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RELIGIOUS CHARACTERISTICS OF ROMANIAN PHYSICIANS: TOWARDS AN INTEGRATIVE SUPPORT OF RELIGIOUS PSYCHIATRIC PATIENTS

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SUMMARY

Background: *The growing closeness between psychiatry and theology may impact positively the healthcare of the religious psychiatric patients. However, some significant divergences regarding the health care religious methods and the concept and believe in the demonic possession of psychiatric patients continue to shape the relationships between these professionals. While the religions generally admit the demonic or spirit possession as real, the current views of physicians and psychiatric patients are just taken for granted and therefore demands new investigations. In this study, we have performed a targeted survey on this subject.*

Subjects and methods: *The survey was based on a questionnaire addressed to 216 psychiatrists and 201 non-psychiatrists, and 408 psychiatric patients. For physicians, the questionnaire was randomized sent to hospitals in Romania. The patients received the questionnaire on paper. Except for patients with dementia and those in the acute phase of a psychiatric illness, all psychiatric disorders available at the time of the investigation were randomized included in the study.*

Results: *The results showed that about 20% of physicians and 60% of psychiatric patients considered that demonic possession might be associated to a psychiatric illness, while the later would like a priest in the therapeutic team (89.4%, CI: 0.86-0.92). In addition, the psychiatrists declared a lower attendance of religious services, although the majority would accept a priest in the therapeutic team (p>0.05, CI: 0.61-0.70).*

Conclusion: *These findings invite to a more practical collaboration between psychiatrists, clinical psychologists, and theologians/priests with training in psychiatry for a more integrative mental care of the religious psychiatric patients. The results call as well for more efficient practical solutions for psychiatric patients, raise awareness towards the personal religious needs and critical beliefs of such patients, and finally might narrow the gap of the controversy between psychiatrists, non-psychiatrists, psychologists and theologians/priests on the addressed issues.*

Key words: *mental healthcare - religion/spirituality - demonic possession - hospitalized psychiatric patients*

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INTRODUCTION

Psychiatry and religion have established a fluctuating divergent relationship over time, depending on historical time, religion or spiritual beliefs of a specific geographical region, the evolution of psychiatric treatments, and the openness of religious leaders, priests and patients to psychiatric care. In addition to ideological differences, the acknowledged divergences could be as well the result of the extreme, malignant religiosity that can generate hate, violence suffering, and poverty, leading as well to social marginalization and disrespect of non-believers (Jakovljevic et al. 2019, Chervenak & McCullough 2020). However, as concerning strictly the positive role of psychiatry in improving the mental state of psychiatric patients, a broad consensus among priests and religious leaders can be found nowadays. As well, there is an even wider openness of the psychiatrists to the religious needs of the patients (Weber & Pargament 2014, Gordon et al. 2018, D'Souza 2007, D'Souza & George 2006) for collaboration with clergy to the benefit of patients. This is in accordance with J.L. Cox's statement that a "psychiatrist who values a theological and sacramental reflection, and a priest who seeks professional [i.e. psychiatric] help for himself, a colleague or relative will have much in common to discuss and evaluate (Cox 1994)." Hence, the World Psychiatric Association (WPA) has recently issued a set of recommendations regarding the position and methods to be used by psychiatrists in their relationship with religious/spiritual patients, recognizing the need for a more direct and close collaboration between psychiatry and religion/spirituality at the institutional level (World Psychiatric Association 2016). This was based on more than 3,000 empirical studies exploring the relationship between religion/spirituality and health, including the challenging recommendations of H.G. Koenig which suggested that the psychiatric practice should take into account the common prayer with patients (though only in "highly selected cases") and consultation with, referral to, or common therapy with trained clergy (Koenig 2008). However, Koenig's recommendations are not entirely

new since the key statements have been made previously (Cook 2011). For instance, Cox found that insertion of religious counselors in a multidisciplinary therapeutic team is generally helpful to patients, although some psychiatrists would keep reserved because of the unusual "line management" (Cox 1994). Further on, he states that a partnership between the sectorised mental health service and Christian churches as well as other religious establishments could improve the "care in the community" (Cox 1994).

However, despite the practical closeness between psychiatry and religion, a number of fundamental disagreements over demonic possession and religious care of psychiatric patients remain a topic of debate. While a total acceptance from the religious side is expected, the psychiatrists generally related the demonic possession, assumed by religion or psychiatric patients, either to a pathological framework or to the natural religious faith. In this context, it is of interest to check if physicians, especially psychiatrists, could nowadays assume a real demonic possession of the psychiatric patients, acknowledging a demonic control that could impact the mental health of a patient. To this end, the phenomenon of demonic possession merits scientific investigations (Gadit 2007).

The evidence of evil spirits and possession has been recorded in many sources and recognized by many cultures (Stafford 2005, Neuner et al. 2012, Igreja et al. 2010). Spiritual possession is found in 90% of the world's population (Guenedi et al. 2009), being known since Biblical times (Kiev 1961, Hussey 1974, Harris 2014). Currently, in social and anthropological literature, the possession assumes a personal experience of being taken over or entered by an alien spirit or other external forces that controls the self and changes human's identity ("executive" possession) or simply causes illness and misfortune ("pathogenic" possession) (Littlewood 2004, Cohen 2008). Generally, possession is analyzed and quantified in relation with social change and society structure, and explained in terms of cross-cultural validity (Bhavsar 2016). However, it is assumed by anthropological literature that uncertainty on this exceptional psychiatric sickness will be maintained as long as diagnostic definitions won't be correlated with the societal background (Bhavsar et al. 2016).

Though anthropological sciences relate the traditional beliefs to the cultural influence, the western medicine places the belief in demons in the range of religious delusions (Mohr & Huguelet 2004). But, since the demonic attributions can be traced in different diagnostic categories, not only in delusional disorders, these attributions are recommended to be thought as part of the multifaceted causal attributions of mental illness, and considered more than simple delusions, and analyzed in the context of cultural and religious background (Mohr 2004, Pfeifer 1999).

The current psychiatric literature is relatively limited on the subject and offers some uncertain clues on the matter. However, there are described several interesting cases from different parts of the world (Cavanna et al. 2010, Obeid et al. 2012, Murphy & Brantley 1982, Ruskin 2007). For instance, a case report published in 1994 described an episodic exorcism-resistant ghost possession of an imprisoned well-educated westernized Indian man (Hale & Pinninti 1994). After failing several multi-religious exorcism trials, he was diagnosed with dissociative state or paranoid schizophrenia and treated and partially stabilized with Clopenthixol. Peculiarly, there were some testimonies of a cellmate and the prison chaplain who described seeing how a ghost - in the form of a descending cloud embodying an unknown woman - possessed the patient in prison. In any case, the exorcism-resistant ghost possession was eventually treated with neuroleptics.

Another investigated clinical case is that of a 22-year-old male patient who showed an altered state of consciousness attributed to possession (Guenedi et al. 2009). He complained that his father changed to "devil" and his meals were shared by evil spirits. Even if the patient showed symptoms associated with chronic schizophrenia and responded to risperidone, the patient's distress was associated with low perfusion in the left temporal lobe and structural abnormality in the left basal ganglia.

Causally, some of the Western psychiatrists, such as Lhermitte, assumed that the majority of the demonic possessions were the subject of the sexual trauma, linked frequently to religion (Drouin et al. 2017). Trying to medically define the possession on a background free of religious criteria, the French psychiatrist stated that: "real possessed people are patients who never blame demonic influence nor external ascendency" (Drouin et al. 2017). However, he admitted the possibility of a real demonic possession according to the religious principles, and consequently tried to make unitary the scientific method and catholic faith (Drouin et al. 2017).

Nowadays, the psychiatry includes demonic possession in the range of histrionic personality disorders (Drouin et al. 2017) or in the framework of dissociative trance disorders (possession trance disorders) when personal identity is replaced by an external "possessing" identity and in which the individual's behaviors or movements are experienced as being controlled by the possessing agent (ICD-11). The definition replaces the usual sense of personal identity with an external "possessing" identity attributed to a spirit, power, deity or other spiritual entity (Reed et al. 2019) such as demons, "jinn" (Obeid et al. 2012), "ghosts" (Hale & Pinninti 1994), or "aliens" (Blakemore et al. 2003).

In this paper, we sought to narrowly address this very challenging topic in psychiatry which has been historically linked to anthropological sciences and

religion, by interrogating the beliefs of Romanian psychiatrists and non-psychiatric physicians on this issue through a national survey. Assessing the physicians' religious beliefs and views along with the desires and religious beliefs of psychiatric patients might propose an additional way to boost the level of the healthcare of psychiatric patients, and shape the basis of a potential multidimensional care afforded by psychiatrists, clinical psychologists and theologians to psychiatric patients.

SUBJECTS AND METHODS

The study was based on a questionnaire of ten questions partially inspired from (Curlin et al. 2007) and addressed to physicians and seven questions addressed to both religious and non-religious patients. In the case of physicians, the questionnaire was sent to hospitals, being completed by a group of practitioners randomly stratified. In most cases, the questionnaire was completed by physicians using an electronic format, mainly through an online survey platform. The patients received the questionnaire on paper, completing it on a voluntary basis in the presence of the investigator. Patients were free to ask and receive explanations whenever needed. A direct question about a personal possession was avoided so as not to affect the privacy of patients. In order to increase the psychiatric significance and analytical power of the study, the group of psychiatrists and psychiatric patients were over-sampled compared to the non-psychiatric physicians. Except for patients with dementia and those in the acute phase of a psychiatric illness (such as acute psychosis or recent suicide attempt), all psychiatric disorders available at the time of the investigation were randomized included in the study. No kind of reward was offered to the physicians and patients for participations at this study. The study design was approved by the ethical committee of the Institute of Psychiatry "Socola" Iasi, Romania, and conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Edinburgh 2000). The patients were informed about the subject of the interview and offered their informed consent.

Descriptive statistic

To examine the differences between psychiatrists, non-psychiatrists and patients, the Pearson Chi square test and *t*-student test were used. Reported *p* values for *t*-student test were two-tailed. Means and standard deviations were calculated for quantitative variables. The confidence intervals, CI, for proportions were calculated through Microsoft Excel 2007. In order to evaluate the influence of religious characteristics on the decision of psychiatric physicians to collaborate with priests for the patients' healthcare, and to choose a response for the demonic possession, the regression method (Microsoft Excel 2007) was used.

RESULTS

Even though the proportion of psychiatrists in the total population of physicians is relatively low, since the focus of this analysis has been on a psychiatric issue, we have sought to balance the number of respondents, and even slightly increase the number of psychiatrists (Table 1). For both categories of physicians the ratio between women and men was about 3:1 ($p=0.66$), higher but near the national ratio (i.e., 73% female physicians in the current study vs. 69% at national level). Respondents who accepted to participate in the study were on average young psychiatrists (33.9 ± 8.7) or non-psychiatrists (37.8 ± 10.6) with no statistically significant difference between them ($p=0.743$).

The religious affiliation of the respondents respected the national profile (Pearson correlation =0.99; $p>0.05$), whereas the majority belonged to Orthodox Christianity (79.8%, CI: 0.76-0.84). However, an important fraction of free-thinkers was observed (11%, CI: 0.08-0.14) that is way higher than the corresponding national level (0.21%).

Psychiatrists did not differ statistically from the other physicians with regard to the attendance at religious services and religiosity level ($p>0.05$). However, there was a statistically significant difference ($p=0.046$) between them as regarding their own perception as religious or spiritual persons, the psychiatrists declaring themselves about 9% (CI: 0.18-0.27) more spiritual and 6.4% (CI: 0.12-0.19) less religious.

The most critical results emerged however from the last three questions addressed to gradually check for the position and availability of physicians to send patients to priests, to include priests in the therapeutic team, and the most challenging one, to check their perspective on the demonic possession of a psychiatric patient.

The results showed a statistically significant difference between psychiatrists and their colleagues ($p=0.004$) with regard to their openness for sending psychiatric patients to a priest for religious support along with medical treatment (68.5%, CI: 0.62 - 0.75 *vs.* 50.7%, CI: 0.44-0.58), or for terminal/disabling illnesses (15.3%, CI: 0.11-0.21 *vs.* 25.4%, CI: 0.2-0.32). It was noteworthy psychiatrists rejected less a separated support offered by a priest to a patient (not necessarily psychiatric) than the non-psychiatrists. Thus, only 16% (CI: 0.12-0.22) of psychiatrists would chose not to send patients to a priest compared to 23% (CI: 0.18-0.3) non-psychiatrists. Lastly, a total submission of physicians to a religious authority which would have been validated by choosing to send all psychiatric patients to priest for religious support was fully rejected by all physicians.

The inclusion of a priest in a therapeutic team, together with psychiatrists or non-psychiatrists, was relatively well received by both categories of physicians (65.7%, CI: 0.61-0.7), the responses being

Table 1. Defining characteristics and medico-religious perspective of psychiatrists versus non-psychiatrists

Defining characteristics	Psychiatrists		Non-psychiatrists		Statistic significance	Confidence interval (CI) for psychiatrists and non-psychiatrists
	N	%	N	%	P*	95 % CI
Sex					0.660	
Women	156	72.2	149	74.1		0.69-0.77
Men	60	27.8	52	25.9		0.23-0.31
Age (M±SD)					0.743	
Women	33.9±8.6		38.9±10.6			
Men	33.8±9.1		34.7±9.9			
Region						
East/North-East	233	55.9				0.51-0.61
South	105	25.2				0.22-0.30
West/North-West	79	18.9				0.21-0.29
Religious affiliation					0.29 (0.71**)	
Orthodox	182	84.2	151	75.1		0.76-0.84
Catholic	3	1.4	15	7.5		0.03-0.07
Protestant	6	2.8	13	6.5		0.03-0.07
Free-thinker	24	11.1	22	10.9		0.08-0.14
Other	1	0.5	0	0		0.00-0.01
Religiosity level					0.210	
High	21	9.7	30	14.9		0.09-0.16
Medium	110	50.9	99	49.2		0.45-0.55
Low	49	22.7	49	24.5		0.19-0.28
Absent	36	16.7	23	11.4		0.11-0.18
Participation at religious services					0.059	
Not at all	64	29.6	40	19.9		0.21-0.29
At most once a month	107	49.6	108	53.7		0.47-0.56
At least twice a month	45	20.8	53	26.4		0.19-0.28
Belonging to the religious or spiritual sphere					0.046	
Religious	26	12.1	37	18.4		0.12-0.19
I try to reconcile religion with spirituality	92	42.6	96	48		0.40-0.50
Spiritual	58	26.8	35	17.4		0.18-0.27
Neither religious nor spiritual	40	18.5	32	16		0.14-0.21
Patient-related medico-religious perspective					0.004	
In some cases would you send the patient to the priest?						
Yes, for religious support corroborated with medical treatment	148	68.5	102	50.7		0.55-0.65
Yes, in the case of terminal or disabling illnesses	33	15.3	51	25.4		0.16-0.24
No, never	35	16.2	47	23.4		0.16-0.24
Yes, only to the priest in the case of psychiatric illnesses	0	0	0	0		0-0.02; one-sided 97.5% confidence interval
Do you agree that a priest with at least a minimum medical training to be included in the therapy act?					0.125	
Yes, with the patient's consent	48	22.2	47	23.4		0.19-0.27
Yes, with the patient and family's consent	94	43.5	77	38.3		0.36-0.46
Yes, with the family's consent	1	0.5	7	3.5		0.01-0.04
No	73	33.8	70	34.8		0.29-0.39
In the case of a patient with psychiatric problems would you take into account a possible associated demonic possession?						
All					0.011	
Yes	33	15.3	51	25.4		0.16-0.24
No	182	84.3	150	74.6		0.76-0.84
Women					0.006	
Yes	22	14.1	40	26.8		0.16-0.25
No	133	85.3	109	73.2		0.75-0.84
Men					0.708	
Yes	11	18.3	11	21.2		0.13-0.28
No	49	81.7	41	78.8		0.72-0.87

* by Chi square test, if not otherwise specified; ** by t-Test: Paired Two Sample for Means (data from the last National Census were used for comparison); Pearson Correlation - 0.99

Table 2. Patient's defining characteristics and illness-related religious perspective

Defining characteristics	Patients		Statistic significance	Confidence interval (95 % confidence level)
	N	%	P	CI
Sex			0.14**	
Women	194	47.55		0.43-0.53
Men	214	52.45		0.48-0.57
Age (M±SD)				
Women	57.3±11.5			
Men	53.5±13.3			
Region				
East/North-East	408	100		
Affiliation			0.29***	
Orthodox	380	93.14		0.90-0.95
Catholic	21	5.15		0.032-0.08
Protestant	5	1.23		0.004-0.03
Free-thinker	1	0.24		0.00-0.014
Other	1	0.24		0.00-0.014
Patient's religious perspective				
Do you agree that a priest with at least a minimum medical training to be included in the therapy act?				
Yes, with the patient's consent	212	51.96		0.49-0.59
Yes, with the patient and family's consent	125	30.64		0.27-0.36
Yes, with the family's consent	17	4.17		0.025-0.07
No	42	10.29		0.08-0.14
Do you believe in the existence of bad angels/demons?			0.01	
Mixed (women and men)				
Yes	220	54.00		0.51-0.61
No	172	42.16		0.39-0.49
Women				
Yes	117	60.31		0.55-0.7
No	69	33.57		0.30-0.44
Men				
Yes	103	48.13		0.43-0.57
No	103	48.13		0.43-0.57
In the case of a patient with psychiatric problems would you take into account a possible associated demonic possession?			0.22	
Mixed (women and men)				
Yes	246	60.29		0.55-0.65
No	162	39.71		0.35-0.45
Women				
Yes	123	63.40		0.562-0.7
No	71	36.60		0.3-0.44
Men				
Yes	123	57.48		0.51-0.64
No	91	42.52		0.36-0.5

* by chi square test, if not otherwise specified; ** According to the Romanian National Institute of Statistics for 2016, there were 10,117,120 women and 9,642,880 men in Romania (National Institute of Statistics 2016); *** by t-Test: Paired Two Sample for Means (data from the 2011 National Census were used for comparison); Pearson Correlation – 0.99

statistically undifferentiated (p=0.125). As regarding the demonic possession, it was considered as an inductive co-factor for a psychiatric illness by 15.3% (CI: 0.11-0.21) of psychiatrists and by 25.4% (CI: 0.2-0.32) of their colleagues. The significant difference between the psychiatrists and non-psychiatrists regarding the belief in demonic possession was mainly given by the female physicians (≈14% vs. ≈27%; p<0.05); the difference between male physicians was statistically insignificant (p>0.05). In addition, all the pediatric psychiatrists (all women), accounting for 2.64% of all physicians (CI: 0.013-0.05), responded negatively to the possibility of demonic possession, clearly diverging from the overall profile of the survey.

Further on, part of the physicians' responses was mirrored in the religious characteristics and beliefs of the psychiatric patients, at least in the most challenging aspect of the study, i.e. demonic possession, in order to evaluate the level of a potential complementary support of religious patients. Compared to physicians, the female/male ratio of the patients was almost unitary, whereas the average age of the patients was much higher (Tables 1 and 2).

The majority of patients were Orthodox Christians with a very low percentage of free-thinkers. The patients' religious affiliation followed the national profile (Pearson correlation = 0.99; $p>0.05$) as in the case of physicians.

The patients' desire for a therapeutic team with an extended professional competence in addressing their religious needs by including a priest in the supportive therapy was clearly underscored. Hence, 87% of patients (CI: 0.86-0.92) would agree with a priest inclusion into the therapeutic team which is relatively close to the physicians' choice. However, a clear divergent opinion concerned the patients' role in making their own decisions on this subject ($p<0.05$). While 52% of patients would like to be solely involved into the acceptance of a priest (CI: 0.49-0.59), only 23% of physicians would prefer an exclusive role of a patient on the matter (CI: 0.19-0.27). On the other hand, patients would like in a lower degree a family consent. There was also a minor fraction of patients that would transfer such a responsibility entirely to the family.

Exclusively for patients' religious profile, before asking about demonic possession, and in order to check for the consistency of their responses, we have introduced a quality control question about their beliefs in bad angels/demons. Some inconsistencies were found when the two last questions were compared, but they were statistically insignificant ($p=0.232$). Precisely, the inconsistencies referred to the non-belief in the existence of demons (CI: 0.39-0.49), but belief in demonic possession (CI: 0.55-0.65). There was also a significant difference ($p=0.01$) between female (60%, CI:0.55-0.7) and male patients (50%, CI: 0.43-0.57) as regarding their belief in bad angels/demons.

DISCUSSION

The level of intrinsic religiosity should be considered the essential parameter in defining the respondents' religious characteristics since it represents the main motivational source of attendance at religious services and the reference factor for defining a correlation with the religiosity/spirituality declared by patients. However, a direct proportionality between the inner religiosity and the associated expected effects might not be validated for any studied case. In our study, the high percentage values of intrinsic religiosity, expressed equally by both categories of physicians, already oriented the subsequent expectations towards a positive attitude of physicians on the religious needs of patient and, consequently, to their willingness for a professional collaboration with clerical workers, despite the challenging religious concepts, such as demonic possession. In fact, in a country with increased religiosity as Romania (Coutinho 2016), the obtained data seem to validate the expectations regarding the important percentages of religious physicians. Part of our results, obtained in a Christian Orthodox country, were highly different from those obtained by F.A. Curlin et al. (Curlin et al. 2007) in a study performed on U.S. physicians belonging to other religions or Christian confessions, pointing out the potential influence of the religious affiliation and even the geographical region on the physicians' religious beliefs that ultimately may impact the content and specificity of a religious supportive program of psychiatric religious patients and the relationship with religious decision-makers.

In this study, the observed highly increased addressability of patients to priest, for religious support under psychiatric therapy, ascribed especially to psychiatrists, while impressive, couldn't be statistically well fitted to their degree of religiosity and attendance to religious services (R squared = 0.2; Regression method), even if the dependence is statistically significant ($F<0.0001$). Hence, addressing patients to the priest could be motivated not necessarily by physicians' inner religious beliefs, but rather by their psychological comprehension that a variation in patients' care, based on inner religious beliefs, might impose a new motivational refresh in their affective life and propose new supportive explanations about the religious meaning and value of their illness. This psychological aspect is better conjectured by psychiatrists than their colleagues, the latter offering a significantly higher percentage for patient addressability to priests only in support of the "terminal/disabling illnesses". Whether physicians were profoundly religious or not, the exclusive religious care of patients was avoided by all physicians, underscoring a clear awareness of the need to separate the healthcare attributes of each category of professionals, and the clergy's inability to cure solely the patients' illnesses.

On the other hand, the unexpected high acceptance by both physicians groups that a priest can be part of the therapeutic team would correspond at first glance to the relatively high religiosity previously declared. Yet, it couldn't be well correlated with the degree of religiosity and attendance to religious services (R squared = 0.23; Regression method), even if the dependence is statistically significant ($F<0.0001$). Therefore, other core reasons for such a choice have to be advanced. Hence, we have to assume that the revealed openness toward an extended professional team with enriched medical and religious competences has been most likely

accepted only in order to fit the patients' most important needs, and not necessarily due to their inner religious constraints. In addition, some professional experience exchange between physicians and medically-trained priests might have also been considered as a team added-value, and for that reason accepted. However, statistically, a bias of the inner religiosity of the physicians on the chosen answers can't be neglected.

The increased number of psychiatric physicians (about 84%, $p<0.05$, CI:0.76-0.84) who rejected the possibility of possession could be reasonably related to their professional creed associated inherently to their medical profession and strengthened over time. Such a position, which rejects demons or, sometimes, even the very idea of God or Heaven, makes them refractory to such possibilities. In fact, opening the gate of their professional creed to such a possibility would be equivalent to accepting a deep interference of the Church and its traditional methods of healing in the treatment of psychiatric patients, whether this interference would be only at the level of possibility or not, with profound implications in the impairment of professional dignity. Moreover, by accepting the interference of the Church on the matter, a justified concern that one might question the performance of psychiatric medication and current therapy methods could rise. Consequently, psychiatrists might necessarily be concerned that patients themselves may lose confidence in the success of psychiatric treatments and, as a result, the developed distrust may consequently decrease the effectiveness of psychiatric therapy. Finally, the long-standing order and relationships established between psychiatric medicine and traditional Church could be overturned against the well-being of patients that also include priests, monks, and other different clergy personnel who benefit from psychiatric care and find the treatments offered by psychiatry as beneficial, at least in some difficult periods of their life.

However, 15% of psychiatrists and 25% of non-psychiatrists ($p<0.05$, CI: 0.16-0.24) have expressed their belief in a demonic possession associated to a psychiatric illness. Considering the class of respondents, these percentages are however unexpectedly high, especially for non-psychiatrists. However, it is debatable whether the current percentages might undergo significant changes in the absence of any association with a strong influential factor, such as the psychiatric illnesses. It is possible though to find them decreasing significantly if the addressed question would have referred only to the belief in demonic possession in general, with no psychiatric illness association.

It is also worthy to note that non-psychiatrists, while agreeing with demonic possession of psychiatric patients in higher percentages compared with psychiatrists, were more reluctant when asked about their availability for sending a patient (*not necessarily psychiatric*) to a priest for religious support corroborated with medical treatment. This behavioral shift related to the "quality" of the patient should be also related to the professional dignity. However, from some objective reasons, it is difficult to compare the answers of the two classes of physicians, especially with regard to demonic possession, since over time there has been crystallized an ordinary belief of one part of the non-psychiatrists and general population that psychiatric patients put forward something different, additional to the typical organic and psychological pattern of the disease, that could be rather connected to religious explanations on the matter and therefore bound to mysticism, ambiguity and fiction. On the other side, this is encouraged by the public opinion which sanctioned the psychiatric facilities during the past decades, whereas several studies underscored the concerns of the respondents about the quality and efficacy of the psychiatric treatments (Sartorius et al. 2010). Also, the public image offered by psychiatrists is largely perceived as negative (Sartorius 2010). Even so, psychiatry is nowadays recognized as the best answer to the most problematical mental issues of the psychiatric patients.

On the other hand, a consistent convergent statement about demonic possession among psychiatrists themselves is currently unlikely since it seems difficult to address it unitary. The reason is the important fraction of the psychiatrists describing themselves as intrinsically highly religious (Coutinho 2016).

However, if for the most psychiatrists the demonic possession cases are psychiatric in nature, under strong influence of the social background (Drouin et al. 2017), for different religious people in many ethno-religious communities this is a real phenomenon (Tajima-Pozo et al. 2011, Leavey 2010). Accordingly, if these people meet a refractory position from the knowledge-based psychiatry against an assumed demonic possession, then other non-psychiatric alternative solutions, generally linked to religious practices, are often sought by patients or their families.

The interviewed patients agreed with a possible association with mental illness three times more than physicians ($p<0.05$, CI: 0.37-0.44) and four times more than psychiatrists ($p<0.05$, CI: 0.41-0.49). The psychiatric males and females patients were equally likely to refer positively to an association between a mental illness and possession ($p=0.22$, CI: 0.55-0.65). This significant discrepancy between physicians and patients is normal if analyzed from the standpoint of the respondents' professional position, mental condition, and even the age. Overall, the obtained result is however impressive both in terms of nominal values expressed by each group, and cumulatively (a 40% percentage calculated for physicians and patients together). Such a result may require a resizing of the

current autonomous therapeutic relations between physician and patient, and between patient and priest, respectively, for defining a more articulated relationship between psychiatrists, clinical psychologists and theologians/priests for the benefit of patient. It also should be added that during the interviews a few patients expressed their belief that psychiatric patients should be treated exclusively by the priest, not psychiatrists.

However, along with the religious motivations, the patients' state of intense psycho(-organic) suffering, often connected to a tainted socio-familial context, might also be considered as a fundamental reason for the answers provided by psychiatric patients. It is this particular state of affliction that, in fact, requires alternatives to current psychiatric and psychological healthcare models and makes the insertion of a religious support able to respond positively to patients' need to confess their most hidden thoughts, dilemmas and sufferings to someone able to release them from the burden. Under these circumstances, a priest may be the one through whom the patient can hope for a sharing with something above the usual yardstick in order to relieve his suffering as it is sometimes described (Ruskin 2007). Perhaps, while the belief of psychiatric patients in a love-filled transcendental world shouldn't be encouraged due to the suicide-associated risks, it shouldn't be neglected since it might offer diverse discharging and rebalancing solutions for some psychological dilemma and trauma and can help alleviate the inner suffering and the state of unfulfilledness. In this context, even if the effects of spiritual-religious support would be only placebo ones, the desire of religious psychiatric patients must be objectively analyzed and prioritized by psychiatrists and psychologists for the benefit of their own patients, especially as it was observed that religiosity/spirituality has a positive effect on survival (Chida et al. 2009). Even if psychiatrists are regularly less religious than the patients and may not regard the religious beliefs as valuable means for patients to control their sickness (Hansdak & Paulraj 2013), for an effective treatment these beliefs must be acknowledged and respected (Favazza 1982). In fact, initial studies focused on the outcome of spiritually-integrated treatments among several psychiatric populations were promising, even if a double-edged capacity of religion to recover a psychiatric patient from a specific mental illness or, by contrary, to accentuate its symptoms can't be neglected (Pargament 2013).

Therefore, to meet the needs of religious patients, a possible solution that could be considered at the request of patients refers to the collaboration between the medical team and a theologian / priest with psychiatric medical training. The complementary supportive interventions have to be however well defined on the basis of specific protocols developed by all involved parties and approved by the medical authority. Such an approach can be an answer to the currently-increased policy interest of government sector and public agencies for the involvement of faith-based organizations in the health and welfare services (Leavey et al. 2007). In addition, the burden on psychiatric services due to the constant increase in hospitalized cases, exacerbated by unforeseen psycho-social problems occurred, for example, in pandemics such as SARS-CoV-2, can be reduced and simplified by applying religious support to religious psychiatric patients, by involving the Church in a multidisciplinary care of these patients, as part of their religious duty in their communities. The fact that religion and religious support might sustain the "health and well-being by putting faith into action during a pandemic such as the COVID-19" is well described by the psychiatrist H.G. Koenig who also offers o series of religious and medical recommendation in order to prevent an infection or recover from it (Koenig 2020a, Koenig 2020b).

Finally, we have to add that some findings of this study are comparable to those obtained in non-Orthodox Christian countries, such as the U.S., U.K. and Canada regarding the importance of spiritual dimensions in the patients' lives, connection between religion and mental illness and recommendation that religious issues should be addressed in treatment (Koenig 2008, Cook 2011). These similar findings would allow the interdisciplinary practice and experience of Western psychiatry related to the religious support of psychiatric patients to be implemented as well in other Christian countries with increased religiosity. However, in order for religious support to be considered for the mental healthcare of psychiatric patients belonging to Christian Orthodoxy, it is necessary to distinctively balance the specific needs, beliefs and values of the Orthodox Christians with the recommendations and the practices which are afforded by the Western psychiatry mainly into Catholic or Protestant Christians area.

CONCLUSIONS

Along with the investigation of physicians' religious beliefs, this study also addressed demonic possession as an intricate issue in psychiatry and psychology, in particular, and medicine, in general. The results expressed an increased need of the religious patients to be religiously supported additionally to the psychiatric and psychological assistance. Significant percentages of physicians responded positively to such a complementary supportive therapy either at the patients' request or in agreement with their family. In addition, both physicians and psychiatric patients agreed with the inclusion of a priest in a therapeutic team under specific conditions.

The demonic possession associated to a psychiatric illness was acknowledged by 15% of psychiatrists and 25% of non-psychiatrists. On the contrary, many more psychiatric patients expressed their belief in the existence of demons and considered the demonic possession as really associated with a mental illness. Such convictions ask for a special care and improved psychiatric, psychological and religious supportive therapies.

Overall, this study shows that psychiatrists would agree with the implementation of a religious support, if patients and their families request it. This position is in line with and responds to the fundamental needs of the psychiatric patient. However, an important bias of psychiatrists' intrinsic religious values should also be considered, given that over 50% of them are declared themselves religious or, at least, religious and spiritual. The religious support, focused on patients' needs, could be beneficial not only in the short term, during the patient's hospitalization, but also in the longer term for outpatients and their families, if they request the maintenance of such support after the patient is discharged.

Therefore, these findings may have significant implications for psychiatric and faith-based settings, both for short and long-term interventions. Special support from a psychiatrically trained priest would afford the patients the opportunity to clarify some religious misconceptions about their mental illness and associated psychiatric treatment, could induce psychological relief and better acceptance of their illness, might alleviate the effort of clinicians in maintaining a stabilized mental disease of these patients, especially on long term, can facilitate the integration of psychiatric patients into their families and can reduce the family burden.

Finally, it would be also greatly useful for religious patients to benefit on demand from a religiously-backed psychiatric treatment along with psychotherapy in order to reduce the patients' quest for different empiric alternatives. A mixed therapeutic group would greatly narrow the admission of the assumed possessed persons to separate supportive religious services once the priests would have the possibility to direct such patients to a psychiatric clinic which afford as well a professional religious support.

Contribution of individual authors:

Speranta-Giulia Herea: original idea, data collection, literature search, and wrote the first draft of the manuscript.

Roxana Chirita & Cristinel Stefanescu: design of the study, additional literature search and the revision of the manuscript.

Gabriela Elena Chele & Andreea Silvana Szalontay: data collection from "Socola" Institute of Psychiatry and to the design of the study.

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