Louis D. Brandeis, published on December 4, 1890 in the Harvard Law Review, became the first systematic manifesto that recognized privacy as a fundamental civil right. The article articulates the "right to be left alone": one's reputation, photographic image, writings, and domestic space are now legally protected. However, it would take many more years for the concept of privacy to be fully embraced. Until the 1930s, telephone conversations were not considered private, even from the perspective of the United States Supreme Court.

The issue of personal privacy has gained even more prominence in the digital era, when it became apparent that the world has become both transparent and rapidly evolving. Nowadays, any piece of content — whether it be a post, a sentence, or a photograph — instantly becomes not only accessible to everyone but also subject to a flurry of comments, innuendos, and rumors, akin to a snowball effect.

Now it is becoming clearer how the phenomenon of psychologization, interwoven into the context of digital transparency, has given rise to a new phenomenon, I would even say a new "breed" of people — "border guards": those who are so preoccupied with their inviolability that they unknowingly begin to live in an impenetrable «bubble».

The simplest method to trap a rat is to place the bait on a piece of cardboard and coat it with a non-drying adhesive. If the rat touches it, it becomes stuck, and the more it struggles, the stronger the adhesive holds it. In a similar manner, psychologization elevates the most tenacious aspect of a person — the ego — to a pedestal. The unspoken but implied motto of the new standard is "I have the right to be whatever I desire, and no one can tell me otherwise!" This new norm removes the old prohibition of unlimited self-indulgence.

The initial "rediscovery" of the Ego appears to be a liberating experience: now any external boundary — social, family, religious — looks outdated. St. Isaac the Syrian compared person consumed by passion to a dog licking the teeth of a saw and getting drunk on the taste of his own blood. Psychologization has added anesthesia: the pain is almost not felt.

However, such "self-love" is fundamentally distinct from Christian love. In the Gospel (Mat. 19:19), it is mentioned only in the context of love for God and neighbor; in parallel, there are calls to reject oneself and not turn "concern for the flesh" into lust (Rom. 13:14). A Christian views himself through the lens of God's plan, which has not yet been realized, so he approaches his desires with caution and seeks external

validation — through prayer, guidance, and community.

The biblical principle is simple: seek first the kingdom of God, and the rest will be added to you (Mat. 6:33). A believer remains active, pursuing the "highest honor," even if he does not reach it yet. The egocentric clings to everything that sticks to him, and the glue of self-love gradually shackles his life. Like Gollum with his "my precious," he doesn't notice that the world is moving on without him.

If a person is considerate, they do not need to be told about what abuse is, where personal boundaries lie, or why not every "good deed" done to another person is right. However, delicacy, when brought up in a religious context, is based on a different philosophy: a person should be considerate not because they are the person themselves, but because God is considerate towards them. The whole Gospel is about this. God of the New Testament doesn't "wash his hands in the blood of sinners" (Ps. 58:10) or "smash infants against a rock" in a frenzy (Ps. 137:9). He will not break a "bruised reed" or "quench a smoking flax" (Mat. 12:20).

In Michael Ende's philosophical fairy tale novel "Momo"⁵, the main character is a homeless orphan Momo, who lives in an amphitheater on the outskirts of the city, has no education, no "traditional" upbringing, no "full family," In other words, is psychologically and socially doomed to be an outcast. However, it is precisely she who is an example of a whole, "unravelling" personality. Beside her, enemies are pacified, children are inspired, and adults realize the truth of life. This is not because Momo "preaches" or "cures" those who approach her. Rather, she simply remains herself and is present, I would even say, "exists" next to them. And this turns out to be not just "enough", but plenty. Because the quality of this "experience" is significantly higher than that of all the others. Her advantage lies in the gift of love, in the ability to listen, accept, and empathize without words or edification. Momo, for all her apparent external marginality and grotesqueness, turns out to be the healthiest and most resistant to those temptations that completely demolish all residents of the town without exception.

In a sense, Momo is the antithesis of a person with psy-glasses: she has no boundaries, she has nothing to "defend" and "protect", she is unprotected, utterly vulnerable, and open to anyone. She is the living embodiment of the very humility that the holy Fathers spoke of as "non-falling," because it already lies at the very bottom. The very humility that the Byzantine fathers called the beautiful Greek word "κένωσις" – "kenosis", the exhaustion, self-impoverishment of God in His Incarnation in man. This term originates from Philippians 2:7 — "ἐαυτὸν ἐκένωσεν" ("[Christ] humbled Himself"), and the depth of this self-abasement is so profound that no one can descend any lower.

In religious culture, the line that separated one's personal identity, crossing which was tantamount to disgrace and loss of human worth, was explicitly defined by divine law. This "line" was not set by the individual, but by the Giver of life — God and His law. And "transgressing" this line — in Greek, παράβασις, in Latin transgressiō — was a sin, a literal overstepping of a certain boundary, a sin in all its ugliness. Sin can be seen as a deliberate transgression of the limits established by God for humanity. However, it is important to note that these limits are not always clear-cut, comfortable, or even acceptable for the person himself. And this is where the gap lies between psychologization, which asserts the unquestioning right of man himself to set his "boundaries" anywhere and in any way with a strict requirement that they must be observed, and a religious tradition in which borders necessarily exist, but they are not "autolegitimate", but have a "supreme Heavenly certificate", a kind of "divine mandate". But when these "boundaries" are set by the person himself, they inevitably

⁵ Ende, M., Momo, or the strange story of the time-thieves and the child who brought the stolen time back to the people. 1973.

blur. Archimandrite Emilian Vafidis, the heron of the Simonopetra Monastery, writes that "teaching in the word of God is ... glasses that God provides us with due to the shortsightedness of our hearts."⁶

Imagine that a person suddenly discovers a strange lump in his stomach and goes to the doctor. After making an examination, the doctor says: "Congratulations! You have a tumor! Now you just need to accept it as an integral part of your body. It is also a part of you! It chose you!"

Shocking? Absolutely! But when a woman visits a psychologist's office, burdened with guilt over her decision to terminate a pregnancy, she is told almost the same thing, if not worse. «You did the right thing! You chose yourself and your life! This is your right! You should not be a prisoner to others' prejudices and religious beliefs! This is how you have used the freedom granted to you, and no one has the right to criticize you! And we will continue to work on your guilt, and after about five sessions, you will no longer dwell on this not-so-pleasant experience!»

"Psy-glasses" elevated not just a person to the highest pedestal as some ideal, as, for example, Christianity asserts the evangelical image of Christ – the God-man – as a model for emulation. The process of psychologization has transformed any self-sufficient individual into an idol, or rather, not even the individual themselves, but their idea of what is «beneficial» for them. It is «beneficial» for one to engage in sexual relations with young children. For another, it is to derive pleasure from acts of violence. The third is to be in a victim state. And all of these are equally «beneficial» because there is no external criterion beyond the individual: everything is relative, everything is situational. And all of this is determined solely by the individual themselves.

Once, during a trip to the United States, I had a chance encounter with an Anglican female pastor who, upon our initial meeting, without any hesitation or shyness, declared, "I am the superior pastor of this church, and I am a practicing lesbian." After regaining my composure from this bold self-introduction, we proceeded to listen to her further. And her message was very explicit: "You have to understand that for me, heterosexual relationships are just as unnatural as homosexual relationships are for you. We are all different, but we must respect and accept each other!" But the most telling thing happened later, when the question was asked: "And what about when attraction to minors, animals, or, forgive me, corpses is also perceived as the only normal and natural thing for someone?" Upon hearing such a question, our superior pastor... started crying. And no wonder: how could anyone dare to compare her sweet romantic relationship with her lover – which everyone knew about! – to pedophilia and bestiality!...

In C.S. Lewis's phantasmagoria, "The Divorce," there's a scene where "spirits" from hell arrive at the very gates of heaven. To their profound surprise, they find that the normally soft, silken grass cuts into their ethereal forms as if it were a razor's blade. Then, epy angel addresses one of the spirits, saying: "Will you come with me to the mountains? It will hurt at first, until your feet are hardened. Reality is harsh to the feet of shadows, but will you come?" Complete surrender to the human "as they are," with all their desires, foolishness, sins, and crimes, inevitably becomes a legitimization of all that is bad and a simultaneous prohibition on calling things by their names: "polyamorous relationships" as fornication, "sexual experiments" as perversions. "Psy-glasses" blur the line between the norm and pathology, truth and deception, and ultimately, between good and evil, attempting to "reconcile" them, or more precisely, to "marry" them.

⁶ Emilian (Vafidis), Schiarchim. Interpretation of the ascetic words of Abba Isaiah [URL: https://azbyka.ru/otechnik/Emilian_Vafidis/tolkovanie-na-podvizhnicheskie-slova-avvy-isaai/2]

In his "Metamorphoses" ⁷ (XI, 85-145), Ovid recounts an instructive tale about King Midas, to whom the god Dionysus granted the "golden touch": everything the king touched instantly turned to gold. Not just objects, but food too. And other people... At first glance, what a promising "option!" However, a significant problem quickly emerged: the king could not... eat – for any food instantly turned into a piece of metal!

Psychologization is the same "cunning gift" of lower spirits, which at first seems delightful and capable of solving almost all life's problems and difficulties, but in reality turns out to be a terrible curse, sending a person into emptiness and loneliness, imprisoning them in the dungeon of a sticky Ego, from which they can no longer escape on their own.

However, according to Ovid, rather than the subsequent medieval reinterpretations, King Midas did not perish from hunger. Instead, realizing his mistake in time, he washed away his "gift" in the river Pactolus and became a normal, whole person again. Perhaps it's time for us to seek our own Pactolus — a "source of living water" — to finally cleanse our souls thoroughly from the clinging dirt of parapsychological delusions?...

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Living the Nicene Confession of Faith: implications for mental health, healing, and caring for the sick

Abstract: This article proposes the Nicene Creed as a shared theological framework to strengthen interdisciplinary collaboration among churches, mental health professionals, and public health practitioners. It argues that each article of the Creed – creation, incarnation, cross, resurrection, Spirit, Church, and eschatological hope – carries concrete implications for how communities understand mental health, respond to trauma, and organise care for the sick. Drawing on theology alongside empirical research in psychiatry, trauma studies, and global health, the article shows how core Christian convictions about the *imago Dei*, solidarity with suffering, and hope beyond death can reinforce evidence-based, person-centred, and rights-based approaches to mental health and psychosocial support. The article calls for practical partnerships in which faith communities reduce stigma, foster belonging, and address social determinants of mental health, working with health systems to promote holistic, culturally rooted, and theologically informed models of healing and resilience.

Keywords: Nicene Creed, theology and mental health, faith-based mental health care, trauma and resilience, *Imago Dei* and human dignity, spirituality and health, Church–health system collaboration, social determinants of mental health, stigma reduction, holistic care and healing

For nearly 1,700 years, Christians across the world have confessed the Nicene Creed as a shared declaration of faith. Yet our world, and often even our churches, continue to bear deep wounds of trauma and fragmentation. In this historic anniversary, the Creed can be rediscovered not merely as a doctrinal summary but as a living confession: a way of being that nurtures mental well-being, affirms human dignity, and calls communities into healing, justice, and compassionate care.

The Creed becomes a lens through which every person is seen as beloved of God, worthy of inclusion, accompaniment, and hope. In an age marked by anxiety, depression, displacement, and systemic inequalities, the Nicene faith can guide the Church into deeper practices of mental-health care, trauma healing, and solidarity with those who suffer (Koenig, 2012; World Health Organization [WHO], 2022).

“We believe in one God, the Father Almighty, maker of heaven and earth”

The Creed affirms God as Creator of all; every nation, every community, and every human being. This foundational truth shapes an understanding of mental health as integral to God’s creative intention for wholeness. The doctrine of creation grounds human dignity in the *imago Dei*, affirming the inherent worth of every person (Torrance, 1996).

To believe in the Creator is to affirm that every person, regardless of mental illness, disability, trauma, stigma, or vulnerability, is made in the divine image. This challenges cultures of shame, fear, and exclusion. Healing begins when individuals are not treated as problems to be fixed but as sacred lives to be honoured and nurtured (Farmer, 2004). A church that confesses the Creator becomes a place where every story is listened to carefully, every wound is taken seriously, and every person belongs.

“For us and for our salvation, he came down from heaven”

The Incarnation reveals God’s profound solidarity with human vulnerability. In Jesus Christ, God fully enters the human condition, experiencing suffering, rejection, and emotional distress. Athanasius’s theology of the Incarnation helps explain why this

matters for healing: if Christ truly took on the fullness of human life, then the fullness of human life can be touched by redemption (Athanasius, 2011). Put simply, “what is not assumed is not healed” means that Christ took on the reality of our humanity: body, mind, emotions, and mortality, so that human nature in its fullness might be restored (Athanasius, 2011).

Christ’s ministry models accompaniment, compassion, and non-judgmental presence - the heart of mental-health care and pastoral support (Swinton, 2001). Contemporary research likewise shows that compassionate presence and relational support are central to healing and recovery (Koenig, 2012; Puchalski & Ferrell, 2010). To follow the Incarnate Christ is to enter places of pain:

- sitting with those who feel abandoned
 - listening to those whose voices are dismissed
 - supporting those burdened by shame, grief, or despair
 - affirming agency and dignity in those whose voices are often not heeded
- Every gesture of presence becomes a participation in the Incarnation.

“He was crucified ... suffered and was buried”

The Cross unmasks the realities of trauma, violence, humiliation, abandonment, and injustice. As Moltmann emphasises, God is not distant from suffering but is revealed within it; the crucified Christ stands in solidarity with all who endure trauma and systemic violence (Moltmann, 1993).

Contemporary trauma studies confirm that experiences of violence, conflict, and exclusion leave deep psychological wounds that require acknowledgement, safety, and accompaniment for healing (Herman, 2015; van der Kolk, 2014). To live this part of the Creed is to create spaces where:

- trauma is acknowledged
- lament is permitted
- people are not shamed for their pain
- communities confront harmful structures such as racism, casteism, sexism, and stigma

Healing requires truth-telling and compassionate accompaniment, not denial or silence (Rambo, 2010).

“He rose again on the third day”

The Resurrection proclaims that despair and death do not have the final word. This is central to mental-health ministry: hope is not illusion, but a transformative reality grounded in God’s action in history (Wright, 2003).

In psychological and public health terms, hope and meaning-making are essential components of resilience and recovery (WHO, 2022). The Church, as a resurrection community, is called to embody this hope:

- refusing to abandon anyone to loneliness or despair
- nurturing resilience and joy
- affirming that healing; emotional, relational, and spiritual- is possible
- treating every act of care as a sign of God’s rising life amid brokenness

“We believe in the Holy Spirit, the Lord, the giver of life”

The Holy Spirit breathes life into fearful, exhausted, and divided communities. The Spirit renews minds and hearts, heals memories, and empowers communities toward compassion and justice.

This renewal aligns with holistic understandings of health that integrate spiritual, emotional, and social dimensions (Koenig, 2012). The Spirit’s work is visible wherever:

- stigma is confronted
- compassion overcomes fear
- people feel safe to share their stories
- communities advocate for justice and dignity

The Church is thus called to cultivate deep listening to God, to one another, and especially to those whose suffering has long been unheard.

“We believe in one, holy, catholic, and apostolic Church”

The Church’s identity is inseparable from its call to healing. As Hauerwas argues, the Church is called to be a community that embodies care, especially for the vulnerable and for those living with illness or disability (Hauerwas, 1986).

A healing Church is:

- **One:** fostering belonging beyond exclusion
- **Holy:** committed to safety, integrity, and compassion
- **Catholic:** embracing diverse contexts and experiences
- **Apostolic:** sent into the world as agents of healing and justice

Faith-based organisations play a critical role globally in delivering health services and addressing mental-health needs, particularly among vulnerable populations (Joint Learning Initiative on Faith and Local Communities, 2022).

“We look for the resurrection of the dead and the life of the world to come”

The Creed culminates in a vision of restored creation, where all wounds are healed and all things made new. This eschatological hope sustains present efforts toward healing and justice.

It calls the Church to:

resist despair

- work for peace in contexts of conflict
- build systems of care for vulnerable communities
- promote equity in health access

Addressing mental health requires not only individual care but also structural transformation, including tackling the social determinants of health such as poverty, inequality, and exclusion (Commission on Social Determinants of Health, 2008; Farmer, 2004; WHO, 2013). Hope thus becomes both a theological conviction and a practical commitment to transformation.

Conclusion

The Nicene Creed may be lived as a pathway of healing, shaping hearts, mental and emotional well-being, communities, ministries of care and presence, and public witness for justice, compassion, and reconciliation. Its confession can empower Christians to nurture mental well-being, stand with the suffering, confront stigma, and embody Christ’s healing love in the world today.

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The role of religion in transcultural research in psychiatry

Abstract: Transcultural psychiatry is an approach to clinical practice that integrates cultural factors, including religious beliefs, into the assessment and treatment of patients from diverse cultural backgrounds. The first step in this process is to develop a "cultural formulation" for each patient, which is based on their cultural identity - their subjective self-identification with a specific culture that provides a sense of belonging and community. Religious/spiritual beliefs play a central role in this formulation. Religiosity influences all aspects of mental life and pathology, from etiological factors and symptomatic manifestations to healing methods and support systems. Religion offers a ready-made set of beliefs and values that shape a person's worldview and the culture in which they live. It provides a framework for understanding the universe, time, and space. It forms ethics, morals, daily practices, rules of conduct, a common history, and a sense of shared destiny. The influence of religion on the perception of mental illness and participation in treatment is manifested through the formation of a "cultural lens" through which people perceive the world and symptoms of the condition. Religion participates in creating explanatory models of illness, influencing the presentation of symptoms (culture-specific syndromes), and shaping coping strategies and support systems. Therefore, taking into account religion and spirituality is crucial for effective and culturally appropriate practice in cross-cultural psychiatry.

Keywords: religiosity, transcultural psychiatry, patient's "cultural formulation", cultural identity of an individual.

The cultural approach to psychiatry developed in the early 20th century. Today, there are several fields that reflect an understanding of the importance of culture in mental health issues and take into account its role in the occurrence and expression of mental disorders. Although these fields have slight differences in focus, they all agree that understanding a patient's cultural background is incomplete without considering their religious and spiritual beliefs. Some of these fields include cultural psychiatry, ethnopsychiatry, cross-cultural psychiatry, transcultural psychiatry, and anthropological psychiatry. Cultural psychiatry is a broad field that examines the influence of culture on mental health and illness. It studies cultural meanings of symptoms, syndromes that are culturally defined, stigma associated with mental illness, and the cultural formulation of diagnoses. Ethnopsychiatry, on the other hand, focuses on how specific cultural beliefs and traditions, including religious practices, shape the experience and treatment of mental health issues within particular ethnic groups. Within the framework of transcultural psychiatry, mental health conditions and treatment strategies are compared across different cultures to identify both universal and culturally specific aspects. This approach offers a practical clinical perspective that incorporates cultural context, including religious beliefs, into the diagnosis and treatment of patients from diverse backgrounds. Unlike previous approaches, transcultural psychiatry focuses on the patient's experience and systematizes existing knowledge to provide effective care for individuals whose cultural background differs from that of their healthcare provider.

This is especially important for states that include many ethnic groups or become multi-ethnic due to migration. Only a few countries can be considered relatively monolithic (more than 95% of inhabitants represent one ethnic group). These include Japan, North and South Korea, Iceland, Albania, Armenia, Bangladesh, Hungary, Italy, Madagascar, Malta, Poland, Portugal, Saudi Arabia, and Greece. The rest of the countries are multi-ethnic. In the Russian Federation, according to the 2020 All-Russia

Population Census, there are 190 ethnic groups. Russians make up 72% of the population, Tatars make up 3.2%, and other ethnic groups make up less than 1.5%.

In the study of human communities, concepts such as race, ethnicity, and nation are typically distinguished (Fernando, S., 2010). Race, in this context, is a biological category; it is defined by biological type, and an individual's belonging to it is not a matter of personal choice. A nation is a politico-social entity; its principal characteristic is a politico-territorial association, citizenship; an individual's belonging to it is defined artificially and legally. Lastly, the ethnos, where the main characteristics are common culture, language, traditions, and self-awareness; the nature of the group's unification (nationality, ethnic community) is socio-historical; an individual's belonging to it is partially chosen independently and reinforced by culture.

An ethnos is a historically formed, stable community of people united by common culture, language, traditions, a perception of shared origins, and a sense of "we" in relation to other groups. The main characteristics of an ethnos are its ethnonym (self-name), common culture and language, religion, historical memory, and a sense of solidarity.

It is impossible to talk about transcultural psychiatry without at least broadly defining the concept of culture (Garssen B., Visser A., 2021).

Culture is defined as a set of meanings, norms, beliefs, values, and patterns of behavior shared by a group of people. Values include social relationships, moral and religious beliefs, language, non-verbal expression of thoughts and emotions, rituals, technologies, economic beliefs, and practices. Culture can be divided into material culture (tangible assets created by members of society) and spiritual culture. The latter encompasses what is produced in the realm of consciousness: religion, science, education, art, and literature. Culture defines behavioral norms, traditions, communication, and symbolism, creating the unique profile of a people or social group. It shapes the entire society's way of life.

To return directly to the report's topic from theoretical and conceptual premises, it's essential to state that in transcultural psychiatric research, the primary and most significant factor, underpinning subsequent actions like choosing psychiatric care approaches, is defining the patient's so-called cultural formulation. This refers to working with patients from diverse cultural backgrounds, including migrants or people belonging to different ethnic groups who are moving within the same country.

Formulating cultural considerations involves assessing the following aspects: 1) an individual's cultural identity; 2) cultural concepts of distress; 3) psychosocial stressors and cultural factors of vulnerability and resilience; 4) cultural aspects of the client-provider relationship; 5) overall cultural assessment.

In formulating cultural particularities, a person's cultural identity takes precedence. Cultural context is important because it defines the norm for a given patient contingent. It determines the adequacy and (in)adequacy of human behavior, which encompasses how people typically behave, think, feel, and exist in social interactions. The norms are not the same in all cultures. Whether a symptom or behavior is considered abnormal and requires medical attention depends on cultural standards. The lines between normal and pathological vary from culture to culture, for certain types of symptoms and behaviors.

The cultural context formulates the threshold of distress, that is, how a person responds to a specific stressful situation. It also forms explanatory models for the disease. Cultural factors determine how treatment methods are perceived by patients and their families as reliable and acceptable, which directly affects treatment adherence. Additionally, culture forms the basis for developing specific models of psychotherapy and approaches to patient care in psychiatry.

So, the first main point in the cultural formulation is the cultural identity of an individual. Cultural identity, or **cultural identification**, is a subjective process through which a person identifies with a particular culture and forms a sense of community, security, and belonging.

Aspects of cultural identity can be arranged in the following order: ethnicity, race, country of origin, language, gender, age, religious/spiritual beliefs, marital status, socio-economic status, education, membership in other identified groups, migration history, level of acculturation, degree of belonging to the above groups.

In fact, after a person's passport data, their religious/spiritual beliefs are considered, as they determine almost all aspects of a person's cultural identity. Religion as a central element of cultural identity affects all aspects of mental life, including mental pathology, from its etiological factors and symptomatic manifestations to its treatment methods and support systems.

I. The influence of religion on cultural identity (Koenig H.G., 2023) is determined by the fact that religion provides a system of meanings that structures a person's and community's worldview. It provides a **cultural framework** in which the problems of the universe are solved: cosmology and origin; chronology and time; space. The category "cosmology and origin" addresses fundamental questions about the creation of the world, the meaning of life, and what happens after death (for example, Divine creation in Abrahamic religions or cycles of rebirth in Dharmic religions).

Religion creates its own chronology and time system, setting the calendar, the starting point for counting time, defining holidays and fasts, and determining the rhythm of life. For example, there is a weekly cycle that includes Sunday for Christians, Friday for Muslims, and Saturday for Jews. Additionally, there are specific holidays such as Ramadan, Easter, and Diwali.

Religion also shapes space: it creates a sacred geography, with holy places, pilgrimage destinations (Jerusalem, Mecca, Varanasi), and temples, as well as sacred rivers, that define the rest of the world in relation to them. A person raised in such a system learns this cultural framework from childhood, like breathing air, and it becomes an integral part of their identity.

In addition to the cultural framework, religion forms the ethical, moral, and daily practices that differentiate one cultural group from another. It establishes certain **rules of conduct** in the realm of family and social interactions; norms and prohibitions; and clothing and appearance.

Family and social relations include relations between men and women, the concept of marriage, attitudes towards older generations, and parenting.

Norms and prohibitions may relate, for example, to food restrictions (fasting, halal, kosher, vegetarianism in Hinduism and Buddhism).

Clothing and appearance, such as skirts of certain lengths, headscarves, and specific hairstyles like the hijab, kippah, and turban, are not merely elements of a person's appearance. They are an important part of how people daily declare their belonging to and connection with a specific cultural group.

Along with the worldview, ethics, and morals, religion forms a **shared history and a unique sense of shared destiny** that brings people together in a community.

Collective memory and shared destiny are composed of several elements. These include a shared history, a sense of purpose, language, and symbols.

Collective history encompasses narratives such as baptism, appeals to saints, and veneration of icons during major liberation wars, or, in other communities, accounts of exodus, exile, martyrdom, and divine covenant. Gradually, this shared history shapes collective memory and a sense of "us."

In addition, the feeling of being chosen or having a special mission can create a strong unifying idea. For example, the ideas of the Third Rome, the "chosen people", and the "Ummah" (the Muslim world community).

Religious language and symbols play a significant role in preserving cultural heritage. Religious texts, prayers, and rituals contain archaic forms of language and unique symbols that can only be understood by members of that specific religious group.

From the above (religious cultural framework, ethical rules, collective memory, shared destiny, religious language, and symbols), it is clear that religion plays an important role in shaping a person's cultural identity when they identify with a particular culture. Cultural identity is shaped throughout a person's life in a constantly changing social context.

II. Religiosity has a significant influence on the patient's perception of mental illness and their participation in the treatment process. It forms a worldview and serves as a "cultural lens" through which individuals perceive the world, including symptoms of mental disorders. It also influences explanatory models of disease, individual manifestations of symptoms, coping with illness, and the patient's support system. Additionally, religiosity plays a role in creating a therapeutic alliance with healthcare providers, fostering trust, and facilitating effective communication and treatment planning.

Religion is a key factor in these areas for several reasons:

1) Religion, as a cultural system that shapes the perception of reality, provides a person with a set of symbols, values, norms of behavior, and an explanatory model for key phenomena of life, such as birth, death, suffering, and good and evil. These form a "cultural lens" through which we perceive the world, including symptoms of mental disorders. For example, guilt can be interpreted as "sin" by a person with a Christian worldview and require confession, while a follower of Buddhism might see it as a sign of attachment that needs to be let go. Depression can be experienced differently in different cultures, such as despondency (one of the Seven Deadly Sins in Christianity) or the absence of Tao (harmonious path) in another.

2) Religion plays a role in explanatory models of disease - how patients explain the cause of their illness. These explanatory models are often based on religious beliefs¹ or supernatural explanations (God's will, a trial, the evil eye, corruption, possession by spirits or demons, or karmic retribution for past sins).

Religiosity can influence diagnosis: if a patient believes they are "haunted by spirits", a Western psychiatrist may diagnose paranoid schizophrenia. However, a transcultural approach requires understanding the cultural and religious background of this belief in order to differentiate between pathological delusions and culturally conditioned expressions of distress.

3) Religion and manifestations of symptoms (culturally determined syndromes). Many syndromes described in ethnopsychiatry are directly related to the religious context (Moreira-Almeida, A. et al, 2021).

¹ The *moral model* implies that the patient's illness is caused by a moral defect, such as selfishness or moral weakness. The *religious model* suggests that the patient is being punished for a religious failing or transgression. A *magical or supernatural model* of explanation may involve attributing witchcraft or sorcery as the cause of symptoms. The *medical model* explains the patient's illness primarily by biological etiology. The *psychosocial model* suggests that excessive psychosocial stressors are the cause or a major contributing factor to the illness.

- Zuk (in Muslim cultures) is a condition interpreted as possession by jinn. This condition can manifest in trance-like states and hysterical seizures. The treatment for this condition is often carried out by an imam through reading the Quran.

- Koro (in Southeast Asia) is a panic fear of pulling the penis or breasts into the stomach, leading to death. This belief is linked to cultural ideas about life force and soul, often with religious roots.

- Possession (in various cultures), is a phenomenon where a person believes they are possessed by an outside force, such as a spirit, demon, or deity. In some cases, this can be a sign of psychosis. In other cultures, it can be a ritualized and socially accepted way of expressing distress (for example, in some Afro-Brazilian cults).

4) Religion can help in coping with the illness and in building a support network.

Religion can be a powerful therapeutic and coping resource, as it affects the formation of meaning: religion helps to find meaning in suffering ("God is testing me", "This is my karma"). It can provide hope and forgiveness: faith in God (or a higher power), forgiveness of sins (or rebirth to a better life). It can be a powerful antidepressant; gain social support: a religious community (parish, umma, sangha) provides a sense of belonging, practical help, and emotional support; Some rituals and practices help to cope with emotional reactions: prayer, meditation, fasting, confession can reduce anxiety, give a sense of control and promote reflection.

5) Religion and the therapeutic alliance. Understanding a patient's religiosity is crucial for establishing trust and effective communication with them (American Psychological Association, 2008). It is crucial to respect a patient's faith: a psychiatrist who disparages the patient's faith as a "prejudice" destroys the therapeutic alliance; and also, joint treatment planning: you can discuss with the patient how drug treatment and psychotherapy can be combined with the support of an imam, pastor or spiritual mentor. For example, treatment for depression may include taking antidepressants, but also prayer, and community involvement. The transcultural approach emphasizes the integration of these elements to provide a more holistic and effective treatment plan.

Therefore, consideration of religion and spirituality is crucial for effective and culturally appropriate practice in transcultural psychiatry.

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Transcultural aspects of religious delusions

Abstract: The article explores the transcultural dimensions of religious delusions in psychotic disorders. It examines the position of religious delusions within the framework of psychopathology, their diagnostic and clinical relevance, as well as the influence of cultural factors on the prevalence and content of these delusions. Special attention is paid to the influence of cultural and historical factors on the selection of religious symbols that shape universal psychological experiences. It is shown that similar psychotic conditions with religious content can be understood as a variation of the norm or a manifestation of mental illness, depending on confessional and cultural traditions. The article emphasizes the importance of a culturally sensitive diagnostic approach that considers the patient's beliefs and allows for the use of religion not only as a potential risk factor, but also as a resource for psychological coping.

Keywords: religious delusion; psychotic disorders; transcultural psychiatry; religiosity; culturally competent diagnostics.

Religious delusion is one of the most complex and paradoxical psychopathological phenomena in modern psychiatry. It is a universal clinical manifestation of psychosis and, at the same time, a deeply culturally specific expression of psychopathological disorders. Despite the fact that religious themes in delusional ideas have been described since the time of E. Kraepelin and E. Bleuler, systematic transcultural studies of this phenomenon remain relatively few.

The paradox of transcultural delusion research lies in the fact that despite the relative stability in the prevalence of schizophrenia and other psychotic disorders (according to the WHO, around 1% of the population over a lifetime across all cultures), the content of psychotic symptoms demonstrates significant cultural differences. This suggests a complex interplay between universal neurobiological mechanisms of psychosis and culturally specific factors that determine the form and themes of delusional experiences.

Religious delusion refers to pathological beliefs with religious content that are resistant to psychological correction, exceed the boundaries of canonically and culturally determined religious traditions, disrupt the patient's daily life, and lead to behavioral disturbances, professional and social decompensation, including the risk of auto- and heteroaggressive actions.

The importance of studying the cross-cultural aspects of religious beliefs stems from several factors.

1. Diagnostic significance.

The content of delusions plays a crucial role in diagnosis, especially within the context of DSM-5 and ICD-11, where delusional ideas are considered one of the key features of psychotic disorders. Modern diagnostic systems declare increased "cultural sensitivity"; the DSM describes culture-specific disorders specifically and emphasizes the importance of considering the socio-cultural context when evaluating psychological phenomena.

2. Clinical need.

The correct differentiation between pathological religious delusions and culturally acceptable religious beliefs is of paramount importance for clinical practice, especially in multicultural and multi-ethnic societies with high migration and cultural diversity. An error towards overdiagnosis leads to the pathologization of normative spiritual practices, while underestimating maladaptive states can result in delayed treatment.

3. Theoretical framework.

Understanding the mechanisms by which universal psychopathological processes transform into culturally specific delusional ideas expands existing models of psychosis and complements the biomedical approach with cognitive, socio-epistemological, and evolutionary-anthropological perspectives.

4. Ethical dimensions.

Culturally competent approaches to diagnosing and treating religious delusions necessitate a profound understanding of the role of culture in shaping and maintaining delusional beliefs, as well as a respectful attitude towards the patient's religious identity.

The aim of this study is to analyze the current data on transcultural aspects of religious delusions and to identify the main patterns of cultural influences on the content and form of religious delusional ideas. For this purpose, a literature review was conducted, including modern quantitative, qualitative, and philosophical studies covering various cultural contexts (Islamic, Hindu, Christian, Confucian, post-Soviet) and theoretical approaches (cognitive, socio-epistemological, evolutionary-anthropological).

The problem of definition: delusion and religious belief

The classical definition of delirium, as described by K. Jaspers and still used in modern diagnostic systems such as the DSM-5 and ICD-11, presents a fundamental logical challenge when applied to religious experiences. According to official criteria, delusions are defined as persistent false beliefs that do not correspond to the patient's socio-cultural context and persist despite contradictory evidence. At the same time, religious beliefs (e.g., "God exists," "My guardian angel protects me"), are not empirically verifiable and therefore cannot be strictly classified as true or false in a scientific sense.

The practical challenge is that the same statement can be interpreted differently depending on the context. For example, a patient with paranoid schizophrenia who holds a traditional faith but demonstrates extreme levels of conviction, other psychotic symptoms, and severe social dysfunction is often automatically assumed to have delusional thinking. This requires shifting the focus from analyzing the content of beliefs to assessing their structure, level of rigidity, relation to the overall mental state, and degree of maladaptation.

Epidemiology of religious delusions

The analysis of epidemiological data reveals significant variability in the prevalence of religious content among psychotic symptoms across different cultures, ranging from approximately 5% to 50% among patients with psychosis. Researchers emphasize that this variation is largely influenced by cultural factors, including the type of dominant religious tradition, level of religiosity or secularism in society, as well as socio-economic and educational factors associated with urbanization and modernization.

In secular and predominantly atheistic societies (such as China), religious delusions are relatively uncommon (about 5%). In moderately religious and diverse cultures (such as Germany, Austria, and Great Britain), the proportion of religious content in delusional thoughts averages between 18% and 21%. In highly religious countries with strong Catholic, Protestant, or Islamic traditions (such as Mexico, the United States, Pakistan, and Malaysia), the frequency of religious delusions can reach 36-50% or higher. In syncretic and traditional religious contexts (like Taiwan, the Philippines, and certain regions of Africa), the prevalence of religious delusions is especially high, often exceeding 45-60%.

In general, the type of culture (atheistic, secular, confessional, traditional) correlates with the degree to which religious themes are used as a "language" for psychotic experiences and included in the structure of delusions.

Historical dynamics of delusional content

One of the most compelling arguments in support of the cultural influence on the content of delusions is their historical development, which allows us to view delusions as a reflection of cultural changes. Historical research reveals a gradual shift in dominant themes from religious and supernatural to technological and digital, reflecting shifts in the dominant explanatory models of the world.

In the late 19th and early 20th centuries (1880-1920), religious, magical, and mystical themes prevailed (up to 60-70% of cases), which reflected the central role of religion and magical thinking in interpreting reality. From the 1920s to the 1960s, the proportion of technological narratives (radio, telegraph, and later television) gradually increased, from around 12% to 31%, as the media became an integral part of everyday life and integrated into delusional systems as a means of influence and control.

In the 1960s and 1980s, political and cybernetic themes came to the fore: the Cold War, ideological confrontation, and fears related to computerization became key sources of delusional interpretations. In the 1980s and 2000s, the motives of satellite surveillance and global communications intensified; electronics and the Internet were perceived as pervasive and threatening. Since the 2000s, the proportion of stories related to digital technologies, social networks, tracking systems and "chipping" has increased significantly; such topics can account for up to 30-40% of delusional content. Since 2019, a new cluster of delusional experiences has emerged, combining medical, political, and conspiracy-related topics (COVID-19, the pandemic, global conspiracy theories, and vaccines), in which epidemiological events are the central focus of delusional interpretation.

Thus, the content of delusions demonstrates a natural historical variability, reflecting the dominant sources of meaning and threats in a particular era, such as religion, technology, politics, and digital technologies, as well as the current socio-historical context. This means that for a clinician, it is important to take into account not only the individual characteristics of a patient, but also the historical and cultural background, including the religious beliefs of society.

Thematic characteristics of religious delusions in various cultural contexts

Research into the content of religious delusions in different cultures shows that universal psychotic manifestations (persecution, grandeur/messianism, control/possession) are shaped by diverse symbolic resources like jinn and the evil eye, demons and saints, ancestral spirits, deities, and magic. The same experiences in one cultural environment can be interpreted as a spiritual gift or religious ritual, and in another as a manifestation of schizophrenia or acute psychotic disorder.

In Islamic societies (Saudi Arabia, Malaysia, traditional Pakistan), the structure of religious delusion frequently includes motifs of persecution by adherents of other religious faiths, religious leaders, confessional conspiracy, and oppression, as well as persecution related to ethnicity or specific religious practices. Grandiose religious delusion can manifest as identification with prophets, imams (in the Shi'a context, with figures like Mahdi, Ali, Hussein, etc.), and a belief in a unique mission to propagate Islam. In women, this can also involve identifying with venerated female saints. Obsession themes encompass the influence of jinn, evil spirits, witchcraft, the evil eye, and magical rituals, understood as factors that exert control over the patient's thoughts and actions.

Within Christian contexts, the religious delusion of obsession encompasses the conviction that the patient has been taken over by demonic or "satanic" powers, resulting in a total loss of control over their mind, body, and soul, often accompanied by the emergence of a perceived "new entity." Also described are specific manifestations, such as "incubus syndrome" – the experience of nocturnal demonic pursuit and sexual possession. Grandiose and messianic delusions are characterized by identification with figures like Jesus Christ, God, or saints, a belief in having supernatural powers (such as healing, resurrection, or salvation), and apocalyptic notions of the world's current or approaching end. The notions of sinfulness and divine retribution can escalate to a delusional intensity, intertwined with a belief in the impossibility of salvation, a profound loss of life's meaning, and a significant risk of suicide.

In the Hindu context (India, Nepal), persecutory delusions are often imbued with imagery of bhoot (spirits of the deceased), malevolent deities, the effects of black tantra, and rituals of subjugation. Grandiose religious ideas include identification with Hindu deities, beliefs in reincarnation as a great guru or epic hero, and the conviction of possessing siddhis – supernatural faculties (such as seeing the past and future, healing, or controlling the elements). Thus, the same type of delusion (persecutory, grandiose, or messianic) is structurally similar, but its specific content is determined by the confessional and cultural context.

Cultural relativity of norms

J. J. López-Ibor and M. I. López-Ibor Alcocer point out that phenomena that are unambiguously treated as delusions in one cultural context might be regarded as normative religious beliefs in another. Thus, In conservative Islamic societies, the belief in the evil eye is widely held among a significant portion of the population and is considered a common belief that is embedded in everyday life. However, if a patient becomes obsessively convinced that they are the target of the evil eye by a specific "enemy" and this leads to severe maladaptation, it would be considered a delusional disorder, even within this cultural context.

In Western Christian societies, the situation is similar: faith in God as a protector and guide of life is normative, but the patient's belief that God directly orders him to commit a certain action (for example, murder or self-destructive behavior) is interpreted as religious delusion. In this regard, several authors, building on the classical approaches of Jaspers and Gruhle, propose evaluating, first and foremost, the structure of thought processes, the level of critical thinking, the degree of flexibility, and the consequences of beliefs, rather than just their content. This approach helps us to distinguish between delusions and religious beliefs, and reduces the risk of cultural biases in diagnosis.

The mechanism of cultural accessibility and clinical findings

Mohr and Pfeifer propose a model that explains how a universal psychotic process can be transformed into a culturally specific religious delusion through the mechanism of cultural accessibility. They argue that abnormal experiences (perceptual and cognitive) are considered universal and occur in all cultures with similar neurobiological prerequisites (hyperactivity of dopaminergic systems, dysfunction of prefrontal and limbic areas, impaired processing of predictive errors and pathological enhancement of salience of stimuli). The specific explanation of these experiences depends on the systems of meaning available to the individual — religious, magical, political, technological.

Religious interpretations ("jinn," demons, karma, divine mission) are prevalent in highly religious societies, while secular societies lean towards political, technological, or conspiratorial frameworks ("intelligence agencies," "wiretapping," internet surveillance, "chipping"). Moreover, for a substantial number of patients (data

from multicenter studies indicate approximately 40–50%), religiosity and spirituality are a crucial coping resource, providing hope and meaning. Religious experience, in turn, can act as either a protective or a pathogenic factor.

Key diagnostic questions for a clinician include:

- If the experience falls within the normative range for the patient's religious and cultural group (utilizing cultural informants as required).
- What is the function of experiences (do they lead to maladjustment and the breakdown of social connections, or do they, on the contrary, integrate into life and support the patient)?
- Are there any additional signs of psychotic disorder (thought disturbances, hallucinations outside of a religious context, emotional blunting, severe social isolation, marked decline in self-care)?

Conclusion

Religious delusion demonstrates the complex interplay of universal psychopathological mechanisms with culturally specific factors, serving as a clear example of how psychotic disorders are "filled" with cultural content reflecting the religious systems, social structures, values, and conflicts of particular societies. However, the decisive factor for clinical assessment is not the content of religious beliefs itself, but rather the degree of the patient's maladjustment, desocialization, and isolation, as well as the loss of insight and behavioral disturbances. To be culturally competent, a physician must understand prevailing religious views, systematically assess the patient's cultural background (encompassing culture-bound syndromes and the relationship between culture and mental health), and be prepared to incorporate beneficial aspects of faith into treatment. The study of transcultural aspects of religious delusion holds not only theoretical significance (deepening the understanding of delusion formation mechanisms) but also direct practical implications for timely diagnosis, the development of culturally sensitive treatment and psychotherapeutic approaches, and the organization of pastoral and spiritual support for individuals with mental disorders.

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Ethical and spiritual aspects of dementias

Abstract: The article discusses the challenges associated with the global epidemic of dementia, highlighting the ethical and spiritual dimensions of this condition. It emphasizes the unique vulnerability of individuals with dementia due to stigmatization, discrimination, and abuse they may face. The author presents data on the prevalence of dementia worldwide and in Russia, noting the challenges of insufficient and delayed diagnosis, as well as the lack of effective long-term care models. The article provides a theological perspective on dementia, citing the document of the Greek Orthodox Church, which argues that the image of God is not diminished in individuals with dementia: even as their minds may weaken, they continue to have communion with God through their soul. A person with dementia should be treated with respect, on par with embryos and infants, and care for them should be seen as a service and blessing.

Keywords: dementia, discrimination, stigmas against people with dementia, ethical aspects of dementia, code of ethics, anti-discrimination language, euthanasia, religious understanding of dementia.

According to the World Health Organization (WHO), 8 million people worldwide develop dementia every year. This means that a new case is registered every three seconds. It is expected that by 2050 the number of people with dementia could reach 153 million, which could undermine the economic development of the planet on a global scale. According to the WHO (2012), the estimated number of people with dementia in Russia is 1.2 million. However, this figure is not confirmed by official statistical reports. Therefore, according to Shport and Makushkina (2024), only 118,787 people with vascular dementia and 45,354 other forms of senile dementia were registered in psychiatric institutions in Russia in 2023 [1]. The reasons for the lack of proper detection of dementia include: late treatment by psychiatrists, mistakes in diagnosis, treatment by non-psychiatrist specialists, incorrect coding of diagnoses under the ICD-10 code "Mental and Behavioral Disorders", low awareness about dementia, and a lack of specialists in this field. At the same time, according to the Russian Federation Law «On Psychiatric Care and Guarantees of Citizens Rights in Its Provision» (Federal Law No. 3185-1, dated 07/02/1992, Article 20), the diagnosis of mental disorders (including dementia) is the sole responsibility of a psychiatrist. The conclusion of a doctor of another specialty on the state of a citizen's mental health is preliminary. According to Alzheimer's Disease International (ADI) (2025), insufficient diagnosis of dementia is a global problem. In cases where the diagnosis is still established, it usually occurs in the later stages of the disease. At the same time, the existing therapy was found to be ineffective.

In low- and middle-income countries, up to 90% of dementia cases go undiagnosed, and patients do not receive treatment and care. They are often stigmatized, and there are no specialists with appropriate expertise.

If dementia therapy is not effective, it may be necessary to provide only palliative care. However, this type of care is also underdeveloped.

Models for organizing long-term care for people with dementia from diagnosis to the end of life are fragmented or even non-existent [2].

The «World Alzheimer Report 2024: Global changes in attitudes to dementia» states that 65% of healthcare and nursing professionals and 80% of the population believe that dementia is a normal manifestation of aging; 88% of people with dementia experience discrimination. More than a quarter of people worldwide believe that prevention of dementia is impossible. More than 90% of caregivers said they would

have been diagnosed with the disease early if effective treatment had been available.

Among the stigmas associated with people with dementia, the report highlights:

- Social stigma - negative stereotypes, prejudices, and discrimination against people with dementia by society. This includes the belief that people with dementia are incapable of making decisions.
- Self-stigma is when people with dementia internalize social stereotypes, turning them into negative beliefs about themselves. This can lead to feelings of shame, low self-esteem, and social isolation.
- Structural stigma is a system of policies, practices, and rules that disadvantages people with dementia, institutionalizes discrimination, and perpetuates inequality. For example, insurance policies that do not cover care for people with dementia, medical institutions that refuse to admit people with dementia because of the additional care requirements, and a lack of free medication for people diagnosed with this condition.
- Affiliated stigma - the stigma faced by caregivers and family members of people with dementia, including discrimination and social exclusion due to their association with people who have dementia [3].

Ethical approaches to dementia

In 2020, the Church-Public Council on Biomedical Ethics developed the "Ethical Code for Older Adults," which emphasizes the following important ethical aspects:

- Providing the highest quality psychiatric care for people with dementia.
- Enabling individuals to remain in their homes as they age.
- Non-discriminatory language when referring to individuals with dementia.
- Ethical issues surrounding end-of-life care [4, 5]

Providing optimal psychiatric assistance

It has been observed that attempts to revise the Russian law "On Psychiatric Assistance and Guarantees of Citizens' Rights in Its Provision," especially in terms of delegating treatment authority for mental disorders to non-psychiatrist doctors, may affect the rights of senior citizens, including people with dementia, regarding their right to access professional psychiatric treatment.

The provision of psychiatric care by non-psychiatrists can lead to stigmatization based on an incorrectly established diagnosis of "dementia," human rights violations, deprivation of legal capacity, and increased economic costs for families due to the necessity of purchasing expensive anti-dementia and psychotropic medications, which should be prescribed free of charge by a psychiatrist.

Delaying seeking psychiatric help leads to the exacerbation of dementia severity, deterioration of the condition's manageability, lack of patient navigation, and untimely provision of necessary medical and social assistance, as well as the determination of disability status. At the same time, the right to receive the best psychiatric care is regulated by the "Principles for the protection of persons with mental illness and for the improvement of mental health care" (UN, 1991). According to the document, in developed nations, the diagnosis of mental disorders is exclusively reserved for psychiatrists. For low-income countries facing a severe deficit of mental health specialists, the delegation of mental healthcare services to primary care is permissible, representing an optimal strategy for populations with limited access to medical care [6].

The ability to live and age in place

According to the "Principles for the protection of persons with mental illness and for the improvement of mental health care" (UN, 1991), all persons with a mental illness have the right to:

- live and work, as far as possible, in the community;
- be treated and cared for, as far as possible, in the community in which he or she lives;
- be treated near his or her home and to return to the community as soon as possible;
- the treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Specialized institutional living is seen as undignified and creates structural and cultural barriers to social interaction.

The UN has developed the "aging in place" concept, which provides older adults with the opportunity to live a safe, independent, and comfortable life within their own home and community, irrespective of their age, income, or individual functional capacity [6].

Non-discriminatory language concerning individuals with dementia

ADI has created a specific non-discriminatory language for individuals living with dementia. This approach is rooted in the conviction that dementia should not be seen as the sole defining characteristic of a person and does not always reflect their abilities or levels of understanding. The authors argue that language should emphasize retained capacities over diminished ones, thereby supporting individuals with dementia in preserving their dignity. Discriminatory definitions include terms like "dementing illness," "senile dementia," and referring to people with dementia as "patients," "sufferers," or "victims." Non-discriminatory language includes "people with dementia," "people living with dementia," or "people diagnosed with dementia."

End-of-life ethical issues

For individuals with dementia, pressing concerns revolve around end-of-life care, specifically the judicious use of medical treatment to spare them unnecessary suffering and enable a natural, peaceful death by discontinuing interventions that would prolong life without alleviating their condition.

The issues of the need for provision of medical care and life-sustaining interventions for elderly individuals with severe dementia are debated, particularly concerning diagnostic assessments, treatment options, and the use of artificial feeding when oral intake is refused.

Meanwhile, active and passive euthanasia, including physician-assisted suicide (specifically involving psychiatrists), are spreading globally, including for elderly individuals with dementia.

In accordance with ethical norms and the positions of Russian legislation, the intention to end the life of terminally ill and elderly people, including without providing them with assistance, should be considered euthanasia. The Federal Law "On the Fundamentals of Protection of the Health of Citizens of the Russian Federation" (Article 45) states that medical workers are forbidden from carrying out euthanasia, which is defined as accelerating a patient's death at their request through any act or omission, or by any means, including the discontinuation of artificial life-sustaining measures.

The position of the Ethics Committee of the World Psychiatric Association (Spain, 1996) states: "A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informed decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability" [7].

Considering its duty to uphold Christian moral values in a secular world, the Church-Public Council on Biomedical Ethics issued the following statements as part of the "Ethical Code for Older Adults" in 2020:

Aging is a natural part of life during which a person's personality continues to

develop and their spirit grows. Discrimination based on age is unacceptable, as is discrimination against people with dementia in any sphere or area.

Abuse, violence, and neglect towards elderly people is a serious violation of professional medical ethics. It is necessary to respect the presumption of mental health (sanity, legal capacity, legal competence) and recognize dementia as a disease, and not as a normative manifestation of aging.

It is necessary to respect human dignity until the end of his earthly journey.

The right to receive medical care and to live and die at home is an inalienable right.

Any attempt to legalize euthanasia, which is the intentional killing of sick or elderly people, is unacceptable. This is based on the fact that euthanasia can be seen as a form of murder (either by the decision of doctors or with the consent of relatives) or as suicide (at the request of the patient), or a combination of both [5].

Religious understanding of dementia

Due to the particular vulnerability of people with dementia, a theological understanding of this condition is important.

The document of the Greek Orthodox Church, "Theological and Ethical Aspects of Dementia" (2012), examines the spiritual dimensions of this illness. It presents a theological understanding of the condition of people suffering from dementia and offers a rationale for this perspective.

The document states that even when a human mind fades, the soul retains the ability to communicate with God. This implies that the value and dignity of a person with dementia deserve the same respect as the life of an embryo or a baby.

The image of God is present in a person from the moment of conception and remains with them throughout their life, even during periods of illness such as dementia. Therefore, the image of God cannot be lost during dementia!

Since we recognize that all people have a common origin, a common Creator, and a common Father, it means that we are all brothers and sisters. People with dementia, even if they can't speak, communicate, or control their behavior, are still part of our family in Christ. A person who becomes a member of the church through Baptism and Anointing, or a member of the body of Christ, remains so regardless of their illness.

And healthy members of the Body of Christ are called to patiently care for a person with dementia, treating them with love and respect, as if they were a brother or sister going through difficult times. It is not acceptable to express contempt or ignore them. If they suffer, we should have compassion and empathy for them, remembering that "if one part of the body suffers, all the parts suffer with it" (1 Cor. 12:26).

"For a sick and suffering neighbor is a beloved brother, even if he causes sorrow. He is desired, even if he is demanding and sometimes unbearable. He is precious, even if he cannot give anything, because he is the visible "least" brother of Christ, according to the Gospel (Mat. 25:40), even if unable to communicate". [8]

"In addition to expressing our love and praying for those who suffer from mental illness, it is also important to pray with them. We can gently instruct them to make the sign of the cross, light a candle in front of them, and invite them to venerate holy icons. We can also anoint them with blessed oil from the Sacrament of Unction. It is important to take them to the Divine Liturgy and, if they have no difficulty swallowing, assist them in taking the Holy Communion" [8].

Serving a person with dementia is a very special and rewarding experience. Since they are unable to express their gratitude, our care for them becomes a selfless act of kindness.

Caring for a person with dementia can be seen as both a service and a blessing.

A person living with dementia is one of the least of these brothers of the Lord and "a child" who should not be considered a "burden" but rather whom we are called to "resemble."

The challenges that a person with dementia faces provide us with an opportunity to serve them and, through this, find salvation, holiness, and strengthen our own spirit.

A humble acceptance of reality and the belief that each moment of human life is precious and unique is essential for supporting a suffering person. After all, we cannot prevent death, which is inevitable. Instead, our task is to provide a suffering person with precious moments of A humble acceptance of reality and the belief that each moment of human life is precious and unique is essential for supporting a suffering person. After all, we cannot prevent death, which is inevitable. Instead, our task is to provide a suffering person with precious moments of communication and love. [8]

Conclusion

In conclusion, it should be noted that elderly people with dementia who live alone often do not seek medical attention and may quietly pass away in their homes. Issues are often discovered by neighbors or strangers when they start to behave in an unusual way, when their apartments become flooded or cluttered, unpleasant smells appear, fires or gas leaks occur, when they get lost on the street and cannot find their way home, end up in the hospital or the police. To solve this problem, it is important for charity services and church communities to identify elderly people who are lonely and in need of assistance.

People with dementia are often discriminated against, mistreated, and abused. They are sometimes placed in neuropsychiatric asylums, and issues of euthanasia have been raised in some cases. It is important to draw attention to the need for better care for these people, the inadmissibility of abuse, discrimination, and ageism. We should also emphasize the importance of following the Fifth Commandment, which calls for honoring one's parents, and update the Code of Ethics for elderly people.

People with dementia face limited access to medical care and social support. There is no coherent and consistent system in place to provide them with the necessary medical assistance. The Anti-Dementia Plan developed in Russia in 2018 has not yet been legally adopted. Therefore it is essential to expand the network of medical institutions and home for seniors that offer specialized care for people with this condition. These facilities should include not only medical care but also spiritual support.

A system of medical and social rehabilitation for people with dementia has not yet been developed, and existing memory clinics are only open to people with a mild level of cognitive impairment. Therefore, it is important to develop rehabilitation programs within the church and other community settings, such as clubs with a theological focus for older adults, including those who have cognitive disorders or dementia.

Sometimes, pastors may consider the participation of people with dementia in church life to be inappropriate, as they may not be able to express their will or remember their sins. They may also be unable to speak or exhibit incorrect behavior, which can lead to denial of confession and communion. However, it is important to remember that dementia is a disease associated with neurodegeneration of the brain that requires spiritual care. Although the person may not be able to fully express their desires, participating in church and community activities can still significantly improve their condition and benefit their loved ones.

Such discriminatory and anti-spiritual beliefs, as the idea that if God wants to punish a person, he will take away their mind, should be debunked. It is important to understand the spiritual significance of dementia for both relatives and the person

affected. Dementia is not a form of punishment for sins, but rather a disease that can be used for spiritual growth and development. Spiritual support, prayer, attending church services, and participating in church activities can help prevent the onset of dementia in later life.

Issues of close collaboration between clergy and mental health professionals are becoming an urgent task. If a person is suspected of having a mental illness or dementia, they should be referred to medical help. When a psychiatrist diagnoses dementia in a religious person, therapy should be conducted in close cooperation with a priest, considering the triad of the human being: body, mind, and spirit.

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Explanatory models of illness, healing, and health in various cultures and religious traditions

Abstract: Explanatory models can exhibit substantial variability, which is manifested in the perception of health, disease symptoms, progression, and recovery across different cultures and religious traditions. There are even entire systems of thought about health, such as Ayurveda, which takes a holistic approach to considering the physical, social, ethical, and spiritual aspects of health and illness. Since the 1970s, research in psychiatry has identified "culture-related syndromes" or "culture-specific disorders," which differ from established psychopathological conditions. It is evident that comprehending the patient's perception of their illness and the perceived remedies is essential for the therapeutic process, as it enhances patient compliance and may impact the overall prognosis of the condition.

Keywords: illness models, therapy models, culture-specific diseases, culture-related syndromes, and treatment adherence.

For effective personalized care to be provided to a patient suffering from mental illness, it is important to carefully consider their existing ideas about their illness, treatment methods, and health. These ideas greatly influence the course of the therapeutic process. It is evident that these perceptions, while unique to the individual, are also shaped by the cultural context in which they are situated.

Anthropologists, and subsequently medical anthropologists and medical ethnographers, initially examined the factors believed to cause specific diseases in various cultural communities, as well as the particular strategies and practices employed to combat these ailments. However, over time, these topics have increasingly captured the interest of medical professionals, notably psychiatrists.

Research in this area has identified culture-specific disorders that are limited to specific geographical regions. These disorders differ from known psychopathological conditions in their unique characteristics. So-called "culture-specific diseases" or "culture-related syndromes" often occur among people who share similar cultural values and beliefs (H.P. Lefley, 1999; R.E. Levine, A.C. Gaw, 1995). An example of this is the epidemic of mental disorders with obsessive-compulsive disorder: hysteria and hiccups (L. E. Pishchikova, 2025).

The 1970s witnessed a growing significance of explanatory models for diseases and therapies. This shift was bolstered by cultural psychiatry research, which delved into linguistic constructs and the underlying symbols. Consequently, medicine became more focused on meaning, recognizing that all disease aspects are fundamentally semantic, and all clinical interventions carry an interpretive component. It is thought that explanatory models for mental illnesses significantly influence the timing and type of assistance individuals and their families can access (G. Leavey, K. Loewenthal, M. King, 2016).

Explanatory models of recovery are linked to medical systems in some way or another. Essentially, there are two healthcare systems in the developing world: the traditional and the official, based on Western scientific and technological principles, within the biomedical paradigm.

Traditional medicine is a general term encompassing the empirical medical practices employed in various cultures globally. It includes all forms of folk medicine and any therapeutic methods transmitted through the traditions of communities or ethnic groups. Traditional medical systems, adhering to a holistic approach, continue to coexist alongside biomedicine. Folk, popular, and orthodox medical practices not only coexist

but also compete and intermingle within the same communities, nations, or regions. Many traditional or popular beliefs about health can be either supported or refuted by biomedical explanations. Medical pluralism provides a diverse range of treatment options, allowing patients to seek therapies and understandings of illness that resonate with their own perceptions (V. Bhasin, 2007).

Medicine, being an integral part of culture, has historically been inextricably linked to social contexts. As a result, the concepts of medical care, treatment, and the origins of illness cannot be understood independently of this social context. Each tribe or ethnic group develops unique methods for identifying and addressing disease. In these communities, the etiology of illness is often bifurcated into natural explanations, attributable to physical factors, and supernatural causes, associated with the influence of malevolent spirits or witchcraft. The methods of treating a disease can vary greatly depending on the cause of the illness (traditional medicine, magical practices, or religious rituals).

Concepts such as life, death, and human suffering are fundamental to many religious traditions, intricately intertwined with rituals, myths, and beliefs. These elements also serve as the foundation for widespread perceptions of disease etiology, healing techniques, and health preservation, ultimately contributing to the evolution of contemporary medical systems. Explanatory frameworks for disease and recovery offer individuals a structured approach to addressing health concerns and delineating the parameters of illness, injury, and disability (G. Leavey, K. Loewenthal, and M. King, 2016).

Culturally specific perspectives on healing, illness, and health

In Arab societies, family support, especially for the elderly, has been a longstanding tradition, which Islam has further strengthened. As a consequence, it is often the family as a whole that makes the decision to seek professional medical assistance. In these communities, it is rare for an individual to pursue psychiatric or general medical treatment independently. Family members offer their support, express concern for the patient's welfare, and contribute to the treatment process. The decision to hospitalize a patient is usually made jointly by the doctor, the patient, and their family members.

Moreover, many Arab patients in Egypt and the Gulf regions anticipate that psychiatrists will "ease" their distress, which inadvertently heightens their reliance on family members, making it challenging for them to engage in self-directed therapy. Often, family members are involved in the treatment process and act as co-therapists. Psychiatrists unfamiliar with Arab culture may misinterpret such behavior as a patient's refusal to cooperate, seeing it as an indication of unwillingness to help themselves. Conversely, patients anticipate that doctors will address their symptoms through the lens of their cultural background rather than solely from a psychiatric perspective.

The inability of expatriate therapists to distinguish between what is culturally alien and what is normative within a given culture can lead to diagnostic and treatment errors. For instance, beliefs held by Western-trained professionals that the devil tempts individuals to think, feel, or act in inappropriate ways may be misidentified as Kurt Schneider's first-rank symptoms of schizophrenia¹ (M. Fakhr El-Islam, 2008).

Certain cultural practices embody comprehensive philosophies of well-being. Ayurveda is an example². This ancient system adopts a comprehensive approach to human existence, encompassing multiple dimensions of health and illness: physical,

¹ The Arabic word "visswas" refers to both the devil and unpleasant thoughts, which can also lead to semantic confusion.

² Ayurveda is an Indian medical system based on ancient traditional texts.

social, moral, and spiritual. Central to Ayurvedic thought is the notion of "karma," which profoundly influences every facet of an individual's life, including their health status and vulnerability to diseases.

Many Hindu patients believe that mental illnesses have supernatural causes. It is common for patients to expect the psychiatrist to listen to and involve every family member present at the appointment in the treatment process. Furthermore, there is a specific understanding of confidentiality that is somewhat similar to the cultural aspects of the Arab tradition described above. Quite often, patients and their families expect the psychiatrist to adopt a more directive role in the therapeutic relationship, acting as an advisor and a teacher (N. V. Juthani, 2001).

The Buddhist focus on compassion is naturally expressed through the care of the sick, a tradition practiced in monasteries for centuries. There are clear connections between Buddhism and traditional Indian medicine, with some researchers noting many parallels between the Buddhist medical practices found in the Pali Canon and those of Ayurveda. Buddhism's holistic understanding of human nature is reflected in modern Western medicine, for instance, through the psychosomatic approach. Within certain Buddhist schools, as in Ayurveda, the concept of 'karma'—often likened to the ripening of a fruit—is considered significant. In this context, the development of a severe somatic or mental illness can be interpreted in a rather positive light, as a resolution or a release from a heavy burden (J. J. Hughes, D. Keown, 1995).

The Japanese perspective is shaped by a blend of Shintoism and Buddhism, which many Japanese people adhere to. Shintoism places a greater emphasis on the themes of birth and life, while Buddhism focuses more on the experience of suffering and the difficulties surrounding death.³

Defilement and purification play a pivotal role in Shinto spirituality. Purifying the body simultaneously cleanses the mind and one's immediate environment. Conversely, if one's environment or mind is polluted, the body is defiled as well. In this sense, the three dimensions—mind, body, and external reality—are viewed as identical, with no single domain taking precedence over the others.

In Japanese Buddhism, the mind and body are not viewed as separate entities. In certain Buddhist traditions, physical exertion—such as long-distance walking and mountain climbing—serves as an essential form of training to detach from worldly attachments. Furthermore, meditation is frequently practiced to strengthen both the mind and the body.

The ideology of Ki⁴, which reached Japan from China alongside Buddhism, plays a considerable—perhaps even more profound—role in shaping the Japanese worldview. In Taoist thought, Ki is the fundamental energy that permeates the universe and circulates through the human body. Taoism does not distinguish between mind and body, nor between internal and external energies. It is believed that when the flow of Ki is obstructed, a person loses their vitality, ultimately leading to sickness or death⁵.

While these three belief systems remain theoretically separate, they have been viewed as one and the same in the Japanese worldview for over a millennium. The notion of mind-body unity, shared by all three traditions, is a cornerstone of Japanese philosophy. This very concept serves as the foundation for how health, disease, and healing are understood within Japanese culture (M. Nakao, C. Ohara, 2014).

Certain research on Aboriginal views of health has shown that it is seen not just as an individual's physical state, but also as the social, emotional, and cultural well-being

³ There is a saying: "Every Japanese person is born a Shintoist and dies a Buddhist".

⁴ In Chinese – Qi (chi).

⁵ A common Japanese greeting: "Gen~~q~~idesuka?" ('Are you all right?') is used to inquire about a person's Qi condition. Additionally, "Qimochi-ga-warui" ('I don't feel well') indicates that something is wrong with the person's Qi.

of their entire community. This comprehensive approach to life includes the idea of the cyclical connection between life and death. For instance, serious illnesses, including mental health issues, are often attributed to external influences or causes, highlighting the intertwining of spirituality with relationships to family, land, and heritage (S. Tse, C. Lloyd, L. Petchkovsky, W. Manaia, 2005).

In conclusion, it should be noted that explanatory models of illness, healing, and health can vary significantly across different cultures and religious traditions. However, when seeking medical care, individuals with mental health issues—regardless of their cultural background—expect their spiritual experiences to be acknowledged as real and meaningful. A clinician's understanding of a patient's conceptualization of their illness and their vision of healing is a prerequisite for the therapeutic process; it fosters treatment adherence and can positively influence the overall prognosis.

It is insufficient to merely identify specific cultural aspects of a patient's worldview or to possess knowledge of the core tenets of major religions. The patient's subjective experience of illness, their interpretation of the situation, and the potential influence of these factors on care delivery constitute a fundamental reality that must be addressed, as they are vital to the overall therapeutic process. (J. Swinton, 2001).

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Religious beliefs and their relationship to mental health

Abstract: The current research aims to analyze and frame the relationship between religious beliefs and mental health through a systematic review of relevant theoretical frameworks and previous studies, and to identify research gaps, particularly in the Iraqi context which has witnessed traumatic conditions that have affected its religious minorities.

To achieve this, the Descriptive-Analytical Method was adopted to analyze the fundamental theoretical models (Allport, Bandura, Pargament, Wong) and to discuss the results of systematic studies that addressed bidirectional correlations and effects. Following the analysis, the results showed a consistency among modern models that religious beliefs are a cognitive-affective element contributing to the enhancement of mental health, and that the quality of religious beliefs is the most important determinant of their influence. Applied studies confirmed that positive coping acts as a protective factor associated with reduced symptoms and levels of depression and anxiety and increased psychological resilience and well-being. In contrast, negative religious beliefs (such as feelings of punishment or divine anger) are linked to increased psychological distress and hopelessness. Based on the results, a set of recommendations and proposals were developed.

Keywords: Religious Beliefs, Mental Health, Positive Religious Coping, Religious Spiritual Conflict, Psychological Resilience.

Introduction

The study of religious beliefs and mental health together is one of the most prominent systematic frameworks in the psychology of religion. Systematic research and reviews indicate that religion, including faith, divine attachment, hope, and the practice of religious rituals, influences important psychological processes such as adjustment, psychological resilience, psychological well-being, feelings of satisfaction, and other psychological, personal, and social aspects.

Religious beliefs are one of the most influential factors on human behavior, as numerous studies have pointed to the association of religion with human behaviors, and psychological and social aspects (Smith, 2017). This was also pointed out by the study (Koenig, 2012) in terms of religious beliefs positively reflecting on mental health and promoting a sense of tranquility and hope (Pargament, 2011). Religious beliefs are considered key factors in human life and can have a noticeable impact on mental health and improving the level of mental health (Bohr et al., 2019), and practicing these beliefs may reduce the rates of some psychological disorders such as anxiety and depression (Bonelli & Koenig, 2013). However, other studies indicated that religious beliefs may lead to feelings of guilt or punitive anxiety, which increases psychological stress and thus negatively affects mental health (Exline et al., 2014, p. 95).

Despite the cognitive richness in these two fields (religious beliefs and mental health), there is still a need for in-depth studies on these two variables in more specific contexts. Therefore, this research focuses on analyzing the contradiction between the effects of the association of religious beliefs on mental health, especially since the researcher, through her review of psychological studies, found a scarcity of studies, which was confirmed by (Al-Kandari, 2019) and (Abu-Raiya & Pargament, 2015). Furthermore, no local studies were found in this field that document the association between religious beliefs and mental health from an integrated psychological perspective, especially since Iraq has gone through successive difficult circumstances of kidnapping, killing, and displacement of Christians from their areas and villages, in

addition to the destruction of some churches, which were considered spiritual symbols for believers, especially during the ISIS occupation, and consequently their suffering from psychological and spiritual effects to this day.

Therefore, the current research aims to analyze the studies and scientific and academic literature that focused on the relationship between religious beliefs and mental health, including the psychological theoretical interpretations and the results of previous studies, to provide an integrated analysis that serves psychological specialists and religious figures in understanding the association of these two variables and the factors influencing them, in order to answer the main research question: "How do theoretical models in psychology interpret the relationship between religious beliefs and mental health?" To achieve the research objectives, the Descriptive-Analytical Method was adopted for a theoretical analysis of psychological theories and previous studies on the subject to reach results, draw conclusions, and set recommendations and proposals.

Theoretical framework

The systematic academic analysis of the topic of religious beliefs and their relationship to mental health required establishing a clear conceptual framework that guides the process of understanding and discussion to interpret the sometimes integrated and sometimes conflicting results in the literature. Therefore, this framework aims to understand the two concepts from the psychological terminological aspect, and to present the theories and previous studies.

First: defining terms

Definition of beliefs: Beliefs have been defined by several scholars as follows:

1. **Aaron Beck (1995)** defined beliefs as *cognitive schemas that function to organize and interpret an individual's experiences through continuous interaction with the surrounding environment* (Beck, 1995, p. 13).
2. **Ajzen (2020)** defined beliefs as *cognitive representations that shape an individual's evaluation of the likelihood or reality of events, and constitute one of the core components in the formation of behavioral intentions and the determination of values* (Ajzen, 2020, p. 7).
3. **Jawhar (2023)** defined beliefs as *the mental representation of an object, serving as the generator and producer of thoughts and other mental activities* (Jawhar, 2023, p. 53).

Religious beliefs: The researchers defined them theoretically as:

Koenig (2012) defined religious beliefs as *a set of ideas and perceptions related to God, faith in the importance of religious rituals, and the attribution of spiritual meaning, which in turn influence an individual's worldview and behavior* (Koenig, 2012).

From a theoretical perspective **the researcher** defines religious beliefs as *ideas associated with belief in the existence of God, the attribution of spiritual meaning to life events, and reliance on religious standards in evaluating one's own behavior as well as the behavior of others*.

Mental health:

World Health Organization (2022) defines mental health as *a state of psychological well-being that enables individuals to cope with the stresses of life, to learn and work effectively, and to contribute to their communities* (World Health Organization [WHO], 2022).

Second: Psychological domains of religious beliefs

Religious beliefs affect the psychological aspects of humans, and they can be divided into three core domains:

1. **Religious orientation and personality:** This focuses on how the individual adopts their religious beliefs and how that becomes part of their personality structure. Gordon Allport's model is the most common, as he distinguished between two types of religious orientations:
 - Intrinsic Orientation: The individual adopts their religious beliefs as a value and an ultimate goal in their life and lives according to the teachings of their faith. This orientation is linked to maturity and psychological cohesion within the self (Allport & Ross, 1967, p. 434).
 - Extrinsic Orientation: The individual uses religion as a means to achieve other non-religious ends, such as obtaining support or social status, or for security. This orientation is not associated with mental health but may be linked to neurosis and psychological illness (Allport & Ross, 1967, p. 435).
2. **Coping and adjustment:** This domain studies how religious beliefs function as effective strategies in coping with daily life pressures and in facing disasters and psychological crises (Pargament, 1997). The domain of Religious Coping is divided into two types: Positive coping, which includes using beliefs in a way that supports mental health, finding meaning from suffering, or believing that God loves; and Negative coping, which includes using beliefs in a way that increases distress, feeling anger towards God, or interpreting suffering as divine punishment, which increases anxiety and psychological conflict (Pargament et al., 2000).
3. **Existential health and meaning:** This domain explains how religious beliefs provide the individual with ultimate answers to major existential questions, which directly affects the feeling of psychological well-being or lack thereof (Wong, 1998). The meaning of life is the availability of religious beliefs that constitute a coherent system for understanding the universe and the human role in it, which leads to reducing the existential vacuum or meaninglessness, which in turn adds a supreme goal to daily behaviors and decisions, thereby promoting hope and optimism in the individual (Wong, 1998, p. 17).

Third: Psychological theories interpreting religious beliefs and their relationship to mental health

After reviewing many psychological theories, the researcher addressed the most prominent theories that interpreted religious belief from a psychological perspective:

1. Psychoanalytic theory (Sigmund Freud, 1927)

Freud attributes the origin of religious beliefs to the human need for a feeling of protection and security, and facing terrifying forces of nature and external difficulties, as the human projects the image of the strong and savior father onto the image of God (Freud, 1927, p. 21). Freud views religious beliefs and rituals as very similar to the obsessive symptoms (obsessive neurosis) in individuals, but here it is a collective phenomenon, as he describes religion as a collective neurosis (Freud, 1927, p. 43). Religious practices such as prayer, confession of sins, and other rituals are like Compulsive Acts whose purpose is atonement for the feeling of guilt that goes back to the initial Oedipus complex. Religion provides a strong system for the Superego and imposes restrictions on the instinctive drive of the Id represented by aggression and sex, which leads to the suppression of these drives and consequently the constant feeling of guilt, where the role of practicing religious rituals comes to alleviate the feeling of guilt (Freud, 1927, p. 43).

2. Analytical psychology theory (Carl Jung, 1938)

Jung views religion as the expression of the innate aspect of humanity, as it is the driver of individuation and represents the collective unconscious, which is represented in the Archetype, which represents inherited primordial models of ideas, images, or behavioral patterns existing in the collective unconscious (Jung, 1938, p. 57).

These religious beliefs are necessary for individuation and integrating aspects of the Self to provide the individual with meaning and purpose in life to achieve mental health (Jung, 1938, p. 75).

3. Self-theory and religious orientations (Gordon Allport, 1967)

The prominent psychologist (Gordon Allport) and his colleagues contributed to studying the relationship between religion and personality, and it was a decisive turning point, as the theory transcended the traditional theoretical frameworks that reduced religion to psychological illness or illusions (as Freud said) and moved to how individuals adopt their religious beliefs and how they are integrated into the Self Structure. The Religious Orientations Model was developed, which assumes that religious beliefs can be functionally classified into two basic patterns (Allport & Ross, 1967, p. 433):

- Intrinsic Orientation: When the individual adopts religious beliefs as a supreme value in their life and makes it a primary motive, this type of religious belief will be associated with better mental health (Allport & Ross, 1967, p. 434).
- Extrinsic Orientation: The individual here uses religion as a means to achieve other goals such as social benefit and a feeling of security, thus being associated with negative psychological outcomes (Allport & Ross, 1967, p. 435).

4. Social cognitive theory (Albert Bandura, 1986)

This theory provides a strong framework for understanding how religious beliefs are acquired as belief systems that are learned, regulated, and self-directed in the social context, and not as an "existential essence" as in Freud's theory or Jung's theory. The Social Cognitive Theory focuses on translating religious beliefs into behavior through mechanisms that in turn affect psychological well-being. The theory assumes that religious beliefs are acquired, organized, and entrenched through social and cognitive learning mechanisms (Bandura, 1986), and the process of acquiring and practicing cognitive beliefs occurs through observing significant social models such as parents, spiritual leaders, or teachers through Observational Learning (Bandura, 1986).

5. Meaning and purpose search theory (Paul T. P. Wong, 1998)

Peter Wong developed a complementary theoretical framework that emphasizes the existential role of religious beliefs in promoting the level of mental health, as religious beliefs provide a comprehensive and ultimate framework for understanding the universe and life and interpreting incomprehensible phenomena such as death and pain. Religion provides individuals with a coherent belief system that gives a sense of order in the face of chaos, which reduces the existential vacuum and meaninglessness that may lead to depression and anxiety (Wong, 1998, p. 12). The meaning and purpose of religious beliefs, the existence of a lofty goal and purpose in life, and the belief that the suffering the individual goes through serves a purpose or leads to future reward (in life or after death) all provide a source of hope and optimism in the most difficult circumstances and lead to psychological resilience and the ability to recover (Wong, 1998, p. 17).

6. Religious coping theory (Kenneth Pargament et al., 2000)

The Religious Coping Model, developed by Kenneth Pargament and his team, is one of the most influential theoretical frameworks in the psychology of religion and mental health. This model provides a comprehensive understanding of how individuals use faith and religious practices as a primary resource for managing major life stresses and crises, as it focuses on religious response being a practical matter and behavior performed by the individual when facing hardships, and that it is not only a matter of faith content, and that there is a Coping Mechanism that represents the efforts exerted by the individual to deal with pressures and situations that exceed their capabilities. It includes efforts centered on faith, as he views religion as a vital and purposeful process that includes thoughts, feelings, and behaviors centered on God, which are used to find

meaning, promote a sense of control, reach comfort, achieve closeness with others, and express or acquire spirituality in difficult times (Pargament et al., 2000, p. 520).

Positive Religious Coping includes positive religious coping strategies that reflect a friendly and secure relationship with God to support psychological and spiritual growth, as the use of this strategy is associated with promoting mental health, reducing symptoms of anxiety and depression, and increasing life satisfaction. Through Collaborative Coping, the individual works with God to solve the problems they face and believes that their effort and divine support will lead to a positive outcome. Also, resorting to spiritual and social support by seeking assistance from the religious community or the religious to feel comfort. The search for sacred meaning and religious belief is an attempt to find a supreme goal or divine meaning for hardships, so they believe that adversity is a divine test for growth (Pargament et al., 2000, p. 525). While Negative Religious Coping reflects a conflict and tension in the relationship with God or within the religious community, as this strategy leads to negative outcomes because it causes existential psychological distress and is closely associated with a deterioration in the level of mental health and consequently an increase in the level of anxiety and depression and poor adjustment. Divine Discontent results as the individual feels anger towards God and may blame Him for the negative events or may feel that God has punished or abandoned them, so the individual feels hopelessness and that God has withdrawn His care (Pargament et al., 2000, p. 526).

7. Dual information processing theory (Daniel Kahneman, 2011)

Beliefs in cognitive psychology are classified according to their mental processing method into two systems that reflect the mechanisms by which the human mind operates (Kahneman, 2011; Sperber, 2006), as belief is divided into two types:

- **Reflective Belief:** It is the belief that a person reaches through conscious and intentional reflection, so when asked about the belief in something, the answer includes their reflective belief, and this type of belief is characterized by being clear and specific and is presented perfectly (Sperber, 2006, p. 5).
- **Sensory or Intuitive Belief:** This is the opposite of the previous type, as it works unconsciously in an automatic and fast manner, as the belief comes directly from the sense. Our minds always produce intuitive beliefs continuously and, and they include beliefs based on sensory stimuli, direct experience, and quick inferences that guide the individual's daily behaviors without strict control (Kahneman, 2011, p. 20).

Fourth: Previous studies

There are numerous previous studies addressing beliefs, religiosity, and mental health. The following is a review of selected relevant studies:

1. Bambr (2013)

This study aimed to examine the beliefs and attitudes of relatives of psychiatric patients and university students toward mental illness by identifying its causes, symptoms, treatment methods, and appropriate ways of dealing with individuals with mental disorders. The study also sought to identify similarities and differences in beliefs and attitudes between patients' relatives and university students attributable to educational level, place of residence, and degree of kinship. For this purpose, the World Health Organization's scale on beliefs and attitudes toward five common mental disorders — intellectual disability, epilepsy, acute psychosis, depression, and schizophrenia — was administered to a sample of 100 participants divided into two groups: 50 relatives of psychiatric patients and 50 students from Hadhramout University. The findings revealed convergence in both groups' beliefs regarding the causes of acute psychosis and depression and the identification of appropriate treatment providers. However, differences emerged in beliefs related to the causes and treatment of intellectual disability and epilepsy. Both groups also exhibited negative attitudes toward marriage,

employment, and housing involving individuals with mental illness. Based on these findings, the researcher proposed several recommendations and highlighted key problems contributing to negative beliefs and attitudes toward mental illness (Bambr, 2013).

2. Khouta et al. (2018)

This study aimed to investigate the relationship between religious beliefs, coping styles, and emotional intelligence among secondary school students in the city of Shush. The descriptive correlational method was employed. The study population consisted of 2,012 male and female secondary school students (1,254 females and 758 males), from which a statistical sample of 200 students was selected. Data were collected using the Bar-On Emotional Intelligence Questionnaire, the Religious Attitude Scale by Khorramzadeh and Baraheni, and Lazarus's Coping Strategies Inventory. Descriptive statistics and Pearson's correlation coefficient were used for data analysis. The results indicated statistically significant positive relationships between religious beliefs and emotional intelligence, as well as between coping styles and emotional intelligence among secondary school students in Shush (Khouta et al., 2018).

3. Al-Dhabet (2017)

This study examined the impact of selected family and demographic variables on religious beliefs among university students. The sample consisted of 280 male and female students. Instruments included a Religious Beliefs Scale, a Socioeconomic Status Scale, and a Family Variables Questionnaire. The sample was categorized by residence (rural/urban), gender, and type of college (theoretical/practical). The results revealed statistically significant differences in religious beliefs according to socioeconomic status, gender, family religiosity, parental education, and family interaction with the internet. Significant differences were also found based on type of study (theoretical vs. practical) (Al-Dhabet, 2017, p. 88).

4. Bohr et al. (2019)

This study aimed to examine the relationship between religious attitudes and psychological symptoms among referred pregnant women attending health and medical centers in Urmia in 2016. A cross-sectional descriptive correlational design was used. The sample consisted of 350 pregnant women attending rural health centers during the last quarter of 2016. Data were collected using a three-part questionnaire covering demographic variables, religious attitudes (25 items), and psychological symptoms including depression, anxiety, and stress (21 items). Statistical analyses included t-tests, chi-square tests, linear regression, and correlation coefficients. The results demonstrated a strong inverse relationship between religious attitudes and levels of depression, anxiety, and stress, indicating that higher religious beliefs were associated with lower psychological distress among pregnant women (Bohr et al., 2019).

5. Coelho-Júnior et al. (2022)

This study examined the relationship between religious and spiritual practices and the prevalence, severity, and manifestation of psychological symptoms among older adults through a systematic review and meta-analysis of cross-sectional and longitudinal studies involving individuals aged 60 years and older. Data were extracted from MEDLINE, LILACS, SCOPUS, CINAHL, and AgeLine databases up to 2021. Risk of bias was assessed using the Newcastle–Ottawa Scale (NOS), and overall effect sizes were calculated using log odds ratios (log OR) and Z-values. The analysis included 102 studies with a total sample of 79,918 older adults residing in communities, institutions, or hospitals. Results indicated strong inverse associations between religiosity/spiritual practices and anxiety and depression, as well as positive associations with life satisfaction, sense of meaning, psychological well-being, and social relationships. The findings suggest that religious and spiritual practices are significantly associated with mental health among older adults (Coelho-Júnior et al., 2022).

6. Marques et al. (2022)

This study aimed to analyze the effects of religious-based interventions on depression through a systematic review of literature published between 2015 and 2021. Databases searched included Cochrane Collaboration, PubMed, Scopus, and Web of Science. Out of 208 relevant publications, findings indicated that religious interventions effectively reduced depressive symptoms among vulnerable populations, including individuals with chronic physical illnesses, pregnant women, dialysis patients, elderly residents in nursing homes, and cardiac patients. The study emphasized the importance of incorporating patients' religious beliefs into the assessment and treatment of depression (Marques et al., 2022).

7. Schwalm et al. (2022)

This study investigated the relationship between spirituality/religiosity and psychological resilience through a systematic review of 34 high-quality studies selected from 2,468 articles. The findings revealed a moderate positive correlation between spirituality/religiosity and resilience, including individuals' ability to adapt to adversity, withstand stress, and recover from negative life events (Schwalm et al. 2022).

8. Aggarwal et al. (2023)

This systematic review included 45 longitudinal studies and 29 intervention studies retrieved from Medline, PsycINFO, and Scopus databases to examine the role of religiosity and spiritual engagement in preventing and managing depression and anxiety among individuals aged 10–24 years. Most studies were conducted in high-income countries. Using Joanna Briggs Institute critical appraisal tools, results indicated that negative religious coping (e.g., beliefs that God has abandoned or is punishing the individual) was associated with increased depressive symptoms over time. Conversely, spiritual well-being demonstrated a protective effect against depression, highlighting the potential role of religious beliefs and practices in designing psychological interventions for youth mental health (Aggarwal et al., 2023).

9. Hassan (2025)

This study examined health beliefs and health behaviors among educational counselors, gender differences in these variables, and the relationship between health beliefs and health behavior. The population consisted of 384 counselors working in schools in Kut city center, with a sample of 200 counselors equally divided by gender. The Health Behavior Scale (Al-Samadi & Al-Samadi, 2011) and a newly developed Health Beliefs Scale were used. Psychometric properties were established through content validity, construct validity, and reliability testing (test-retest and Cronbach's alpha). Results indicated that counselors demonstrated good levels of health beliefs and health behaviors, with statistically significant gender differences favoring females, and a significant positive correlation between health beliefs and health behaviors (Hassan, 2025).

10. Zwingmann (2025)

This meta-analysis examined the relationship between religiosity/spirituality and mental health, including 39 studies conducted in German-speaking countries between 2016 and 2023. Results indicated a statistically significant moderate association between higher levels of religiosity/spirituality and better mental health outcomes after excluding negative forms of religiosity. The findings suggest that in highly secularized societies, non-institutional and conceptually open forms of religiosity and spirituality exhibit stronger associations with mental health compared to traditional religious expressions (Zwingmann, 2025).

Results

First: Results of the theoretical analysis of religious beliefs and their relationship to mental health

The review of theoretical frameworks in psychology showed a general consistency among most psychological models in interpreting the role of religious beliefs as a cognitive-affective element that contributes to psychological adjustment and well-being, with variation in the interpretation of the mechanisms:

Analytical theories (Freud, Jung) focused on the unconscious roots of religious beliefs, as Freud interpreted religion as a "collective neurosis" that provides protection from anxiety through the formation of the Superego. While Jung's theory viewed religion as part of the collective unconscious and contributes to the process of individuation and psychological integration, these theories agreed that religion plays a structural role in regulating psychological experience, despite their different interpretations of that role. As for the Religious Orientations theory (Allport), it showed that the effect of religious beliefs on mental health is related to the pattern of religiosity itself, as intrinsic religiosity is associated with better mental health, while extrinsic religiosity is associated with anxiety and neurosis, and that the psychological effect of religion is determined by the pattern of religious commitment and not merely by general religiosity. The Social Cognitive Theory (Bandura) confirmed that religious beliefs are acquired through social learning and form expectations of success and control, and are a source of religious self-efficacy, and that religious beliefs promote the cognitive-regulatory variables that support adjustment and psychological resilience. The Meaning Search Theory (Wong) clarified that religion provides an existential framework for meaning and purpose, which is an essential element for psychological well-being and reducing existential anxiety, and that religious meaning has a direct role in preventing existential disorders such as anxiety and depression. As for the Religious Coping Theory (Pargament), it indicated that the influence of religion on mental health is bidirectional and depends on the type of coping. It differentiated between: Positive Religious Coping (submission, trust, cooperation with God) $\rightarrow$ linked to mental health, and Negative Religious Coping (anger at God, feeling divine punishment) which is linked to high anxiety and depression.

Second: Results of the analysis of previous studies

The systematic review of previous studies related to religious beliefs and mental health revealed a theoretical and applied consensus on the existence of a deep and dual relationship, where beliefs act as a protective factor or a risk factor, depending on the nature of their adoption and activation, including:

1. The positive effects of religious beliefs as a protective factor:

The majority of systematic and meta-analytic evidence confirms clear and positive effects of religious beliefs and practices on both positive and negative mental health indicators. These effects are manifested in the following:

- **Reduced Psychological Disorders:** High levels of religiosity and spirituality are linked to reduced rates of depression and anxiety among different age groups, including the elderly and youth (Coelho-Júnior et al., 2022; Aggarwal et al., 2023).
- **Increased Psychological and Existential Well-being:** Beliefs act as a primary source of meaning and purpose in life, which contributes to raising Psychological Well-being and increasing life satisfaction (Coelho-Júnior et al., 2022).
- **Support for Coping with Stress and Psychological Resilience:** Religious beliefs support the individual's ability to cope with life stressors effectively, and promote Resilience by providing a social support network and positive outcome expectations (Schwalm et al., 2022).

2. The potential negative effects of negative religious beliefs:

Despite strong evidence of benefits, the relationship is not linear; research indicates that the quality of religiosity is the decisive factor. Negative effects emerge from negative religious beliefs, which act as a source of psychological distress:

- **Negative Religious Coping:** Negative religious coping strategies (such as the feeling that God is punishing or has abandoned the individual) lead to counterproductive outcomes.
- **Increased Psychological Distress:** Negative coping is linked to increased hopelessness, excessive guilt, worsening Punitive Anxiety, and increased symptoms of depression (Aggarwal et al., 2023).

Discussion of results

These results are discussed in the context of modern cognitive and functional theoretical frameworks, to confirm the alignment between theory and application and identify the mediating factors, and this can be summarized as:

1. Theoretical consistency and evolution from roots to functional mechanisms

The theoretical analysis results confirmed a general consistency among psychological schools in recognizing the structural role of religious beliefs in regulating psychological experience and adjustment, despite the difference in interpreting the roots. While analytical theories (Freud, Jung) focused on the unconscious roots and symbolic meanings that provide protection from anxiety or contribute to psychological integration (Individuation), modern models (Allport, Bandura, Pargament, Wong) moved beyond the roots to the direct functional mechanisms. This shift constitutes a consensus that scientific value lies in interpreting how beliefs affect, and not why they originated. These positive mechanisms are explained through three main paths:

- **The cognitive path:** The Meaning Search Theory (Wong) and the Social Cognitive Theory (Bandura) confirmed that religious belief provides an existential framework for meaning and purpose and supports religious self-efficacy, which promotes cognitive variables that support adjustment and psychological resilience.
- **The emotional and social path:** The positive effect of intrinsic religiosity (Allport) and positive coping (Pargament) is explained by reducing tension and anxiety and supporting psychological tranquility through the sense of trust and spiritual and social support.

2. Confirmation of the bidirectional relationship and conditional psychological influence:

The applied results derived from the Meta-Analysis align with the distinction presented by Pargament, confirming that the relationship between religious beliefs and mental health is Conditional and Bidirectional, and includes:

- **The protective role of positive religiosity:** evidence strongly supports that high levels of positive religiosity (intrinsic orientation and positive coping) act as a factor in increasing mental health, as they are associated with reduced psychological disorders (depression and anxiety) and increased existential well-being.
- **Consequences of negative beliefs:** results indicate that negatively interpreted faith or faith characterized by negative religious coping leads to the worsening of psychological distress. The association of negative coping with hopelessness, punitive anxiety, and increased depression symptoms (Aggarwal et al., 2023) suggests that some religious beliefs can be a source of conflict and distress when translated negatively, which imposes the importance of studying the dimensions of religious spiritual conflict.

3. Discussion in the cultural and methodological context (research gaps)

Despite the consistency of the general results, the review of the literature revealed critical research gaps that require moving towards contextual framing regarding:

- **Methodological and geographical bias:** The scarcity of longitudinal studies

indicates a methodological bias in favor of cross-sectional correlation studies, which impedes the extraction of a confirmed causal relationship. More important is the geographical bias, as the majority of research is concentrated in Western contexts, which makes its conclusions about the strength of the association debatable in other different societies with specific characteristics, especially in light of the scarcity of Arab and Iraqi studies that address this topic.

- The belief gap in the context of psychological trauma: The absence of research on the impact of traumatic conditions on religious belief (especially among minorities in Iraq) constitutes a critical scientific gap. This gap imposes a challenge to the religious coping model and requires studying how religious beliefs under the weight of trauma transform into sources of strength or vulnerability.

4. **As for the research gaps revealed by the study, they were:**

- Scarcity of Arabic and Iraqi studies on the topic of religious beliefs and mental health.
- The need for more longitudinal studies to explain the causal relationship between religious beliefs and mental health.
- Absence of studies on the impact of traumatic conditions on religious beliefs among Christians in Iraq.

Conclusions

Based on the results achieved by the study, the following methodological and theoretical conclusions are drawn:

1. Religious beliefs act as a fundamental Functional Variable in psychological regulation. The influence on mental health is not determined by the absolute existence of belief but by the cognitive and behavioral mechanism through which the individual adopts this belief, such as self-efficacy and intrinsic orientation.
2. The psychological effect of religious beliefs is a complex and conditional effect. Positive coping is associated with well-being and prevention of psychological disorders, while any form of negative coping or spiritual conflict becomes a cause of increased psychological distress and pathological symptoms.
3. The existence of a fundamental research gap represented by the scarcity of local studies, which raises questions about the possibility of generalizing Western coping models to cultural and religious contexts (Iraq as a model) that have suffered from high levels of trauma.
4. Religious beliefs, when positively guided, provide effective mechanisms suitable for Intervention Models in guidance and psychotherapy to help reduce levels of depression and anxiety.

Recommendations

Through the results reached by the current research, the researcher set a set of recommendations, which are:

- Relevant institutions should conduct field studies in Iraqi society to find and understand the relationship between patterns of religious beliefs and mental health.
- Specialists in the field of mental health should understand and analyze how psychological trauma is formed in light of religious beliefs, especially among Christian communities (Assyrian, Syriac, and Armenian) that have been exposed to traumatic conditions for many years.
- The necessity of cooperation between religious figures and psychological specialists as an attempt to integrate interventions based on the psychology of religion into guidance and Cognitive-Behavioral Therapy (CBT) plans, especially those that include promoting existential meaning and affirming trust in God, as effective tools for reducing levels of depression and anxiety.

- Psychological specialists should provide training programs aimed at developing positive religious coping skills and limiting negative interpretations of suffering that increase feelings of hopelessness and guilt.

Suggestion: Conduct field studies to identify:

1. Religious beliefs and their relationship to reducing the level of anxiety and depression among those affected by the ISIS invasion in Iraq.
2. Religious beliefs and their relationship to anxiety and depression among the Assyrian Christian community in northern Iraq.
3. Religious beliefs and their relationship to demographic variables (age, gender, economic status, education).

The effectiveness of a psycho-religious program in modifying negative religious beliefs to raise levels of mental health.

implementing constructive coping strategies for adolescents.

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Stigma associated with mental disorders (transcultural and religious aspects)

Abstract: This article explores the issue of stigma surrounding people with mental health conditions and psychiatry, with a focus on the transcultural and religious dimensions of its manifestation and study. The historical development of attitudes towards people with mental illness in different cultures and religious backgrounds is discussed. It is stressed that, despite advances in the pharmacological treatment of mental illnesses, stigma continues to be a significant obstacle to effective treatment, recovery, social reintegration of patients, and the attractiveness of psychiatry as a career. The influence of stigma and self-stigma (self-stigmatization) on seeking help, adherence to therapy, and quality of life is analyzed. Recommendations of the World Psychiatric Association on combating stigma in psychiatry and psychiatrists are presented. Special attention is paid to recent research that demonstrates significant cultural and religious differences in the ways stigmatization manifests itself, as well as to the adaptation of diagnostic tools for studying this phenomenon. Ways to reduce stigma are discussed, such as educational programs, support for religious communities, collaboration with the media, and continued research. The prospects for further research into stigma in mental illness are explored. The complex nature of the impact of the religious factor on stigma is acknowledged, highlighting the need for a more differentiated approach.

Keywords: stigma, self-stigma, mental disorders, transcultural psychiatry, religiosity, destigmatization, stigmatization in psychiatry, psychiatrists.

Introduction

Stigma related to mental health disorders, encompassing both the stigmatization of patients and psychiatry as a discipline, continues to be one of the most enduring and harmful challenges in mental health care, even in light of considerable progress in comprehending the neurobiological basis of psychiatric conditions and in creating effective therapeutic approaches (1,21). Stigma not only exacerbates the suffering of patients themselves and their reactions to illness, but also creates serious obstacles to recovery and full participation in society. Furthermore, it undermines trust in psychiatrists and fosters a negative attitude towards psychiatry as a whole. The World Health Organization (WHO) has recognized the fight against stigma as one of the most important priorities in mental health (2).

The relevance of this report is driven by the need for an in-depth study of stigma within contemporary multicultural societies. Transcultural and religious aspects are key to understanding the variability of stigma, as notions of norm and pathology, sin and illness, responsibility and compassion are largely shaped by cultural and religious traditions (4).

The purpose of this paper is to investigate the historical foundations of mental illness stigma, its present-day realities, the consequences of stigma for patients and the perception of psychiatry and mental healthcare, considering transcultural and religious perspectives, and to propose solutions for combating stigmatization.

1. Attitudes towards mentally ill people in historical perspective: cultural and religious differences

Historical analysis demonstrates significant differences in how various cultures and religions perceived and treated individuals with mental illnesses (5).

Western culture and Christianity. Medieval Europe was dominated by a religious explanation for mental disorders, viewing them as a consequence of demonic

possession, divine punishment for sins, or witchcraft. This resulted in isolation, persecution, and "exorcism," which was often extremely brutal during that era. With the development of medicine and psychiatry in the 17th-18th centuries, the mentally ill were placed in "madhouses" (e.g., Bedlam in London), which often served as prisons rather than treatment facilities (5). However, within Christianity, particularly in Orthodoxy, and specifically in Rus', there was a strong tradition of compassionate treatment towards mentally ill individuals. This fostered the creation of special shelters attached to monasteries, where the afflicted could find shelter and solace. The Athonite elders – Saint Paisios the Athonite and Saint Porphyrios Kavsokalyvitis – taught that an individual who patiently carries the cross of a serious mental illness can be likened to a martyr.

Islamic world. During the classical period of Islam (8th-12th centuries), mental illnesses were treated more as medical rather than religious problems. Scholars such as Ar-Razi and Ibn Sina (Avicenna) developed humane treatment methods based on diet, herbal medicine, and psychotherapy (6). A call for compassion towards the weak and the sick is found in the Quran, which contributed to a generally more tolerant approach to individuals with mental disorders. Surah An-Nisa (4:5) instructs: "And provide for them (the foolish) out of the property and clothe them and speak to them words of kindness." Later, mental illness was seen as a punishment from Allah, the result of the influence of the jinn, and patients were excluded from society.

Eastern cultures (India, China). In Hinduism and Buddhism, mental disorders were conceptualized as either the consequence of karma from past lives or a disharmony in corporeal and spiritual energies. This interpretation, on the one hand, could lead to fatalism, but on the other hand, it did not entail moral condemnation, as in Abrahamic religions. In traditional Chinese culture, mental illness was often considered a source of shame for the entire family, which fostered its concealment and the isolation of the individual suffering from it (7).

These historical examples illustrate how cultural and religious paradigms have shaped the foundation for modern stigmatizing attitudes.

2. Stigma in the dawn of psychopharmacology: conceptualization and negative impact

Despite the "pharmacological revolution" in psychiatry during the second half of the 20th century, stigma not only persisted but also acquired new forms.

The concept of "stigma" originates from the Ancient Greek word *στίγμα* (stigma) – meaning "mark, brand, tattoo, spot, or blemish." Historically, "stigma" was used to brand slaves and criminals.

Currently, the concept of "stigma" is used as a social label that shapes a negative attitude of others towards an individual, or towards oneself. Examples of stigma can include physical and personal characteristics, sexual preferences, social status, belonging to a particular race, nationality, religion, and so on. Stigmas inherently lead to negative consequences for individuals or groups, manifesting as discredit, devaluation, rejection, discrimination, and social isolation.

The foundations of the modern study of stigmatization and mental stigma were laid by Irving Goffman in 1963, who defined it as a "discreditable attribute" (8). Subsequently, the concept was expanded, and currently, the notion of stigma encompasses:

- **Institutional stigma** – discrimination embedded within institutions (laws, healthcare).

- **Public stigma** – negative stereotypes and discrimination from society.

- **Self-stigma (internalized stigma)** – a psychological phenomenon where individuals, due to negative social conditioning, internalize and apply societal biases

and discrimination to themselves (9).

The negative impact of stigma is multifaceted and leads to:

- **Deterrence from seeking help:** The apprehension of being branded "mentally ill" compels individuals to postpone or shun professional consultations.

- **Impaired treatment adherence and compliance:** Self-stigma can foster the belief that "treatment is useless," contributing to medication non-adherence.

- **A decline in quality of life:** stigma results in social isolation, challenges in finding employment and housing, and poverty (10).

Stigmatization can act as a "second illness" in itself: the psychological weight of stigma often creates further stress and distress, intensifying the primary disorder.

Stigmatization often extends not only to patients but also to their family members, relatives, and children. It can also affect communication and socialization processes.

Thus, stigma acts as a powerful barrier, undermining clinicians' efforts and hindering the process of rehabilitation and socialization.

3. Stigmatizing psychiatry and psychiatrists

The stigma is not limited to patients; it also encompasses psychiatry as a field and psychiatrists as practitioners. The World Psychiatric Association (WPA) has designated the fight against the stigmatization of psychiatry as a key priority (2). For centuries, public opinion regarding psychiatric institutions has been negative, often associated with large, closed-type facilities (11). Psychiatric hospitals are frequently portrayed in the press as places of confinement, and the term "psychiatry" is sometimes used by non-specialists in the context of ineffective treatment and punitive approach to patients (12,13). Up to the present time, there has been a low level of awareness among the population of European countries about the difference between a psychiatrist, a psychologist, and a psychotherapist (16).

4. Transcultural and religious dimensions of stigma understanding in modern research

Current studies strongly indicate that the prevalence and manifestation of stigma exhibit crucial differences across various cultures and are intrinsically tied to religious convictions.

The comparison of Abrahamic and Eastern religions, presented in the study by Papadopoulos et al. (2021), showed that in cultures dominated by Abrahamic religions (Christianity, Islam, Judaism), where the concept of personal responsibility and sin is strong, stigma often carries a morally judgmental character (24). Meanwhile, in cultures influenced by Eastern religions (Buddhism, Hinduism), which emphasize karma and determinism, stigma can manifest as social distancing and a fatalistic acceptance, accompanied by a reduced sense of guilt in the patient.

Christianity. In Christian communities, the legacy of viewing mental disorders as demonic possession or the consequence of sin endures. Research indicates that Christian patients are more frequently afflicted with religious delusions linked to guilt and sin (27). About half of believers report that, while mental health issues can be discussed openly, stigma towards the mentally ill nevertheless endures: disorders are often viewed by believers themselves, patients, and clergy as stemming from a lack of faith (28).

Islam. In Islamic societies, mental illness can be interpreted as a punishment from Allah, the result of the evil eye, or the influence of jinn. Disclosure of mental illness is often considered "shameful" for the family (30). However, the Quran also contains direct calls for compassion, which can reduce stigmatization (30, 31).

Buddhism. Within Buddhist cultures, like in Thailand, it's common to find beliefs in supernatural reasons for mental illnesses, such as being possessed by evil spirits. The doctrine of karma can contribute to stigmatizing those who are ill, making them seem as if they "earned" their condition. While the concept of compassion (karuna) frequently helps to lower stigma, this doesn't always play out in practice. Studies suggest a potential correlation between high involvement in religious practices in some Buddhist communities and elevated stigma (25, 31).

Hinduism. Research in India reveals a very high prevalence of belief in supernatural causes among patients with schizophrenia and their relatives"(27). In the Hindu tradition, mental disorders are often explained by karma, reincarnation, lack of faith, or the "evil eye." This increases stigma, as the illness is perceived as the person's fault (31, 32).

African traditional religions. In African cultures, mental disorders are often explained by witchcraft, curses, spirit possession, or a disruption in relationships with ancestors. There are complex systems for classifying mental states, for example, among the Xhosa people in South Africa (32). Stigma frequently appears as collective shame: a disgrace to the whole family; having a mentally ill person brings shame upon the entire kin. Consequently, the illness is often hidden. It's not uncommon (in Nigeria, for instance) for a person not to be distinguished from their illness: they're not "a person with schizophrenia," but simply "mad," and their social standing is revoked (34).

Judaism. Historically, within Jewish tradition, mental disorders have been interpreted through a mystical lens, often attributed to phenomena such as spirit possession (dybbuk). In certain communities (for instance, Moroccan Jews in Israel), there is a prevalence of beliefs in demonic entities and witchcraft as underlying causes of psychological issues (33). Contemporary studies reveal a persistent, relatively high degree of stigma in Judaism, especially among Orthodox groups. This is often linked to collectivist values and anxieties about family reputation and how it affects marriage opportunities (shidduchim) (26).

Notably, religiosity is typically associated with lower stigma and improved psychological well-being, offering coping strategies for the illness and social support (40, 41). Koenig's large-scale analysis found a positive influence of religion on mental health in 40-50% of those examined (41). However, in cases of negative religiosity (e.g., the belief that illness is a punishment from God, a negative attitude from a clergyman), religiosity can significantly amplify both public stigma and self-stigma. Research also indicates that high involvement in religious practices in some communities (Buddhist, Hindu) can correlate with higher stigma (26).

5. The use of diagnostic and "measurement" tools in modern stigmatization research

In recent years, contemporary studies investigating stigma towards mental illness have actively undertaken the adaptation, validation, and application of scales for stigma assessment (for instance, the Internalized Stigma of Mental Illness scale – ISMI, and a range of other tools) in various languages and cultural groups (38). This demonstrates a growing awareness of the importance of evidence-based investigation into stigma with the use of culturally sensitive tools for an accurate assessment of the phenomenon.

6. Ways to overcome stigma: a multi-level strategy

Addressing stigma requires integrated work across different areas and levels, involving both the destigmatization of psychiatric conditions and the improvement of psychiatry's overall image. This work entails:

1) **Improving treatment and compliance.** Effective and accessible care is, in itself, a powerful anti-stigma factor.

2) **Connecting with people in recovery.** The personal stories of individuals living with and successfully navigating mental health disorders are one of the most impactful ways to shift public perceptions.

3) **Educational programs.**

Implementing psychoeducation for patients and their families fosters a better understanding of the illness, thereby reducing stigma towards those with mental health conditions and their loved ones, as well as self-stigma among patients. Public awareness campaigns, as well as targeted outreach to specific groups such as teachers, employers, and religious leaders, foster understanding of the medical nature of mental health conditions and promote acceptance of individuals with mental disorders. Equipping religious leaders with foundational psychiatric knowledge can enable them to distinguish spiritual concerns from mental health issues and refer congregants to appropriate professionals (29,39).

4) **Support groups and the role of religious communities in the destigmatization process.**

Religious communities can provide powerful social support, a sense of belonging, and meaning, serving as a buffer against self-stigma and isolation (40). Establishing self-help groups within religious institutions can be highly effective in cultures with strong religious traditions.

5) **Collaboration with media.**

It is vital for the psychiatric community to actively engage with the media to disseminate accurate information, dispel myths, and foster realistic perceptions of psychiatry and psychiatrists (2,12). Media training can equip psychiatrists to communicate more effectively with the press.

6) **Changes in psychiatric education.**

Modernizing medical school curricula to include contact with recovered patients, integrating psychiatry and neurosciences, and prioritizing practical skill development could foster more positive student attitudes towards psychiatry and boost its appeal as a career choice (2,42).

7) **Strengthening links and cooperation.** Strengthening the links of national psychiatric associations with other professional societies, patient and family associations, and religious organizations for joint work on stigma reduction (22).

8) **Psychiatrists' own conduct.** Psychiatrists must be aware that their professional conduct: respectful relationships with patients, adherence to ethical standards, and maintenance of professional competence – directly influences the image of the profession (22).

7. Understudied questions of psychiatric stigma and directions for further scientific research

While progress has been made in understanding the stigmatization of individuals with mental illnesses across diverse cultures and societies, and the impact of religiosity, many unresolved and understudied questions persist:

- Under what conditions and for which groups of people does a religious community become a resource, and under what conditions does it become a source of further traumatization?
- How can religious leaders be integrated into the support system without violating the secular principles of medicine?
- How does stigma manifest in religious and ethnic minorities?
- How can a balance be struck between the evidence base of modern psychiatry and psychology and the effectiveness (within its cultural context) of traditional

practices? Is their integration into the official healthcare system possible?

The results of studies on the stigmatization of people with mental illnesses in recent years often present contradictory data about the influence of cultural factors, destigmatization programs, and religiosity. These findings require further research and identification of effective ways to overcome stigma.

For example, the paradox of education: Many studies have shown that increasing patient awareness of their condition, especially if it is chronic and severe (such as schizophrenia), can paradoxically lead to increased self-stigmatization, reinforcing feelings of hopelessness and inevitable fate (42). It can be assumed that, in this context, spiritual support and working with the meaning-making aspects of religion can help the patient accept the diagnosis and find resources to cope with the disease, mitigating this negative effect.

The paradox of religiosity is of interest as it can act as both a powerful antistigma factor and a source of increased stigma. On the one hand, religiosity can provide compassion, community and meaning, which can help reduce the stigma associated with mental illness. However, on the other hand, dogmatism and belief in supernatural causes of mental illness can create a barrier to seeking professional help (43). The stigma-enhancing effect of religiosity may also be determined by the style of religiosity (44). Thus, dogmatic, rigid forms of religion (corresponding to manifestations of so-called "external religiosity") tend to stigmatize the "other," while manifestations of "internal religiosity," a focus on compassion and spiritual quests within religion, promote understanding and reduce the level of stigma and self-stigmatization. Therefore, modern approaches to destigmatization must focus on collaborating with religious leaders to promote evidence-based and compassionate views on mental health.

Conclusion

Stigma surrounding mental illness and psychiatry remains a complex and multifaceted phenomenon, deeply rooted in cultural and religious contexts. Science has moved away from the idea of a single "stigma" and now recognizes its multiple, culturally determined forms.

Overcoming stigma is only possible with an **interdisciplinary approach**, requiring close collaboration between psychiatrists, psychologists, anthropologists, sociologists, and theologians. Research should be **practice-oriented** and aim not just to describe but to develop specific, effective, and culturally sensitive interventions.

The paradoxical influence of factors such as education, religiosity, and awareness points to the need for further, more nuanced research that takes into account the diversity of cultural and individual trajectories. Combating stigma is not only a medical but also a sociocultural challenge, requiring the combined efforts of scientists, clinicians, the public, and religious leaders.

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Typology of life worlds as a key to understanding psychopathology of various levels. Paradoxes of universality

Abstract: This article presents a comparative analysis of two theoretical frameworks used in psychotherapeutic counseling practice. Specifically, the psychoanalytic model of the levels of psychic functioning, as developed by Otto Kernberg, is juxtaposed with the typology of life worlds proposed by F.E. Vasilyuk. Through this comparative analysis, the study identifies four distinct types of therapeutic strategies, which are tailored to correspond with the level of client's mental functioning and the type of his experience.

Keywords: psychological counseling, understanding psychotherapy, life world, levels of mental functioning, experience.

The notion of levels of psychic functioning started to form by the early 20th century in Sigmund Freud's works and was actively expanded upon within the psychodynamic approach. In 1938, Adolph Stern identified a category of neuroses that resisted classical psychoanalytic intervention, designating it as a intermediate state between neurotic and psychotic disorders. This terminology became ingrained in the psychoanalytic tradition to describe a wide group of conditions that initially did not align with existing diagnostic categories, and patients afflicted with these conditions failed to respond to conventional treatment methods. Consequently, a new category of pathologies, known as borderline conditions, was established and eventually incorporated into reference materials.

Psychology and psychiatry encompass several approaches to personality organization: descriptive, genetic, and structural. The structural approach aims to identify structures, i.e., generalized types of functioning of the personality organization. The most prominent representatives of the structural approach are Otto Kernberg (Kernberg O., 2000) and Nancy McWilliams (McWilliams N., 2001). Within this approach, personality organization is understood as a specific personality structure that develops during a person's development and determines the individual's strategy for interacting with reality, their stable stereotype of relating to the external world. The structural approach also considers the degree of ego integration, reality testing mechanisms, and the types of habitual defense mechanisms.

Thus, this approach postulates the existence of three levels of personality organization, which in this article are considered synonymous levels of mental functioning: psychotic, borderline, and neurotic. Today, reliance on this typology is an important tool for working with clients in the context of psychotherapeutic interaction. In this study, we would like to conduct a small experiment to correlate personality organization types with the typology of life worlds within the context of the understanding psychotherapy approach. This field was developed by the Russian psychologist Fyodor Efimovich Vasilyuk, building upon the methodological base of the cultural-historical approach (Vasilyuk F.E. 2023).

The understanding psychotherapy is a process-oriented approach where the psychologist interacts with the client's experience. In this context, experience, as defined by F.E. Vasilyuk, is understood as activity. F.E. Vasilyuk defines experience as "a special work of restructuring the psychological world, aimed at establishing a correspondence between the meanings of consciousness and being, the overall goal of which is to enhance the meaningfulness of life" (Vasilyuk F.E., 2023). In this context, experience is classified into types based on the type of life-world in which it occurs.

From an ontological standpoint, human experience can be understood as infantile, realistic, value-driven, and creative, and each type of experience corresponds to its own life world with a set of ontological characteristics (Vasilyuk, F.E., 2025). The experiment comparing types of psychic functioning in the psychodynamic approach with F.E. Vasilyuk's typology of life-worlds rests on the idea that, given a certain psychic organization, an experience may proceed in its own specific manner, and this specificity can take forms similar to how an experience proceeds within a particular life world.

Let us begin the analysis by comparing the *psychotic level of consciousness functioning with the infantile life world*, as defined by F.E. Vasilyuk. Within the psychodynamic and structural approach, the identity of the subject has distinct characteristics. Individuals with this type of personality organization are not consistently or fully certain of their own existence; they may occasionally question their identity. The differentiation between the self and the object of representation is either blurred or characterized by delusional identity. The observing Ego of such individuals is absent. Self-criticism regarding their state is impaired or absent. The relationship with reality is such that the ability to test reality is partially or completely lost. The person does not understand which feelings and thoughts are their own and which have come from outside. This is often accompanied by withdrawal from the external world and loss of interests. Phenomena such as drift and loss of independence in life path decision-making may also occur. Defense mechanisms employed are primitive and archaic. At the level of interaction with the body, catatonia, psychomotor agitation, suicidal attempts, and paroxysms are often encountered. Coping with stress is predominantly mediated through bodily responses, with limited involvement of the psyche.

According to F. E. Vasilyuk, the *infantile life world* is characterized by an infantile experience, which can be described as the interaction between mother and infant. In the infantile life world, the identity of the subject is virtually nonexistent due to the complete symbiosis with the mother. At the infancy stage, it is also difficult to speak about the level of identity formation. The observing self is attributed to the mother. The capacity for reality testing is in its nascent stages and has not yet been sufficiently developed. At this phase of life, the infant utilizes the earliest defense mechanisms. The image of mother cannot be comprehended and separated due to the infant's age. The infant experiences the mother as an integral part of himself. The ability to engage in social interactions and perform work-related activities has not yet matured. Stress experiences predominantly manifest on a somatic level. There are several common features that suggest infantile experience dominates in psychotic personality organization.

Let's compare the functioning of the psyche in a *borderline personality organization with a realistic experience*. In the psychodynamic approach, in borderline personality organization, the level of identity is associated with the complexity of identity integration. The sense of self is often characterized by contradictions and gaps, and the distinction between oneself and others is blurred. The ability to recognize one's own pathology is significantly impaired. Despite these identity challenges, individuals are aware of their condition. Reality is often perceived through a binary lens, with little room for nuance. Defense mechanisms tend to be primitive, including splitting, negation, projective identification, omnipotence, devaluation, and idealization. Descriptions of significant others are often flat, global, and overly simplistic, reflecting a "black and white" approach. Symptoms at the level of body interaction are marked by poor body awareness and a vegetative component. Individuals with this condition may frequently engage in self-harm, ranging from cuts and burns to self-injury in the gym, as well as suicidal attempts, promiscuity, and other sexual aberrations. The discrepancy between their perceived body and reality is manifested in the desire to explore it

through tattoos and piercings. In terms of interaction with reality, these individuals exhibit instability, impulsivity, shifting goals, a propensity for chemical and non-chemical dependencies, and a tendency to form intense and painful relationships.

According to F. E. Vasilyuk, the *realistic life world* is marked by a straightforward inner experience and a focused pursuit of goals. The process of identity formation continues intensively, but due to its internal simplicity, it has not been completed. The self-image is fragmented. The ability to critically evaluate oneself is not fully developed, as it requires the guidance of a significant other who is able to give an assessment. Despite this, the self-image is beginning to take shape. Interaction with reality is hindered by a tendency to overlook certain contexts. The primary objective in this life world is to achieve goals at any cost. Defense mechanisms are underdeveloped and immature. Coping strategies include patience, persistence, and aggression. The role of the significant other is simplified, with a need for a reliable adult who provides care, establishes rules, and assists in goal attainment and managing frustration. As we can see, the realistic type of experience fits quite naturally into the borderline level of the psyche's functioning.

The *neurotic level* of personal functioning forms a continuum that ranges from a state of relative normality, i.e. health, to a state of neurosis. Now let's compare the functioning of the psyche in a neurotic organization during a neurotic episode with a value experience. In the psychodynamic approach, a neurotic personality maintains a degree of integrity and stability, with the ability to experience and reflect on their own experiences. Such individuals have a clear distinction between their Self and object representations. The relationship with reality is characterized by reliable contact and the capability to differentiate between Self and non-Self. The defense mechanisms employed by such individuals vary from primitive to mature, with a preference for more mature strategies. Descriptions of significant others are generally detailed and multifaceted, and these descriptions do not typically cause difficulties. Contradictory images of both Self and others are integrated into a cohesive conceptual framework. An internal crisis is often a manifestation of a neurotic conflict. Symptoms at the bodily level frequently manifest in conversion symptoms, such as neurological and somatic manifestations of psychogenic origin, as well as somatoform disorders. Neurotic disorders accompanied by secondary physical symptoms – somatization, which can occur through psychovegetative, psychoendocrine, or psychoneuroimmune mechanisms by displacing internal conflicts or other disturbing content into the body. At the level of interaction with reality, social, situational anxiety, neurotic (not endogenous, but existential) depression, and demonstrative behaviors are typical. Many neuroses involve internal conflicts arising from conflicting rules, values, or situations.

According to F. E. Vasilyuk, the *value-based life world* is characterized by a value experience in which the internal world is complex, and this experience tends to organize value constructs. A complex internal world enables the formation of an observing Self. The external world is perceived as luminous, allowing for detachment from reality and increased focus on internal processes. The developed observing Self facilitates the differentiation of the Self from the non-Self. The internal reflective component enables the creation, hierarchization, and re-hierarchization of values through mature forms of cognition. Mature mental mechanisms allow for the formulation of comprehensive concepts regarding other parties to relationships and concepts that incorporate beliefs and values. The internal critical condition is conflict. Consequently, the neurotic level of mental functioning, characterized by the presence of neurosis, aligns organically with the value experience and its internal conflicts.

Finally, the neurotic level of personal functioning within the conditional norm is comparable to a creative experience. In the psychodynamic approach, at the neurotic level of personality organization in a state of conditional norm, identity is characterized

by its integrity. Even amidst emotional outbursts and related stressors, an individual maintains their rational and objective faculties. Their connection to reality remains stable. They rely on more sophisticated defense mechanisms, such as sublimation and compensation, to shield themselves from internal conflicts. He demonstrates is a significant degree of adaptation. Possible symptoms at the level of interaction with the body can be caused by good physical contact, the ability to perceive and feel one's body and its needs. In terms of interaction with reality, cooperation is exemplified by incorporating society, resources, and knowledge into coping processes.

According to F. E. Vasilyuk, the *creative life world* is characterized by a creative experience with complex internal life and a challenging external environment. A mature identity is able to rely on its own values and adapt its value system as it evolves. The individual demonstrates resilience in the face of the instability inherent in other parties in relationships. Relationships with reality are grounded in awareness and the utilization of external challenges, diversity, and opportunities. Creative processes, sublimation, and reliance on cultural experiences (education, self-improvement) are instrumental in driving personal growth. Knowledge acquisition expands the range of available resources. The subject has a high level of symbolic representation of his experiences. Significant others can be integrated into their life concept at the level of life meanings. An individual has the ability to include subjects in co-creative, partnering, and co-research relationships. Also, there is an ability to effectively manage stress, frustration, and internal conflicts. An internal critical situation represents a life crisis that necessitates the establishment of new value guidelines. The body is regarded as an asset, appreciated, developed, and meticulously maintained. Reality is perceived as a domain of possibilities and prospects. As we see, at the neurotic level of mental functioning, creative experience is realized most concisely within the context of mental health.

How can this comparison be useful for practicing psychologists? Based on the type of mental functioning, a therapist can suggest which type of experience is most dominant in a particular client and therefore more precisely formulate psychotherapeutic intervention strategies. When confronted with a client's dominant infantile experience, the therapist's role may resemble that of a nurturing parent, with the focus on socialization and adaptation being facilitated by healthcare and social assistance organizations and structures, which can be conceptualized as serving a collective parental function. It is crucial to integrate the client's family members into a supportive interaction strategy. Psychotherapeutic tactics encompass the use of gentle, nuanced interventions aimed at integrating disparate elements of the client's experience and evaluating them through the lens of reality. The acute mental states of the client may be interpreted as symbolic regressions to the perinatal period, while hospitalization can be seen as a metaphorical representation of the womb environment.

When facing a *realistic experience*, the **therapist's role** can be seen as an "anchor" of sorts. This role involves being a stable adult who can withstand the emotional turbulence of the client. Given the client's internal simplicity, it can be challenging for them to grasp and process the experience independently. The psychologist steps into a position where they reflect on the client's experience from outside of it, acting as a unifying figure that integrates disparate elements of the client's experiences. The relationship between the psychologist and the client serves as a mirror to the client's relationship with the world. The journey from achieving clarity in their relationship with the therapist leads to a clearer understanding of their relationship with reality.

When encountering a client's *value experience, neurosis, or internal conflict*, the therapist's position may resemble the role of a detective and be realized in a joint search for an internal conflict, an opportunity to uncover it, identify the field around the conflict, and co-examine the client's values and attitudes.

When encountering a *creative experience*, the psychologist's approach to the client aligns with the stance of the philosopher-interlocutor. This involves facilitating introspective reflection on the client's life trajectory and assisting in identifying available resources for support, ensuring a comprehensive arsenal of assistance. The objective is to stimulate an alternative perspective on the issue, to aid in uncovering new life meanings and to facilitate the exploration of opportunities for their realization.

Vasilyuk's classification of life worlds is universally applicable and highly beneficial both in a theoretical context and in practical implementation. The correlation between life world typology and the psychodynamic model of mental functioning offers a valuable methodological tool for the practice of psychological counseling.

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The relationship between spiritual well-being and destructive personality traits

Abstract: In 2025, Priest Ioann Bakushkin and R.V. Ershova, PhD in Psychology and Professor at the RUDN University, adapted the Russian version of the "Scale of Spiritual Well-Being" questionnaire, which is used globally as a psychometric instrument. A study was also conducted involving 959 participants to explore the relationship between spiritual well-being - as an integral and systematic indicator of health and life satisfaction - and destructive personality traits such as Machiavellianism, psychopathy, narcissism, and sadism. This area remains one of the least studied, and no similar studies have been conducted on Russian samples before. The findings suggest that the connection between spiritual well-being and negative personality traits is not simply negative, but rather involves complex interactions. The key finding was the change in the association between psychopathy and religious well-being, from a negative correlation in the one-dimensional model to a positive correlation in the multidimensional model, when controlling for sadism. This study allows us to better understand spiritual well-being as a significant factor contributing to the psychological health and social adjustment of individuals who are prone to deviant and anti-social behavior.

Keywords: scale of spiritual well-being, spiritual well-being, religious well-being, existential well-being, personality traits, "dark tetrad", Machiavellianism, narcissism, psychopathy, sadism.

The word "spiritual" originates from the Latin term *spiritualis*, which in turn derives from the Greek word *pneumatikos*, as evidenced in the epistles of the Apostle Paul to the Romans and Corinthians. Subsequently, a spiritual person was considered to be one with whom the "Spirit of God" dwelled or whose life was influenced by this "Spirit" (Sheldrake, 2007). Throughout much of history, the terms "spiritual" and "spirituality" were understood as exclusively religious. Up until the mid-20th century, "religion" and "spirituality" were used as interchangeable terms (Paloutzian, 2006). In the process of secularization, the term "spirituality" has come to be used as a substitute for "religion" by individuals who dislike what is typically implied by religion. Spirituality is a broader concept than traditional religion, encompassing an orientation towards a higher power, values, and principles distinct from any church, synagogue, mosque, shrine, or group of people. Religions are characterized by adherence to a belief system, while spirituality can exist without sacred texts or a defined creed, and doesn't necessarily entail a belief in the supernatural.

In psychology, spirituality is a complex, multidimensional concept that manifests as a striving for and experience of connection with oneself, with other people, and with the transcendent. This connection can be experienced intrapersonally (as a connection within oneself), interpersonally (in the context of others and the natural environment), and transpersonally (referring to a sense of connection with the unseen, God, or a power greater than ourselves) (Reed, 1992). Spirituality serves as a wider concept, covering a range of beliefs, values, principles, and sources of meaning. Spiritual well-being, in contrast, is a distinct measure of how these beliefs are realized in practice and shape a person's lived experience.

One of the most extensively studied methods for measuring spiritual well-being is the Spiritual Well-Being Scale (SWBS), developed by R. Paloutzian and C. Ellison (Paloutzian & Ellison, 1982), which simultaneously investigates religious and existential well-being. The questionnaire measures an individual's overall perceived spiritual quality of life. When people refer to their spirituality, they typically mean

either their relationship with God or what they understand as their spiritual being, or their sense of life satisfaction, purpose, and meaning. "The Spiritual Well-being Scale measures self-rated well-being, as understood by individuals within the context of the word "spiritual," but it is not spirituality itself nor an indicator of spirituality (Garssen et al., 2016). It is an indicator of well-being-health, reflecting how the respondent understands and evaluates it within a "spiritual" context. The Spiritual Well-being Scale is a construct consisting of two subscales: religious and existential well-being." Assessment of religious well-being is conducted through questions containing the word "God," describing a person's experience of connection with God or the transcendent. Assessment of existential well-being occurs through questions that demonstrate the ability to adapt to life circumstances and surroundings, and characterize a person's perception of their life experience (Boivin et al., 1999). Since the questionnaire has two subscales: Religious Well-Being (RWBS) and Existential Well-Being (EWBS), it is a non-denominational instrument (Paloutzian et al., 2021). This questionnaire was translated and adapted for a Russian-speaking sample only in 2025 by I.A. Bakushkin and R.V. Ershova (Bakushkin & Ershova, 2025).

The relationship between spiritual well-being and destructive personality traits has received very little research attention. The "dark tetrad" is a term that groups together a cluster of "negative" personality traits: Machiavellianism, subclinical psychopathy, subclinical narcissism, and subclinical sadism. The interrelation of these traits is grounded in personality attributes such as emotional coldness, low agreeableness, a predisposition to deception, primary psychopathy, and high self-regard. Machiavellianism involves a tendency to manipulate others, emotional coldness, cynicism, and diminished empathy (Johnson et al., 2019). Nonclinical narcissism is described as a sense of superiority, grandiosity, and a drive to exploit others for personal gain (Paulhus & Williams, 2002). Research findings suggest that narcissism, in comparison to two other traits, can be viewed as a positive aspect of the "dark tetrad," as it shows positive associations with extraversion, openness to experience, verbal intelligence, and tolerance for ambiguity (Krasavtseva & Kornilova, 2019). Non-clinical psychopathy includes characteristics such as impulsivity, aggression, callousness, low anxiety, and a propensity for deceit. The phenomenon of ordinary, everyday sadism is considered a normative personality trait characterized by a tendency to humiliate others, inflict physical, sexualized, or psychological suffering for one's own satisfaction (Atajykova & Yenikolopov, 2021), heartlessness, impaired empathy, pleasure in causing pain to others, and dominance.

Materials and methods

The study was conducted on a Russian-speaking sample of 959 respondents (761 women and 198 men) with a mean age of 38.6 ± 14 years. Spiritual well-being was assessed using the "Spiritual Well-being Scale" adapted by I.A. Bakushkin and R.V. Ershova (2025). Personality traits, specifically Machiavellianism, narcissism, psychopathy, and sadism, were diagnosed using the Short Dark Tetrad Questionnaire adapted by D.S. Kornienko, V.K. Vyazovkin, and I.S. Gornostaev (2022). For data analysis, the R statistical computing environment (version 4.5.1, R Foundation for Statistical Computing, Vienna, Austria) was utilized, along with descriptive statistics, Spearman's rank correlation coefficient (ρ), and simple and multivariate linear regression analysis.

Results

The study's results demonstrated a confirmed negative correlation between spiritual well-being characteristics and "Machiavellianism," "psychopathy," "narcissism," and "sadism" through correlational analysis. Nevertheless, univariate and

multivariate regression analyses uncovered intricate interactions between the examined personality traits. In the multivariate model, a key outcome for Religious Well-Being (SWBS) was the shift in the association of "psychopathy" from negative ($\beta=-0.44$ [95% CI: -0.61; -0.28]) to positive ($\beta=0.38$ [95% CI: 0.21; 0.55] $p<0.001$), after accounting for the impact of sadism. Narcissism significantly contributes to indicators of existential well-being and overall spiritual well-being ($\beta=0.32$ [95% CI: 0.22; 0.42] $p<0.001$ and $\beta=0.26$ [95% CI: 0.07; 0.46] $p=0.009$, respectively).

Conclusions

The conducted research revealed complex and ambiguous interrelationships between the "dark tetrad" traits and various aspects of spiritual well-being in a non-clinical sample.

The results confirmed the overall hypothesis of a negative association between destructive personality traits and spiritual well-being. Correlation analysis revealed statistically significant inverse correlations between most components of the "dark tetrad," subscales of religious and existential well-being, and the overall and specific measures of spiritual well-being. Translation: Sadism proved to be the most potent negative predictor, highlighting the significant contribution of heartlessness and cruelty to the decline in an individual's overall spiritual well-being.

The most crucial research finding was the discovery of the ambivalent role of certain "dark tetrad" traits when their synergistic influence was considered in multifactorial models:

- Narcissism has demonstrated the potential for positive influence. When controlling for other destructive traits (such as sadism and Machiavellianism), its adaptive aspects (confidence, self-esteem) became a significant positive predictor of both existential and general spiritual well-being. Thus, narcissism is not a completely destructive trait when it comes to finding meaning in life and achieving self-realization.

- Psychopathy demonstrated a similar paradoxical effect concerning religious well-being. When isolated from sadistic tendencies, its components (impulsivity, reduced anxiety) can contribute to its increase, possibly due to a propensity for sensation-seeking that may find an outlet in religious practices. This suggests that in the case of a complete absence of sadistic traits associated with cruelty and callousness (sadism), psychopathy (impulsivity, aggressiveness and reduced anxiety) can lead to an increase in religious well-being.

This study allows us to better understand spiritual well-being as a crucial factor in the mental health and social adjustment of individuals who are prone to deviant or antisocial behavior.

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Personal religiosity as a psychological phenomenon

Abstract: This article explores personal religiosity as a psychological phenomenon within the context of Russian psychology. It analyzes various approaches to conceptualizing religiosity through key psychological constructs: meaning, experience, attitude, self-awareness, and psychological tools. The article notes a trend toward the legitimization of religiosity in Russian psychological science and the overcoming of its pathologizing interpretations. The proposed three-level model allows for the differentiation between religiosity in norm and pathology, while the concept of personality serves as a bridge between psychology and theology in the interdisciplinary study of religious experience.

Keywords: religiosity, spirituality, activity, consciousness, personality, mental illness.

Human religiosity remains largely terra incognita within modern Russian psychology. For far too long, Russian science and philosophy viewed religion as little more than a 'cultural-archaeological' exhibit. Breaking away from this stereotype and perceiving it as a living phenomenon, rather than a mere relic of the past, has proven to be a difficult task.

The study of religiosity in Russian psychology, as we see it, follows two paths: 1) the application of Western models of religiosity to the domestic context, and 2) the development of a domestic approach through establishing links between religiosity and the psychological concepts that form the foundation of various classical Russian psychological schools. The first approach, which frequently leans on quantitative methods, is favored in academia for its ease of analysis. However, the downside is that applying these polished findings to real-world psychological practice often hits a wall: the actual local client, who does not necessarily think in the categories typical of Western psychological frameworks.

The second approach involves developing a domestic perspective based on existing indigenous psychological theories, which are often articulated through a specific key concept.

Examples of such concepts include: '*meaning*' within the framework of the spiritual level of the meaning sphere of consciousness, as proposed by B.S. Bratus (B.S. Bratus, 2019); and '*lived experience*' (*perezhivanie*), the psychological impossibility of which, according to F.E. Vasilyuk, leads to prayer (F.E. Vasilyuk, 2005). According to A.M. Dvoynin, faith is conceptualized in two ways: first, as a context for the formation of *value-meaning orientations* that shape the content of self-consciousness structures (following V.S. Mukhina, 2007); and second, as a distinct internal stance toward the world—a specific instance of the psychological category of '*attitude*' established by A.F. Lazursky and V.N. Myasishchev (A.M. Dvoynin, 2014). For instance, the author examines the images of heaven and hell as *psychological tools*, a concept introduced by L.S. Vygotsky (A.M. Dvoynin, 2025). It can be hypothesized that, at the present stage, virtually every domestic psychological approach seeks to establish a meaningful connection with the phenomenon of religiosity.

In this process of correlating phenomena of inner religious life with psychological concepts, one can discern an attempt to legitimize human religiosity within Russian psychological science. Religiosity is transformed from something secret, mystical, or, conversely, eccentric and alienating, into a phenomenon that is comprehensible and integrated into the general psychological context. Religiosity is also

being cleared of the pathological stigma often attached to it by psychiatry and clinical psychology.

The multiplicity of psychological concepts employed (meaning, experience, attitude, self-awareness, tool) does not, in our view, indicate a failure in the process of correlation; rather, it serves to confirm the anthropological thesis of the Russian philosopher V.V. Zenkovsky that spirituality (specifically, religious spirituality) 'in man is not a separate sphere, not some special and isolated life¹, but a creative force that entelechially permeates the entire life of a person (both soul and body) and determines a new "quality" of life' (V.V. Zenkovsky, 1993).

While the first dimension of spirituality—its integration with the entire psyche—has been thoroughly examined through conceptual correlation, the second—the transformation of life's quality—is often sidelined. One must wonder: do attempts to frame religiosity as a psychological phenomenon inadvertently reduce it to psychology alone? Does it become nothing more than a meaning, an attitude, a tool, a coping mechanism, and so on?

We believe that the value of the psychology of religion will be significantly enhanced if it adopts an interdisciplinary approach, which can only happen when the phenomenon and the term describing it are common to both disciplines. For psychology and theology, personality is one such concept.

While this report cannot offer a comprehensive overview of theological approaches to the person, it is worth noting that current theological interest in this subject stems from the neo-patristic school—specifically from Vladimir N. Lossky, who is frequently cited as the leading Russian personalist. His view of the person as something irreducible to nature—free, yet accountable for the realization of the image of God within humanity—closely aligns with the Russian psychological tradition. In this tradition, personality is viewed as a tool for fulfilling human nature, one that embodies the principle of relating to the 'Other' and accepts responsibility for one's actions, particularly those of a moral nature (Lossky, 2000; Bratus, 2019).

In the tradition of the Moscow School of Psychology, personality is conceptualized in relation to two other constructs: consciousness and activity. This framework finds its most crystallized expression in A.N. Leontiev's seminal work, *Activity, Consciousness, and Personality* (1975). Here, consciousness is regarded as an internal process driven by activity, and personality is defined as the sum of social relations manifested through activity. In healthy individuals, activity, consciousness, and personality are intrinsically connected. However, in cases of mental pathology, which is frequently marked by fragmentation and the breakdown of these ties, these psychic components may function independently. As B.V. Zeigarnik, a pioneer of Russian pathopsychology, observed, this phenomenon allows pathology to highlight and distinguish elements that are otherwise merged and indivisible in a healthy psyche.

Examples of religiosity in individuals suffering from severe mental disorders allow us to hypothesize the existence of three levels of religiosity: consciousness-based religiosity, activity-based religiosity, and personality-based religiosity. (One of the foundations for this hypothesis is our previous theoretical analysis of the psychological aspect of faith, which enabled us to distinguish faith as a component of consciousness, faith as an aspect of activity, and faith as an aspect of personality (A.V. Nemtsev, 2025)).

An example of religious consciousness can be seen in numerous cases of mentally ill individuals whose primary motivation for religiosity is symptom relief. For instance, in our pilot study conducted in collaboration with psychiatrists from the Department of Transcultural Psychiatry at the Mental Health Research Center

¹ Not intersecting with the psyche, or intersecting only in a narrow place. – A.N.

(Moscow), a 29-year-old man participated who finds that attending church helps him cope with auditory hallucinations, which he attributes to evil spirits; this practice brings him to a stable emotional state and enables him to continue functioning in daily life. At the same time, the young man's life itself, his goals, and his activities are essentially unrelated to religion. For instance, he devotes his time to DJ training, online social interaction, and the like. It can be concluded that in this case, religiosity, while becoming a part of his consciousness, serves to integrate that consciousness. However, his actual activities, goals, and personal meanings remain unaffected by this religiosity.

It can be hypothesized that this level of religiosity is characteristic of the patient group identified by researchers at the Department of Transcultural Psychiatry of the Mental Health Research Center (MHRC) using clinical psychiatric methods. This group was characterized by a sharp increase in the significance of religiosity at the onset of the disease and a subsequent decline, leading to the abandonment of religious life, upon the remission of psychotic symptoms. The function of religiosity here is to provide a sense of wholeness to consciousness. Upon the resolution of symptoms, this function loses its relevance

At the second level, religiosity permeates the activity-related component of the psyche. Once integrated into one's activity, it engages with various structural elements—such as objectives, operational procedures, and performance outcomes—thereby influencing both success and failure. For instance, a woman suffering from an endogenous mental disorder (67 years old) describes how she invokes God's help to refuse a difficult request from her daughter. Or consider a patient (55 years old) who, during a severe life crisis (dismissal from a high-ranking position), sets a goal to strictly follow all church precepts. Yet, when asked about the meaning of life, she admits, even years later, that she lost it the moment she was fired. In this case, religiosity provides integrity to the behavioral component of the psyche, but does not reach the personal (existential/meaning-making) level.

Finally, the third level of religiosity is the personal level. In this case, religiosity enters the realm of personal meanings (a concept introduced by A.N. Leontiev). It might seem that patients who answer 'the salvation of the soul' when asked about the meaning of life belong to this group. However, the ease, speed, and 'rote' nature of their response suggest a theological rather than a psychological content. The meaning of life, like any personal meaning, is in most cases the result of profound experiences (often crisis-related, as F.E. Vasilyuk suggests), of suffering, and of the development of one's meaning sphere through hierarchization — that is, the prioritization of certain meanings over others.

Paradoxically, the refusal of a specific patient (35 years old) to answer a question about the content of her meaning of life, while acknowledging its existence, may be more meaningful. This reminds us that the personality is a mystery (F.E. Vasilyuk, 2005), and the meaning of life — the semantic core of the personality — is the heart of this mystery. This brings us back to that healthy sense of mystery in religiosity, which implies not mystical obscurity or vagueness, but the non-predetermined nature and freedom of a person's response to God's call. Perhaps the psychologist's task is not to definitively uncover the meaning of a person's life or to lift the veil of mystery, but rather to support the individual in their search for this meaning.

We posit that the psychological function of personal religiosity is to create a sense of wholeness within one's meaning system by weaving together hard-won personal meanings with religious ones, connecting them to each other and to the individual as a complete human being.

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A theological exploration of the concept of pharmacological enhancement of morality

Abstract: Within current international scientific discourse, the application of pharmacological means as an alternative to conventional approaches to moral development is gaining increasing attention and discussion. These agents, by affecting the central nervous system, are thought to potentially influence human behavior and moral choices. The report analyzes a radical idea in this field, practically demonstrated by the famous "Good Friday Experiment" in the USA in 1962. The experiment's core objective was to deliberately enhance a person's moral condition by facilitating a mystical religious experience via a psychoactive substance. The unique aspect of the experiment was the synthesis of psychopharmacology and mystical experience: the goal was to induce a profound spiritual experience of "communion with God," which, according to the experiment's authors, was intended to lead to a lasting moral transformation of the individual. The report presents a theological assessment of this concept of "moral enhancement" from the standpoint of the patristic heritage of the Orthodox Church and the principles of Orthodox anthropology.

Keywords: human enhancement, moral enhancement, psychoactive substances, psychedelics, mysticism, delusion, Orthodox anthropology, theological assessment, morality, ethics.

Introduction

Today, the possibility of developing human enhancement technologies is being explored in three main areas: physical, cognitive, and moral. Of the three areas mentioned, the field of moral enhancement is of particular interest to theological science. In this field, an attempt is being made to replace the natural mechanisms of human moral formation with external technological tools.

The idea of moral human enhancement is based on the possibility of the inevitable self-destruction due to uncontrolled and improper use of technological advancements. It is believed that moral decline or underdevelopment in individuals can lead to the misuse of modern technology for evil purposes against the outside world. At the same time, moral enhancement is presented as an effective and guaranteed solution to aggression, hatred, violence, and racial discrimination in the world. While this idea may seem positive, it could be seen as contradictory to the concept of human perfection in Christian tradition through deification.

The concept of "moral enhancement" was first introduced in scientific literature by the English philosopher and bioethicist, T. Douglas. He published an article with the same title, "Moral Enhancement," in the *American Journal of Applied Philosophy* in 2008 [Douglas, 2008]. In this article, Douglas argues for the permissibility of using moral enhancement to improve human morality. In the same issue of the journal that discussed human improvement, another article was published by I. Persson and J. Savulescu, where the authors discussed the necessity and importance of moral enhancement for the safe future of humanity [Persson, Savulescu, 2008].

These two publications laid the groundwork for further discussion about the possibility and desirability of technologically enhancing human moral qualities, a topic that is still being debated today.

The main tools of moral enhancement today include genetic technologies, neurotechnology, and pharmaceutical technologies.

Genetic technologies for moral enhancement

The first group of technologies related to moral genetic enhancement is focused on the formation of human morality at an early stage of planning. Obviously, any parents of an unborn child tend to think and worry about what their child will be like. The results of recent studies in behavior genetics suggest that our moral qualities are not only shaped through upbringing but also may be inherited. Regardless of the relative contribution of genetic and nongenetic factors in shaping a person's moral character, these studies raise the question of whether and how genetic engineering could be used to create moral qualities in future generations [Popova, 2020].

It is assumed that the main focus of moral genetic enhancement will be on hormones (and their associated receptors) that predispose us towards greater empathy or concern for justice. Oxytocin, cortisol, and testosterone, for example, are thought to influence empathy, aggression, trust, and the tendency to care about justice.

Proponents of moral enhancement suggest that we could identify and select clusters of genes that influence hormones in a way that could predictably make people more generous or develop a stronger sense of justice. Research is also ongoing to identify a genetic predisposition towards empathy or aggression [Caspi, 2002].

Neurotechnologies for moral enhancement

The second category of tools for moral enhancement includes neurotechnology. Current research suggests that non-invasive brain stimulation can influence certain cognitive and emotional processes related to moral behavior, potentially leading to increased moral development. It should be noted that brain stimulation does not enhance any specific moral capacity, but rather alters certain neuropsychological processes that influence moral behavior. Enhancing these processes may lead to more ethical conduct in some circumstances and less ethical behavior in others.

Thus, suppression of the activity in the right dorsolateral prefrontal cortex reduces the impact of harm on decision-making, both when committing harmful actions and when responding to harmful or unfair actions by others. This decreases the likelihood of making decisions to punish or disapprove of potentially morally harmful actions by others. However, it also increases the likelihood of harmful actions, such as lying or reacting aggressively. In contrast, excitatory stimulation of the right dorsolateral prefrontal cortex reduces aggression and promotes adherence to social norms. Collectively, these findings suggest that the right dorsal prefrontal cortex plays a significant role in the development of aversion to harm, motivating people to avoid causing harm to others and to punish those who do harm [Darby, 2017].

As for technologies such as transcranial direct current stimulation and deep brain stimulation, there is currently no conclusive evidence to suggest that these techniques can influence a person's moral development.

Meanwhile, some researchers have proposed the idea of performing neurosurgical interventions on psychopaths or individuals who have committed sexual offenses in order to improve their moral conduct. These proposals are supported by the successful treatment of hyperaggression in individuals with severe intellectual and physical impairments through neurosurgery, as well as the use of psychosurgery during the 1970s.

The main focus of such brain stimulation technologies today is primarily on therapeutic applications, such as preventing criminal acts and managing antisocial behavior.

In particular, the main goals of deep brain stimulation applications are focused on:

- reducing aggression,
- regulating sexual activity,

- reducing psychopathy and sociopathy.

Sabine Müller, a German bioethics researcher and PhD in psychiatric neurosurgery, believes that based on the current state of knowledge and discussions, the question of whether it is possible to improve morality through neurosurgery can be answered in the following way. It is theoretically possible that neurosurgical interventions could enhance self-control and, consequently, possibly also moral decision-making. However, this is still a speculative idea due to the lack of empirical evidence to support it. However, in terms of reality, reducing aggression or sexual desire can make moral resolve less demanding, reducing the likelihood of aggressive and sexually deviant behavior. This, however, would not be a moral improvement, but rather a behavioral one, as a person's moral abilities and attitudes would not improve [Müller, 2018].

Pharmacological technologies for moral enhancement

The debate about moral enhancement through pharmacology is becoming more and more popular due to advancements in neuroscience. These advancements have led to the discovery and improvement of models of human behavior, as well as the possibility of influencing the neural structure that underpins behavior.

Based on a review of the literature on potential areas for pharmacological intervention, three main categories of interventions can be identified [Macpherson, 2019].

The first category includes pharmacological interventions that affect romantic and emotional relationships, such as attachment, trust, intimacy, fidelity, and marital stability. It also includes interventions related to love addiction and jealousy. The main neuromodulators involved in this process are oxytocin, testosterone, dopamine, vasopressin, and corticotropin-releasing hormone. The use of pharmaceutical drugs in this category raises a moral dilemma regarding their appropriateness for resolving marital conflicts or improving communication skills, fostering attachment, and enhancing emotional well-being. The main ethical concern regarding these interventions is the authenticity and sincerity of the loving and emotional bonds that may arise under the influence of neuromodulators.

The second category of interventions focuses on social behavior, understanding, and altruism. These interventions aim to change behaviors such as racial bias, trust, cognitive empathy, altruism, and aggressiveness. These changes are mediated by the use of selective serotonin reuptake inhibitors, oxytocin, methylphenidate, and methylenedioxymethamphetamine. However, the moral dilemma with these interventions is the potential for the artificial development of altruism and sociability, which may lead to interpersonal conflicts within groups.

And finally, the third category, which is related to the pharmacological effect on an individual's moral judgment and decision-making. The main characteristics of this category are the elements and features associated with the decision-making process, such as aversion to harm and punishment, perception of pain, utilitarian judgment, consistency, rationality, authenticity, rejection of injustice, perception of what is forbidden, self-knowledge, and impulsivity, etc. Neurochemical compounds that play a role in these activities include propranolol, dopamine, oxytocin, norepinephrine, psilocybin, and fluoxetine. These substances can lead to moral issues related to virtual or imagined virtues, a change in perception of harm and trust in others, and a shift in self-knowledge and self-awareness.

Psychoactive substances as a means of moral improvement

However, there is another form of intervention that differs from the tools for moral improvement discussed above. This is the use of psychoactive substances, or

psychedelic drugs, which are illegal in most countries, for the purpose of improving a person's morality. Research into these substances began in the 1950s and 1960s.

Since the 1990s, there has been a steady increase in research on the effects of psychoactive substances on humans in the Western world. This research aims to better understand the basic neurophysiological mechanisms and to identify the key manifestations of these substances' effects on the human brain and mind.

The entire range of effects of psychoactive substances on humans can be divided into three main categories [Swanson, 2018].

The first category, known as perceptual effects, includes manifestations associated with changes in perception of reality.

The next category includes emotional effects, which manifest in an increase in the intensity of sensory perception and the appearance of various emotions, mostly positive.

Finally, the third category includes the so-called cognitive effects, which reflect changes in human cognitive abilities and thinking processes.

It should be noted that the use of psychoactive substances for achieving altered states of consciousness, and for religious and mystical experiences, is one of the oldest practices in human history. In many cultures around the world, the use of psychedelic substances for religious or spiritual purposes dates back thousands of years.

If we are talking about attempts to scientifically explain this mystical experience, we should remember that at the beginning of the 20th century, the American philosopher and psychologist, one of the founders of psychology of religion, William James, linked the possibility of changing consciousness and the occurrence of "mystical" experiences to the use of substances such as laughing gas, chloroform, ether and others. In the twentieth century, researchers of religious experience such as Robert Charles Zahner, Houston Smith, and William Stace turned to the history of entheogens. They relied on the ideas of James when forming new hypotheses about the possibility of influencing human religiosity through natural substances and artificial chemical compounds [Malevich, 2014].

The Good Friday experiment

This article discusses a theological analysis of one such idea for the use of psychoactive substances, which was tested as part of the "Good Friday Experiment" in the United States in 1962 [Pahnke 1963]. The uniqueness of this concept lies in the effort to improve a person's moral state through experiencing a mystical connection with God while under the influence of psychedelic substances.

On April 20, 1962, during Good Friday in the American city of Boston, an event took place that has gone down in history as the "Good Friday Experiment" or "Marsh Chapel Experiment." The event was organized by Walter N. Pahnke, a Protestant minister, physician, and theologian, who was conducting a research project in the field of religious psychology, focusing on the effects of psychedelic drugs on mystical experiences.

Pahnke defined the purpose of the experiment as collecting empirical data on the state of consciousness of subjects who had used psychoactive substances as a means of inducing religious feelings. The study aimed to identify similarities and differences between natural mystical experiences and those caused by psychedelic drugs.

Given the religious character of the experiment, the Marsh Chapel of the University of Boston was selected as the location for the event. The event took place during Good Friday services, which lasted for 2.5 hours. During the service, prayers, readings from the Holy Scriptures, and hymns were read, accompanied by organ music. The purpose of the music was to create a spiritual atmosphere for the participants. 20 volunteers from a local theological seminary were tested who had never previously used

psychedelic substances. All the participants in the experiment were Protestants from various denominations.

Based on questionnaires and interviews conducted following W. Pahnke's experiment, a key finding was that mystical experiences can be reproduced through the use of psychedelic substances, similar to natural religious experiences [Pahnke, 1966].

A quarter of a century later, between 1986 and 1989, American scientist Rick Doblin interviewed 16 of the 20 participants in the Good Friday experiment in order to assess the long-term sustainability of the findings [Doblin, 1991]. Doblin's research supported the findings of W. Pahnke's study. All participants, who had taken a psychoactive substance, years later still believed that their initial experience had contained truly mystical elements and had made a unique contribution to their spiritual journey.

For us it is important to note that most of the effects discussed during the interview were linked to a deeper understanding of life, a stronger sense of joy, a greater commitment to Christian ministry or other chosen vocations, a higher tolerance for other religions, resilience in the face of difficult life challenges, as well as a greater sense of solidarity with other people, national minorities, women, and the world around them. Most of the participants in the interview attributed these positive changes to the "encounter with Christ" they experienced during the action of the surfactant.

The question arises: What did the participants in the "Good Friday Experiment" really experience, and is everything truly as positive from a spiritual perspective as it seems from the reports and conclusions presented?

A view of interaction with the supernatural world from the perspective of Orthodox anthropology

In the three-part division of human nature, the key element responsible for interacting with the suprasensible world is the highest part of the soul - the human spirit. It is through this aspect of our nature that we are able to receive the grace of God through communion with Him. The connection with God is made through the mind, or rather, the contemplative aspect of human nature. The primordial state of man can be described as the uncluttered state of mind, where the spiritual "eye" contemplates the "mysteries of God, the spirit, and the material world" [Theophan the Recluse, 2010]. In the teachings of the Holy Fathers, vision is divided into two categories. The first category is natural contemplation, achieved through the mind's ability to independently or through reasoning to understand the essence of things, without the involvement of the senses. The second category is supernatural contemplation, which allows for such understanding through divine grace, received directly through communion with God and with the assistance of the Holy Spirit. It was through the natural contemplation of the wisdom of God imprinted in the surrounding world that the human mind gradually attained supernatural contemplation. This opened up the possibility of perfecting both man and the created world. The process of ascending to this supernatural state requires a great deal of spiritual effort on the part of the individual, as they must free their minds from everything sensual and physical.

However, the original sin disrupted this relationship through damage to human nature, changing the nature of the reflective faculty of the mind and putting it in an unnatural state. This led to man's spiritual blindness and made him insensitive and incapable of direct communication with God.

Nevertheless, in this state of spiritual blindness, one may experience an unnatural or abnormal contemplation of the mind. This type of contemplation focuses solely on sensory perception and leaves the spiritual aspect of one's being beyond comprehension, not revealing the need for connection with God or knowledge of Him.

Contemplation, which dominated the mind before the fall, has been replaced by thinking, which in some ways has the opposite direction of activity and is based on perception of the sensory world.

Under the influence of sensory images and the stimulation of the imagination with various illusory pictures, the human mind can become dreamy, characterized by a forgetfulness of God and the spiritual world, leading to a state of self-deception. The lie, generated by daydreaming and accepted as truth, becomes the reality of a person's life. Being deceived by the devil in the Garden of Eden, a person often continues to live in a state of demonic delusion, which opens the possibility of pseudo-knowledge about God and the supernatural world, without acquiring divine grace in the purity of their spirit and mind.

Therefore, attempts to explore the mysteries of the supernatural world solely through the power of the human mind, including by externally stimulating the human brain with various psychoactive substances, are clearly futile.

Patristic teaching of delusion

As noted earlier, one of the characteristics of the effects of psychoactive substances is the distortion of a person's perception of reality. In other words, a person can enter a state of self-deception through external means. These means can also be considered tools of diabolic influence, designed to lead a person into a state of delusion. Confirmation of this can be found in the writings of many Church fathers. St. Ignatiy Bryanchaninov writes that a lie was originally used by the devil to "destroy the human race" [Ignatiy (Bryanchaninov), 2021 (v.1): 261]. And today, the logical outcome of psychedelic states is the death of a person's soul, and in some cases, their body.

An assessment of the various delusionary experiences that are characteristic of the psychedelic experience can be found in the writings of Church Fathers. One of the most structured and systematic approaches to understanding this sinful passion, however, is presented by St. Ignatiy Bryanchaninov. He defines delusion as "the damage done to human nature through lying" [Ibid.: 260] and "the assimilation of a lie by man, which he has accepted as truth" [Ibid.: 262].

Let's try to compare the experiences of the experiment participants with the teachings of St. Ignatiy on delusion.

The first is the desire or boldness to experience communion with God. Typically, a believer's longing for communion with God is accompanied by a certain level of zeal of God or spiritual fervor, which is particularly evident among new Christians who lack sufficient experience in gradually organizing their spiritual life and growth. If we consider the idea of quickly experiencing the so-called mystical experience of communion with God through psychedelic drugs, in the absence of a genuine experience of gradually ascending the spiritual ladder, the carnal nature of such an experience becomes apparent. The intensity of the spirit and the excited state that accompany a person during these mystical experiences speak to the passionate nature of these emerging experiences. The true spiritual zeal, according to St. Ignatiy, should help calm a person and free them from delusional daydreaming. "The zeal of God is like a fire, but it doesn't heat the blood! It extinguishes its flames, bringing it to a state of calm" [Ignatiy (Bryanchaninov) 2021 (v. 5): 289]. However, as has been previously shown, the experiences of those who have undergone similar psychedelic states suggest the opposite. "The zeal of carnal wisdom is always accompanied by a heating of the blood, an invasion of numerous thoughts and dreams." [Ibid: 289]

The second effect is a perceived improvement in one's moral character. A close examination of the results from the interviews with participants in the Good Friday study can, in some cases, lead to the reader forming an opinion about the positive character of the experience for the subjects. Primarily, such an opinion may arise after

reading about the participants' strong desire to improve their inner moral state and do good deeds for others. However, referring to the spiritual experience of St. Ignatius, in such cases, it can be stated that moral improvement requires a gradual and profound change in a person's spiritual life. And no impetuosity in striving for spiritual heights can be justified from the standpoint of virtuous growth. "The fallen angel tries to deceive and lead the monks to destruction, offering them not only sin in various forms, but also the most exalted virtues that are unusual for them" (Ignatius (Bryanchaninov), 2021, v. 5, p. 57). St. Ignatius warns those who are not yet steadfast in their faith and are at the beginning of their spiritual journey against placing their trust in "thoughts, understanding, dreams, and desires, even if they seem the most good to you" (Ibid.: 57). According to the saint, such a desire for the virtues of the fallen world can foster self-delusion, arrogance, self-conceit and pride in a person.

A characteristic feature of the mystical experience is the **lack of a sense of repentance among the experiment participants**. However, we know that repentance is the fundamental basis for purifying the human soul and opening the possibility of receiving God's grace. Without repentance, which forms the basis for prayer, St. Ignatius sees the reason for various types of demonic delusion. In the case of the described Good Friday experiment, we can see not only the absence of the usual "repentance, contrition, and weeping" that precede it, but also the absence of prayer itself. This indicates a deviation in the wrong direction and is a sign of self-deception or infertility [Ignatius (Bryanchaninov) 2021 (v. 1): 264].

Another feature of psychedelic mystical practice is the occurrence of visual images of the Lord Jesus Christ, the Mother of God, saints, and angels in individuals under the influence of hallucinogenic substances. While these phenomena are considered to be manifestations of divine presence according to some religious traditions, they can also be understood as a result of the worshipper's imagination and the effects of chemicals on the brain, according to St. Ignatius. Although St. Ignatius considers these phenomena in the context of the worshipper's use of imagination, they can also be related to the psychedelic experience, adjusted for the fact that this reverie is caused by the effects of chemical elements on the human brain. What is significant in this case is the apparent similarity between the two instances in terms of the manifestation of delusion. "Everything composed by the dreaminess of our fallen nature, perverted by the fall of nature, does not actually exist - there is fiction and lies, which are so characteristic and beloved of the fallen angel." [Ignatius (Bryanchaninov), 2021, v. 1:265]. Being impressed by such meetings, a person only flatters his self-esteem, his vanity, his arrogance and his pride, and deceives himself [Ibid.: 256].

Thus, based on the patristic understanding of delusion, it is clear that the manifestation of so-called spiritual virtues in experiments such as the Good Friday experiment is quite different from truly spiritual states characterized by feelings of penitence, "deep humility and meekness, ... evangelical love for all people, the desire for anonymity and distance from the world" (Ignatius (Bryanchaninov), 2021, v.1, page 284). Falling into delusion, even under the influence of external means such as psychedelic drugs, a person may "appropriate the virtues given by God" and "compose for themselves virtues that do not exist" [Ibid.: 286], ultimately "glorifying God for the sake of glorifying themselves" [Ibid.: 257], and realizing as much as possible that they have pride in themselves, being deceived by the prince of this world.

Conclusion

Today, the West is once again considering the possibility of using psychedelic drugs as a potential tool for improving human morality. There are studies that attempt to demonstrate, albeit often in an exaggerated manner, the positive effects of these drugs on human behavior, attitudes towards others, and the world around us. Despite the fact

that the results of such studies often indicate the possibility of human enhancement, many researchers in the fields of bioethics and philosophy remain ambivalent about the prospects of using psychedelics for this purpose. The presented attempt of a psychedelic enhancement of the moral state of humanity is another utopian vision of the triumph of human intelligence, which in this instance has dared to transcend the limitations imposed by its nature, damaged by ancestral sins, through the use of knowledge and scientific advancements.

An analysis of the work of W. Pahnke and other Western researchers on psychedelics reveals that their approach fails to take into account the spiritual dimension of man in the understanding of Orthodox anthropology. As a result, they arrive at the mistaken idea that supernatural experiences can be artificially induced through the manipulation of the soul and body. From the perspective of patristic teachings, phenomena like the "Good Friday" experiment can be seen as a delusion - a consequence of seeking pleasure and the hidden influence of demons. Therefore, psychedelic drugs do not lead to true moral perfection, but rather repeat the ancient deception of promising God-likeness without God or spiritual effort.

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Competence boundaries: clergy and psychiatrists

Abstract: This report analyzes the limits of competency of clergy and psychiatrists in assisting people suffering from mental and spiritual disorders. It examines historical, theological, and clinical approaches to distinguishing between mental illnesses and spiritual conditions, including demonic possession. Special attention is given to the teachings of the holy Church fathers, including the Armenian tradition, as well as to modern principles of psychiatric science and medical ethics. The importance of interdisciplinary collaboration between clergy and mental health professionals is emphasized, as well as the risks of a narrow approach. Illustrative clinical and pastoral cases are presented to support this argument. It is concluded that theological and medical approaches can be complementary, as long as the boundaries of professional responsibility are respected.

Keywords: mental disorders, spiritual care, possession, pastoral psychology, psychiatry, patristic heritage, interdisciplinary interaction, boundaries of competence.

Introduction

The limits of the competence of clergy and psychiatrists and, as a result, the distinction between mental disorders and spiritual problems remain one of the most difficult and at the same time controversial topics at the intersection of theology, psychology and medicine. This issue has been of concern to the Church and the medical community for centuries, and its relevance continues unabated in our time. Our goal is to examine the historical, theological, psychological, and clinical aspects of this problem, as well as to identify the limits of the competence of the clergy and medicine.

The issue of mental suffering has long been at the intersection of religion and medicine. For thousands of years, spiritual traditions have attributed phenomena such as auditory hallucinations, seizures, split personalities, deep depression, suicidal thoughts, and uncontrolled aggression to the action of supernatural forces, including demons, spirits, divine punishment, or the curse of the family. However, the ancient Church already understood that not all mentally ill people were suffering from supernatural causes.

For example, St. John Chrysostom warned: "Not everyone who is in turmoil and cries is possessed by demons; for even diseases of the body can lead to such a state" (Homilies on the Gospel of Matthew., Mat. 8:28). Or, "Not every disease is diabolical, but diabolical is often disguised as a disease" (Chrysostom, Homiliae on Matthew, XXIX, 2). Gregory the Theologian said: "A priest must distinguish between mental illness and demonic attacks, so as not to harm the sufferer." And Thomas Aquinas noted that "sometimes the mind is darkened due to a disease of the body, and then there is no sin in it."

The Armenian Church Fathers also distinguished between mental illness and demonic possession, but noted that they may overlap. St. Grigor Tatevatsi says: "Just as a possessed man is driven by the devil, so a madman is driven by passion." The Armenian patristic tradition emphasizes that a person suffering from mental illness should not be left alone in his suffering, he needs prayer and mercy, not condemnation and contempt. Already in the middle of the fourth century, hospitals were established in Armenian churches and monasteries. There, people suffering from both mental and physical illnesses received medical treatment and support.

Thus, even the early Church fathers emphasized the need to distinguish between the attack of spiritual beings and physical illness.

In the Middle Ages, mental illnesses were largely attributed to demonic possession. People with psychotic symptoms were often subjected to exorcisms, torture, and isolation. Exorcism practices were regulated, but at the same time, doctors began to recognize the symptoms that distinguished mental illness from spiritual possession. As early as the 17th and 18th centuries, doctors in Europe described cases of "mania" and "hysteria", which seemed to be caused by demonic influences but had natural explanations. For example, Philippe Pinel freed mentally ill people from chains in 1793, Esquirol coined the term "hallucination", and it was only in the 19th century that a medical explanation for mental disorders began to take hold. Kraepelin classified psychoses and Freud and Jung offered psychological interpretations of them.

With the development of scientific psychiatry, mental suffering has been recognized as a mental disorder.

However, despite the progress made in psychology and psychiatry, there are still many unexplored areas in this field, and millions of people continue to turn to clergy for spiritual and mental support. It is therefore important to understand the boundaries of the competency of religious leaders and psychiatrists and to explore the possibilities for collaboration between them.

To better understand the limits of the competency of clergy and psychiatry, we should consider their rights, areas of expertise, and methods of work separately.

So, a psychiatrist is a medical doctor who has the authority to:

- make a diagnosis based on the ICD-11 and DSM-5,
- prescribe medication,
- hospitalize patients,
- provide psychotherapy,
- conduct examinations, and administer various diagnostic tests.

The object of psychiatry is mental illness:

- Psychoses (schizophrenia, bipolar disorder),
- Depression,
- Personality disorders,
- Anxiety states,
- Dependencies,
- Dementia, etc.

Psychiatry does not view the soul as a metaphysical entity, but rather works with the psyche, which is a function of the brain. Mental disorders are seen as a disruption of this function, rather than a problem with the soul.

A psychiatrist is not qualified to diagnose "demonic possession" or interpret a patient's condition in terms of "punishment from above" or "spiritual interference". These are theological issues that fall outside the scope of their expertise.

As for the legal and ethical boundaries, a psychiatrist is obliged to:

- follow the principle of "do no harm",
- respect the rights of the patient,
- ensure that treatment is voluntary (except in dangerous cases),
- take into account the patient's religious beliefs and worldview.

The clergy's competence includes pastoral ministry, namely:

- moral guidance,
- interpretation of spiritual crises, problems of guilt, the meaning of life and repentance, prayerful help, spiritual support in illness, communion with the holy sacraments.

A priest does not cure the brain, but the inner world of a person.

From a religious perspective, the causes of mental illness, along with the above, can be:

- A consequence of the Fall
- A trial

- The result of a destruction of spiritual life
- Internal conflicts
- The influence of evil forces

A religious leader does not have the authority to cancel or alter medical treatment.

Based on the above, we can conclude that a psychiatrist and a clergyman can effectively collaborate. A psychiatrist, armed with knowledge of cognitive processes, emotional regulation, and behavioral patterns, is able to provide scientifically-based therapies aimed at addressing maladaptive thoughts and behaviors. In turn, a priest, with experience working with existential issues, can provide support for finding meaning in life, forgiveness, and reconciliation with oneself and others. If at the stage of acute psychotic disorder, the leading role is played by a psychiatrist, then, after the acute condition has been relieved and during the stage of remission, where mood instability and states of despair are often noted, the role of the priest becomes more significant, as the patient and their relatives face the challenge of finding meaning in the disease.

It is important to emphasize that successful cooperation can only be achieved if there is mutual respect, an openness to dialogue, and a willingness to work together. At the same time, it is essential to observe ethical boundaries and respect the patient's right to personal freedom when choosing treatment methods and seeking spiritual support.

Specific forms of interaction can include joint consultations, case discussions, and organizing group events to strengthen mental health and develop spiritual resilience. In some cases, a priest may provide support to a patient within the context of religious practice, while a psychotherapist (psychiatrist) can help integrate spiritual experiences into daily life.

The interaction between a psychiatrist and a priest has the potential to be a promising area for the treatment of people with mental health issues, as it can enrich the therapeutic process and lead to more sustainable outcomes. In this context, the knowledge of a clergyman in the fields of psychology and psychiatry plays an important role.

I would like to draw your attention to the fact that one of the significant challenges in the interaction between a priest and a psychiatrist is the issue of providing care for patients who are under the diabolic influence. Although instances of actual possession are rare, they can often present a barrier to the successful diagnosis and subsequent treatment of the individual.

The complexity of the issue lies in the fact that symptoms of mental health conditions and possession are often intertwined, making it difficult to distinguish one from the other. This can lead to a misdiagnosis, and requires close collaboration between a psychiatrist and clergyman to accurately diagnose a patient. For example, I would like to briefly discuss two cases to illustrate this point.

In the first instance, a young man from a charismatic religious group began to exhibit aggressive behavior towards others, coupled with blasphemous language. Rather than seeking professional help from a psychiatrist, his family attempted to address his issues through prayer, which ultimately led to a suicide attempt. It was only after this incident that they sought the assistance of a mental health professional, and following treatment, remission was achieved.

And the second case, which I personally witnessed, was when a young, educated lawyer started to make sacrifices to Moloch in the form of cakes and then money and gold jewelry. Her parents, noticing this, consulted a psychiatrist. The prescribed treatment did not lead to improvement; on the contrary, she became more and more antisocial and lost a lot of weight. Only after my long persuasion did they turn to the priest for help at the church. There, she lost consciousness, but after a prayer from the

priest, she regained it. After Confession and Communion, the so-called Moloch ceased "visiting" her. A month later, she returned to work.

These are two striking examples of people who go to extremes and refuse to see a doctor, or, in the second case, ignore the spiritual aspect of their illness.

Even C. G. Jung noted that mental phenomena can have an archetypal character and be perceived as manifestations of a "different world" (Jung, 1938). He warned about the risk of psychologizing spiritual experiences, emphasizing the need for a collaborative approach between psychologists and priests. Alexander Men, in his research on church tradition, noted that obsessions are usually accompanied by pronounced spiritual symptoms - an irresistible aversion to sacred places, obsessive curses, and bodily manifestations that contradict natural reactions. Psychoses, on the other hand, more often have an emotional and logical structure of disorders. (Men, 1993).

Theological perspective and limits of competence

From a theological perspective, the Church acknowledges the existence of spiritual realities, including the influence of evil spirits. However, both the Holy Fathers and modern practice emphasize the need for caution. Today, this is being translated into joint practice: a clergyman can direct prayer, confession, and spiritual guidance, **but the diagnosis and treatment of mental health issues remains the responsibility of psychiatrists**. Interdisciplinary collaboration is essential to avoid misinterpretations, such as mistaking psychiatric conditions for demonic possession or interpreting spiritual struggles as medical issues.

In practice, distinguishing between obsession and mental illness involves:

1. A thorough medical history, including medical history and spiritual experiences.
2. Monitoring reactions to religious sites and practices to assess for psychopathological signs.
3. Consulting with specialists, such as psychiatrists and psychologists, in case of uncertainty.

The clergy of the Armenian Apostolic Church works closely with psychiatrists in this area. If a priest notices obvious signs of a mental illness or what is known as an possession, they will direct the person to seek help from a psychiatrist. They help the person understand that it is normal and necessary to seek professional help for their well-being. The priest stays in touch with the doctor, patient, or their family to provide additional support and spiritual guidance.

Conclusions

Thus, the differentiation of mental disorders requires an interdisciplinary approach that combines theological wisdom with the scientific methods of psychiatry. The Church and medicine have different, but complementary competencies. Today, the official positions of most denominations and psychiatric associations converge:

- A psychiatrist **explores pathology**, refraining from spiritual interpretations.
- A priest **spiritually** guides and heals a person, without intervening in their therapy.
- Both can cooperate with the patient's consent, upholding respect for their faith.

The World Psychiatric Association (WPA, 2015) notes that a person's spiritual life can serve as a resource in treatment, provided it does not replace professional help.

In conclusion, I would like to quote the words of Alexander Me: "True discernment is not just recognizing symptoms, but caring for the integrity of the human soul and body" (Men, 1991). This statement vividly illustrates that the approach to the treatment of the mentally ill must be both humane, scientific and spiritually sensitive.

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Integration of psychological and spiritual care within the scope of the priest, therapist, and psychiatrist roles in serving the human being

Abstract: This paper presents an integrated model for psychological and spiritual care within clearly defined professional boundaries, focusing on the complementary roles of the priest, psychotherapist, and psychiatrist in serving the human person. In response to increasing mental health challenges and the frequent confusion between faith-based and clinical interventions, the paper argues that effective healing requires cooperation rather than role overlap. Drawing on clinical psychology, psychiatry, and the pastoral tradition of the Coptic Orthodox Church, the study proposes a "3D Comprehensive Care Model" that addresses the human being as spirit, soul, and body. Through practical role delineation and clinical case examples, the paper demonstrates how integration enhances patient dignity, prevents misdiagnosis, and promotes ethical, holistic care. The model affirms that spiritual care complements - rather than replaces - scientific mental health treatment, offering a framework that respects professional specialization while fostering teamwork in service of human healing and hope.

Keywords: Psychological care; Spiritual care; Integrated mental health model; Pastoral counseling; Psychiatry and psychotherapy; Holistic healing; Coptic Orthodox Church; Professional boundaries.

Introduction

Today, we face a fundamental question in caring for the human person: **How can we develop an integrated model that cares the whole person: spirit, soul, and body without creating conflict between faith and science?** In a time of growing psychological and social challenges, the question is no longer: **Does the church have a role?** But rather: **How do we cooperate — without overlap — in serving the human being?** No single field can treat the whole person. Healing requires an integrated framework that respects each specialization, works as one team, and places human dignity at the center.

This is why the Coptic Orthodox Church emphasizes this principle today: **Integration is not a blending of roles, but the respect of their boundaries in service to the one human being.**

First: The role of the priest — giving meaning and shepherding hope

The priest does not replace psychological treatment, but he provides a spiritual ministry that no other profession can offer. His role includes three essential dimensions:

1. Spiritual and theological counseling

- o Offering a theological understanding of pain, suffering, and meaning.
- o Accompanying the person through prayer, sacraments, and spiritual practices.
- o Rebuilding hope during grief, confusion, existential crises, or loss.

2. Social and ecclesial support

- o Helping restore family and community relationships.
- o Providing a supportive church community that reduces isolation.
- o Positive psychology research shows that community support is a crucial factor in recovery.

3. Professional role

- o The priest does not diagnose psychological disorders.
- o He does not prescribe medication or conduct clinical therapy.

- o **His mission** is to guide and illuminate the path, not to design the treatment plan.

Second: The role of the psychiatrist and therapist (scientific precision and clinical expertise)

•Psychiatrist

- o Diagnoses disorders according to DSM-5.
- o Prescribes and monitors medication and biological treatments.
- o Does not provide spiritual or theological interpretation of suffering.

•Therapist / Psychologist

- o Provides evidence-based therapies such as CBT, DBT, and family therapy.
- o Treats trauma and reshapes cognitive and behavioral patterns.
- o Respects the patient's faith and uses it as a source of strength.

•Clear scope of practice:

- o The therapist does not prescribe medication.
- o The psychiatrist does not replace spiritual guidance.
- o Each professional works within their scope of practice, complementing the others.

Third: Practical integration — how do we work together? (The 3D Comprehensive Care Model)

1.Diagnosis and assessment

- o **Priest:** Identifies spiritual needs and level of spiritual support.
- o **Psychotherapist:** Provides a clinical (non-medical) psychological assessment.
- o **Psychiatrist:** Provides medical diagnosis and medication planning.

2.Primary therapeutic intervention

- o **Priest:** Builds meaning, strengthens hope, reinforces community support.
- o **Therapist:** Provides psychological therapy.
- o **Psychiatrist:** Provides biological or pharmacological treatment.

3.Shared communication

- o **The priest** refers the person when psychological symptoms appear.
- o **The therapist** shares updates to support overall healing.
- o **The psychiatrist** coordinates medication with the therapist.

4.Clear professional boundaries

- o **Priest:** No medication, no clinical diagnosis.
- o **Therapist:** No theological teaching, no medication.
- o **Psychiatrist:** No issuing of spiritual judgments on the case.

5.Case studies

Case one: Clinical depression

- o **Risk:** Interpreting depression as "weak faith."
- o **Correct integration:**
 - **Psychiatrist:** Antidepressants and follow-up.
 - **Therapist:** CBT to address negative thoughts.
 - **Priest:** Restores hope and prevents spiritual self-blame.

Case two: Religious obsessive compulsive disorder

- o **Risk:** Mistaking compulsive behavior for "spiritual zeal."
- o **Correct integration:**
 - **Psychiatrist:** Diagnosis and appropriate medication.
 - **Therapist:** Cognitive-behavioral therapy addressing obsessive thoughts.

▪ **Priest:** Provides healthy theological guidance and stops practices that worsen symptoms.

With this model, specializations do not compete, but integrate within one healing framework.

Fourth: The role of the Coptic Orthodox Church in this integrated model

1. Clear institutional framework

- o Under the leadership of His Holiness Pope Tawadros II and the Holy Synod, the Church established a balanced mental-health model through a dedicated Mental Health Committee, integrating patristic wisdom with modern science.

2. Contemporary spiritual foundations

- o The Church offers a spiritual vision that complements scientific knowledge and provides a mature, balanced understanding of the human being.

3. Training of priests and servants

- o **Through specialized institutes such as:**
 - Institute of Care and Education
 - Coptic Institute of Psychological Studies
 - Other counseling institutes across Egypt
- o **Training includes:**
 - Basics of mental health
 - First aid intervention skills
 - Proper professional referral
 - Distinguishing spiritual from psychological disorders

4. Professional partnerships

- o Joint teams
- o Evaluation committees
- o Psychological services in church institutions
- o Cooperation with national health services

5. Protection of the patient and the care system

- o Preventing confusion between spiritual and psychological disorders
- o Protecting patients from misuse, misdiagnosis, or exploitation
- o Protecting clergy and therapists from overstepping their respective roles
- o Immediate referral in dangerous cases

Thus the Church becomes not only "a spiritual home", but a "professional institutional partner" in the national mental health system.

Conclusion

Beloved church leaders and esteemed researchers,

Integration of psychological and spiritual care is not a theoretical project but an ethical commitment before a suffering human seeking meaning, healing, and hope.

The Coptic Orthodox Church believes that science is a gift from God, and that spirit and mind are inseparable on the path to healing.

We don't offer an alternative to medicine or psychological therapy but a bridge connecting the human being to God, to self, and to community within an integrated system that respects specialization and works in a spirit of teamwork.

Finally

"Now may the God of peace Himself sanctify you completely; and may your whole spirit, soul, and body be preserved blameless... "(1 Thes. 5:23)

Integration does more than provide treatment, it restores dignity, inner peace, and prepares the person for eternal life.

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Humanizing psychology through Christian anthropological training for future psychologists

Abstract: Psychological training in universities is increasingly focused on research methodology and neuropsychology, to the detriment of humanistic training. This professional preparation contrasts with the reality of the human problems addressed in psychological consultations and the psychologist's capacity for action, beyond the biochemical alterations that underlie them. Therefore, the need to recover Christian anthropological training in universities is argued. Thus, future psychologists and psychotherapists will be able to better understand and accompany people who come to consultation for such human issues as remorse, guilt, perfectionism, or lack of hope.

Keywords: Christian anthropology, Psychology, Mental health, Humanization of psychology, Spirituality

This research is part of the CEU identity project "The humanization of mental health: psychological diagnoses and psychotherapeutic interventions" HUMANPSY B324FP12

1. Introduction

University studies in psychology in Spain were developed within the faculty of philosophy, together with studies in sociology. Initially, they were established as sections or specialties within philosophy. In the case of psychology, as a specialty in psychology and educational sciences. Later, the psychology and sociology sections became independent and, in Barcelona, the first faculty of psychology in Spain was formed, offering studies in psychology, pedagogy, and speech therapy, and, on the other hand, the faculty of sociology. Despite its emancipation, psychology was considered part of the humanities, as its object of study is linked to individual human development in its family and social context.

Currently, university psychology studies are gradually being incorporated into health science faculties, alongside medicine, nursing, and other medical specialties. This reality is very illustrative of the change that has taken place in the conception of the nature of psychology as a science, its object of study, and the appropriate methodology for better understanding it.

The significance of this change warrants critical reflection. Certainly, scientific improvement has been sought, as, in the face of practices whose effectiveness has not been proven, the aim has been to reinforce evidence-based psychology (Wright, Pade, Gottfried et al. 2022), but it should also be noted that a clinical perspective has been promoted to the detriment of a personal, human one. No hasty judgment can be made about the change, but it must be reflected upon, as it is not a simple change of attitude, but a reformulation of the theoretical foundations of this science.

On the one hand, in basic research, Aristotle's philosophy of nature, in which the psyche was considered a principle of life, has been replaced by August Comte's positivism, which considers only that which can be quantified to be knowable. This has forced a complete operational reformulation of all concepts.

On the other hand, psychotherapy has also been influenced by the scientific and cultural evolution of its time. Thus, in psychological intervention, there has been a very significant evolution in its logotherapeutic approach, that is, healing through words, which has remained constant. From its beginnings, when Christian morality was identified as the cause of mental illness, to the focus on self-actualization typical of humanistic psychology (Ford, 1991).

The interest in validating the effectiveness of psychotherapeutic intervention has highlighted the importance of the relationship established with the therapist, rather than the therapeutic methodology used. Furthermore, it must be acknowledged that there are certain disorders in which psychotherapeutic care has limited effectiveness and a multidisciplinary intervention is required. In these cases, psychotherapy plays a personal support role in the process, aiming to increase the patient's adherence to treatment and fulfilling an adjunctive function. In any case, it seems that in both situations, the psychotherapist is providing personal, friendly support, rediscovering the importance of personal support, especially in difficult situations.

Friendship with patients, as well as the parental or moral guidance role that psychologists can play, are highly debated about topics given the supposed neutrality and professionalism that psychotherapists must maintain. However, it cannot be denied that different psychotherapeutic approaches base their methodology on a particular anthropology, from which they understand human health and illness, the nature of mental disorders, and the purpose of human existence. This is, therefore, the moral framework from which they practice their profession.

The Church has preceded psychotherapists and counselors in the personal accompaniment of troubled individuals, offering a path to salvation for all people, regardless of their mental state. Based on the conviction that human nature is fallen, it recognizes the need for the salvation of mankind and presents Jesus as "the way, the truth, and the life" (John. 14:6), who calls especially those who are "weary and burdened" (Mat. 11:28). Among other historical figures, St. John of God stands out as a concrete reference point for this form of apostolate, dedicated entirely to the care of the mentally ill long before the profession was institutionalized (Riesco Álvarez, 2022).

This reflection seeks to highlight those essential aspects that give deep meaning and significance to the profession of psychotherapy, noting the risk of overlooking them from the clinical, biomedical approach that has taken hold in the training of future mental health professionals. To this end, we draw on the work carried out in the identity project subsidized by the Abat Oliba CEU University in Barcelona, aimed at the humanization of psychology.

2. Health psychology

Psychology as a profession can be understood as the study of psychic life and also as psychotherapeutic accompaniment. In the first conception, it seems that neurophysiology and computational cognitive models are leading the way in the advancement of knowledge. In the second, there seems to be more dispersion in terms of the predominant lines of advance, as each psychotherapeutic current seems to have its own autonomous path that each psychotherapist follows, or else eclectically picks and chooses from among the various currents (Wucherpfennig, Bock & Abidi, 2025).

Personal psychological development occurs alongside organic maturation, influenced by environmental and intrapersonal factors, such as one's own beliefs and the decisions made throughout life. This personal psychological development can be considered in terms of health from a functional perspective, but it also requires a sense of purpose to guide that development.

The criteria used to assess a person's psychological health must take into account their nature, not just their functionality, if we want to achieve more than just an unstable balance in the people we accompany (Walker, 1956). Human existential concern compels this, making it so that, beyond functionality, personal happiness lies in achieving a sense of meaning in life. An example of this reality is the increase in depression among Western citizens who live in a state of well-being, with guaranteed health care and education, but without a vital commitment to a cause that gives meaning to their lives, their joys, and their sorrows.

The clinical approach to psychotherapeutic care emphasizes the importance of diagnoses and protocols for action in different situations in order to achieve a rebalancing of the person. However, it is limited in terms of providing vital guidance to patients so as not to overstep the bounds of professional intervention. The danger in this situation is that the patient has to take on, on their own, a life orientation that the therapist does not want to judge, or that the therapist gives advice without having sufficient training to do so.

This is where humanistic training can be indispensable in accompanying patients who are not only seeking to sleep better or stop worrying about their problems, but also a meaning in life that allows them to orient themselves in their current situation and provides a commitment to adhere to (Frankl, 2008). As a metaphor, consider the guide sticks that help trees grow straight. This help, in human beings, is morality, indispensable for everyone, since the alternative, living "beyond good and evil," leads to dehumanization.

It should be noted that there is a moral proposal in every psychotherapeutic school and that the scientific solution is not to eliminate it in the psychotherapeutic relationship, but to be guided by the one that humanizes the person the most, facilitating their flourishing as a human being. However, this is not part of the training of psychologists, which is more oriented towards physiological training or a merely descriptive explanation of the different psychotherapeutic approaches. For this reason, it is necessary to insist on the need to train future mental health professionals in the humanities.

3. A humanized view of psychology

There have been psychotherapists who have emphasized the need for meaning as a psychotherapeutic criterion. Beyond the clinical manifestations of mental disorders and their immediate management, they have thought about therapeutic intervention from a life-oriented perspective. With varying degrees of religious commitment, they have defended transcendence, stepping outside of oneself, as the basic idea for achieving mental health. In this regard, the author of the book *"Man's Search for Meaning"* is paradigmatic.

Viktor Frankl, for example, proposed a therapy focused on shaping one's own existence from the meaning of life. Without being overly varied in terms of psychotherapeutic techniques, he understood that the meaning of life was the axis around which each person revolves and the fulcrum on which personal hope rests, from which one experiences the joys and sorrows of life. For Frankl, mental health was not considered a balance but a commitment to meaning, beyond the living conditions one was experiencing. In this way, his psychotherapeutic work did not focus primarily on symptomatic relief, which he managed through the technique of de-reflection and paradoxical intention, but rather on accompanying the patient in the search for the meaning of their own existence through the discovery of fundamental values.

This group of authors also includes Alfred Adler, Frankl's predecessor, who understood that healing an inferiority complex was possible by opening up to others, shifting the gaze that was neurotically turned inward. For him, this form of egocentrism was the core cause of neurotic symptoms, causing the individual to exist in a state of constant anxiety and victimhood in comparison to others (Adler, 2005). The feeling of community as opposed to the feeling of compensatory personality is, for him, the way to overcome this neurotic egocentrism. It should also be understood in this proposal that a healthy life orientation involves dedication to others and the development of a transcendent meaning in one's own life. Psychotherapeutic work does not focus directly on symptomatic relief, but rather on a reorientation of life from which these symptoms will be minimized.

These proposals, rooted in psychoanalysis, differ significantly from Sigmund Freud's original proposal, guiding the patient toward a meaning outside of themselves. They go beyond awareness and a certain resignation to the unstable balance of repressive action on the drive force, considered by Freud to be the essence of the psyche.

The anthropology underlying Freud's mechanistic psychology is pessimistic, condemned by the impotence of the ego in the face of drive dynamics, which he considers to be the essence of psychic life (Freud, 1990). It is a deterministic dynamic, since the only psychic instance that can counteract it, the superego, is extrinsic to the subject, as it appears to be the result of introjection.

This conception of man is not incidental, but rather the cause of the configuration of Freudian psychoanalytic practice, based on the free association of ideas by the patient. For Freud, this soliloquy will allow the person to become aware of the reasons for their neurotic distress and, naturally assuming that they cannot modify the instinctual origin of their motivations, their distress will be alleviated by relaxing the repressive force that their superego may exert.

Given this basic conception, it is necessary for the psychotherapist to have the ability to reflect critically on this anthropological conception and not be content with a superficial understanding of psychoanalytic practice, interpreting this therapy as emphasizing the importance of the patient being able to express their discomfort.

Nor is the solution to dispense with the anthropological foundation, attempting to work from a purely "clinical" perspective, because this is as naive as it is dehumanizing. Moral conflict is part of being human and underlies most mental disorders or neuroses.

In a deliberate attempt to empower the patient, techniques such as cognitive restructuring can easily promote a "tailor-made" morality, in which emotional well-being takes priority over the reality of the situations that someone may be experiencing (Ellis & MacLaren, 2005). Morality is not ignored, therefore, but is subordinated to the criterion of well-being. It should be assumed that all psychotherapeutic techniques and proposals are based on a particular view of humanity, an anthropology. Since psychotherapists treat people and not just symptoms, they must, consequently, be sufficiently trained in this field.

The anthropological training that future psychotherapists must have should address fundamental issues such as evil in man, freedom, and meaning. This training will enable them to understand the self-destructive dynamics, egocentrism, and lack of hope that underlie the clinical manifestations that may be evident in the consultation.

Christian anthropology understands human passionate disorder from the doctrine of original sin, whereby reason is obscured and concupiscence tends toward disorder. This point is crucial because it allows us to understand that educational action is not unnatural but rather seeks to restore the proper order. Asceticism in this process is therefore not the introjection of aggressive impulses, but rather an effort that has a perfective meaning.

Human freedom, from the perspective of Christian anthropology, is not conceived as a multiplicity of options, but, as Augustine of Hippo understood it, as the choice of the greater good (Augustinus, 1992). Human beings are not indifferent to different options, but, due to the inclination of concupiscence, they will not choose spontaneously from the right reason, but from passion.

This conception of freedom allows the future psychotherapist to better understand the inadequacy of cognitive restructuring, which can easily fall into moral intellectualism. There is a disorder in human affectivity that cannot be remedied solely by a restructuring of beliefs. Such a restructuring will, in any case, accommodate reason to what the affections determine. Paradoxically, reason would give way to passions. On

the other hand, without denying human freedom, we must recognize that human beings find themselves in a non-neutral situation, due to the inclination of concupiscence. As St. Paul acknowledges: "I do not do the good I want, and I do the evil I do not want." (Rom. 7, 19). Not to admit this situation is naive, beyond the idiosyncratic constitutional differences of each individual.

The explanation of the aspects in which human psychology and psychotherapeutic intervention are illuminated by Christian anthropology could be further detailed, but it suffices to comment on one last aspect, which is the ultimate orientation of therapeutic work. The ultimate meaning of this claim is to restore order in human life in order to achieve its natural end to the maximum extent possible. As Jesus says: "but from the beginning it was not so" (Mat. 19:8).

The meaning of psychotherapeutic work must go beyond the limits of immanence, in which the cultivation of virtues would become an end in itself. This approach would be difficult to escape the risk of falling into perfectionism or scruples, in addition to assuming full responsibility for the process of improvement. Christian anthropology also sheds light on this aspect, by interpreting the reality of the human condition and its possibilities for improvement in a supernatural way. With this in mind, the therapist will be able to interpret therapeutic progress or lack thereof in terms that are less blaming of the patient and the effectiveness of their professional intervention.

4. Conclusion

Psychotherapy always refers to a particular anthropology, from which it understands mental health and illness and the appropriate way to intervene to achieve it. The exclusively clinical approach that psychology is progressively adopting jeopardizes the necessary humanistic training of future mental health professionals, who, beyond knowing those practices that have proven to be effective, must know human nature. After all, they will be dealing with people, not pathologies.

In addition to running the risk of working on pathologies in a superficial, symptomatic way, like someone who treats a fever but not the infection that causes it, they lack the criteria to guide people beyond the relief of the symptoms that cause them discomfort. For this reason, it is necessary for future psychotherapists to have an anthropological education from which to understand the vicissitudes of human life and thus be able to provide existential guidance to the person.

Anthropological training must address fundamental human issues such as evil, freedom, and the meaning of life. Christian anthropology can shed light on pathological situations and the appropriate therapeutic action without resorting to superficial or dehumanizing proposals.

Recognizing emotional disorder, whereby individuals do not usually make the best decisions spontaneously, and the need to understand health not as an unstable balance but as a commitment to a meaning beyond oneself, are key aspects for adequate therapeutic progress.

Finally, a supernatural view of these issues will make it possible to overcome both resigned pessimism and voluntarism, which foster despair and perfectionism, respectively.

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Religion and psychotherapy: points of convergence – confession, psychotherapeutic process, family therapy

Abstract: This report examines the interaction between clergy members and mental health professionals, including psychiatrists, psychotherapists, and psychologists. The paper explores the conceptual similarities between various psychotherapeutic approaches and religious sacraments, such as Confession. Furthermore, it analyzes specific aspects of psychoanalysis and Acceptance and Commitment Therapy (ACT) through the lens of their commonalities with religious tenets. The article examines the issue of separation as both a psychological and therapeutic process, highlighting its significance in the formation of a mature personality. The importance of parent-child dialogue is emphasized, and parallels are drawn between the roles of a therapist and a member of the clergy in the separation process. Furthermore, the study addresses the three-generational family as a critical factor in the context of separation.

Keywords: psychotherapy, religion, Confession, separation, clergyman, therapeutic process.

Throughout most of psychiatry's history, its growth has been intertwined with the Church. The first places where individuals with mental health issues could find refuge, sustenance, solace, and medical care were monasteries and churches. Priests could refer patients to psychiatrists and offer support throughout the treatment journey. Religious coping methods have proven effective for patients with various mental conditions. Consequently, the collaboration between a priest and a physician can boost the efficacy of the treatment process and holds significance for further investigation.

The concept of the psychotherapeutic process is rooted in several fundamental principles: voluntariness, professional competence, a secure environment, a focus on personal transformation, and the maintenance of medical confidentiality. Similar principles can be observed in the practice of Confession. Key elements include the minimum age of 7 years, voluntary participation, individual accountability for sins, and the assurance of confidentiality. The Christian Sacrament of Confession originated in the early centuries, yet its practice as a formal rite was established between the late 4th and 5th centuries. The foundation for this sacrament is found in the Apostle John's words: "If we confess our sins, he is faithful and just to forgive us *our* sins, and to cleanse us from all unrighteousness." (1 John 1:9). In early Christian communities, 'public confession' was practiced: the penitent would confess their sins before the entire congregation, and all the Christians present would pray for the penitent, regarding the sins as their own. However, this practice gradually fell out of use by the 5th century. In the Russian Orthodox Church, the Confession rite, as it is known today, was formalized and included in the Book of Offices during the 17th century. At the turn of the 20th century, St. John of Kronstadt popularized 'general confession,' a practice in which a priest would recite a list of common sins aloud, and the penitents would acknowledge their own transgressions.

In the Catholic tradition, Confession first acquired official recognition in 452, thanks to the decree of Pope Leo I the Great. However, it was not initially considered mandatory but was viewed as beneficial. Subsequently, confession became mandatory for monks of several orders (initially the Benedictines), and, following the decision of the Fourth Lateran Council in 1215, it became compulsory for all parishioners. Confession became auricular, and the emphasis shifted from the penance imposed on the penitent to the sincere repentance of the sinner. The Fourth Lateran Council

mandated that all believers who had reached the age of reason must confess at least once a year.

The phenomenon of Confession is studied by various humanities. In theology, confession is understood as one of the church sacraments – a form of repentance, the essence of which lies in the admission of sin and a transformation of human consciousness. From an ethical perspective, confession is characterized as a means of altering one's inner world, value system, moral principles, and attitudes, as well as an acknowledgment of the erroneous nature of one's actions and conduct. Philosophical anthropology treats confession as a means of self-discovery – a search for one's spiritual identity and life's purpose, and a way to articulate inner experience.

The psychotherapeutic process shares considerable similarities with the act of Confession. Both share fundamental principles and foundational concepts, yet they are not identical.

Confession is a sacrament in which a person communes with God, experiencing deep repentance and profound spiritual insights. Psychotherapy is a method aimed at altering a person's psycho-emotional state, behavior, and communication patterns, as well as improving their overall well-being. At the same time, Confession and psychotherapy can complement one another: psychotherapy helps to remove internal barriers to Confession, while Confession can be a step toward resolving the life issues addressed in therapy.

We would also like to note the methodological similarities between psychoanalytic concepts and the religious idea of man as a triune being.

Personality structure

Freud proposed a three-component model of personality structure:

Id ("It") — the totality of instinctive desires and needs. It is based on the pleasure principle and seeks to satisfy its impulses immediately, regardless of social norms or consequences.

Ego ("I") — develops primarily in response to the demands of the environment; it strives to satisfy the desires of the Id, but takes the "reality principle" into account. It acts as a regulator of behavior and serves as a mediator between the desires of the Id and the demands of the Superego.

Superego ("Over-I") — is formed through the internalization of moral norms and values. It shapes concepts of good and evil, moral standards, and rules of conduct, acting as a "punisher" and a "conscience." This can be viewed as an analogy to the triune nature of the personality: body, soul, and spirit.

When looking at the principles of *Acceptance and Commitment Therapy*, we see that it is based on the idea that suffering is an inevitable part of being human, and that there is no point in avoiding or fighting pain. Instead, we should accept suffering by experiencing it and allowing it to be. It is equally important to take personal responsibility: to focus on building the life you want to live and becoming the person you want to be. "We can draw an analogy here to the theology of suffering: the Apostle Paul taught that 'it is through many tribulations that we must enter the kingdom of God.' Through suffering, the Lord teaches the believer and purifies their soul and body from sin, ultimately making the whole person righteous (Heb. 12:4–13). Even though righteousness is given to man by God as a free gift through faith (Rom. 4:3), receiving it still requires human effort in the form of works of faith or patient endurance of suffering. We should also keep in mind the basic religious principle of free will.

Moreover, looking at the phenomenon of separation and tracing its history in the traditional Russian family of the past two centuries, we can find many parallels in terms of its effectiveness. Separation (from the Latin *separatio* — 'separation') is a psychological and psychotherapeutic term describing the process of becoming

independent from one's parents or loved ones. The goal is to foster autonomy and independence, to learn how to make decisions, provide for oneself, and form one's own views without being influenced by parental opinions and expectations. The primary objective of psychotherapy during separation is to help individuals cope with the emotional challenges associated with detaching from the familiar and entering a new phase of life. A therapist can help the client recognize their emotions, understand their underlying causes, and learn to manage them effectively. Furthermore, psychotherapy can assist in developing strategies for adapting to a new environment or new relationships. Looking back at the traditional family of the 19th century, we find the three-generational model, which was typical of pre-revolutionary Russia. Historians believe that this family structure provided a sense of stability. In such a household, parents live with their children and grandparents. Often, grandparents live with their adult children and grandchildren to remain close and offer assistance. Some of the characteristics of life in a three-generational family are:

Mutual support and care. Grandparents often help with childcare, which allows parents to remain productive at work.

Passing down traditions, values, and knowledge. Interaction between children and their older relatives plays a key role in preserving family traditions across generations.

Intrafamilial protection. As parents age and become more frail, their children step in to care for them, while grandparents, in turn, help look after the grandchildren. It is often from their grandparents that children learn essential life skills and cultural values.

I would like to highlight that in a three-generation family, despite the physical proximity, mental separation was not an issue. This contrasts sharply with the current situation, where the younger generation is attempting to achieve mental separation through physical distance.

In a conventional three-generation household, where members often lived together or in close proximity, there was typically a single confessor. By addressing the concerns of family members from different generations, he facilitated the resolution of mental separation issues.

Conclusions

Psychology and the psychotherapeutic process share many commonalities with religion. This fact can be leveraged either to bridge the gap between medicine, psychology, and the Church for subsequent synergistic collaboration, or to foster distancing and counter-positioning. Engaging in open dialogue and collaboration can help foster greater unity among professionals in the helping fields.

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Clergy – psychiatrist interaction: a theological-anthropological perspective on illness in a multidisciplinary context

Abstract: This report explores the theological basis for collaboration between clergy and psychiatrists in addressing, preventing, and treating mental illness. It posits that illness is a phenomenon that impacts both the psychophysiological and spiritual dimensions of the human life. Orthodox anthropology provides conceptual foundations for integrating a medical approach within a holistic model of human nature, where physicians and priests can act as co-workers in the formation of a healthy person. Through a comprehensive approach, the article presents practical examples of professional interaction between priests and psychiatrists. The study concludes that there is a need for interdisciplinary cooperation based on a holistic understanding of the person, which will contribute to building a more effective system of spiritual and psychiatric care focused on the formation of a healthy person.

Keywords: mental disorders, psychiatry, Orthodox theology, Christian anthropology, human integrity, passions, illness, pastoral care, medical treatment, interdisciplinary (multidisciplinary) approach.

Providing high-quality psychiatric care is one of the significant social challenges in modern Russia. Today, psychiatry successfully addresses many issues related to mental disorders: the scientific community is constantly developing more effective methods for their diagnosis, prevention, and treatment. At the same time, the anthropological integrity of a human being encompasses not only the physical component but also those aspects that are inaccessible to analysis solely through natural scientific methods — the mental and spiritual spheres. Therefore, an effective approach to supporting individuals with mental health conditions requires a holistic framework based on interdisciplinary principles. This approach allows for the integration of biological, psychological, sociocultural, and spiritual factors, thereby ensuring higher-quality treatment and rehabilitation.

The **multidisciplinary principle can be traced back to the Orthodox doctrine of humanity**. According to this doctrine, the **ultimate goal of human existence is the attainment of the fullness of life with God**: 'You have made us for Yourself, and our heart is restless until it rests in You' (St. Augustine of Hippo) [1]. This goal structures the path toward its achievement, provides the tools for its realization, and defines one's attitude toward surrounding realities and phenomena. It is precisely the striving toward God that acts as the key factor in shaping the spiritual path, facilitates the overcoming of passions, and provides the necessary instruments for achieving the set goal.

The Image of God lies at the foundation of human nature, serving as 'a God-given origin that allows man to live in communion with God and bestows upon him divine qualities' (Archpriest V. Leonov) [11]. By creating man, **the Lord did not only instill His divine essence in him but also summoned him to attain the likeness of God**: man is called not only to seek God but to grow in and through Him. This is fostered by the ontological nature of all created beings—their inherent **changeability**—which grants man the capacity for growth and self-perfection. As Saint John of Damascus observes, man was created as a living being who 'becomes god through his yearning for God; yet he becomes god by participating in the Divine light, rather than by being transformed into the Divine essence' [6].

God created man in his entirety, not in parts; therefore, man is always perceived as a unified whole. St. John of Damascus asserts: 'The body and the soul were created at the same time, not as Origen foolishly claimed, that one was created before

the other.' [6] According to the teachings of the Holy Fathers, **human nature is viewed in its integrity through the prism of dichotomy** (body and soul) **and trichotomy** (body, soul, and spirit). This intra-natural hierarchy must be structured in such a way that the body 'is in perfect harmony with the soul, and the soul is in perfect harmony with the spirit.' [5] Such hierarchy reflects not only the proper arrangement of the internal structure of nature, but also the principle whereby the physical, psychic, and spiritual components mutually influence one another and do not exist in isolation. Human nature is inconceivable without this unity, and a human being is inconceivable without wholeness. The Holy Martyr Irenaeus of Lyons asserts: 'Neither is the fleshly creation by itself the perfect man, but it is the body of man and a part of man; nor is the soul by itself man, but it is the soul of man and a part of man' [7]. Therefore, a human being can only be viewed through the prism of wholeness.

Having fallen away from God and severed himself from the Source of life, man introduced into his life a series of sinful consequences that affected both himself and the entire world. These include: **falling away from God, submission to the devil, the corruption of the image of God in man, the corruption of human nature, and the disruption of relationships with the surrounding world.** Original sin is 'a sinful state of man, transmitted from generation to generation through passionate physical birth and manifesting itself as a universal inclination of people toward sinful acts' (Archpriest V. Leonov) [11]. **Among these consequences are the upheaval of the natural order and the emergence of passions. The term "passion" (πάθος) originates from the Greek word "to suffer" (πάσχω), signifying something that inflicts pain and suffering upon an individual. Theological discourse distinguishes between two types of passions: natural or immaculate — "human states of suffering caused by the imperfection of the world and the inherent limitations of human nature following the fall" (Archpriest V. Leonov) [11], and unnatural — "sinful conditions arising from the exploitation of natural attributes and passions in ways that contradict God's divine plan, in pursuit of sinful gratification" (Archpriest V. Leonov) [11].**

After the fall of humanity, sorrow, disease, and death entered into human life. Therefore, disease is perceived as a consequence of the fall. It is often considered a punishment from God, but this is not always true: disease has become natural for fallen human nature and human life.

In the 3rd century, during an epidemic, Christians asked Saint Cyprian, the martyr of Carthage, why they were becoming sick and dying alongside pagans? Cyprian responded, "So long as we are here in the world, we are associated with the human race in fleshly equality, but are separated in spirit. Therefore until this corruptible shall put on incorruption, and this mortal receive immortality (1 Cor. 15:53), and the Spirit lead us to God the Father, whatsoever are the disadvantages of the flesh are common to us with the human race... and the disease of the eyes, and the attack of fevers, and the feebleness of all the limbs is common to us with others, so long as this common flesh of ours is borne by us in the world." [8] Thus, the disease encompasses all.

According to Christian doctrine, the origin of disease is traced back to the first man's disobedience to God, making it an inherent part of human existence. Jean-Claude Larchet elaborates: "This condition is perpetuated biologically, from one generation to the next, and as a result, every individual is born with Adam's fallen nature — afflicted, frail, and bearing the marks of his transgression." [9] The natural law of heredity, while serving both positive and negative purposes in anthropology and soteriology, inevitably brings diseases to all who carry human nature. Often, these ailments are not the consequence of personal sins but stem from the inherent imperfection of human nature. In Pharisaic circles, it was commonly believed that diseases were divine punishment for sins. However, the Lord, when healing a man born blind, declared, "*Neither he nor his parents sinned*" (John. 9:3).

Jean-Claude Larchet, following St. John of Damascus, observes: "In essence, Christ eliminated the inescapability of sin, thwarted the devil's dominion, and triumphed over death; however, He did not obliterate sin itself, the demonic influence, or physical mortality, nor the repercussions of sin in general, in order not to infringe upon the free will that brought it about." [9] It will not be until the Second Coming that God will establish a new earth devoid of sin, where the entirety of the advantages of the Savior's redemptive offering can be fully realized.

At present, man is bound by the laws of this world, which encompass infirmity, suffering, and death. Even saints are not immune to illnesses. **There is no inherent link between the state of one's soul and physical health:** saints can fall ill just as frequently as ordinary people. Multiple factors contribute to this: **the natural progression of diseases, which may be permitted by God; the potential influence of passions or the devil, who may attempt to test the ascetic; and divine intervention, which can either strengthen the ascetic or reveal divine glory.** Thus, the idea that disease is exclusively a result of sin is rejected.

Christian doctrine regards illness as a divine gift or a means for personal improvement. Regarding illness, the Church Fathers suggest asking not 'why is this happening?' but 'what is the purpose of this? Illness prompts us to reassess our lives, alter our outlook, diminish our worldly attachments, or fortify our spiritual and mental resilience. St. John Chrysostom states: "God did not permit this to demean us <...> He did not design our bodies in this manner due to our frailty, <...> but (He designed our bodies in this manner) to enhance our character, rationality, and obedience to Him, which form the foundation of our salvation [12]."

One should not simply tolerate illness passively. For instance, Saint Barsanuphius advises a monk: "You are stricken by this sickness, so that you will not depart barren to God. If you can endure, and give thanks to God, this sickness will be accounted to you as a spiritual work" (Saint Barsanuphius, Philokalia) [4]. This process entails personal growth, fostering humility, and trust in God's plan, ultimately leading to spiritual advancement and holiness.

It is also crucial to remember that **fighting disease effectively requires a responsible approach and the help of qualified professionals.** Blessed Diadochus wrote, "It is by no means forbidden to call a physician to the sick. In human experience too there is skill, and this is why there are physicians among men. But we must place our hope of recovery not in them but in our true Saviour and Physician, Jesus Christ." (Diadochus) [3]. This passage underscores two important principles: the medical profession is a God-sanctioned service, making it appropriate to seek medical assistance; yet, doctors are merely instruments in God's hands, so while expressing gratitude for their care, one should put their main hope in Jesus Christ and, with that hope, overcome illness.

Thus, **Orthodox theology does not limit the question of healing to pastoral care alone; by addressing the anthropological aspect, it allows for the inclusion of not only the priest but also other specialists who help a person attain a healthy life.**

Mental disorders are also considered diseases, but they have their own characteristics and causes.

The first cause of mental illness is physical, stemming from a disturbance in physiological processes. Gregory of Nyssa observed that physical sickness can impair thinking and result in mental disorders. In addressing the nature of madness, many Church Fathers turned to naturalistic knowledge, utilizing all available means for prevention and healing that fostered physical and spiritual well-being. The goal, regarding the physical aspect, is to restore the body to its normal state and re-establish its natural order.

The holy fathers, examining the link between mental disorders and physical ailments, concluded that these conditions are not a disorder of the soul but rather an outward manifestation of it. Regardless of external injuries, the essence of the soul remains intact. When a mental disorder stems from a somatic cause, medical intervention is required to restore the body's proper functioning. However, even with these physical constraints, individuals continue to seek spiritual connection with God. Consequently, alongside medical care, a priest plays a crucial role in supporting the patient, helping them find their way back to God and healing their spiritual afflictions. Thus, even at this stage, the necessity of a multidisciplinary approach based on a holistic view of human nature becomes evident.

The second cause of mental disorders is demonic possession. Identifying demonic possession can be extremely challenging, which is why the Church Fathers stressed that only individuals with the gift of spiritual insight could accurately determine the true nature of the affliction—whether it stemmed from physical or non-physical sources. Therefore, the diagnosis and treatment of such conditions must be entrusted to an experienced pastor or confessor who possesses a high degree of sanctity.

According to Orthodox doctrine, only individuals with deep faith, a pure heart, profound humility, and great compassion for those ensnared by the devil can effectively confront demons and curtail their influence (Larchet J.-C.). [10] Healing from demonic possession is not accomplished by human effort alone but is the prerogative of Jesus Christ. However, there is a role for medical professionals in this process. A physician, applying their professional expertise, can mitigate the patient's pain and bolster their frail physical condition, making it easier to reach their soul.

Within the framework of ministering to the demon-possessed, traditional healing practices included anointing with holy oil, the use of holy water, and occasionally, the laying on of hands. The stereotypical rite of exorcism is documented in only a few instances. Nevertheless, the treatment is rooted in the sacraments of Penance and the Eucharist, as well as in the words of the Savior: "This kind can come out by nothing but prayer and fasting" (Mark. 9:29).

The third cause involves the harm inflicted by personal passions. Deep immersion in a life driven by passions can result in mental illness. In this context, the path to healing lies in the struggle against sin and passion, with the primary remedy being participation in the sacraments of Confession and Eucharist. While the priest plays a central role, the involvement of a psychotherapist is equally crucial, as they manage the physiological aspects of the condition. A comprehensive approach is necessary, as even at a minimal level, it is essential to alleviate the person's suffering and enable them to live. When someone is enduring unbearable pain, whether physical or existential, it becomes difficult for them to receive proper spiritual guidance. Only after their condition has stabilized can further support be offered.

The fourth cause is God's connivance. This cause belongs to the realm of divine Providence: the Lord permits the ailment as part of His special care and for the sake of spiritual salvation

Although each of these causes can be considered separately, in practice they operate in combination. The body is inextricably linked to the soul, which explains the combined manifestation of all these aspects. This understanding allows us to view mental disorders as a multifaceted problem, while also providing opportunities for their prevention and treatment through an interdisciplinary approach involving specialists from various fields.

From an anthropological perspective, **human nature, whether in health or illness, remains fundamentally tripartite and unaltered.** Despite cognitive limitations, the soul persists and continually seeks self-expression. Given that human nature is integral, our attitude toward a person must be based on their human essence.

Love, however, should transcend external circumstances and be unconditional. St. Ignatius Brianchaninov emphasizes: "Show reverence to the blind, the leper, the insane, the infant at breast, the criminal, and the pagan, as they are all the Image of God. What does it matter about their infirmities and shortcomings? Focus on yourself so that you do not lack love [5]." This means that those who engage in the service of others, regardless of their professional background, must cultivate love and compassion. **In spiritual life and in the service to the Church and one's neighbor, stigmatization is unacceptable** - love is essential, both for the patient and for the healthcare professionals involved in their care. This underscores another dimension of the interdisciplinary approach.

The modern scientific community faces a significant challenge: its fragmentation. Each expert often prioritizes their own perspective, narrowing their focus. Only through genuine collaboration can the full potential of preventive measures be realized. This cooperation helps address shortcomings, enhances knowledge, and ensures comprehensive support for individuals. For any professional aiming to provide effective assistance, utilizing all available resources is essential. **Collaboration and interaction are crucial for enhancing the efficacy of preventive and therapeutic efforts.**

To illustrate the benefits of such cooperation, consider two real-life examples of successful collaboration between a pastor and a psychiatrist.

The first case: A woman struggling with alcohol abuse reached out to me in my capacity as a priest involved in addiction prevention through the 'Orthodox Parish Family Sobriety Clubs' program. Initially, she was reluctant to disclose the true reasons behind her addiction, but it later became clear that her drinking was tied to phenomena she considered demonic. The woman regularly attended Confession and received Holy Communion, therefore, the origin of her visions was likely physiological. Not being a mental health professional, I contacted a psychiatrist and arranged for her to receive joint support. Initially, the woman was resistant to the idea of professional intervention and medication, but she eventually agreed to seek help. Through a comprehensive approach encompassing medical treatment, group support, pastoral counseling, and integration into church life, her visions ceased, and her alcohol abuse came to an end. Although some manifestations of the mental disorder persisted, the core issues were resolved.

The second case: A young girl claimed that she was seeing demons. Initially, we agreed that she would engage in regular Confessions and receive Communion. As our relationship grew more trusting, I carefully introduced the notion that her issue had both physical and spiritual dimensions. Due to her sleep disturbances, malnutrition, and debilitation, we considered the necessity of medical intervention. She consented, and I facilitated her consultation with a psychiatrist, thereby commencing the treatment process. Throughout therapy, there were instances of her refusing medication, which resulted in a decline in her health; during these times, I spoke with her about the importance of consulting a doctor to adjust her treatment plan. Through our collective efforts, her condition improved, the visions ceased, she resumed social interactions, attended parish activities, returned to work, and continued her spiritual life.

The examples provided demonstrate the potential for fruitful collaboration between a pastor and a psychiatrist. Their joint efforts enhance professional expertise, foster a productive interdisciplinary exchange, and improve comprehensive rehabilitation for individuals. Achieving comprehensive support necessitates close interdisciplinary cooperation between a priest and a psychiatrist. This integrated approach ensures that both the psychophysiological and spiritual-moral dimensions of a person's condition are addressed. The doctor provides diagnosis and medical support, working with the clinical manifestations of the disorder, while the priest helps to form

support in God, comprehend the path of life and actualize the internal resources necessary for inner work. This collaboration prevents the problem from being reduced to a purely medical or spiritual issue, promoting a holistic approach. Moreover, it aids in distinguishing mental disorders from spiritual states, which is essential for selecting an appropriate and effective treatment strategy. Consequently, the combined support of a patient by a priest and a psychiatrist enhances the effectiveness of therapy, bolsters the patient's inner strength, and creates conditions for authentic rehabilitation, encompassing physical, mental, and spiritual well-being.

It is important that such interaction becomes more widespread to serve people. Only by joining forces can specialists help those in need as effectively as possible — preserving the integrity of human nature and respecting its diversity.

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Some aspects of teaching psychiatry in a religious educational institution

Abstract: A substantive, consistent approach to the problem of distinguishing between spiritual experience and mental disorder, filled with experiences with religious content, is possible by relying on the trichotomy (spirit, soul, and body), being inherent in both Christian anthropology and the modern biopsychosocial model of diseases. Mental disorders are understood primarily as a disruption of mental processes (the reality of which is justified by the concept of the Natural Semantic Metalanguage by A. Vezhbitskaya.) The article discusses some situations and experiences of believers that pose a challenge to distinguish between spiritual experience and mental disorder. Diagnostic and therapeutic recommendations are provided.

Keywords: spirit, soul, body, mental disorder, reflection, instincts, good, evil, pathological mysticism, psychotherapy.

Teaching psychiatry in a religious educational institution is determined by both theoretical and practical considerations. The main one is that with a superficial approach, religious experience and morbid psychopathological experiences turn out to be difficult to distinguish, and each side stresses its own aspects.

This polarization can be explained culturally and historically. It was only in the course of its spiritual development and the accumulation of scientific knowledge that humanity realized that some "visions", "voices", and "ecstatic states" turn out to be manifestations of a mental disorder, since they are followed by "deformation" and impoverishment of mental processes. However, discrepancies in assessment persist to this day. We see the basis of this in the inherent human desire for personal, spiritual freedom. It is often impossible for a subject (be it the psychiatrist's patient or the patient's family member) to recognize that his experiences and worldview are formed and built (in the presence of a mental disorder) not by himself, but by the logic and algorithm of the disease. And for an inquiring mind, the question arises: "What is it really like?" Therefore, we characterize our educational and diagnostic-treatment activities in the field of religiosity and mental disorders as a metaphorical tightrope walk on a razor's edge. This kind of position has a fixed place in the cultural history of humanity. It is no coincidence that representatives of the most important helping professions (clergyman, doctor, lawyer) are sometimes referred to, in a peculiar mythological and psychoanalytic language, as psychopomps – creatures who exist and act on peculiar edges – righteousness and sin, life and death, law abiding and crime.

However, teaching a course in clinical psychiatry in itself (clinical psychiatry focuses on the patient's experiences and aims at solving diagnostic and therapeutic problems) is a challenging and unusual task for any educational institution. The difficulties that arise along this path are diverse. For a medical student, they are defined by the fact that "Psychiatry introduces a doctor to a world beyond the disciplines he already knows. His education is mainly based on chemistry, physics and physiology; psychiatry assumes a completely different basis. That is why psychiatry, practiced by doctors without humanitarian training, does not give the impression of a full-fledged systematically developed scientific discipline" (Jaspers) [1]. It is obvious that a religious educational institution does not suffer such lopsidedness and provides favorable conditions for the formation of the widest possible and multifaceted understanding of the problem.

The course should focus not only on theory but also on rich clinical descriptions, observations, and examples. This approach ensures that psychopathological experiences are not seen as a random assortment of absurdities cobbled together by a doctor for a

diagnosis. Instead, they are presented as structured images produced by a deeply disordered psyche. By incorporating historical and cultural comparisons of normal and pathological states, as well as explorations of the spiritual dimensions of mental illness, the course can offer more compelling insights. This, in turn, fosters a more qualified and imaginative use of the knowledge acquired.

In implementing this approach, we use clinical illustrations and detailed quotations from fiction. We justify this methodological technique by arguing that the diagnostic thinking of a psychiatrist is figurative. The premorbid (initial) mental state of the patient is compared to their current altered state, which is the result of the disease.

So, to avoid making this definition of imagery seem too declarative, let's compare it with the diagnostic approaches in other medical specialties. We believe that it should be easier for non-medical professionals to understand these approaches. The thinking of a neurologist is spatial, as they seek to localize disorders. A surgeon's approach is more like engineering and design. And so on.

For us, the starting point in teaching the course "Religiosity and Mental Disorders" is the trichotomous concept of man - Christian anthropology, introduced into Russian psychiatry by the prominent psychiatrist Professor D.E. Melekhov [7]. This concept is used as a biopsychosocial model for understanding any kind of disease, not just mental illness, and is supported by modern scientific and medical research. This demonstrates the reliability and usefulness of this view of the human "structure". Teaching and diagnostic practice require us to provide clear definitions of all the components of the trichotomy [6]. Of particular importance was the justification of the reality of essentially intangible mental processes (mental processes in the narrow sense - perception, thinking, emotions, will, etc.). To this end, the concept of "natural semantic language" by A. Vezhbitskaya was used.

What was striking was the significant coincidence between the verbs from A. Vezhbitskaya's linguistic anthropology (to see, hear, think, feel, etc.) [5] and the list of actions (mental and spiritual processes) referenced in the daily confession of sins during the evening prayer rule. Consequently, in Christianity, these mental processes are initially filled with spiritual content.

A mental disorder can be broadly understood as a peculiar transformation of ordinary mental functions into unusual ones, such as hallucinations, delusions, and mood fluctuations, including mania and depression, among others. This transformation is often accompanied by a subsequent decline, impoverishment, or even disappearance of these mental processes. Additionally, it is worth mentioning that in some cases, mental pathology can manifest simply as a quantitative alteration in normal, natural mental activities.¹

The question of the causes of mental disorders can be approached from two different perspectives. Academic psychiatry generally recognizes (although this is a simplified and general view) three categories. The first category is somato-cerebral disorders, which are caused by biological processes that damage the body (the "body" in the trichotomy). The second category is endogenous functional disorders, such as schizophrenia and affective disorders, which involve changes in the brain but do not fully explain the symptoms (the "soul" in the trichotomy). The third group is psychogenic, stress-related (the causes in the sphere of the "spirit" - mental traumas,

¹ This does not negate the role of cerebral (brain-related) biochemical, physiological, and anatomical abnormalities in the 'mechanisms' underlying mental disorders. Nevertheless, the classification of these disorders relies primarily on the evaluation of the patient's lived experience. In a state of optimal mental health, visual, auditory, and cognitive processes are experienced by the subject and assessed by both the subject and the observer in terms of structure and meaning. When a subject becomes preoccupied with 'tracking' the physiology of their mental processes, this often necessitates clinical evaluation.

"blows of fate", as they were described last century), possible changes in the brain also explain almost nothing².

In Orthodox thinking, sin is viewed as the primary—and frequently the only—cause of neuropsychiatric disorders, leading to a rejection of medical treatment. Yet, the Gospel account of the man born blind (John. 9:3) remarkably aligns with the classifications used in medical science. To facilitate our discussion, we shall start with group 3 mentioned above. These are the ones who have sinned, specifically believers, that is, in the context of believers, those who failed to accept the misfortune (stress, 'a blow of fate') that befell them as the will of God (or who literally transgressed against it). In the second group (schizophrenic and affective spectrum disorders), neither he nor his parents sinned; the illness arose 'from nowhere' and 'for no reason' (which is the essence of the term 'endogenous')³. It is reasonable to classify patients in the first group (as defined above) as having a specific predisposition to certain pathologies—a 'point of least resistance'—that manifests as a full-scale disease when the individual disregards their underlying 'weakness' (a term used here in its broadest sense, encompassing lack of knowledge). We categorize this group as 'mixed'.⁴

While our (B.V., R.B.) conception of the soul is, to repeat, saturated with psychic processes (perception, cognition, will, etc.), the famous dictum 'the soul is naturally Christian' remains deeply relevant to both psychiatric and psychotherapeutic theory and practice. This application is grounded in a statement by C.G. Jung: 'The process of psychic development, which we call Christian...' (emphasis added) [10].

The point is that the ultimate stage in the ontogenesis of consciousness is reflexive consciousness—self-awareness and self-assessment, where the individual (the subject) views themselves from an external perspective, as an object. It invariably becomes clear that absolute perfection is unattainable; only the Lord is perfect⁵. It is this reflexive consciousness that enables a person to maintain a critical self-view and provides the potential for spiritual growth, including within the Christian tradition. Consequently, the study of the norms and pathologies of consciousness and self-awareness evolves into a psychotherapeutically nuanced reflection on original sin as an inherent 'tool' for recognizing one's own imperfection, as well as on the nature of freedom and responsibility.

The discussion of how consciousness is formed also offers a chance to address a phenomenon that stands in stark contrast to high spirituality, yet remains, unfortunately, quite prevalent: the use of obscene language. Such usage signals a regression to the primitive stages of mental development. Historically and ontogenetically, the psyche was originally rooted in the genitals and the abdomen (omphalopsychism), only later ascending to the heart and the mind. The use of sexually explicit profanity is a primary indicator of an 'underdeveloped' or 'lower' psyche, which expresses itself freely not only

² Modern psychiatry rejects the distinction between 'functional' and 'organic,' assuming that all mental processes, whether normal or pathological, will ultimately be reduced to anatomical and biochemical mechanisms. This is the biological reductionism referred to earlier. We disagree with this perspective, as 'functional' and 'organic' conditions are fundamentally different in terms of psychopathological experience; they manifest as entirely distinct experiences.

³ In light of the clinical reality (the hereditary predisposition in the families of patients within this group), we underscore that in these instances, the presence of the condition in the parents is as inexplicable as its manifestation in the offspring (the enigma of original sin is beyond the scope of this discourse).

⁴ The proposed comparison of the "biblical" and clinical approaches can also be found in the works of Metropolitan Anthony of Surozh [Anthony (Bloom), Metropolitan. Matter and Spirit. Kiev: Prolog, 2007, p. 146] and the Orthodox French theologian J.C. Larchet [Larchet, J.C. The Healing of Mental Illnesses. Moscow: Sretensky Monastery, 2007, p. 158].

⁵ Without dwelling on the problem in detail, we note that this approach turns out to be one of the arguments in the search for a formula for mental health. But it is impossible, it does not exist. Only God is perfect. And the norm of mental health is apophatic – it is the absence of illness. Diseases are known, diagnosed, and treatable (albeit to varying degrees).

through specific vocabulary but also through physical aggression (as motor activity is one of the most 'primitive' manifestations of psychic activity). There is no 'profound, homespun truth' to be found in such language. In this context, and in relation to the closely associated topic of 'psychoanalysis–psyche–mental disorder,' we are guided by Martin Buber's exhortation: not to deify instincts, but to spiritualize them [4].

Yet another, undeniably distressing, form of cognitive decline manifests not only through aggression and irritability but also through disorientation and memory loss. This constitutes the psycho-organic (or encephalopathic) syndrome. The spiritual aspect of this state can be understood through a quote by I. Brodsky: "The point is not so much that virtue does not constitute a guarantee for producing a masterpiece, as that **evil**, especially political evil, is always a **bad stylist**. The more substantial an individual's aesthetic experience is, the sounder his taste, the sharper his moral focus, the freer — though not necessarily the happier — he is. It is precisely in this applied, rather than Platonic, sense that we should understand Dostoevsky's remark that beauty will save the world. Or, as Matthew Arnold put it, 'poetry will save us.' The world, perhaps, cannot be saved anymore, but an individual man can always be saved." [3].

In practice, in everyday life, this means that an angry person is not productive in their intellectual activity and, therefore, can hardly be considered a spiritual mentor.

Reflections on good and evil—on the very nature of 'right and wrong'—naturally emerge when exploring other areas of psychiatry. A case in point is the 'antagonistic (Manichaeism) delusion.' Patients with this condition are convinced they are at the epicenter of a battle between opposing forces. From a spiritual standpoint, it is intriguing to consider which side the patient identifies with. Typically, they claim to be on the 'good' or 'our' side; if they align with the 'bad,' they attribute it to the influence of 'dark forces.' However, it is almost never possible to arrive at a convincing, substantive, and 'universal' distinction or definition of these 'camps.' Upon targeted and even insistent questioning, the answer remains: 'It is impossible to define.' Yet, in the context of a healthy psyche, this situation is not hopeless. N.A. Berdyaev emphasized: 'A moral act is not the fulfillment of a law, but a creative novelty in the world' [1].

For a Christian, this choice is self-evident: '...I have set before you life and death, blessing and cursing: therefore choose life, that both thou and thy seed may live.' (Deuteronomy 30:19)

Trichotomy allows for the justification and formulation of certain psychotherapeutic rehabilitation recommendations for mentally ill believers. Spiritual life, including religious practice, and mental (psychic) changes resulting from illness (in the medical sense) unfold in different dimensions, yet they are interconnected and can influence each other in various ways. Three scenarios are possible. The first, most unfavorable scenario: psychopathological experiences (specifically those with religious content) completely overwhelm the spiritual sphere, rendering any active church life impossible. The second scenario: the patient maintains an active church life, yet during periods of psychiatric exacerbation, their religious experiences become integrated into the symptomatology of the episode. The degree of involvement in church and community activities is determined on an individual basis, considering the specific mental state of the person. Finally, there is the scenario where spiritual and church life remain independent of the symptoms (specifically, the content) of mental distress. In this case, restrictions are minimal or nonexistent.

Mystical states represent a stumbling block in the discourse on 'religiosity and mental disorders,' both for the general public and, at times, even for psychiatrists. Due to space constraints, we cannot explore this concept in depth and will instead focus on a few key clinical considerations.

The most critical fundamental criterion for diagnosing a serious mental disorder (psychosis) is a change in the psyche (negative symptoms, in psychiatric terms). A

healthy psyche does not allow for this: 'I have seen God face to face, and my life is preserved' (Gen. 32:30)⁶. A contemporary philosopher echoes this sentiment: '...the Fathers invariably emphasize that Theosis, the union with God, preserves the identity of the human person, their sameness and self-awareness: the person does not remain the same, yet they remain *themselves*' (S.S. Khoruzhiy, emphasis added by the author) [9].

Let us provide an example that clearly illustrates the absolute necessity of professional psychiatric training for making diagnostic judgments in such situations. People who are wary of Christianity and prone to unprofessionally broadening the boundaries of mental pathology sometimes interpret the phrase 'I do not understand what I do. For what I want to do I do not do, but what I hate I do' (Rom. 7:15) as the Apostle Paul's statement of experiencing 'influence' (the syndrome of mental automatism, one of the most significant in the repertoire of mental disorders). Yet, in such types of delusions, the subject undergoes a distinct, 'utterly abnormal' (B.V., R.B.) feeling—the intrusion of an external force or energy into their cognition, emotions, and motor activity. This experience is vividly depicted in a poem by V. Khodasevich: 'And someone's names and numbers pierce the dissected brain' [8].

However, the author of the message in question 'acts,' 'understands,' and 'wants' of their own volition; it is their 'I' that is actively manifesting itself, rather than any external forces or characters.

When distinguishing between genuine mystical experiences and psychopathology of a similar content (*pathomysticism* — a term coined by us: B.V., R.B.), we tell the patient: 'God does not intrude by force,' and we quote: 'Behold, I stand at the door and knock: if any man hear My voice, and open the door, I will come in to him, and will sup with him, and he with Me' (Rev. 3:20)⁷.

There exist other distinct indicators that allow us to categorize certain experiences as pathological. Yet, the validity of spiritual experience itself is a matter to be judged by those with spiritual expertise and formal recognition, such as members of the clergy, theologians, and religious philosophers. Their approach is fundamentally different from that of medicine: 'It is only within the realm of the soul and the thinking bound to it that one can question correspondence to reality or seek proofs for God's existence. In spiritual experience, however, such a question is inconceivable... For in the spiritual life, spiritual realities are self-evident; thus, there can be no question of whether reality corresponds to what is revealed therein. In the realm of the spirit, there are no objective realities that correspond to experience; rather, spiritual experience itself is a reality of a higher order. Spiritual life is not a reflection of some other reality; it is reality in its essence' (N.A. Berdyaev) [2].

We believe the cases presented here illustrate that psychiatrists have at their disposal specific 'tools' to differentiate between the 'spiritual' and the 'psychological': despondency versus depression, 'life after death' versus mental disorders in terminal states, holy foolishness versus pathological inadequacy and buffoonery, asceticism versus autism. Furthermore, these tools allow for the distinction between habits, rituals, superstitions, and obsessions, as well as between neophytic zeal and pathological obsessions, delusions, and so on. Rather than relying on the 'knife-edge' analogy—fraught with inherent instability and the precarious balancing of incompatible notions—we propose that a trichotomous concept of the human being (what we term '*psychiatric anthropology*') would be more effective. It is this very approach that enables us to

⁶ It is certain that the biblical conception of the soul differs from that offered by clinically oriented trichotomy; nevertheless, we maintain that this divergence is of no fundamental significance in the present context. The very fact that such a clarification is made is striking.

⁷ Certainly, such a dialogue doesn't eradicate delusional disorders, but it can facilitate the formation of a psychotherapeutic rapport and encourage openness to therapy.

address, with both sensitivity and depth, the questions that emerge not only at the intersection of 'religiosity and mental illness,' but also in other equally critical confrontations—whether it be 'genius and insanity,' 'crime and mental abnormality,' 'psychiatry and dissent,' or any other challenges life might throw our way.

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Can psycho-spiritual integration be achieved without religious references?

Abstract: This article explores whether a person with no religious references can achieve psycho-spiritual integration and what spiritual dynamics might facilitate such benefits. Rather than applying a conventional scientific methodology, the conclusions rest on a psycho-spiritual analysis of a real clinical case. The piece engages with the definitional landscape of spirituality in mental health, highlights limitations of common definitions, and proposes a concept of transformative experiences as catalysts for psycho-spiritual openness. Through an adolescent case involving severe childhood sexual abuse and maternal abandonment, the narrative illustrates how life narratives, truth-telling, and a perceived sense of the sacred can contribute to integration, even amid relapse and ongoing life challenges.

Introduction

The core question guiding this intervention is twofold:

(1) Is psycho-spiritual integration achievable for someone without religious references? (2) If so, which spiritual dynamics foster these benefits? This analysis eschews a traditional empirical methodology in favor of a psycho-spiritual reading of a real case to illuminate the mechanisms by which transformation may occur.

Definitions and limitations of spirituality in mental health

In mental health discourse, there is no universally agreed-upon definition of spirituality. Notable formulations include:

- Pargament (2007): spirituality as the search for the sacred.
- Seligman (2002), founder of positive psychology: spirituality as the totality of emotional strengths that extend beyond the individual to connect us with something higher, ampler, and more permanent—encompassing others, the future, evolution, the divine or the universe.

Two important limitations of these definitions warrant emphasis (Tany, 2002):

- They conflate spiritual experiences with outcomes of wellness.
- They reflect an anthropological confusion, tending to emphasize self-realization over relations with others and with the Absolute.

Critical perspectives have cautioned that certain spiritual techniques and experiences can promote egocentrism rather than authentic self-transcendence (Vitz, 1997). In light of this, we consider **transformative experiences** as a distinct category—events that disrupt normal rhythms, provoke astonishment (López Quintás, 2009), and imply a call toward transcendence—where the spirit is addressed through a felt presence guiding toward openness to the transcendent. Such experiences reach “the deepest part of the soul or spirit” and push toward a higher end.

Concept and scope of transformative experience

Transformative experiences begin with a disruption in the ordinary flow of life, eliciting astonishment and a call to a higher end. Epistemological origins (Paul, 2014) have expanded to a broader phenomenology of transformation, wherein the individual encounters a presence prompting an openness to the transcendent. These experiences bear upon the deepest strata of the self and steer the person toward meaning and purpose beyond self-centered concerns.

Clinical case

We present a real clinical case to explore how psycho-spiritual integration may unfold in a developmentally vulnerable context. The subject is an adolescent, Laura, who experienced severe childhood sexual abuse and maternal abandonment. Details are limited to protect confidentiality, but the essential element is the exploration of psychospiritual integration.

A central pillar of the intervention involved using Laura's life narratives to provide trauma psychoeducation and to observe how current events activate negative self-beliefs rooted in her trauma. Over four years of treatment, the course included periods of improvement, relapses, and disengagement from studies, alongside substance use and sexual risk-taking.

Key developmental and psychospiritual insights emerged:

- Laura gradually embraced a truth about herself, internalizing her value as a beloved daughter, even as her life remained distorted by past injuries.
- She identified deeper desires and recognized self-deception in relationships as a means to feel loved, acknowledging that such patterns were illusory.
- In several sessions, she described self-persuasion in relationships, where she idealized potential partners, leading to self-destructive patterns. She voiced a longing for a paternal presence and a need to feel cared for, with implications for relationship failures.

The paradox of the human condition is evident: openness to truth and goodness, felt as a daughter of God, did not always align with sound life choices. This tension is particularly acute in adolescence and in the context of severe early trauma. Approaching adulthood, Laura briefly disengaged from care, driven by fear of the future.

Approximately a year after leaving treatment, Laura sought a reunion to share a significant development. She appeared serene, having resumed studies, stopped using substances, and no longer requiring medication. She disclosed a ten-month relationship and an ensuing pregnancy, signaling a transformative reorientation toward life and responsibility. Laura and her partner continue to care for their child.

Laura interpreted her pregnancy as a personal invitation from a transcendent source to give life, transforming fear into a grateful realization of creating something meaningful. She described initial fear followed by deep gladness in offering new life to existence. Today, both she and her partner actively care for a child who is now more than a year old.

The pregnancy provided conditions conducive to transformative experience: an unpredictable interruption of the normal sequence of events that invites profound personal change. Such experiences operate on three levels—cognitive (meaning), affective (emotional), and volitional (willful direction)—culminating in greater commitment to others and a break from self-centered conditioning. The transformative impulse carries an ecstatic energy that challenges psychological conditioning and invites self-transcendence; however, it requires not only openness but also an invitation that precedes action (Rielo, 2025).

Discussion

This case challenges the assumption that mental health models overemphasize trauma and ego-centricity at the expense of relational and transcendent dimensions. While Laura's life continues to present ongoing challenges and relapse risk, her experience highlights the potential of transformative, meaning-centered experiences to foster psycho-spiritual integration without religious affiliation. Narrative-based approaches and trauma-informed psychoeducation can illuminate patterns of relationship and core affective needs, supporting a sense of meaning, responsibility, and connectedness.

Conclusion

Psycho-spiritual integration is plausible for individuals without explicit religious references, mediated by dynamics that foster openness to truth, goodness, and a sense of the transcendent. Transformative experiences can catalyze deep change when they arise within a framework of vulnerability, personal responsibility, and relational engagement with others. This case demonstrates that healing and growth can occur through a synthesis of personal development, emotional education, and spiritual openness, offering a trajectory toward a healthier future.

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Escalation of responsibility and the emergence of self-awareness among middle-aged Christian widows from Kerala, India: a psychological perspective

Abstract: Widowhood, the state of having lost one's spouse through death, presents several psychological and social challenges. This study investigates the psychological process and experience of widowhood in middle aged widows, with an emphasis on escalation of responsibility and self-awareness. The study was conducted with five widows from Kerala who have completed ten or more years of post-loss period. Present study used qualitative method to understand process and experience of widowhood and narrative inquiry as a data collection technique. The data collected through purposive sampling were transcribed and analyzed based on William Labov's narrative analysis. Findings of the study reveal that the imposed self-change have made impression in widow's life and gradually it leads to self-awareness. The study also highlights the crucial role of social support and mental health interventions in fostering adaptation and resilience among widows. Implications of this study suggest that comprehensive interventions, support systems, and educational programs can significantly enhance the well-being of widows. This research offers valuable insights into the widowhood experience, contributing to the development of effective interventions and support mechanisms to aid widows in their journey towards adaptation and resilience.

Keywords: widowhood, escalation of responsibility, self-awareness, widows.

Widowhood is widely recognised as one of the most distressing life events, often causing profound emotional and social disruption (Utz, Caserta, Lund, 2011). However, it can also catalyse personal growth and the discovery of inner strength amid adversity (Stroebe, Schut, Stroebe, 2007). Widowhood is an event that has a significant impact on a woman's social and personal life, often accompanied by various adverse consequences (Greg, 1976). Based on different perspectives, widowhood is a prolonged and challenging process that a woman needs to reconstruct their identity. In the context of the present study, widowhood is considered to represent an important transition stage that involves enduring psychological struggles for the widow and her children.

Similar to the stages of grief described by Kübler-Ross (1969), widowhood is an emotional journey for widows and widowers. The stages of grief in widowers may not experience all stages in the same sequence, but the process begins with denial, marked by shock, numbness, and difficulty accepting the loss. Generally, the reality starts with anger often directed toward oneself, the deceased spouse, the medical professionals, or even a higher power, stemming from feelings of abandonment or injustice. This is followed by bargaining, where individuals reflect on "what if" or "if only" thoughts, wishing they could alter the outcome or make a deal to undo their loss. The stage of depression, featuring profound sadness, loneliness, and despair, often comes hand in hand with withdrawal from social life and disruptions in daily functioning. Lastly, acceptance covers coming to terms with the permanence of such loss, not to return to happiness but to acknowledge a new reality where the bereaved may start to learn to adapt, rebuild meaning, and reconnect with life.

When considering the bereavement in the process of widowhood, different theoretical perspectives are dealing with it. The Dual Process Model (DPM) for coping with loss was proposed by Stroebe and Schut in 1999 and depicts the way people adapt to death through two interrelated methods of coping: loss-oriented and restoration-oriented coping. Engaging in grief work, allowing oneself to suffer the pain of loss, hoping the deceased might come back, or even refusing to accept changes that could

mean moving on are all forms of loss-oriented coping. Daily situations might evoke very strong feelings, for example, if one sees a person who looks like the dead or finds some of his/her personal items. Conversely, restoration-oriented coping focuses on adapting to life changes, such as managing financial affairs, assuming new roles, building new relationships, or participating in new activities. It may also include temporarily avoiding reminders of grief by staying occupied or distant from emotionally charged places. Central to the DPM is the concept of oscillation, the natural movement between confronting the loss and engaging in restorative activities, allowing individuals to gradually adjust to life after bereavement (Stroebe & Schut, 1999).

Later, the model was integrated with cognitive stress theory (Lazarus & Folkman, 1984) to form an integrative risk factor framework (Stroebe, Folkman, Hansson, Schut, 2006), highlighting how coping with bereavement involves both emotional and cognitive adaptation. Anticipatory bereavement, particularly among women, cannot be understood solely in terms of caring for a dying spouse but must also be viewed within broader social and demographic contexts, such as the fact that husbands are typically older and expected to die first. Furthermore, widowed individuals often face diminished social status and support, leading to financial, social, and psychological disadvantages compared to their married counterparts.

Similarly, there is another approach, the role theory has its roots in the time when social scientists started to compare social life with the theatre, where people's performances were anticipated "roles." The psychologist Jacob Moreno, who was a proponent of this idea, stated that roles get to be the habitual patterns of behaviour in the most intimate interpersonal relationships and that copying others' behaviour or role-playing is a very effective learning method for mastering new roles. Role theorists concede to a large extent that people's actions are determined by the context in which they find themselves and are strongly connected to the person's social standing, such that one's acts are determined by the expectations one has of oneself as well as of others. In the given context, the concept of roles captures both the notion of structures and that of interactions. The term role, when referred to as a structure, indicates the socially defined expectations, although the enactment might be different due to contextual differences or the disparity in resources available. On the other hand, when referred to as an interaction, a role indicates a process of continuous action that is shaped by the prevailing norms, attitudes, self-image, and the dynamics that arise in social interactions among the parties involved.

Role overload and role conflict are the two main concepts in role theory. Role overload happens when the individuals do not have enough time, energy or resources to meet the demands of their multiple roles. On the other hand, role conflict takes place when one role's expectations are in conflict with another's. The tensions caused by these circumstances usually result in role strain, i.e., being unable to live up to the role demands, (Goode, 1960). Women in particular face multiple roles such as daughters, wives, mothers, professionals, etc. Once a woman loses her husband, society imposes on her the new role of a widow, which means she has to give up her previous role as a married woman, and at the same time, she will have to get through the new expectations and the limitations that come along.

Role theory explains how widows negotiate their identities and duties in the context of widowhood. The move towards widowhood compels women to suddenly adjust their lives and prioritise, e.g., they have to independently deal with the matter of finance, take care of the kids who are still depending on them, and keep the house stable. Nevertheless, the actions actually taken by the widows in society are very often different from what people expect them to do because of the surrounding factors like lack of social support, economic hardship, and different ways of coping personally. As a result, widows might have to break the barriers of traditional practices or expectations

about themselves to get through the new challenges. Role theory, therefore, is an efficient model for the present study in understanding how the rise of obligations in widowhood influences both widows and their offspring.

Widowhood and escalation of responsibility

The death of a spouse means that the surviving partner takes over all the responsibilities which were already divided or shared by the dead partner, such as taking care of finances, in case of children, household duties, and participating in social activities, furthermore, this abrupt increase in responsibilities can be very demoralising and stressful (Utz et al., 2004). Among all the grief, society attracts widow women more because they are required to conform to certain standards of behaviour, dressing, and manners that are typically associated with the grieving status. To add to the dilemma of widowed mothers, their kids rely heavily on them to provide all the emotional and material needs, thus making them feel even more responsible. A lot of the time, widows will find themselves tangled in a mesh of role expectations where they have to juggle their personal aspirations, family obligations, and social norms, while at times, having to take up a job or modify their careers to work as both mother and father. The load of managing new responsibilities and making independent decisions can be a big stress factor, especially for those who were previously not very much exposed to financial or admin-related issues (Umberson, Wortman, Kessler, 1992).

Widowhood and emergence of self-awareness

The current research focuses on the impact of the increase in responsibilities that comes with widowhood on the growth of self-awareness and, thereby, on the psychological adaptation of widows. Duval and Wicklund (1972) define self-awareness as the ability to take one's self as the object of attention, to actively identify, to process and to evaluate information about oneself. Following their theory of objective self-awareness (1972), when people direct their attention inwards, they assess their present behaviour against the criteria and values they hold, which results in a self-evaluation and a self-regulation state being triggered. Consequently, this might result in self-criticism, changing one's behaviour to be more in line with the ideal self, or even lowering one's standards to close the gap between the real and the ideal self. Self-awareness is thus a very complex and multifaceted concept involving such interrelated aspects as self-evaluation, self-knowledge and self-regulation, all of which are essential for personal development and adaptive functioning.

Several studies have established that self-awareness leads to accurate self-knowledge (Gibbons, 1983; Markus, 1983) and is the main factor in the development of the aforementioned traits (Gibbons, 1978). It also facilitates the acknowledgement of the disadvantages one has in relation to others (Duval & Silvia, 2002) and encourages honesty in social interactions (Davis & Franzoi, 1986) among others. In this scenario, self-awareness turns out to be a major factor for self-control since it helps people to change their actions, control their feelings and cope with difficult situations better (Baumeister & Vohs, 2003). Moreover, self-awareness is said to be interlinked with the Theory of Mind (ToM), which is the capacity to give the mental states of oneself and others, such as beliefs, intentions, and feelings (Gallagher & Frith, 2003; Malle, 2005). To be more precise, the widows' self-awareness that basically develops out of their newly gained responsibilities could end up being the very source of their emotional insight, self-restraint, and social comprehension, which could in turn give a push in their psychological adjustment and resiliency in coping with loss.

The present study

The experience of widowhood in middle-aged women is a complex process marked by emotional, social, and psychological transformations. Widowhood during middle age often coincides with critical life phases such as career peaks and parenting responsibilities. The abrupt shift from partnership to singlehood can lead to significant psychological distress, impacting mental health and overall well-being. Understanding the unique challenges faced by middle-aged widows can help in designing targeted interventions to support their mental health and social adjustment. There is little research attention on understanding the personal experiences that contribute to adaptability and resilience among widows. Here, the importance of exploring the self-awareness of widows emerges. Middle-aged widows often find themselves navigating new roles and responsibilities, which can lead to enhanced self-awareness and personal growth. Identifying these factors can provide insights into the adaptive processes that facilitate resilience and empowerment in widows. There is strong research support for the relationship between role change and self. Hence, the research attempted to study the psychological underpinnings that influence self-awareness with the escalation of responsibility in middle-aged widows. This study is qualitative and exploratory in nature, addressing the following research questions:

Research question 1: How do middle-aged widows cope with the transition to the state of widowhood psychologically?

Research question 2: How does the escalation of responsibility help with self-awareness in middle-aged widows?

Method

A qualitative narrative inquiry design was adopted to explore widows lived experiences. Five participants aged 45–60 years, with a minimum of ten years post-loss, were selected using purposive sampling. Narrative interviews were conducted to elicit detailed personal accounts of widowhood. Data were transcribed and analysed following Labov's (1972) narrative analysis framework, comprising orientation, complicating action, resolution, evaluation, and coda.

Participants

The population of the study are middle-aged widows from Kerala state, India. We deliberately choose a research group based on a set of criteria. The present study consists of only middle-aged widows. Post-loss period or period of widowhood of participants ranges from 10 years to 13 years.

Measures

This study used narrative inquiry; more specifically, an episodic narrative interview was used. Narrative inquiry is a method that focuses on the power of storytelling as a means of generating data (Huber, Caine, Huber, & Steeves, 2013). Although narrative inquiry usually involves a suite of specific data collection strategies, it is thought to be a significant departure from the semi-structured interview format because of its sole focus on the narrative aspect of communication. There are possibilities to probe and ask more questions if needed, depending on the nature of the answers from the participants.

Procedure

The study was done in two phases; phase 1: pilot study and phase 2: main study. The main study was structured and shaped by the reflections from the pilot study.

Phase 1: Pilot study

To select the participant who met the criteria of the present study investigators used purposive sampling. Collect details of widows and call them and ask for permission. Those who showed willingness to participate in the present study were selected and given general information about the study. Investigator first selected one participant. After establishing a time and place according to the participant's convenience, data collection was performed. The participant was informed about the study and audio recordings were allowed during the process. The investigator got some important insights from the pilot study. The participant might have trouble telling his/her story. A longer time is required to build up a rapport that is strong enough to bring out the narrative because it involves the unveiling of the private emotional experiences. It took the participant over an hour to come to a point where he/she could share his/her story. Furthermore, the researchers came to the realization that they had to give the participants time and that they should not interrupt too much during the storytelling. All these aspects are taken into account in the final data collection.

Phase 2: Main study

The final sample was composed of narratives of five participants. After fixing the time and venue of conducting the study based on the convenience of each participant, data collection was started. Similar to a pilot study, all ethical guidelines such as privacy, confidentiality, right to withdraw and informed consent were taken from each participant. Verbal and written consent were gathered from the participants, and asked to narrate their life situation regarding the romantic relationship dissolution. Also, the investigator provided a considerable time for the establishment of a good rapport.

Analysis of the data

The investigator used narrative analysis to analyse the data. Daiute and Lightfoot (2004) mention that narrative research can be different kinds, and is taken from different social and humanities disciplines. Narrative can be thought of as a specific event being narrated, and as the research method, e.g., as in "the process of enacting interpretive narratives of a narrated event" (Chase, 2005; Clandinin and Connolly, 2000; Pinnegar and Daynes, 2007).

The stories were transcribed and analysed using William Labov's narrative analysis. The narrative inquiry helps understand social patterns found in stories. As narrative inquiry is grounded in storytelling, the researcher left with the stories told by the participants in the study, as well as the researcher's account of the participant's stories and considered both are valid. Labov's narrative analysis emerged in Labov's 1972 essay entitled *The Transformation of Experience in Narrative Syntax* which outlined his ideas for narrative analysis. With his essay, he not only introduced, he also explained the six main components of a narrative. In addition, each component is a tool to identify narrative patterns and capture themes and messages that emerge repeatedly.

The components of Labov's framework are: abstract, orientation, complicating action, evaluation, resolution, and coda and considered the totality of these six components are not a necessity for every narrative.

Steps of Labov's model:

1. Abstract

The introductory part of the narrative is the one that gives a summary of the whole story. The abstract is a representation of the story's characteristics and occurrences. Labov defines an abstract as, "an initial clause in a narrative that reports the entire sequence of events in the narrative" (Labov, 1997).

2. Orientation

The orientation typically provides information about the time, story participants, activity setting, or context in which the narrative takes place. Labov (1972) defines the orientation section as "free clauses at the beginning of the complexity."

3. Complicating action

The complicated action refers to the story's actual events, which propel the plot and keep the audience engaged. The story's backbone is made up of a series of narrative phrases that describe the following events in response to the question, "And then what happened?" (Labov, 1997).

4. Resolution

The resolution of a personal narrative is the collection of complicating actions that follow the most reportable incident, Labov (1997) defines. It answers the question, "What finally happened?" (Johnston, 2001).

5. Evaluation

The point or reason for the narrative being told is referred to as evaluation. The primary goal of evaluation is to clarify the story's point. It is also used to highlight attitudes or command the listener's attention at key points in the story. According to Labov (1972), evaluation is "that part of the narrative which reveals the narrator's attitude towards the narrative by emphasising the relative importance of some narrative units compared to others."

6. Coda

The coda indicates that the story is finished. It acts as a link between the story world and the present. Labov explains that the coda is something in which the narrator emphasises the story's relevance by connecting it to everyday life. It may also refer to events or actions that occur outside the scope of the story.

Along with this, major themes of each participant's narration were found, compared and arrived at the core themes.

Findings

Consolidating all the narratives, it has been possible to identify certain similarities that ran through the different participants' accounts. The main overlapping themes include loss of intimacy, hope and persistent grief, emotional distress due to social stigma, escalation of responsibility, need for affection and support, post-loss adaptation and resilience, self-efficacy, self-identity and self-worth. It turned out that the people involved in the research experienced pretty much the same problems and went through similar processes.

Loss of intimacy, hope and persistent grief

One of the points that constantly came up in all the stories was the loss of intimacy, hope, and the eternal state of mourning. They show the extent to which losing their partner affects their mental state. The partner's absence was the primary cause of their psychological deterioration, moreover, it resulted in losing intimacy, hope, and ongoing sorrow.

The emotional desert left by lack of a close relationship with their partner was brought up in nearly all the stories, leading to feeling isolated and wanting the company of others among the widows. Intimacy loss becomes a very serious psychological barrier to be crossed for the widows and it negatively influences not only their emotional state but also their social life. Losing a spouse is very tough for the one left alive as it can provoke feelings of loneliness and dividing because of the sudden loss of the partner in both emotional and physical terms (Baarsen, 2002). The death of hope is a common theme in all the tales, and the narrators suffer the same way at first feeling despair and being powerless.

Such participants usually talk about their time of mourning when they have to deal with the loss of hope for the future; this is particularly true during the early days of grief when everything seems so unclear and uncertain. Based on the dual process model of coping with bereavement proposed by Stroebe and Schut (1999), mourning can reduce one's perspective about the future and optimism, thus affecting one's motivation and goal-setting activities.

All the narratives revealing the suffering greatly emphasize the long-lasting nature of grief, whereby the narrators go on to feel the pangs of intense sorrow and emotional torment much longer than the actual loss occurred. Stories show the long-lasting nature of grief where they still go through and feel prolonged waves of intense sorrow and emotional pain long after the initial loss. Mourning has been pointed out to be the principal psychological response to the loss of husband or wife. (Boelen and Lenferink, 2020). It can lead to significant psychological distress and impairments in daily functioning (Szuhany, 2021).

Emotional distress due to social stigma

Another theme is the emotional distress due to societal norms. (P1, P3, P4, and P5). The stories narrate a scenario wherein the individuals involved were shunned by the society and this, in turn, added to their mental suffering and sense of being non-valuable. The participants had to conform to the societal norms and values that were generally accepted by society, so they had to suppress their personal preferences, including that in clothing. They were obliged to adopt not only the societal and cultural views but also the interests and choices relating to them. The spousal death was felt by them as a situation where they could not present their true selves or demonstrate their uniqueness. They experienced a similar situation of oppression due to spousal death where they could not present their true selves or demonstrate their uniqueness. The participants perceived widowed life as a state of having no power and no worth. Through the power of self-reflection and mutual support, they began to doubt the validity of their own thoughts, emotions, and actions (P1, P3, and P5), which, in turn, helped them to comprehend their situation and gradually reclaim their identity. Widows often struggle with a loss of identity and role ambiguity after their spouse's death, as societal norms may dictate prescribed roles that no longer apply (Shafiq and Ullah, 2024). Societal pressures and norms can exacerbate mental health issues such as depression and anxiety in widows (Nasir & Giménez-Llort, 2023). Societal norms, which lead to heightened emotional distress and a sense of being marginalised, as reported by P1: "But at a point, I realised how hard it is to be a widow in this society. I was looked at as damaged goods. Someone worthless just because my man wasn't by my side now."

Escalation of responsibility

Another theme that arises from these narratives is the escalation of responsibility (P1, P2, P3, P4 and P5). Narratives highlight how widows take on additional responsibilities previously managed by their spouses, such as financial management and household maintenance, leading to increased stress and burden. The transition from shared to sole responsibility for household and family needs highlights the emotional and practical challenges they face. Widows experience an escalation of household responsibilities following the death of a spouse, which can be overwhelming and emotionally exhausting (Williams, C. 2023). As reported by P2, "He was the one who did all the things in the family. From father's and mother's medicine to children's fees, from house current bill to grocery purchase, he used to do everything. It seems that the thought of how to do all this also affected my mind. It seems that I was more affected by these things and the thought of having to take all the responsibility; it was not to avoid the responsibility." The transition from being a spouse to a sole caregiver and decision-maker can lead to a sense of heightened responsibility and pressure to fulfil

multiple roles effectively (Prigerson et al., 2009). This escalation of responsibilities leads to adapting to new roles amidst grief and loss.

Need for affection and support

Need for affection and support can be considered another theme. Narratives frequently emphasise the importance of emotional support. Supportive relationships can enhance well-being and mitigate the loneliness and grief often experienced after spousal loss (Vedder et al. 2022). The process of rebuilding life after loss involves reevaluating one's identity and roles. P3 mentioned that she identified remarriage as a way to rebuild her life. But she was denied by her mother and daughter cause of this reason. The desire for remarriage, especially in the context of a supportive partner, reflects a natural human need for companionship and support. The resistance from family, including the daughter, adds a complex dynamic to the grief and coping process. This conflict between personal needs and family expectations is a common but challenging aspect of widowhood, especially in cultures with strong traditional values. The story of P4 shows another dimension of the need for affection. After the death of her husband, she dedicated her life to the children, especially her son, who had some physical issues. But for some reason, she was denied by the son. This denial of affection or lack of support deepens the existing grief. Adequate affection and support contribute positively to mental health outcomes, including reduced feelings of isolation and depression (Bonanno et al., 2005). Supportive relationships and networks play a crucial role in alleviating emotional distress and promoting resilience in widows.

Post-loss adaptation and resilience

The narratives illustrate how the participants discover new capabilities and strengths, turning adversity into an opportunity for personal development and resilience. Widowhood can also be a period of personal growth, where individuals develop resilience by overcoming challenges and finding new strengths within themselves (Hahn et al., 2011). All the participants gradually adapt to the needs of life and show resilience. Each narrative emphasises children as their fuel or motivation to bounce back. Stories depict the emotional journey of participants as they move from intense grief to a place of acceptance, finding solace in memories and support from loved ones. Emotional adaptation involves dealing with grief and finding ways to cope with the loss. Over time, many widows develop new routines and find meaning in their changed circumstances (Stroebe & Schut, 1999).

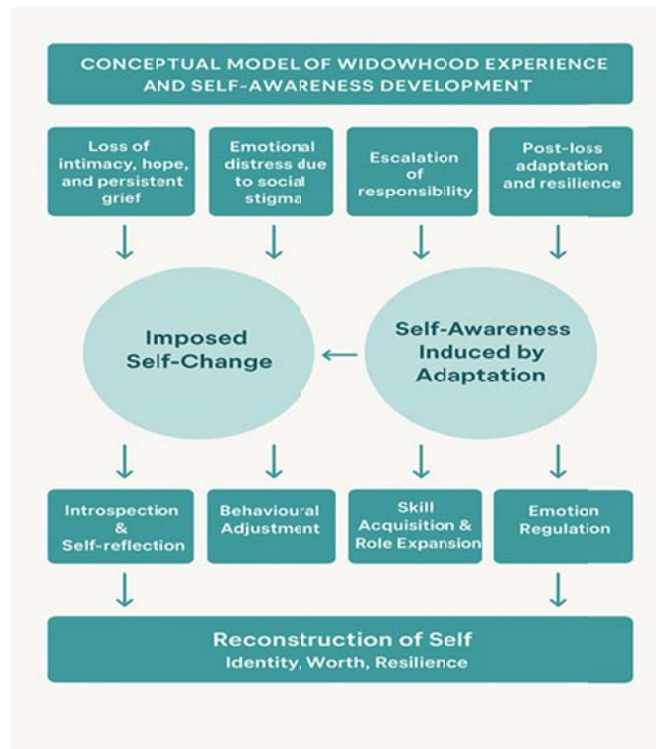
Self-efficacy, self-identity and self-worth

Widows often need to take on roles and responsibilities that were previously managed by their spouse, which can significantly impact their sense of self-efficacy. This adjustment process often involves learning new skills and gaining confidence in their ability to manage independently (Bandura, 1997). All the participants show how they adapted by assuming full responsibility for household and family duties. This process of taking charge and successfully managing new tasks demonstrates increased self-efficacy. Most of the narrator's experience highlights their effort in redefining identities, showing how they evolve from seeing themselves primarily as part of a couple to finding a new, independent identity. The loss of a spouse can affect a widow's self-identity, as they transition from being part of a marital unit to leading a life independently. This redefinition process involves reconciling past roles with new self-perceptions and identities (Montpetit, 2010). Most of the narratives (P1, P3, P4, and P5) frequently mention the struggle against societal judgments and the journey toward self-acceptance and self-worth. They describe how they have fought to maintain their dignity and self-respect in the face of societal bias and stigma. Societal norms and cultural expectations can challenge a widow's sense of self-worth, especially in cultures with strong traditional values that may stigmatise widowhood. Overcoming these

societal pressures and maintaining a sense of self-worth is crucial for emotional well-being (Mburugu et al, 2015).

Discussion

By analysing the narratives and identified themes, several strong and repeated themes emerge that contribute to the self-awareness of widows regarding the escalation of responsibility. There are two core themes: ‘imposed self-change’ and ‘self-awareness induced by adaptation’



Imposed self-change

Self is the totality of the individual, consisting of all characteristic attributes, conscious and unconscious, mental and physical. (American Psychological Association, n.d.; Merriam-Webster, n.d.). According to William James, self can refer either to the person as the target of appraisal (i.e., one introspectively evaluates how one is doing) or to the person as the source of agency (i.e., one attributes the source of regulation of perception, thought, and behaviour to one’s body or mind). The present study identified an imposed self-change in widows after spousal death. The participants reported that they felt pressure to change their preferences to match social concepts about widows. They had to give up their dressing style and interests that society did not approve of. They had to adopt the societal views, interests, and choices. They felt that they could not be themselves or express their individuality. The participants eventually became aware of the negative impact of these stigmatised beliefs on their sense of self and identity. They realised that they had lost their identity, self-esteem, and self-respect. According to Role theory, role strain occurs when individuals experience difficulty in fulfilling multiple roles simultaneously, and role conflict arises when the expectations of different roles clash. Widows often face role strain as they balance responsibilities as a caregiver, breadwinner, and individual coping with personal grief. Another factor contributing to the imposed self-change is the escalation of responsibility. Widows took on new roles and responsibilities, such as becoming the primary caregiver and breadwinner for their families. Participants took responsibilities and acquired new skills, and developed confidence. This can be validated with the theory of psychosocial

development proposed by Erikson. Erikson's theory posits that individuals go through eight stages of psychosocial development, each characterised by a central conflict that must be resolved for healthy psychological growth. Widowhood, particularly in mid-adulthood, intersects with the stage of "Generativity vs. Stagnation". This stage involves contributing to society and helping to guide the next generation. Failure to achieve generativity can result in stagnation and self-absorption. Participants experience a heightened sense of responsibility, as seen in the narratives where they take on new roles and responsibilities to ensure the well-being of their children and household. The detachment process and establishment of new forms of emotional security can also be taken into account. Experiences of the participant reflect the deep emotional distress and the subsequent efforts to rebuild self-worth and emotional stability. In a widow's life, changes in self, occur as part of societal norms, role change and an increase in responsibility. This imposed self-change has made two kinds of impression on their life. In the immediate transition state, it causes emotional distress. But later, the heightened responsibilities made them self-sufficient and helped to rebuild self-worth.

Self-awareness induced by adaptation

The narratives of widows adapting to life after the loss of their spouses highlight the crucial role of self-awareness in their journey. Self-awareness, as explained by Duval and Wicklund's Self-Awareness theory (1972), involves a conscious knowledge of one's own character, feelings, motives, and desires. This theory states that when individuals focus their attention on themselves, they compare their current state to their internal standards and values, leading to self-evaluation and, potentially, behaviour change. Self-awareness is increased in participants as they face significant changes in their lives.

The process of adapting to widowhood necessitates an introspective evaluation of their new reality and the roles they must assume. This increased self-awareness is evident in several aspects of the narrative. The experience of widowhood leads them to the recognition of personal strengths and limitations. All the participants become acutely aware of their capabilities and areas where they need growth. The transition to new roles and responsibilities requires widows to evaluate their skills and adapt accordingly. These are exemplified by P5, who realised her ability to supervise house construction, and found strength she might not have recognised previously and P4, who continued working as a home nurse and managed her son's surgery and highlighting her adaptability and resourcefulness.

Self-focus is an important component in self-awareness theory. When individuals focus on themselves, they compare their behaviour and circumstances to their internal standards and values. (Duval & Wicklund, 1972). The loss of a spouse forces widows to focus on themselves and their new reality. It leads to heightened self-focus. All the participants reflect on their identity and the changes they must make to adapt to their new circumstances.

Self-evaluation is another component of self-awareness theory where individuals assess their current state against their desired state. Participants evaluate their abilities to handle new responsibilities and compare their current state to their expectations and societal norms. For example, P2 recognised her capability to manage household responsibilities, which boosted her self-esteem and sense of accomplishment. If discrepancies are found between the actual self and the ideal self, individuals are motivated to change their behaviour to reduce these discrepancies. This is referred to as behaviour adjustment. The need to align their behaviour with their new roles and responsibilities leads widows to adapt and develop new skills. The experience of all the participants depicts this.

Emotion regulation is a component that contributes to self-awareness. (Gross, 2002). Self-awareness involves recognising and managing one's emotions. Participant develop new coping strategies to deal with their grief and responsibilities.

That is, the experiences in the state of widowhood evoked self-awareness in almost all the participants, and that remains as one of the major factors which contribute to their adaptation and resilience.

Limitations and future directions

Although the study was conducted to be as comprehensive and comprehensible as possible, there are certain areas where it could have been improved. One of the most significant drawbacks was the time issue, which had the most direct effect on the use of narrative analysis as the main technique for data analysis. The study's focus was on the private and emotional side of widowhood and it depended on respondents who were prepared to give up a great deal of their lives; thus, some important data may have been accidentally left out. The study concentrated only on middle-aged widows, thus limiting the possibility of extending its results to the entire population of widows regardless of age. Moreover, it is possible that the study has not taken into account the various environmental and social factors that are at work in the different contexts of widowhood to the full extent.

In the future, researchers could take the longitudinal perspective and follow the path of widows adapting and becoming more resilient over the years, thus, shedding light on the evolution of their experiences and the changes in coping strategies. The inclusion of the viewpoint of children in future research would also help in gaining a more thorough understanding of widowhood, especially regarding family relationships. Not only that, but also looking into the lives of widowers and carrying out cross-group comparisons with other populations who have gone through the same type of loss could really help in deepening the understanding of grief and adjustment. If the research is expanded to include people from different geographical and cultural backgrounds, it would not only enhance the richness of the findings but also make them applicable to various social contexts.

Implications

The findings of the study offer valuable insights into the need for strong support systems-comprising family, friends, and community help widows cope with grief and the practical challenges of life. The research also aids in the process of developing new interventions in the area of grief counselling and therapy and thus provides helping hand in the process of dealing with the psychological conflicts of widows. Not only this, but also the results indicate that it is very important that interventions are heavyweight in terms of culture and are based on societal norms while their negative effects are at least partly reduced. The research prompts the support of the policies that not only confront and wipe out the stigma and discrimination that are usually imposed upon widows but also give a strong voice to the development of community-based programs that through skill training, financial independence, and boosting of self-esteem, empower widows. Moreover, the incorporation of the directing principles of the study into the public health programs will have the effect of improving the entire health status of the widows. At last, the research lays down a path for the potential study of the various experiences and requirements of widows, and its outcomes could not only be used by the future students of social workers, psychologists, and health professionals but also be a part of informing the policy and practice.

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The experience of the Belarusian Orthodox Church in pastoral support for families where a child has committed suicide. Causes of suicidal behavior in minors

Abstract: Suicidal behavior among minors is one of the most pressing issues facing contemporary society. The article explores the key factors contributing to suicidal behavior, with family disorganization holding a particularly significant position. Analysis of domestic and international research data confirms the significance of an interdisciplinary approach to the prevention and correction of suicidal manifestations. Specific focus is given to the role of the family, the Church, and state institutions in providing holistic support during crisis situations, encompassing the first 24 hours post-tragedy, family accompaniment during funeral preparations, and the prevention of post-traumatic stress disorder. The significance and particularities of performing the burial rite and providing pastoral care to families in the Belarusian Orthodox Church in cases of minor suicide are examined. Emphasis is placed on the emergency psychological support system, including hotline 133 – the nationwide, round-the-clock, free crisis support service in the Republic of Belarus.

Keywords: suicidal behavior, adolescents, family, prevention, psychological assistance, psychological emergency number 133, interdisciplinary approach, post-traumatic stress disorder, spiritual support.

Suicidal behavior (SB) includes a wide array of manifestations, from thoughts of suicide to suicide attempts and completed suicides. Data from the World Health Organization (WHO) indicates that suicide is the third leading cause of death for adolescents between 15 and 19 years old [1].

In the Republic of Belarus, as in other post-Soviet countries, hundreds of cases of suicidal behavior among children and adolescents are registered annually [2].

Of particular concern is the fact that suicidal behavior in adolescents is often a reaction to family conflicts, lack of emotional support, school bullying, or the perception of being a "burden" to their family [3]. At the same time, the family and the Church, as institutions upholding traditional values, can become effective barriers against tragedy – provided they are involved in the prevention system and post-crisis support.

This article takes a comprehensive look at not only the causes and prevention of suicide, but also crisis intervention for families. This covers psychological, medical, and spiritual support in the immediate 24 hours after a tragedy, as well as the church's funeral rite as an act of mercy and consolation for the bereaved.

Causes of suicidal behavior: a biopsychosocial perspective.

Modern research confirms that suicidal behavior is best explained from a biopsychosocial perspective [4]. According to the diathesis-stress hypothesis (J.C. Coyne, G. Downey, 1991), suicide is the result of the interaction between biological predisposition and psychosocial stressors [5].

Biological factors include:

Genetic predisposition (16% of cases – heredity for mental illness);

Organic brain damage (identified in 30% of adolescents with suicidal ideation) [2].

Psychological predictors include:

depressive states (neurotic depression in 7%);

pathological character formation (52% exhibiting histrionic, excitable, or unstable traits);

experiences of hopelessness, despair, and "psychic pain" [5].

In 80% of cases, social determinants are associated with family disorganization. Key factors contributing to this include:

- parental divorce;
- family conflicts;
- death of one parent (observed in 8% of cases);
- alcoholism of one or both parents (44% of cases) [2].

Of particular concern are the demonstrative-coercive manifestations of suicidal behavior (41% of cases), predominantly targeting parents. These actions are frequently misconstrued by adults as mere "games" or "manipulations," when in reality, for the child, they constitute a profound emotional outcry, a final endeavor to gain attention and understanding [2].

Prevention of STIs: the role of family, school, and state

STI prevention requires a systemic approach. In the Republic of Belarus, the comprehensive program "Heritage: Spirituality, Family, Culture, History" is being implemented, in which key roles are played by:

The Ministry of Healthcare – through psychological services and programs for parents;

The Ministry of Education – through school trust rooms and emotional intelligence lessons.

The Belarusian Orthodox Church – by means of Sunday schools, spiritual and educational initiatives for parents of minors and families across parishes, clergy meetings, and through explaining the spiritual significance of the Sacrament of Matrimony as the foundation of family to prospective spouses.

Family counseling and re-establishing communication within the family hold special significance. A study found that in 49% of cases, suicide attempts (SAs) were preceded by the individual running away from home. These instances of running away, often a symbolic "message," could develop into more severe situations if they went unaddressed.

Emergency psychological support: the first day after a tragedy.

When a minor commits suicide, the family is in a state of acute psychological shock. The first 24-72 hours are a critical period requiring immediate intervention.

Goals of emergency assistance:

Reducing the risk of PTSD in parents, brothers, and sisters.

Emotional stabilization – processing feelings of guilt, anger, and despair.

Psychological preparation for the funeral – accepting reality, organizing the ritual.

Family support – restoration of family functions, prevention of family system breakdown.

According to WHO recommendations and data from Russian studies (K.V. Syrokvashina et al., 2017), within the first 24 hours, it is necessary to:

provide individual and family sessions with a psychologist or psychotherapist;

clarify the normality of grief responses: numbness, anger, denial, guilt;

provide clear instructions for organizing a funeral and contacting law enforcement.

facilitate community support, involving schools and the church parish.

In the Republic of Belarus, emergency psychological assistance is available by calling 133 – a republican, 24/7 service for crisis support. Operators are trained to handle crisis situations, including the suicide of a loved one. The call is free and anonymous, which is especially important for families experiencing shame or fear of judgment.

The role of the Belarusian Orthodox Church: pastoral care and funeral services.

On February 20, 2025, a scientific and practical seminar for clergy of the Belarusian Orthodox Church was held at the "Ark" Cultural, Spiritual, and Educational Center of St. Elisabeth Convent in Minsk. The seminar was themed "The Path to Life: The Potential for Cooperation between Doctors and Clergy."

The meeting was organized by the Synodal Department of the Belarusian Orthodox Church for Family, Motherhood and Childhood Protection, the State Institution "Republican Scientific and Practical Center for Mental Health," and the Healthcare Committee of the Minsk City Executive Committee.

The main goal of the seminar was to enhance the knowledge and skills of the clergy of the Belarusian Orthodox Church regarding current issues and research related to the mental health of citizens, particularly in relation to the problem of suicide.

The seminar was attended by over 100 people, including 38 clergy representing all dioceses of the Belarusian Orthodox Church, doctors and medical staff from Minsk city children's polyclinics, psychologists from Adolescent-Friendly Centers, representatives of the Prosecutor General's Office, the Ministry of Labor and Social Protection, the Ministry of Education, the Ministry of Internal Affairs of the Republic of Belarus, the Republican Scientific and Practical Center "Mother and Child," and the "Pokrov" charitable foundation for the support of family, motherhood, and childhood.

The presidium of the seminar included Metropolitan Veniamin of Minsk and Zaslavl, Patriarchal Exarch of All Belarus; Bishop Avksenty of Nesvizh, Vicar of the Patriarchal Exarchate of all Belarus. Also present were: Director of the Russian Orthodox Church's Mental Health Department, Candidate of Medical Sciences, Associate Professor, Chief Freelance Psychiatrist and Narcologist at the Ministry of Health of the Republic of Belarus, Yulia Kaminskaya, and Deputy Director and Head of the Youth Psychiatry Department at the Russian Scientific Center for Mental Health, MD and Professor at St. Tikhon's Orthodox University, Vasiliy Kaleda. The moderator was Archpriest Pavel Serdyuk, chairman of the Synodal Department for Family, Motherhood and Childhood Protection.

At its meeting on March 13, 2025 (Journal No. 14), the Synod of the Belarusian Exarchate adopted the following decision:

"2. To recognize the necessity of establishing joint projects within the Belarusian Orthodox Church, involving medical professionals and educators, to provide comprehensive and multifaceted support to families who have lost their minor children.

3. To establish in the dioceses of the Belarusian Exarchate, within the diocesan departments for family affairs, the position of a clergyman responsible for the pastoral care of families in which minor children have attempted suicide or committed suicide.

4. To recommend the introduction of the subject "Fundamentals of Pastoral Psychiatry" into the curricula of the Belarusian Orthodox Church's higher theological institutions (Minsk Theological Academy, Minsk Theological Seminary, Vitebsk Theological Seminary) for full-time and distance learning students. Also, recommend a special course, "Symptoms of Mental and Behavioral Disorders," for clergy participating in advanced training courses.

5. To submit a request to the Ministry of Health of the Republic of Belarus for healthcare workers to regularly hold educational seminars for the clergy of the Belarusian Orthodox Church on providing psychological support to persons whose children or family members have attempted or died by suicide.

6. The Synodal Information Department of the Belarusian Orthodox Church and diocesan information departments, in cooperation with the Synodal Department of the Belarusian Orthodox Church for Family, Motherhood and Childhood Protection, are to

ensure the placement in electronic and print church media of informational materials aimed at fostering among young people a grateful attitude towards life as a precious gift from God.

*7. The Synodal Department of the Belarusian Orthodox Church for Family, Motherhood and Childhood Protection shall be responsible for the overall guidance of church work focused on the pastoral support of families where minor children have attempted suicide or died by suicide, as well as for preparing relevant methodological materials and recommendations for the dioceses of the Belarusian Orthodox Church."*¹

Within the traditional Orthodox understanding, suicide is regarded as a grave mortal sin, a transgression against the divine gift of life, and the funeral rites for those who commit suicide are, by general rule, not offered. However, church canons and documents applicable within the canonical territory of the Russian Orthodox Church, as well as the pastoral practice of the Belarusian Orthodox Church, suggest that exceptions can be made. Diocesan authorities have the discretion to consider these exceptions when deciding to bless the funeral service of a minor, taking into account their mental and emotional state and the context of the tragedy.

Thus, taking into account age-related immaturity (the instability of adolescent and child psyches and their susceptibility to external manipulation), severe psychological states, and experienced family traumas, the diocesan bishop has the right to bless the performance of the funeral rite over the bodies of deceased minors. These decisions are grounded in the 14th Canon of Patriarch Timothy of Alexandria and the July 27, 2011, Holy Synod ruling of the Russian Orthodox Church (Journal No. 87) regarding the funeral rites for those who have taken their own lives due to mental illness.

Our entire discussion, our entire religious life, and our reflection are made possible by the very fact of our existence. The Lord brings us into the life of this world. And this fact serves as the foundation for the Church to preserve life here and now, and to preserve it hereafter, bearing witness to the 'life of the world to come.'

In light of this, the sanctity of life renders its rejection the most grievous of all human transgressions. Thus, many extremist cults aim to dismantle the spiritual link between the Creator and the creation, ultimately stripping life of its inherent worth.

The distortion of life's value takes place in the human mind, while the value of life itself remains constant. This leads to a question: if our perception has changed, what does this signify? Is it a normal reaction of a healthy human nature? A legitimate way of being? Or is it a symptom of distortion, impairment, disease, or catastrophe?

The mere thought of suicide stems from a form of damage. A mature, well-established individual can recognize this as damage (the thought "it's okay not to live"). However, the development of such a destructive thought in the unformed mind of a young person, leading to their demise, cannot be judged with the same severity. Here, we are discussing the absolute nature of canonical judgments and condemnations. Are all suicides alike? No, not always.

In the seminary course 'Practical Guide for Pastors,' the age for a child's first Confession is clearly specified. By age seven, children have typically developed the skills of self-reflection and moral judgment, as well as a formed sense of ideals.

Regrettably, one must note that the true value of life is often grasped only through the experience of loss. In youth, with few exceptions, such experience is lacking. Young people do not lose; they only gain. They have yet to develop a profound sense of life's worth. This perspective invites us to reconsider, from a canonical and pastoral standpoint, the reasons behind a young person's decision to take their own life. Such an immature desire is, at its core, inherently unhealthy.

¹ URL: <http://church.by/docs/zhurnaly-zasedaniya-sinoda-belorusskogo-ekzarhata-ot-13-marta-2025-goda>

Based on this, the Belarusian Exarchate, with the blessing of the Patriarchal Exarch, has implemented a practice of providing immediate pastoral care to bereaved families. This initiative involves clergy working closely with Natalia Gromova, the Ministry of Health's Chief Freelance Specialist in Medical Psychology. For a priest fulfilling his ministry in the image of Christ, the Chief Shepherd who 'descended even into hell,' it is vital that in this critical moment—when a person has willfully ended their own life and nothing can be undone—he is able to provide comprehensive spiritual and prayerful support to a family facing such a terrible tragedy. And that all the efforts of pastoral love, care, and condescension should be directed towards the relatives and loved ones of the deceased: to show compassion to the relatives of the deceased, addressing them with words of support and prayerful comfort; to explain to them that their relationship with the child who committed suicide has not ended, and that he needs their faith and prayer; to call them to prayer for the departed, to an active Christian life, to visiting the church and participating in the sacraments of the Church, and, if there is a blessing from the diocesan authority (in which the priest should provide all possible assistance to the family of the deceased), to perform the funeral service itself.

For in the hearts of all loved ones, one agonizing question echoes: 'WHY?' And unfortunately, no matter what suicide notes the deceased may have left, or what medical records confirming behavioral or mental disorders may be provided, no one will ever be able to answer the question: 'WHY DOES THIS HAPPEN?' In other words, the loved ones of those who die by suicide are forced to live with an unanswerable question. From this agonizing and intractable question stems a sense of guilt: 'Are we to blame?' or 'Is someone else at fault?' In the acute phase of grief, it is crucial to turn to the experience of prayer. It can help manage the feeling of guilt—this vivid emotion—and its subsequent rationalization: 'What did I do wrong?' or 'Did someone else do something wrong?' It is vital to help the bereaved realize that although a person has passed from this world, their life continues within the Church. The Church holds them in remembrance, shares in the sorrow, and mourns their loss.

The Church does not justify this act, yet it does not abandon its pastoral care for the soul of the departed or for their grieving parents. Addressing this issue requires great delicacy, as there is a certain inertia in ecclesiastical consciousness regarding the strict application of canons to such tragic deeds. Yet, this is not necessarily a bad thing—it is a testament to our firm grounding in traditional values. Any social consciousness is subject to continuous development and is inevitably confronted with the necessity of morally evaluating certain phenomena. The Church, existing within the social fabric, is bound to consider the state of public consciousness and provide a pastoral response to contemporary issues.

Cases of juvenile suicide require further reflection and the development of an official position within the ecclesiastical framework.

In our view, the category of children and adolescents should be given special consideration regarding the admissibility of funeral rites for those who have committed suicide, for a number of reasons:

- The developmental immaturity of a minor's psyche accounts for its inherent instability and the volatility of emotional responses. Consequently, actions that a child or adolescent would not commit under normal rational conditions are often performed impulsively, driven by sudden affect. This phenomenon can be attributed to the ongoing process of mental development, which makes behavior, especially during adolescence, unpredictable and often inappropriate.

- Children and adolescents who commit suicide are often victims of manipulation—for instance, through phenomena like the 'Blue Whale' or social media platforms that romanticize death and glorify suicide. A child with an underdeveloped psyche becomes a mere instrument in the hands of others.

Based on the circumstances, we deem it appropriate to propose that the funeral rite for minors be administered in the ordinary, general order, as is customary in the tradition of our Church. Not only to offer comfort to relatives facing the depths of despair, but also based on common sense and the circumstances cited above, it is evident that children and adolescents cannot commit suicide while being fully cognizant and accountable for their actions. In the case of a child or adolescent, this is more likely a genuine example of an unconscious, irrational act, performed without a full understanding of its consequences. It is often a true 'cry for help' or a demonstrative, manipulative act of self-harm.

The funeral rite should be viewed not as a formal procedure, but as an act of God's mercy toward a suffering soul; a source of spiritual comfort for the family, helping them cope with feelings of guilt and abandonment; and a symbol of the community's support that allows for the acceptance of tragedy and aids the family in their healing. The Church does not judge; it heals. The teenager who has passed away is not a sinner, but a victim of pain they could no longer bear. It is our duty to pray for them and to stand by those left behind.

Parishes of the Belarusian Orthodox Church are involved in establishing 'grief support groups,' where families can share their experiences, receive guidance from clergy and psychologists, and participate in prayer meetings.

PTSD prevention for family members: a long-term approach

Without timely support, the experience of a child's suicide can lead to PTSD, depression, parental divorce, and suicidal ideation in siblings [4].

Comprehensive crisis intervention includes:

short-term therapy (3–6 weeks): addressing shock, guilt, and ambivalence.

Medium-term support (3-12 months): Reconstruction of family roles, restoration of daily life/routine.

Mid-term support (3-12 months): Rebuilding family roles, re-establishing life patterns.

Long-term support (over a year): dealing with trauma.

Conclusion

Suicidal behavior in adolescents is not an isolated tragedy, but a reflection of a society in crisis—one marked by a loss of spiritual direction, the disintegration of family ties, and a profound lack of emotional support. Yet, even when faced with suicide, no one should have to stand alone."

State authorities, civil society organizations, schools, and especially the Belarusian Orthodox Church are tasked with creating a 'network of mercy' that can:

prevent tragedies through enlightenment and family support;

provide urgent aid in the immediate aftermath of a loss;

support the bereaved on their path to recovery;

restore meaning and hope through prayer, remembrance, and community.

One of the most poignant and clear verses in the Bible that highlights how much every person matters to God is: 'Do not be afraid, little flock, for your Father has been pleased to give you the kingdom' (Luke. 12:32). While addressed to Christ's disciples, this verse speaks to everyone. It reassures us that even if you feel small, unimportant, or forgotten, you are not alone—God sees you, and He is pleased to grant you the Kingdom of Heaven.

Another profound quote emphasizing the value of every human life: 'Are not two sparrows sold for a penny? Yet not one of them will fall to the ground outside your

Father's care. 30 And even the very hairs of your head are all numbered. 31 So don't be afraid; you are worth more than many sparrows.' (Mat. 10:29-31).

This passage is particularly important in the context of SB and the sense of "being a burden" that afflicts weak and vulnerable members of society: it reminds us that no one is superfluous, even the smallest bird is under God's providence. And man is more precious than all creation. God even knows the number of hairs on everyone's head – that's how attentive He is to each individual. These words bring comfort, hope, and affirm: every life is precious, necessary, loved.

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Specifics of religiosity in patients with mental disorders - participants of the Special Military Operation

Abstract: The aim of our research was to explore the religious beliefs of patients at the Military Medical Academy's psychiatric clinic who had participated in the Special Military Operation (SMO). Among the patients with mental disorders – SMO participants – who regularly attended the church at this clinic, a significant number exhibited neurotic and stress-related disorders. Schizophrenia-related conditions and disorders associated with alcohol and psychoactive substance abuse were also prevalent within this group. These conditions revealed peculiar aspects of religiosity in these individuals. The majority of Orthodox patients could be characterized as individuals with limited church attendance and minimal religious knowledge.

Keywords: Religiosity of military personnel, Special Military Operation, mental disorders of combatants, spiritually oriented psychotherapy.

We conducted a comprehensive study examining the structure of mental disorders and religious beliefs of 55 individuals who participated in the Special Military Operation in Ukraine during the period 2022-2025. Following their participation, these individuals underwent a thorough examination and treatment at the Military Medical Academy's psychiatric clinic. Additionally, they actively engaged in religious activities at the hospital's affiliated church. The structure of mental disorders observed in this patient cohort is presented in Table 1.

Table 1. The structure of mental disorders in patients participating in the SMO who attended the Church.

ICD-10 codes	Number of patients (%)
F01-F09	3 (5,5 %)
F10- F19	8 (14,5 %)
F20-F29	17 (30,9 %)
F30-F39	1 (1,8 %)
F40-F49	27 (49,1 %)

Approximately half of the patients in this category (49.1%) demonstrated predominantly anxiety-depressive symptoms and/or conversion (dissociative) symptoms, which are classified within the neurotic and stress-related disorders category (ICD-10 code F40-49).

Many patients in this subgroup reported that their faith in God had strengthened during the war. They told of various miracles, myroblyting icons, the miraculous preservation of icons when part of the building was destroyed, and the saving of their lives in situations that seemed to be hopeless. For these patients, visits to the church and participation in religious services, characterized by an atmosphere of tranquility and prayer, often resulted in a reduction in anxiety levels and a gradual alleviation of depressive neurotic symptoms. However, as the discharge from the hospital approached, some patients experienced a relapse of their neurotic symptoms. This deterioration was frequently associated with their negative perception of the necessity to continue military service and their apprehension about returning to the war zone. Some patients regarded visits to the church as a form of divine intervention that would shield them from

military service. If they were deemed fit for continued service, they often expressed dissatisfaction and frustration, stating, "I prayed, but it did not help." Our observations suggest that this attitude among patients who are not deeply ingrained in the Orthodox tradition and possess a magical perception of church prayers, rituals, and sacraments was influenced by myths spread through media and social networks. During counseling sessions or confessions, the priest immediately delineates the scope of their professional competence: clergy and medical professionals collaborate to provide assistance to the patient, each within their respective domains of expertise. It is crucial to emphasize that the priest cannot exert influence over the outcomes of medical treatment or the determinations of the military medical commission (MMC).

Some patients with neurotic conditions visited the temple primarily for the purpose of "lighting a candle and praying for their departed friends." However, they refused f.e. to confess their sins, stating, "I will return there anyhow," or "What is this confession about? I have taken lives." Despite participating in church services and sacraments, several patients experienced suicidal thoughts and intentions during their stay in the hospital. These thoughts typically originated from anxiety-depressive conditions and a profound sense of guilt. Some expressed a combination of faith and resentment towards God, questioning why He had not assisted in challenging situations or why He had not saved those who perished. For certain patients, their faith appeared to be superficial, they rather wanted to get religious amulets, with rings bearing the inscription "Save and preserve" being particularly popular. One patient admitted to not believing in God but wore a cross "as a talisman." But most of the patients who attended the church considered themselves Orthodox and sought to pray and participate in the sacraments. However, preparing for these sacraments presented challenges, particularly abstaining from smoking before services. To enhance comprehension among parishioners in a community with a limited number of churches, it was decided to conduct all services in Church-Russian language.² These services have been held at the church for over five years, and for many patients, they partially compensate for the lack of initial religious education.

The second largest group consists of individuals with schizophrenia-spectrum and delusional disorders (ICD-10 code F20-29), accounting for 30.9% of the total cases. The elevated prevalence of psychosis among this military subpopulation can be attributed to several factors. This is primarily attributed to the lack of professional selection for most SMO participants, a group predominantly composed of non-career military personnel, specifically those who signed contracts with the Russian Ministry of Defense only after the Special Military Operation began. Regrettably, these individuals typically undergo only cursory medical check-up during the signing of their contracts. Some patients successfully concealed their history of psychiatric treatment and use of antipsychotic medication. The decision to join SMO was frequently impulsive and without thorough consideration of the potential consequences. For example, one might say, "I saw a drone fly over the Kremlin on the news and decided to enlist." Specifically, they failed to consider that during combat operations, they would be unable to receive supportive treatment. They were running out of antipsychotics, and a psychotic exacerbation would soon follow. Some patients signed contracts due to delusional motives. They believed they could shoot down planes and drones with a single glance and therefore "were simply obliged to go there to help the guys." Some patients had ideas of 'religious omnipotence,' where the patient, for example, believed themselves to be God or Archangel Michael. However, in the majority of patients in this

² The Church-Russian language is a translation into literary Russian of traditional liturgical texts with full preservation of their semantic, dogmatic and doctrinal content and adapted for understanding by our contemporaries.

group, persecutory delusions predominated. The tense atmosphere, the need to constantly be on guard, fear, the presence of a vital threat, and often complex relationships with colleagues (including due to the patients' personality and behavioral peculiarities) progressively increased anxiety and triggered delusions of reference and persecution.

Such patients, when admitted to a psychiatric clinic, would often try to go to a church even in an acute psychotic state. Their treating physician's temporary ban on attending church services would provoke a negative reaction, perceived by them as a violation of their religious rights and freedoms. In certain cases, it was necessary to accommodate the patients' wishes by inviting a clergyman or, if their condition allowed, transporting them to the church prior to the complete resolution of their psychotic symptoms. The results, however, were varied. Some patients attended the service quite calmly, their behavior not standing out in any way. In others, especially those with religious-delusional symptoms, feelings of persecution by "evil forces" and ideas of possession intensified. Confessions and conversations with a priest for such patients in a psychotic state were usually unproductive. At the same time, some patients gradually recovered from their psychotic state during treatment and willingly continued to attend church. Others, after their delusional symptoms were alleviated, quickly lost interest in religion.

As an illustrative clinical example, we present the case of a female service member diagnosed with paranoid schizophrenia.

Patient K., 42 y.o., does not have a history of psychopathology within her family. She exhibited normal development during childhood, achieving academic excellence, and subsequently graduated from a medical college. At the age of 24, she experienced her first psychotic episode characterized by affective-delusional symptoms. Patient K. underwent treatment at a psychiatric facility in her hometown, where she was prescribed neuroleptic medication. Following discharge, she discontinued follow-up care and did not seek further specialized psychiatric assistance. She worked in her profession as a nurse.

During the fall of 2022, Patient K. voluntarily enlisted in the military under a contract, concealing her history of hospitalization in a psychiatric facility. While serving, she participated in military operations, worked as a nurse, and encountered repeated life-threatening situations, as well as witnessed the death of colleagues. Six months later, she began to feel that others were against her and considered her a "Ukrainian agent." She became suspicious, anxious, and her sleep was disrupted. Patient K. was admitted to a military hospital with an initial diagnosis of schizophrenia. Subsequently, she received treatment at the psychiatric clinic of the Military Medical Academy and municipal psychiatric hospital No. 3, where delusional persecutory ideations were diagnosed. She believed that the Federal Security Service was "monitoring her with the intent to imprison and kill her," so she intended to "jump out of the window." Additionally, she reported perceptual distortions, including visions of "soldiers without heads and arms," and asserted that people in her battalion intended to remove her to assume her position. Structural abnormalities in her thought processes, such as verbal slips and paralogisms, were also observed. Patient K. expressed symptoms of anxiety, mood instability, and thought confusion. Her condition improved gradually with the administration of neuroleptic and mood-stabilizing medications. Upon stabilization of her mental state, she frequently attended church services. The military-medical commission found her medically unfit for military service.

The third largest subgroup of patients, 14.5% of the total, comprises individuals suffering from alcohol and drug addiction, as well as mental disorders, often of a psychotic nature, due to the use of psychoactive substances (ICD-10 code F10-F19).

Among these patients, there were more people who had signed contracts while in detention, compared to other subgroups. At the same time, these patients could be characterized by a strong interest in religion, which was manifested in various ways. In particular, they often had numerous tattoos with religious symbols on their bodies. Generally, their attitude towards alcohol and drug abuse was more positive. It is important to note that many patients abstained from alcohol and drugs during combat, recognizing the potential for severe consequences, including rapid death. However, upon admission to the hospital or following leave, they typically resumed alcohol and substance use almost immediately. Within this subgroup, there are individuals who are deeply religious and devout churchgoers. They sincerely regret their inability to independently control their cravings for psychoactive substances. These patients regularly attend religious services, confess their sins, receive communion, and engage with religious literature. The clergy consistently offers support to such patients through therapeutic groups or specialized centers upon their discharge from the clinic. Nevertheless, only a small number of them seek further assistance to overcome their addictions.

It is noteworthy that among the patients who visited the temple, there were very few patients with organic disorders (5.5%). This can be primarily attributed to the fact that individuals with such conditions typically receive treatment in neurological and neurosurgical clinics following injuries and head trauma. These patients undergo MMC, receive psychiatric consultations, and, if necessary, receive prescribed medication. Our church is located within a psychiatric clinic, and occasionally, patients from other clinics within the academy visit us for worship, though this is rather the exception rather than the norm. In the future, we plan to cooperate more actively with the nearest clinics so that patients who are being treated there and have the opportunity to freely enter the academy's territory visit the church more frequently. It is likely that many of these patients could benefit from spiritually oriented psychotherapy and pastoral counseling.

We conducted a survey of 30 patients who were not visiting church at the time of the inquiry. These individuals were undergoing treatment at a psychiatric facility subsequent to their involvement in the SMO. The survey uncovered that 24 individuals (80%) identified themselves as Orthodox, 4 (13.3%) were atheists, and 2 (6.7%) adhered to Islam. Thus, there was a majority of Orthodox Christians.

However, a significant portion of these Orthodox patients could not be categorized as regular church attendees. Only 54.2% of Orthodox respondents had ever read the Old or New Testament. 41.7% of Orthodox Christians prayed almost daily, 29.2% prayed rarely and mostly in their own words (they did not even know "The Lord's prayer"). 29.2% of Orthodox patients did not pray at all. Of all Orthodox Christians, 37.9% have never confessed or received communion (and most of them did not even know what confession and communion were), 25% of patients occasionally received communion, and 37.5% of Orthodox Christians received it regularly (once a year and more often). The most Orthodox patients were baptized in childhood, and only 1 patient was baptized as an adult, respectively, the majority did not undergo any catechisation.

Conclusion

In the cohort of patients with mental disorders who participated in SMO and actively attended church services at the Psychiatric Clinic at the Military Medical Academy, neurotic disorders and stress-related conditions were most frequently observed. Additionally, schizophrenia-spectrum disorders and disorders associated with alcohol and substance abuse were also prevalent among these individuals, revealing unusual features of their religiosity. The most Orthodox patients could be categorized as having limited church attendance and minimal religious knowledge. It can be assumed

that both of these factors influence self-reflection and motivation when there is an opportunity to choose one's own position on religious issues outside of extreme combat conditions.

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The impact of fraudulent activities and periods of general social tension on mental health (introduction to the problem)

Abstract: This article addresses the critical issue of mental health disorders resulting from fraudulent activities. It examines the multifaceted impact on spiritual and mental well-being, as well as social stability. The characteristics of mental disorders, common across all age groups and differentiated by age, are elucidated. The clinical picture of mental disorders that developed in the current situation becomes more complex as the patient's age increases. Victims from older age groups are particularly vulnerable, exhibiting a propensity towards negative mental health trajectories, even after the resolution of the fraudulent situation. The risks to spiritual well-being, particularly in relation to the cessation of Eucharistic participation, are highlighted. The roles of psychiatrists, psychologists, clergy, and spiritual counselors are delineated. The findings once again underscore the necessity for collaborative efforts between psychiatrists, psychologists, and clergy to address acute mental health challenges, particularly in socially challenging circumstances.

Keywords: fraudulent actions, victimization, mental disorders, age periods, psychopharmacotherapy.

Over the few past years, especially with the beginning of SMO, there has been a notable increase in offenses involving fraudulent activities, particularly telephone scams. Since the problem affects all segments of the population, the scientific community, primarily lawyers, psychologists, and psychiatrists, could not remain indifferent. They began to investigate the causes and patterns of behavior of the victims. According to the Russian Science Citation Index (RSCI), more than 200 studies on this critical topic have been published since 2020. However, research on the changes in mental state and personality traits of victims of remote fraud remains limited and predominantly focuses on the psychological dimension [1,4,5,7,8]. For example, the research of N.V. Meshkova, V.T. Kudryavtsev, and S.N. Enikolopov indicates that the phenomenon of victimization spans a range from a "fear of losing" to a "desire to enrich oneself." The fear of loss serves as a crucial tool of manipulation, effectively placing the victim in a position where they have no choice. F.S. Safuanov, O.F. Savina, M.V. Morozova, and Yu.O. Perepravina highlight that the integration of digital technologies into personal life has significantly eroded personal boundaries and reduced personal space [3]. This, in turn, has led to careless behavior among individuals with a strong sense of duty, responsibility, and heightened anxiety traits. The authors draw a fundamental conclusion that the primary psychological state of victims is characterized by delusion, arising from an erroneous interpretation and evaluation of the situation under the influence of psychological manipulation by fraudsters [6]. In the face of traumatic situations involving material losses (such as loans exceeding repayment capacity, loss of housing, etc.) and legal consequences (commission of criminal acts), victims usually experience changes in their mental state, up to clinically defined manifestations of various mental disorders. In light of the above, this article **aims** to provide a preliminary overview of the existing data on mental disorders among victims of fraudulent activities and their associated outcomes.

Since the beginning of 2025, 65 individuals have been examined on an outpatient basis — 15 men and 50 women — who had no prior history of mental illness. They were referred to psychiatrists due to legal procedures. Isolated, initially diagnostically clear cases with severe chronic mental disorders, implying a worsening of the condition with an exacerbation of psychopathological symptoms, were not included

in this group. The age range of the participants was from 18 to 82 years old. In some cases, their religious affiliations were clarified, with most identifying as Orthodox Christians, 1 as Catholic, and 1 as Muslim. According to the data received, regardless of gender, age, educational background, social status, or religion, the initial and prolonged reaction to the scammers' actions was **fear**. This fear had both rational grounds, such as threats to material well-being, health, and the future, including the possibility of incarceration, as well as irrational components. Nearly all participants reported never having experienced anything similar before. Those with some religious background "disengaged" temporarily, ignoring the Lord's repeated admonition "be not afraid" (Mat. 10:30-31, Mark. 5:36, Luke. 8:50) and did not attempt to pray. In all cases, even those involved in scientific and social activities had difficulty verbally describing their current condition. Additionally, a sense of "being controlled and manipulated" was noted in almost all cases, making it difficult to gather detailed accounts of their experiences. Alongside fear, participants reported anxiety, confusion, mood swings, sleep and appetite disturbances, and a complete "submission" to the scammers' instructions, leading to difficulties in fulfilling work and school obligations. During this period, those who were church members actually ceased participating in the Eucharistic liturgy. Essentially, their capacity to reason and seek God's will was significantly impaired, as John Climacus noted: "Reasoning, in the broad sense, is acquired to accurately and correctly perceive the Divine will at any time, in any place, and in any situation." [2]

According to the preliminary analysis of the patients' mental state, they showed some differences depending on their age, along with the general clinical manifestations mentioned above. Specifically, in younger individuals, characterized by a somewhat relaxed attitude towards the situation due to perceived immaturity and subjective support from older relatives, anxiety-depressive and sleep disturbances were relatively transient. Typically, the daily routine of study or work was altered for a brief period, and in some instances, they sought outpatient psychiatric or neurological assistance. In the majority of these cases, a diagnosis of "adjustment disorder, unspecified" (F43.20 according to ICD-10) was established.

In the middle age group, which determines the social stability of the family, the clinical picture was characterized by significantly pronounced and prolonged anxiety and depression, often leading to disorganized behavior and self-blame for perceived "thoughtlessness". Persistent sleep disturbances, an extended period of confusion, and difficulties in critically understanding the current situation were also observed. These symptoms necessitated supportive psychopharmacological intervention. The diagnoses included "Adjustment disorder with depressed mood" (F43.21 according to ICD-10), "Adjustment Disorder with Anxiety" (F43.22 according to ICD-10), and "Adjustment disorder with mixed disturbance of emotions and conduct" (F43.25 according to ICD-10).

The most vulnerable individuals in the analyzed scenario are those from older age groups. This vulnerability is attributed to the physiological decline in central nervous system plasticity, which is compounded by somatic conditions that form an "organic backdrop." Additionally, there is a rigidity in attitudes and established behavioral patterns. Among those who did not receive psychiatric intervention prior to experiencing fraudulent activities, a retrospective analysis of their mental state revealed pre-incident changes consistent with the following diagnoses according to the ICD-10: organic anxiety disorder (F06.4), organic emotionally labile [asthenic] disorder (F06.6), and mild cognitive disorder (F06.7). The depressive states that developed in response to these traumatic situations were characterized by general disorganization, notable cognitive deficits, persistent insomnia, self-blame, and self-deprecation, often expressed as feelings of having let down family and children. These individuals also exhibited atypical reactions, emotional instability, and a tendency toward peculiar interpretations

of the actions of their close environment. At the insistence of relatives, these individuals typically sought psychiatric assistance and received psychopharmacotherapy for a relatively long period, including during the course of the examination. In addition to these mild organic mental disorders, acute stress reactions (F43.0) and mixed anxiety and depressive disorder (F41.2) were also diagnosed prior to the commission of the illegal acts. In a number of cases, there was a negative trend with the formation of organic personality and behavioural disorders (F07.08) and non-psychotic mixed organic disorder (F06.37) by the time of the examination, which required consultative psychiatric supervision and, in some cases, inpatient treatment.

The data indicates a significant impact of fraudulent activities, particularly in adverse social conditions, on the emotional and psychological health of individuals across various demographic groups and socioeconomic backgrounds, as well as on their social stability. Victims, especially those in the active working age group who have never previously sought psychiatric help, often experience significant stress. This experience can be distressing and may lead to concerns about potential negative consequences for their professional lives. In many cases, individuals, even professionals such as lawyers and economists, lacking any prior credit history and having already resolved their housing issues, struggle to accept the need for substantial lifestyle adjustments, which can be inherently traumatic and hinder the restoration of mental well-being. These issues highlight the necessity for timely and appropriate psychopharmacological treatment under the constant supervision of psychiatrists, along with psychotherapeutic and psychocorrective interventions by psychological specialists to develop effective coping strategies in the actual situation. Of particular concern are cases where Christians have ceased to participate in the life of their church (or other denominations, as appropriate). This requires close attention from clergy and spiritual leaders in order to help these individuals overcome their spiritual crisis.

Conclusion

Fraudulent actions, particularly in socially tense environments, exert a substantial influence on the psychological and emotional well-being of individuals across diverse age groups and social strata. In addition to causing significant financial losses and psychological distress, these activities frequently lead to spiritual crises, which further exacerbate mental and social instability. The imperative to address this issue underscores the validity of the proposition that the most effective strategy for resolution involves collaborative efforts between psychiatrists, psychologists, and clergy.

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Counseling of families with mental issues based on a spiritually-oriented approach

Abstract: This paper explores the role of spirituality and religion in the context of mental health disorders and their influence on family caregiving systems. It focuses specifically on the psychological and social profiles of relatives of patients with mental illness, whose lifestyle is transformed under the influence of a loved one's illness. It has been shown that the inclusion of a spiritually-oriented component in psychotherapy contributes to the improvement of families' social functioning, the correction of codependent behavior, the reduction of relapse rates, and the formation of meaningful religious behavior. The general structure of a psychotherapeutic model is presented, which includes a spiritually-oriented approach based on T.A. Florenskaya's model of spiritually-oriented dialogue.

Keywords: mental disorders, spiritually-oriented approach, family counseling, spiritual support, religious coping, spiritually-oriented approach by T.A. Florenskaya.

In the works of philosophers and psychologists, one can find diverse perspectives on the role of spirituality in human life. Some argue that a person's spiritual world is a natural manifestation of living a meaningful life. Others believe that turning to spirituality imbues life with profound significance and infuses interpersonal communication with essential depth. Spiritual values and meanings are universal in nature, while the realm of eternal values, universal symbols, and archetypes is culturally conditioned, serving as a 'window into the spiritual world, a language of eternity' [Jung, 2019].

Spirituality and religion can serve as a significant pillar of support for families of patients with mental disorders. According to some researchers, spirituality and religion can play a role in managing mental health challenges [Kaleda, 2025]. Additionally, spiritual resources and religious coping mechanisms may be effectively employed within spiritually-oriented psychotherapeutic interventions for psychiatric patients [Verhagen, 2019]."

For patients with a religious worldview, mental illness leaves a distinct mark on their faith, resulting in a unique form of religiosity shaped by their psychiatric condition. Several studies have shown that in some cases, religious patients may experience a gradual transformation of overvalued religious ideas into religious delusions [Kopeyko & Samsonov, 2020]. Furthermore, pseudo-religious concepts may emerge, representing an absurd and bizarre mixture of ideas from various religious systems [Kopeyko & Orekhova, 2021]. As a result of the progression of mental illness, patients with a religious worldview may distance themselves both from individuals who adhere to the traditional values of their society and from their own families [T.V. Vladimirova, E.V. Smirnova, A.G. Alekseeva, 2025].

The relatives of patients with mental disorders generally possess unique psychological and social profiles, requiring the application of specific psychotherapeutic approaches [A.B. Kholmogorova, 1993]. Notable examples include characteristic emotional responses, such as the emergence of distrust and oppositional behavior, alongside frequent challenges in emotional regulation and a tendency to fixate on negative experiences. Intellectual functioning may be characterized by cognitive difficulties, deficits in concentration and memory, and a tendency to make categorical judgments [Rivkina & Salnikova, 2009]. Changes in the family's outlook and way of life are driven by the relatives' preoccupation with the patient's needs and their commitment to safeguarding the patient's mental health [Sudin, 2016].

The adoption of the four-part bio-psycho-socio-spiritual framework in psychiatry over the last few decades has driven a shift toward exploring innovative family-centered interventions and counseling practices. Recognized by the World Health Organization (WHO) as a key element of the bio-psycho-social-spiritual model, the spiritual component offers substantial resources for navigating the difficulties associated with mental illness. This applies to both patients and their caregivers and should be integrated into rehabilitation programs [Solokhina, 2025].

Over the last few decades, a new paradigm has developed in the approach to families of patients with mental illness, where relatives are considered partners and essential support systems throughout all stages of the treatment process. Acting as partners in the care process, families can offer mutual emotional support, identify early signs of relapse, encourage patients to seek professional help, promote their reintegration into family and community life, help fight stigma and discrimination, and advocate for legislative improvements [T.A. Solokhina, A.I. Tsapenko, S.V. Trushkina, 2015]. The European Psychiatry journal increasingly features studies reporting on the use of spiritually-oriented approaches and religious forms of support in family counseling [T. Turgut, F. Ekşi, 2020].

Support from the church community is of significant importance for patients suffering from mental illness and their families. The relationships formed within the church, along with the sense of community inherent in a religious environment, enable such families to receive both moral and material support. The feeling of unity and a deep sense of empathy and compassion make it possible to directly internalize the principles of religious life. This is rooted in the core values of faith and the commitment of the church community to serving others with mercy. In this context, suffering resulting from mental illness is understood as an opportunity to draw closer to God, and a family's decision to seek help is less associated with a resistance to revealing their suffering.

The role of spiritual meanings and religious beliefs in coping with mental illness was investigated in patients with schizophrenia and comorbid conditions, in individuals with addiction, and in their family members. It was shown that religious patients exhibited greater preservation of value orientations compared to a sample of non-religious patients, and that turning to spirituality and religion has the ability to preserve mental health [G.I. Kopeyko, O.A. Borisova, O.Y. Kazmina, 2016]. In the course of family therapy for patients with comorbid pathology and addictive disorders, the integration of spiritually-oriented support enhanced the effectiveness of rehabilitation interventions by influencing the life meanings of the members of sobriety clubs [A.N. Baburin et al., 2023].

The document 'Pastoral Care for the Mentally Ill in the Russian Orthodox Church' emphasizes the importance of family dynamics for those with mental disorders, noting that internal conflicts in religious families can contribute to the exacerbation of mental health conditions. Addressing the needs of patients with mental health disorders and religious backgrounds, along with their families, requires the development of effective therapeutic and medico-social rehabilitation strategies. These strategies should incorporate a multidisciplinary approach, fostering collaboration between mental health professionals and clergy members.

Evidence from family programs designed for religious populations suggests that integrating a spiritually oriented component into psychotherapy enhances its effectiveness for religious families compared to standard approaches [Magay, 2024]. One promising approach to this interaction is counseling based on the spiritually oriented dialogue developed by T.A. Florenskaya and adapted for use with families of individuals with mental illness [Magay & Ryazanova, 2023].

The spiritually-oriented approach, referred to in T.A. Florenskaya's thesaurus as the dialogical approach in practical psychology, "is founded on the acknowledgment of the human spiritual world and seeks to reinterpret their psychic life, fostering the development and transformation of the personality on this basis [T.A. Florenskaya, 2001]. Accordingly, the author proposes the concepts of the 'potential, spiritual Self' and the 'actual, present Self.' The former denotes an orientation toward higher spiritual values, whereas the latter signifies a state of being preoccupied with immediate experiences and dominated by lower ego-centric concerns.

The "Actual Self" and the "Spiritual Self" in the spiritually-oriented approach are consistent with the concepts of "Real Self" and "Ideal Self", which are accepted in humanistic psychology. According to Florenskaya, the distinction lies in the fact that the "Spiritual Self" in the spiritually-oriented approach, unlike the "Ideal Self" in Carl Rogers' theory, "is not a conscious image-ideal... but can be actualized in the process of personal development." She continues: "The Spiritual Self" is the essential core of the personality, which we refer to as the voice of conscience, as creative intuition. Following the 'inner voice,' the 'call' of one's 'Spiritual Self' is a necessary condition for normal human development [T.A. Florenskaya, 2001]. When development moves toward realizing the 'Spiritual Self,' "one can speak of normal, harmonious personality development." If a person acts in a way that is contrary to this, "deviations and difficulties in their mental state are inevitable—up to the disintegration and pathology of personality."

T. A. Florenskaya developed the method of spiritually-oriented dialogue. Within the structure of a dialogical conversation, she identified the method of dialogical listening, the method of questioning to facilitate the dialogue, the creation of a problem situation, and the method of catharsis. Adapting this method for the relatives of patients with mental disorders allowed for the development of a four-stage counseling approach: introduction, request formulation, support, and feedback. These counseling sessions were further supplemented by psychoeducational training.

It is important to note that the effectiveness of such counseling has been observed both among the relatives of patients with endogenous mental disorders and among the relatives of individuals with comorbid conditions and addictions. Key achievements of this method include improvements in social functioning and quality of life for families with a religious worldview, the formation of social networks for families and support groups, a reduction in the number of exacerbations and relapses among patients, correction of codependent behaviors in relatives, increased family awareness of ways to support and cope with mental health issues, understanding the specifics of the illness, and living with someone who has a psychiatric diagnosis, as well as changes in spiritual and religious behavior, expressed in a deeper and more conscious perception of spiritual and religious meanings.

In conclusion, we would like to emphasize the importance of further developing the counseling methodology based on a spiritually-oriented approach. A promising direction for this work, in our opinion, could be the integration of various forms of family interventions, a differentiated approach to the immediate environment taking into account the unique characteristics of each family, and the conduct of quantitative and qualitative research to assess the effectiveness of such efforts.

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Is addiction a fatal disease? A Christian addictologist's perspective

Abstract: This article reflects on the question of how one can say that addiction leads to death. Alcoholism and drug addiction are clearly life-threatening diseases. But does the same apply to other addictions, such as behavioral ones—like gambling or sex addiction? The article explores how this question can be answered from the perspective of Christian spirituality. The key concept discussed in the article is unmanageability.

Keywords: addiction studies, addiction, death, Christian theology, Christian addiction studies, unmanageability.

Introduction

This article is the result of the work of the Center for Christian Addictology, which I head and which has been operating for several years under the auspices of the Danilov Monastery in Moscow. The concept of 'addictology,' it seems to me, is no longer a novelty, neither in the scientific community nor in the public consciousness. Increasingly, this discipline is attracting the interest of domestic addiction medicine. Back in November 2025, the Deputy Speaker of the Russian State Duma put forward a proposal to introduce the profession of 'addictologist' in Russia. It seems that the day when addictology gains official recognition and starts to flourish is just around the corner. Regrettably, there is still a lack of academic literature on the subject. Our Center is making some modest efforts to contribute to this field ¹.

The mission of 'Christian addictology,' a minor branch of addictology, is to bridge scientific achievements in the field of addiction studies with Christian theological anthropology. The goal of this new discipline is to create a space for productive dialogue between science, the Church, and society, as well as to develop a scientifically grounded yet ecclesially oriented perspective on the problem of addiction and its overcoming.

Currently, the Center focuses on two priority projects: the course 'Fundamentals of Christian Addictology' for ordinands (conducted since 2021) and the 'Parish Addiction Counseling Ministry' course for parish-based social workers (conducted since 2024). The Center's staff conducts ongoing theoretical and research activities aimed at strengthening the scientific and theological foundation of the discipline ².

This article is an attempt to reflect on a very specific topic through the lens of a Christian addiction specialist. We are exploring the question: "Is addiction a terminal disease, and if so, how?"

¹ I would like to thank R. Y. Kuzmin, PhD, an employee of the Center for Christian Addiction Studies, for his assistance in preparing this article.

² See, for example:

- Zaimovskiy, L.E. (Hegumen Iona) and Kuzmin, R.Y., *Theology and Dependence: The Experience of Building Christian Addictology. A Scientific Monograph* (Moscow: Praktika, 2021).
- Hegumen Iona (Zaimovskiy L.E.), and Kuzmin, R.Y., "Prevention of Addiction in the Church Community: From Rivalry to Cooperation," *Narcology* (2024), No. 11, pp. 30-37.
- Zaimovskiy, et al., "Christian Addictology as a New Field of Pastoral Counseling," *Sretenskoye Slovo*, a scientific journal (Moscow: Sretensky Theological Academy Publishing House, 2022), No. 2, pp. 111-132.
- Hegumen Iona (Zaimovskiy) et al., "The Theology of Personality in the Arsenal of Christian Addictology," *Ugresh Collection: Works of Teachers and Undergraduates of the Nikolo-Ugresh Orthodox Theological Seminary* (Issue 12, Moscow: Nikolo-Ugresh Theological Seminary, 2022), pp. 23-53.
- Hegumen Iona (Zaimovskiy) and R. Y. Kuzmin, "Christian Addictology as a New Research Field," *Bulletin of Christian Psychology* (2023), No. 1, pp. 172-198.; Iona Hegumen (L.E. Zaimovskiy), and R.Y. Kuzmin. "Codependency in the Arsenal of Christian Addiction." *Bulletin of Christian Psychology*. 2024; 2: 253-78.

Following the SARS-CoV-2 pandemic, which claimed the lives of tens of millions worldwide overnight, the discourse on death has gained unprecedented relevance. Research increasingly focuses on the threat posed by various diseases—not merely to individual lives, but to humanity as a whole. The field of addictology has not remained on the sidelines of this discussion.

Chemical addiction is, without a doubt, a disease that poses a deadly threat to humanity. It is clear that alcoholism and drug addiction result in widespread premature death. Substance abuse is the root cause of the majority of car accidents, serious and violent crimes, and accidental fatalities, not to mention the diseases directly caused by substance misuse.

However, unlike cancer, addiction is a condition that can be treated today. In our view, this fact is one of the greatest achievements of the 20th century. To be more precise, addiction cannot be 'cured' in the absolute sense, but its progression can be halted, allowing one to live a dignified life without relapsing into destructive behavior.

The advancements in addiction medicine, the efficacy of self-help groups, and the expansion of the rehabilitation industry serve as compelling evidence of this. Given the desire, an individual in the modern world can find the opportunity to cease destructive behaviors and lead a dignified life.

E. M. Jellinek, M.D., a pioneer in the scientific study of alcoholism and a staunch supporter of the Alcoholics Anonymous movement, mapped the progression of alcoholism in a diagram known as the Jellinek Curve (Fig. 1).

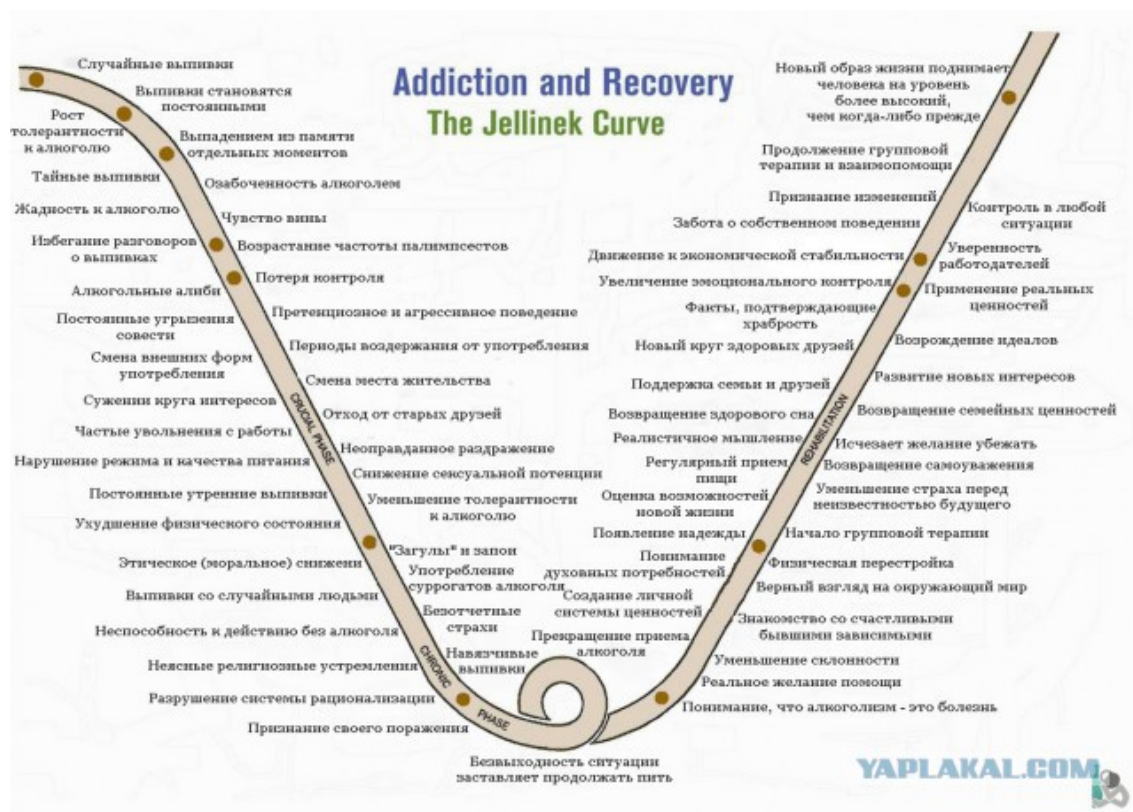


Fig. 1. The original "Jellinek curve" in Russian. The diagram provides a detailed description of each stage of the illness process, rehabilitation, and recovery.

Jellinek's reflections are imbued with optimism, as he posits that humanity has finally resolved another tormenting issue: finding a method to arrest chemical dependency. This outlook was shaped by his extensive experience working with

Alcoholics Anonymous. He became a firsthand witness to the miracle of countless individuals overcoming alcoholism and maintaining stable, long-term remission.

Note that the Jellinek model offers a comprehensive perspective on alcoholism and recovery, distinguishing it from the deeply elaborated, yet strictly medicalized and reductionist approach characteristic of Soviet narcology.

The modern version of the Jellinek curve, used in all rehabilitation programs, has a small graphic addition that carries significant meaning—it indicates the possibility of a fatal outcome due to substance use. Consider it a sort of appendix of death (Fig. 2)!

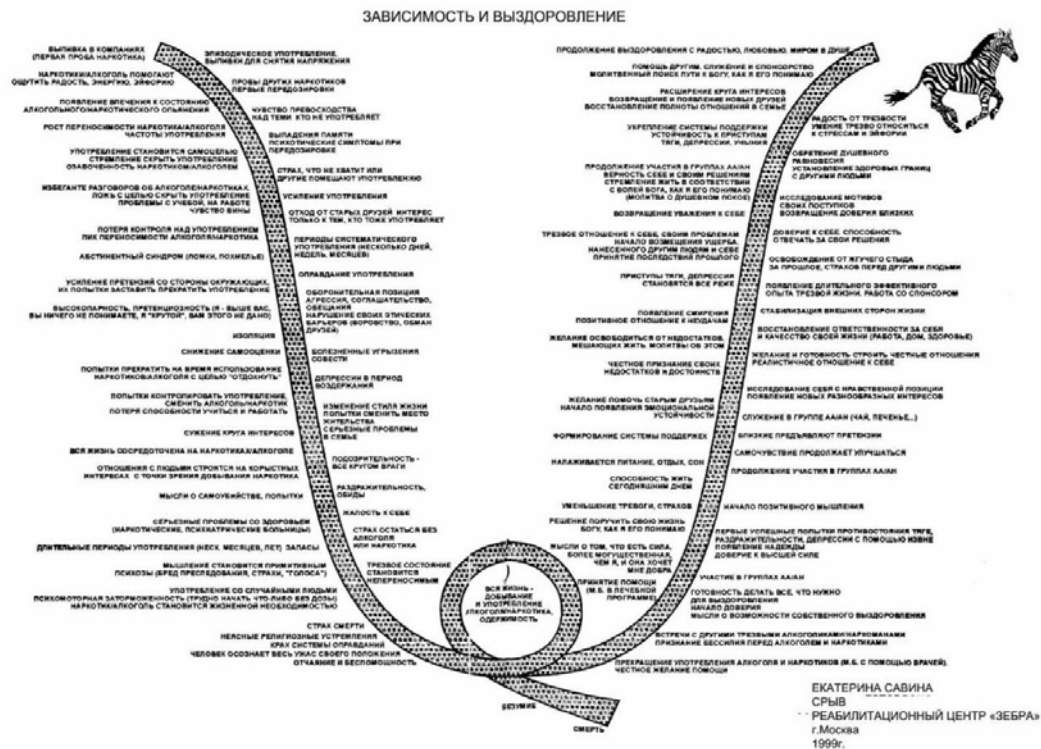


Fig. 2. This diagram was created at the Russian rehabilitation center "Zebra" in 1999.

An addict can hit their "rock bottom" and still avoid death, embarking on a path to recovery and returning to a fulfilling life without substance use. We see that after reaching the lowest point of the parabola – the "bottom" – a rapid ascent begins, marking the phases of rehabilitation and recovery.

But why doesn't Jellinek's optimism align with reality? The fact that the disease can be managed, treated, or halted does not mean it ceases to be a deadly threat to individuals and humanity as a whole

On the contrary, despite the successful advancement of addiction medicine and the robust rehabilitation movement, the deadly danger posed by addictions is only increasing, taking on a truly global scale. For instance, we can mention the two horrific fentanyl epidemics in America from 2021 to 2023, which claimed the lives of over a hundred thousand young people. Humanity has never experienced anything like this in the realm of substance use.

In the diagram, we see that the person struggling with addiction is presented with two paths: one leads to premature death due to substance use, while the other leads to a fulfilling life without it.

It seems to me that this diagram captures the essence of addiction—not only its medical and psychological stages but also its existential core. Today, Jellinek's model is used widely and applied to describe any form of addiction (Fig. 3).



Fig. 3. The modern unified view of the "Jellinek curve".

The diagram reflects the general phases of any addiction: progressive, crucial, chronic, as well as the rehabilitation phase and recovery phase for those on the path to healing.

An expanded understanding of Dr. Jellinek's diagram became possible due to the formation of the main hypothesis of addictive medicine, specifically, the hypothesis that all addictions share the same biochemical mechanism, develop according to the same laws, and can be described within a single common model.

But if this is the case, and if we know for certain about the deadly dangers of alcoholism and drug addiction, in what sense is this applicable to other dependencies? What does the term "deadly" mean in relation to addiction as such? What does it mean for addiction to be a fatal disease? Does every addict face a fateful choice?

The answer is less straightforward than it might initially appear. Even with alcoholism, a fatal outcome is not an inevitable certainty. Many active alcoholics and drug users live well into old age. Furthermore, alcohol consumption is deeply embedded in culture and religious practices, and it remains widely available for purchase across most of the globe.

While the drug situation is not identical, certain parallels exist: on the one hand, there are substances strictly prohibited by law, where possession entails criminal penalties and consumption frequently leads to fatal outcomes. Conversely, some drugs are being legalized in various jurisdictions globally. The pharmaceutical industry is developing increasingly subtle and complex pharmaceuticals, permitted for use by prescription. What, then, does this selectivity signify?

The situation with behavioral addictions is even more complex. Can we say with any certainty that video games, overeating, or pornography will lead an addict to death? Perhaps the thesis that addiction leads to death is only applicable to certain types of addiction, and even then, only in their most severe forms? But wouldn't that undermine the central idea of addictology—that all addictions are fundamentally related? It is these very generalizations and assumptions that make evidence-based medicine circles look at addictology with suspicion.

However, the key lies in the spiritual nature of the problem. We believe that, in a certain sense, any addiction is a disease leading to death – this is the thesis of Christian addictology. In what sense should this be understood?

Addictologists agree that the primary, defining characteristic of addiction is the loss of control over consumption, resulting in a state of being unmanageable³.

This is also evidenced by the First Step of any 12-Step program: 'we... became powerless over [our addiction],' meaning we became unmanageable.

Any addiction specialist or counselor can share numerous tragic stories from the lives of addicts. In each such story, we see how this unmanageability manifests itself and how it leads first to irreparable losses, and then (in many cases) to a fatal outcome.

But what lies behind this lack of control, this irresistible drive, this obsession? Can we claim that psychology or psychiatry has the answer? While this phenomenon is explored by psychology, deviantology, pedagogy, and psychiatry, the deep-seated nature and root causes of it—much like any other aspect of human consciousness—remain without a definitive scientific explanation.

Within the study and treatment of addiction, the concept of 'unmanageability' stands as a cornerstone. One might say that in cases of addictive personality disorder, unmanageability makes itself heard loud and clear. People who appear healthy, competent, and rational engage in shameful, dangerous, and destructive behaviors, unable to explain the reasons behind them—neither to themselves nor to anyone else.

What makes addiction so uncontrollable is that it cannot be attributed solely to social, biographical, psychological, or psychiatric reasons. It seems, in all likelihood, to be rooted in the very mystery of what it means to be a human being.

This is why social measures alone—ranging from harm reduction, decriminalization, and legalization to stricter drug laws and prohibitionist policies, or even preventive work—are insufficient for society and the state to resolve the issue of addiction. Addiction is simply not just a medical or social problem. We maintain that the phenomenon of unmanageability should be viewed primarily as a spiritual issue.

The specialized literature of various 12-Step programs provides compelling evidence that addiction is a terminal illness and that the addict loses control over their own life. There is a remarkable unanimity in the way unmanageability and the death drive are portrayed across the literature of alcohol, drug, food, nicotine, gambling, and sex addiction. Having conducted a thorough analysis of these books, we found that, without exception, all 'basic' texts for recovering addicts define the disease as fatal and the addict's life as unmanageable. And this is the testimony of hundreds of thousands, if not millions, of people around the world.

We contend that, from a spiritual perspective, unmanageability can paradoxically be described as the opposite process — as a form of 'manageability'.

When gripped by addiction, a person falls under the sway of the spiritual forces behind it. These forces drive the individual in one direction only—toward a biological, psychological, and social decline, leading inevitably to physical and spiritual death.

This assertion cannot be demonstrated within the realm of science; rather, it is revealed and understood through the experience of Christian Revelation.

The teaching of Jesus Christ explicitly declares that the world is surrendered to the 'prince of this world' (John. 14:30), the prince of darkness, who comes only to 'steal,

³ «The pivotal point in addiction is loss of control. The individual swears that there will be no more episodes, that he or she will go to the party and have two beers. Instead, the person drinks until he or she experiences a blackout and swears the next morning, "Never again!" only to repeat the behavior the following night. The individual may be able to stop for a period of time, or control use for a period of time, but will always return to compulsive, out-of-control use». Handbook of Addictive Disorders. A practical Guide to Diagnosis and Treatment. Ed. by Robert Holman Coombs. John Wiley & Sons, Inc., Hoboken, New Jersey. 2004, P. 5.

kill, and destroy' (John. 10:10). In the Gospel, the Lord Jesus Christ describes the role of the devil in the life of man and humanity as follows: he is 'a murderer from the beginning' (John. 8:44). In the Epistle of the Apostle Peter, we read that the devil is 'a roaring lion, seeking whom he may devour' (1 Pet. 5:8). According to Christian theology, the devil has set himself against man because man is God's beloved creation. By harming people, the devil seeks to inflict pain upon their loving heavenly Father⁴.

Why does Satan possess the power to 'steal, kill, and destroy'? He acquires dominion over anyone who has, in some way, sinned or departed from God. The adversary of God holds a legal claim to pursue those who have transgressed His law. This peril looms over every human being without exception, as 'all have sinned and fall short of the glory of God' (Rom. 3:23). Sin provides an entry point for the devil, and 'the wages of sin is death' (Rom. 6:23). Sin is our conscious agreement with death. St. John of Damascus teaches that death entered the world through sin, consuming human life like a savage and indomitable beast. The Cross-sacrifice of our Lord Jesus Christ has redeemed humanity from death; yet, this redemption must be known, embraced, and lived out in our daily lives.

God did not create death, yet in a fallen world, death is inevitable. In Christian theology, bodily death in itself is not an inherent evil. The death of the Lord Christ on the Cross, and the death of His witnesses who did not renounce their faith, are victories, not defeats.

Bodily and physical death becomes an evil when a person fails to fulfill their human purpose, when their life is squandered, and when, instead of living, they choose a slow and agonizing process of dying. This is precisely what happens in addiction. It is the spiritual death of a person—that is, complete separation from God—that is the ultimate goal of Satan's work. When a person gives themselves over to addiction more and more, their physical end may very well coincide with their spiritual death. These are truly chilling words!

Every addict knows deep down that their illness is a self-destructive path—a way of dying before life has even ended.

Death is the inevitable fate of those who have surrendered their lives to the control of God's adversary.

However, the kerygma of the Gospel is this: God abhors death; it is alien to His purpose and is the 'last enemy' to be destroyed (1 Cor. 15:26). Jesus said: "I am the resurrection and the life. Whoever believes in me, though he die, yet shall he live, and everyone who lives and believes in me shall never die" (John. 11:25-26).

The message of Christian addictology is simple: God heals addiction. He delivers those who seek Him from being out of control. But because the power of addiction is so strong, the addict needs constant perseverance, steadfastness, faithfulness, and faith. That is why rehabilitation, support groups, the 12 Steps, and ministry are indispensable.

However, victory over death is the prerogative of God, and God has already achieved it in the life of every person. In the Book of Deuteronomy, we read: "I have set before you life and death, blessing and cursing; therefore choose life, that both you and your descendants may live..." (Deut. 30:19). 'Christian Addictology' offers us a lens through which to perceive the deep biblical significance underlying the question raised at the start of this article. The Jellinek curve — a graphic representation of addiction and recovery — also implicitly carries a biblical message of fall and redemption, of the prodigal son's return to the Father's house. Addiction is a life-threatening disease,

⁴ St. Augustine, in his work "The City of God", considered envy to be the root of the devil's actions against humanity.

primarily in the same sense that a battlefield is life-threatening. It is a battlefield between God and His adversaries. Yet, the victory will ultimately belong to God.

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The basic principles of conducting spiritually-oriented therapy to combatants

Abstract: In the provision of care for the wounded and sick, and in their subsequent medical-psychological rehabilitation, the synergy between the church and the army can be pivotal. Spiritual support, by nurturing an individual's reliance on their inner divinity, empowers them to surmount maladaptive manifestations of traumatic illness, particularly when faced with disfigurement. The involvement of clergy is important at all stages of the rehabilitation process: the initial, hospital, and concluding stages. The combined efforts of the Church and medicine accelerate the achievement of positive results in the rehabilitation process.

Keywords: spiritually-oriented therapy, medical and psychological rehabilitation, combatants, traumatic disease.

The collaboration between the military and the Church in Russia dates back centuries. The Orthodox faith served as the spiritual and ethical foundation for Russian soldiers. A Christ-loving fighting force and a faithful commander together represent the perfect ideal of the Russian army.

The interaction between the church and the army acquires special importance in the context of providing aid to the wounded and sick, and their subsequent medical and psychological rehabilitation. Spiritually-oriented therapy for those involved in combat is a vital area of psychological assistance, aiming to restore emotional states, increase their awareness of their place in the world, and help them discover meaning in their lives.

The core principles of spiritually-oriented therapy include:

1. Tailored approach. Recognizing the uniqueness of each patient, it is essential to account for the individual characteristics of every combat veteran. Therapy must be designed around the patient's personal attributes, religious convictions, cultural background, and life situation.

2. The principle of humanism: A person is seen as a unique individual with dignity and rights. Empathy and respect for the patient are essential, as well as a desire to support their inner world and help them reach their full potential.

3. Awareness and self-acceptance. The patient needs to become aware of their feelings, thoughts, and actions, and accept their story and traumas. This involves working through feelings of guilt, shame, fear, and anxiety in order to start the healing process.

4. Overcoming the crisis of meaning. Participants in combat operations often face existential crises that can lead to a loss of meaning in life, a belief in the unfairness of the world, and a feeling of meaninglessness. The therapist's role is to help these individuals restore lost meaning, regain faith in their lives, and find hope for the future.

5. Support for spiritual growth. Helping patients to develop their spiritual sphere contributes to their psychological well-being. This involves working with their religious beliefs, moral values, ethical orientations, and life goals.

6. The integrity of the personality. The goal of therapy is to help restore the individual's integrity, including physical health, mental well-being, social adaptation and spiritual development. It is important to maintain harmony in all aspects of the patient's life.

7. Dealing with trauma. It is necessary to help patients cope with traumatic experiences, minimize the effects of stress and adapt to a normal life.

In combat situations, we face combat-related mental trauma and pathology. Combat-related psychological trauma refers to psychogenically induced (stress-

associated) disorders that arise as a result of exposure to specific factors of the combat environment during direct combat operations.

Combat psychiatric pathology refers to all mental disorders (including stress-related conditions) that developed and manifested within the theater of military operations.

A special group consists of combatants who have additional conditions that can lead to the development of the aforementioned types of disorders. They receive medical care and subsequent rehabilitation at various stages of treatment (Fig. 1).

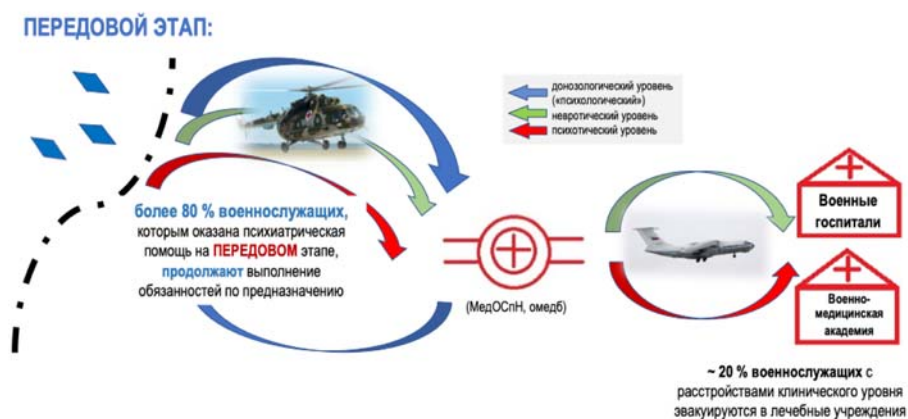


Fig. 1: The scheme of medical care in combat conditions.

At each stage, the implementation of medical and psychological rehabilitation measures is crucial. At the same time, the clergy play a significant role in providing assistance to combatants throughout all stages of their recovery.

During the acute phase of illness and trauma, the human soul does not change in its essential qualities. It remains precious and valuable in the eyes of God. As St. Gregory Palamas says, "The grace of the Holy Spirit penetrates the human soul, for grace is uncreated. Nothing created can unite with the soul. Even if evil spirits manage to attach themselves to the sinner's soul, being created, they cannot unite with it".

In these circumstances, spiritual support and the formation of a reliance on a higher divine power in man play a special role.

The priest provides invaluable assistance to the sick and wounded, explaining that trauma is not punishment, but providence. In prayer, "beg God not to leave you helpless, do not hesitate to ask Him"¹.

At the first stage, spiritual care and spiritually-oriented therapy play an essential role in providing assistance for acute stress reactions and short-term neurotic disorders, such as anxiety and conversion disorders. In addition, there is a category of people who use harmful substances without signs of dependency.

In these and similar challenging situations, the priest has an additional responsibility – to establish mutually supportive and trusting relationships with members of the military. At the early stages of a mental illness, there is a real chance to slow the progression of the condition, restore and enhance the patient's resilience, and contribute to their recovery.

¹ Hieromonk Mikhail (Chapel) [URL: <https://solba.ru/news/kak-pomoch-stradayushemu-starcheskoj-demenciej>]

In the subsequent stages of providing medical care for combatants and conducting medical and psychological rehabilitation, the role of the priest remains equally important, and in many cases, it becomes even more significant. During a traumatic illness or injury, various personality traits can become more pronounced, creating conditions for depression and lack of trust in God. Often, the priest becomes the closest person they can confide in and share their thoughts and aspirations with.

During the process of medical and psychological rehabilitation, various emotional disorders may arise. These disorders manifest themselves through a variety of symptoms, including asthenia, anxiety, depression, irritability, and hypochondria. Depressive symptoms are the most prevalent. At the same time, interest in the outside world is reduced or absent, and dysthymia and dysphoria may be noted. Pathology may be complicated by vegetative-vascular disorders, such as dizziness, muscle weakness, and headache. A person may feel tired quickly, unable to concentrate, and mental processes may slow down. Sleep disorders, insomnia, and nightmares may occur, and the idea of the futility of existence and suicidal moods may prevail, along with feelings of guilt and disappointment.

In this case, the collaboration between a medical professional and a religious leader is particularly significant. The patient's anti-suicidal barriers are weakened, and the risk of self-harm increases. Thorough psychosocial intervention with these patients is essential.

Hypomanic and manic episodes that occur on an organic basis, on the other hand, are accompanied by an overestimated sense of self-worth and impulsive behavior. When a person faces difficulties or resistance, they may experience negative emotions such as anger and aggression. At the same time, spiritually-oriented therapy should aim to correct cognitive attitudes. In this case, spiritual care plays a crucial role.

Thus, spiritually oriented therapy is a comprehensive approach that considers the physical, psychological, and spiritual aspects of human nature. Its goal is to improve the quality of life for patients, reduce the effects of mental trauma, and help them return to full social activity.

In conclusion, I would like to quote Archpriest Sergiy Filimonov's statement: "... these days, it seems that it is time to combine the efforts of the Church and medicine. The priest and the doctor are working towards the same goal. The role of a pastor is to guide a person on the moral and spiritual path towards the Lord, so that they can achieve the desired freedom and immortality in the future. The role of a doctor, on the other hand, is to restore mental balance and help find inner harmony. This, in turn, can only be achieved with God's help. So there is a need for a kind of partnership between a priest and a psychiatrist, a spiritual guide and a "mental therapist."

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