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Apparitions and Possessions as Boundary Objects

An Exploration into Some Tensions Between Mental Health Care and Pastoral Care

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Abstract Apparitions and possessions can be taken as genuine spiritual events or as symptoms of psychopathology. We focus upon occasions when the two seemingly conflicting "interpretations" co-exist in order to explore these phenomena as kinds of boundary objects—polymorphous realities stable and graspable enough, yet belonging to different worlds at once. Related diagnostic knowledge is often uncertain and always incomplete. Yet it enables authoritative and effective professional interventions. We conclude by discussing the relevance of such a view for contemporary efforts to validate patients' spiritual experiences within mental health care.

Keywords Psychopathology · Spirituality · Ambivalence · Boundary objects

Introduction

Having an apparition of the Virgin Mary, hearing the voice of God, or being possessed by demons are ambiguous phenomena. They can be taken as extraordinary, strong, and often controversial forms of (Christian) religiosity. As supernatural phenomena or spiritual experiences, usually subjectively intense and personally significant, they seem to be relatively rare and difficult to be shared with or accepted by the others—at least in the authors' modern Western culture. They provoke great interest, but also doubts and skepticism. At the same time, however, similar experiences quite often are not viewed as spiritual phenomena or events, but as symptoms of mental illnesses or other pathologies.

In other words, these phenomena belong to two different worlds—that of modern medicine and mental health on one hand, and that of pastoral care and religious life on the other. The two worlds imply two perspectives, often contradicting each other. If the reported experience turns out to be qualified as a symptom of mental illness, it is disqualified—by definition—as a genuine spiritual event. If something becomes a symptom of

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disease, it hardly can simultaneously keep its spiritual meaning. That is, for instance, why church commissions, charged with the difficult task of determining whether an apparition is to be recognized as true, rely, among others, on the expertise of psychiatrists. That is also why appointed exorcists and other priests should consult with medical experts and proceed only very carefully, not to mistake mental illness for demonic possession or oppression. Alternatively, if an experience is accepted as a legitimate part of religious life, it seems difficult or precarious to declare it as merely a symptom of pathology.

In particular cases, it sometimes seems relatively obvious to participants how things are—whether they are facing a clear delusion or some spiritual reality. Other times, it is hard to tell. Anyway, however, it requires some work to make it clear. Having knowledge, including the expert knowledge science affords, is always an achievement (Berger and Luckmann 1967; Bloor 1991).

We focus upon phenomena such as apparitions or possessions in order to better understand their ambivalent existence as practical and social achievements, rooted in two specific "expert" settings and having "more than one identity to negotiate" (Bowker and Star 1999, p. 302). We study situations, in which doctors, priests, clients, and patients, worshippers and unbelievers, their relatives and friends, journalists, scientists, and theologians have to deal with practical questions such as: is this a true or false apparition? Was it the voice of the Virgin Mary or a manifestation of pathology? Are we facing a demonic possession or a psychomotor hallucination? Is it an act of deep devoutness or a sign of a neurotic disease? It is not our intention to decide on behalf of our subjects to solve these important questions. We are not interested here in "how things really are". Not directly. Rather, we want to analytically describe how this or that (spiritual event or medical symptom) is *made real* by the situated practices and interactions of participants; how pathology or spirituality is performed, enacted, produced or, if you wish, constructed.

Our empirical data has come mostly from the Czech Republic and the Slovak Republic (Central Europe). We interviewed mental health professionals and patients, catholic priests, and believers. We also analyzed local media and did ethnographic fieldwork as part of our research. Within the European context, which seems rather exceptional from the global perspective on religiousness (Davie 2001), the two countries—formerly known as Czechoslovakia—represent a telling example of European diversity. While the Czech Republic is sometimes called the most secularized country in Europe, at least in terms of institutionalized religion (Nešpor 2004), Slovakia traditionally has the reputation of a relatively religious, mainly catholic country (e.g., Lužný and Navrátilová 2001). Also, the role of science and expertise in public life seems rather specific in post-communist countries (Konopásek 2006; Konopásek et al. 2008). Yet our main focus is not comparative. Although we do believe that the cases we analyze should always be studied within their unique local contexts, our principal aim is to be found elsewhere than in an identification and discussion of some characteristic national features.

Our inquiry falls within the broad and diverse field of contemporary science and technology studies (STS) and related sociological traditions. We focus on knowledge in the making, on unsettled controversies, attempting to offer a symmetrical description of incommensurable positions and of various practical means by which closure is reached on the disputed matters (Collins 1983). Also, our study is close to ethnomethodology (Garfinkel 1967, 2002; Lynch 1997), and its emphasis on how actions and situations are made accountable (observable-and-reportable) by social actors, and thus how order is (re)produced in practical ordinary situations.

Participants' "knowing of how things are" is not, of course, a matter of following formal epistemic rules or pure logic. Rather, it is always embedded in some epistemic

culture (Knorr-Cetina 1991, 1999)—or, in our particular case, in the epistemic cultures of psychiatry and pastoral care. Making decisions about what the reported event or experience really is cannot be separated from wider medical and pastoral contexts and practical actions.

In this paper, we would like to develop the argument about the pragmatic quality of epistemic rules and claims by discussing specific cases or instances, in which medical and spiritual realities are not mutually exclusive and incommensurable (as might be presupposed), but rather co-existing and non-exclusive. Such cases make evident that knowing whether the person is talking about a true religious experience or reporting a delusion is not some precondition for further action, but already an output of particular medical treatment or pastoral work. And even more. We will see how professionals from both fields can pursue their actions, in particular cases, *without knowing* how it really is and even *without taking such knowledge as essential*.

Knowing with Certainty

Before looking at the cases that are characteristic by their ambivalence and uncertainty, let us briefly discuss the nature and qualities of "knowing with certainty". This would provide a context for better understanding our main points that are to come later.

How can one be sure about a thing—about what it is? How it happens that a "doctor can recognize mental illness, even if it is manifesting itself through the religious content" (Kašparů 2002, p. 79)? What makes a priest firmly convinced that a person telling him about a supernatural encounter did not have a real apparition (and that it was a matter of mere imagination or even mental illness)?

Sociologists have spent a lot of effort to show various *collective practices* of making things certain. Knowledge- or fact-making is understood by them in terms of complex achievements that cannot be reduced to following formal cognitive or epistemological rules. This applies not only to everyday lay knowledge, but also to various kinds of expertise, including medical expertise.

Ethnomethodological studies of medical consultations, for instance, show the diagnostic process (ideally resulting in strong, reliable, and authoritative diagnostic statements, widely respectable and usable in medical practice) as a rather subtle, interactive achievement. A diagnosis does not simply come out of the doctor's critical mind, comparing observed or reported symptoms with standardized categories of a diagnostic manual, but is negotiated with the patient (Drew 2001; Pomerantz 1984a, b; Maynard 2004).

STS have developed such a perspective even further, emphasizing the heterogeneity and scope of these negotiations (Berg and Mol 1998; Palladino 2002; Mol 2002; Berg 1997; Timmermans and Berg 2003). Besides everyday routines and interpersonal speech acts, many other things turn out to be relevant for the diagnostic process: organizational settings, computer software, possibilities to visualize, cultures of paperwork, and accounting.

In his study preceding our current research, Paleček (2004) describes the complexity and habitual nature of standard diagnostic practices in psychiatry. He shows, for instance, how the diagnostic evidences are often and routinely derived not from symptoms of illness as such but rather from circumstances of preceding psychiatric intervention. The examining mental health professionals, trying to identify and categorize the nature of problems, regularly ask patients about their previous hospitalizations and medications prescribed—and these answers are often taken as crucial keys for the final diagnosis. Simply put, to be a "chronic schizophrenic" sometimes means having been repeatedly hospitalized, taking

specific medications and being given electroconvulsive therapy. The ascribed diagnosis has not only a cognitive, but also an administrative value: related therapeutic sessions can be paid from health insurance. Precisely with reference to all these conditions, we can understand the diagnostic process as part of a (psychiatric) "epistemic culture".

Our current fieldwork offers a number of similar examples. Let us take, for instance, a story told by a psychiatrist, in which her "knowing with certainty" is constituted, in an important way, by the effectiveness of medical treatment.

> Psychiatrist M: "She ((the woman who thought she was possessed)) started feeling that the devil made her body moving and spoke through her mouth. She started to emit ((laughing)) bizarre sounds, sort of squawks. And the priest was charismatic and believed in her interpretation, he believed that what was happening with her, that she emitted so strange squawks, these strange movements—which is called psychomotoric hallucinations—he believed it was possession, so ((laughing)) he started treating her by confessions and Eucharists. He spent almost three days with her. Most of the time in the church, praying for her. He was praying unceasingly, while the problems were rising. (…) And after some time he got exhausted, as much as the woman. Somebody told him about me as a believing psychiatrist, so he gave me a call. And said: "I have a possessed woman here" ((laughing)), asking if he could come to see me with her ((laughing)). And he described in a few words what was happening and I told him "ok, get her to me" ((laughing)). It was not easy for him to convince her, but they really arrived to my home, it took them entire day, because both of them were still tempted to believe that it was a spiritual matter and that it was a sin to give it a psychiatric label, you see ((laughing)). So they came and I have to say that within an hour after she had been given antipsychotics, Risperidon, she calmed down. And within two days all the symptoms completely disappeared. It was a kind of short-term schizophrenic psychosis. And then she was quickly able to competently describe what had been happening with her, to separate the psychotic, the pathological, from what was normal. And she is ((now)) completely well. She currently does not suffer from any disease. During the subsequent years, she repeatedly dropped in to see me, to make me sure that she was good." (emphasis ours)

The sheer effectiveness of medications is emphasized here, among others, by means of contrasting the 3 days of praying in vain with not even 1 h of Risperidon's successful work. The recovery was not only fast, but also complete and attested by the patient. The diagnosis is construed as clear and decisive through this account of strikingly successful medication. Professional routine plays an important role here. A few words by which the priest described the situation were enough for the psychiatrist to immediately and at a distance see that some psychopathology was involved. Diagnostic decisions can be made quickly and easily, if everything seems to be fitting into previous, well-established professional experience. In such circumstances, textbook definitions seem less important than practice-based knowledge of countless cases, types of which psychiatrist gradually learn to recognize (Luhrman 2000). Illness can immediately be *seen* with such knowledge.

According to textbooks, it may seem that "knowing with certainty" what the condition of the patient is means having a good knowledge of definitions contained in diagnostic manuals and applying this knowledge to real-life cases. In practice, however, being able to tell the pathological from the normal (or supernatural) is something much more complicated, and inseparable from treatment practices. An individual professional's "seeing" of non-pathology can be studied as something established through repeated experience of

similar cases, webs of professional routines, privileged practices of specific psychiatric facilities, written records, observable effects of medications, etc.

The field of pastoral work and the problem of "diagnosing" miracles, of differentiating authentic revealed truths from non-authentic and false ones, have been much less subjected to this kind of sociological investigation. Yet we can suppose that the situation would be pretty much the same. Our interviewees engaged in pastoral work often indicate or explicitly say that they could, in particular cases, easily and quickly recognize the spiritual from the medical, the truly religious from everything else:

> Researcher: "And what if (…) somebody comes and simply says that… either she is possessed or that she has had unusual religious experiences … ((such as)) hearing voices that="
>
> Pastor S: "=So I clearly say it is a delusion. A woman from B. recently came to see me. She told me she had had a stunning apparition of Jesus: Jesus Christ was sitting on a kitchen desk during her cooking at home, dangling his legs like this ((laughing)). And he was writing down all what she was saying… Well, I did not ridicule her. I only told her: "You know, I think Jesus Christ wouldn't sit in your kitchen asking questions such as 'Do you eat carrots?'". So this was a clear delusion. There are countless such delusions, hallucinations and illusions."

Or another example, a more general statement:

> Pastor N (about the work of exorcists): "If it is a clear possession, then you can tell. He ((the exorcist)) can tell. As exorcist, he can see it. He feels it is there."

Without any ambition to analyze here the complicated way in which such certainty is achieved, we can note that being sure about how things are is deeply rooted in the culture of pastoral work—in its organizational settings, political contexts (Halemba 2008), specific professional experiences, diverse theological conceptions, and personal preferences related to "pastoral governance" in the parish. Perhaps the only difference from the situation in the field of mental health care is that priests are only very rarely confronted with "positive cases", i.e., with apparitions or possessions more generally recognized as true.

Let us now shift our attention to other cases—the relatively frequent cases of spiritual/medical phenomena, in which one does *not* know with certainty.

Living with Ambivalence

The cases or situations of not knowing with certainty refer, on a general level, to the idea of "living with ambivalence" (Bauman 1991). Uncertainties and ambivalences are, according to many authors, constitutive features of contemporary advanced societies. Their manifestations, however, go hand in hand with increasing pressures on certainty, reliable classifications, and control. Modern medicine (and perhaps contemporary pastoral practice too) is a nice example of this tension.

Let us start with one important clarification. The ambivalent cases, resisting the either-or logic, are not different or interesting because of being handled in some less "rational" and more "cultural" ways than other cases. As we have just seen in the preceding section, even "knowing with certainty" can be studied as practical and collective achievement, as a result of doing many more things than just following some formal epistemic rules. Handling ambivalent cases that resist simple and unambiguous classifications thus belongs to

the same epistemic culture as making quick, reliable, and clear-cut diagnoses, as immediate "seeing" of how things are.

Routine knowing with certainty is very frequent. But situations characterized by certain openness and undecidability are rather common too. In the field of mental health care, a sort of undecidability necessarily is part of the therapeutic relationship. This relationship is commonly based on the therapist's empathy associated with acceptance of the patient experience (Mahrer 1997). A kind of "belief" in what the client says is practically enacted, no matter how strange it may sound. Even the overall framing of a patients experience in medical terms and understanding them as psychopathological does not prevent psychotherapists from taking patients' views seriously.

This commonplace therapeutic strategy can be observed in most of our cases, when people with "weird" spiritual/religious experiences are treated as psychiatric patients. However, these cases also make evident that the above-mentioned ambivalence is not only a matter of instrumentally and conventionally established mutual "therapeutic trust". Keeping both spiritual and pathological versions conceivable during psychotherapy may, for instance, untie therapist's hands for using certain therapeutic techniques.

Let us take the following case (reported to us by a psychiatrist from a community crisis team) to develop this point. A client came to the psychiatrist because he had felt the presence of the Devil when reading Holy Scripture. The client had aggressive compulsions to kill somebody and, consequently, he felt guilty and was thinking about killing himself rather than somebody else. When asked about the two possible views of the patient's problem, that of mental illness and that of the Devil interfering in the client's life, the psychiatrist explains:

> Psychiatrist P: "Well, I think that I rather did not respect the Devil in this case ((as the Devil)). I categorized it as part of the illness… I somewhat tried working with it ((the Devil)) in a symbolic way—I mean to what extent the Devil can influence his life and to what extent he can exist independently of the Devil and so on." (And she further develops the point.) "I say ((to him)) that it evidently is an illness, that I would consider it as illness, you know, but also… I mean that I did in a way accept his way of experiencing it and I also tried to think ((with him)) in what ways he could be strong and resistant enough to stand up to the Devil, you know? (…) So the Devil had ((in the therapeutic process)) a rather beneficial externalizing function."

Working with the notion of the Devil on a symbolic level apparently does not mean, for the therapist, accepting the Devil as a real religious entity (as if interpreting the Devil symbolically was something alien to theology or Christian life and reserved only for profane purposes). Here, the therapist unobtrusively uncouples her therapeutic contexts of use from the contexts of spirituality. She declares and explains that her approach is essentially medical, be it in a specific way, in which the Devil does play a role.

In fact, the Devil's symbolic role in this case is perfectly compatible with standard therapeutic procedures. Why? Speaking about the Devil with the patient, the therapist constitutes the source of aggressive compulsions outside of himself. The compulsions of the patient thus need not be taken by him as a part of his mind or personality, but rather as extrinsic interferences that can be more or less resisted. In such a situation, it is easier for the patient to accept himself and to mobilize, with the help of the therapist, his own self for the struggle against something that can be fought. Such a strategy is fully conforming to what psychiatrists often aim at when they guide the patient to gain the fundamental insight that it is a treatable illness (and not him or herself) that is responsible for his or her mental suffering. The psychiatrist's interpretation of what the patient is saying about the Devil

therefore is a reasonable alternative to the therapeutic technique known as externalization, which constitutes the source of the problem outside of the patient's self (Epston and White 1990; Tomm 1989).

While from the therapist's point of view the references to the Devil may seem purely instrumental, the situation gets more complicated from a less subjective perspective. From a more "sociological" point of view, the interactive construction of what we take as "real" can be appreciated. Let us note: by preserving and *practically using* the patient's reference to the Devil, the psychiatrist keeps doing her therapy, while the patient seems to keep (with the active contribution from the therapist) the spiritual/religious content of his suffering. Regardless of what both sides of the therapeutic interaction think or are convinced of, the interactive construction of reality remains indecisive as far as the question of "what the patient's experience is" is concerned. Both the patient and the therapist practically proceed together without any definite shared closure and even without any need for such shared closure. They *act together as if* the reality they are creating together could have derived from either or both of them.

The situated use of ambivalence in therapy, transcending the usual "therapeutic trust", brings us to another example. It is a case of a Jungian psychologist and his client. The psychotherapist is known among his colleagues in a day clinic for his sensitivity toward spiritual issues. One day, he was asked by his colleague, a psychiatrist, to take care of a young man suffering from a strange religious-like experience.

This man reported that he had been visited by the Lord Jesus Christ in the confinement of a psychiatric hospital. During this religious encounter, Jesus turned his sight away from the man, in a way which seemed significant. Since that moment, the client was convinced he had been damned forever by Jesus Christ—irreparably, without any possibility of salvation. Something like this does not really correspond to the Christian theological vision of who Jesus as the Christ: he would not damn anybody, he is merciful. It was therefore hard to believe in the authenticity of this encounter not only for agnostic relatives and friends of the client, but also for Christians. The psychiatrist from the same clinic who also was taking care of the client and prescribed some medications to him was clearly dismissive too. For him, the patient was suffering from a schizophrenic delusion. But the patient, deprived of all energy, feeling no joy, no pain, lifeless, frustrated by not being taken seriously even by his family, repeatedly insisted: he suffered from Jesus' eternal damnation. He talked about the experience of damnation again and again. The only person accepting his experience in his own terms was the psychotherapist. He explained to us:

> Psychotherapist M: "I do not care if it is schizophrenia or not. I do not care about whether he has been damned or not. The crucial thing for me is what he needs. Or what I think he needs. And my conviction about what he needs is being confirmed by his responses—if I proceed accordingly. So I believe he needs acceptance. I have it that he simply needs that somebody would accept what happened to him and think it through with him. Instead of arguing with him all the time ((about the nature of his experience)). Thus, I offer him a space for acceptance and reflection. I also think that he needs (…) to get to some symbolic meaning of what happened to him. The atmosphere of not being accepted did not allow him to understand, in a symbolic way, what happened. Because you cannot give an unambiguous meaning to symbols. And when he was refused, he was forced, in fact, to think about his experience in a clear-cut way. So when I ask him what everything it could mean ((that Jesus Christ turned his sight away)), what contexts it could have had, I am broadening a space for him to approach the event in a symbolic way."

We would like to make two observations on this case. First, therapeutic attitudes of this mental health professional are more radical and more consciously developed than the attitude of the psychiatrist from the previous example. As such, they reveal some practical consequences of the lack of certainty in our knowledge especially clearly. Second, this case nicely illustrates the complicated issue of "naming things with (the right) words". As already indicated, together with the question "does it matter what it really is?" we also have to pay attention to a slightly different question: "does it matter what we call it?"

Not unlike the example above, here too the client's needs are more important than the question of what nature of his experience "really" is. But now the client's definition of the situation is accepted even more strongly. The more "it does not matter" (what it really was) for the therapist, the more the experience can be accepted and discussed in the client's terms. Yet, again, accepting what his client says does not prevent the therapist from keeping his specific professional perspective. The therapist does not reject the psychiatric diagnosis that had been ascribed to his client during the diagnostic process as something wrong:

> Therapist M: "I am accepting both his damnation and his schizophrenic diagnosis, because it is in fact the same (…). For me it is in fact the same. Or better, the damnation and the diagnosis are two different markers for the same thing, in two different frames of interpretation."

In this ambivalent situation, in which "damnation" and "schizophrenia" seem to be just two words for the same thing, potential abrasive surfaces are reduced in a remarkable way. The therapist takes very seriously (although still rather instrumentally) the religious/spiritual content of the client's experience, and he even tries, as we will see later, to encourage the client's family to be similarly accepting. However, while debating the case with his colleagues, the medical discourse remains readily at hand. When talking "medically", the therapist need not openly dispute the reality of damnation, since he can use the word "schizophrenia" as synonymous. "Damnation" may refer, in such a context, to the client's subjective reality. Such an account smoothly fits into the rules of conventional psychiatric discourse as well as obligatory medical documentation. Although the therapist takes the problem of damnation during the therapy as a real spiritual problem, he need not necessarily classify his work as sessions with a damned person. For the purpose of official medical records, he describes his therapy in appropriate medical terms. He has to—otherwise, it would not be paid by the insurance company.

It is relatively easy for the therapist to keep both vocabularies at play, since—as he explained to us—words do not matter for him… Or do they? Let us consider the following episode. The client asked the therapist to explain to his girlfriend and his mother that they should not take him as mentally ill. And here is an account of how the therapist argued during the subsequent meeting with the girlfriend and mother:

> Therapist M: "I asked them first whether they believed he experienced life as 'empty'. Whether they believed he had no desire to live, no motivation for action, as he had repeatedly claimed. Simply, whether they believed in what he experienced. And here we were in agreement. They believed in all these things and so did I. Thus it was the first thing we could build on. And then I continued by suggesting that all that was happening to him, what he was experiencing, was simply evident, no matter how we call it."

This is a significant moment: i.e., why the therapist emphasizes "no matter how we call it"? It is, paradoxically, not because words or names are irrelevant here. On the contrary,

the therapist's suggestion indicates, in fact, how much words, by which we call things and events, *do matter*. By insisting upon the unimportance of how the client's condition is called, he is *asking* his mother and girlfriend *to use words with greatest care*, i.e., not to name it schizophrenia. It is simply important for the client and for the entire therapeutic effort that proper words are used.

So we have a seemingly paradoxical observation here: Only if words, by which we call and grasp clients' conditions, are handled with the greatest of care, it can also be said that it does not really matter how these conditions are called. In fact, it is precisely the therapist's sensitivity toward the subtleties of language use and toward the performative force of naming things that enables him to make effective therapeutic use of undecidability and uncertainty.

During our next interview, a couple of months later, the therapist told us about what happened with the client. The young man recovered, somehow. His recovery, interestingly enough, is described by the therapist neither in terms of his client's mental state, nor in terms of successful therapeutic intervention. The client simply started working again and established new relationships. What happened? Probably encouraged by the therapist's "accepting approach" (or rather by therapeutical openness toward the religious nature of his experience), the man started visiting a priest and preparing himself for baptism, which he gradually began seeing as a chance for himself. By being baptized, he got redeemed and found relief, in a way. Actually, the therapist himself proposed to stop the therapy at that point, given the client stopped talking about serious difficulties; instead, he started dedicatedly and ceaselessly narrating about his salvation. The theme of damnation, so frequently recounted up to this moment, turned into its opposite. Although the therapist interpreted this reversal, or what Jung would call an *enantiodromia*, as a possible manifestation of pathological psychic structures, he did not try to further elaborate the condition in psychopathological terms. The subjectively perceived suffering disappeared, and even the social life of the client significantly improved. The client was obviously not a "living dead" anymore. A kind of recovery occurred. Who is responsible for this recovery? Is it God? The act of baptism? The newly found religious community? The therapist, after all? Or the client himself? It is difficult to tell exactly in an unambiguous way.

It is interesting for us that the client's new condition seems to have been brought about, in an important respect, by the intricate therapeutic strategy, in which the question "what is the real nature of the problem" was kept relatively open, undecided. This openness cannot be understood, as we tried to show, as a result of resignation from further action. It was not associated with doing nothing or with not knowing enough. Rather, the openness was implied in a pragmatic approach, in the frame of which it was more important to carefully ask *what to do/what it does* (and with what consequences) rather than *what it is*.

In the preceding paragraphs, the two stories from psychiatric/psychotherapeutic settings were used as examples of how epistemic undecidability is not eliminated, but rather maintained and used. Indeed, we could find similar examples in the field of pastoral work too. Although one might expect a strong emphasis, among religious leaders and church authorities, on spiritual authenticity and on distinguishing religious truths from false beliefs or delusions, a kind of pragmatic approach described above can be found even here. One of the interviewed priests said about the famous site of the Virgin Mary's apparition in Medjugorje in Bosnia and Herzegovina (see Claverie 2003, for an anthropological study of this case):

Pastor G: "… it does not matter whether Virgin Mary really appeared there in 1981 and whether she still manifests Herself to pilgrims today… but note, the fruit of it! The fruit is there. That is essential."

For this priest, the site is special not so much by reported events of apparitions themselves (which have not been approved by the Church to date and remain controversial), but rather because it is the story of The Virgin's appearance at what has now become a sacred space for many has penetrated the piety and prayers of countless visitors who make the pilgrimage to see the place. Similarly, the priest from Litmanova, a small, mostly Greek-Catholic village in eastern Slovakia where two young girls saw the Virgin Mary (and communicated with her) in 1990–1995, told us:

Pastor D: "I am often asked by journalists whether I believe it ((the apparition)) or not. But, you know, it remains rather open for me. And I have no need to close it in any way. (…) I do not have problem with people coming here. Our task, as clergy, is simple: to provide them with communion and confession. That's it. Just these two things. It is better if we do this than ignoring it entirely. This way we can at least have some control over these events and provide the believers the basic service." (paraphrased, not recorded)

Again, it is irrelevant, in a way, what the event really was—whether it was a genuine, authentic apparition or not. After all, it is hard to say. There are different opinions about the events, representing various perspectives. An official verdict of the Church is still on the way and perhaps it may never come. But as pilgrims, convinced that the apparition was true, are coming in thousands, other things than an authoritative answer to the question "what it really was" (in 1990–1995) become important. Having the question open and hesitating to give a definite answer from the side of the Church does not prevent it and lay believers from religious actions and the Virgin Mary from doing her work.

Concluding Remarks

One would think that it is essential for therapeutic or pastoral work to know with certainty the truth about the case. Such diagnostic knowing is often understood as a precondition of any further action. It seems crucial to determine whether the person is ill or not (and then eventually start a cure); or, to decide whether the person experienced a real apparition or suffers from a real demonic possession (and only then eventually start blessing and worshipping or to utilize the ritual of exorcism). But in fact, knowing of any kind does not, strictly speaking, precede practical action, but is, fact, part of it and cannot be separated from it. Our study of controversial and ambivalent cases on the border between pastoral work and medical practice brings further evidence of this and perhaps even brings some new understanding of practices by which the experiences on the border between mental and spiritual problems are coped with, managed and treated.

We suggest that ambivalent cases on the border between spirituality and mental pathology can be usefully understood and practically treated in terms of the concept of "boundary objects". In other words, we present a perspective (documented by examples from therapeutic practice), in which seeing a psychiatric symptom and having recognition of spiritual experience need not refer to mutually exclusive capacities, but rather to a psychospiritual phenomenon, which, however it may subsist in itself, can be seen from multiple perspectives, and thus sustaining identities. We can speak of a *boundary object*.

Boundary objects have been characterized as "both plastic enough to adapt to local needs and constraints,… yet robust enough to maintain a common identity across sites" (Bowker and Star 1999, p. 297). They are not amorphous, but polymorphous entities—depending on the context, on where and when and how we tell the story (see also Law and Mol 1995). If it is sometimes impossible, in principle, to unambiguously tell what these phenomena or objects are, it is not due to some knowledge (preventing further action). On the contrary, it may be a consequence of our fuller and very practical understanding of what they are.

Thus, in our last case, we can follow the psychotherapist M dealing across various sites with "the same thing" all the time—i.e., with the condition characterized by the patient's spiritual vision, by his conviction about the meaning of it, by his fears, helplessness and loneliness, and by his devastated social ties. All these defining qualities remain the same, while the therapist is talking to the patient, to his colleagues, to the client's family, to the insurance company, and even to us, researchers. Yet, however, his client can effectively take it that, with the therapist's support, he is trying to find a solution to Jesus' damnation; members of the psychiatric community and of the therapeutic institution, on the other hand, have no doubt that they discuss and properly treat a patient with schizophrenia. Let us be clear: this is not just a matter of differing subjective interpretations. Rather, the reality of the client's troubles is being interactively enacted from various sides and in various directions, so that it is in simultaneously elaborated (sometimes with overlaps and tensions) both as a quite *real* illness and as a *real* spiritual issue. Although boundary objects represent a relatively frequent and mundane "ontological form", such a development is neither trivial nor effortless. In fact, it was enabled by the therapist's specific style, which unobtrusively builds upon the conventional therapeutic "accepting attitude", while bringing it much further. Such an approach is not commonplace within contemporary psychiatry. And it is not a one-sided matter of professional practice. As noted by Leach et al. (2009, p. 76) it is often clients themselves who believe that issues of psychology and religion should be kept separate and ask for either a psychiatric or pastoral approach, depending upon how they understand the phenomena presented for treatment as well as their own belief systems.

We can see something similar in the afore mentioned case of Marian apparitions in Litmanova. Here too, the space for practical action seems opened up (rather than closed or narrowed) by suspending clear-cut judgments about the nature of the phenomena and by allowing various "truths" of the apparition to operate in parallel (Konopásek and Paleček 2009). Essentialist and pragmatist approaches "peacefully coexist" here, without undermining each other. Both lay people and the Church switch between them seamlessly and frequently. By doing so, they satisfy the need for practical cultivation and strengthening of faith as well as the requirement to cautiously handle such miraculous events in terms of theology. This openness to various truths at once allows the Church to get firmly associated with the respective religious practices and keeps control over the site without any final official conclusion regarding the status of the apparition. Further, this openness also lets thousands of pilgrims come to the site to pray and testify to the power of God, Jesus and the Virgin Mary. Such activities, in turn, validate the religious truth of the apparition, since the (real) spiritual presence of the gracious Virgin Mary and her Son would hardly be manifested without the (real) physical and regular presence of believers.

Let us now illustrate the relevance of this perspective by a few further comments on the relationship between spirituality and psychopathology in contemporary mental health care. This relationship, often embodying the reductionism of institutional psychiatry regarding spiritual phenomena, has been discussed by mental health professionals and other experts for at least the last two decades (see Verhagen et al. 2010, for an overview of topics and

problems). In 1994, the category of "Religious or spiritual problem" was introduced into the American diagnostic manual DSM-IV. David Lukoff, one of the co-authors of this non-pathological diagnostic category, wrote: "(w)e viewed such an addition to the nomenclature as the most effective way to increase the sensitivity of mental health professionals to spiritual issues in therapy" (www.spiritualcompetency.com). We should not overlook, however, that this "way of increasing the sensitivity of mental health professionals" is in fact based on strict differentiation between the pathological and the spiritual. Differential diagnostics is remarkably debated especially in some texts dedicated to the problem of spiritual emergency (Vančura 2002; Lukoff et al. 1998). But the either-or logic is familiar also to general diagnostic manuals. These manuals require careful examination of symptoms in order to distinguish one pathological condition from another. With the introduction of the new diagnostic category "religious or spiritual problem", rigorous diagnostic assessment of clients' experiences is demanded even more: the key task here is to identify genuine spiritual experiences to exempt them from inappropriate treatment within the traditional mental health system. And it is suggested that the newly revised version of DSM would provide even clearer criteria for such distinctions (Lukoff et al. 2010, p. 440).

As noted by Koenig (2000), referring to the work of Larson et al. (1993), the low level of sensitivity toward religious concerns was associated with the fact that in the previous versions of the diagnostic manual religion was overrepresented in psychopathological case examples. Therapists would therefore become more sensitive to religiosity, it was supposed, when spirituality becomes less pathologized. Introduction of the (non-pathological) category "religious or spiritual problem" was regarded as a key step in this direction. Accordingly, Diabasis, the only Czech organization providing services for people undergoing spiritual emergency, explicitly states on its website that its workers do not work with mentally ill people. Spiritual emergency professionals simply try to keep away from the mental health care system, ascribing a complementary role for themselves. In a similar vein, Betty (2005) proposes that demonic possessions should be treated by *non*-psychiatric experts and foresees that in 50 years, it might be clear to psychiatrists "that in some cases it is almost certain that a hostile or mischievous spiritual being causes its victim to hear voices and see images that emanate not from the mind of the victim but from the mind of the spirit" (p. 29). And no doubt, for some it is clear already today (see Peck 1983, 2005).

But our main argument does not refer to clearly classifiable cases and mental/emotional pathological entities about which there is a high level of certainty as to their nosological character. It is more subtle. We point out that the division of labor implied in the above-mentioned efforts focused on the introduction of the new diagnostic category in DSM pushes spiritual issues *out* of mental health care, which may bring paradoxical results: even if some psychiatric patients still talk about God, the Virgin Mary or demons after such differentiation of the pathological from the spiritual, the elaborate differential diagnostics can easily translate such accounts into pure pathology, and perhaps in a more justified way than before.

A stronger impulse for rethinking the relationship between the religious and the psychiatric has been brought about by the more general trend toward cross-cultural dialogue and transcultural psychiatry (Cox 1996; see Gopaul-McNicol 1997, or Martínez-Taboas 1999, for clinical examples). The confrontation of modern psychiatry with non-European spirituality as well as traditional healing systems has inspired some authors to reflect more systematically on this neglected area (see Bhugra 1996; Boehnlein 2000). Although theoretical positions on this topic vary, it is not rare that the logic of rather strict differential diagnostics operates also here. On one hand, Koenig (2000) admits that the boundaries between the two professional realms are necessarily blurred, at least to some extent; on the

other hand, he insists that the limits and boundaries of the respective professions are recognized, so that professionals are able to complement one another, being "aware of each other's strengths and weaknesses" (p. 176). A similar division of labor between pastoral care and medical treatment seems to be implied in the recent WHO report on mental health: "Diverse ways of thinking and behaving across cultures may influence the way mental disorders manifest but are not, of themselves, indicative of a disorder. Thus, culturally determined normal variations must not be labeled mental disorders. Nor can social, religious, or political beliefs be taken as evidence of mental disorder" (WHO 2001, p. 21).

The crucial thing many of these approaches have in common is the following *implicit* assumption: to recognize the relevance of the spiritual in psychiatry is to emphasize it, to clearly show it; and to show it means to show it as *something else* than illness, i.e., as its Other. This produces a paradox. Spiritual issues are recognized as relevant only to be expelled from the realm of psychiatry—instead of being recognized as a "border" part of what the secular discipline of psychiatry has to cope with in a not so reductionist way.

There are authors, nonetheless, whose position is in a way opposite, closer to what we want to emphasize. Dennis L. Bull (2001), for instance, proposes to *integrate* exorcism into psychotherapeutic process. He gives successful examples of "therapeutic exorcism" of clients with dissociative identity disorder, who considered themselves possessed by demons. While psychological dynamics of dissociation remains substantial for Bull, he also claims that expulsion of demons should become a reasonable part of psychotherapy even for non-Christian and non-religious therapists: "exorcism can also be viewed as a cognitive behavioral approach to dealing with patients' distress in a culturally sensitive manner" (Bull 2001, p. 137). The fact that Bull feels the need defend the compatibility of psychotherapy with exorcism indicates, in fact, how uncommon and difficult such an approach still is in contemporary medical work.

Our analysis shows that sensitivity toward spiritual/religious issues *within* institutionalized mental health work may come not from diagnostic certainty but from an opposite direction. Then, it is not based on being certain about the nature of "what the thing is" in itself, but rather on one's ability and willingness to work with ambivalence. In other words, this sensitivity is associated with the ability to work with the controversial phenomena often encountered within psychotherapeutic or pastoral work as boundary objects—i.e., as entities that are contained enough in the therapeutic or pastoral relationship to become increasingly stabilized, yet open enough for therapeutic or pastoral actions that may unfold in various directions as these phenomena become more familiar to both therapst/pastor and patient/parishioner/client.

This is not to say, of course, that differentiation and clarity are unnecessary. We only subscribe to the view, according to which "knowing with certainty" is characteristically not given or acquired in the beginning of therapeutic or pastoral work, as its precondition, but is rather produced along with it, as one of its achievements. The ambiguous cases we discussed in this paper are examples of this. Even if the essences of the phenomena are not of primary importance and remain undecided, essential results may still be socially enacted: clients can recover, in one way or another, with the help of various healing powers, worldly and spiritual; the Virgin Mary can successfully spread her message to the world, while pilgrims clearly feel Her presence and grace. However, having no definite knowledge of how things really are is not necessarily associated with resignation, passivity and inability to act. On the contrary, it may open space for further purposeful action, therapeutic or religious.

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