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Depressive, Anxiety, and Obsessive-Compulsive Disorders: Case Reports and Suggestions for Pastoral Care

Depresivni, anksiozni i opsesivno-kompulzivni poremećaj: prikazi slučajeva i savjeti za pastoralnu skrb

Summary: The article explores the pastoral care of individuals with mental health disorders, i.e. depression, anxiety, and obsessive-compulsive disorder (OCD), emphasizing the need for spiritual direction alongside medical intervention. It highlights that mental disorders affect a significant portion of the population and are often untreated. Depression, anxiety, and OCD are outlined with clinical features, prevalence, and treatment approaches. Two case studies illustrate the importance of compassionate pastoral care tailored to individual needs, highlighting the integration of spiritual and psychological support. The role of spirituality in improving mental health outcomes and reducing stigma is emphasized, and a combined therapeutic approach is advocated, involving pharmacotherapy, psychotherapy, and spiritual direction based on sound doctrine.

Keywords: depression; anxiety; obsessive-compulsive disorder; pastoral care; homosexuality; spiritual direction.

Sažetak: Članak istražuje pastoralnu skrb za osobe s mentalnim poremećajima - depresijom, anksioznošću i opsesivno-kompulzivnim poremećajem (OKP) te naglašava važnost duhovnog vodstva uz medicinsku skrb. Ističe se da mentalni poremećaji pogađaju značajan dio populacije i često ostaju neliječeni. Prikazane su značajke depresije, anksioznosti i OKP-a, njihova prevalencija te pristupi liječenju. Dva prikaza slučajeva ilustriraju važnost suosjećajne pastoralne skrbi prilagođene individualnim potrebama, naglašavajući integraciju duhovne i psihološke podrške. Naglašena je uloga duhovnosti u poboljšanju ishoda mentalnog zdravlja i smanjenju stigme, uz zagovaranje kombiniranog terapijskog pristupa koji uključuje farmakoterapiju, psihoterapiju i duhovno vodstvo u skladu s ispravnim naukom.

Ključne riječi: depresija; anksioznost; opsesivno-kompulzivni poremećaj; pastoralno praćenje; homoseksualnost; duhovno vodstvo.

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Introduction

Pastoral work, by its very nature, includes helping those in need. Considering that mental disorders are among the most disabling conditions in the general population, it is clear that pastoral workers frequently encounter this issue in their work, sometimes without adequate competence for working with such individuals (Rajkumar 1; GBD 2019 Mental Disorders Collaborators 137).

According to the World Health Organization, 13% of the population has some form of mental disorder (World Health Organization 39). Other research suggests that approximately 38.2% of the adult population in Europe suffers from mental illness (Stolzer 230). Anxiety disorders have the highest prevalence (31%), followed by depressive disorders (28.9%) (World Health Organization 40). These disorders are 50% more common in women than in men and are more frequent in economically advanced countries (World Health Organization 43–44). An important factor to highlight is that one in ten deaths worldwide is due to suicide, with an even higher number of suicide attempts, as only one in twenty attempts results in death (World Health Organization 46). Although women attempt suicide more often, men are three times more likely to die by suicide (World Health Organization 46). Suicide is a particularly significant issue among young people; it is the fourth leading cause of death for those aged 15 to 29 (World Health Organization 47). On a positive note, there has been a 36% decrease in the suicide rate over the past twenty years (World Health Organization 47).

A major problem with psychiatric illnesses is that only a small proportion of patients receive treatment. Globally, for example, only one-third of people with depression receive treatment (World Health Organization 62). In Europe, only 26% of people who are thought to have mental disorders receive adequate treatment (Stolzer 230). When it comes to treating mental illnesses, a combined approach that includes pharmacotherapy, psychotherapy, and other forms of treatment has proven most effective (Gregurek 98; Rajkumar 1). Psychotherapy deserves special attention, as it has been shown to be as effective as pharmacotherapy and, in some cases, even more effective (Stolzer 237).

The importance of spirituality in the treatment of mental illnesses is increasingly recognized. Research shows that more patients with moderate depression and/or anxiety visit complementary medicine specialists than mental health professionals, and preliminary research indicates improvement with combined therapy that includes spiritual assistance alongside classical therapy (Stub et al. 1–2). The role of spirituality in treating addiction is well known and widely accepted (Miller et al. 434). Studies also show a reduction in depression levels as a result of receiving spiritual assistance (Braam and Koenig 428). Religious or spiritual beliefs can help people cope with or adapt to stressful life situations (Bonelli et al. 2). Higher levels of religiosity are associated with better mental health (Bay et al. 58).

A literature review reveals that most studies (67%) have noted a decrease in depression levels, faster recovery, or better response to therapy due to the use of

spiritual approaches in treatment, while 7% of studies have suggested the opposite (Bonelli et al. 3). An even more significant finding is the negative correlation between religious interventions and tendencies toward suicide, the frequency of suicide attempts, and completed suicides (Bonelli et al. 4). Research shows that many people who consider spirituality important are afraid to seek secular psychotherapy because they believe their religious beliefs will not be respected (Bonelli et al. 5).

Given this issue and the fact that psychotherapy in Croatia is still inaccessible to many, pastoral workers have an opportunity to provide spiritual assistance to those in need. It is important to emphasize that every pastoral worker should act only within the scope of their competence, which is why it is crucial to recognize mental illnesses and refer patients to professional help in a timely manner.

The aim of this article is to highlight the main characteristics of three mental illnesses that are often encountered in pastoral care and, through the analysis of two specific cases, to demonstrate the issues that give rise to these psychological problems and provide guidelines for pastoral care.

I. Depression

When considering depression, we are not referring to a single narrow disorder but rather to a heterogeneous concept that encompasses multiple disorders, each with its own classification and diagnostic criteria (Krishnan; Lyness, »Unipolar Minor Depression in Adults: Epidemiology, Clinical Presentation, and Diagnosis«; Lyness, »Unipolar Depression in Adults: Clinical Features«; Belmaker and Agam 55). The term »depression« may refer to a normal mood state or a mood that is part of a psychopathological syndrome; it may involve a syndrome that includes a group of symptoms and signs; or it may also represent a mental disorder that meets specific clinical criteria (Lyness, »Unipolar Minor Depression in Adults: Epidemiology, Clinical Presentation, and Diagnosis«). To avoid arbitrariness in diagnosis, professional organizations recommend using clearly defined diagnostic criteria (Lyness, »Unipolar Depression in Adults: Assessment and Diagnosis«). Despite the existence of clear diagnostic criteria, meta-analytic research indicates that there are 15–20% false-positive diagnoses of depression in primary health care, meaning that depression is diagnosed in patients who do not meet the criteria for the diagnosis (Lyness, »Unipolar Depression in Adults: Assessment and Diagnosis«).

We usually refer to major depressive disorder (MDD) when discussing depression. It is diagnosed in patients who have experienced at least one major depressive episode (American Psychiatric Association). According to DSM-5, a major depressive episode is a period lasting at least two weeks, during which five or more of the following nine symptoms are present: depressed mood, loss of interest or pleasure in most or all activities, insomnia or hypersomnia, changes in appetite or weight, psychomotor retardation or agitation, low energy, poor concentration, feelings of

worthlessness or guilt, and recurrent thoughts of death or suicide (American Psychiatric Association). In what follows, we will discuss each of the nine symptoms included in the diagnosis of a depressive episode.

Dysphoria (adepressed or low mood) is a fundamental characteristic of unipolar depression (Lyness, »Unipolar Depression in Adults: Clinical Features«). It manifests in various ways, including sadness, despondency, feelings of hopelessness, or discouragement (Lyness, »Unipolar Depression in Adults: Clinical Features«). Patients who appear sad during the examination often deny feeling sadness, reporting instead feelings of anxiety or a lack of distinct emotions (Lyness, »Unipolar Depression in Adults: Clinical Features«). Approximately 50% of patients with major depression experience increased irritability, frustration, anger, or aggression (Lyness, »Unipolar Depression in Adults: Clinical Features«). Another important symptom of depression is anhedonia, which involves the loss of interest or pleasure in things that previously interested or delighted the individual (Lyness, »Unipolar Depression in Adults: Clinical Features«). This may be associated with social isolation and a decrease in libido (Gigli et al. 1).

Depressed individuals often experience sleep disturbances, which can manifest as insomnia or hypersomnia (Guerrera et al. 1). Hypersomnia means that individuals sleep excessively at night or during the day (Lyness, »Unipolar Depression in Adults: Clinical Features«). Patients often report feeling tired and unable to rest properly during sleep, or they struggle to wake up in the morning (Lyness, »Unipolar Depression in Adults: Clinical Features«). Changes in appetite and body weight are common, with some patients losing their appetite, while others experience increased appetite, especially craving specific foods, such as sweets and snacks (Lyness, »Unipolar Depression in Adults: Clinical Features«). Psychomotor disturbances can manifest as either agitation or retardation (Lyness, »Unipolar Depression in Adults: Clinical Features«). Agitation involves excessive, repetitive activity that is generally unproductive and accompanied by a sense of inner tension (Lyness, »Unipolar Depression in Adults: Clinical Features«). Retardation involves generalized slowing of body movements, thoughts, or speech, which may include a quieter tone of voice, reduced quantity of speech, and longer pauses when responding to questions (Lyness, »Unipolar Depression in Adults: Clinical Features«). These symptoms are less common but indicate a more severe form of the disorder (Lyness, »Unipolar Depression in Adults: Clinical Features«).

Another characteristic symptom is fatigue or a feeling of exhaustion, which manifests as an increased need for rest during the day, a heaviness in the limbs, or difficulty starting or completing daily activities (Lyness, »Unipolar Depression in Adults: Clinical Features«). Neurocognitive impairments are also frequent, manifesting as reduced capacity for thinking, concentration, or decision-making, diminished cognitive flexibility, poorer executive functioning, reduced verbal fluency, lower social intelligence, and so on (Lyness, »Unipolar Depression in Adults: Clinical Features«).

Patients may report being distracted in their thoughts and experiencing memory problems (Lyness, »Unipolar Depression in Adults: Clinical Features«). It is important to note that these symptoms are mild, mostly subjective, and generally withdraw after the depressive episode ends (Brodaty and Connors).

Nearly three-quarters of individuals with depression have suicidal thoughts, and 10–15% follow through with the act (Hotujac 171). The incidence of suicide among those with depression is 27 times higher than in the general population (Lyness, »Unipolar Minor Depression in Adults: Epidemiology, Clinical Presentation, and Diagnosis«). Suicidal ideation may be passive, meaning individuals feel that their lives are not worth living or that others would be better off without them (Lyness, »Unipolar Minor Depression in Adults: Epidemiology, Clinical Presentation, and Diagnosis«). Active ideation involves a desire to die or commit suicide and indicates a more severe level of illness, especially when there are plans for suicide, preparatory actions, and previous suicide attempts (Lyness, »Unipolar Minor Depression in Adults: Epidemiology, Clinical Presentation, and Diagnosis«). If a person experiences suicidal ideations, the pastoral worker must encourage the person to seek professional help without delay.

A challenge in diagnosing depression lies in the fact that nearly half of those affected deny their symptoms and do not physically appear as depressed individuals (Hotujac 171). Consequently, family medicine doctors fail to recognize depression in half of the cases (Mitchell et al. 127). Diagnosis is further complicated by the fact that two-thirds of depressed patients who visit their family doctors experience physical symptoms only, such as headaches, gastrointestinal issues, fatigue, or chronic pain; hence, calling this phenomenon »masked depression« (Rakel 212). The described physical, emotional, and psychosocial symptoms are more common in women, while men more often display what are termed depressive equivalents, which include aggression, outbursts of anger, substance abuse, and risky behaviour (Lyness, »Unipolar Depression in Adults: Clinical Features«).

It is incorrect to consider depression as something imaginary or purely spiritual, as several studies have indicated the existence of structural and functional changes in the brain associated with depression (Krishnan; Nestler et al. 13–25). Causal factors vary and include genetic, social, inflammatory, stress-related, and other factors (Belmaker and Agam; Berk et al.; Hammen). Depression is the leading cause of disability as measured by Years Lived with Disability, and the fourth leading contributor to the global burden of disease and is twice as common in women, with around one-fifth of women experiencing depression at least once in their lifetime (Siu et al. 380; Malhi and Mann 2299; Reddy 1).

Some individuals experience only one major depressive episode; others experience multiple episodes with complete remission of symptoms in between; while still others may have an almost continuous depressive state (Coryell). The intensity of symptoms may also vary from one individual to another (Coryell).

2. Anxiety

Anxiety is one of the most common mental disorders, with one-fifth of adults experiencing at least one of the anxiety disorders in their lifetime (Boland et al. 1285). Despite its prevalence, it remains one of the least treated psychiatric conditions (Sadock et al. 4407). It can be assessed at the symptom level or as a disorder (Sadock et al. 4410). In pastoral care, anxiety as a symptom is more important, as pastoral care workers do not diagnose.

Anxiety disorders are a heterogeneous group of disorders, including the panic disorder, agoraphobia, different specific phobias, social phobias, and generalized anxiety disorder (Boland et al. 1287). Among all of those, specific phobias are the most prevalent (Shah and Han 773). Even though these disorders have many different symptoms, they generally have two fundamental components: the subjective sensation of nervousness or fear and the presence of physiological sensations such as restlessness, headache, tremor, chest pain, muscle tension, perspiration, palpitations, or gastrointestinal symptoms (Boland et al. 1286; Sadock et al. 4426). The symptoms resemble a state of fear, but occur without an obvious object to be feared, as is the case in actual fear (Boland et al. 1286). In chronic anxiety, the symptoms may resemble depression (Boland et al.). In more than half of anxiety cases, depression is also present (Shah and Han 772).

Women are twice as likely to develop a panic disorder, generalized anxiety disorder, agoraphobia and specific phobia than men, but are equally likely to develop social anxiety as men (Sadock et al. 4443). Anxiety disorders have been associated with both genetic and familial factors, as well as with certain personality traits (Sadock et al. 4445).

Treatment for anxiety disorders commonly includes pharmacotherapy and psychotherapy, with physical exercise shown to be a successful complementary measure (Shah and Han 1). The role of religion in anxiety is complex, as studies have reported mixed findings: some indicate a positive correlation between religiosity and anxiety, and still others a negative correlation, and others no effect at all (Shreve-Neiger and Edelstein 397; Weber and Pargament 358; Koenig 283).

3. Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is a disorder in which the person experiences obsessions and/or compulsions (Stein et al. 1). Obsessions can be defined as repetitive and persistent thoughts, images, urges, or impulses that the person experiences as unwanted and intrusive (Stein et al. 2). They can manifest in various ways and revolve around topics such as perceived danger, contamination, sex, religion, order or asymmetry (Cervin 2). They are often associated with anxiety and have therefore previously been part of the diagnostic category of anxiety disorders (Sadock et al. 4415).

The term compulsion pertains to repetitive behaviours or thoughts that the person does in response to an obsession, or following rigid rules to relieve anxiety or to achieve a sense of completeness (Stein et al. 2). While obsessive thoughts, repetitive behaviour and rituals are common and normal, they become pathological when clinically significant distress or functional impairment exists, or when they consume more than an hour a day (Stein et al. 2–3; World Health Organization 32).

It has a prevalence of 0.8%, lifetime prevalence of 2–3%, and it is more common in women than in men in the general population (Stein et al. 2; Heyman et al. 1). It is often accompanied by another psychiatric disorder; in the case of persons with OCD, as many as 60–90% exhibit other psychiatric comorbidities (Stein et al. 2). The most common comorbidities are depressive and anxiety disorders (Cervin 5). It is important to note that most people suffering from OCD don't seek treatment (Cervin 10).

The disorder may present in several different types, for pastoral workers, the most significant variant is scrupulosity (Stein et al. 1). It can be defined as: »a psychological disorder primarily characterized by pathological guilt or obsession associated with moral or religious issues that is often accompanied by compulsive moral or religious observance and is highly distressing and maladaptive.« (Miller and Hedges 1042) It is often referred to as religious OCD symptoms (Nelson et al. 1072). Scrupulosity is a common presentation of OCD, with 5.9% of patients having religious obsessions as the primary obsessional symptom, while scrupulosity in OCD varies from 0 to 93% of cases (Nelson et al. 1072; Greenberg and Huppert 282). Religious upbringing was not shown to induce OCD, however, if a religious person develops OCD, it is likely that the religiosity will manifest itself in the OCD (Greenberg and Huppert).

Cognitive-behavioural therapy was shown to be the most successful form of psychotherapy in treating OCD (Stein et al. 10). Although exposure and response prevention therapy is considered to be the most effective treatment option, it is often not applicable to patients with scrupulosity as it means exposure to situations the persons consider to be sinful (Nelson et al. 1083). Certain authors recommend that a religious authority be involved in the treatment of scrupulosity (Greenberg and Huppert 287–288).

4. Case report 1

The first case involves a 25-year-old man who seeks help due to anxiety that prevents him from attending Mass and going to confession. He has tried several times to attend Mass but has either been unable to go or unable to stay until the end.

In childhood, he experienced scruples. He was involved in sports and believed that if he didn't pray, God would punish him with failure. He also feared punishment for his sins in a similar way. Before an important match, he would go to confession. He would always pray in the same way, and if he didn't, he would feel discomfort. In

the 8th grade, he felt a spiritual vocation, which he ignored. During high school, he entered a relationship in which he was sexually active. His spiritual life during this time was less intense; he attended Sunday Masses and went to confession a few times a year. During this period, sins against chastity caused him significant anxiety, which gradually intensified and began to interfere with his normal functioning, impacting his athletic performance. The relationship ended after he expressed a desire to live in chastity.

After the breakup, he felt great anxiety as he became aware of the seriousness of his sins and that he hadn't lived in alignment with what he believed was right. These thoughts and anxieties led to an increase in scrupulosity. He would occasionally go to confession, which would be lengthy and scrupulous. He attended weekday Masses, but would usually take Communion only after confession and rarely on any other day. Most of the time, he refrained from receiving Communion.

Obsessive thoughts emerged that he had to spend all his free time praying, attending prayer groups, and volunteering. This exhausted him physically and mentally and led to stagnation in his sports career. Eventually, an injury forced him to withdraw from sports.

Due to his psychological state, he was unable to start a relationship. He had a brief relationship lasting two months, after which he felt guilty for entering it unprepared and using the girl for attention. This exacerbated his scrupulosity, making him feel he was repulsive to God and unwelcome in the Church. He felt worse after Communion and eventually stopped going to Mass and confession for several months. During this period, he unsuccessfully sought a spiritual director for three years, talking with several priests but without receiving consistent direction.

At this point, he decided to seek psychiatric help. He was prescribed an antidepressant but says he's unsure if it helped. He eventually found a spiritual director with whom he began working systematically. He noticed positive changes, which he associated with having found a stable job and a spiritual guide.

Seeing significant progress in his mental health, he decided to stop using medication. He has been without treatment for a year and is functioning well, though some symptoms remain but at a lower intensity. He regularly reads spiritual literature, prays mentally, and attends weekday Masses, functioning normally at work.

After a year without therapy, his scrupulosity has begun to increase again, causing him to avoid regular Communion, although he is in a better state than before starting spiritual direction. Following his spiritual director's advice, he plans to resume psychiatric treatment alongside continued spiritual direction.

The elements of spiritual direction he found most helpful are, firstly, the sense of obedience to his spiritual director and limiting his daily options, which significantly reduced his anxiety, as he previously felt obligated to participate in all available activities. Secondly, the availability and dedication of his spiritual director, which gave him a sense of closeness and being worthy of attention. Thirdly, tasks and

encouragements he was expected to complete. Fourthly, the feeling of having someone to trust; regular communication and verbalization of arising problems.

He believes that a traditional approach to spiritual direction, where he would meet less frequently with his spiritual director, would not have been sufficient, as he would not have been able to open up and share what was building up. He states that he has learned to better manage his emotions and distance himself from despair. He now takes a more rational approach to what he can objectively accomplish in his daily life.

4.1. Points for Reflection with Implications for Pastoral Practice

In this example, we consider a young man dealing with a combined anxiety-depressive disorder and obsessive-compulsive disorder. In this section, we will highlight key elements that may be useful for pastoral workers.

Moral injury is a term that refers to the possible negative consequences that arise when deeply held moral values and beliefs are violated (Farnsworth et al. 249). In this case we can observe a deterioration of mental health following prolonged sexual behaviour that the person deemed sinful. It is important to make sure that persons coming to confession feel that they are not being condemned, and that they can be forgiven. This may alleviate the pressure these persons put on themselves.

It is important to recognize that scrupulosity is, as mentioned earlier, in many cases actually a manifestation of obsessive-compulsive disorder (Nelson et al. 1072). When scrupulosity does not interfere with normal functioning and the person can follow the advice of a spiritual director or confessor regarding sins and Communion, a referral to a medical professional is usually unnecessary. The pastoral worker should encourage the person to seek professional help if the scruples lead to a deterioration in normal functioning or if they persist for more than an hour each day (Stein et al. 8–9). The management of scrupulous persons in confession is outside the scope of this article. However, it is important to note that not all scrupulous individuals come to confession daily; some believers avoid confession out of shame and prefer not to take Communion for prolonged periods of time.

Although this was not the case here, many believers struggle with intrusive thoughts they often fear discussing. These intrusive thoughts are frequently blasphemous or of a deviant sexual nature. Penitents often fear defining these issues even in confession, even though such thoughts often motivate their confession. It is essential to ask penitents if they would like to discuss these issues and to create an environment where they feel safe to verbalize their difficulties. It is also important to leave the impression that even outside of confession they can come and talk without fear of judgment or condemnation. It is important to note that when the content of these thoughts is distressing, individuals often hesitate to talk even to a psychiatrist, making confession a privileged space where these matters can be discussed and support can be offered.

5. Case report 2

The second case report involves a young man aged 18 who came seeking spiritual direction. He has been an altar server in his parish for several years. He is an excellent student. He states that he normally has difficulty opening up to people and that he has never talked to anyone about the fundamental problems that bother him because he did not feel he could be honest enough. During the interview, it was revealed that he has problems with depression.

His mood problems began to manifest when he was in the sixth grade of elementary school when he was diagnosed with diabetes. Suicidal ideations appeared, which is why he went to a psychologist. He associated the initial mood problems with difficulties in accepting the disease, which progressed as he got older. He began to have mood swings, he was often sad, serious, and depressed. He began to hate himself and stopped laughing. After the death of his grandfather when he was 17, his symptoms of depression worsened, which is why he went to a psychiatrist, who introduced him to pharmacotherapy that reduced his symptoms. Despite this, suicidal ideations appeared and progressed, and he developed ideas of self-harm and suicide.

An important factor that leads him to despondency and despair are problems related to sexuality. At the age of 12 or 13, he began masturbating and did so on average every day. He states that he did not know that it was a sin. When he found out that it was a sin, he had great difficulty admitting it in confession, which is why he sometimes hid it and took communion. Another important factor that he never talked about are the same-sex tendencies that he feels and because of which he feels less worthy and »not normal«.

Since he started talking regularly to a priest about his inner self, he has felt positive changes because he is able to verbalize his problems without fear of judgment. Having an objective observer benefits him, because it helps him see the situation from a broader perspective. He also states that he falls into sins against the sixth commandment of God significantly less often.

He continues pharmacotherapy and attends check-ups with a psychiatrist. Although there is a significant reduction in his depressive symptoms, he still occasionally experiences mood swings and suicidal ideation, which are less intense since he regularly verbalizes them, which is why these conditions do not progress significantly.

5.1. Points for Reflection with Implications for Pastoral Practice

The second case report involves a young man with a depressive spectrum disorder characterized by low mood and self-destructive ideation. The depressive symptoms were comorbid with diabetes, which is often the case (Zhu et al. 1). Several important elements should be mentioned.

Firstly, in this case report we are dealing with a young person who has been active in his parish as an altar boy since childhood. Although pastoral workers have

young people in their parishes and other communities with whom they have frequent contact, they must not assume that the young people feel that the pastoral workers are available for conversation and consultation with them. Especially in cases where sensitive topics related to sexuality are involved, many young people will not want to talk to a priest about it for fear of judgment. Therefore, it is important to create an atmosphere of openness, and this must be explicitly said.

Secondly, we cannot assume that young people know what is and what is not a sin, even in the case of those who regularly attend Holy Mass. Important questions of morality must be discussed with the faithful openly. It is important to clearly emphasize the Church's teaching on sexuality, as well as on God's mercy. When speaking about the topic of homosexuality, it is essential to distinguish between acts (Catholic Church no 2537) and inclinations (Catholic Church no. 2358) and the teaching on the acceptance of these persons, as is stated in the Catechism of the Catholic Church (Maher 500). The phenomenon of priests demonizing people with same-sex tendencies is extremely destructive as they can lead to self-destructive behaviour in these persons. It is important to note that many believers who have same-sex tendencies feel a great deal of self-contempt, they feel that they are »not normal« and worthy of condemnation for something they cannot themselves control (Grossman and Kerner 25). In spiritual direction, it is extremely important to raise awareness of the fact of the dignity of every person, to foster awareness that every person is a beloved child of God and that the existence of certain difficulties does not change this fact. It is important that a person does not identify with their sexuality but instead clearly distinguishes between the constructs: »I am homosexual« and »I have same-sex tendencies«. It is important to establish a person in the identity of a child of God regardless of the objective problems they have. Believers must feel that the Church accepts them even when they cannot accept themselves. The priest must play the role of a father and direct the person to the love of God, which is unconditional and free. The response to this love of God must be the motivation for living a Christian life. Internalizing the problem leads to frustrations that can lead to a person's psychological breakdown and distancing from God and organized religion. A significant number of believers are moving away from the faith because they feel they cannot talk to priests about their sexuality and that they are rejected. Research shows a significantly higher rate of moving away from organized religion among people with same-sex attraction, while maintaining the rate of maintaining a prayer life (Woodell and Schwadel 379, 393). Woodell and Schwadel suggest that in religions like Judaism, Christianity, and Islam, sexual minorities often face the challenge of navigating conflicting cultural identities to minimize the effects of cognitive dissonance, and that this struggle may result in either rejecting one of these identities or striving to reconcile them (381). Individuals who cannot or choose not to reconcile these conflicting identities might reduce their religious practices or disassociate from their faith entirely (Woodell and Schwadel 381). It is important for young people to feel that they can go to confession without fear of a negative reaction from a

priest, which is especially important for avoiding sacrilegious communions. It is important to note that symptoms of depression and anxiety are significantly more common in people with same-sex preferences, about 1.5 times more common (King et al. 1). The suicide rate is twice as high, and in the population of men with same-sex preferences it is more than four times higher than in the general population (King et al. 1). There is certainly more available support today than before, but some believers with these problems refuse to openly discuss their sexual orientation, and often the priest is the only person they will open up to.

Thirdly, in the case of suicidal ideation and affective disorders that interfere with normal functioning, it is necessary to encourage persons to seek psychiatric treatment, even when symptoms improve (Weber et al.).

6. Pastoral implications

As the conclusion of this article, we will try to provide several final points for reflection that might prove useful for pastoral workers dealing with persons with possible mental health issues.

Firstly, it is very important that pastoral workers are available for spiritual direction. The importance of spiritual direction is often emphasized in Church documents (Benedict XVI.; Congregation for the Clergy no. 81). In the first case report, we had a young, healthy person who had been seeking spiritual direction for three years without success. Spiritual direction during the initial period of his symptoms could decrease the severity and potentially prevent the progression of his psychiatric symptoms. Pastoral workers need to provide an individual approach, be open, and ensure that the person in need has the feeling that they can be open without fear of judgment. Even though it is a difficult topic, pastoral workers must be prepared to talk openly about sexuality, because avoiding difficult topics does not solve the problem, but rather makes it worse, as it may lead to sacrilegious communions, scrupulosity, or distancing from the Church.

Secondly, it is important to note that many people, especially introverts and people with low self-esteem, do not like the concept of spiritual direction based on infrequent conversations, because they are too closed off and will not seek help for fear of being burdensome. If meetings with the spiritual director are not frequent, persons in need might not open up and develop trust in the spiritual director. In the case where the person has several key issues that they wish to discuss, they might feel that while discussing current problems, the root problems are not being assessed and managed.

Thirdly, as seen in the second case report, in working with young people it is often necessary to initiate a conversation, to ask if they want to talk about something, especially if it is felt during confessions or conversations that there may be certain difficulties in the background. Introverted persons often have difficulty approaching a pastoral worker and asking for help.

Fourthly, it is essential that pastoral workers have adequate knowledge of at least the basic psychopathological conditions that are commonly present in the confessional. In this way, they can help direct penitents to a psychiatrist. If symptoms progress or if there is a loss of the ability to function normally, this is a sign that the penitent needs to be referred to a psychiatrist. This, however, entails that a pastoral worker can recognize these symptoms in order to refer the penitent to seek professional help. A priest will often be the first person from whom individuals will seek help due to the great stigmatization of psychiatric disorders in society (Corrigan and Wassel 42). It is the priest who has the duty to break the stigma of mental disorders, to point out the fact that psychiatric disorders are not purely spiritual, but that they are conditions as real as other physical illnesses. A major problem today is that some believers believe that all psychiatric illnesses can be cured by prayer. It is important to direct believers to the true doctrine and the use of modern medicine that man has come to through the use of his reason, rather than purely supernatural ones.

Fifthly, psychological and spiritual disorders are often intertwined. An important rule in the case of a combined spiritual and psychiatric disorder is that each disorder should be treated separately (O'Connor 137; May 156). The treatment of psychiatric symptoms should be left to a psychiatrist, and in parallel, spiritual direction and resolution of spiritual problems should be addressed by a pastoral worker. It is often difficult to determine whether the underlying cause is spiritual or psychological, as spiritual problems can spill over into the body, which should be taken into account during spiritual direction (de L'Enfant-Jésus 318). Psychiatric issues, such as scrupulosity, may lead to the creation of a distorted picture of God – in the case of scrupulosity, the picture of a God as a strict judge without mercy. Appropriate management of these issues may lead to a healthier view of God and religion.

Sixthly, research has shown that a combined approach to the treatment of psychiatric illnesses is best: a combination of pharmacotherapy, psychotherapy, spiritual direction, changes in lifestyle habits, and more (Rajkumar).

Conclusions

Pastoral care for people experiencing mental health issues presents a challenge, but also an opportunity. It is important for pastoral workers to show compassion, but also for them to be knowledgeable about mental disorders. A trusting environment is very important, especially in the case of sensitive issues such as sexuality and sin. The sense of being judged or misunderstood may increase feelings of guilt or unworthiness. Pastoral workers should aim to create spaces where people feel seen as children of God, regardless of the issues they face. Pastoral workers need to know when to advise persons to seek professional help, as they are often the first point of contact for people struggling with mental health issues.

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