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Grzegorz Wąchol

grzegorz.wachol@upjp2.edu.pl
https://orcid.org/0000-0002-6427-7231
The Pontifical University of John Paul II in Krakow, Poland
https://ror.org/0583g9182

Andrzej K. Jastrzębski

https://orcid.org/0000-0003-2637-7706
Saint Paul University, Canada
https://ror.org/01x3t1868

A Consideration of Spiritual Motivation in Patients Suffering from Mood Disorders

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Abstract

A substantial body of recent research indicates that religion and spirituality can play an important role in health recovery and overall well-being among individuals facing diverse health challenges, including mental disorders. This article examines the potential contribution of pastoral care providers to strengthening patients' motivation for therapy in cases of mood disorders. The issue is particularly relevant to the development of mature faith among patients. Mood disorders are among the most prevalent mental health conditions and are frequently associated with a marked decline in motivation to seek and continue treatment. In addition to more customary forms of sacramental ministry, the involvement of spiritual care providers in fostering motivation may improve interdisciplinary collaboration in medical institutions. This article presents several core examples demonstrating the potential efficacy of pastoral interventions, especially in the Roman Catholic context, in increasing patients' willingness to engage in the treatment of mood disorders.

Keywords

spiritual care, mood disorder, motivation, treatment, holistic approach

In recent decades, research on the role of religion and spirituality in improving health outcomes among individuals with various medical conditions has expanded considerably (Jastrzębski 2024, 691–711). The evidence suggests that religion and spirituality can help individuals cope with significant life challenges (Pargament 1997, 359–406). This observation also applies to mental health problems in general and to mood disorders in particular (Koenig 2012, 5).

Closer collaboration between mental health professionals and spiritual care personnel, including chaplains, is therefore recommended in order to provide the most effective assistance to patients. Although the employment of clergy in mental health facilities may raise certain reservations — for example, in the case of Catholic priests working within the Polish cultural context — the absence of adequate spiritual care can impede patients' recovery and their ability to regain psychosocial functioning (Jastrzębski 2024, 700).

A notable feature of many mental disorders is diminished motivation for treatment, frequently associated with poor insight, understood as a limited recognition of problems concerning one's own well-being. Reduced motivation is particularly evident in mood disorders, especially depression. This article proposes ways of involving spiritual care personnel in fostering motivation for therapy among individuals affected by mood disorders and presents this involvement as a form of pastoral action. The proposed measures are intended primarily to enhance pastoral care in medical facilities, especially those providing psychiatric treatment. The approach arises from the Polish context of psychiatric chaplaincy; however, it may also be adapted by other spiritual care providers who accompany individuals affected by this type of disorder.

1. General characteristics of mood disorders

Mood disorders comprise a broad spectrum of clinical conditions. In general terms, they are characterised by disturbances in affective experience and by altered perceptions of the self and the surrounding world. These disturbances may manifest themselves in symptoms ranging from profound despondency and helplessness to elevated mood, increased psychomotor activity, and excessive goal-directed behaviour.

At the depressive pole of the spectrum, the most common disorder is depressive disorder, which the World Health Organisation (WHO) identifies

as a common mental health condition and emphasises that effective psychological and pharmacological treatments are available (World Health Organisation 2025). Depression disrupts everyday functioning and may be associated with a serious risk of suicide. It can occur among middle-aged adults who have experienced traumatic events, severe illness, or invasive clinical procedures. The treatment of depression is increasingly recognised as important in medical fields such as oncology and cardiology.

Depression is characterised by a pervasive sense of emptiness and isolation that significantly impairs daily functioning. Individuals affected by this condition often experience a marked reluctance to engage in activity. Symptoms include a negative view of the world and a sense of despair (Mulder 2002, 359–371; Poniatowska-Leszczyńska and Małyszczak 2013, 201–209). Depression has also been linked to somatic manifestations, including persistent fatigue, weight changes, circulatory and digestive disturbances, sleep disorders, headaches, muscle pain, and dryness of the mucous membranes (Cierpiałkowska 2021, 244–247). Patients frequently assume that pharmacological or psychological interventions will not improve their condition and consequently imagine the future as a period of suffering and loneliness. Although awareness of illness may increase during hospitalisation, the fundamental problem often persists: a low perception of treatment efficacy (Kociuba 2020, 234–245).

Conversely, at the opposite end of the mood-disorder spectrum are conditions characterised by excessive agitation and elevated mood. According to the DSM-5 framework, manic and hypomanic episodes differ in duration and severity. Core symptoms include inflated self-esteem or grandiosity, increased psychomotor activity, decreased need for sleep, and pressured speech. Patients may also experience an intensified sense of purpose, an urgent need to correct perceived irregularities, or a sense of mission to promote significant values. In diagnosis, careful differentiation is required between manic states, substance-induced conditions, and psychotic disorders. Although these are classified as distinct entities, psychotic symptoms may occur in the course of other psychiatric conditions (Łojko, Suwalska, and Rybakowski 2014, 245–260; Morrison 2023, 108–215).

The most prevalent condition involving recurrent episodes of elevated mood is bipolar disorder. Other, less frequent and less structured forms of affective dysfunction may also occur. Disorders accompanied by elevated mood appear less frequently than conditions characterised primarily by depressed mood. In these cases, motivation for therapy may likewise be diminished because

treatment can be perceived as interrupting the patient's sense of uniqueness, vocation, or mission (Morrison 2023, 108–126).

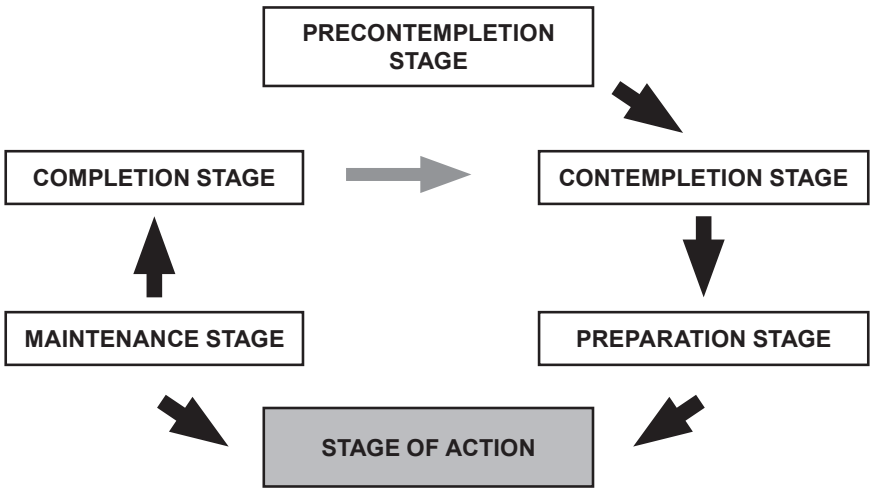
2. Model of health behaviour change

In common usage, health is often understood as the absence of symptoms associated with disease or infirmity. It is also treated as a fundamental good and is therefore placed high in the hierarchy of values. This valuation is reflected in everyday language and in recurrent expressions of the wish for good health (Obodyńska 2015, 148–154). In the salutogenic approach associated with Aaron Antonovsky, however, health is understood as a lifelong process. From this perspective, health-promoting practices that help individuals maintain the balance necessary to reduce stress and function well are of primary importance. A critical factor is personal commitment to attitudes that facilitate such balance. This commitment is related to a sense of agency and a genuine opportunity to influence one's health (Eriksson 2016, 91–96; Piotrowicz and Cianciara 2011, 521–527).

As early as 1974, Marc Lalonde's report indicated that a substantial proportion of health determinants are related to lifestyle. Environmental and biological factors also play an important role, whereas medical care accounts for a smaller share of overall health outcomes. Lalonde's work marked a significant shift in thinking about health policy and health promotion, emphasising education and healthy lifestyles rather than limiting the health system to the treatment of illness (Woźniak-Holecka 2012, 11–12). The validity of these assumptions was confirmed by twentieth-century changes in public health, including progress in the control of infectious diseases and a decline in mortality from cardiovascular disease in many populations (Piwowarska 2023).

Awareness of the risks and benefits associated with particular behaviours is essential but insufficient to producing lifestyle change. Consequently, various models have been developed to describe the stages required for cultivating and consolidating pro-health attitudes. Among them, the Transtheoretical Model of Behaviour Change (TTM) has received wide scholarly attention. The model emerged in the late 1970s and early 1980s and is associated with James O. Prochaska and Carlo C. DiClemente. It is grounded in assumptions from cognitive and behavioural psychology and may support the development of pro-health attitudes in clinical settings and individual practice (Prochaska, Norcross, and DiClemente 2007, 87–114; Sęk 2000, 17–34). The model consists of six stages:

1. Precontemplation — the person rejects health-related recommendations because the problem is not perceived as personally relevant.
2. Contemplation — an initial intention to change risky behaviours in the coming months is present; potential health risks are recognised, but willpower remains insufficient, which may cause frustration and reduce motivation.
3. Preparation — a concrete plan to change attitudes or behaviours in the near future exists; motivation is sufficient to begin change, but confidence in long-term effects remains limited.
4. Action — behavioural changes are initiated and become visible to others, but the risk of relapse remains high; therefore, social support is important.
5. Maintenance — this stage is generally assumed to occur approximately six months after the beginning of behavioural change, and the primary task is to prevent relapse into maladaptive attitudes; environmental support remains important.
6. Termination — the behavioural change is permanent and constitutes a stable component of everyday functioning, forming a new lifestyle; for many people, this stage remains idealised and difficult to attain (Prochaska, Norcross, and DiClemente 2007).



The Stage-Based Model of Behaviour Change. Based on James O. Prochaska, John C. Norcross, and Carlo C. DiClemente, *Changing for Good* (New York: Avon Books, 2007).

Many patients diagnosed with mood disorders may remain in the precontemplation stage, and even traumatic experiences such as suicide attempts do not necessarily change this attitude. Nevertheless, sustained engagement in therapeutic interventions can produce positive health outcomes within weeks. A critical component of treatment is the patient's personal conviction that treatment is worthwhile and that habits acquired during therapy should be maintained. The role of spiritual care providers is to support and accompany patients at each stage of medical treatment, including preparation, action, and maintenance. In the final phase, after discharge and return home, contact with a priest or other spiritual care provider outside the facility may be necessary (Sieroń 2021, 568–583).

3. Spiritual domains of influence on motivation for therapy

Personal involvement in a relationship with God may support the formation of motivation for treatment (the precontemplation and contemplation stages) or the maintenance of such motivation (the maintenance stage). It therefore affects spiritual well-being rather than functioning merely as a health-promoting measure. The therapeutic process thus acquires a spiritual dimension and is not reducible to the somatic dimension. The relationship between these domains is expressed in the ancient ecclesial principle *salus animarum suprema lex* ('the salvation of souls is the supreme law'), in which the noun *salus* may refer both to health and to salvation. The following arguments may help motivate individuals affected by mood disorders to seek and continue treatment.

3.1. Personal effort *toward* mature religiosity

Mature religiosity or spirituality is generally considered an important factor in healing. This is also true for patients with mood disorders (Jastrzębski 2023, 114). In the absence of maturity, however, faith may fail to support treatment and may even hinder it (Bukalski 2019, 57–79). One prevalent form of religious immaturity is the use of faith as a defence mechanism, commonly described as 'spiritual bypassing' (Jastrzębski 2022, 157–172).

Research on religiosity also points to the trend of pentecostalisation, understood as the adoption of Pentecostal beliefs and practices within traditional Christian denominations, including Catholicism. One of its more dangerous expressions in the field of mental health is a magical approach to religious

practice, in which attention shifts from the individual's relationship with God to the performance of specific ritual procedures. Such an approach can foster a distorted image of God and the expectation that God will intervene coercively as a consequence of a particular prayer or devotional practice (Barth 2015, 39–55). Therefore, patients with mood disorders should be offered a theologically sound understanding of grace: grace operates within concrete reality while respecting human nature and the patient's personal effort.

Reflection on the mission of Jesus Christ and His contribution to the salvation of humanity can serve as a point of departure for contemplating the reality of Christianity. Such reflection shows that Christianity does not disregard human freedom and requires engagement in the process of development. The sign of the cross, a central Christian symbol, expresses this logic of salvation through suffering and self-giving; its meaning differs markedly from religious images that emphasise serenity or detachment from suffering (Cielecki 2010; Zasuń 2011, 235–252; Skorupka 2017, 133–147).

3.2. The virtue of freedom and the problem of suffering

Freedom is sometimes perceived as constrained by a higher power that determines an individual's circumstances without the possibility of change. In this context, suffering may be interpreted as divinely sanctioned, making resistance appear futile. Many individuals adhere to the erroneous view that God manifests love by inflicting suffering, as suggested by the popular adage, 'Whom the Lord loves, He disciplines.' Marek Dziewiecki has noted an internal inconsistency in this view: it implies that God does not love everyone and simultaneously suggests that He imposes suffering precisely on those whom He loves (Dziewiecki 2012, 11–24). The Old Testament tradition, the actions of Jesus Christ, and subsequent Christian reflection present God primarily as the source of love rather than pain, death, or suffering. Suffering may acquire deeper meaning when endured in the pursuit of spiritual purification or in self-sacrifice for others; however, this must not be interpreted as a divine prohibition against seeking health (Bartoszek 1999, 357–368).

In the New Testament, the Christian understanding of God is centred on the incarnate Son, who offers Himself for humanity. The benevolent intervention of the Divine Word and His willingness to share human suffering are central to Christian belief, with the purpose of redeeming the fallen world. The Son of God reveals suffering as a possible path within salvation history, not as the

purpose of human existence. Human life, although marked by sin, remains the object of God's redemptive care. Jesus' prayer in Gethsemane, in which Christ asks the Father to remove the cup of suffering (Luke 22:42), offers a clear example of an appeal for transformation of one's circumstances. This theme has been examined by major Christian authors across historical periods and has remained important in theological reflection on creation and incarnation, including in the work of Origen and Pope Benedict XVI (Ratzinger/Benedict XVI 2007, 41–42; Szymik 2011, 96–108).

3.3. The concept of bodily resurrection

The symptoms associated with mood disorders include persistent emotional states, prolonged disturbances of affect, and physical manifestations. Research indicates correlations between biochemical balance — including hormonal activity and neurotransmission — and these disorders. While some religious perspectives mistakenly view the physical body as an obstacle to spiritual growth, thereby tending toward dualism, Christianity emphasises the inherent goodness of the body (Jastrzębski 2022, 140). Consequently, appropriate catechesis on the theology of the body and holiness attained through resurrection is important. This theme is central to pastoral reflection on the Assumption of the Blessed Virgin Mary, which affirms the ultimate dignity of human nature and its bodily dimension (Pius XII 1950; Jastrzębski 2022, 140).

The necessity of self-care is among the fundamental characteristics of human beings and follows from the belief that life is a divine gift. Psychologically, it is reflected in the instinct for self-preservation. Theologically, it is connected with the Fifth Commandment of the Decalogue and with the command to love God, one's neighbour, and oneself. It is also exemplified in the attitude of Christ Himself: the Gospels repeatedly present Him as healing people from diverse ailments, prioritising their temporal good, and avoiding threats from those who sought to kill Him (Mazzeo 2017, 211–227; Dąbek 2006, 139–149).

A careful examination of this issue, supplemented by examples from salvation history and references to personal encounters with God among people experiencing disorder, can support the restoration of dignity, which is a prerequisite for therapeutic motivation. Patients should be encouraged to seek confirmation of dignity beyond their distorted self-perception, including in relationships with others and in their theological identity. During mood disorders, a patient's self-image may become distorted, producing either excessively negative

or excessively positive self-evaluation. For believers, the foundation of dignity lies first in baptism, in the doctrine of the human person as the image of God, and in Christ's salvific mission (Trochalski 2018/2019, 145–155).

3.4. Responsibility for the community of the Church

Through baptism, individuals become members of the Church community, a status that has consequences for both temporal and eternal life. The reconstruction of functional relationships in various environments — including the family home, the neighbourhood, the workplace, and interpersonal interactions — signals a return to ordinary functioning in the earthly dimension. This process entails the cultivation of social love, whose source is understood theologically as divine (Sztaba 2011, 27–42).

Participation in society at various levels requires a stance against selfishness, which directly contradicts the essence of love. In contemporary society, marked by widespread narcissistic tendencies, this task has become increasingly important (Jastrzębski 2022, 140). In the encyclical *Deus caritas est*, Pope Benedict XVI characterises this form of love as social and political and shows how it can extend from interpersonal relationships to broader social and international relations.

In this way, relationships are elevated to a more dignified and humane status. Love becomes a norm of conduct, and those who practice it become educators of society (Benedict XVI 2005, 26–30; Perzyński 2021, 223–232). In addition to its social benefits, this attitude can strengthen patients' sense of self-efficacy and agency. A hallmark of many mood disorders is the experience of personal insignificance and incapacity for action. Concrete acts of benevolence may therefore become an important step in overcoming harmful self-perceptions. In this context, a priest may help the patient identify practical ways to exert a constructive influence on the surrounding environment, even through ordinary daily activities.

3.5. Divine Mercy in light of the hiddenness of God

A lack of motivation for action among religious believers suffering from mood disorders is often rooted in a personal belief in condemnation. This is particularly relevant for individuals who have previously committed serious moral wrongs, including abortion, the abandonment of a spouse, neglect of child-rearing responsibilities, causing another person's death, or major theft. In such

cases, the conviction may emerge that justice is the fundamental attribute of God and that salvation is therefore unattainable. Holiness is then perceived as an exclusive quality inaccessible to the average person. An essential component of pastoral care is therefore a comprehensive explanation of divine mercy. Pastoral ministry to individuals with mood disorders should include reflection on the roots of mercy in the Old Testament, the paradigm established by Jesus Christ's actions, and the experience of the communion of saints throughout salvation history.

A significant challenge is to provide spiritual direction that enables individuals to move beyond intellectual acceptance of divine mercy toward an inward and personal relationship with God. Various personal experiences may impede this growth; frequently, an inability to forgive others becomes a barrier to receiving mercy. It is therefore necessary to address the patient's history and the harms the patient has suffered. Healing such memories can dispose the person to experience mercy, imparting not only the supernatural virtue of charity but also openness to perseverance in sanctifying grace (Francis 2022).

Mercy is also connected with the problem of divine hiddenness. A longstanding tradition holds that God is both revealed and hidden — the *Deus absconditus*. This means that although the divine presence remains veiled from direct observation, the light of faith can give rise to the conviction that God acts mercifully on behalf of humanity. In a pastoral or therapeutic context, this may involve helping the patient cooperate with grace in recalling instances of divine mercy in his or her own life. The aim is to free the individual from the false perception of being abandoned by God or excluded from God's redemptive plan (Hołda 2020, 65–78).

3.6. Mental clarity as a path to mature religiosity

The final area of pastoral support for individuals diagnosed with mood disorders concerns a holistic understanding of the human person. Many patients affected by these conditions may assume that spiritual development and the cultivation of faith are the only matters of real importance (Jastrzębski 2022, 144). In making this assumption, however, they often overlook the unity of body, mind, and soul, already noted in the argument concerning the dignity of the human body. The objective is therefore to demonstrate the interrelation and mutual influence of these three dimensions and to connect them with the quality of human functioning. The classical maxim of a sound mind in a sound body may serve

as a useful motivation for seeking therapy, provided that therapeutic intervention is presented not merely as a means of enhancing physical well-being but also as a support for spiritual health.

A substantial body of research suggests a correlation between mood disorders, particularly depression, and a pessimistic image of God, as well as a diminished intensity of spiritual experience (Jastrzębski 2023, 148–149). Spiritual care providers can help articulate the connection between the physical, psychological, and spiritual dimensions of life. They may also propose that improved well-being is significant for developing a personal relationship with God. This claim is supported by studies showing correlations between mental agility and physical functioning, particularly in late adulthood (Czarnecki et al. 2023, 175–179).

This line of argument is deeply theological. Sobriety — understood not only as freedom from psychoactive substances but also as a disposition of attentiveness and readiness to discern the surrounding world — has been regarded as a fundamental virtue since the beginning of Christianity. The Apostle Peter exhorts believers: 'Be alert and of sober mind. Your enemy the devil prowls around like a roaring lion looking for someone to devour. Resist him, standing firm in the faith, because you know that the family of believers throughout the world is undergoing the same kind of sufferings' (1 Peter 5:8–9; The New Jerusalem Bible 1985). The early Church identified the absence of vigilance (*nepsis*) as a grave spiritual danger, because a wandering mind may lose the capacity for discernment and mistake an apparent good for spiritual truth. Confronted with the emergence of diverse religious movements, the Church Fathers warned the faithful against such deceptions. In the contemporary era, believers are continually confronted with moral dilemmas and the risk of misguided decisions. Therefore, spiritual sobriety and presence of mind are prerequisites for a mature and discerning experience of faith (Clement of Alexandria; MacIntyre 1996, 37–42).

Conclusions

In the contemporary world, marked by material culture, there is a growing tendency to neglect the spiritual dimension of human existence. Despite major advances in medicine and the emergence of new therapeutic modalities, the question of the meaning of life often remains insufficiently addressed. This omission

may be especially problematic for patients experiencing profound existential distress. Spiritual care personnel, as illustrated by the Polish context of priests working in mental health institutions, can assist patients in developing a mature spiritual interpretation of their mental disorders that also takes account of the physical and psychological dimensions of well-being. Accordingly, the therapeutic process can be enriched by spiritual interventions that facilitate the spiritual growth of believing patients and strengthen their pursuit of holiness.

Spiritual care providers can promote the restoration of dignity and support an honest confrontation with oneself. Moreover, mood disorders may coexist with religious delusions, including convictions of absolute condemnation or, conversely, a perceived divine mandate to undertake specific actions (Niesporek 2016, 245–266; Poniatowska-Leszczyńska and Małyszczak 2013, 201–209; Wąchol 2023, 153–166). It is therefore imperative to cultivate mature faith in patients, since such maturity can contribute to the integrity and effectiveness of the therapeutic process as a whole.

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