

## MY AREA OR YOUR AREA? ASSUMPTIONS ABOUT PASTORAL CARE, SPIRITUALITY AND MENTAL HEALTH.

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**Abstract:** *In this presentation, we are called to draw up an outline of the spiritual dimensions of healthcare focusing on the differences between psychologists, psychiatrists, psychotherapists, social workers, priests and chaplains. Some basic questions, which need to be answered, are why we still face so many major problems in the relationships between some of the basic healthcare specialists, including chaplains. Given though, modern therapy and healthcare are multidisciplinary tasks by definition. What is the role of spiritual care in health care? Why are the tensions often sharply visible in the assumptions that chaplains, psychologists and psychiatrists have about each other? We will try to answer these questions by following a spiral ascension which starts from history and moves to recent definitions and the framing of each discipline. From these tensions and assumptions we will move to the boundaries of chaplaincy and the chaplain's identity. Here, some unconscious conflicts of the chaplains will be discussed. Finally, we attempt to formulate some conclusions and proposals on the discussed issues.*

### Introduction

Our century is the era of the multidisciplinary and of cooperation between sciences and professionals. Modern therapy and healthcare at large are provided by a therapeutic team of different specialists. Then, why do we still face so many major problems in the relationships between some of the basic healthcare professionals?

In fact, conflicts between psychiatrists and psychologists, psychologists and social workers, psychiatrists and chaplains, chaplains and nurses or between any other possible combination, including oppositions even between priests and chaplains, are undermining the outcome of a global approach of the suffering individual who needs all of them. Thus, if both Theology and Human Sciences do not understand the substance and the underground of all those difficulties, the development of an effective cooperation between them and of pastoral care itself will be a slow, difficult and not very optimistic process.

The main scope of this text is to draw an outline of the differences between mental health professionals (psychologists, psychiatrists, psychotherapists, social workers, etc.) and priests or pastoral care professionals at large. It is also an attempt to make

some assumptions especially on Hospital Pastoral Care and the 'utility' and role of spiritual care in healthcare. We chose to focus on the example of hospital pastoral care as it shows better the developments and the difficulties in the relation and cooperation between pastoral and psychological approach of the person who needs help or therapy.

This paper is constructed like a spiral staircase. First landing is history. Second landing is the recent definitions and the framing of each discipline. Third landing is the questions about the borders of pastoral care and of the priest's or pastoral counsellor's identity referring also on some of their unconscious conflicts. Finally, arriving at the top of the stair, we will attempt to formulate some conclusions and proposals on the discussed issues.

### Landing on History

History teaches that when a new religion replaces a previous one, we never have – at least for a very long period of time, if not for ever – an absolute, total change, in spite of all the major changes. (Nilsson, 1949) It is like a forest which is replanted after a fire. What we finally face if we look at the new trees from a distance, is a new totally different forest. Yet, from close we can easily recognize the same ground,

the same grass and almost all the small plants from the past.

The same happened with the “wood” of healthcare. In the past, Philosophy, Psychology and Medicine used to be trees of the same wood (Heitink, 1999). They belonged to a continuum of ideas and practice that tried to interpret and understand the Universe. Originally, apart from their specific tasks and differences (i.e. research for the Science or salvation for the Church etc.) their common motivation and scope was to conquer the suffering and to comfort the human being. What they also had in common was an accepted experience of finiteness. For hundreds and hundreds of years priests played a major role in Medicine, when Psychiatry almost didn't exist and Psychology was an abstract part of Philosophy (Hergenhahn, 2001).

Some centuries ago the big fire of the Enlightenment burned this “wood”. Today, the new formation looks totally different. We see several separated forests in the same wood. In the historic frame of Modernity, Psychology was separated from Philosophy and became an empirical, experimental science (Robinson, 1986). This separation led also to the abandonment of the ontological speculation and to focus only on the behavioural and practical-therapeutic questions. Modern Psychology is a science with its own presuppositions, theories and practice, and, of course, –as a good child of Modernity- had to be more or less against religion (Richards, 2002). Psychiatry went through major conflicts with religion to, and that was not just because of an abstract scientific opposition.

Under the influence of Saint Augustine's ideas, early Christianity tended to believe that psychiatric diseases were coming from the devil (Hartokolis, 1991, pp 37-39). The story of the “*Malleus Maleficarum*” is very characteristic of the opposition between Psychiatry and Religion. In 1486 two German monks Heinrich Kramer and Jacob Sprenger published the famous book “*The Hammer of Witches*” (“*Malleus Maleficarum*”) (Kramer, Sprenger, 1971). This book was an attempt to codify all the theories and rules of demonology. According to those medieval ideas, mentally ill persons were believed to be possessed by the Devil rather than to have some form of illness. Having been approved by the Pope, the King of Rome and the School of Theology of Cologne's University,

the book was adopted by the Inquisition (Hergenhahn, 2001, pp436-437).

In fact, *various types of misfortune or suffering often were perceived as just punishments meted out through divine intervention as a consequence of sinful behaviour. Thus, it was easy to believe that a person who fell into the deep despondency of depression, and who was experiencing a delusion of sin and guilt, was spiritually rather than physically ill. A person with the agitation and mental confusion, that often accompany severe psychosis, could easily be seen as possessed by diabolical forces. Such individuals often were 'treated' through the Church rather than through medicine, and many were tortured or burnt at the stake.* (Andreasen, Black, 2001, pp 6-7) The last witch was hanged in England in 1684 and in 1692 in the USA (Salem, Massachusetts) (Bonfanti, 1992), but witch trials continued in Salem, Massachusetts, USA, into the eighteenth century (Weisman, 1984).

It is worth mentioning that some scientists reacted to those “dark” ideas, like Juan Louis Vives (Spain, 1538), a forerunner of Freud, writer of the book “*De Anima et Vita*” (“*Of Soul and Life*”). In this book he describes the importance of psychological associations and their influence in forming emotions, and pointed out the need for a more humanistic care of the psychiatric patient (Kaplan, Sadock, 1988, p2). Very characteristic is the case of Johann Weyer (Holland, 1563), writer of the book “*De Prestigiis Daemonum*” (“*The Deception of Demons*”) (Kaplan, Sadock, 1982) in order to refute “*The Hammer of Witches*” (“*Malleus Maleficarum*”). Weyer is mentioned as the first real psychiatrist and his book as a real textbook of Psychiatry (Hartokolis, 1991, p38). Unfortunately, his name was included in the list of forbidden writers by the Roman Catholic Church and it was there until the beginning of the last century.

Apart from those very visible oppositions, the relationship between Psychiatry and Theology was mutually disdainful. Indeed, the tension between Pastoral Care and Psychiatry is not so strange if we take into account that, “Augustine's view dominated Christian Pastoral Psychology for over a millennium and traces remain today” (Crapps, 1990, pp 57-58).

We have to keep in mind that Psychiatry also needed to fight for a place in the spectrum of medicine. Even today psychiatrists are very sensitive about the fact

that “their researches are often viewed as ‘soft’ science by research colleagues, or that they are compared with ‘shamans’, witch doctors, or clergy” (Draper, 1970, p21).

Summarising the information from the landing of history, it is visible that the Enlightenment separated the religious and scientific world view. Tensions between Psychiatry, Philosophy and Religion took a new turn and we can still detect those traces even today.

### **Landing on the defining of the specialties**

While Psychiatry wanted to be medical, i.e. to be free of any religious, metaphysical or superstitious influences, the new-born Psychology was very keen in psychologizing everything in society. That happened since the beginning of the 20<sup>th</sup> century, when Psychology became the language to express human developments and encounters. In that climate new theological (or psychological?) sciences appeared.

At first there was “Psychology of religion”, which originally appeared as an attempt to psychologically interpret religion and religiosity at large (Loewenthal, 2000) (Begzos, 1996, pp8-9). “Pastoral Psychology” appeared later as an attempt of some clergy to use and incorporate the psychological knowledge and experience in their pastoral work (Pfister, 1944).

We have to keep in our minds the atmosphere and the circumstances of the beginning of the 20<sup>th</sup> century. In Europe, reverend Oscar Pfister had been part of the psychoanalytic movement (Jones, 1961). But, in spite of Freud’s and Pfister’s mutual respect and admiration, Freud insisted that those who would practice psycho-analysis shouldn’t be medicines or clergy men (Freud, 1963, p17).

In the USA, the “Emmanuel movement” (Cunningham, 1962, pp 48-63)(Worcester, McComb, 1931), the “Social Gospel Movement” (Gerkin, 1997, pp57-60), and mainly the initiatives of Anton Boisen (Gerkin, 1997, pp60-63), which finally led to the establishment of C.P.E. (Clinical Pastoral Education), were not simply personal achievements (Hall, 1992). They also reflected the need of some Christian Churches to re-orient pastoral care in the new “modern” reality. That is to say, to incorporate

in their ministry the new scientific knowledge, especially in the area of human sciences (Jacobs, 1982).

The same separation process happened with the development of a new kind of care-givers named “social workers”. Ever since the well-fare services became a duty of the State, i.e. of the secular institutions, the need for specialists in helping people with their problems, such as practical discomforts or difficulties dealing with health problems, poverty, social or family life, became necessary. Obviously, this field belonged for centuries to the religious orders and the clergy. So a new conflict and a new need for borders and clarifications came up.

To make a long story short, the forest was burned and the new wood consists out of trees named Medicine, Psychiatry, Psychology, Science of Social Work etc, and certainly, Pastoral Care. In the modern wood of healthcare, Psychiatry defines its self as a clear medical branch. According to a modern dictionary of Psychology: *Psychiatry is a medical specialty concerned with the study, diagnosis, treatment, and prevention of mental and emotional disorders. Training for psychiatry includes the study of psychopathology, biochemistry, psychopharmacology, neurology, neuropathology, psychology, psychoanalysis, genetics, social science, and community mental health, as well as the many theories and approaches advanced in the field itself* (Corsini, 2002, p777). Consequently: *“A psychiatrist is a physician who specializes in the diagnosis, treatment, prevention, and study of mental and emotional disorders* (Corsini, 2002, p777).

Modern Psychiatry, in all its levels of practice, which are prevention, therapy and rehabilitation, is based on the “bio-psycho-social” model, accepting that “most illnesses, mental and physical, result from a combination of biological, psychological and social factors” (Stefanis, Economou, 2005, p8), though mental disorders are understood in the same way of any other physical disease, being different only in the symptomatology (Fahrer, Lipsitt, 2002, pp147-152).

Obviously, a psychiatrist cannot cover all the needs of a patient. Therapy has to be provided by a therapeutic team which needs psychologists for the “psycho”-logical part and at least social workers or other professionals for the “socio”-logical part of the new model.

Inevitably, under the demands of Modernity, the borders between specialties need to be well clarified: *A psychologist is, by definition, a professionally trained person who spends working time in researching, teaching, writing, or practicing clinically in one or more branches of behavioural science. Training includes a wide variety of courses leading to a doctorate obtained at a university or school of professional psychology. In most jurisdictions certification or licensing is required for participation in the profession. Psychologist's activities are carried out in a variety of settings: schools, colleges, social agencies, hospitals, clinics, the military, industry and business, prisons, government agencies, and in private practice* (Corsini, 2002, p784).

Of course, no one can work in the modern health care system if he/she is not a professional. Consequently, the social worker must also have its own qualifications. *The modern social worker is a person trained in an accredited graduate school to help individuals and families deal with personal and practical problems, including problems related to mental or physical disorder, poverty, living arrangements, social life, marital relationships, child care, occupational stress, and unemployment. Social workers are major members of treatment and rehabilitation teams in clinics, social agencies, mental-health centres, psychiatric units, and general hospitals* (Corsini, 2002, p919).

Apparently, modern therapeutic teams include also nurses, music-therapists, art-therapists, speech-therapists and many other specialists, all with an approved level of training and skills and defined tasks and areas of work. The main idea behind the use of so many different professionals is to cover every patient's need, scoping to the best therapeutic outcome of the offered services.

This new reality raised serious questions, at least in some Christian denominations, about the pastoral care for the sick. In a classic book of 1936 we read: *Has the Protestant minister of today any good reason to visit the sick? The doctor diagnoses and treats them. The apothecary prepares their medicines. The nurse or the family give bedside care. The social worker looks after domestic, legal and industrial difficulties. The librarian supplies books. The occupational therapist gives manual work. The Catholic priest hears confessions, gives absolutions*

*and administers extreme unction. But can the Protestant minister be anything but a nuisance? By what authority, then, does the minister go to the sick room?* (Cabot, Dicks, 1936, p3)

But, then, if we take into account all the changes in our even more secularized times, what is left for the priests and for pastoral care at large in the context of healthcare services? And further more, what could be a Christian Orthodox answer to all these questions?

## **Landing on the borders of Pastoral Care and minister's identity**

All the aforementioned make it clear that a priest, a pastoral counsellor or a chaplain cannot be a religious substitute of the psychiatrist, the psychologist, the social worker or of any other specialty. Nevertheless, there are some crucial aspects that characterize modern Psychiatry and Medicine at large, which point to the need for "religious professionals" in the health-care context.

1. The psychiatric "bio-psycho-social" model, which in fact should be a model for all branches of medicine, cannot ignore the crucial role that religion or faith plays in social life, in personality formation (Oates, 1987), in adjusting to ordinary life difficulties (Dohrenwend, Dohrenwend, 1984) (Rabkin, Struening, 1976, pp1013-1020), to existential anxiety, to family and life values (Olson, DeFraim, 1994, p132) and so forth.

The implementation of this model claims that, when psychiatry organises its preventive or therapeutic methods, it must be aware of all the psychological, biological and social elements of the human being. Undoubtedly religiosity is one of those elements. Religiosity was always a serious and multilateral influencing psychosocial factor in everyone's personality construction and way of living (Loewenthal, 1995). Indeed, it constitutes a structural element of our civilisation, either directly for the religious believers or indirectly for most others.

2. The classical medical model is based on the treatment of a sick organ, for instance of the liver or of the heart, and not of the suffering patient as a person (Cassel, 1979, pp103-131). Thus, there is still a tendency, even in modern medicine, to neglect the psychological or social parameters and of course the spiritual ones which might have a positive or nega-

tive impact either in being ill or in recovering and being in a good health (Koenig, Larson, 2001, pp67-78).

What seems to be missing most of all is the importance of the existential issues for any patient. Every one who suffers a physical illness, even not a terminal one, consciously or unconsciously, goes through a vast experience of finiteness, of mortality:

*A sick person, even when not terminally ill, lives through an experience of finiteness. Thoughts come crowding in after visiting hours and during the nights. Mortality becomes an existential experience..... Not infrequently, there are experiences of guilt, both real and false. Or there is a primitive anxiety: 'Illness is the consequence of guilt; illness is revenge;' 'Why did this happen to me? Did I deserve this?'*...

*These are questions which reveal a much deeper conflict than the relationship with the body, with the world, and with fellow humans..... These are all 'religious' questions, even if they are not explicitly addressed to God. ... To recover does not mean to have a ready-made answer to all these questions. The process of recovery starts when people 'dare' ask questions. (Depoortere, 1995, p8)*

It is quite obvious that the more medicine and the health care system at large are aware of the patient's every need as a person - and not as a carrier of a sick organ -the more room for priests and pastoral professionals they have to make (Moyer, 1989, pp171-183). In the new wood of healthcare the "tree of pastoral care" has to gain its own space, in spite of all the differences it shows from all the other "trees". That also raises questions about identity, scope and tasks.

The most basic description of what a pastoral care giver does is tending to the existential, spiritual and religious needs of the patients.

We can leave further descriptions to the specialists and concentrate on the "small plants" and "grass" that could prevent the "Pastoral Care tree" of growing sufficiently and healthy and taking its own significant place in the new "wood".

1 .In the past there was an automatic respect for the clergy and consequently for all the representatives of God. Unfortunately, this respect and the therapeutic context of the past led, at least for some in the priesthood, to feel like the only important and authorized therapists (Guggenbühl-Graig, 1971, pp5-9). Sometimes in a way that undermined or had no respect for medicine itself. Modern pastoral care professionals are paying now for the arrogance of some of our spiritual ancestors and they have to fight for their place in the healthcare context. They also have to prove as objectively as possible that their work is needed and is beneficial for the patient.

2. In fact priests, especially those who work in hospitals, need to understand that they are not there as medical therapists. They are there to look after the spiritual, the existential or even the simple needs of the human being as a person interrelated with other persons or with God. Undoubtedly, their intervention and specific religious care might also have a positive impact on the physical therapeutic process (Vanderpool, 1980, pp7-17) but this is not a scope itself.

The priest and the chaplain at large represent God and the Church as the Body of Christ. So both the main scope of spiritual guiding and the main concern of pastoral care are beyond the individual problem solving or the behavioral guidance. The ultimate purpose of the pastoral intervention is to assist and provide spiritual growth. That doesn't mean in any sense to neglect the physical or psychological or practical needs and dimensions of the patient's situation and do whatever possible about them. But in the end, the major concern is the reaching of "God-like-ness" of the human being, into which a person grows through his or her free choices regarding both God and other persons.

We need to remember that, the priest or the chaplain are not dealing with the physical (somatic) disease only but mainly with the "spiritual" problem, which is what the patient will make of his/hers physical problem, while his/her faith towards God or his/her loss of faith and bitterness against God may increase. So the pastor has to help the suffering person to discern in a way of finding a meaning in the unavoidable pain and sorrow. They have to help or guide the patient to discover that in the middle of the problem the meaning of his/her existence might be hidden. Spiritual growth and maturity means also to get rid of all the "idols" we have created and discover what is

truly necessary in order for us to “cooperate” with God and recompose our self – image. And, as we all know, only in communion with God a person becomes him or her self. In the Christian Orthodox Tradition communion with God cannot be understood out of the sacramental life of the Church (Allen, 2004).

3. Pastoral care professionals need to be aware of the load that comes from the past. The “grass” and the “small plants”, which represent the conflicts, the prejudices and the debates of the past, might not be visible but they bring on unconscious defences and they drive into mutual incomprehension or even to mutual disdain. It practically means that ministers need to be aware of not struggling to find their identity and fulfilment as professionals by implementing “a ‘vital’, ‘dynamic’ church program that will exert a leadership and not a follow - ship” (Draper, 1970, p27). We need to always remember that the “savior’s syndrome” or the need to “play God” (Jonson, 1961, p140) it is not a “privilege” of only the priests and not of the other health professionals to. Nevertheless, pastoral care professionals have to be very much aware of it more than any other healthcare worker.

4. Because of all the aforementioned tensions, *the wish to help may, paradoxically, border on the dangerous when it springs from a self-protective device whose latent meaning is ‘let me help you so I’ll know my role, my profession, my calling and preserve my integrity’* (Draper, 1970, p27).

5. Over and above, we still work in the cultural context of modernity and the ideological conflicts between science and religion are spread all around (Carbine, 1980, pp40-47). Thus, the priests and pastoral workers need to be aware of not taking any contestation as personal attack or assault. *These assaults strike the person himself and he responds with the antagonism appropriate to a personal attack. He is then no longer defending Freud or defending God – he is defending himself* (Draper, 1970, p27).

6. Focusing especially in hospital pastoral care, we have to keep in mind that chaplaincy is a new discipline which demands from the pastoral care giver to be aware of his inner motives for choosing this kind of work. For instance a hospital priest or a priest trained in psychology must be aware of what

his vocation is psychologically dealing with and not being in a conflict with his own vocation or with the other parish priests. Further more, it must be very clear that being a “chaplain” means ... being nothing but “chaplain”. It doesn’t mean a superior priest or a modern “shaman”.

7. Training, global education and openness are very important. We need to understand not only what the pastoral care field of work is but even more to understand what is not of the pastoral care giver business (Scherzer, 1971). The theological principles and the ecclesiastical tradition are important to be the determinant elements of any pastoral or even psychological intervention of the pastoral counsellor (Larchet, 2002).

## Conclusions

Our laborious ascension through history and modern healthcare specialties to the sketching out the borders of pastoral care professional identity lead us to a top landing, that is to say to some conclusions and suggestions.

Stephen Muse summarizes the recent reality as follows: *Over the course of the last century, until quite recently, religion slowly faded from the medical scene. Personals first became ‘patients’ and then, as both the healers and those seeking relief were managed and defined by forces that regulated our lives not according to wholeness, ecological harmony, depth and meaning in the light of Christ, but rather according to numerical efficiency and cost, ‘patient’ has given way to “customer” or merely consumer. This is certainly not ‘spiritual’ progress, whatever face may be put upon it* (Muse, 2004, p4).

In this particular context modern pastoral care has to find its own borders, identity and methods. It has also to fulfill a very demanding, complicated and delicate task. That is to find a modern and inclusive way to put some major aspects of religiosity and spirituality together with the scientific and the technical knowledge.

Some of these crucial aspects are:

- The spiritual and the ecclesiastical tradition,
- Theology,
- The patient’s community principles and values,
- Pastoral care giver’s skills of communication and of understanding the story of the individual,

- Some basic knowledge of both medicine and psychology, including the principles of the healthcare functions, like the way a particular ward in a hospital functions and so on. All these need to be indivisibly incorporated in the formation of the pastoral care professional.

In other words, the priest himself, as a mature person with its own spirituality and able to implement all the aforementioned, has to become an existentially healing "instrument". He has to become a spiritual healer who must be integrated in the health care team as a professional of pastoral care who is able to communicate with other team workers about his professional scope and approach.

To communicate does not mean to "preach" but it means, instead of talking, to let be clear what he does and how he does it through his work with the patients. It also means that he must respect all the approaches and professionalism of the others without letting them fill in his.

The Christian Orthodox pastoral "therapist" has to always remember that *apart of the fullness of the divine life, there will always be something incomplete in us, a kind of longing that cannot be satisfied in this world, but only on the next, and never alone, but only in relationship with God and others. Therefore we desperately need healers who treat us not only for ills in this world, but offer guidance and care for achieving health and citizenship in the other; healers who rely not on technology derived from humanly devised research protocols alone, but who themselves are struggling to enter into the fullness of relationship with God and the beloved community and so bring to the healing partnership humility, a loving awareness of the presence of God and the sanctity and mystery of every life* (Muse, 2004, p10).

In any case, knowing that modern pastoral care is provided in the era of the multidisciplinary and of cooperation between sciences and professionals we should always be aware of the tensions between professions and protect pastoral work and above all the patient from any damaging conflicts, including professionalism (Fosket, 2005, pp279-281). Of course, a good start to understand what is happening, prevent conflicts and be conscious of what we do and how can we be effective is to look first inside of our selves.

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