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

CHURCH CARE FOR MENTALLY ILL PEOPLE

International Conference

Reports

13-14 November 2018

Moscow, 2019

Church Care for Mentally Ill People. International Conference. Reports. 13-14 November 2018: – M., 2019. – 103 p., illustrations.

This book presents reports of the International Conference "Church Care for Mentally Ill People", made by representatives of Orthodox, Catholic and Protestant religious organizations – theologians, psychiatrists, clergy, teachers of theological schools, specialists of public health institutions from Russia, Belarus, Kazakhstan, the Netherlands, Cyprus, Great Britain, Romania, Italy, Spain and Poland.

The conference was held with the blessing of His Holiness Patriarch Kirill of Moscow and All Russia. It was organized by the Moscow Patriarchate's Department for External Church Relations, the Commission on Church Formation and Diaconia of the Inter-Council Presence of the Russian Orthodox Church, the Voronezh Metropolia of the Russian Orthodox Church, Scientific Center for Mental Health of the Russian Academy of Sciences. The conference was held with the support of the 'Aid to the Church in Need' Charity.

CONTENT

REPORTS

Metropolitan Sergiy of Voronezh and Liski
Mental Health of the Population – a Space of Common Responsibility of Clergy and Medical Workers ……..…….5

Maria Teresa Ferla
The Contribution of Phenomenology to a Humane Psychiatry with a Human and Christian Face..... 8

Monk Dociphey (Gorbachevsky)
Perception of Church Sacraments – Confession, Eucharist and Extreme Unction – by Mental Patients……..……...……..…16

Vladimir Vorobyov
Mental Illness and Possession……...…….…….…28

G. I. Kopeyko
Religious Delusion of Possession in Case of Schizophrenia.… …….....34

Priest José Maria Vegas
Mental Illnesses and Possession ……...…...…..39

V. G. Kaleda
Pastoral Psychiatry as Challenge of Our Times (New Subject in Theological Schools Curriculum) …….…….52

Peter G. Coleman
Religiosity and Depressive Disorders in Elderly People ……..……60

Panayiota Mama Agapiou
Religiosity and Psychopathology in Children and Adolescents…….…….68

Peter J. Verhagen
Religion and Psychotherapy: Understanding and Religious Adapted Psychotherapeutic Strategies to Help Mentally Ill People ……..…….78

Rev. Fr Jesus Colomo Gomez
Mental Illness and Spiritual Life of the Patient: Pastoral Care for the Mentally Ill in the Modern Healthcare System …….....……85

Archpriest Victor Gusev
Archpriest Ilya Odyakov
Peculiarities of Pastoral Care of Patients at a Psychiatric Facility….....94

AUTHORS…….……...…….....…...102

REPORTS

Metropolitan Sergiy of Voronezh and Liski

Mental Health of the Population – a Space of Common Responsibility of Clergy and Medical Workers

Dear Fathers, Brothers and Sisters, Distinguished Participants and Guests of the conference!

First, let me greet all of you cordially, especially, the researchers and experts from other countries, who have expressed their readiness to take part in the discussion on problems of pastoral care for mental patients.

The love of God for man is a fundamental value of Christian faith, and help to the neighbour is an effective expression of this love. Therefore, the international cooperation of Christians in the service of our neighbours becomes a natural manifestation of compassion and charity to which we as Christians are called by the love of our Saviour Himself. Our today's conference is devoted to a discussion on the most pressing problems of dialogue between the Church and medicine in protecting mental health and offering help to mental patients. The continued development of knowledge in psychiatry, the changed views of the causes of mental illnesses and ways of their healing have provoked a polemic in the medical community while posing new questions for the Church, which needs a reflection from both the theological perspective and from the point of view of everyday pastoral practice.

The clergy everywhere have ever more frequently encountered unhealthy people whose number is rather increasing than decreasing. The rapid development of society is not accompanied by equally intensive moral human improvement. Moreover, we often become witnesses of extremely strong deviations of people from the norms of Christian morality: 'For when they had taken liberty, they despised the most High, thought scorn of His law, and forsook His ways" (2 Esdras 8:56). In the modern world, the society and family are losing their ties with God and the

Church, which becomes a source of mental illness. Our contemporaries tend to misunderstand that the integrity of man, his health and the very life on earth were and will always be closely tied with the Church headed by Jesus Christ Who is the true source of healing understood as reunion with God and His creation.

Taking into account the data of the World Health Organization on the steadfast increase in the number of mental illnesses, Christians consider the mental health of the population to be a space for common responsibility of the clergy and medical workers. Meanwhile, the idea of common work of the clergy and mental health services does not always find support among medical workers, patients, their relatives and sometimes clergy. One of the problems is that people's bias, myths and prejudices with regard to mental patients make patients ignore doctors and turn for help to the Church, trying mistakenly to substitute a priest for a medical doctor and to regard mental illnesses as a form of demonic possession.

The ages-old experience of the Church of Christ shows that mentally ill people, through initiation to the Church and participation in church sacraments, achieve an improvement in their condition and overcome social isolation when receiving all possible support on their way to spiritual growth. At the same time, the religiosity of mental patients in various periods of their life poses complicated questions before pastors. The church life of a child, youth or an old man has its peculiarities, the more so if in these age periods one suffers from a mental illness. Clearly, the Church's help to mental patients depends on the peculiarities of age, the type of mental illness and its stages. And we should admit that the clergy are not always ready to answer questions arising in the church milieu, also because the problem of the age religiosity and psychopathology is one of the most underdeveloped in pastoral psychiatry.

Very often one comes to think about one's mental health only after coming through a mental illness. The Church however begins to take care of our mental health long before we are born, taking care even before conception of the mental health condition, moral constitution and faith of the parents. A mother's love of her child is the foundation on which first the ability to distinguish between good and evil is built, then a system of moral values is developed and only after that one's intellectual abilities and professional skills are formed. The feeling of love as the foundation of love revealed by God to man through the mother's love is present throughout one's life. The ability to feel love never disappears in a human being under any circumstances. The Church of Christ attests that a person with a mental illness or behavioural disorder is a bearer of the image of God, remaining our brother who needs compassion and help (Basic Social Concept of the Russian Orthodox Church, XI.5). Despite a mental illness, we as humans never lose our ability to feel love and to respond to it and the ability to distinguish in our hearts between good and evil. Therefore, all the mentally

ill have prerequisites for spiritual improvement and religious life. No illnesses can come into conflict with the Christian duty of a patient to seek the Truth and a life in virtue. And though patients suffering from mental illnesses are limited in their abilities, they are still capable, with the help of the Church, of following the path of Christian and moral improvement.

At the same time, we can see that a mental illness can provoke distortions in spiritual life, a sort of 'pathological religiosity', which needs to be considered in the practice of pastoral care of the mentally ill. Pastors cannot always discern symptoms of a mental illness and distinguish them from manifestations of religious devotion or mystical phenomena, which can be encountered in the life of mentally healthy people. Therefore, among the pressing tasks of religious education today is the pastoral psychology and psychiatry training of theological schools students, the clergy and monastics. It should be mentioned that today there are no commonly recognized criteria that would help determine which psychotherapeutic methods can inflict a mental damage on a patient, being actually an occult practice for making an impact on people. A mentally ill person will find help and support in a parish and a monastery if he meets a pastor who has not only an experience of spiritual life and guidance, but also the basic medical and psychological knowledge. In this connection, it would be important to hear the opinions of our colleagues from abroad about various systems of teaching pastoral psychiatry in theological schools and their personal experience of participation in training pastors for psychiatry.

One of the difficulties the clergy encounter is the need to distinguish the manifestations of demonic possession from symptoms of mental illnesses. The possessed, just as the mentally ill, remain to be our brothers and sisters and it is inadmissible to reject or despise them. Demonic possession is a trial tolerated by God, which often helps one to discover the existence of spiritual reality. The Church believes it equally unjustified to reduce all the mental illnesses to manifestations of possession (which involves the ungrounded performance of the rite of exorcism) and to seek to treat any mental disorders exclusively by clinical methods (Basic Social Concept of the Russian Orthodox Church, XI, 5). Those who are insufficiently rooted in the church tradition and have no integral perception of the religious life, seek to take part in rites of the exorcism of demons, of which they and those who perform them have no proper idea. An opportunity for receiving a miraculous deliverance from possession in response to the inner spiritual efforts aimed to reunite with God should not be turned into a ritual in which one can be automatically delivered from the suffering. Those who offer such simple solutions should not forget the Gospel's words: 'Jesus I know, and Paul I know about, but who are you?' (Acts 19:15). Jesus did exorcize demons and granted the Church the power to exorcize demons as part of His mission (Mk. 3:13-15; 6:6-13). But it is

only the clergy prepared by their spiritual experience and sanctity of their life to meet demons can take part in the healing of possession.

In connection with demonic possession, I cannot help saying that the severest consequence of mental disorders is suicide committed by those who belonged to the Church by their baptism. Suicidal behaviour very often pointes to a close relation between mental illnesses and the influence of demons on a human soul. Long inner dialogues preceding a suicide is not just a manifestation of illness. The development of pastoral care for people with suicidal intentions is one of the challenges faced by the Church in today's society.

Christians are firmly convinced that mental health is impossible without spiritual well-being, without living a life with God. Therefore, the problem of improving the mental health of the population has a direct bearing on the ministry of the Church in the world. The Church of Christ is called to help people follow the path of transformation and healing. Psychiatry will hardly manage to eradicate illnesses from the face of the earth, but, together with the Church, it offers a possibility for man to recover his relations with God, once lost in the fall, for the sake of acquiring the fullness of health.

I thank you for your attention and suggest that we move to an active and open discussion on questions arising in dialogue between the Church and psychiatry. I hope that among the fruits of our work will be the understanding and summing up of the problems most pressing for pastoral psychiatry and further development of Christian cooperation in this area.

I wish you all God's blessing, success in your work and fruitful participation in the work of the conference!

Maria Teresa Ferla

The Contribution of Phenomenology to a Humane Psychiatry with a Human and Christian Face

In every person, even when psychic disturbances become particularly intense and anguished, as in schizophrenia or melancholy (psychotic depression), areas of freedom remain.

"Every experience of psychic suffering is "an anthropological mystery". In psychic suffering, the anthropological texture of a person is even more transparent" (Kurt Schneider).

The fundamental structures of existence can be found in most exponents of phenomenological thought (Husserl and Heidegger), and

have been codified in psychopathology by Karl Jaspers (Allgemeine Psychopatologie, 1913) and by Ludwig Binswanger (Zur phanomenologischen Anthropologie, 1947).

An important member of that school in Italy today is Eugenio Borgna (who I was lucky enough to have as my professor and guide from 1986 to 2000, while I worked at his side in the Psychiatry department of the Ospedale Maggiore in Novara).

Borgna's words document that even the most serious psychopathological disturbances are full of meaning, and witness that the fragility within which the ill person is immersed is not an absurd chasm but is instead a fully meaningful experience. The dimension of fragilità, indeed, is the existential dimension in which all humans live, whether in a ill or healthy state:

"Human fragility is a pillar of life: in the sign of the mystery surrounding us which makes us grasp only a part of what we glimpse within ourselves and others: mirrors that endlessly reflect dark images, which are not always decipherable, of the expressible and inexpressible, of anguish and hope, of the living and dying that is in each one of us" (Eugenio Borgna).

The heart and phenomenological psychopathology

The school of phenomenological psychopathology has opened up the narrow horizons of naturalistic or biological psychiatry, moving towards a conception of psychiatry as a human science which, within a global conception of man, finds within psychotic experience structures of sense and meaning which can ultimately be led back to human fundamental needs, to the very heart of man. It is thus possible to analyse the features of psychotic existence in an anthropological light: psychotic experience gains its own Gestalt, a form of life full of unity and meaning. Intuition is fundamental if one is to know and enter that reality, and those forms of life (Erlebnisse). Intuition is the phenomenological means of entering deep into the wounds of psychopathological experience: it is knowledge which is born from the heart, in the Pascalian sense.

In this regard, Maria Zambrano wrote: in the permanent culture of the heart, it does not burn like a fire but like a flame, a flame that does not generate pain but happiness. It is the light which lights up the path leading out of impossible difficulties, sweet light that offers comfort. In this same culture, the heart has wounds, which heal slowly and sometimes not at all: it could be said that these wounds never close because in a certain sense they are active, live wounds like those which constantly drip blood, preventing them from healing.

The transcultural anthropological elements to be found behind and within all symptoms and which are the foundation of the psychic world of the person are:
the affective life, and in this the relational dynamics of primary relations (those with the paternal or maternal figures)
the experience of being rooted somewhere, of belonging and identity;
the experience of the lived physical body;
the experience of time and space;
language and communication (language as the house of being);
the experience of memory and remembering;
the experience of death and dying;
the experience of blame;
the experience of hope.

To get to know the person who is suffering and is entrusted to our care, it is fundamental to discover these dimensions of his life. The trust that is born within a therapeutic relationship, while accompanying the person along the treatment path, opens the way to this cognitive experience, which interprets symptom-signs: in some way, this is already a way to heal the anguish and fear of madness as phenomena of non-sense, of the absurd. It is precisely this absurdity which is frightening, and unsettles not only us, the so-called healthy ones, or the relatives or people who live close to those who are immersed in this suffering, but above all to the person suffering.

Empathy is the other cognitive and therapeutic instrument which enables one to create a relationship of sharing which is rehabilitative as regards the healthy part which survives even in the most serious forms of psychosis. The relationship becomes a type of involvement which happens through the body but beyond the body; through but beyond the face; through silence, beyond silence, through lived time and space, and the discovery of the meaning of illness.

If one remains at a distance, merely observing, then one cannot even scratch the surface of the psychotic experience. In so far as we try to grasp not only what separates us but also what we have in common with the psychotic person, then it is possible to enter the realm of human nearness, and of the reciprocità of the dialogic encounter with a “you” as Romano Guardini said and wrote.

The rationalistic reduction in psychiatry

Rationalistic reduction is seen as the biologicalistic and socio-genetic-sociological concept of psychic disturbances: both these reductions deny the persistence of this elementary experience, this nucleus within the person making the person unique and is the very foundation of personal freedom.

The biologicalistic or sociologistic reduction of human beings deny the persistence of this elementary experience, this nucleus within the person which cannot be separated from will and freedom. The most noble and complex human expressions, such as feelings, intelligence, will, conscience (defined by psychopathology as the human functions through which man expresses his freedom as a desire for infinity and the experience of the satisfaction of that desire) are, within the sociological paradigm, the unchangeable result of conditionings and conflicts which the person has undergone; according to the biologistic paradigm, on the other hand, they are the result of biochemical reactions within the brain, and cerebral synaptic interactions and mediations.

Within the organistic-biologistic model, under the umbrella of Kraepelin's Praecox Dementia, which was identified at the end of the 1800s, but which lives on in the widespread conception today of chronic Psychosis, the patient is also denied the dimension of possible change (being cured). Therapy is denied the possibility of making an encounter with another happen in any moment of one's life, which will give the patient the chance - the hope - of an authentic relationship, which can allow for the sharing of suffering and its lessening within the path of a healing relationship.

The psychic world of the person therefore represents a much vaster world, and in order to understand and describe it, one has to broaden the paradigms of knowledge and leave rationalism behind.

The biological-naturalistic model partially explains the physiological bases of psychic processes; on the other hand, the social model partially explains the influences, adaptive and defensive capacities that humans develop in relations. However, it is only with the anthropological-existential model that we can understand (in the sense of verstehen to understand, not erklaeren – to explain, as Jaspers puts it) the meaning and sense of the lived events and agitations of someone in a psychotic condition: the expressive and communicative modalities change, but the constitutive nucleus even of someone who is suffering is that of the research for meaning, happiness, freedom, justice.

Symptoms or signs?

There have been schools of thought, first of all the German one which tends towards the clinical, psychopathological-phenomenonlogical, which have tried to find and bring out a human reading of psychopathological phenomena which are considered by naturalistic, behaviouristic and cognitivistic psychiatry as being absurd or simple symptoms indicating an illness "of the brain".

Illnesses of the mind are not illnesses of the brain (the phenomenological thesis which overturns Wernick's thesis, which affirmed the exact opposite).

The corner-stone which makes human beings human is the conscience (as Brentano and Dilthey have defined it, and above all Kurt Schneider, who brought it to light in psychopathology).

Of course, what is meant here is not the state of conscience (which would move us into neurology or neuropathology), but the I's conscience in the complex structure which Kurt Schneider discerned, and which has founded all psychopathology of psychotic experiences since.

When, as in psychotic experiences, the state of conscience is shown to be intact (in other words, there are no compromises at a neurological or biological level), psychopathological phenomena gain a dignity and significance which find their (psycho) origin in the unfolding of life, its primary relations, and the building up of the fundamental dynamics of relational and communicative life between the self and the world. They are therefore signs which need to be read and interpreted within the global context of an existence.

These patients' freedom can be seen within their own histories (anamnesis), examining them like a canvas against the light, rereading desires and acts and decisions in which it is possible to discern will and freedom. Certainly, one often sees the fear to desire, fear of one's own will, omissions and suspension of actions because of blocks and affective cohartations which depend on a state of anguish, the splitting of the I, deep depression or experiences of depersonalization or extraneousness to the point of delirium.

The experience of delirium needs to be seen as a radical set-back in communication in which the meanings of things, situations, events are radically "other" than what is commonly shared.

In delirium the capacity to trust caves in: everything is read within the figure of self-referentiality, in which the I is dominated by the extraneousness and hostility that the other represents with regard to oneself, one's goods and own life.

Reconstructing delirium from a psychogenetic point of view enables one to rediscover within the person's life moments and experiences which have generated such diffidence and such a closed attitude to the world: first of all, stories of betrayal, abandonment can be found within primary (parent) relations which determine the crisis of trust to the point of hostility (paranoia) towards everything and everyone. In delirium, there is a defensive and compensatory attempt to fill an emptiness which has been left by radical loneliness, and to reconstruct meanings which can piece back together the fragmentation into which the I has plunged.

In the same way one can understand hallucinations, in which listening (to voices), touching and seeing are different ways of communicating in which, since there is no-one other from the self with whom one can set up a relationship, an alternative relationship, a hallucinatory one, is built up.

Hallucinations can represent the last, distorted and desperate attempt to communicate through the perceptive organs (sight, hearing, touch) when all other communicative experiences have been destroyed. The hallucinatory world (that of voices) thus becomes the only space of relational exchange of which the I may become a victim, or else carry out in a passive way. More often hallucinations are interwoven with the world of delirium, colouring its contents with elements of ruin, persecution, guilt, greatness. Moreover, delirium can express the unsuccessful processing of the experience of guilt which is an anthropological characteristic that each person has to face and live. Projecting guilt outside oneself, on others who are close (family members or flatmates) or far (extraterrestrial beings or secret police) represents the most simplistic way of throwing outside oneself the weight and anguish which the guilt, if it is not worked out (or rather, forgiven) can generate: it is not necessary for particular events or situations to have taken place as regards guiltiness. It can be enough just to have the feeling that one has not been able to transmit and communicate affection, thanking: an act that did not succeed, an omission to the point of a thought believed to be have deleterious and devastating effects because of its harmful content. What has not come about is the experience of guilt within an affective relationship that forgives and relaunches.

"It is a sort of delirium of man's will… to find oneself guilty and reprovable to the point of the impossibility of expiation" (Nietzsche)

The experiences of the alteration of the I's conscience, which are the most serious conditions, can be read as the failure to reach the definition of one's self, of one's history, one's origins and identity (which may lead to the atrocious doubt or conviction that one is not what one thinks one has always been) or the failed definition of relations between oneself and the outside world, which remain marked by pathological links such as symbiosis in which the expressiveness of the I never manages to emerge as distinct and autonomous. The extent to which affective dynamics within the family act on this alteration has been well demonstrated by many psychologists of the family with regard to the pathological role played by symbiotic relations in the genesis of schizophrenic psychosis.

Freedom and responsibility

If this is the way psychopathological phenomena are conceived, then, clearly, also the desires and acts performed by those who live psychopathological experiences (even the most serious) must be analysed as an expression of people who can and want to answer for their own will and their acts like any other person; only exceptionally are they devastated and changed beyond recognition in these capacities.

It is not by chance that it is not so much the clinical but the legal expert who evaluates such capacities: they must be described with an extra specificity, i.e. with a special reading that also analyses the patient's judicial law awareness as well as their awareness of the illness in a broad sense.

There are particular psychotic conditions which, because of the total loss of contact with the world (schizophrenic autism) or because of the pervasiveness of persecutory delirious experience (which invades every area of one's experience) or because of the devastating experience of guilt become evidently dangerous or at least extremely aggressive.

This type of psychotic experience compromises "intention" and "will", alienating the ill person, towards whom it is necessary to set up "protection" of the patient's and others' rights, starting from the right to exist and let others exist.

These serious psychopathological experiences therefore require "assertive" methods, in which the loss of the patient's freedom is juxtaposed with the carer's taking on of the responsibility, even making use of ways of containing possible repeated dangerous acts.

That said, and recognizing that there are specific, partial or total compromising conditions of the ability to understand and will, and therefore of the liability of the patient, the principle of liability, responsibility and accountability of the psychic patient as regards illegal acts remains intact.

The need to be guilty (according to the book by Stangerup) is a need common to everyone, even to people who are ill: in it one can recognize the ultimate need to expiate guilt, to be redeemed, forgiven, saved at the start, once and for all, but also each time, in our specific and repeated faults and errors.

Conclusion

It is the reasons of the Pascalian, Schelerian heart which allow us to know in psychiatry too, the interior life, interiority without which the various expressions of psychic suffering are banalized and emptied of meaning.

Psychopathological experiences are manifestations of communication disturbances (in the heart-rending nostalgia for this dialogue which is our destiny).

Only if we approach a person affected slightly or drastically by psychic suffering, with an immediate openness to dialogue, and with the love of which we are capable (in the sense of modus amoris of Binswanger), can there be the hope that the other person reveals to us what is in their heart and memory, allowing us to glimpse the secret correlations of his or her suffering, pain, desperation and interior wounds.

The boundless regions of the heart and soul lie in the depths of every life: psychotic or non-psychotic.

This psychiatry is like a raft sailing against the current created by to the luxury cruise ship on which the dominant psychiatry of today travels: that of drugs and indifference to dialogue.

Our raft travels towards the mysterious path of suffering, listening to it and interpreting its secret resonances, which are invisibile to the cartesian eyes of reason, but recognizable by the reasons of the heart.

References:

Basaglia F., *Scritti, I, 1953-1968,* Einaudi, Torino 1981.
Binswanger L., *Schizophrenie,* Neske, Pfullingen 1957.
Binswanger L., *Per una antropologia fenomenologica*, Feltrinelli, Milano 1970.
Binswanger L., *Melanconia e Mania,* Bollati Boringhieri*,* Torino 1971.
Binswanger L., *Il caso Ellen West ed altri saggi*, Bompiani, Milano 1973.
Bleuler E., *Trattato di psichiatria,* Feltrinelli, Milano 1967.
Borgna E., *I conflitti del conoscere. Strutture ed esperienza della follia*, Feltrinelli, Milano 1988.
Borgna E., *Malinconia,* Feltrinelli, Milano 1992.
Borgna E., *Come se finisse il mondo,* Feltrinelli, Milano 1995.
Borgna E., *Noi siamo un colloquio*, Feltrinelli, Milano 1999.
Borgna E., *L'arcipelago delle emozioni*, Feltrinelli, Milano 2002.
Borgna E. *Le intermittenze del cuore*, Feltrinelli, Milano 2003.
Cargnello D., *Alterità e alienità*, Feltrinelli, Milano, 1977.
Cazzullo C.L., *La fenomenologia: terreno di incontro tra filosofia e psichiatria*, in Cazzullo C.L., Sini C., *Fenomenologia: filosofia e psichiatria*, Masson, Milano 1984.
Ferla M.T., Mittino F., *Psicopatologia e prassi psichiatrica*, in Ballerini A., Callieri B. (a cura di), *Breviario di Psicopatologia*, Feltrinelli, Milano 1996, pp. 75-79.
Ferla M.T., *L'uomo dei ragni*, ETS, Pisa, 2007.
Fornari U., *Psicopatologia e psichiatria forense*, Utet, Torino 1989.
Galimberti U., *Psichiatria e Fenomenologia,* Feltrinelli, Milano 1979.
Giussani L., *Il senso religioso,* Rizzoli, Milano, 1997.
Glatzel J., *Über den manischen Autismus,* in *Schweizer Archiv für Neurologie, Neurochirurgie und Psychiatrie*, 130, 1982, pp.69-76.
Guardini R., *Welt und Person*,Werkbund-Verlag,Wurzburg, 1939.
Jaspers K., *Psicopatologia generale*, Il Pensiero Scientifico Editore, Roma, 1992.
Minkowski E., *Il tempo vissuto*, Einaudi, Torino 2004.
Minkowski E., *Trattato di psicopatologia,* Feltrinelli, Milano 1973.

Scheler M., *Il formalismo nell'etica*, San Paolo, Milano 1996.
Schneider K., *Psicopatologia clinica*, Città Nuova, Roma 1983.
Stangerup H., *L'uomo che voleva essere colpevole,* Iperborea, 1990.
Starobinski J., *L'immortalité mélanconique*. *Le temps de la réflexion*, Gallimard, Paris 1982, pp. 231-251.
Zambrano M., *Verso un sapere dell'anima,* Cortina, Milano, 1996.

Monk Dociphey (Gorbachevsky)

Perception of Church Sacraments – Confession, Eucharist and Extreme Unction – by Mental Patients

I. Theological understanding of illness, suffering and healing

I.1 Illnesses, sin and fragility of human nature

Any religion sets the task of giving answer to a personal quest, caused by illness and inevitable death. Christianity does this through the image of suffering Christ on the Cross and through the thought that His sacrifice liberates man from death and opens a possibility of eternal life. Christian spirituality offers healing to the human nature and deep transformation. The path to God, however, means acceptance of suffering and a personal cross, which is to be carried to the meeting point with death.

Spirituality can offer a good remedy in the face of illness, as the Christian faith contains the thought about God changing the nature of those, who chose to follow Him. Along with that, any illness may turn into an abyss of revolt against God and suppress the optimism of recovery.

If the roots of illness are identified, it is possible to find treatment and form a trajectory of recovery. The Christian theology finds the source of suffering and death in the Fall of the first people. Created in the physical form that was foreign to illness and could be immortal, Adam and Eve chose to step into the world of decay and death through sin. "Here we do not mean some moral vices, but a universal tragedy, and not a long or short list of wrongdoings, but rather a comprehensive distortion of the content of life. This is, so to say, descent into oblivion, destruction, which is perceived by man as God's absence, as absence of persons around and their own person, as loss of reality and, all in all, as fading out of purpose and meaning that transforms into interminable abandonment and anxiety". [1]

[1] Panayotis Nellas, Omul – animal îndumnezeit. Perspective pentru o antropologie ortodoxă, trad. diac. Ioan I. Ică jr., Ed. Deisis, Sibiu, 1999, p. 198.

Getting up from sin must be identical to recovery and return of man to oneself. Thus, sin is perceived as a source of suffering, pain and cause of death – the last concretization of the fallen state. So, evil means moving away from the source of life. Death is a natural consequence of sin. "So, it was not God, who created death, but we incurred it onto ourselves by our deceitful volition. God did not impede our destruction for the reasons given above, so that ailment did not stay immortal in us, like a pot maker would not put a leaking pottery vessel into the oven until he corrects the defect therein".[2]

The mortal state, that dominates human life and existence, is a continuous source of misfortune. From now on life has intertwined with death, and pleasure ensured by sin has an irreversible match. "...For man's soul, as the spirit created by God, shall not find pleasure, quietude, peace, comfort or joy in anything but God, in whose image and likeness it was created; and when it separates from Him, it is forced to look for pleasures in different creatures and passions, and nurtures on them alone, like on locusts, without appropriate peace or joy, and thus dies of hunger, for the spirit needs to be nurtured on a spiritual food", St. Tikhon of Zadonsk says (18th c.). [3]The spirit was to find its food in God, was to live in God; the soul was to nurture on the body; the body was to live by the soul. This was set as the initial order of immortal nature. But, "Having turned away from God, the spirit begins to live at the soul's cost, breading on its essence (that is what we usually call 'spiritual values'), instead of giving food thereto; the soul in its turn begins to live the body's life, and this generates passions; and, finally, the body is forced to look for food outside, in the inanimate matter, and eventually finds death. Man's composition falls apart".[4]

St. Maximus the Confessor draws a very complex picture to us, when studying the roots and meaning of evil. The fallen state is presented as a continuous chain of pleasure and pain. The human life flows between these two elements.[5] From now on man takes refuge in pleasure, where he tries to spend his life. However, this pleasure brings no other effect but ontological diminishing, experienced in the form of suffering.[6]

Physical evil, caused by sin, presents itself to us in the form of numerous essences or aspects. In a broad sense, it is something that generates the negative side in existence or something that gradually reduces it down to death. Besides the immediate effect, sin destroys existence; it ends up with the sense of insufficiency, death and suffering. From the point

[2] Sf. Vasile cel Mare, Omilii şi cuvântări, în vol. Scrieri I, trad. D. Fecioru, Ed. Institutului Biblic, Bucureşti, 1986, p. 443.
[3] Vladimir Lossky, Teologia mistică a Bisericii de Răsărit, trad. V. Răducă, Ed. Anastasia, 1993, p. 156
[4] V. Lossky, Teologia mistică…, p. 156.
[5] Sf. Maxim Mărturisitorul, Răspunsuri către Talasie, în Filocalia, vol. 3, trad. Dumitru Stăniloae, Ed. Humanitas, Bucureşti, 1999, p. 29.
[6] Sf. Maxim Mărturisitorul, Răspunsuri către Talasie, p. 30.

of Christian spirituality, it is the state of exclusion. It is a *failure of existence*[7], from which man must be saved. Here we deal with the source of unhappiness, ontological disability, because of which man can no longer stand up on his own. This means an exclusion from life, the exclusion that quite often causes hell. "*Judgement or punishment is a free choice of man who voluntarily brings himself into a torturous absence of life, in his free refusal from communication with the all-loving God's kindness, with the "true life*". [8]

There is conscience that oppresses man, and an embarrassing state of existence that tortures him and makes him mourn over his sins and yearn for their forgiveness. Man has a desire for universal reconciliation that confronts universal destruction, caused by sin. The drive to the neighbour and to God calls for deliverance from sin. This deliverance begins and ends with Christ. Revival through Baptism is the first salvific act. The sacraments that follow Baptism, open themselves up to man as a way to deliver him from the misery of suffering. This gives him a step by step reunification with Christ, a continuous healing process.

I.2 Suffering and healing

Christian spirituality positively describes spiritual life as an upward movement to Theosis, whereas from the negative point of view – the one turned to the human nature weakened by sin – it is a continuous spiritual battle.

The Orthodox Christian tradition insists on this aspect of the battle with sin, on efforts to acquire a grace-filled freedom where man's nature is no longer constrained by passions, but gradually partakes of the life of Christ which flows in through the Cross and Resurrection.

Christian life in general envisages death of the Old man, death for this world to come alive in the Heavenly Kingdom. It is not only a martyr that is identified with Christ's sacrifice, but any Christian. In this sense, "a Christian endeavor means gradual death with Christ as a manifestation of strength, death of the Old man, and extension of Baptism through will; it is not only to emulate Christ, but courageously die with Christ and in Christ. We are one with Christ long before our mystical resurrection, still in the act of our deadening. We do not only resurrect with Christ but die with Him as well; or do not resurrect with Him, if we do not die with Him first". [9]

Suffering, pain and death may turn into a mithridate to evil, if they are correctly understood. This understanding is possible only in Christ, who experiences them Himself, breaking the chain of pain and pleasure. The reality of salvation is in discontinuation of the search for pleasure and in

[7] Christos Yannaras, Libertatea moralei, trad. Mihai Cantuniari, Ed. Anastasia, Bucureşti, 2004, p. 23.
[8] C. Yannaras, Libertatea moralei, p. 27.
[9] Dumitru Stăniloae, Sensul ascezei monahale, Ed. Reîntregirea, Cluj, 2005, p. 15.

tolerating pain. Thus, evil is curable only by means of intensive spiritual efforts.

"Satan discredited the body and its human sensuousness, as wellas the sensuous surface of the world, but Christ has restored the importance of the body and the sensuous world. What He did has turned the soul into the carrier of Divinity, and through that He has restored chestity of the body and its sensuousness, and the role of the world as God's transparency. He has shown that evil is not fatally roped to the body and world. Along with that He has restored the strength of man's will to keep the body beyond control through sensousness of the world's surface. The body and its senses have become something that they should have been, an organ of pure perception of the sensuous world; and the latter a transparent place of God's presence". [10]

In the final effect, evil has been cured by human's will, supported this time by grace, namely bearing of pain and death together with Christ, as well as descent in hell. This vision points at the price of human nature which ontologically cannot be bound to sin and evil, as well as at the freedom of human beings who cannot lose their person of God's image no matter how far they get from the source of life or from their divine Archetype. Eventually, suffering and death creep on human existence in a woeful way, but freedom invites man to take a responsible approach to his own acts, separating evil, death and suffering from God's act of creation. All these consequences would be inexplicable, had God been their cause. "No, it was not God, who created him [man] like that; otherwise He would not punish him. If we do not place the guilt on our servants for something, we ourselves can be guilty of, all the more God will not do this". [11]

Life of the world, where we live, may become the field of evil and demons. There is no other place where evil is so obvious as in day-to-day indifference, wherein the world draws us.

Life of saints teaches us how to take hell and pain for others: "A saint's prayer may be the most lethal weapon against the Lier, and the destiny of hell also depends on the mercy of saints. Man, on his own, prepares hell for himself, closing himself from the divine Love that stays unchanged".[12]

I.3 Church as healing environment via Holy Sacraments

Rev. Fr. Dumitru Staniloae (1903-1993) underlined that "Church in its fullness is a sacrament in its broad sense. If a sacrament in a broad sense is God's way to connect with the visible reality, primarily, with the

[10] Dumitru Stăniloae, Teologia dogmatică ortodoxă, vol. 1, p. 317-318.
[11] Sf. Ioan Gură de Aur, Omilii la Matei, în vol. Scrieri III, trad. D. Fecioru, Ed. Institutului Biblic, Bucureşti, 1994, p. 684.
[12] Paul Evdokimov, Vârstele vieţii spirituale, trad. Ion Buga, Ed. Christiana, Bucureşti, 1993, p. 84.

sacrament of humanity, then Church in her own fullness is a sacrament as an expansion and extension in time or as an environment, emitting the initial sacrament, which is Christ". [13]

The mystic reality of Church proclaims salvation as a continuous unity with Christ. For the Orthodox Church "salvation does not end with Christ's death on the cross, as a legal equivalent of offence, caused by the humanity to God, but with the connection of Christ Crucified and Resurrected with people who believe in Him, so that they also could die to sin and resurrect"[14]. This is possible via sacraments which makes them very important. It is through them that the human mystery is recreated, restored and brought back from the anonymity of individual nature wherein it was brought by sin. They open an endless mystery of existence of personality.

Only by means of the holy sacraments offered in the Church that the faithful can partake the Mystery of Incarnation of our Saviour. Rev. Fr. Dumitru Radu (1926 - 2014) asserts in this sense that "the life of Christ in us and with Christ in the Holy Spirit via Holy Sacraments takes place only in the Church because it is only here that Christ fulfils our salvation together with us via the Holy Spirit...". [15]

The same Rev. Fr. Staniloae comments when describing the interdependence between the sacraments and the Church, "...The Church, as a sacrament, is, in its entirety, a continuous result of sacraments as acts performed … But if the Church in its entirety as a sacrament were a result of sacraments, this would have meant that those who become its members, get into it by means of sacraments that are performed outside it. Actually, the sacraments are acts of the Church; this means that the sacraments are ecclesiastical to the extend the Church is sacramental". [16]

However, the effect of the holy sacraments on the mystical Body of Christ spread in His members, continuously generates a common sacrament, which is the Church. In the nutshell, the Church is a format of manifestation of the holy sacraments; she is born continuously and, more than that, all members of the mystical body continuously improve themselves till the end of time.

The Church, on the one hand, "is communication by means of the sacraments, is based on them and described thereby, and on the other, she (the Church) is also their finisher". [17]

[13] Pr. Prof. Dumitru Stăniloae, Din aspectul sacramental al Bisericii, în „Studii Teologice", 1966, nr. 9-10, p. 531-532.
[14] Idem, Teologia Dogmatică Ortodoxă, vol. 3, Edit. Institutului Biblic..., Bucureşti, 1997, p. 7.
[15] Pr. Prof. Dumitru Radu, Sfintele Taine în viaţa Bisericii, în „Studii Teologice", 1981, nr.3-4, p. 172.
[16] Idem, Din aspectul sacramental al Bisericii..., p. 533.
[17] Pr. D. Radu, Sfintele Taine în viaţa Bisericii..., p. 177.

I.4 Healing via Holy Sacraments

Baptism is the first gate opened towards God. Practically, it is the action through which man is born again to participate in the life of Christ. But this time man is born from within its archetype, God. The moment of baptism separates the Old mad from the New one. It is not only the birth of man, but the birth of Christ in one's soul, rearrangement of the image by means of returning to the blessed state. This does not depend on man's natural strength, for grace is granted by God. The difference between the state before baptism, while preparing to it, and the state of a renewed man is underlined by such Fathers as Diadochus of Photike. Thus, "…before renewal, grace acts on soul from the outside, and hides therein through renewal. On the contrary, Satan acts within soul before its Baptism, and from outside thereafter. This must be understood this way – before Baptism man feels encouraged to step out of the shell of his selfishness but is not capable of following this encouragement. Starting with the moment of Baptist, the grace of Christ strengthens man's decision to smash the prison of his selfishness so much that he truly accomplishes this". [18]

Besides that, the grace, present in Baptism, wipes away the forefathers' sin. However, this grace does not ensure the final state. Even being reborn and recreated, man is still prone to the fall. Thence, solvation envisages man's active involvement, with regards to grace – collaboration with it; the grace of this sacrament is nothing but the starting point for personal (subjective) solvation. For instance, Diadochus speaks of two kinds of good, given to us by Baptism, "The first is given to us instantaneously, for it renews us in water itself and blesses all features of our soul, that is what is in the image, washing away every blemish of our sin. The other waits, so that together with us brings to fulfilment, what is in the likeness… the holy divine grace returns man's image to the original state he once had at the time of creation, first through Baptism, and then, when it sees a persistent eagerness, the beauty of likeness: a virtue blossoms after virtue and lifts the image of soul up from glory to glory, giving man the seal of likeness". [19]

II. Twenty-four years of pastoral care at mental hospital

The Clinical Hospital of Psychiatry Socola, Iasi, offers treatment simultaneously to 1310 patients, 870 of them are treated at the long-term healthcare hospital, and 440 at the one-day hospital. Of all these patients, 123 are chronically ill without a possibility to be released for the following

[18] Idem, Teologia Dogmatică..., vol. 2, p. 229.

[19] Diadoh al Foticeii, Cuvânt ascetic, cap. 89, în „Filocalia", vol. 1, trad. Pr. D. Stăniloae, Sibiu, 1947, p 379, apud Drd. Ştefan N. Sandu, art. cit., p. 237.

reasons: no passport or other ID, abandoned by relatives, no treatment is possible at home (see the table).

Type of beds	**Location**	**Quantity**	
Beds for acute pathology (I-VIII wards)	General	**435**	**487**
	Substance Abuse	**30**	
	Pediatry	**22**	
Beds for chronical pathology	Main hospital building	**50**	**260**
	1st outer ward	**150**	
	2nd outer ward	**60**	
Beds for palliative care	Main hospital building	**30**	**123**
	1st outer ward	**93**	
Beds for one-day in-patients	One-day hospital	**440**	**440**
TOTAL			**1310**

Various forms of schizophrenia are a dominating pathology.

Here I would like to present long-term experience of Protosyncellus Justin Niagu, ThD, who has been caring for these patients for 24 years. According to his experience, 30% of patients are religiously receptive; 30% are not very receptive due to their state, but subsequently become such; and 40% are refractory due to the lack of religious education and personal sins.

II.1 Sacrament of Confession

The sacrament of Confession vividly manifests the action of a free flowing dialogue as man's responsibility before God and the Church. This sacrament *"is the means through which the believers are freed from the prison of selfishness, where they were put by sin, so that they could be brought back to communication with God and the neighbour"*. [20]It contains three substantial components – confession of sins witnessed by a priest, repentance in them and forgiveness, granted by Christ through a priest or bishop. In the Didahe we read, *"You shall confess your sins in the Church, and you shall not go to the prayer with a poor conscience". The believers are invited, "On the Lord's day gathered together, and break bread, and give thanksgiving after having confessed your transgressions, that your sacrifice may be pure"*.[21] Here we see the connection – confession before Eucharist. Similarly, we read in the Letter of Barnabas*, "Confess your own sins. You shall not go to prayer with an evil conscience"*[22], because it is "better to confess sins to a man than harden your heart"[23], as St. Clement of Rome advises us, for the gravest sin against confession is the hardening of

[20] Pr. Asist. Dumitru Popescu, Pocăinţa ca refacere a legăturii credincioşilor cu Dumnezeu şi cu semenii, în „Biserica Ortodoxă Română", 1971, nr. 9-10, p. 1022.
[21] Didahia, cap. IV, 14; XIV, 1, în vol. Scrierile Părinţilor Apostolici..., p. 29-34.
[22] Epistola lui Barnaba, cap. XIX, 12, în Scrierile Părinţilor Apostolici…, p. 163.
[23] Sfântul Clement Romanul, Epistola către Corinteni (I), cap. LI, 3, în Scrierile Părinţilor Apostolici…, p. 83.

soul. He also instructs us, *"Obey your pastors (I Peter 5:5) and let yourself be brought up in repentance, having bent the knees of our soul"*[24]. St. Ignatius of Antioch recommends personal confession to a bishop.[25]

In the Shepard of Hermas a sincere complete repentance manifested not only in consciousness, but in deeds accomplished with the contrition of the heart, is called a prerequisite for repentance. He tells us that we can avail of repentance only once, *"If somebody has sinned tempted by the devil after this great and holy calling, he has only one repentance; but if he sins and repents continuously, repentance will be of no use for such a person, and his life will be difficult"*[26]. Naturally these words should be understood in the context of faith of those times, when the second Coming of Christ was believed to be very near.

St. Clement of Alexandria calls repentance a "second baptism" and draws our attention to the fact that it should be done only in the Church and by the Church. [27]

The mercy of God as a result of humicubation and humiliation should be another result of the sacrament of Confession, according to Tertullian. [28]

As for the rule given to the sinner, the same author writes, what the priest should keep in mind, "Usually this rite is called confession, by which we confess our sins to God, not that He does not know them, but because confession is the beginning of correction and satisfaction for sins. Confession draws on repentance, and repentance pacifies the Lord. Confession shatters and abases man - it changes him and makes worthy of God's heavenly mercy"[29]. This Church writer brings analogy between the sacrament of Confession and definition of the patients' diseases by doctors, who [the patients] "being ashamed of showing their inner sores to the physicians, die of shameful diseases"[30].

St. John the Chrysostom counselled confessors be attentive to the way penitents come to them. From this point of view there are several categories of those who repent:

* prepared or unprepared;
* coming on his own will or not;
* consciously and sincerely or under obligation;
* in the state of contrition or negligence.

Thus, the father confessor, having all this in mind, looks for the benefit and correction of the believer with understanding and love.

---

[24] Ibidem, cap. LVII, 3, în Scrierile Părinţilor Apostolici…, p. 86.
[25] Sfântul Ignatie Teoforul, Epistola către Filadelfieni, cap. VIII, 1, în Scrierile Părinţilor Apostolici…, p. 217.
[26] Magistrand Ştefan C. Alexe, Eclesiologia părinţilor apostolici, în „Studii Teologice", 1955, nr. 5-6, p. 374.
[27] Pr. Ilarion Felea, Pocăinţa, Edit. Scara, Bucureşti, 2000, p. 48.
[28] Tertulian, Liber de penitentia, cap. 9, în Migne, P.L. I, col. 1354, apud Pr. Prof. D. Stăniloae, Mărturisirea păcatelor şi pocăinţa în trecutul Bisericii, în „Biserica Ortodoxă Română", 1955, nr. 3-4, p. 224.
[29] Idem, Liber de penitentia, cap. 9, în Migne, P.L. I, col. 1354, apud D. Stăniloae, Mărturisirea păcatelor şi pocăinţa…, p. 224.
[30] Ibid.

Unlike mentally healthy people, who sooner or later come to communion, we deal with 2 exceptional categories.

1. Mentally ill believers (**90 %**), who have aggrieved consciousness, but are very willing to take communion after confession.

Out of them:

- **70 %** are oblationary communicants, i.e. those, who are capable of fulfilling their rule after catechism.

The devil exerts impact on man's soul in an unpredicted way, so that the patient is not aware of the gravity, or time, or frequency of such an impact.

- **30 %** are non-oblationary communicants, i.e. those, who reveal total unconsciousness and inability to be aware of the importance of the act of Eucharist. We should treat such patients with paternal love and give them more attention than to the previous category. They also can be offered communion before their death, but only with their consent.

2. Mentally ill believers (**10%**), who are characterized by an exaggerated devoutness, caused by a certain genetic family background, that shows in the form of enhanced sense of responsibility. These patients forego communion or delay it at their own discretion.

Out of them:

- **70 %** should be given communion against their will (but with their consent, during the time of their mental clearing up.

- in **30 %** cases we agree with their refusal not to cause spiritual trauma, specifically in case of schizophrenic patients, obvious sadness, cut of links with the father confessor, unfavourable course of illness.

As for their perception of the sacrament of Confession, we can say that the majority demonstrates an accelerated, and even, instantaneous dynamics to improvement of their state (lower intensity and frequency of acute states) and even to recovery. However, there are cases when the sacrament of Confession is impossible – patients are in the state of continuous absence of consciousness and rational disability. We need to watchfully observe them not to miss an opportunity to offer communion to them before their death.

A father confessor at a mental hospital must be comprehensively and substantively prepared and have a special calling, the attribute of unconditional love up to self-sacrifice. The father confessor of such a clinic should, more often than an average confessor, deliberately practice the sacrament of Confession himself. He should be like a father confessor at a monastery. Only then the two missions of this sacrament will be fulfilled – remission of sins and correction of the believer.

II.2 Sacrament of Extreme Unction

Extreme Unction is a holy sacrament by which means, through the application of blessed oil to the body of a sick and the prayer of priests, remission of sins and healing of illnesses is granted; besides people derive strength from Crucified Christ to carry the cross of their bodily ailments and stay patient, facilitated by the joy of Christ's Resurrection which will resurrect them as well.

This courageous patience, supported by the hope in Resurrection, accumulates all strength of the body, which, through grace given from above, can lead to recovery or, should God's will be different, give peace of mind and humbleness to the patient before death[31].

It can complement Confession, like Chrismation complements Baptism.

The sacrament of Extreme Unction does not envisage an exclusive care for the believer's soul, but for his bodily health as well. For "the Church knows the price of the body, through which the soul carries out its responsibilities, knows the sacrament of the body, which gets transformed by means of good efforts of the soul and participates in bringing a Christian in unity with Christ. Extreme Unction takes the sacrament of the body into account, through which [the patient] lives more than ever during illness and before death"[32].

According to the Orthodox Christian teaching, the sacrament of Extreme Unction envisages amalgamation of prayer in the Church and reveals this amalgamation. Seven priests that administer this sacrament symbolize the number of gifts of the Holy Spirit. The attending believers pray together with the finishers of the sacrament. This togetherness increases the patient's life forces or strengthens him with its warmth when he stands at the threshold of cold solitude of separation with everyone and everything on the earth[33].

It is recommended to administer the sacrament to a patient of a mental health hospital in person, nominally and preferably after confession, since then the sacrament does more good. The clergy and laity ignore the illness of the soul; Extreme Unction is usually offered in case of a biological illness.

According to the Holy Tradition of the Church, up until the 20th century Anointing (Extreme Unction) was administered during periods of fast, draughts, cataclysms, or epidemies. Some Local Churches have the practice of more or less frequent public Extreme Unction. The course of illness does not allow for public Extreme Unction at a mental hospital. The hospital administration demands, that first- or second-degree relatives must

[31] Pr. D. Radu, Caracterul ecleziologic al Sfintelor Taine..., p. 306.
[32] Pr. D. Stăniloae, Din aspectul sacramental..., p. 556.
[33] Ibidem, p. 557.

assist their patient during the sacrament to withstand the lengthy service. However, during each of the 4 fasting periods we serve one public Extreme Unction. Priests should show tolerance and patience to patients' behaviour that may be rather agitated.

II.3 Sacrament of Eucharist

Paul Evdokimov notes, that "man is truly what he eats – "the forbidden fruit" or "the eucharistic matter of his King" and His gifts"[34]. The whole life of a man fluctuates between the specifics of the forbidden fruit (the pain of sin) and the specifics of Eucharist. Thus, these two realia reveal different states of manhood, that either corrode its existence through sin, or finds its integrity in Christ. And the only specific way to get access to Christ is presented by the sacraments in the Church, and the Church itself is a unique sacrament of bringing the divine and the human together.

The Apostolic Fathers preach the initial faith of the Church in respect to Eucharist, faith which is explained by instructions given in the Scripture. Their texts make it clear that Eucharist took the central place in the early Church. Christian life is nourished by partaking the body and blood of the Saviour, by the practice of Eucharist. St. Ignatius of Antioch, for instance, describes the sacrament the following way, "Especially if the Lord make known to me that ye come together man by man in common through grace, individually, in one faith, and in Jesus Christ, who was of the seed of David according to the flesh, being both the Son of man and the Son of God, so that ye obey the bishop and the presbytery with an undivided mind, breaking one and the same bread, which is the medicine of immortality, and the antidote to prevent us from dying, but that we should live forever in Jesus Christ"[35].

In another Epistles by St. Ignatius of Antioch we also read, "They abstain from the Eucharist and from prayer, because they confess not the Eucharist to be the flesh of our Saviour Jesus Christ, which suffered for our sins, and which the Father, of His goodness, raised up again. Those, therefore, who speak against this gift of God, incur death in the midst of their disputes. But it were better for them to treat it with respect, that they also might rise again"[36].

St. Ignatius also writes that the Eucharist is something that unites and strengthens the Church. "Take heed, then, often to come together for the Eucharist and to give thanks to God. For when ye assemble frequently in the same place, the powers of Satan are destroyed, and the destruction at which he aims is prevented by the unity of your faith.[37]"

[34] Paul Evdokimov, Rugăciunea în Biserica de Răsărit, trad. Carmen Bolocan, Edit. Polirom, Iaşi, 1996, p. 17.
[35] Sf. Ignatie Teoforul, Către Efeseni, în vol. Scrierile Părinţilor Apostolici (PSB 1), trad. Pr. D. Fecioru, Edit. Institutului Biblic..., Bucureşti, 1979, p. 164.
[36] Sf. Ignatie Teoforul, Către Smirneni, în vol. Scrierile Părinţilor Apostolici,…, p. 184.
[37] Idem, Către Efeseni, p. 161.

The Epistle to the Philadelphians says that the faith in Eucharist is reliable and essential for a Christian's personality. The real presence of the Saviour in the Eucharistic components is explained in very simple and trustworthy terms, "Take ye heed, then, to have but one Eucharist. For there is one flesh of our Lord Jesus Christ, and one cup to the unity of His blood; one altar; as there is one bishop, along with the presbytery and deacons, my fellow-servants: that so, whatsoever ye do, ye may do it according to [the will of] God"[38].

Eucharist is the centre of our renewed, restored life, and Eucharistic Christ is the heart of this life, because it is from the heart that the feeling of personal and love comes. For this it is essentially immortal. "Knowing that Christ being raised from the dead dieth no more; death hath no more domination over Him" (Rom. 6:9), likewise Christ's members "shall never see death" (John 8:51). For, how can they see death, if they are always connected with the living heart?"[39] Sin alone could separate man from that heart and give him to sin.

According to the centuries-long tradition, communion can be frequent or rare, during the four fasting periods. Mentally ill patients that can die any moment should take communion not less frequent than every 40 days. Communion must be administered with attention, as the patient may have uncontrollable movements. Special attention should be given to young patients (20%), who can unconsciously spit communion fragments out or upset the chalice. To avoid this, it is recommended to have two attending deacons or two believers as assistants; 80% of communicants take the communion without incident. Most of the communicants are titular believers. Smokers are given communion after one week of abstention.

It is advisable to check the patient's ability to swallow food. It is only after this that the priest should administer communion. After communion medical workers must be watchful of the patient for him not to disgorge the sacrament.

Changes in the state of mind of mentally ill patients that we observe after taking communion:

1. They immediately come to a more balanced state of thinking, behaviour and mental activity;

2. Their illness does not progress for a long time;

3. Communication and dialogue may bring to unity which was impossible before;

4. Lucidity and clarity of mind, resumed relations of friendship and closeness with relatives and benefactors;

[38] Idem, Către Filadelfieni, în vol. Scrierile Părinţilor Apostolici,…, p. 179.

[39] Nicolae Cabasila, Tâlcuirea dumnezeieştii Liturghii şi Despre viaţa în Hristos, traducere şi studiu introductiv de Pr. Prof. Dr. Ene Branişte şi Pr. Prof. Teodor Bodogae, Edit. Arhiepiscopiei Bucureştilor, Bucureşti, 1989, p. 204.

5. We observe increasingly more conscious and attentive attitude to prayer and sacred objects;

6. They begin to show signs of piety (sign of cross, bows, benevolent behaviour), which they never had before.

Although doctors of the hospital do not hinder the process of offering care to the patients, only 15% of them are willing to collaborate with the clergy in their work and monitor changes in the state of those patients who take communion, in comparison with those who do not take them.

III. Conclusions

According to the Orthodox Christian teaching, Christ is the healer of our souls and bodies. Since our union with God is attained through sacraments, much attention should be given to participation of mental patients therein, who like somatic patients and all Christians in general are to inherit the kingdom of God which they are to seek (Matt. 6:33). Unlike other believers, they need a special approach in pastoral care, relevant to their illness and its stages. In any case, a correct approach (in cooperation with their attending doctor) to administering the sacraments of Confession, Extreme Unction and Eucharist does not only propel the patient to salvation, but improves the course of illness, which in itself facilitates the path to the Heavenly Kingdom for the patient. For this reason collaboration between the priest and the doctor plays a very important role not only for the patient's treatment, but also for salvation in spirit and redemption.

Archpriest Vladimir Vorobyov

Mental Illness and Possession

1. Spirit, soul and body. Trichotomy and dichotomy

The Apostolic Epistles, specifically the epistles by Apostle Paul, speak about dichotomy and trichotomy of human nature. Dichotomy teaches that human nature consists of the soul and body; trichotomy says that human nature consists of three elements, the spirit, soul and body. The Fathers of Alexandria, in particular St Clement of Alexandria and St Gregory of Nyssa, referred to trichotomy, whereas most of the Church Fathers speak about dichotomy. The contradiction is ostensible, since they speak about different things. Apparently, they mean mortality of the body and immortality of the soul, when they divide human nature into two

aspects. The term trichotomy is used to analyze the concept of soul, when its various properties are identified and the spiritual is set against the mental in man's life.

St Gregory of Nyssa (4th c.) clearly speaks about the incomprehensibility of the essence of human nature by human reason like the nature of God is incomprehensible, "… since one of the attributes we contemplate in the Divine nature is incomprehensibility of essence, it is clearly necessary that in this point the image should be able to show its imitation of the archetype. For if, while the archetype transcends comprehension, the nature of the image were comprehended, the contrary character of the attributes we behold in them would prove the defect of the image; but since the nature of our mind, which is the likeness of the Creator evades our knowledge, it has an accurate resemblance to the superior nature, figuring by its own unknowableness the incomprehensible Nature"[1] . St Anastasios of Sinai wrote the same, pointing at two important features that make man's soul similar to God – "it is foreign to any [other] created nature" and "man's mind is incapable of comprehending either reasonable grounds of existing of the Devine, or similar grounds of the essence of our soul; likewise it is incapable of comprehending how it was created and came into being"[2].

Mental, bodily make of man will stay secret forever at its ultimate depth. The deeper science goes in man's nature, the more the ultimate incomprehensibility of human being will become obvious. With the physical nature of man partially opening to science and lending itself to experimental study, man's soul remains an incomprehensible mystery in its essence and allows study of manifestations only 'visible' to our eyes, i.e. of a very limited phenomenology. The spiritual sphere allows us to comprehend only what is revealed to us by God, by the spiritual world. All these spheres are closely linked with each other, and it would be naïve to think their nature can be studied separately. We are face to face with a mystery, when we find out that these or those hormones influence people's psychic, mental life. It is specifically difficult to speak about the division of mental and spiritual in a man. We can only register observations of man's spiritual and mental life. The rest remains a mystery, and our speculations should not be regarded as an attempt to unveil it, but rather to somehow describe it, feel its depth and hear the revelations from the above, which bring us a little bit closer thereto.

[1] St Gregory of Nyssa, On the Making of Man [Григорий Нисский, святитель. Об устроении человека. СПб: Axioma, 1995. С.31]

[2] St Anastasios of Sinai, Three discourses on man being made in the image and liking of God // Selected works. M.: Palomnik [Паломник, 203. С.43.] Quoted after the paper by V.Rev. Guennady Yegorov "On dichotomy and trichotomy of human nature and the paradox of person in anthropology of St Theophan" [«Проблема дихотомии-трихотомии человеческой природы и парадокс личности в антропологии святителя Феофана»].

A good way to describe man's spiritual and mental organization is through the image of fire and iron which can well be distinguished one from the other in the beginning, but later with iron warming up in fire, they merge completely, and iron gets imbued with the nature of fire to the extend, that it can set other objects on fire when they contact therewith. Man's soul which has spiritual nature, is capable of entering in the grace of the Holy Spirit or connecting with the spirits of darkness. This connection of man's soul with the grace of God's Spirit may at least partially explain the trichotomic understanding of man's making. This image seems to explain better than any other the teaching of the Holy Fathers about passions as actions of a dark spiritual force in men, about possession with devils and casting of devils out of the possessed men which is so well known in Christian history.

2. Passions and addictions in man

Nearly all people are carriers of some passions or addictions, this way or another – gluttony and voluptuousness, lust, greed for money and covetousness, wrath and temper, melancholy, sloth, vanity, pride and their derivatives. According to the Holy Fathers, passions are active energies of soul, distorted by the original sin, that has lost their original chastity and harmony. The original sin, having settled in human nature, grows in the form of personal sin in each and every human being, like weed plants grow again and again every year. As rusty iron can be purified by fire, so human soul can be cleansed of sin and passions, which are sinful energies, and transformed through God's grace that makes it perfect, holy. However, a different thing is possible: a dark spiritual power imbues a man's soul and can trigger a malignant growth of passions therein, affecting the man's good will, submitting it to an evil inclination, turning the man into a prisoner of preposterous evil wants. Passions are divided into bodily (gluttony, lust) and spiritual. Actually, all passions have spiritual nature, although some of them act through excitation of desires of the flesh. Passions can, so to say, act moderately in a man, being curbed by rational will that does not allow them to get fully out of control. Such a man may not commit major (deadly) sins, but will not stay completely free thereof, does not get cleansed or improve in a due way, and fails to attain holiness, which God calls him to achieve.

3. Possession by an evil spiritual power

A man, imprisoned by a passion, be that alcohol or drug addition, gambling or greed for money, can be called possessed by such a passion, and according to the teaching of the Holy Fathers – by the demon of this passion. Indeed, we all know absolutely normal people – adequate

industrious, creative, married people – who nevertheless suddenly commit some crazy acts. This can be vividly illustrated by the gambling passion, which is capable of turning even a rich person into a bankrupt, make him cheat and steal large moneys. Not in a drunken state! Alcoholism and drug addiction, another example, are capable of imprisoning a great number of people who have recently shown no sign of inadequacy or illness. There are numerous reports of actions by demons in such cases. Here is just one of them, described by Rev. Konstantin Rovinsky in the early 20th century[3]. A certain man was fond of occult experiments. A group of friends gathered in a house to do fortune-telling on a saucer and thus get some advice from a spirit. That man gambled on a stock exchange and asked the spirit through the saucer if he should place his money stake hoping to win. The saucer prompted him to do so, and the man won a large amount, then he repeated this again and again. The last time he asked, the man was instructed, 'Place all your money and you shall win'. He did so, and lost all his wealth. He asked his adviser through the saucer what had gone wrong, and heard nothing but 'Ha-ha-ha!', and so he went mad. That accident cannot be explained by a hike or drop of testosterone, serotonin or adrenaline, i.e. some biochemical changes.

As a rule, the attribute possessed is applied to those who have completely lost control over themselves and whose mind and will has been fully enslaved. The Gospel and hagiography give us numerous examples. I believe, every experienced priest has run into such phenomena. From the Gospel we know that a single word by Christ was enough to drive demons out of a possessed man, the same as Christ healed bodily ailments with just a word alone. Great saints also had such power over demons – apostles, Venerable Sergius [of Radonezh], Righteous John of Kronstadt and many others. However nowadays such possessed people are locked in psychiatric hospitals as mentally ill persons and are offered medication. What does this mean? Does it mean that 'possession' is nothing but another type of acute mental disorder and nothing else? If that can be corrected with medication, why speak about demons?

4. Psychotherapy and spiritual help

Dmitry E. Melekhov, prominent psychiatrist of the 20th century, said that humble people did not have mental illnesses. Obviously, he did not believe it to be a proven theory, but he was clearly guided by the teaching of the Holy Fathers about sin being the source of illness in general, and pride (a spiritual state opposite to humbleness), in particular, in its ultimate development, causes insanity, i.e. a psychiatric disorder of mental and rational life of a person. If sin is a cause of illness, it should primarily be

[3] Rev. Konstantin Rovinsky, Dialogues of an Old Priest and his Spiritual Children [Ровинский Константин, прот. Беседы старого священника со своими духовными детьми.]– М.: Изд-во ПСТГУ, 2015.

treated by repentance, hence it is necessary to win a victory over sin. Is there a place to doctors and medication in this case?

Actually, this has no contradiction. If a smoker has developed lung cancer, his doctor will prohibit him to smoke, but will not deny him of medical treatment required for a malignant tumour. Following the prohibition to smoke is already a starting point of repentance, whereas the consequences of the sin will be treated or eased with medicines. This stays relevant for psychiatry. If depression started with the sin of despondency or it was triggered by genetic disposition as a sinful heritage from ancestors, pharmacological therapy will in no way exclude a spiritual fight against despondency and victory over it through strengthening of faith, hope and love to God and the neighbour, learning to thank God and take joy in the beauty of God's world. This can be achieved through prayer and blessed church life.

Obvious possession with an evil spirit is the most mysterious case. There are numerous evidences of such possession, which cannot be confused with a regular mental disorder or psychic endogenic illness. We come across this in the Church so often that every priest learns to identify such a state quickly.

If the level of possession is high, this is a state of indescribable gloom, heaviness and horror. Those who once got a firsthand experience seeing that will never confuse such presence of an evil spirit in a man with an ordinary illness. However, the state of possession is more often combined with a mental illness. This is not surprising, for a mental illness affects man's rational will, and they no longer can resist the evil spirit the way a healthy person can do.

Are there convincing signs of possession? Yes, it is the reaction to sacred objects and saints. You may remember the man with the unclean spirit from the country of the Gadarenes, who ran to Christ crying, "What have you to do with me, Jesus, Son of the Most High God? I adjure you by God, do not torment me" (Mark 5:7). Sometimes even babies in arms, who understand nothing yet – start struggling and crying when they are brought to the Holy Chalice. The same happens with older children even more often. It always turns out that such a child is brought for the first time or has not been brought to communion for a long time. If things do not go well at home, the evil spirit starts impacting younger children. Speaking about possessed adults, one may not stop to be surprised at the way they respond to the presence of a sacred thing without even knowing this.

On the other hand, I personally knew some people with a severe form of schizophrenia who would often take communion, pray and be an embodiment of holy humbleness and blessed life. Their illness would show itself in particular mental disorders, inability to be actively involved in some work, absence of adequate contact with the surrounding reality and people. But along with that, there was no sign of possession by a passion;

on the contrary there was an obvious turn to spiritual reality and God. The death of such people was blessed. In case of possession, we should persistently pray and employ all possible means to facilitate the lot of the suffering person. If there is a holy person who can cast the demon away with his prayer, then no medicinal treatment will be necessary. However, if there is no such an ascetic, who has prepared himself through fast and prayer and was granted from God the power to "cast out devils" and "lay hands on the sick, and they shall recover" (Mark 16:18), then doctors' and medicinal help is not excluded and can bring significant reduction to the illness, for instance, to eliminate horrible affective states of possession. However, possession as spiritual captivity by an evil power will stay, but will become less obvious though.

As for exorcism, there is no simple answer to this. A prayer always does good, but exorcism brings so many different people together – clinically ill people who are in need of medicinal treatment, various types of hysterical women, genuine or merely playing such a role, who can sometimes be 'cured' with just a good scare. One of such hysterical women began to scream at a patriarchal worship service, so the father superior pushed her into an auxiliary room and ordered an assistant to bring a bucket of cold water. That was winter time; when that woman realized that in a moment's time she would be splashed with cold water and driven of the church right in the frost outside, she started to plead the priest to let her go, promising never to return to that church. There is much noise and great cry during exorcism, so truly mentally ill persons are not advised to attend such rites. There are ascetic priests who truly help possessed people with their prayer. And there are those who virtually turn exorcism into a show-business.

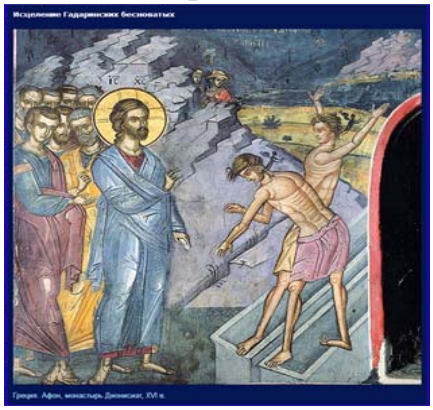
One thing is clear for sure, that a spiritual illness, which comes with sin, leads to a mental illness, if the sinner does not repent, i.e. does not turn for spiritual healing. A mental illness, if not being cured, often leads to death or severe bodily illnesses. A spiritual illness 'goes down' the ladder of man's spiritual-mental-physical making. It is good if the physiological cause of a disorder is identified by biochemical methods and gets corrected. But if it were only chemistry that would determine man's spiritual life, they would have stopped being human long ago. The mystery of verbal mind, godlike freedom, creative genius, understanding of the essence of life, kindness, spiritual beauty – all this cannot be reduced to chemistry or biology. Likewise, spiritual illnesses find their roots in the wrong of the life of the spirit and cannot be fully reduced to the level of hormones.

G.I. Kopeyko

Religious Delusion of Possession in Case of Schizophrenia

This paper is on schizophrenia as a mental illness and does not consider the problem of a true possession with demons.

Mental disorders can take various forms. For example, there can be somatic symptoms disorders, states under which mental disorders imitate heart or gastro-intestinal tract pathologies, bronchospastic syndrome or some dermatological ailments. There can be somatic "masks", manifestations of a mental disorder that include headaches, back pain, dorsal spine pain, etc. These symptoms are often observed during depression, and antidepressants reduce these somatic phenomena. There can be behavioural disorders, foar instance, run-out from school, theft, sexual excesses, or psychopathy-like behaviour when they become adult. Symptomatic alcoholism and symptomatic toxic substance addiction fall under the same category. All these take roots in depression, and those, who want to get rid of a difficult mental state, take to alcohol. However, this is not a true alcohol addiction, but what is called dipsomania. And finally come hetero-aggressive behaviours, such as suicide or homicide under depression. These are manifestations of mental illnesses that have certain masks. It is about such a mask, which has religious manifestations, that I want to tell you. In this particular case it is a mask of schizophrenia.



The delusion of possession was described long ago, even in the texts that belong to the prescientific age (the Holy Scripture and Tradition, lives of the Fathers and saints, etc.).

This fresco from a Greek monastery on the Mount Athos illustrates the Gospel story about the Saviour casting out demons out of two men with the unclean spirit from the country of the Gadarenes.

Psychiatrists of the scientific age were already equipped the concept that demons caused many illnesses, including mental.

This picture shows how demons torture a man in various ways. That is what people believed in those times.

Sergey S. Korsakov, a prominent Russian psychiatrist, described the state of a young woman who had been delivered to his clinic. "The patient, a woman of 28 years old, was delivered to our hospital <…> Believes <…> that she is

possessed with the devil; she remembers how it all happened: while in church she suddenly felt that something as if entered her and settled in her anticardium… She has become restless since then, she feels that the devil is in her; sometimes it seems to her that it swishes its tail exactly underneath her heart, and then she feels so unbearably bad, that she would prefer to die".[1]

Another psychiatrist, Wilhelm Griesinger, described demonic images that can show themselves in different parts of the body and cause deviant sensations. Some patients see this as an extraneous creature that has penetrated their body.

Still another psychiatrist, R. von Krafft-Ebing, wrote in his *Guide on Psychiatry for Practicing Doctors and Students*, 1882, "If patients express delusion of being possessed with demons, they often reject food, impose uncompromising silence on themselves, and torture themselves to a maim state as a result of precordial anxiety and demonic visions".

H. Schule, German psychiatrist, described a psychotic disorder with delusion of being possessed with demons, having called that state *demonic insanity* in his guide to mental illnesses published in 1880. He wrote about a possibility of spontaneous recovery of some patients, as well as a transition to a chronic form.

Karl Jaspers, the leading German psychiatrist, identified several types of such states. He underlined that psychopathological reality was not homogeneous. In plain words, one sort of states may belong to the endogenic spectrum, e.g. schizophrenia, others to the hysteric spectrum, what is sometimes called hand-wringing. These states are worlds apart.

French psychiatrists spoke about delusion of jinx, an evil eye or curse. This is so called external demonomania, when the sick person is sure that the devil acts against them from outside. Internal demonomania takes the form of the patient's believe that the demon has got into his/her body and triggers various sensations there. Two other French psychiatrists – J-E. Esquirol and J. Seglas – identified demonomania with a genital hallucinatory syndrome, when women were sure that demons had raped them and they even had 'conceived a baby'.

Prof. E.N. Kameneva states in her article "*On Archaic Forms of Delusion*" that delusionary ideas of possession, unlike other forms of delusion, are of primitive magic nature and constitute a certain regression of thinking to a primitive stage. Here we observe a combination of the delusion of possession with other kinds of delusionary disorders that align with primitive forms of thinking, such as delusionary ides of an evil spell, witchcraft or magic with insignificant intensity of other forms of delusional constructs. Delusion of possession belongs to a special kind of hypochondriac delusion, according to prof. Kameneva.

[1] S.S. Korsakov. General Psychopathology [С. С. Корсаков. Общая психопатология. 1901.]

Finally, prof. B.E. Pashkovsky has rather recently studied these states and described many different types of possession with demons. He has identified four varieties of symptoms of possession:

1. Dissociative variety with histrionic disorders of consciousness and delusion-like fantasies;

2. Paranoid-hypochondriac variety with dominating delusionary hypochondria and cenesthopathic disorders;

3. Hallucinatory variety with the Kandinsky-Clerambault syndrome and delusion of being possessed by an evil spirit;

4. Affective psychosis with verbal and smell hallucinations and delusion of possession.

I shall not dig deep here since a relevant study was published on this theme.

In the course of our study in the ward of special forms of psychopathology, Mental Health Research Centre, we have gathered data of approx. 20 persons with this pathology since 1994. We carry out prospective follow-up (catamnesis). This is done only for those patients that we examined personally.

Patients under study developed symptomatic psychosis at a mature age, 8-17 years after the initial signs of their illness. The beginning of their illness was acute, not uncommon like an insight. Such patients would suddenly perceive that '*the devil entered'* their body like '*a clot of energy*', and would virtually experience movements of a living being in them, *'a demon with a long tail'*. The demon would penetrate their eyes, ears, move within their body, enwrap the limbs as if '*by twigs'*. In some other cases the demon in the form of a creature with palps resided inside them, moved, '*occluded the throat with a palp, thrust worms in there*', which the patients perceived when swallowing.

The patients reported that the demon influenced not only their body, but also their will, planted thoughts of blasphemy, inwardly shouted out curse words and insults, gave orders of imperative nature, invasively unwound sinful memories, ordered to commit suicide, rushing from a height. Often there were episodes when the patients felt that the devil controlled their speech, showed them vividly scenes of erotic obscene content. In some cases, the patients reported that the demon inside them had an impact on others, causing them to yawn, cough, and violate the norms of decent behaviour. They felt that they were the source of '*demonic energy'*, which transmitted to the loved ones, and the latter developed '*harmful passions*'. In some cases, the patients even believed that the demon residing in them could also influence others. This is the so-called reverse variety of the Kandinsky-Clerambault syndrome. The devil can control their speech, the patients believe, i.e. the devil speaks through them. These are the so-called Seglas' speech hallucinations.

Finally, the sexual focus of the illness, when the patients said that the demon stuck to their body under their heart, drank their blood, took energy,

grabbed breasts, raped and even brought to orgasm. Some patients said that they became pregnant due to such sexual intercourse with demons, they were sure of that and even forced their relatives to go to a gynecologist with them. Naturally, no pregnancy was identified. One patient felt that there was a baby-antichrist in her womb, wriggling and even kicking. With this she felt alive in the worldly life and spiritually dead inside. Here I present various descriptions of the state of delirium in schizophrenic patients.

The patients naturally tried to fight their state of possession with demons in every way they could. They severely rationed their food ration to starve that demon to death, did not take liquids, induced vomiting, and sometimes they even had to be hospitalized in the intensive care unit so that they would not die of all that. Many of these patients had attended exorcists. One patient had visited exorcists more than 20 times, virtually all those currently living in Russia. They read the so-called Akathists driving out demons; performed magic rituals, drew special circles on the floor so that the demon could not enter them, stood in them for a long time, or sometimes simply made serious suicidal attempts.

Psychiatrists believed that these states, which I have described so extensively, are based on psychopathological disorders called *hallucinations of the general feeling*.

The acute state was followed by the formation of an explicit Kandinsky-Clerambault syndrome, named after two psychiatrists - Russian and French - who described it. The patients had a full range of psychic automatisms, i.e. control of thoughts, movements, feelings and sensations, up to the point that the patients stopped perceiving themselves as people. Some of them said that they had horns and a tail grown; others asserted a demon was growing in them like a tree, enveloping all parts of their body and brain, and completely subordinating the patient to the devilish influence.

When analyzing the peculiarities of the course of illness in our patients, we discovered that its type was close to the so-called paranoid delusional schizophrenia. Everything began with predominant religious ideas, then they developed primary delusion, and then more complex primary delusionary ideas of polythematic content, i.e. reference delusion, delusion of bewitchment, eschatological delusion. All that would later turn into an explicit Kandinsky-Clerambault syndrome. In some cases, the illness progressed continuously, in some others, it came in attacks with acute picturesque delusion, expressed emotional disease, or without any systematization of delusional ideas.

If the illness took a continuous nature, patients were generally impervious, demonstrated a very poor level of reporting of their experiences, had no contact with the doctor, were not at all critical of delusional disorders, and were characterized by the so-called *negative disorders*, a reduced energy level, emotional impoverishment, rigidity,

circumstantiality of thinking. They would turn into a recluse who stopped taking interest in their family life, would let themselves go, deteriorated dramatically in social and household life, lost ability to work and formalized their disability.

The patients, we observed, cause mixed reactions in others: some believe them to be possessed, others mentally ill, and still others put the sign of equality between the two.

Now let us move on to psychiatric assessment of these cases, i.e. I would like to show you that these are really cases of schizophrenia. First, I would like to refer to the opinion of Kurt Schneider, a prominent German psychiatrist, who described the *first-rank symptoms*. These include special types of mental disorders (thought echo, thought insertion, withdrawal or broadcasting), delusions of control, of being possessed up to the state of delusional depersonalization, transient or persistent pseudo-delusional disorders - all of which are characteristic of patients with schizophrenia.

This proves, from our point of view, that all the patients under study with these symptoms were characterized by the endogenic schizophrenic process.

I shall list once again the disorders that are considered classical for the endogenic process and we find in our patients: reduced affect, stereotypy, social estrangement, cognitive deficit, autism, reduced energy potential, progressing introversion, emotional blunting, drift phenomenon, specific thought disorders, pseudohallucinatory disorders and delusions. Although these symptoms are not specific to schizophrenia in their entirety, their combination with a special personality defect leads to the formation of syndromes with typical dynamics characteristic of this illness. Following this pattern of typical dynamics, we dare to assert that we deal with an endogenic process of schizophrenic nature. This conclusion can be supported by the loss of previous social ties, reduced mental activity, especially in case of acute delusion, hallucinations and other productive symptoms. All this results in a significant social maladjustment of the patients.

In conclusion, I would like to say that our ward of special forms of psychopathology at the Mental Health Research Centre (MHRC), which studies the relationship between mental disorders and religiosity of patients, collaborated at some point with the Franciscan Catholic community in Moscow, then headed by Rev. Gregory Ceroch. He would refer patients to us. Once he came with a patient who thought she was possessed by demons. Since I was curious, I asked him, as a Catholic monk, about his point of view on the phenomenon of possession with demons. He smiled modestly and said that 99.9% of the cases involved mentally ill people. The patient he had brought to us had also attended exorcism rites and turned out to be mentally ill as well. The patient was successfully treated at out MHRC and demonstrated long-lasting remission after the treatment.

Priest José M. Vegas

Mental Illnesses and Possession

1. General prerequisites: believe with the faith of Church and pastoral care of people

It is a challenging task to discern clearly when a person is under the genuine extraordinary influence of the devil and when he/she is merely physically or mentally ill. Symptoms may not only be similar, but sometimes they can intertwine. At least the first prerequisite that helps to tell a spiritual ailment from a mental one, is to accept that there exist truly spiritual phenomena, which do not, in fact, come down to the psychical sphere. So, in this situation we comprehensively accept the faith of Church that recognizes the existence of angels – pure spiritual persons – and fallen angels, demons or the devil, that once revolted against God and have been in a continuous fight against Him ever since.

We express this in a certain way when we confess our Christian faith and read the Creed, saying "I believe in God, the Father almighty, Maker of *heaven and earth*", or (in the Nicene-Constantinopolitan Creed), "… Maker of heaven and earth, visible and *invisible*".

The Catholic Church openly recognizes the existence of angels and demons, in its Catechism:

"The existence of angels is a truth of faith. The existence of the spiritual, non-corporeal beings that Sacred Scripture usually calls "angels" is a truth of faith. The witness of Scripture is as clear as the unanimity of Tradition" (Catechism of the Catholic Church, 328, hereinafter referred to as CCC).

"Behind the disobedient choice of our first parents lurks a seductive voice, opposed to God, which makes them fall into death out of envy (cf. Gen 3, 1-5; Wis 2,24). Scripture and the Church's Tradition see in this being a fallen angel, called "Satan" or the "devil" (cf .Jn 8:44; Rev 12:9). The Church teaches that Satan was at first a good angel, made by God: "The devil and the other demons were indeed created naturally good by God, but they became evil by their own doing" (CCC 391).

"Scripture speaks of a *sin* of these angels (cf. 2 Pt 2,4). This "fall" consists in the free choice of these created spirits, who radically and irrevocably *rejected* God and his reign. We find a reflection of that rebellion in the tempter's words to our first parents: "You will be like God" (Gen 3, 5). The devil "has sinned from the beginning"; he is "a liar and the father of lies" (I Jn 3,8; Jn 8,44)" (CCC 392).[1]

[1] Besides the Catholic Church Catechism (CCC 2851) asserts that evil is not an abstraction, but refers to a person, Satan, the Evil One, the angel who opposes God.

If one does not believe in the real existence of this type of spiritual problems, then any phenomenon that steps beyond the framework of 'normality' is automatically assigned to the sphere of mental illnesses, and people who suffer from these problems, do not find understanding in the Church. For this reason, they often turn to 'wise women', wizards, psychic mediums, witchdoctors, healers, etc., and in the final effect their state only gets worse.

It well may be that these people suffer, indeed, from mental illnesses and think that some evil spirit resides in them. Even so, these are people who suffer and need our help, which may mean a patient and thoughtful explanation that they need psychological support. The sick are also part of our congregation and object of our pastoral care.

Consequently, if the faith in the existence of the devil and evil spirits that may have their influence on man is the first prerequisite for discerning between spiritual and mental problems, the second one is an unconditional acceptance of those who come to us with such problems.

Here we should add, that all this (recognition of the devil's existence and pastoral acceptance of people) is done in the framework of our faith in the supremacy and victory of Christ. We should speak about the devil and his influence exclusively from this Christological point of view, without falling into irrational fears, exaggeration of demons' power and some forms of superstition or magical approach to these problems.

Speculating about these spiritual problems, what do we mean? What are the possible types of demonic influence?

2. Levels of the devil's influence

The Catholic Church, and specifically those who practice exorcism, discern four levels of the devil's influence, one ordinary, trivial, and three extraordinary ones.

2.1. Ordinary level: temptation

The ordinary level of demonic influence shows through *temptation*. There is one natural aspect in temptation connected with the limitedness of man's freedom, and he himself (with the help of grace and other people) should aspire to improve oneself. Man has various levels of existence (physical, psychological, related to soul/emotional, and spiritual), thus he has various wants, needs and demands, which correspond with various values.

"Man experiences temptation when lower values attract him to such an extent that this affects his higher ones.

Thus, pleasure, profit, wealth, power, beauty, etc. are not evil on their own. They are positive values in their nature, and man can lawfully aspire them. But moral integrity prompts that one cannot aspire them at the

price of justice and human dignity (their own or that of others), or lawful rights and expectations of other people.

For this, respect to higher values and demands is a condition for the satisfaction of the lower ones.

When this order is not observed, man begins to perceive and choose as good (pleasant, beneficial, etc.) something, which is not actually good, drugs, excessive drinking, sex without love, power without justice, etc.

To have a correct understanding of the role of temptation in committing the evil, we should add, that it does not force man's freedom to the extent that the letter disappears. A genuine temptation is always vincible, thence, the evil is committed only if there is consent on man's behalf".[2]

It is in this type of temptation that we see man's imperfection and weakness. But there is one more aspect in temptation that can be linked to the devil's direct influence.[3] It is still possible to preserve a clear understanding of good and evil in the state of weakness. But there is a more sophisticated temptation with some elements of deception – when good is called evil and evil good.[4] The devil – seducer and father of lie – tries to tempt man and distract him not only from the path of truth and good, but to make him lose awareness of what is good or evil, make him think that what is evil is actually good, and vice versa.

The story about the Fall (see Gen. 3:1-22) clearly depicts this way of the tempter's behavior. First, he sows confusion through an ambiguous statement: God does nothing but prohibit everything ("Ye shall not eat of every tree in the garden", v.1), limits arbitrary our freedom with his commandments, does not allow us to be free… Second, he presents evil as good: it is pleasant to eat of the tree, it gives knowledge, power. Thus, he dilutes the line between the right and wrong, and shifts the moral judgement. Third, he offends God: he tries to prove, that God is not good, that He limits us and, moreover, deceives us ("Ye shall not surely die, for God doth know…"). Finally, he promises direct subjective satisfaction and, more than that, – something impossible – personal development ("ye shall be as gods, knowing good and evil"), which gives us omnipotence, hence comes unlimited freedom, with no accountability – thus, what we desire will be good. Such a temptation, that entails rejection of God, trust in Him, also means rejection of oneself, one's own being, one's own truth and genuine good[5], since man wants to become something what he is not and cannot be. This particularly reflects the radical sin of Satan and his demons: rejection and non-acceptance of the limited existence of a creation, i.e.

[2] *Vegas J. M.,* Basics of Christian Ethics. St. Petersburg: Studia Petropolitana, 2014. P. 169.

[3] We say 'direct' since it is always possible to discover the indirect presence of the devil who uses man's weakness to tempt him.

[4] "Woe unto them that call evil good, and good evil" (Is 5:20).

[5] See *Lavatori R.,* "Satana e il mistero del male nel mondo". // Atti Convegno Internazionale AIE. 20-25 ottobre 2014, Roma, pp. 96-97.

refusal to take the place, designed for it, in the divine order.[6] For this reason Satan fights against God striving to prove (to himself and others) that God is not good, but does not do it directly against Him (too high for the former), but through the one who is His image on the earth, through man, showing that nobody is truly good, that anything good is a disguise for some dirty interest, and finally everyone has their price. This becomes specifically clear from the dialogues between Satan and God in the beginning of the Book of Job (see Job 1:7-11; 2:1-5). This fight encapsulates the tragedy and contradiction of the radical sin of pride: the choice in favour of not being formed according to the measure of created strength, which depends on God, i.e. the choice of rejection of their true being, the truth and the good, the choice of not being oneself. Hence, deep dissatisfaction that imbues the devil and all those who decide to live like him.[7]

We should say right away, that the devil bears no responsibility for the sin: he is a tempter (who 'motivates' us though lies), but it is man who decides. For this reason, it is believed that this kind of demonic influence, although an ordinary one, is the most dangerous: if it turns to be successful, it separates us from God and his grace.

2.2. Extraordinary levels of demonic influence

The Catholic theology and practice of exorcism identifies three levels of extraordinary demonic influence:

Oppression is a demonic influence which seems to come from outside a person, causing a depressed state, weariness, aches and illnesses with no evident reason. For instance, man suffering from oppression may turn to a doctor, and the latter will not find any illness in him/her that would explain such physical condition.

Experts say that the devil oppresses some people in such physical way when he fails to tempt them. It is worth noting, that quite often (although not always) oppression is a result of actions of an evil spirit triggered by evil people because of envy, hatred, desire to take revenge, etc. There were cases when saints suffered from such devil's temptation.[8]

Some authors believe that in case of oppression, it is enough to order the evil spirits leave the person in the name of Jesus Christ.[9] But others (including me) think, that this requires the prayer of deliverance.

Obsession. "Unlike the meaning that modern psychology puts into the word 'obsession', the Church employs this notion in its more ancient meaning 'siege' (Lat. *obsidere* – to besiege), i.e. 'obsession' means a

[6] Ib., p. 98.

[7] Ib., p. 99.

[8] *Babolin S.* L'esorcismo. Ministero della consolazione. Padova: Edizioni Messaggero. 2014, p. 175.

[9] *Davies J.* Exorcism. Understanding exorcism in scripture and practice. London: Catholic Truth Society. 2008, p. 27.

devil's attack, which is internal, in a sense, but still is not inferior to possession".[10]

In case of obsession, the devil acts at the level of imagination (i.e. at the psychic level) and tries to trigger hellish feelings in a man, extremely negative thoughts and desires: despair, mistrust, compulsive thoughts about suicide, ungrounded states of panic, emptiness, loneliness, futility, unclear hatred to beloved people, sacred objects, etc. Obsession is not a permanent state. It is characterized by times of tranquility and moments of severe attack.[11]

"Authors may differ in their opinion about the division line between obsession and possession. 'Obsession is a sequence of unusually strong and steady temptations' (Fr. A. Tanqueray). The devil lays siege, so to say, upon a person during obsession, and is capable of 'attacking from outside, causing serious disruption and chaos in the soul. Obsession is not merely a strong temptation. It has its own crises periods. During these times the freedom of will is reduced considerably but does not cease to exist completely. The obsessed person can actively oppose the emotional pressure that the devil wants to exert' (Fr. Adolphe Rodevique). Fr. Michel Scanlan puts obsession between possession and oppression: 'In case of obsession evil spirits besiege some part of man's personality. They, however, do not come in possession of the whole man's personality. On the contrary, causing anxiety to man, they do not act from outside, but as if from within'".[12]

"Basically, it is assumed that minor exorcism may help to recover from obsession, but it is not absolutely necessary – the usual means of the Church are enough. These means are 'usual' only from the point of their habitual employment – the word of God, sacraments, prayer and membership in the Church – all these are as extraordinary as the Incarnation and Resurrection (…) Obsession usually demands the prayer of deliverance".[13]

Possession. The person, possessed by the devil, usually experiences all symptoms characteristic of obsession and oppression, but besides that, the devil is present in the person's body and can control it, sometimes even fully, although there can be a broad range of symptoms of possession. The Catholic Church says the following about these symptoms in the rite of exorcism:

"According to the tested practice, possession with demons has the following symptoms: speaking many words in a language earlier unknown to the possessed, or understanding another person speaking the language; clairvoyance; display of strength exceeding the age or state of the possessed. These signs can serve as a certain indicator. Since such

[10] Ib., pp. 25-26.
[11] *Babolin S.* Ib., p. 175-176.
[12] *Davies J.* Ib., p. 26
[13] Ib.

symptoms may not necessarily come from the devil, it is worth paying attention to other signs as well, specifically to those that belong to the moral or spiritual sphere, that identify the devil's intervention in a different way, such as aversion to God, Holy Name of Jesus, Holy Virgin Mary and saints, the Church, the word of God, things, rites, specifically, sacramentalia, and holy icons. Finally, in some cases, it is necessary to assess thoroughly the relation of all these symptoms with faith and spiritual warfare in a Christian life, since the evil one is, primarily, the enemy to God and everything that the believers associate with God' salvific action".[14]

"If compared with obsession, possession is characterized by a higher degree of demonic influence, larger scale, more internal and more forced nature. Except for the cases, when the person committed oneself consciously into the hands of evil spirits (perfect possession), possession with demons is always of partial nature and may vary in intensity. The area of possession is often somewhat sealed, like in the case of an abscess, being separated from the rest of the person's existence, so that the person can function with a certain freedom, if the affected area is not touched. Sometimes three clear areas can be identified in the person which represent three concentric circles. The person may be sort of normal in the external circle; those who know the person well may identify some features that are not typical (e.g., race prejudice) in the middle one; and only when it comes to the inner circle, one may expect a fit of possession (outburst of demonic energy)".

"Two elements constitute possession: first, the devil's presence in the body of the possessed, and, second, control, exercised directly by a demon over the body and psyche of the possessed person, as well as over his/her soul" (Fr. A. Tanqueray). Possession means that "the devil has seized the 'city' and keeps under control all its inner fortifications" (Fr. Adolphe Rodevique). "Be possessed may mean that Satan has brought the person's mind in complete confusion (see Mark 5:15). In some cases of possession, described in the New Testament, the devil's invasion shows itself in various ailments of the human body, for example, when the devil takes control over the person's sense of vision (Matt. 12:22, 'Then was brought unto him one possessed with the devil, blind and dumb; and he healed him, insomuch that the blind and dumb both spoke and saw', hearing (Mark 9:25-26), speech (Matt. 9:32) or the whole body (Mark 5:1-22)" (Fr. Philip Weller)".[15]

It should be noted that true cases of possession are extremely rare.

Perfect possession or subjection. Jeremy Davis speaks about 'perfect possession' when a person voluntarily dedicated oneself to Satan, for instance, by means of satanic rituals or some other ways. However, other specialists believe that in this case we should not speak about

[14] Catholic Church Porteous for Exorcism. Introductory Note #16.

[15] *Davies J.* Ib., p. 27-28. See Babolin S. Ib., p. 176.

'possession', but rather about 'subjection' *(soggezione* or *assoggettamento diabolico*).[16] Unlike possession, which may happen through no fault of the afflicted person and, if so, he/she may have repented and rejected Satan and the causes of his/her state long ago, and, consequently, can live in the grace of Lord, although the devil is present in his/her body and partially possesses it, but against the person's will, in case of subjection the person gives oneself freely into the hands of the devil, having opened his/her will, and tries to consciously live and act according to the plans of an evil spirit. Thus, there is no need for the devil to be present in the person's body, since the person him/herself submits to Satan's plans. Unlike possession, subjection always entails own responsibility of the subject. However, when the person, who dedicated oneself to Satan, repents and tries to separate oneself from the devil and come closer to Christ, this is the time when possession may take place, since the devil will not give up on his prey easily and will take revenge for the 'betrayal'.

Infestation (invasion) is the presence of a demon not in persons, but in animals, places or objects. Possible signs of infestation are as following: moving things – may hit like a bullet, fall down without any impact on them and, possibly, get back to their places; doors that open and close on their own; some phenomena with electricity; sensations as if somebody touches you or whispers in your ear; smell (malodour) of a privy, sulfur or burning; unclear sounds, etc. The Catholic Church Porteous for Exorcism includes an appendix with prayers for such cases as well.[17]

2.3. Reasons of Demonic Extraordinary Influence

Except for the case of subjection, where the responsibility lies on the subjected person him/herself, other cases may be caused by very different reasons.

Overall, we believe that a human sin always lays ground for such influence. However, the extreme nature of such forms of a devil's presence prompts that usually there are some other specific reasons in place.

The most trivial and direct path that opens doors to the devil is a contact – active or passive – with something occult, occultism, spiritism, astrology, magic, healing, witchcraft, etc. There are other ways as well that seem less harmful or dangerous because seem to be the true paths of spirituality, but provoke major hazard since they separate from true God, deform His true Image (which He revealed us himself through the Revelation, and ultimately in Jesus Christ) and substitute Him with depersonalized ideas about God as a positive energy, a certain impersonal pantheism, etc. New Age, some forms of eastern spirituality, alternative medicine (reiki and others) fall under this category. Sometimes these

[16] See Burgo P. "La soggezione diabolica". // Atti Convegno Internazionale AIE. 7-12 settembre 2015, Roma, pp. 175-188. Ref. Babolin S. Ib., p. 177.

[17] *Babolin S.* Ib., p. 174-175.

contacts happen indirectly, for example, through some music rock-groups that spread satanic texts.

Quite often a person suffers from some forms of demonic extraordinary influence initiated by other people, who try to cast a bad spell, put an evil eye or love spell, curse or use some other forms of bewitching for many different reasons: envy, hatred, vampirism, or as simple as to take hold of the other person's flat, etc.

Man's state, determined by these reasons (oppression, obsession or possession), is compatible with God's grace if he has repented and tries to lead his life, connected with Christ through the prayer and sacraments.

We are aware of all these kinds of the devil's extraordinary actions, but we know that it is not that easy to recognize them in practice. Many symptoms of these phenomena seem akin to those of physical (in case of oppression) or mental illnesses. How do we differ them? Besides, sometimes both spiritual and physical or mental problems may coexist in one person.

Before I get to the role of doctors, specifically, psychiatrists and psychologists in recognizing these ailments, I would like to present a simple typology of people who usually come to an exorcist (a simplified version, since there well too many various complex cases).

3. Typology of people who turn to an exorcist

There are four groups of people who turn to an exorcist for help and believe that an evil spirit is in them.

First group, people who are **definitely ill.** I am not a doctor and have no right to diagnose. But still common sense helps me understand that the person has some sort of a mental illness. There may be a clear situation, when the person confesses that he/she has a diagnosis and is on medication. However, things are not always so unequivocal, especially when doctors do not believe in spiritual problems. Then they always diagnose with something general, like a neurological disorder. But if the person him/herself recognizes the illness, it makes things easier. People still come, since they believe that a prayer may help, which is true, if the person accepts his/her illness and does not run away from it. However, things may be different. I had several cases, when families did not want to put up with the fact that their son or daughter was mentally ill, and tried to verify that they were invaded by some evil spirit, in hope that in such a case the problem can be resolved with a prayer, whereas in case of a serious mental illness such hope weakens. In such a case it is important to turn to a good psychiatrist (who is a believer as well), who can professionally set a diagnosis. The family, however, may not always be willing to accept it.

Second group, people who are not ill, but have **unsound psyche and somewhat unhealthy religiosity**. These are people who see the devil in everything and assign everything (bad) that happens in their lives to his

influence. They often believe that somebody – quite often their relatives – have jinxed them or cast an evil spirit on them, for various purposes. The Introductory comments to the Catholic Church Porteous for Exorcism say about them,

"Priests should diligently discriminate cases of the devil's attacks from a false opinion following which some people – including religious ones [who belong to the Church] – believe to be objects of witchcraft, charms or curse, that was set on them by some [evil] people, as well as on their relatives or their property. We should not deny spiritual help to them, but there is no need to resort to exorcism in such cases; it is enough to pray appropriately for them and with them, so that they acquire peace of God. (…) This help can be extended by a priest who is not an exorcist, or by a deacon who should read relevant prayers and supplications" (No. 15).

Although I said, that these people are not ill, sometimes it is possible to identify the persecution complex in them, as well as a magic approach to religion and the exorcist (priest). It is very difficult to prove this to them, say nothing, to send to a psychiatrist (as it is not always possible to turn to them with such insignificant cases). It happens to be difficult to persuade these people that their case is within the norm.

However, it is here that I find one of the criteria for distinguishing between truly spiritual and psychical or psychological problems. A person genuinely suffering from the influent of an evil spirit no doubt wants to break free from it, whereas the person with problems not connected with an evil spirit 'yearns' to have 'something of this sort' and continuously looks for signs of an evil spirit's presence. Often they are deeply wounded people (in their childhood or along their life), who need attention, care and beneficence. We need to work with them and embrace with pastoral care, explaining the truth and encouraging them to pursue a normal and healthy religious practice and life, to work and develop autonomy – for quite often these are the people who do nothing but hang around the church. Sometimes it is advisable for them to get some psychotherapeutic assistance. I recognize that it is extremely difficult to persuade such people that they have no real spiritual problems connected with the devil. You can pray with them for (spiritual and physical) cure and sometimes even for deliverance, but you should always clearly tell them the truth about their state and not allow them to guide you as to which prayers an exorcist must read, which they tend to do.

People with **genuine problems of oppression and obsession** come relatively often. They belong to the **third group**. They are those who had contacts with some forms of occultism (practiced magic, visited witch doctors or spiritual healers, belonged to eastern religions or New Age groups, etc.) or they fell victim to an evil or love spell, jinx, etc. There are different signals of reality of these problems. For instance, they regard what is happening with them as unbelievable – they often start saying, "Father, you may think I'm insane…". They have a clear willingness to free

themselves from the problem, as soon as possible. They are ready and open to all instructions and advice from the priest… They also need pastoral care, brief catechism, if they are not communicant believers, so that they turn to Christ through their personal prayer and participation in the Liturgy and sacraments. You need to make it clear to them, that without this, actions of an exorcist are useless – it is like vitamins without normal daily diet. They need prayers for cure and deliverance and, on very rare occasions, the rite of exorcism.

Finally, the **fourth group** – cases of **true possession**. As I said before, such cases are extremely rare. I have run into three to four cases during over 10 years of my service. There are specific difficulties with recognition and verification here, since symptoms of possession are often similar or coincide with those of mental illnesses. Although symptoms are rather clear as those that are described in the rite of exorcism (No. 16, see above), but still they are not always revealed, or not immediately, or not obviously. Deception may take place, caused both by the devil and the afflicted.

"The exorcist in case of a so-called demonic intervention must, first of all, exercise necessary and extreme prudence and discretion. First, he should not take for granted that every person who suffers from some illness, especially that of mental kind, is possessed with a demon (CCC 1673). Neither should he believe that he deals with a case of possession, if somebody asserts that he/she is tempted by a devil in some specific way, experiences godforsakenness, and for this they are tortured [by the devil]; for any person can easily be deluded by their own imagination. He should also be alert to tricks and contrivances that demons use to deceive man, in particular to persuade the possessed person so that he/she does not expose themselves to exorcism, because the illness is natural or cannot be treated in a regular way. The priest should diligently and closely study, whether the person who is said to be tortured by a demon, truly is".[18]

We clearly see that it is not an easy task to recognize the presence of an evil spirit; one may easily make a mistake; and it is important to exclude a mental illness – which is an important element of such recognition – and this calls for cooperation with psychiatrists, psychotherapists and other doctors.

4. Role of doctors and psychiatrists in exorcism

The Catholic Church Porteous for Exorcism, its Introductory comments, No. 17 says:

"The exorcist must prudently decide about the need to apply the rite for exorcism after a thorough study, keeping the seal of confession in any case, consulting, to the extend it is possible, with specialists on spiritual

[18] Ib., No. 14.

issues and, to the extend it is necessary, with *trained medical doctors and psychiatrists who are well versed in spiritual problems*".

This necessity can be explained by the requirement of the previous point , i.e. *moral confidence*, that the person who resorts to exorcism is truly possessed by a demon.[19] However, the priest who performs exorcism is not usually a psychiatrist, nor is he capable of diagnosing with a guarantee, to exclude psychiatric disorders (as well as physical ones, in case of oppression); to achieve such a moral confidence, he needs to turn to somebody who can give a competent opinion on whether the person is ill or not.

Certain conditions must be observed to make this preliminary step successful. First, the psychiatrist and psychotherapist must be religious people.[20] It is important, since a non-religious specialist always interpret symptoms of possession and obsession as signs of a mental illness, for he/she does not recognize any other alternative. Usually when he/she cannot understand what exactly is happening with a person, but cannot acknowledge unnatural roots, they give a general and unspecific diagnosis, like 'patient with delirium', 'dissociative picture', 'psychosis', 'neurological disorder', etc.

However, it is not enough for a psychiatrist to be religious in 'general', so to say. He must believe in the devil and demons and that they can influence man in an extraordinary way.[21] We know that religious and practicing Christians (even priests) often do not believe in angels and demons. The devil, Satan, etc. for them are just symbolic figures ('personification') of evil with no objective content. They are 'non-believers' in this particular respect and tend to reduce all these problems to a purely psychological level.

We can say that these two are prerequisites. There is one more, third, condition, which is optional but (very) preferable – these professionals should act as permanent assistants to the exorcist, be members of his team. If they participate in the process of discrimination and the rite of exorcism (or in the prayers of deliverance) on a systematic basis, they can gain first-hand experience and see for themselves the truthfulness such phenomena, which will help them substantially to expand their views and gradually facilitate the process of telling an illness form demonic extraordinary influence. All this implies an intensive spiritual life, comprehension on the meaning of their mission as a Christian and a doctor, participation in the

[19] In the same place we read – and this is important – that besides this moral confidence we need to acquire the possessed person's consent. This means that you cannot practice exorcism without this consent (for instance, at a distance or without awareness/knowledge of the person who suffers from a demonic influence. This is important, because relatives often ask for the rite of exorcism to be performed without the affected person's knowledge. Besides, such exorcism is useless, since it is impossible to treat someone who rejects such treatment.

[20] It is not that important in case of a doctor, since he has to deal with physical symptoms about which he can an opinion irrespective of his religious views.

[21] See *Cascioli V.* "Esorcistica e psichiatria a confronto. Modalità di dialogo. Problemi interpretative e diagnosi differenziale". // Atti Convegno Internazionale AIE. 20-25 ottobre 2014, Roma, p. 108.

Church sacraments and, if possible, in prayer groups connected with the ministry of exorcism.

All this is described in the above given excerpt from the Porteous, "Psychiatrists that are well-versed in spiritual problems".

Unfortunately, it is very difficult to find such psychiatrists, religious and believing in the possibility of demonic influence. For this reason, cooperation is a challenge, but nevertheless, such psychiatrists and psychotherapists exist. Some of them, having encountered such problems, experienced real conversion. There are countries – personally I know cases in Italy, Argentina and Mexico – where psychiatrists and psychotherapists are integrated in teams of exorcists; they are the first to contact the afflicted person, who comes for an appointment. Some of them are members of the International Association of Exorcists[22] as medical advisors, and try to spread their ministry, expand the mentality of other psychiatrists, organize educational courses and raise awareness, also they often run into severe lack of understanding on behalf of their colleagues.

What is their role? According to one of them,[23] their task is to give psychiatric or psychological argument that would not allow the team to easily assign symptoms caused by demonic influence, to psychic problems. In contrast to general opinion, experts in psychological health say that these people (possessed and under some demonic influence) are neither insane, nor ill.

The psychiatrist's task is exclusively auxiliary: they are not to identify the devil's presence in the suffering person, since this is, first, beyond the psychiatrist's competence, and, second, this is what only the exorcist determines himself. The psychiatrist must simply answer questions, like: 'Can there be psychical reasons for what this person tells or what I see with my own eyes?' And if so, 'What clinical (psychiatric) picture does this belong to?' Thus, this task has a 'negative' meaning – not reveal the real presence of the devil, but rather to exclude (or confirm) a mental illness.

For this purpose, the psychiatrist informs the exorcist (preferably in a written form), first, about problems (or their absence) with mental health of the afflicted person and gives a diagnosis; and second, says if there is a scientific explanation to what he is observing or what the patient tells him about. The psychologist, in his turn, informs the exorcist, first, about the man's personal characteristics and diagnosis; second, if there is some natural explanation to what he observes or what the patient has told him.

This task is 'negative', preventive, but extremely useful for the exorcist, when he hears from professionals in the field of mental health, that what has happened with the afflicted person, has clear natural

[22] One of the goals of the Association is to 'promote cooperation between people, experts in medicine and psychiatry, and those who are competent in spiritual problems' (Charter, Art. 3.6).

[23] See Ezcurra H. de, "La tarea de un psiquiatra en el equipo de auxiliares de un exorcista", manuscript of the report, presented at Convegno Internazionale AIE. 24-29 settembre 2018, Roma.

(pathological) causes or, the other way round, what is happening with this particular person cannot be explained by a mental illness.

It is very important to have these reports in a written form to avoid, what is called, 'memory erosion', i.e. when the initial arguments, that brought the exorcist to the conclusion about the devil's presence and extraordinary influence, begin to fade away, specifically when the person's condition improves, and when there may be doubts about the true spiritual nature of the problem.

5. Mentall illnesses and demonic extraordinary presence – some symptoms[24]

Although the pattern of psychiatric problems that can be confused with various levels of demonic extraordinary influence, is very broad[25], and thus it is always necessary to have a diagnosis from an expert in mental health, it is possible to define some characteristic features of these illnesses that allow us to differ them from the phenomena of demonic extraordinary influence.

In case of mental illnesses, it has been observed that a patient's pathological state is nearly continuous, although there may be moments of crisis when the illness becomes more acute; in case of demonic extraordinary influence, the person acts quite normally and may lead an ordinary life outside the moments of crisis.

A person with a mental illness gets progressively socially isolated, gradually weakening and spoiling relations with other people, whereas in case of demonic extraordinary influence relations with people around are absolutely normal outside moments of crisis.

Mental illnesses as a rule have their roots in adolescence and young age, and after a crisis they get to the stage of so-called 'residual deterioration'. In the event of demonic extraordinary influence, the exact date is usually known when all this began (for instance, when an occult contact took place), and there is no residual deterioration.

Mental illnesses and their symptoms decrease under medication, whereas exorcism causes no change (on the contrary, the state may even worsen). In cases of demonic extraordinary influence, on the contrary, the state does not improve (and may get even worse) with medication, whereas exorcism (or the prayer of deliverance) improves the state.

[24] See *Ezcurra H. de,* "La tarea de un psiquiatra en el equipo de auxiliares de un exorcista", manuscript of the report presented at Convegno Internazionale AIE. 24-29 settembre 2018, Roma.

[25] Some examples: schizophrenia, delusional disorder, general psychotic disorder, altered states of conscience due to substence consumption, hysterical personality disorder, conversion disorder, multiple personality disorder, depression, maniacal syndrom, obsessive-compulsive disorder, etc.

References:

Vegas J. M., *Basics of Christian Ethics*. St. Petersburg: Studia Petropolitana, 2014.
Amorth G. Esorcisti e Psichiatri. Bologna: Edizioni Dehoniane. 2007.
Babolin S. *L'esorcismo. Ministero della consolazione.* Padova: Edizioni Messaggero. 2014.
Burgo P. *"La soggezione diabolica". //* Atti Convegno Internazionale AIE. 7-12 settembre 2015, Roma.
Cascioli V. *"Esorcistica e psichiatria a confronto. Modalità di dialogo. Problemi interpretative e diagnosi differenziale". //* Atti Convegno Internazionale AIE. 20-25 ottobre 2014, Roma.
Davies J., *Exorcism. Understanding exorcism in scripture and practice.* London: Catholic Truth Society. 2008
Ezcurra H. de*, "La tarea de un psiquiatra en el equipo de auxiliares de un exorcista",* manuscript of the report presented at Convegno Internazionale AIE. 24-29 settembre 2018, Roma.
Lavatori R., *"Satana e il mistero del male nel mondo". //* Atti Convegno Internazionale AIE. 20-25 ottobre 2014, Roma.

V. G. Kaleda

Pastoral Psychiatry as Challenge of Our Times (New Subject in Theological Schools Curriculum)

Pastoral psychiatry is an interdisciplinary course on the main manifestations, patterns of progression, and causes of mental illnesses, as well as peculiarities of pastoral care of persons suffering from them.

The purpose of the course is to prepare future priests for pastoral care for people with mental disorders.

Course objectives are to give an overview of symptoms of mental disorders, teach how to recognize the main symptoms, outline the peculiarities of pastoral and medical approach to such patients, and shape the principles of pastoral tactics in case of particular manifestations of mental illness.

Priests continuously come across people with mental disorders in their everyday practice. The prevalence rate of mental disorders is very high. Approximately 20-25% of the population have behavioural and mental disorders, according to WHO. Depression currently affects about 9-20% of the population (about 300 million people), schizophrenia — about 1%, dementia — about 2%, personality disorders (character traits that affect the person and others) — one person in three, neurotic symptoms occur in 10-20%. In some cases, these illnesses can coexist. About 4 million people — approx. 2.8% of the RF population — sought psychiatric

help in 2015-2017, according to the official data [1]. Approximately 5.6% of the population in the Russian Federation need help of a psychiatrist and/or psychotherapist, with mental disorders occurring in 14-15% of the Russian population, according to the Scientific Center for Mental Health (SCMH) [2]. WHO cites data on a higher prevalence of mental disorders, which is apparently due to the fact that the diagnostic criteria used at MHRC are more stringent.

The Church is a place of healing, so it is there that mentally ill people often come; and many come in crisis situations. It is a known fact, that religious people regard some events in their lives as a sign that God gives them, encouraging them to turn to the Church. Along with this, many mental disorders have a religious overtone. If we take a small parish of about 100 people, there will be 1-2 persons with various forms of schizophrenia — both hallucinatory and delusional disorders, among the parishioners; 10-20% may have depression, including a severe one, which will definitely require help of a psychiatrist; about 10% of the parishioners will have a personality disorder, previously called psychopathy. It is notable that some books on pastoral theology say that hysterical persons are a cross for both the pastor and the Orthodox community.

Students at theological schools who plan to become priests often do not expect that they will find many people in their parish with mental health problems, not just spiritual issues. The priest must be prepared for such challenges, because in some cases, the priest's words may determine not only the parishioner's spiritual life, but also their life in general. There have been numerous cases when an unthoughtfully said word by a priest led to most sad, irreversible and tragic consequences. However, we can also remember many cases when a priest was the first and only person who noticed a serious mental pathology and timely referred the person to a psychiatrist, thus saving the person's life.

Currently, a number of higher educational institutions of the Russian Orthodox Church offer a special subject, Pastoral Psychiatry. The concept of this subject was developed by professor of theology archimandrite Cyprian (Kern) and professor of psychiatry Dmitry Melekhov. They were contemporaries, both born in 1899. One of them taught pastoral theology at St. Sergius Orthodox Theological Institute in Paris, the other was one of the most prominent Russian psychiatrists of the 20th century and founders of social psychiatry. In 1957 Fr Cyprian published a Guide on Orthodox Pastoral Ministry [3], where a special chapter, called Pastoral Psychiatry, was included for the first time. It reads that "there are states of mind that do not

[1] N.K. Demcheva and others. Coverage of the RF population and Federal Regions with psychiatric help in 2015-2017 [Демчева Н.К. и др. Обеспеченность психиатрической помощью населения Российской Федерации и Федеральных округов в 2015-2017 годы // Психическое здоровье, 2018, №6, 10–19].

[2] Guidelines to psychiatry in 2 volumes, edit. by A.S. Tiganov [Руководство по психиатрии в 2-х томах, под редакцией А.С.Тиганова, М., 2012].

[3] Archimandrite Cyprian (Kern), Orthodox Pastoral Ministry [Киприан (Керн), архим. Православное пастырское служение. Париж, 1957. 255 с.].

belong to the categories of moral theology and are not included in the concept of good and evil, virtue and sin. They are those depths of the soul that belong to the field of psychopathology, rather than asceticism". A pastor should read at least 1-2 books on pastoral psychiatry in order "not to judge as a sin in a man what is in fact nothing but a tragic distortion of mental life, a mystery, not a sin, a mysterious depth of the soul, rather than moral corruption".

Archimandrite Cyprian spoke ironically of priests who are straightforward in their attempt to thrust everything into the categories of good or evil with ease and put everything under the category of diabolic possession. Familiarity with scientific data will make the pastor more cautious in his moral judgements. Such a clergyman, having learned a lot, will not make wrong steps and give wrong advice in doubtful cases which raise concern.

This idea was later repeated by another famous clergyman, a military surgeon, metropolitan Anthony (Bloom). He wrote that the priest cannot act as a professional psychiatrist, but he must have knowledge of how a mental illness manifests itself, and that the state of mind of a religious mentally ill person casts shadow on everything, including their life in the Church, which is what priests should remember. A priest should be able to distinguish between an illness and a true mystical experience [4].

Prof. D.E. Melekhov wrote Psychiatry and problems of spiritual life. This work was the fruit of his last decade. Although the book stayed unfinished, he had written and formulated the basic concept. His work was first published in 1980 in samizdat [dissident self-published books in the USSR], then was included without attribution in Volume 8 of the Priest's Handbook [5], and later was repeatedly reprinted. Prof. Melekhov was a true enthusiast of his ministry to the mentally ill. He wrote, "My main sphere is in everyday work, like for a monk his monastic obedience ... to work means to pray".

Dmitry Melekhov was born in a priest's family in the Ryazan province, both his grandfathers were priests. He always remained a deeply religious, spiritual man and belonged to the Orthodox Christian intelligentsia, which was not numerous in our country in those years. He suffered twice for his faith: the first time he was arrested as a member of the Christian student movement in 1923, the second time, in 1933, when he was already a medical doctor. In some miraculous way this did not prevent him from becoming director of one of the leading institutions — the Moscow Research Centre of Psychiatry under the RSFSR Ministry of Health in the 1950s. He was one of the outstanding Russian psychiatrists of

[4] Antony (Bloom), Metropolitan of Surozh. On Mental and Bodily Illnesses [Антоний (Блум), митр. Сурожский. О болезни душевной и телесной. URL: https://www.liveinternet.ru/users/rayusha/post250128031/].

[5] Priest's Handbook, Moscow Patriarchate, 1988 [Настольной книги священнослужителя, т.8. Издание Московской Патриархии, Москва, 1988, с.304–332].

the 20th century; his works have not lost their relevance, and they are still quoted. He followed the concept of trichotomy in his understanding of the human person — man consists of the spirit, soul and body, which are inextricably linked. This gives ground for identifying the spheres of competence of doctors: those dealing with the body (physicians, neurologists, etc.), psychiatrists, and spiritual doctors, priests, i.e. each of the specialists should be engaged in the sphere of their competence.

Prof. D.E. Melekhov emphasized the importance of distinguishing between religious experiences of the men-tally ill as a sign of illness, false mysticism, and normal, healthy religious experiences as a manifestation of healthy mysticism, and believed that the patient's religious experiences were a powerful therapeutic factor against the illness. While rehabilitating a mentally ill person, a psychiatrist should rely on the healthy islets of his life and personality, he wrote, religious faith being one of the most important of such islets. It is their faith that helps many patients to compensate for the defect (the term used in psychiatry with respect to some schizophrenia manifestations) and to preserve the core of the personality, although the person may be disabled.

Prof. D.E. Melekhov noted, that in some cases spiritual experience could become a source of positive spiritual experience for people with mental disorders. Metropolitan Antony (Bloom) shared a rather interesting case from his pre-war practice: an icon painter in the Paris Orthodox Christian community had developed a mental disorder. He began to hear voices and had episodes of inadequate exaltation and grotesquery. The clergy tried to administer the sacrament of extreme unction, etc. Ignoring protests of others, Father Antony advised to take the icon painter to a psychiatrist and offer the patient a course of electroconvulsive therapy, saying that "The only thing I know — although it may seem cynical to you — that the electric current will not harm the devil, if it is a case of possession. And if it is an illness, our friend will recover". So, the patient was taken to a psychiatrist, and an ECT course was applied to the former, which helped him recover from his psychotic state. The most paradoxical thing, according to metropolitan Antony, was that after the illness the iconographer began to paint more mature, profound, heartfelt images[6].

Prof. D.E. Melekhov wrote that in case of borderline disorders it was necessary to find not only a psychiatric, but also a spiritual diagnosis. The father-confessor, as well as the religious psychiatrist, must understand that a person’s mental suffering has spiritual and moral roots and is subject to religious treatment, i.e. it is necessary to refer the person to experience of the Church and the clergy. At the same time, he should identify what has a biological nature and falls under the competence of psychiatrists. A psychiatrist, in his turn, should not treat any religious experience as a

[6] Antony (Bloom), Metropolitan of Surozh. On Mental and Bodily Illnesses [Антоний (Блум), митр. Сурожский. О болезни душевной и телесной. URL: https://www.liveinternet.ru/users/rayusha/post250128031/].

pathology or delusion, and, regardless of his personal religious beliefs, should treat the patient's experience with great respect. Many of our patients, especially with endogenic diagnoses, lose their ability to work, and 25 — 30 year olds acquire a disability status. The only place where they can find meaning in life is in the religious worldview, the importance of which can hardly be overestimated for the rehabilitation of patients. Awareness of the importance of religious values for patients led to the opening of a church at the Scientific Center for Mental Health, which was consecrated by His Holiness Patriarch Alexiy II in 1992. Prof. D.E. Melekhov's concept is reflected in the official document — Bases of the Social Concept of the Russian Orthodox Church [7], where the concept of trichotomy of the human person is explained and a clear delineation between the spheres of competence of a priest and psychiatrist is given.

Unfortunately, only a few institutions of higher education have introduced the course Pastoral Psychiatry. This course has been taught at the Moscow Theological Academy since the mid-1990s. St Tikhon Orthodox University has offered this course since 2003. In addition, this subject is included in the curricula of the Sretenskaya Theological Seminary and the Theological Seminary in Belgorod; it was also taught at the Kiev Theological Academy for some time.

The Pastoral Psychiatry course is designed for a year. Only those students who plan to become priests are admitted to the classes. Tutorials are designed in such a way that students have an opportunity to attend supervision of clinical cases. One can talk a lot about depression and argue whether it is an illness or a sin of despondency, and the patient "needs to pull himself together". However, when students see a particular patient, his or her suffering, they will remember for a lifetime the image of a sick person suffering from mental illness. So, when they come across such a case in their pastoral practice, they will already have firsthand experience and own understanding how to act in a particular situation. It is not uncommon for some students to be skeptical at first, but at the end of the course we come to a common understanding of certain situations. Students see patients with a broad range of mental health conditions, including delusion of possession. The course pursues the goal of coming to a common understanding of the patient, because the priest and the Orthodox Christian psychiatrist should not have opposing views on the illness.

The Pastoral Psychiatry course consists of two main parts. The first part includes study of the main manifestations (symptoms and syndromes) of mental disorders (depression, mania, phobias, obsessions, delusions, illusions, hallucinations, etc.) in comparison with some states of the spirit (sadness, despondency, possession by an evil spirit, etc.). The second part includes study of the main mental illnesses, their most important manifestations, patterns, peculiarities of pastoral care for mentally ill

[7] Bases of Social Concept of the Russian Orthodox Church [Основы социальной концепции Русской Православной Церкви. Раздел XI.5.]

people. All mental illnesses presented during the course of pastoral psychiatry can be divided into four groups: borderline, endogenic, organic, addictive (impulse disorders), and pathology of mental development.

The first group of illnesses consists of the most com-mon psychiatric disorders, which the parish priest may come across most often. These are so-called borderline disorders, which include neurotic disorders (phobic anxiety-ty, obsessive-compulsive), a variety of personality disorders (psychopathy), psychogenic (reactive) illnesses. Mental disorders associated with somatic pathology (oncology, myocardial infarction, AIDS, rheumatic disorders, etc.) are also included in this group.

The second group of mental illnesses is called endo-genic [8]disorders (i.e. pathological processes in a body caused by inner (endogenic) factors, rather than by external factors, such as infections, psychoactive substances, stressful situations, etc.). These include affective disorders (bipolar affective disorder, recurrent depressive disorder, cyclothymia, dysthymia) and various forms of schizophrenia. The underlying pathogenesis (i.e. causes) of these conditions is a genetic predisposition. Scientific studies of recent decades have revealed in these diseases some abnormalities that can be detected during molecular genetic, magnetic resonance, neuropsychological, immunological and some other types of clinical and biological research.

The third group consists of illnesses caused by organic processes in the brain, which are registered in neurophysiological (EEG) tests and neuroimaging procedure. This group includes atrophic conditions of old and senile age, mental disorders in case of injuries and brain tumours, consequences of neuroinfections, as well as Alzheimer dementia with associated disorders and genuine genetic epilepsy. Some of the illnesses in this group belong to endogenic organic diseases under some modern classifications.

The fourth group of illnesses is formed by addictive disorders (alcoholism, drug addiction, substance abuse and non-chemical addictions — gambling, computer addiction, etc.), which are characterized by the formation of pathological dependence with pronounced medical and social consequences. The modern international experience of therapy of these conditions proves high efficiency of psychotherapeutic methods based on the development of the spiritual dimension and formation of religiosity [9].

The pathology of mental development includes various forms of congenital dementia and mental retardation (oligophrenia), as well as autistic spectrum disorders.

---

[8] Endogenous process (from ancient Greek. ἔνδον — inside and ancient Greek. γένεσις — origin) — a pathological process in the body, due to internal (endogenous) factors, and not caused by external influences, such as infections, psychoactive substances, stressful situations, etc.

[9] Rev. Fr. Alexey Baburin, Orthodox Christian Psycho-herapeutic Approach to Prevention and Healing of Addictions [Бабурин Алексей, прот. Православный психотерапевтический подход в профилактике и врачевании пристрастий // Церковь и медицина. 2010. № 5. с. 124–127].

Sexual disorders (transsexuality, exhibitionism, sadomasochism, homosexuality, paedophilia, etc.) are singled out as a separate group.

Future priests need to be aware of the main symptoms of mental illness, however making a diagnosis is not part of their job. They simply need to understand that a certain person's behaviour and experiences are not normal religious experiences with some peculiarities characteristic of this particular person. A priest should generally be aware of the pastoral approach to mentally ill people and understand which tactics he should pursue as a priest with mentally ill people with various expressions of a mental pathology.

The tutorials deal with the main symptoms of mental disorders and focus on the peculiarities of their display in persons with a religious worldview. For instance, ideas of self-accusation are characteristic of depression, hence, religious people will develop ideas of specific sinfulness. And this is not the sinfulness, which every person living a spiritual life finds in himself. In this case, it is an excessive, pathological feeling of their own sinfulness (psychiatry even uses the term delirium of sinfulness). Believers in depression can also experience the state of lifeless indifference. Such people say that they pray continuously, but "the heavens are silent", they do not feel any response.

The priest should be aware of general patterns of the most common mental illnesses, so that he could under-stand how the person's condition will affect his or her future life. For example, if psychosis of schizophrenic nature develops, it is necessary to know that the illness is chronic, seizure-like and with a high risk of relapse, so the person needs preventive therapy. With this in mind, the priest should understand what can happen to this person. It is often with the priest's blessing that Orthodox Christian patients take medicines. After all, many of our patients do not recognize themselves as mentally ill, and their treatment and, consequently, improvement of quality of their lives becomes possible only thanks to the authority of the Church.

At the tutorials we discuss causes of mental illness, biological, psychological and social factors triggering mental illness, as well as basic approaches to treatment, so that the priest becomes equipped with an understanding of how these illnesses are treated, what medication is available, how medicines work, and what are their possible side effects. We also talk about the distortion of spiritual life in case of mental illnesses.

When we diagnose mental disorders, the diagnostics should be adequate. There are two extremes — hyperdiagnostics and hypodiagnostics. In the first case, all human mental experiences are viewed through the prism of psychiatry, as part of a psychiatric diagnosis. There have been cases, when priests referred their spiritual children to a psychiatrist for consultation, and no mental illness was identified. However, it is always better to be on the safe side. Hypodiagnostics is the other extreme, the problem that is common for our society, not only for the

Church. People often try to explain psychiatric problems from a psychological or spiritual point of view. For example, even delusional disorders and infantile autism are sometimes interpreted as a kind of coping mechanism. Sometimes we find priests explaining mental disorders as a result of personal sin and ancestral sins, etc. and force such people to confess more thoroughly, thus plunging them into psychopathological experiences.

The priest should help his spiritual child to understand that experiences of the latter are painful and not spiritually mystical, and to show that the illness is given to him/her for a certain purpose, the purpose of salvation. Neither the Kingdom of God nor communicant membership in the life of the Church is closed for a mentally ill person. The priest should help the sick person to contact mental health professionals. There are examples when the priest not only encouraged his parishioner to go to a doctor, but personally took his spiritual child to a psychiatrist. Along with this we must understand, that the priest has no right to interfere in medical prescriptions. This is stated in the Bases of the Social Concept of the Russian Orthodox Church. Unfortunately, there have been such cases, although it is beyond the priest's competence, he has neither proper training, nor legal right for this.

We should also note a special role that the church community plays for many of our Orthodox Christian patients. It is in the community that they experience themselves as full members not only of the Church, but also of society. It is there that they find spiritual support. Mentally ill people fulfil some assignments in many churches, gaining spiritual and social support. Priests threat these illnesses and peculiarities of such patients with understanding. If possible, a social worker should be appointed to assist such a person in his/her difficult life.

When we talk about cooperation between a psychiatrist and a priest, it should be noted that in many cases they should join their efforts assisting a mentally ill person. When the person is in a state of acute psychosis, psychomotor agitation, the priest needs not strive to administer communion to the patient at any cost, this may even be dangerous. It is the psychiatrist who takes the lead at the acute stage of a mental illness. A pre-revolutionary job description for the medical staff of one of the hospitals contained, among other things, an instruction for the hospital priest that he could invite patients to participate in the Sacraments only on the doctor's recommendation, when the patient had been brought in a relatively balanced state. The priest's role is enormous during remission, when spiritual and mental life needs to be normalized.

Educational work in psychiatry should be carried out not only among students, but also among the clergy at various pastoral seminars, capacity-building training for the clergy and even for bishops. This has already been practiced. It is also necessary to introduce psychiatrists into the basics of

religion, structural organization of a religious community, understanding of the role of a father-confessor for an Orthodox Christian patient.

Spiritual torment — "the soul is aching" — is worse than physical suffering. In a state of severe depression, the patient feels him/herself at the very bottom of a deep abyss, from where nothing is visible, everything that has been important is devalued, and all connections seem to be severed. It is notable that the level of suicide is particularly high among these patients. Many patients with mental disorders feel rejected by society because of their peculiarities, and, indeed, society often turns its back on them. Our task is to learn to "treat them with the same understanding, kindness and thoughtfulness, as well as with the same straightforwardness as mentally healthy people", Russian psychiatrist P.B. Gannushkin wrote.

Every person, according to metropolitan Anthony (Bloom), is an image of God, an icon that can be "partially disfigured ... Nevertheless, it is a work of the Great Master before us". Let us keep this in mind.

Peter G. Coleman

Religiosity and Depressive Disorders in Elderly People

Since I was young, thanks I think to the closeness I felt to my grandmothers, I have always been fascinated by old age, both the challenges it brings as well as its achievements, expressed above all in concern for future generations. Ageing usually involves considerable loss, physical, social and psychological, but it is also true that most elderly people cope remarkably well with these changes, at least until the very last stages of extreme weakness and frailty. Even then much can be done to support them through what is after all a natural stage of life and to help them face death with serenity.

I have worked throughout my career as a psychologist in departments of gerontology and geriatric medicine, first in the Netherlands and then back in England where I had been educated. When I came to work in a medical school in Southampton more than 40 years ago I was closely involved in evaluating the new forms of specialist psychogeriatric services then being opened in particular areas of the UK. These services were based on new principles: a recognition of the close interaction between physical and mental illness in older people; encouragement of early referral to the service by the patient's general medical practitioner (GP); a careful diagnosis, particularly in discriminating functional depressive disorders from organic brain disorders; active and continuing treatment of any depressive element in a person's illness; and regular and programmed

support to those suffering from forms of dementia, including as well their family carers. (Sadly, in more recent years the previous high standards of such services have declined as the UK National Health Service has failed to respond adequately to the rising numbers of elderly people in the population.)

This presentation is focused on depression rather than dementia. Neither should be thought of as inevitable products of ageing but as conditions to be defeated and managed by good quality care. Dementia is a form of neurological disease and becomes more common in later life but depression does not have such a clear relationship with age. In fact major psychotic depressive disorder is less common among the older groups of the population. Rather what is more prevalent, at least in modern societies, is an increase in chronic disorders of low mood, where persons experience life as no longer worth living or just too much effort, accompanied by a generalised loss of meaning in life. To no longer perceive value in life can be seen as a weakness of the person but it is also the responsibility of the family, community and society in which the older person lives. Religion is as we know one of the great providers of meaning and value, providing perspectives on life that transcend individual decline and death.

Although good psychogeriatric care has always acknowledged the need to attend to the spiritual needs of patients who displayed strong religious affiliations, there was little understanding of how important religious faith and practice were in sustaining human recovery from illness and in maintaining psychological well-being. The situation has now changed as a result of the considerable growth in studies on the subject of ageing, mental health and religion over the last twenty years, particularly in North America, but also elsewhere (Koenig, King & Carson, 2012; Coleman, Schröder-Butterfill and Spreadbury, 2016). This consistently shows the health and well-being benefits of faith and practice throughout life, but also tending to increase in importance as persons come closer to death in the final years of their lives. Analyses of the results of large scale studies attribute the main influence of religious faith on health to the provision of meaning through life changes, and secondarily to the social support it provides not only through life's stresses but to the maintenance of a lively and healthy faith in the face of inevitable doubts and questioning.

Ageing and religion in Western Europe

However while the importance of meaning in life and the role of spiritual belief is better understood nowadays, traditional religious beliefs are increasingly discounted in the UK and much of Western Europe. These countries have experienced a declining religiosity within their populations, a dramatic loss of faith which has begun to affect even their older members (Coleman and Mills, 2019). These changes have been attributed to the

cultural and social upheavals which began to challenge authority, and especially religious authority, beginning in the 1960s. In our longitudinal study of the well-being of persons over 65 years in the city of Southampton which we began in 1977 we recorded how the numbers attributing importance to religious faith dropped from 70% to below 50% as the sample aged over the following 10-15 years. Although there was no further change as the sample aged further into their 80s and 90s, there was also no recovery of faith. We caught this trend in its early stages. It is not uncommon now to observe persons in their 80s questioning and arguing against important elements of the Christian faith in which they were educated in childhood.

As a result of the loss of religious belief in these populations research questions have shifted from investigating the particular benefits of religious faith to comparative studies of meaning giving by different types of "world views" (Lazarus and Lazarus, 2006). Do for example different belief systems provide equivalent moral and psychological support in the trials of later life? For example the well-known biological scientist and campaigner for atheism Richard Dawkins has proposed that a scientific and atheistic based set of beliefs can give rise to a 'world view' that fulfils the same four basic functions in people's lives that religions traditionally fulfil – 'explanation, exhortation, consolation and inspiration' (Dawkins, 2006, p. 347). The same type of questions can be raised about forms of Eastern spirituality and practice very popular now among many younger people in the West and well-represented as well in the post Second World War 'baby boom' birth generations now reaching retirement age. They came to adulthood amid the shifting fashions of the 1960-70s including the introduction of Asian teaching on reincarnation and the practice of mantra based meditation. Islam too is also now well represented in Western European countries. As a result research on ageing, belief and spirituality is beginning to give as much attention to these alternative 'world-views' and belief systems as to traditional Judaeo-Christian belief (Manning, 2019)

I have recently attended a British Psychological Society's working group on the contribution of psychology to end of life care, and the issues raised there are important for all age groups. There is much more research evidence available now on the psychology of very late life. It appears that previously successful modes of psychological adaptation as assimilation and accommodation fail at this stage of life to be as effective as in the earlier stages of ageing. Low mood and depression increase in prevalence accordingly (Coleman, 2017). There is rising social pressure for forms of assisted dying to be legalised and for use of methods of medication that even very recently would not have been countenanced. There is a dramatic return to favour of the use of psychedelic drugs like LSD that achieved such popularity in the 1960s as ways of enhancing or freeing consciousness to its new use of sending terminally ill persons into other states of being where the painful reality of their situation is masked by hopefully euphoric

images and sensations (Pollan, 2018). With the huge expansion expected in the population over 85 years of the age in the coming years questions on the choices of ways of living and dying in the last stages of life will become major ethical questions for all of our societies.

Comparisons between Eastern and Western Europe

Over the last twenty years I have been fortunate to have been able to conduct research on mental health and ageing in Eastern Europe first in Russia and the Ukraine and more recently in Bulgaria and Romania. All of these societies experienced, as you very well know, an enforced loss of access to religious life earlier in the 20th century. Together with colleagues, especially Dr Ignat Petrov, psychogeriatician in Sofia, I have conducted studies on the experience of depression in late life in Bulgaria and Romania. Religious practitioners in both countries suffered persecution in the last century, similarly to that of the Soviet Union, if over a shorter period and of lesser severity. Bulgaria is of particular interest both in regard to changes in religious practice and depressive illness. Perhaps learning from the Soviet experience, the post-war Bulgarian government applied a much more subtle but seemingly more effective long term strategy of undermining Church practice and vocations following seizure of power after WWII. It also worked hard on providing alternative secular forms of ritual to accompany the key transitions of life. By comparison Romanian persecution of religious practitioners although having severe consequences on the lives of particular individuals was not as systematic nor as destructive of religious practice.

In our studies of Bulgarian and Romanian villages we identified high rates of depression. In large part of course this can be understood in terms of the decay of traditional village life, outmigration of younger people to larger cities and abroad, and a decline in health service provision. But religious faith and practice also appears to play a significant role. Our comparative studies with similar villages in Bulgaria and Romania examined the influence of supportive factors, including religious faith and practice, in sustaining morale and preventing depressive states. We also applied a measure of strength of belief in a spiritual power outside of the self which had been developed for use in psychiatric services in London's increasingly multi-ethnic and multi-faith communities.

As we expected religious practice was much higher and depression much lower in the Romanian situations. My colleague Dr Petrov had also conducted studies of rates of depression among older people in the same villages in the 1970s, so it is possible to make comparisons. There had been almost a tripling of rates in the intervening 35 years, with one in two of the population over 65 years in these villages now showing indications of likely clinical depression. We were also able in Bulgaria to conduct a follow-up study over one year retracing those who had been visited the

year before. Those who had evidenced a strong degree of religious faith and practice showed better recovery from depression a year later (a finding also observed in North American studies) (Coleman et al, 2011).

In a subsequent study we obtained funding to investigate experience as well as memories of religious and non-religious ritual in Bulgaria and Romania as well as the UK over the last seventy and more years, thus from before the rise to power of atheistic communism in Eastern Europe and from a time of greater religiosity also in Western Europe. Our interviews on religious life, prayer and ritual, with those in the oldest age groups, who had come to an established religious practice before the establishment of atheistic rule in 1944, showed that they had by and large retained their faith, endured hardship as a consequence of retaining their faith, and in our interviews were able to display many examples of effective religious coping in later life. Many had also succeeded in passing on their faith to children and grandchildren, often by surreptitious means. By comparison some of those brought up in the Christian faith in the UK were experiencing distress in the latter part of their lives because of the loss as well as changing character of religious practice. Others had found ways of reconciling themselves to the changed nature of society and the new forms of ritual practice both religious and non-religious. Bulgarians by contrast had rejected the non-religious rituals proposed by the communist authorities and had returned strongly to traditional religious rituals for births, marriages and deaths (Coleman, Grama & Petrov, 2013).

Bereavement, religion and depression

In the remainder of this report I want to focus on the experience of bereavement, one of the major sources of depression in later life, its impact on older people generally underestimated and with important implications for pastoral practice. In our longitudinal study of ageing in Southampton which I referred to earlier (Coleman, Ivani-Chalian and Robinson, 2015) we noted how a number of our participants reported losing their faith or stopping religious practice after their spouse died. Persons would refer to questioning things they had previously accepted and no longer finding answers. Also divorce was commonly referred to as a source of distancing from the faith of their childhood. Men elaborated less about their religious attitudes but one man provided a very explicit account of the disappointment he experienced in his church after his wife died: “I felt very let down with religion, because I was always brought up in the Church of England … After the funeral the pastor just said “cheerio, I’m off”, and nobody even bothered whether I was alright or not…”

The suggestion of an association between the experience of spousal bereavement in later life and declining church attendance and allegiance was part of the motivation for seeking funding for an in depth investigation of the subject of religious faith and adjustment to bereavement from the

UK's government funded 'Growing Older' research programme (1999-2003). We obtained permission to approach bereaved spouses over the age of 60 years from general medical practices from the first anniversary of the death, and interviewed them three times over the course of the succeeding year. Survivors were also followed up a further six years later. In the course of these interviews we explored both the experience of bereavement and the role played by their religious, spiritual or philosophical attitudes to life and death.

Although the sample we collected was small (n=26) analysis of the results produced a surprisingly strong impression of a curvilinear association between indices of well-being and strength of spiritual belief (Coleman et al, 2007). The latter was assessed by a five item measure of belief in a transcendent spiritual power which could influence their lives. Those who expressed weak to moderate belief were more likely to indicate low levels of expressed meaning in life and symptoms of depression than those who expressed secure religious beliefs or securely held non-religious attitudes. But obtaining such security of attitude, whether religious or irreligious, appears to be far from common and liable to break down in the face of losses such as bereavement.

Two case examples of bereaved older women may illustrate the different consequences of a secure and an insecure faith in response to their husbands' deaths. The first had encountered two stages of bereavement, the actual physical death of her spouse following a gradual psychological separation as a result of his long and progressive dementing illness. She expressed a confidence in God's continuous presence in her life through the difficulties which faced her. Like many of the other older people in this sample she tended to believe that these challenges had been planned for her to undergo beforehand. But whereas others spoke of the role of 'fate' or 'destiny' she referred to the providence of a personal God. Such strong personal faith was often rooted in key personal influences in early life. She referred to her mother saying to her: He never gives you a cross without Him knowing you can carry it.

The second woman had also experienced successive losses but these had led to her gradually losing the faith of her childhood. She could not comprehend how there could be a God who cared for each individual person who ever lived. She continued to go to church in the hope of recovering her faith: I hear the church bells ringing and I think if you don't go today you're never going to believe in any of it again, so you'd better go and see …. I'm hoping that He might give me some kind of sign but I don't know what it is. She envied the strong faith she imagined she saw in her fellow parishioners but sadly never spoke with them or with the religious minister about her doubts, nor would consider the possibility of spiritual counselling. She remained stuck in an internal dialogue with her doubts. This woman like many of the others who were losing or had lost their faith said she could not reconcile belief in a good God with the reality of unfair

suffering she had experienced in her own life and that of others. She remained depressed, without a sense of meaning in life and in her own words 'not at peace with her beliefs'.

A brief mention of our bereavement study in SAGA Magazine, a specialist magazine for older people, led to many readers writing to us with their comments. Over a period of seven months more than a hundred letters were sent to the research team, many long and detailed. A large proportion included narratives of disillusionment with the church and with the Christian faith often as a result of lack of support especially following bereavement and watching close relatives suffer. They also commonly expressed the wish to be better consulted and their concerns taken more seriously by their religious ministers (Mills, Speck, & Coleman, 2011).

Bereavement of spouse appears to be an especially critical testing time for religious faith and as a consequence it is one of the more revealing contexts for studying belief in action. A subsequent study in a Roman Catholic parish in the south of England analysed the various benefits a strong religious faith brought to persons who were bereaved. These included: 'benevolent religious cognitions' about the loved person's relationship with God which provided a positive perspective on their experience of loss; 'biblical assurances' in gospel passages, psalms and elsewhere in the Old and New Testaments which they were able to draw on and repeat to themselves to reinforce acceptance of their beliefs; 'religious ritual' during church services which helped them both to regulate their emotions and to express their sense of closeness to the deceased person; 'spiritual capital' in the opportunities church membership provided for new activities, contacts and roles for the bereaved person within the church community (Spreadbury & Coleman, 2011).

Concluding comments: believing and disbelieving in the last stages of life

Our studies have implications for pastoral work. Firstly clergy need to realize that an older person may be more questioning of his or her faith than they imagine. It is easy to assume that an elderly people should have a secure faith after a whole lifetime of attending church services but this is not necessarily so. Older people have more time to reflect on their lives and the state of the world and their thoughts may lead them to question Christian doctrines. Job's question – 'how can a good and powerful God permit evil?' – is ever present and may well become more acute with age. Serious crises of faith can be precipitated by tragic events within their families, such as early bereavements and seeing loved ones suffer in ways which appear unjust. In our studies we interviewed persons who had come to see God as imperfect or as limited in His power. Belief in an impersonal and overriding fate or destiny determining each person's life was also common.

Christianity of course does not pretend to provide a ready intellectual answer to the question why a good and omnipotent Creator should allow evil. This is hidden in the mystery of the origins of evil in an invisible spiritual world given freedom by God, as mankind was as well, to act in harmony or in opposition to God. Instead our Christian faith provides a triumphal response to evil in the incarnation of Christ, Son of God, His life, His ministry, His death and His glorious resurrection. But this faith has to be communicated effectively. Older people nowadays as much as younger people need to believe in ways that they can accept rather than only on the words of external authority. Faith is not the same as certain knowledge and inevitably involves times of doubt. It requires trust in God to reach the deeper commitment required. But still this trust has to be made understandable, first ideally in the child's original family context of loving parents, but throughout life right until advanced old age in the response of those who care for them. We always need to be reminded by others and to remind ourselves that God is good and loves mankind.

Church communities should be alert to the needs of those in their midst who are in distress. Those with signs of mental and spiritual suffering should be listened to with loving care. There should be greater acceptance inside the Church of those questioning and 'wrestling with faith'. Ageing can be a time not only of mourning and lament, but also of complaint, protest and even anger against God. Despite their negative appearances these latter emotions can all be signs of ultimate hope and trust in God, urging His action to transform a painful situation. The Church's liturgies with their regular use of the powerful Hebrew psalms, alternating between distress, protest, trust and hope mirror these natural human emotions wonderfully well. They should regularly be on our lips together with the most loved Gospel passages and the Church's wise commentaries on them. But above all people at the end of their lives should not be left alone to struggle in silence with their doubts.

References:

Coleman, P.G., McKiernan, F., Mills, M. and Speck, P. (2007). *In sure and uncertain faith: belief and coping with loss of spouse in later life. Ageing and Society,* 27: 869-890.

Coleman, P.G., Carare, R.O., Petrov, I., Forbes, E., Saigal, A., Spreadbury, J.H., Yap, A. & Kendrick, T. (2011). *Spiritual belief, social support, physical functioning and depression among older people in Bulgaria and Romania. Aging & Mental Health,* 15:327-333.

Coleman, P.G., Grama, S. & Petrov, I.C. (2013). *Ritual in the changing lives of the very old.* In P.G.Coleman, D. Koleva, & J. Bornat, J. (Eds.) *Ageing, ritual and social change: comparing the secular and religious in Eastern and Western Europe.* (pp. 229-246). Farnham, Surrey: Ashgate.

Coleman, P.G., Koleva, D. & Bornat, J. (Eds.) (2013). *Ageing, ritual and social change: comparing the secular and religious in Eastern and Western Europe.* Farnham, Surrey: Ashgate.

Coleman, P.G., Ivani-Chalian, C. & Robinson, M. (2015). *Self and meaning in the lives of older people: case studies over twenty years.* Cambridge: Cambridge University Press.
Coleman, P.G., Schröder-Butterfill, E. & Spreadbury, J.H. (2016). *Religion, spirituality and aging*. In V.L Bengtson & R.A. Settersten, Jr. (Eds.), *Handbook of theories of aging. Third edition.* (pp.577-598). New York: Springer Publishing Company.
Coleman, P.G. (2017). *Development and adaptation in advanced old age*. In P.G.Coleman and A. O'Hanlon, *Aging and development: social and emotional perspectives.* (pp. 131-188). London: Routledge.
Coleman, P.G. & Mills, M.A. (2019). *Uncertain faith in later life: studies of the last religious generations in England (UK).* In V.L.Bengtson & M. Silverstein (Eds.), *New dimensions in research on spirituality, religion and aging.* New York: Routledge (in press).
Dawkins, R. (2006). *The God delusion.* London: Bantam Books.
Koenig, H., King, D., and Carson, V. (2012). *Handbook of religion and health.* New York: Oxford University Press
Krause, N. (2019). *How religion affects health: views from midway through an odyssey.* In V.L.Bengtson & M. Silverstein (Eds.), *New dimensions in research on spirituality, religion and aging.* New York: Routledge (in press).
Lazarus, R.S. & Lazarus, B.N. (2006). *Coping with aging.* New York: Oxford University Press.
Manning, C. (2019). *Meaning making narratives among non-religious individuals facing the end of life.* In V.L.Bengtson & M. Silverstein (Eds.), *New dimensions in research on spirituality, religion and aging.* New York: Routledge (in press).
Mills, M.A., Speck, P. and Coleman, P.G. (2011). *Listening and enabling the sharing of beliefs and values in later life*. In P.G.Coleman & Colleagues, *Belief and ageing: spiritual pathways in later life.* (pp. 35-58). Bristol: The Policy Press.
Pollan, M. (2018). *How to change your mind: the new science of psychedelics.* London: Allen Lane.
Spreadbury, J.H. & Coleman, P.G. (2011). *Religious responses in coping with spousal bereavement* In P.G.Coleman & Colleagues, *Belief and ageing: spiritual pathways in later life.* (pp. 79-96). Bristol: The Policy Press.

Panayiota Mama Agapiou

Religiosity and Psychopathology in Children and Adolescents

Revered Fathers, dear colleagues, friends, *rejoice*!

I think this is the best greeting for such a forum. This is how our Lord Jesus Christ welcomed the Myrrh Bearers after His glorious resurrection, according to the Gospel of St. Matthew (Matt.28:8-9). The verb *rejoice* in Greek means *experience joy*, which is very similar to the greeting that St. Seraphim of Sarov used to welcome every believer, "Christ is risen, my joy!", since he saw the image of God, i.e. the source of joy, in every human being.

It is a great honour and pleasure for me to participate in this conference. I came here from Cyprus, a small island in the Mediterranean with a centuries-old Orthodox Christian tradition dating back to the Apostolic times. Holy Apostle Barnabas of the Seventy and Apostle Paul's co-worker is the heavenly patron of Cyprus. I experience special joy here in Moscow, since it is the town of St. Matrona, whom I love dearly and venerate, as well as of many other saints of our common Orthodox Church, for we are all brothers and sisters in Christ Jesus; He is the vine, and we are branches, as Apostle and Evangelist John says (John 15:5).

Since I began to talk about my journey, let me make another stop in the homeland of democracy, Athens, where we shall visit the Athens Academy and see a picturesque image of the personified Sciences on the facade of the Kapodystria National University of Athens. It is worth noting that Medicine and Theology are depicted here conversing with each other. Closeness between them is obvious and symbolically shows that both sciences are sisters in the work of cognition and healing of man.

Today we celebrate the Holy Unmercenaries Cosmas and Damian, who, together with many other saints-patrons of medical science, clearly echo with the words of the Old Testament, *"Doctors and medicines are given by God!"*(Sirach 38:4-7*)*.

The Greek word "θεραπεύω" consists of two roots — "θερμό" (*adj.* hot, warm) and "άπτω" (*verb*, touch) — and means "*touch someone with warmth*". This is exactly what we try to do in child psychiatry — to touch the child's and his/her family's problems with warmth. This is what makes child psychiatry so special: it is not only a child or teenager who is *sick*, but the whole family, because the minor is an immediate member thereof and partly depends on it.

Following this introduction, I would like to turn directly to the topic of my presentation, which is divided into four parts for the purpose of our discussion. (Here I would like to share one challenge with you, which I experience daily as a clinical doctor when grouping together various medical cases I encountered in different hospitals where I have worked for the past 18 years. Doing so, I feel that I am destroying the uniqueness of a personality, because each person is unique and, therefore, each case is special. This is what the theology of our Holy Fathers teaches us; biology proves this; and mental health sciences — psychiatry and psychology — substantiate this. However, I had to carry out such a systematization due to the peculiarities of the presentational format, choosing, where it was suitable for better perception, just one example that combines a number of features and therefore can serve as a backdrop for various clinical cases).

These sections deal with the following issues:

1. Normal stages of psycho-emotional development, which can be burdened by sins or mistakes that religious people believe necessary to limit in order to protect their children's spiritual development.

2. Cases mistakenly perceived as expressions of religiosity, but actually psychopathological in their presentations.
3. Heterogeneous group of adolescents with suicidal behaviour (usually cutting themselves on different parts of the body).
4. Family-based spiritual care — the importance of parent-child relationship in building children's personal relationship with God.

Part 1. Normal stages in the psycho-emotional development of children and adolescents, as well as conditions in children and/or adolescents that cause anxiety among religious parents that their child breaks Christian commandments

A child or teenager is not a diminished copy of an adult, but they have their own special stages of psycho-emotional development, which would be good for us to know. Take the following as a guideline to help us better understand our topic: as adults, we should put ourselves in the shoes of the younger people to look at their problems, especially those related to growth, and then help them, using our mature function. This empathy experience will help us better understand their reality so that we, as adult believers, could continue to surround them with care. The leading mark to us on this path of condescension that we are called to take, is our Saviour Jesus Christ, who, being the Divine Word, has condescended to us and taken on the human nature through incarnation.

I will not go into detail, because time does not permit me, but I will limit myself to those stages or states that can be interpreted as errors of spiritual life, their wrong identification can cause even greater problems for the shaping psyche of a child or teenager.

When an adult believer (parent, catechist, teacher, or priest) feels that a child or young person is breaking a commandment, the situation often raises a particular concern in the former and a hasty desire to expose and punish the latter in order to prevent a repetition of the sin. In particular, the fifth ("*Honour thy father and thy mother: that thy days may be long upon the land which the Lord thy God giveth thee"*), seventh (*"Thou shalt not steal"*), ninth (*"Thou shalt not bear false witness against your neighbour"*) or tenth (*"Thou shalt not covet ... anything that* is *thy neighbour's*") commandment. These are the ones that encourage us to oppose the child or young person in order to correct some of their sins. This also includes states of selfishness and narcissism, as well as other states that encourage us to belligerently oppose child's or young person's possible self-indulgence, motivating our position that egoism and pride are deadly sins. But is this always the case? Is this always situation of a blatant passion that need to be eradicated?

Let us take a closer look at this issue and examine a few situations which, at first glance, could be interpreted in the above way, being not

actually related to passions and sins, but rather to completely different states.

1. Some special cases of child's lie

Transitional object.

I shall share with you an excerpt from a mother's diary about her daughter's relationship and play with her teddy bear. The mother mentions that when Katerina was 14 months old, she got a big teddy bear, at the age of 16 months she would take it everywhere around the house with her, and at the age of 18 months she would fall sleep with it in her crib. When at the age of 21 months she was given a child safety seat, the girl began to put the toy in it as well. Three months later, Katerina began to read fairy tales to the teddy bear. However, when the girl was 30 months old, her mother made the following note: "Katerina drew on the walls. When we asked her who had done that, she replied, "Teddy bear, and I gonna punish him". The days after that incident, Katerina was getting more and more angry with the teddy bear and scolded him, "Don't ever do it again, or I won't read you any more fairy tales at night"".

In adults' terms, Katerina lies, because she does not want to take responsibility for what she did and shifts the blame on the teddy bear. What does this mean for her? The cited fragment from the dairy shows that the toy has taken a special place in her life, and a special connection has formed between them; her reactions prove this. Little by little it has become her "man", and she does not feel alone any more. The teddy bear does not only satisfy Katerina's needs in communication and love, but it has turned into a very appropriate recipient of the little girl's anxiety and fear. This is what D. Winnicott calls a *transitional object*. It refers to a toy or some other inanimate object with which a child has a strong emotional connection and through which he or she realizes his or her desires and needs. This is the child's first "acquisition" and "creation" outside his or her body, with which all significant things can be associated — ideas, emotions, aspirations, fears. It represents the infant's transition from the state of "co-existence" with his/her mother to the state of "relationship" with his/her mother, helping the child to become increasingly independent and experience his or her own essence, according to D. Winnicott.

The *transitional object* is a bridge between the inner and outer reality. From all this, we may conclude that if we perceive this naughtiness with the teddy bear only as a lie that needs to be limited or as an incipient passion that needs to be eradicated, then we miss a precious opportunity to use the *teddy bear* to talk about the feelings of the naughty girl; if we take a different approach this will help the girl to avoid doing such things and many others in the future, which could otherwise remain obscured from us.

Fantasy misuse by children of pre-school and primary school age.

To some extent, fantasy is something predictable and even welcomed, as it helps to shape critical thinking through a symbolic process. Children's rich imagination, as a positive prove of their creativity, encourages them to make stories, exaggerate facts or add fantastic elements. However, this often goes beyond realistic narratives, as if the child does not feel the boundary between reality and fiction. It may be necessary to have an expert's point of view on what makes the child so excessively imaginative. But certainly, this should not be seen as a lie, because the child has not yet developed the sense of self-awareness and can be confused.

Children's lie.

In the eyes of children, their lies are as serious as those of adults; they are not made for fun or a joke. At this age, imitation and identification with parents is very strong. Therefore, when we hear a lie from a child, we must first of all look at ourselves honestly and critically at how often we tell lie ourselves; and not only when we lie to our child, but also in his/her presence to others. If we are sure that this should be ruled out in our particular case, then it is even more worth asking ourselves what makes our child lie. Usually children are afraid, often fairly, that they will be chastised or even beaten up. Therefore, lying in this case is similar to self-defense, and before limiting it, we need to think about what kind of relationship we want to build with our children: their only and first goal is to create good relationships with us.

Sudden lies at the adolescent age.

The reasons are often linked with the changes that take place at this stage of adolescent development. A teen begins to look for their personal identity, begins to distance himself from his parents, strives for independence and seeks his identity as a person rather than as an extension of his parents. This distancing and search for independence can take quite a long time and is often quite painful. Even if there have been close relations between the teenager and his/her parents, and he/she shares everything with them, he has a completely natural need to gradually create his personal space (internal and external). If we deny this need and do not allow his individuality to be formed, then the lie becomes an equivalent form of this inner space.

2. Cases of apparent breach of the fifth commandment

Assertion of a teenager's independence.

It has been previously noted, children make special efforts to gain their autonomy and independence during adolescence. On this path, they oppose any form of power to demonstrate their ability to do so. Their parents are the first adults to whom they apply this impulse. If parents perceive this position of a teenager as an expression of disrespect for themselves, rather than an immature way of communicating with them, they miss a valuable opportunity to help the teenager in becoming mature.

Nervousness and irritation with signs of resistance to parents are tantamount to depression in childhood and adolescence.

Depression in children and adolescents does not manifest itself in the same way as in adults, but signs of resistance to parents, irritation and nervousness are often taken for disobedience and disrespect, because of ignorance of the parents or other adults around the child. However, these children need help of a mental health professional.

Attention deficit / hyperactivity disorder (ADHD).

ADHD often manifests itself in disobedience, violation of boundaries and rules, irritation and resistance. However, this is not an expression of disrespect for parents or disobedience. Such behaviour suggests that it is more difficult for a child to concentrate and complete a task or fulfil some work in a satisfactory way, while breaking the rules is associated with an increase in impulsiveness compared with the general population, which in its turn is due to the child's lower concentration of attention. In such situations, it is an application of a specific medicine that helps to improve concentration by making the child more obedient and focused on tasks that are given to him/her.

3. Cases of seemingly selfish behaviour associated with a developmental stage in a child's life, or some form of psychopathology?

Adolescent narcissism.

Narcissism, where a young person turns to himself or herself, acting in a self-centered way because they feel vulnerable and unprotected, is characteristic of an early adolescence, i.e. from 12 to 14 years of age. By criticizing this *defense* and not understanding the teen's vulnerability, we leave them unprotected from the intactness of their own adolescent psyche.

Autistic spectrum: difficulties in socialization and understanding other people's feelings.

This is another condition that deserves special attention, for it concerns a whole group of children and adolescents.

I cannot forget one teenager with the Asperger syndrome who said to me, "I'm not a bad person, I simply don't understand how people feel...".

Part 2. Cases mistakenly perceived as expressions of religiosity which are in fact presentations of psychopathological conditions

Cases of psychogenic anorexia in religious families, which can be confused with the virtue of harnessing the passion of gluttony at an early stage.

Athena is an excellent ninth grade student and attends catechetical classes at her parish weekly. She has been reducing the amount of food she eats for several months already, since she believes that a Christian should be moderate in food and ascetical in everything. She also restricted types of food during the Lent, eating only fruits and vegetables. She lost a lot of

weight, and three months after she stopped menstruating. In spite of this, she believed herself to be fat, and on the Easter day she refused to break fast with everyone, later confessing that she had thrown away her food and did not eat the meat that had been served. She was referred to us by the local bishop, her parents' father-confessor, because he had realized that this was an illness, rather than true abstinence, because abstinence mortifies passions, not the body.

Cases of depression in religious believers, in which self-mortification, joylessness and a negative image of oneself are interpreted as remembrance about death, self-condemnation and awareness of vanity of being.

Elpida, a 10th grade student from a deeply religious family, where the lives of saints were constantly presented as role models, children were instructed to be just like them, emphasizing the fact that the saints wept day and night over their sins, constantly grieved them, and thus attained grace from God. These conversations about the lives of saints took place not in a benignant atmosphere, but under pressure. Elpida attended her classes lately very tired, without desire to learn. Her academic progress had worsened, and she saw no point in further schooling, because, as she said, life was fruitless. She often cried for no reason and said that she would better die, for this would bring her closer to Christ and salvation. At first, her parents thought she was a mature child who followed her family's instructions. She avoided peer groups, saying she did not see any point in communicating with them, and felt bored with them. In a while, her parents realized that something was wrong and brought her to our ward. We confirmed that she was in depression and needed medication and psychotherapeutic treatment. Among other things, she also admitted that she would have committed suicide had she not been held back by the consciousness that this was a sin.

Obsessive-compulsive disorder, which can be mistaken for exceptional piety or other manifestations of spiritual life.

Ten-year-old Nicholas, before he does anything, makes the sign of the cross three times. If he loses count, he repeats it from the beginning; he is often not sure if he has made the sign of the cross three times and repeats it until he is sure that the number is correct. He thinks that if he doesn't do the right number of times, something bad will happen to his family; so, he is protecting them. Gradually Nikolas stopped leaving his house, as his classmates found him strange and became ashamed of his behaviour. When his parents brought him to our ward, it was clear to us that his actions were a compulsive disorder.

Another case: nine-year-old Antony describes the following, "I see demons around me in a female form. The only way to drive them away is to wash my hands".

At this age, children's obsessions often take the form of repetitive images, and because of their immaturity they cannot distinguish them from

reality. In both cases, we worked through psychotherapeutic methods — more specifically, family psychotherapy — which gave a fairly positive result as children were under 12.

Psychosis with obsessive ideas with religious content.

Janis is a 14-year-old boy. Before he came to us, he had recently begun to withdraw in his room, refused to take shower, and said that he heard voices of the different saints who were opening up the future to him. Being sure that Nicholas was possessed with a demon, his parents first brought him to a priest for exorcism. Fortunately, the priest realized that the child's mental health needed to be examined, and asked his parents to contact us. When he was brought to us, it was discovered that Janis was psychotic; a course of medication was prescribed to the boy with a very good result.

The four described cases have one feature in common that distinguishes psychopathology from a virtue — anxiety. In all these cases, anyone who tried to stop the children's strange behaviour, would meet strong resistance; and if the children obeyed, it was not easy for them and triggered much anxiety.

A virtue drives anxiety, according to the tradition of patristic theology and asceticism. Depression leads to despondency, whereas the virtue of self-condemnation brings the person to the hope in God and joy that despite many of my faults, God's love is so great that it covers and forgives my wrongdoings, as Metropolitan Anthony of Surozh (Bloom) said, "If God has created each of us and brought us into this tragic world in which we live, He has done so because He believes in us, He has trust and hope in us". Moreover, the symptoms in the 4 cases above contradict the age norm we expect to see in the respective age groups, and interfere with the normal life and activities of these children. It should be remembered that if a teenager falls out of his or her age group pattern, regardless of the reasons they give, we must study these reasons with particular care.

Before I conclude this part, I would like to point out the following: another feature of a mental illness of a child or adolescent is a loss of their ability to enjoy simple and everyday things. We try to breathe life back into them through psychotherapy, to give value to something simple and prosaic.

As an example, I will cite the case of one girl who was at hospital with psychogenic anorexia. One morning, a nurse put a beautiful rose on the girl's bedstand. The girl was delighted with the nurse's gesture and brought the flower to the session with the doctor. "See how many beautiful things you've forgotten that surround you? And you let anorexia steal your thoughts?", I said. I asked her to bring this present to our next session. The next day, the flower didn't look so attractive anymore, and Athena was clearly upset. At the end of our session, I said, "See, Athena, ... and you are like this rose ... By refusing to eat, you fade ..." That was the point when she started to fight anorexia.

Part 3. Heterogeneous group of adolescents with suicidal behaviour (usually cutting themselves on different parts of the body).

As I mentioned, this is a heterogeneous group of teenagers. The number of cases of clinical depression is low; the purpose of suicidal behaviour is to alleviate a strong feeling of sadness experienced by the child. Religiosity and faith in Christ in this group are strong deterrents against the implementation of obsessive suicidal thoughts.

A small part of this group, which in recent years has a tendency to grow, is represented by teenagers who belong to a certain subculture: they listen to heavy rock, are pessimistic about life, look for contacts with the other world, some of them wear black and refer themselves to Satanists; skulls, desperate people, knives and blood are the leitmotif on their web pages. When they are in our hospital, they are not allowed to listen to the hard rock in their spare time, because we have noticed its negative impact. At the same time, we try to awaken their desire to create: children's ideas and initiatives to decorate the premises of the hospital, do arts and crafts. The children are encouraged to redirect their activity into the creative sphere, which is often an important component of psychotherapy. Thus, they discover other aspects of themselves that were previously unknown to them, and feel that they are meaningful. As a consequence, the need in the subculture as a factor that distinguishes them from the others, subsides. One should not forget that man was granted creativity as he was made in "God's image", and God is the Creator.

The group consists primarily of children who describe relationships with their parents, mainly with their mothers, as charged with conflict. When asked why they cut their veins, they would say, "At this point I feel alive... The physical pain I experience helps to release the feeling of empty inside me". We may conclude that these teenagers failed to receive sufficient emotional support in their childhood, not because their parents neglected them, but for various reasons that interest was expressed in a wrong way. These adolescents need family therapy more than medication.

Part 4. Family pastoral care, the importance of parent-child relationships in the formation of children's personal relationships with God

In conclusion, I would like to touch upon the important topic of family pastoral care. Here I shall cite a 19-year-old boy who, before leaving from home to continue his education, told me, "I am very lucky. My parents have been able to teach me how to build a relationship with God, through the example of our family relationship, because He is our common Father ... It is very challenging to be a parent, because the child builds his relationship with God along the line of his relationship with his

parents...” Frankly speaking, this young man’s words surprised me very much, they were like a gulp of fresh air for me. He gave voice to what we know as experts: a child's relationship with God is the relationship he has learned to build with his parents.

If the child believes that his/her parent is a strict judge who continuously punishes the slightest sin, then God will also be a strict judge for the child, punishing and constantly controlling. If, however, the parents have understanding and limit their child’s freedom caring for his/her safety, rather than with the idea to forbid pleasures, then the God’s commandments will be fulfilled willingly and with responsibility. When we accept the child with his/her mistakes and covering them up, it makes them easier to follow the path of repentance, for they know that this path leads to the loving arms of the Father.

Parental spiritual care should therefore contribute to the establishment of proper relationship with children on the basis of love, which will be a great contribution to their development and will prevent psychopathological developments. To this end, the Churches of Greece and Cyprus have established parenting schools where psychologists and psychiatrists are invited. These schools are venues for various seminars, lectures and, if necessary, individual sessions on relevant issues. For example, on the eve of my departure to this conference I gave a talk to young parents on “How to Reveal the Family’s Creative Potential”, at one of our parishes right after the Divine Liturgy.

I would like to conclude with the words by St. John of Kronstadt, “Saying ‘Our Father’, we must believe and remember that the Heavenly Father always remembers about us and will never forget us, for even a good earthly father does not forget and cares about his children. “I will not forget you, the Lord says” (Isaiah 49:15). “For your heavenly Father knows that you need all these things” (Matt 6:32). Plant these words in your heart! Remember that your heavenly Father always surrounds you with love and care, and is your Father not in vain. The Father is not a name without meaning or power, but a name with full meaning and power” (St. John of Kronstadt, *On Prayer: Selected Writings. VII on the Lord’s Prayer*, [св., прав. Иоанн Кронштадтский. *О молитве: выборки из его писаний. VII О молитве Господней, 78*]).

Peter J. Verhagen

Religion and Psychotherapy: Understanding and Religious Adapted Psychotherapeutic Strategies to Help Mentally Ill People

Outline

In the first part of my presentation I would like to broaden our field of view from which we look at psychotherapy practice. To be faithful, we need to see the context of our work beyond our professional psychotherapeutic boundaries. From that broadened perspective, I will continue on divine-human dynamics based on the biblical concept of 'dunamis'. Based on that I propose two main religious strategies in therapy. I will present a brief clinical vignette as illustration. This will be followed by a few words on postures of demoralization and resilience. In the final part of my presentation I will briefly pay attention to empirical research on faith adapted therapies and will end with a brief conclusion.

Broadening our scope: theodrama

Is it not true that we could depict human beings as being part of and participant in a big theodrama (Johnson, 2017, 130-146)? Perhaps one would prefer another expression, nevertheless I assume that one can imagine what I intend to say. In this drama, as it is revealed in Scripture, creation, fall, covenant, the birth, death, and resurrection of Christ have their place and essential meaning as major events. They form the Christian ground-motive. As human beings on our way through time to eternity we live our lives within this drama and because of that we have the possibility through Christ by the work of the holy Spirit to understand something of who we are and what it is that moves us and who we may be through and in Him. By being able to see our life within this perspective, there could possibly be a beginning of understanding the suffering and the brokenness that affects us as people, a beginning to look from a different angle at psychological misery in connection with this, and a beginning of longing for and appreciation of the signs of hope that God gives us.

To put it a little bit more in Calvinist terms: Calvin (1509-1564) described this world, moved by God's providence, as theatrum gloriae Dei (theatre of glory to the Lord). For him, every aspect of life from work to worship, and from art to technology bears the potential to glorify God (Institutes of the Christian Religion, 1.11.12). Creation is depicted as a platform for God's glory (1.14.20) or a 'dazzling theater' (1.5.8; 2.6.1), displaying God's glorious works. As creatures, I mean as being created, we take part in the ongoing play on the stage of this theater.

Or to quote Eric Johnson, who wrote a crucial book entitled God & Soul Care (2017): The triune God created human beings to develop into

participants in his glory, the grateful reception of which contributes to their fullest flourishing (p. 183).; it is one of his principles for Christian psychotherapy and counseling.

Reading and understanding our lives in this way has important meaning with regard to science and scientific knowledge. Being aware of this theodrama we are able to value the knowledge that scientific research yields in a different way, we can understand it in a more encompassing, holistic approach and we can evaluate more differentiated the direction scientific knowledge can give and the impact it could have on our lives. By 'more differentiated' I mean from differentiated angles, not only from a strict scientific one, but also from ethical, moral, religious and philosophical points of view, which are as valuable as the scientific one. Although scientific knowledge gives us insight in the structure of reality, such as psychology that gives us insight into the determinants of behavior, this insight, and especially these insights in psychological theories, are far from being value-free, which certainly applies to these theories about influencing behavior. That is as such not problematic, but it is essential that we are aware of it, and that we are alert when scientists try to convince us of the contrary, by stating that science is value-free, or the only way to acquire true or rational knowledge. That would be a version of scientism.

Assuming that we can read the Bible as a great testimony of this theodrama, and that this testimony is a meaningful resource to get to know ourselves and our world, we could say that psychology and especially psychopathology can be understood as explanations, as descriptions and as attempts to explain what according to Biblical discourse is the result of the brokenness and fallenness of man. That also gives us insight in why people put so much energy into self-rescue strategies.

Divine-human dynamics

If we try to find a connection between this view on the context of our lives and the setbacks that force us to therapy, then the biblical concept of dynamics comes into mind. I mean 'dynamic' as St. Paul understands it, as he writes in Rom. 1: 16 that the gospel for which he does not say he is ashamed, is the saving power of God. The evangelical, Greek keyword in those words from Paul's letter to the Romans is 'dunamis'; translated with 'power', or better, if you allow me, with the divine or divine-human dynamics. It is a superhuman power, sacred power, uncreated energies of God (Pleizier, 2010, 57). This dynamics in particular is the research area of practical theology and is, for example, analyzed when it comes to preaching. However, we could use this concept in our field of work as well. It is the divine power that takes place in the inner self of humans, and that creates faith. And in His Word God provides a redemptive future, which means that the believers are kept for the Kingdom of God. I would suggest that these two aspects of the evangelical 'dunamis' refers to two major

issues in psychotherapy, especially in faith adapted psychotherapy: (a) coping based on this inner presence of the inhabiting Word and holy Spirit, and, (b) forgiveness based on this redemptive reality and future in our Lord Jesus Christ. Coping and forgiveness are the two religious oriented strategies in psychotherapy I want to point at, although I cannot go further into it.

Clinical vignette

I present a short clinical vignette. My patient has heard a sermon about Isaac and Rebekah (Gen. 24: 62-65). It appealed to him very much, the reverend had kindly gone into how spouses during years of marriage nevertheless can grow apart; my patient is now divorced and does not understand why his wife, initially without saying anything, left him. They have not communicated since then, other than the most necessary. From what he tells me it is clear that Rebekka is the culprit, she incites Jacob to cunning and deceit. When I, after a while listening to him, ask him if he also has thoughts at, for example, the basis of that marriage, it was an arranged marriage, and at the possible role of Isaak as a parent, with his apparent pronounced preferences, then he has of course his thoughts about the things I ask. He has always thought about it before when I ask him something or propose something to him. However, his reflection, which possibly could lead to a question about his own role, leads seldom to something new, let alone self-reflection.

So in the light of what I tried to state, it is clear that this patient is somehow aware of the fact that his life is indeed part of a wider, religious context, and he is willing, in a way, to pay attention seriously to biblical stories and teaching. However, he seems to do so in a rather self directed way. He externalizes. His coping seems above all self-justification with an appeal to how he understands the biblical story, but he finds no rest. Asking for forgiveness, and giving forgiveness have yet not come up.

Existential issues

Let us have a closer look at what happens when one is confronted with life issues. Existential, religious, spiritual issues in the confrontation with adversity have at least two aspects to address: how did it affect the person, how did she respond to it. In other words, how one relates to the dramatic event. In the table 1 I show a list of existential postures. In the left column the features of demoralization are listed, in the right column the features of resilience. These features of demoralization remind us to various degrees of hopelessness, helplessness, confusion, feelings of incompetence, that people experience when they are failing their own and other’s expectations, and when they cannot cope with life’s challenges. From a spiritual or religious point of view we could call demoralization

dispirited, like the disappearance of one's spirit or even like the loosing of the holy Spirit.

It is an important clinical skill to be able to recognize these features. It is in a way an art to hear and to listen to the manifold expressions people use, such as metaphors, stories, beliefs, prayers, spiritual practices, and other commitments. Careful listening enable the therapist and the patient to engage in an open conversation that supports resilience by clarifying meaning, purpose and connection (Griffith, 2012, p. 229).

Vulnerability	*Resilience*
Confusion	Coherence
Isolation	Communion
Despair	Hope
Helplessness	Agency
Meaningless	Purpose
Indifference	Commitment
Cowardice	Courage
Resentment	Gratitude

Tabel 1. Demoralization or being 'di-spirited'. Existential postures of vulnerability and resilience (Griffith, 2012, p. 299).

Religious and spiritual adaptations to psychotherapy

There is a growing amount of studies on the effect of integration of religious and spiritual issues and techniques in psychotherapy on treatment outcome; until recently such studies have been sparse . A meta-analytic review from 2007 reported on outcome studies conducted from 1984-2005 and showed some empirical evidence that spiritually oriented therapies may be beneficial Smith, Bartz, & Richards, 2007). In the same year Wade and colleagues reported on the effectiveness of religiously tailored interventions in Christian therapy (Wade, Worthington, & Vogel, 2007). They found in their study that clients in Christian and in secular therapy felt equally close to their therapists and they reported equal improvements in their problems over time. The Christian therapists used secular interventions as often and religious interventions more often. Furthermore, they found a difference between low and high religious commitment on the part of the clients. Clients with high religious commitment reported greater closeness with their therapists and greater improvement in their problems when receiving religious interventions than did clients with low religious commitment.

This last finding is interesting to note. It is not only a matter of the use of religiously tailored interventions, the degree of religious commitment on the part of the patient is also a variable.

Nearly 10 years later Anderson and colleagues conducted a study on faith adapted psychological therapies for depression and anxiety. They performed a systematic review and meta-analysis of randomized controlled trials (Anderson, Heywood-Everett, Siddiqi, Wright, Meredith, & McMillan, 2015). The authors presented the following results: The literature search yielded 2274 citations of which16 studies were eligible for inclusion. All these studies used cognitive or cognitive behavioural models as the basis for their faith-adapted treatment (F-CBT). They identified statistically significant benefits of using F-CBT. However, quality assessment using a (the Cochrane) risk of bias tool revealed methodological limitations that reduced the apparent strength of these findings. Whilst the effect sizes identified were statistically significant, there were relatively a few relevant RCTs available, and those included were typically small and susceptible to significant biases. Biases associated with researcher or therapist allegiance were identified as a particular concern. Anderson and colleagues (2015) concluded as follows. Despite some suggestion that faith-adapted CBT may out-perform both standard CBT and control conditions (waiting list or "treatment as usual"), the effect sizes identified in this meta-analysis must be considered in the light of the substantial methodological limitations that affect the primary research data. Before firm recommendations about the value of faith-adapted treatments can be made, further large-scale, rigorously performed trials are required.

In Table 2 the kind of faith adaptations are summarized: using religious beliefs and practices to support coping skills, discussion of spiritual histories and gifts (eg., forgiveness, hope), dispute of irrational beliefs, attention to prayer and Christian content within therapy, the use of biblical and religious teachings, and applying Christian rationales for psychotherapy procedures. Comparable strategies according to other religious traditions are listed as well.

These are all very creative examples of how interventions can be religiously tailored. And besides that, there is a lot of important research on coping and forgiveness (see Worthington & Sandage, 2016).

Christian-CBT

Barron (2007)	Used religious beliefs and practices to support religious coping skills.
Bowland et al. (2012)	Discussed spiritual histories and spiritual "gifts" (e.g., forgiveness, trust); formulated a "spiritual recovery action plan".
Johnson and Ridley (1992); Johnson et al. (1994)	Used biblical teachings to dispute irrational beliefs; emphasized prayer and Christian content within therapy.

Pecheur and Edwards (1984)	Used religious and biblical teachings to challenge negative cognitions.
Propst et al. (1992)	Applied Christian religious rationales for CBT procedures (e.g., to counter irrational thoughts)

Spiritual-CBT

Armento et al. (2012)	Used value assessments based on religious/spiritual views; encouraged participation in religious activities; reframed situations using religious ideas of acceptance.
Gibbel (2011)	Used spiritual strategies to try to cope with and overcome negative cognitions.

Muslim-CBT

Akuchekian et al. (2011)	Incorporated Muslim teachings into therapy; provided joint care from a psychiatrist and a religious teacher.
Azhar and Varma (1995)); Azhar et al. (1994)	Discussion of religious issues with reference to Koran; included prayer.
Ebrahimi et al. (2013.)	Used religious beliefs to suggest goals and questions used within therapy.
Razali et al. (1998, 2002)	Challenged negative thoughts using teachings from the Koran and Hadith; discussed religious issues related to illness.

Jewish-CBT

Rosmarin (2010)	Used Jewish scriptures and stories to inspire change; used spiritual exercises and prayer.
Zhang et al. (2002)	Incorporated Taoist values into therapy.

Table 2. Description of ways that faith was incorporated into the faith-adapted treatment. (Anderson et al. 2015, 188).

Conclusion

Again, in order to be able to do our therapeutic work we need to be aware of the context of our lives as it is revealed in Biblical history and teaching. That is, in my view, the professional attitude of being faithful.

Not in a slavish manner but in a relation of fellowship with the one who appeals to us for our help. We do not proclaim the gospel in our professional work, but we try to connect our professional psychological and psychopathological insights with a deeper understanding of human nature and it's functioning within a religious realm of inner renewal and a redemptive perspective. Therefore I think that religious coping and forgiveness are the main therapeutic strategies to be used in mental health care and therapy. Fortunately, although there are severe limitations, empirical research is promising.

References:

Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). *Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis* [Адаптированные к вере психологические терапии для депрессии и тревожности: Систематический обзор и мета-анализ]. *Journal of Affective Disorders*, *176*, 183-196.

Calvin, J. (1960). *Institutes of the Christian religion.* [Институты христианской религии (F.L. Battles, Trans.). Philadelphia: Westminster Press (Оригинал опубликован в 1559 г.).

Griffith, J.L. (2012). *Psychiatry and mental health treatment*. [Психиатрия и лечение душевного здоровья] в M. Cobb, Ch. M. Puchalski, & B. Rumbold (Eds.), *Oxford textbook of spirituality in healthcare* [Оксфордский учебник духовности в здравоохранении] (pp. 227-233). Oxford: Oxford University Press.

Johnson, E. L. (2017). *God & Soul Care. The therapeutic resources of the Christian faith.* [Бог и душепопечение] Downers Grove IL: InterVarsity Press.

Norcross, J.C., & Wampold, B.E. (2011). *Evidence-based therapy relationships: Research conclusions and clinical practices*. [Доказательные терапевтические отношения: Исследования и клинические методы] в J.C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* [Действенные отношения в психотерапии: Доказательная восприимчивость (pp. 423-430) (2nd ed.). Oxford: Oxford University Press.

Pleizier, Th. (2010). *Religious involvement in hearing sermon. A grounded theory study in empirical theology and homiletics.* [Религиозное участие при слушании проповеди. Исследование закрепленной теории в эмпирическом богословии и гомилетике] Delft: Eburon Academic Publishers.

Smith, T.B., Bartz, J., & Richards, P.S. (2007). *Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review*. [Результаты религиозной и духовной адаптации психотерапии] *Psychotherapy Research, 17*, 643-655.

Wade, N.G., Worthington, E.L., & Vogel, D.L. (2007). *Effectiveness of religiously tailored interventions in Christian therapy*. [Эффективность религиозно-адаптированного вмешательства в христианскую терапию] *Psychotherapy Research, 17*, 91-105.

Rev. Fr Jesus Colomo Gomez

Mental Illness and Spiritual Life of the Patient: Pastoral Care for the Mentally Ill in the Modern Healthcare System

I would like to address the issue of pastoral care in terms of practice and my personal experience. **I shall not talk** about the connection between **religion and psychiatry** or **the mind and the brain**[1], and will not give **statistics** on pastoral care of the mentally ill in different countries.

1. Introduction

Viktor Frankl, Freud's successor at the Department Psychoanalysis and Psychiatry of the University of Vienna, has been one of the brightest scientists to me since the beginning of my university studies. It is well known that **he has transformed psychoanalysis** (based on the concept of sexual instinct dominating in human psychology**)** into **logo therapy,** the main idea of which is that life itself makes sense.

I was introduced to his works, when I studied psychology at my third year of the Medical School. We were to write a paper at the end of the course. I thought about writing about mental "norm and pathology", but my friend convinced me to do a coursework as a comment to Frankl's book ***Man's Search for Meaning*[2]*.***

I was deeply impressed with his story about how he had been prisoner in the Auschwitz and Dachau **death camps**. I read with shudder the account of his torturous experience and the discovery he had arrived to through suffering: **prisoners**, falling victim to any disease, **died faster** when they lost hope that they would ever be liberated, that is, when their **lives and their suffering would become meaningless**. On the contrary, thoughts about work he would have after his release and prayers to God so that his wife, who was also in the concentration camp, would escape all the suffering he had endured, helped him, a practicing Jew, to survive. **The meaning of life and the use of his sufferings** made it easier to Frankl to accept the circumstances of his life. ***"Those who know "why" to live will overcome almost any "how""***. This phrase by Nietzsche is very often repeated in Frankl's work.

That experience made him realize the value that is given to every person, including mentally ill people: to find a meaning of life and be able to give a meaning to life. This set the beginning for the development of the third branch of the Western school of psychotherapy: logotherapy, which

[1] You may find very interesting ideas on this topic in the paper by John Paul II, Address to the Participants of the International Conference "Human Mind", 17.XI.1990, in the book by Pablo Mercier Mazzala (ed.), del *Psicología y Psiquiatría. Textos Magisterio Pontificio*, B.A.C., Madrid 2011.pp. 180-186. Texts of papal Magisterium can also be found on the official web-site of the Holy See, www.vatican.va.

[2] Viktor Frankl, *El hombre en busca de sentido*, Herder, Barcelona 1962.

had been preceded by Freud's psychoanalysis and Adler's individual psychology.

My medical education was at the very beginning at that time, but I had already developed an impression – naturally superficial – that a pharmacological intervention was the only effective way of treatment of mentally ill individuals. This was the main idea of the so-called *organic* psychiatric schools. Books by Frankl helped me to understand that it was necessary to combine medication with an adequate psychotherapy. He made me realize the importance of each person asking himself about the meaning of life and discovering it himself. And not only the meaning of life that each person chooses, but also the meaning of those circumstances that are beyond his own will. I was able to confirm the significance of this when I became chaplain at the Navarre University Hospital.

A chaplain's work consists of different tasks. One of them, the fundamental one for a successful gospel preaching, is to help us understand that our lives always make sense, although sometimes it is difficult for us to identify it. The true meaning of life – we, the Christians, know this well – is to enter the Kingdom of Heaven. To attain it, we must fulfil the two commandments that Christ himself reminds us of, "The first of all the commandments is: 'Hear, O Israel, the Lord our God, the Lord is one. And you shall love the Lord your God with all your heart, with all your soul, with all your mind, and with all your strength'. This is the first commandment. And the second, like it, is this: 'You shall love your neighbour as yourself. ' There is no other commandment greater than these" (Mark 12:29-31).

2. Mental patients in Europe[3]

Before we talk about pastoral care for the mentally ill in Europe, I would like to begin by looking at the situation with mental patients in the European health care system.

Patients with severe and chronic mental illness have been isolated and mistreated for centuries. In all societies, they were among the most disadvantaged groups and could count only on the support of their own families or some charity organizations, most often set up by the Church. At different times, and in different countries, they were often considered to be dangerous to society and therefore had to be locked in institutions known as **madhouses**. Unfortunately, these institutions would often turn into real prisons: patients would be disobliged and subjected to all sorts of torture and humiliation.

Success in promoting respect to every person on the basis of the Universal Declaration of Human Rights, as well as progress in the

[3] A comprehensive study "Mental Health in Europe: Policy and Practice. Future Lines of Mental Health" was undertaken by the Health Ministry of Spain, published on: https://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/.../saludMentalEuropa.pdf

development of treatment methods in psychiatry, had promoted a radical change in these institutions, which had become **psychiatric hospitals,** very common until the last third of the 20th century. These institutions were meant as places of residence for the mentally ill, where patients were not always treated[4]. Often, mentally ill individuals could stay there until their death.

Subsequent discoveries of psychopharmacologists have made it possible to significantly improve the status of some patients. In this regard, it was recognized appropriate to reduce the number of psychiatric hospitals and to open **psychiatric wards in clinics and general hospitals**. It became possible for individuals to continue treatment as outpatients, staying with their families and their habitual communities, with temporary hospitalization when the patient's condition worsened. This health policy had been developing in Europe since the 60s or 70s, and by the 80s it had spread to almost all countries: psychiatric hospitals almost disappeared from the public health system. Most countries have retained psychiatric hospitals only within the penitentiary system, where criminals, sentenced for various crimes and recognized as mentally ill by courts, are held.[5] Besides, there are other psychiatric hospitals – private or established by various religious institutions – that address the problem of patients' long-term stay.

3. Pastoral care for mental patients

A mental patient is a person who is ill in a very specific way – this is an important starting point for all those concerned, patients themselves, their family members and everyone involved in the care process. A mental illness may be severe or mild, of longer or shorter duration, curable or not, with or without symptoms... but it is an illness, or rather an ill person. He or she may have different kinds of limitations, as is the case with any patient, but they need – like any other patient – adequate human and spiritual attention.

Pope John Paul II reminded us in one of his speeches, "Those who experience a mental illness always contain the image and likeness of God, just like every other man. Besides, they always have an inalienable right not only to **be considered God's image** and, consequently, a personality, but to be **treated as such**" (image of God)[6].

---

[4] See Paul VI, *Address to a Group of specialists from the Italian and French Association of Neurologists*, 8.VI.74, - in Pablo Mercier Mazzala (ed.), *Psicología y Psiquiatría. Textos del Magisterio Pontificio*, B.A.C., Madrid 2011, pp. 109-111.

[5] For more details see: www.sespas.es/informe2002/cap15.pdf . Chapter 15: La salud mental en España: cenicienta en el país de las maravillas.

[6] John Paul II, *Address to the Participants of the XI International Conference on Pastoral Health Care*, in the book of Pablo Mercier Mazzala (ed.), *Psicología y Psiquiatría. Textos del Magisterio Pontificio*, B.A.C., Madrid 2011, p. 212. See also the Encyclic *Dolentium hominum. Revista del pontificio consejo para la pastoral de los agentes sanitarios*, n. 34 (Año XII - N. 1) 1997; the same volume of the magazine contains many articles on mentally ill people.

3.1. Various situations with mentally ill persons

There are two different situations from the point of organization of the healthcare system:

a) Hospitalized mentally ill persons

Hospitalized patients may be visited by a chaplain on their request at an appropriate time. The **chaplain** understands that he deals with a mentally ill person and may even be aware of the diagnoses. The chaplain must always follow the advice, provided by a psychiatrist. In some cases, the doctor may say that the priest cannot provide pastoral care to a particular patient.

In case of a public health psychiatric hospital, the chaplain has ample opportunity to visit patients, ranging from a few days to only a few hours a week, the latter being the most frequent situation. If we talk about a general hospital, there is usually no chaplain who attends exclusively the psychiatric ward; any hospital chaplain provides pastoral care to mental patients when necessary.

If the hospital is run by a religious institution, the scope of pastoral care expands greatly.

b) Non-hospitalized mentally ill persons

Non-hospitalized patients with a mental disorder may contact any priest who, except for very specific cases, may not be fully aware about the person's situation. There may be members of the parish who have already been diagnosed with a mental illness. The priest may **intuitively sense** that there is a mental illness, judging by what the person shares with him:

- Dysphoria, fatigue, persistent decline in habitual activity, difficulties in performing new tasks, lack of goals, excessively long pain, etc. may be symptoms of depression.
- Strange or absurd ideas and behaviours accompanied by loss of contact with the reality can be a sign of a mental disorder, earlier know as paranoia.
- Doubts or obsessive thoughts may correspond to thinking disorders previously known as paranoia.

In all of these cases, it is appropriate to refer the person to a psychiatrist; it is advisable to be consulted by several specialist, not just hear one opinion. These doctors should be practicing Christians and act in accordance with the teachings of the Church.

3.2. Chaplains' work

The mentally ill should be treated with special care and attention. Very often they have a subtle ability to sense the inner state of their interlocutors. Moreover, we should not forget that mentally ill people rarely meet people who are willing to listen to them.

3.2.1. Dialogue with patients and their family members

3.2.1.1. Questions and answers in the face of any serious illness

A severe illness – not only mental – causes confusion in both those who suffer from it and their relatives. In such cases, there are fundamental questions that are difficult to answer. To begin with, it is worth clarifying some points:

a) Illness was contracted with no fault of the man

Very often patients ask about the cause of a serious illness, they have developed, and consider themselves innocent: "Why is this happening to me? I haven't done anything particularly bad, have I?" Or, on the contrary, the person believes him/herself be guilty: "God punishes me for the sin I have committed".

Indeed, we may be guilty of having committed some evil against ourselves or against others, but the consequences of this evil are well expressed by the phrase: "God always forgives; men sometimes forgive; but nature never forgives"[7]. If we go against nature, it is very likely that we will cause serious harm to ourselves and others; and in some cases, this can lead to a real tragedy.

However, God does not tend to punish **in this life**. Although he can do so, He rewards us or punishes us in **the other life**. We should insist on this reality when communicating with a patient, in particular, by reminding him that suffering helps to cleanse our sins and reduce the time we will spend in the Purgatory.

b) Mystery of suffering

"Why is this happening to me?" And in a more general form: "Why do the innocent suffer?" These are rhetorical questions, if we do not take God's will into account.

We all understand why the guilty suffer. If a car driver gets drunk and speeds along the highway at 200 km/h, the trip will end in a car crash; and we shall probably think: "He looked for that". But if a child develops leukemia or some other serious illness, if a driver gets in a car accident because of another immoral or insane driver, or if there is a natural disaster, **we face the mystery of innocent people's pain**.

In the book *Crossing the Threshold of Hope* [8] **-** a long interview with St. John Paul II edited by Vittorio Messori **-** the journalist asks about the suffering of the innocent**, and the Pope answers that it is a mystery.**

[7] The authorship of this phrase is not clear: some attribute it to Darwin, others to Claudio Albis ... In any case, it is quoted very often. Pope Francis cited it in several speeches; among other things, during the General audience on 21.V. 2014.

[8] Juan Pablo II, Cruzando el umbral de la esperanza, Plaza y Janés, Barcelona 1994, pp. 77-79.

- We do not find a full explanation for this mystery in the Old Testament: the Book of Job offers us the Divine will as the only explanation. In the last chapters of the Book of Job, when the Lord intervenes, saying: "Who is this that darkeneth Counsel by words without knowledge? (...): Where wast thou when I laid the foundations of the earth? declare, if thou hast understanding" (Job 38:2-4 (KJV)).

- Jesus give no theoretical explanation in the Gospel either[9]. He does not explain, but he does something which is much more: he suffers with us. So, no one can tell him, 'You do not know what suffering is'.

- Thus, the mystery becomes even more profound: how is it possible that God the Father would want to save us by sacrificing his Son on the Cross? God does this to show us His love and the possibility of salvation with Christ[10].

Saint John Paul II develops this thought in his Encyclic Salvifici doloris[11].

c) Acceptance of God's will

There is no need to ask questions **in the face of suffering**: **we simply must accept God's will,** and only then will there come an explanation for the suffering - our union with Christ crucified on the Cross acquires a redemptive value. With all our lives, but especially through our suffering, we partake in what was accomplished through the Atonement.

3.2.1.2. Thoughts about specific mental pathologies[12]

In addition to what has already been said, it is important that the priest should advise the mentally ill person to follow the specific recommendations given thereto by his/her doctors.

I shall focus only on the most common pathologies:

a) Patients with affective disorders (depressions)

Saint Teresa opposes what she calls melancholy, in a specifically clear way. The saint warns us against the seriousness of this condition for two reasons. First, melancholy does not look like an illness, because it does not require confinement to bed, such patients do not have fever and do not

[9] It is Apostle Paul who does this in his Epistle to Colossians, "I now rejoice in my sufferings for you, and fill up in my flesh what is lacking in the afflictions of Christ, for the sake of His body, which is the church" (Col. 1:24).

[10] Jesus taking the Father's love to all people in His human heart "loved them to the end" (John 13:1), because "Greater love has no one than this, than to lay down one's life for his friends" (John 15:13). His human nature, both in His suffering and death, became a willing and perfect tool of His Devine love that wants to save people. Actually, He willingly accepted his suffering and death out of love to His Father and people, whom the Father wants to save, "No one takes it from Me, but I lay it down of Myself" (John 10:18). This results in an unlimited freedom of the Son of God, who goes to death on His Own decision (Catholic Church Catechism No. 609).

[11] John Paul II, Encyclic *Salvifici doloris*, 11.II.1984.

[12] This section briefly presents thoughts from Miguel Ángel Monge, *Medicina pastoral*, EUNSA, Orcoyen (Navarra), 2002, 439-447.

need to call for a doctor at all...[13] Second, this condition does not lead to death. Although it is not treatable. This is more than strange: melancholy is not curable, but it does not lead to death[14]. Therefore, Teresa insists that those who suffer from this condition deserve mercy. They do not harm anyone. But the only way to stop melancholy is through the awe to the clergy[15].

Patients with depression are particularly sensitive to pastoral attention. They should be made aware that this is an illness, and not their fault. Although the illness is accompanied by suffering, the patient has an opportunity to connect him/herself with Christ's suffering on the Cross[16]. It is also necessary to support the hope of recovery, which very often becomes reality**.**

We need to help people understand the meaning of their suffering or suggest that meaning. As I said above, when he was imprisoned, Frankl initially regarded all his suffering as a way to spare his wife from suffering. He also described how he managed to reduce depression in a man who had recently lost his wife; and that was a very good marriage. His wife would have suffered terribly, had he died first; this man's suffering was the *price* he paid to spare his wife from this suffering.

Along with this line of reasoning, it is appropriate to encourage the patient to find strength to get out of loneliness, go in for sports, walk in the open air ... but above all, take care of his piety: prayer and participation in the sacraments.

b) Psychotic disorders (schizophrenia, etc.)

They are an intermittent pathology, relapses are followed by periods of completely normal behavior, when patients do not need any special attention. In relapses with hallucinatory images, when touch with reality is lost, it is more appropriate not to contradict the patient. You can listen to the person without expressing disagreement with what we think is wrong. The patient can be gradually brought to the idea that s/he should not be completely convinced of the reality of what s/he thinks or sees, as it has already happened to them more than once, and that their current condition is caused by a new attack of the illness[17].

c) Addictions

Addictions of any type may initially be mild mental disorders, but they progress and can be stubborn: alcoholism, drug addiction, sexual

[13] Libro de las Fundaciones, en Teresa de Jesus, Obras Completas, 11ª edición, Aguilar, Madrid 1979, 556.
[14] Ibid.
[15] Ibid, 554.
[16] See above, 3.2.1.2.
[17] One schizophrenic patient, a practicing Christian and a very good person, used to come to my office. From time to time he would be sure that he was God. I would always be following the guidelines and say nothing, but that he shouldn't be too sure, because it could be another psychotic attack. A few days after, with psychoactive support, he would come to me, saying that that idea had already passed.

addiction, gambling, addiction to pornography, they can completely destroy the life of the patient and their family.

It is important **for the addict to become aware of their illness** and turn to a doctor. It is highly likely that they will need to join groups that work with this pathology; the most famous one is Alcoholics Anonymous (AA) where they help to overcome alcoholism. However, there are also some new groups that are constantly set up to treat other addictions.

Pastoral care should be offered with such frequency at which the mentally ill person is willing to accept it and the priest is ready to provide, even daily. We should always maintain hope for recovery in patients. Sometimes frequent confessions are required, and it is **strongly recommended to avoid situations** that would destroy this "addiction".

3.2.2. Church Sacraments

Let's consider only the general rules here. In moral and dogmatic theology, each case is considered individually and needs specific approach. This is especially necessary in the case of mentally ill people: there are not only differences between such patients, but also between individual periods of life of each patient. The following should be taken into account:

- Level of awareness;
- Ability to act independently;
- The family's opinion should be taken into account in some cases.

a) Baptism and Anointment

If patients wish to accept these sacraments freely, on their own free will, these sacraments are administered to them.

These sacraments can also be administered for fear of death and if there is no objection made by the patient or his/her family. If there is doubt whether the person was baptized or anointed earlier, these sacraments are offered in a special rite of *sub condicione*.

b) Confession

This sacrament can also be offered whenever the mentally ill person so desires, under the same conditions that apply to any Christian - first of all, the possibility to examine their consciousness and to repent their sins.

Sometimes, for example, the person's will may be weekend because of addiction or obsessive states[18]. In such cases, the father-confessor should assess the moral state of the penitent, but always in a merciful way.

c) Communion

In principle, any mentally ill person can participate in the Eucharist

[18] To make a correct judgement about moral responsibility of a person, it is necessary to take into account such factors as affective immaturity, the power of habits, torments of conscience, and other mental and social factors that may mitigate or lessen, and sometimes even reduce to the minimum, the person's moral guilt. (*Catecismo de la Iglesia Católica.* n. 2.352).

and receive communion every time they are ready for it. This sacrament is not offered only to those who, through their actions, may make it difficult to serve the Eucharist.

In case of some types of dementia, such as severe mental impairment or intellectual disability, patients may well receive communion. Even if they are unable to distinguish between an ordinary bread and the Eucharistic bread, they can be offered the communion by the faith of the Church. Such cases are similar to the baptism of infants who have not developed a full power of the mind yet; they are baptized by the faith of their closest relatives, their parents and God-parents, as well as by the faith of the whole Church[19].

d) Marriage

This is a particularly delicate topic: the decision about a church marriage depends on the severity of the illness and the extent to which it has affected the mind and will of potential participants thereof. A person with mild depression and a person with schizophrenia on medication to have his/her behaviour controlled, are two completely different cases. It is necessary to be especially careful when making pastoral decisions to support such marriages.

e) Sacrament of Order

Here we could say the same thing as about marriage, although each case should be considered individually with even greater stringency.

f) Extreme Unction

In case of a grave illness or fear of death, this sacrament may be administered whenever the patient or his/her family do not mind.

4. Conclusion

Progress in medical care of the mentally ill has been particularly obvious in the recent decades, but there is still a long way to go for psychiatry.

Pastoral care for the mentally ill must also be improved:

- The staff at each diocese could devote more pastoral attention to the mentally ill; the best choice for this purpose is priests with experience of ministry to mentally ill people;
- It would be useful to introduce "*Pastoral Psychiatry*" in the curriculum of seminaries, as well as to organize courses or master classes for the clergy who could develop this area of pastoral care;

[19] Communion must be offered, whenever it is possible, to mentally ill disabled people – baptized and anointed; they receive the Eucharist by the faith of their family or community that is accompanying them (Benedict XVI, *Exhortación Apostólica Sacramentum caritatis*, 22.II.2007, n. 58 in fine).

- It would also be useful to have psychiatrists who are willing to cooperate and have good doctrinal training that would help them deal better with their patients and avoid using psychotherapeutic methods incompatible with Christian life.

Archpriest Victor Gusev
Archpriest Ilya Odyakov

Peculiarities of Pastoral Care of Patients at a Psychiatric Facility

1. Introduction

The paper is on the practice of pastoral care of patients at a psychiatric hospital.

1.1. History of the Church

Our Church in the name of the icon of Theotokos the Healer was the first to be set up at a psychiatric hospital after the 1917 Revolution, on the initiative of the staff of the Research Centre of Mental Health, Russian Academy of Science. As early as 1989 priests Valery Larichev and Alexey Baburin started to take pastoral care of patients of the Centre. They both had been trained as medical doctors-psychiatrists and had good practical experience.

The hospital church was set up with the support of academic Marat E. Vartanyan, director of the Centre. The church was consecrated by Patriarch Alexey II in 1992.

We would like to use this opportunity to extend our gratitude to metropolitan Sergiy of Voronezh and Liska for being our patron at the early stages of our church. The department for the study of special forms of psychopathology is a direct result of that support; the stuff of the department has already addressed you; whereas we are the clergy of this church.

Late archimandrite Kyrill (Pavlov) blessed and continuously took care of our department. “The believers are also entitled to professional psychiatric help”, he said at an early stage of our work.

Absence of free access is a peculiarity of our church.

1.2. Relations with doctors

Relations with the doctors can be presented in two ways.

On the one hand, the church was set up on the initiative of a group of doctors and other staff members of the Centre. Currently we actively cooperate with the medical workers. A number of employees come to our church for continuous spiritual advice and support.

Besides that, access of patients to the church is administered by physician when they believe that the patient's state has become stable enough for receiving spiritual support from the Church.

For this reason, our church is mostly attended by people after seven to ten days at hospital as in-patients, when the acute mental status has been allayed and a potential threat of inadequate actions that may lead to sacrilege has been reduced to the minimum. When this period elapses, patients can actively partake of the church Sacraments.

In more complex cases the priests often speak with the doctors first; they do this either at a special meeting or when visiting patients in their wards.

On the other hand, we often encounter churchliness among many medical doctors and lack of or inadequate understanding by them of the meaning of faith and rela-tions with God. In some extreme cases their attitude boils down to the statement 'you believe, this is the reason of your illness', or the doctor would not let their patients go to church under any possible condition (be that the patient's status or want).

In the best case they would consider faith, prayer, sacraments and God as an additional "resource" – along with medication – that helps the person to curb his or her illness. It is specifically hard to see such an attitude (to faith, prayer and God as a resource) in doctors who seem to be churched, since this is an attitude of a non-believer rather than of an Orthodox Christian. However, this is not so relevant to this topic.

2. Main part

2.1. Main forms of care

The main forms of spiritual care and direction that have proven their strength and become traditional in our church are as following:

1. Divine worship, sacraments, sermons offer a possibility for the patients to actively participate in the mystical life of the Church;
2. Catechetical talk, a way to help understand the meaning of sacraments administered to the patients;
3. Pilgrimages offer a possibility for rehabilitation, setting up and expanding social ties during remission;
4. Pageants on church feasts as a way give support and carry on missionary work.

2.2 Peculiarities of the worship practice

In everything we do we take two factors into consideration: first, the patient's state; second, the regime established in the Centre as in a medical institution (time of checkup and administering treatment to patient, meals, rest time, etc.).

We reduce the time of divine worship since the patients are weak, as a rule, and in an altered state of consciousness because of their illness and medication. However, we try to offer specific beauty of worship to make up for a shortened canonical service. We use bell-ringing and homogeneous male choir singing the Byzantine chant.

With pastoral forgiveness we usually reduce Liturgical fasting to the last evening meal and abstention from smoking.

The Divine Liturgy is served daily.

Since the patients are most often in a challenging psychic state – they find it difficult to concentrate, they get weak and drowsy, impossible to read texts – the prayerful preparation to the Liturgy is limited either to their attending the Vespers, or an accommodated payer rule.

Considering the fact that we deal with mentally ill people, we offer the sacrament of extreme unction (Anointing of the Sick) once a month. Following the Russian Church tradition, which finds it reflection in the prayers of access, the sacrament is offered for healing the body and soul.

2.3. Pastoral care

Speaking specifically about pastoral care, we should first elaborate on the approach and attitude to the patient and illness.

We believe that a genuine mental health is possible only when three aspects of man – spirit, soul and body – are in harmony with each other. It is the spiritual sphere that takes the lead out of the three, when in norm.

We remember that every person is an image of God. We also remember that deification is the mission of every person, i.e. it envisages such a transformation when they become capable of attaining the Heavenly Kingdom, with God's help. The life of man unfolds in the context of eternity. Another thing we remember, is that his/her personality is something that drives each and every man's life. It is the personality that sets a specific way of existence of man's nature. It is his/her personality that determines freedom and the way of man's existence in the face of illness.

Thus, we look at "man's health as an integrity of all aspects of human existence that inherently belong to the God-created nature of man by the goodness, wisdom and mercy of God. It is impossible to preserve mental health thinking merely of man's physical nature and psychosocial wellbeing and ignoring his/her moral and ascetic state, worldview and relationship with God" (Orthodox Christian Encyclopedia, art. Health).

Along with that, mental illnesses are man's states opposite to the one we have just described. They "show themselves through the inability to preserve the inner integrity, as well as through the failure to maintain a desirable emotional state, sanity of thought, behaviour and perception of the surrounding reality".

Thus, our main task is to help man to continue his conscious growth towards God even when he is ill. We are to help the person so that his/her progress towards God becomes a solid foundation for the development of his/her soul and body, that together form a unique unity.

Such an approach is feasible, which is proven by many years of practical experience in our Centre, on the one hand. On the other hand, the Centre has carried out some research, dedicated to peculiarities of patients' axiological sphere. These studies revealed that Orthodox Christian patients preserve both the content and structure of the axiological sphere during their illness, unlike nonreligious persons. The latter experience a significant shift in the content and structure of their axiological sphere when they fall ill. Since the former preserve the basics of their worldview, of their axiological sphere, they happen to be still capable of living a Christian life even during their mental illness. For this reason, it is possible to form their lives constructively in the context of movement towards God on the path of salvation even during mental illness. This context can and must be focal, core, on which basis relations are being formed and problems resolved, with regard to the person's meaning of existence during illness.

The main directions of such help in our understanding, are as following:

1. Help patients understand the meaning of their ill-ness. The patient quite often is in need of such comprehension. And here are some important points:

To begin with, it is important to help the person understand, that his/her illness does NOT mean that God has abandoned him/her. God still loves him/her and cares.

It is important to help the person understand that illness does not tear that person away from God (as it happens in case of sin), but illness is a special way of bearing the Cross, which is given to the person for salvation, and brings him/her closer to God. It is an act of special Divine Providence. We should help the patient to consciously accept his/her illness as a path to grow towards God, as a path that is to be taken from now on, since it is God who placed him/her there.

It is important to explain to the patient that illness may often have a favourable course.

With this, God does not necessarily take away or eliminate the illness out of love. The fact that the illness persists, does not hinder attainment of holiness and salvation. Apostle Paul, St Ambrose of Optina, and St Syncletica may be referred to as examples.

This is a very important point, since patients pray to be healed and, if they do not receive healing, the issue becomes topical for them.

We never use or support the attitude to a mental illness as to a punishment for a sinful life or inherited sins. The patient, who experiences much suffering, primarily needs support and strengthening, rather than a rigorous rebuke.

2. Support to the patient and "bringing" him/her to God's Devine help: payer and sacraments. Here we should remind the patient that a Christian life means a continuous collaboration of man and God. Without special – in particular, Devine – help neither God can be attained, nor challenges of life be handled, nor life lived in a Christian way. For this reason, it is important to encourage and bolster patients both in their strive for grace-filled God's help through sacraments and forming their personal relations with God through the prayer.

We serve Divine Liturgy weekly in our church, and we advise our patients to take communion regularly, preferably at every service.

3. Wake the patient's own activity at this stage of his/her salvation. We said that man's path is that of collaboration between God and man. Speaking about Sacraments, we mean special help and a special act of God who is capable of accepting man; whereas here we focus on the activity of man himself, because people always – at least in a balanced, not acute, state – can offer something to oppose illness and do something that brings them closer to God. This is the moment that makes obvious the free will, granted to man by God. It is a presentation of their own conscious and focused activity. It is very important and often brings to positive results.

It is important to communicate two things to the pa-tient:

1. Man CAN DO something on his/her OWN to counteract illness, because her/she is a free creature. Man is free to choose and decide how to live and treat himself, the world and his illness. This is the freedom that we discuss here. Man can do something on his/her own to become better and healthier. The patient can hardly do anything with his/her body and soul – it is the doctor's domain (who, by the way, is not omnipotent, has his own limitations and, from time to time, fails to provide a cure). However, we have mentioned that health is connected to all three, body, soul and spirit. It is in the domain of spirit that it is up to the patient how he/she is going to move forward and evolve. For this reason, the patient can act and develop, despite illness, strengthening and improving his/her overall health.

2. It is very important to understand and feel what exactly the person can do. It is no enough to say, "You can". It should be said, what exactly he/she can do and how this can be done. In this case our Church's experience of both piety and ascetism can be applied (naturally with a necessary adjustment to patients). What do we mean by this? Here are some examples that can help us understand which direction to go working with such patients.

It should be added, that each person is unique. Thus, approaches that we apply and advice that we give at this stage, are unique as well. Each time we search what can be accepted by the person we deal with. This is a creative and hardly formalized process.

St Ambrose of Optina said, that 'God does not demand much from an ailing man – enough if he bears his illness with confidence and, if he can, gives his thanks to God'. This confidence is a signal both of his trust in God and acceptance of His good Providence. Remember God's Providence and by force of faith keep one's trust in Him is a very major practical step undertaken on the path of following the will of God. This is the direction in which we should encourage patients.

Patience is a virtue, tightly connected with the abovesaid. No good thing can be done without it. Patient's attitude to illness looking forward to God is another important doing of a Christian, available to those who are ill. This is the direction in which we can also try urge the patients.

The ascetic practice of combating thoughts is also applicable in a number of cases. For instance, compulsive ideas and voices can be regarded as thoughts. One may try to weaken (or even overcome, which we have seen in our practice) influence of these symptoms of illness with the approach used for combating thoughts. In such a case it is necessary to explain to the patient – so that he/she understands and senses – what exactly is meant and suggest various ways of combating thoughts. This approach is feasible, and it works.

There is another possible approach to directing pa-tients. Our Lord urges us to fulfill His commandments. Always and everywhere, regardless any circumstances, health or illness. In this sense, mental illness is not an excuse. It is just a special circumstance of the person's existence. Even when being ill, man is called to fulfill the commandments. By doing so, the person will demonstrate his/her faith, faithfulness and love to God, desire to be with Him. This is our most important action when following Christ. The invitation to fulfill God's commandments can be addressed to patients (under the condition that they have preserved critical attitude to what is being said and enough understanding) who are in delirium or hear voices. In other words, we try to guide the person to pay more attention to the commandments rather than the voices.

And the last point. Our Lord urges us to 'pray continuously'. In a number of cases, we can address this invitation to pray to the patients, encouraging them not to turn this in a mere formality of reading a text. We focus on the call for prayer, rather than on following their thoughts or images. The prayer may be of two kinds. To begin with, the patients are to pray for themselves, for their recovery, for help from God. Besides, they can pray for their neighbours, for each other, for their doctors as a manifestation of their hope and trust in God (the Only Healer of souls and bodies), who guides minds and souls of doctors (His earthly followers and disciples) working to bring cure.

I hope you understand that everything said above is just a few examples of possible ways of development. When we communicate with a real patient we take many factors into account, that were not marked here as important; for instance, understanding and 'feeling' the patient; awareness of his/her level of adequacy; understanding of the affected and intact parts of his/her soul (where we can lean on, and where we cannot); search for what he/she is capable of perceiving and doing; awareness of the realm of their possibility and forms of advice we can give them…

We as believers cannot but assert the reality of miracle in our lives. The miracle of healing, the miracle of transformation. They do happen. Here is an example.

A young woman of about 19-20 years with a five-year record of heroin addiction, stealing money and prostitution got into the Research Centre of Mental Health on a priest's recommendation who had accepted her in his community. Having observed the intensification of her depressive symptoms he asked our doctors for help. Every effort to treat her with medication, ECT and other means gave no result – her state continued to worsen. She obediently carried that cross. At some point of time I took her for Epiphany bathing rites to the Moskva-river. She went there only because of obedience, barely moving her feet and without any desire to live. After that pilgrimage and bathing in the ice-hole, the treatment plan that had not worked before, began to bring results. She came back to life within a short period of time, was released from the hospital with significant improvement and has been in steady remission for 20 years. She is a nun now.

On Confession

We should also add that at confession of mentally ill people priests should be very sensitive, taking peculiarities of illness into account and differentiating between what belongs to the illness in the patient's words (and in this context does not represent sin or belong to the sphere of personal responsibility) and what comes from their fallen soul and requires the priest's relevant response.

On Doctors and Illness

We believe, that priests and doctors see patients and their illness differently.

The doctor sees a suffering person and sets the main task of curing the illness to spare the patient of his/her suffering.

The priest sees an image of God in every person, perceiving him/her in the context of eternity and being aware that the main task for a man is to get into the likeness of God and enter the Heavenly Kingdom. The main task that a priest accomplishes is to help the person take the path in his/her life that will bring them to God, encourage them to grow into Him, no matter whether the person is ill or healthy.

Here is another point that we would like to make on some specific situations that we regularly run into when directing patients.

1. Quite often we have to “find a place for the doctor”. The matter is that some patients - specifically not very churched or churched not in a quite right way – do not want to speak frankly with their doctor on a whole range of issues saying, “Why should I tell him what I open to the priest at confession? How dare he ask me about this?” Our task that we regularly run into is to help the patient find a correct attitude to the doctor.

2. Another challenge is to find proper wordings in a conversation with the doctor about his patient to com-municate thoughts, actions and inclinations dangerous to the patient without breaking the seal of confession.

3. Respond to the patient’s desire to stop taking medication (or partially reduce it) without informing the doctor. This is another situation we have to deal with regularly.

3. Conclusion

Pastoral care of mentally ill people has its obvious peculiarities and sets special requirements to the clergy. The priest is to be aware of psychopathologic realia, have understanding of the ways and nature of treatment and effect of psychotropic medication. He should also be particularly sensitive to the patient and take responsibility for his words and actions; more than that, not only for his words, but for the way the patient may perceive them because of his/her illness and use them.

AUTHORS

Dr. Peter G. **Coleman**, Emeritus Professor of Psychogerontology in the University of Southampton, MA from the University of Oxford, PhD from the University of London, Fellow of the British Psychological Society, Fellow of the Academy of Social Sciences (UK).

Monk **Dociphey** (Gorbachevsky), master of theology, doctor endocrinologist, monk of the Radu Voda Monastery (Romania).

Dr. Maria Teresa **Ferla**, Director-Primary of the complex Structure of Operative Unit of Judicial Psychiatry of the Mental Health Department of the Bollate Hospital (Milan), Professor of phenomenological psychopathology at the University of Milan – Bicocca, expert psychiatrist of the Court of Milan (Italy).

Priest Jesús Colomo **Gómez**, Bachelor of Medicine from the Complutense University of Madrid (Spain), Doctor in Medicine from the University of La Laguna (Spain), Doctor in Theology from the Pontificia Università della Santa Croce. Rome Italy), Master in Bioethics from the University of Valladolid (Spain), Chaplain Emeritus of the University Clinic of Navarra (Spain).

Archpriest Victor **Gusev**, cleric of the hospital church to the Icon of the Mother of God the Healer at the Scientific Center for Mental Health, Russian Academy of Sciences.

Kaleda V. G., MD, deputy director of the Research Center of Mental Health, Russian Academy of Sciences, Chief Researcher at the Department for the Study of endogenous psychoses and affective states, professor of practical theology at Orthodox St. Tikhon Humanities University.

Kopeyko G. I., Ph.D., Deputy Director for Research of the Scientific Center for Mental Health, Russian Academy of Sciences.

Archpriest Ilya Odyakov, cleric of the hospital church to the Icon of the Mother of God the Healer at the Scientific Center for Mental Health, Russian Academy of Sciences.

Dr. **Panayiota** Mama Agapiou, child psychiatrist, systematic family/group therapist (Cyprus).

Metropolitan **Sergiy** of Voronezh and Liski.

Priest José María **Vegas**, Candidate of Philosophical Sciences (St. Petersburg State University), teacher at the Catholic Higher Seminary "Mary – Queen of the Apostles", licentiate of theology and philosophy (Pontifical Gregorian University, Rome).

Dr. Peter J. **Verhagen**, MD, psychiatrist, group psychotherapist, theologian, past chair and honorary member of the World Psychiatric Association, Section on Religion, Spirituality and Psychiatry (Netherlands).

Archpriest Vladimir **Vorobyev**, Cand.Sc., Doctor of Theology Honoris Causa at Orthodox St. Sergius Theological Institute in Paris, Rector of Orthodox St. Tikhon Humanities University, Professor.