PARRHÈSIA
Recherches critiques en sante mentale et droit
Critical Research in Mental Health and Law

Mending the Religiosity Gap?Critical Investigation of the Nexus of Religion, Psychiatry and Gender Normalization in Mental Health Services in Poland

Agnieszka Doll, Ph.D.
University of British Columbia, Okanagan
agnieszka.doll@ubc.ca

Braelyn Spruce
University of British Columbia, Okanagan

Abstract

Current psychiatric and public health literature supports the broader involvement of clergy and faith-based organizations in advocacy and service delivery to people with mental illness. It posits that faith, religion, and church communities may provide a source of strength to patients going through and recovering from mental distress. Yet, our article problematizes this general claim by considering the gender-normalizing implications of religious involvement in mental health support services in countries where one religion holds a dominant position. Applying a feminist critical lens and using Poland as an example, we argue that while faith, religion, and church communities may provide a source of strength to patients, it is crucial to recognize that the involvement of institutionalized religion, such as the Catholic Church in Poland, brings with it a profoundly gendered ideology that can shape the meaning of mental illness and recovery from it. Thus, such religious and spiritual interventions need to be carefully considered in relation to the religious, social, and political contexts of a given country.

Keywords

Religion, Psychiatry, Mental distress, Faith-based organizations, Gender normalization, Poland

Résumé

Les écrits scientifiques en psychiatrie et en santé publique reconnaissent l'implication plus large du clergé et des organisations confessionnelles dans la défense et la prestation de services aux personnes atteintes de maladie mentale. Ils postulent que la foi, la religion et les communautés religieuses peuvent constituer une source de force pour les patients vivant de la détresse mentale. Notre article questionne cette affirmation générale en considérant les implications normalisatrices de genre découlant de l'implication religieuse dans les services de soutien en santé mentale dans les pays où la religion occupe une position dominante. En appliquant une perspective critique féministe et en utilisant la Pologne comme exemple, nous soutenons que, bien que la foi, la religion et les communautés religieuses puissent constituer une source de force pour les patients, il est crucial de reconnaître que l'implication de la religion institutionnalisée, comme l'Église catholique en Pologne, apporte avec elle une idéologie profondément genrée qui peut façonner la signification de la maladie mentale et le rétablissement. Ainsi, ces interventions religieuses et spirituelles doivent être soigneusement considérées en relation avec les contextes religieux, sociaux et politiques d'un pays donné.

Mots-clés

Religion, Psychiatrie, Détresse mentale, Organisations confessionnelles, Normalisation de genre, Pologne

Introduction

A leading newspaper in Poland – Rzeczpospolita –reported Polish bishops' concerns about an increased demand for exorcists. Some of them see the need for exorcists as a result of changes to the traditional gender order related to the inflow of so-called Western gender ideologies and the following loss of the moral, aka Catholic, point of reference for the organization of social life. One of the bishops argues that moral relativism found its logical consequence in the problem of Satan's possession (Krzyzak, November 2, 2013). In Genesis, through Eve's transgression, Satan's possession and sin-causing have been already symbolically attached to women. Satan attacks the weakest – the woman and, through them, indirectly destroys the strong – the man. Hence, women are not only presented as sinful but also as potentially causing the trespasses of others (Crawford 2004). Therefore, being already 'prone' to temptation and trespassing, women must guard their behaviour and adhere to the 'unachievable' moral standards for the womanhood of the Virgin Mary.

The bipolar space described here is one that feminist scholars have shown that women symbolically occupy in the Christian religions across countries – the whore (the transgressor) or the virgin (the norm upholder) provide a powerful frame for interpreting individual mental distress as evidence of personal sin or demonic influence, evidenced, for instance, in non-adherence to traditional gender roles (Ussher, 2011, 2017; Rimke, 2018). Not surprisingly, so-considered possessed women, in trying to restore their 'sanity' and social position, may turn to religion as a guide for purifying themselves from sins, transgressions and Satan's possessions (Collins et al., 2008; Webb, 2012). Thus, applying a feminist critical lens and using Poland as an example, we problematize literature that supports the broader involvement of clergy and faith-based organizations (FBOs) in advocacy and service delivery to people with mental illness (Heffernan & Weatherhead, 2014; Jarvis et al. 2022; Kramer, 2010) by illuminating how these interventions may serve as sites of gender normalization. This gender normalization is also occurring in the context of neoliberalism, a new overarching 'religion', where economic policies and social structures continue to reinforce gendered inequalities under the guise of deregulation, privatization and individual responsibility (Oldale, 2020). While not denying that faith, religion, and church communities may provide a source of strength to patients, it is important to recognize that some religions also come with profoundly gendered ideologies that may shape the meaning of mental illness and recovery.

Our interest in the intersections of psychiatry, religion, and gender stems from observations that occurred during another project conducted by the first author into the socio-legal organization of involuntary emergency admission to psychiatric facilities in Poland (Doll 2017). During the fieldwork, the first author conducted observations in a psychiatric hospital and a clinic, various courts, EMS stations, a local bar association, and lawyers' offices, as well as other sites and venues where relevant activities and events were happening (e.g., professional conferences, professional workshops, and public events related to mental health care). Alongside observations and informal conversations with relevant professionals (N>200 hrs), formal interviews were conducted with those practitioners involved in decision-making about involuntary admission as well as those who are involved in those decisions indirectly through their administrative roles (N=32). In total, the fieldwork lasted 18 months. Additionally, extensive documentary data was collected, including legal files on involuntary admission, medical documentation (N>2,000 pages), statutes, court decisions, etc. Through those daily

observations conducted in psychiatric facilities, the first author became aware of the extensive and exclusive presence of Catholic priests in the daily lives of psychiatric wards and their engagement in functions that go beyond pastoral care. This presence was perplexing. Building on the authors' feminist interests in the gendered aspect of mental illness. In this article we would like to interrogate the often invisible ways in which Catholicism and the Church may reinforce traditional gender order through its material and ideological presence in the Polish psychiatric system.

We organize our paper as follows: First, we will review the literature on the role of religion and spirituality in the mental health context and the existing discussion on the involvement of FBOs or clergy in mental health service delivery, noting its lack of attention to the countries' religious landscape and how it may complicate the objectives of church and FBOs involvement as imagined in the spiritual or pastoral care model. Next, we introduce the reader to the Catholic church's moral and political position in Poland, as well as its involvement in health care. Then, drawing on feminist scholarship, we discuss some of the ways that religion and psychiatry work in tandem to pathologize certain behaviours in women as well as disciplining certain kinds of gender roles. In the last section, we outline specific sites of encounters with Catholic priests during their psychiatric institutionalization and pathways to recovery for patients in Poland and analyze their potential implications for psychiatrized women in relation to the Polish Catholic Church's war against so-called genderism (Graff, 2014). We conclude with contemporary concerns and suggestions for future research.

1. Clergy and Faith-based Organizations' Involvement in Psychiatric Service Delivery

Psychiatry and religion are often seen as separate or even opposing fields (Fulford, 2018). Psychiatry focuses on scientific, 'value-neutral' approaches to mental disorders through biomedical treatments (Fulford, 2018; Rimke, 2018), while religion offers value-based interpretations and support to individuals, especially during times of life adversities (Sutherland, 2018; Fitchett, 2017). In other words, while psychiatry posits that it treats illness through medical intervention delivered by experts, religion and clergy are claimed to serve as a guiding spiritual force informing all aspects of a person's life, including their coping with illnesses. For at least two decades, there has been a growing recognition that while psychiatry and religion are still perceived as autonomous fields, there is growing recognition of where boundaries overlap and can complement each other in the context of mental health care (Breakey, 2001; Fulford, 2018; Leavey et al. 2011). Although traditional biomedical models of psychiatry, which prioritize diagnosis, symptom treatment, and view serious mental illness as chronic and incapacitating, still predominate in the practice of psychiatry, the inclusion of more holistic approaches that pay attention to patients' culture, religion and spirituality has been gaining traction within Western psychiatry. This can be linked to the consumer-led changes in the mental field and the emergence of transcultural psychiatry. Both of these emphasized a person-centred, choice-based approach to treatment (Jarvis et al., 2021) and the focus on recovery as a "growth and transformation" (Jarvis et al., 2021, p. 227), a process of empowering patients to learn to live

with mental illness, instead of seeing the end goals as living without it. These perspectives emphasize the social aspects of rehabilitation, such as family support, community integration, and spirituality, as important resources during psychiatric treatment in the process of recovery (Fallot, 1998). In this context, religious and spiritual themes and support may be important as they can provide a comprehensive scheme for understanding, adopting and overcoming challenges related to mental illness (Fallot, 1998). In this sense, religion/spirituality and biomedicine can potentially work together to enhance psychiatric care.

There have been multiple ways/articulations of how these intersections came to/could be realized in practice. Due to the limited space, we outline two: the cultural/religious competency of psychiatrists and the involvement of FBOs, clergy, chaplains or priests in pastoral care in the context of mental health services. Attention has been placed on transcultural psychiatry to address cultural competence in multicultural societies, where culture, including understanding the patient's religion and conceptualization of mental illness, is central to the patient's effective treatment (Sperry, 2017). It has been argued that psychiatrists should consider the patient's culture and religious beliefs during diagnosis and the development of a treatment plan. For example, they are advised to obtain a spiritual history or extend the classification of so-called "religious or spiritual problems" per the DSM (Cox, 2018, p.157). Yet, literature also reports that practitioners often feel either unwilling or unprepared to engage with patients' religious beliefs or to ethically include spirituality or religion within treatment (Cox, 2018; Leavey et al., 2011). Thus, despite the discourses surrounding support, it is unclear how much it is implemented into clinical practice in inpatient mental health services (Kehoe & Dell, 2021; Heffernan & Weatherhead, 2014). As a result, a so-called religiosity gap may emerge between religious patients and mental health services (Leavey et al., 2011).

In the context of mental health programs clinical psychiatrists particularly appreciate how church and FBOs' position in communities and their already existing network of services can help address and strengthen the religious and cultural elements of holistic mental health care (Kramer, 2010). A few examples of collaborations which aimed to raise awareness of mental illness and treatment among clergy, congregations, and individuals who seek faith as a component of their recovery from the US include the National Alliance on Mental Illness FaithNet, Pathways to Promise, United Church of Christ Mental Health Network and Mental Health Ministries, where mental health professionals offered frameworks for clergy to support mental health initiatives within church communities and may run programs that provide support and education integrating religious elements (Kehoe & Dell, 2021). Yet, generally, clergy feel underprepared or undereducated regarding serious mental illness, leading to a lack of confidence in referrals to the appropriate avenues (Leavey et al., 2011).

Furthermore, by utilizing religious networks and infrastructure care, practitioners also hope to reach poorly serviced populations or groups who may resist mental health care when delivered by practitioners located in the healthcare system and the medical model of mental illness (Leavey et al., 2011; Koenig et al., 2020; Campbell et al., 2007; Young et al., 2003). The latter can be related to the lack of trust some communities may have in the mainstream health system and prefer the support of faith-based organizations during their life crises. Thus, mental health practitioners, their governing bodies, and the state may see the collaboration with FBOs as beneficial in addressing mental health crises (Leavey et al., 2011). In some countries, such as the

US, there are policies and provisions facilitating access to public funding for FBOs to provide behavioural health, mental health and broader welfare services, especially for rural communities where religion plays a central role (Leavey et al., 2007, 2011). Yet, there is also contestation on how to ensure that such interventions are not opportunities for the church's evangelization mission but rather to enhance needed services for individuals with mental health disorders.

Similarly, finding a balance between wider availability and evangelization is challenging in a global context where FBOs support healthcare more generally and have deep-rooted relationships within local underserved or rural communities, particularly in the Global South (Haakenstad et al., 2015). FBOs have the infrastructure and proficiency to connect international and governmental funds to support health initiatives and improve service quality through funding received from donations, user fees, government grants, and aid agencies, the majority coming from non-governmental sources (Haakenstad et al., 2015). FBO's long-standing relationship with development is rooted particularly in Christian colonial and missionary projects (Haakenstad et al., 2015; Deacon & Tomalin, 2015). The recent shift in acknowledgement of FBOs is primarily based on the funding structure and subsequent service delivery benefits, obscuring colonial violence's history with public health improvements or neoliberal development goals. As neoliberalism emphasizes capitalist inequality on a global scale, the role of FBOs becomes stronger and arguably continues evangelization mission colonization. By juxtaposing Western medicine as secular and modern with significant religiosity gaps, the Global South is presented as developing with the infrastructure of religious groups to gain social improvements where neoliberal ideology and religion reinforce dominant power structures in both contexts (Deacon & Tomalin, 2015; Oldale, 2020).

Without denying that faith, religion, and church communities may provide a source of strength to patients going through and recovering from mental distress, we posit that in countries where one religion holds a dominant position or even where the Church is an important political actor, active in its evangelization mission around a specific normative agenda, the involvement of FBOs, priests, chaplains in the delivery of support for psychiatrized persons gains another dimension with a new set of risks. Furthermore, deeper consideration needs to be given to the consequences of the possible lack of diversity in spiritual counselling in hospitals where one religious denomination provides all in-patient and outpatient services to patients or former patients of psychiatric hospitals. While understanding cultural competency is integral to psychiatric practice, support in this regard along with the involvement of FBOs in accessibility speak to social inequities that are intertwined with an individual's overall well-being. When considering addressing the gaps between the two binaries, attention should be paid to where clear boundaries lie. The discourses surrounding gaps focus on increased collaboration and patient choice. However, the people who fall within these spaces are in a vulnerable position subject to the support FBOs and clergy offer in supporting inpatient and outpatient models and the hegemonic position they hold, specifically in Christian religions, which reproduce gender normalization and pathologize mental illness.

We illustrate this claim by turning to the case study of Poland, where not only does the Catholic Church hold a strong moral, cultural, and political position but also a very conservative gender-normalizing stance. The Polish case offers a unique opportunity to understand the interplay between religion and psychiatry in shaping gender norms. This is especially revealing

in light of the Catholic Church's strong authority in Polish society, the Church's conservative social orientation and aggressive evangelization efforts, and the close collaboration between psychiatrists and theologians religious authorities to define normality and abnormality.

Before we move to this discussion, we first provide contextual information on the position of the Catholic religion and the Catholic Church in Poland.

2. The Position of the Catholic Church in Poland

Poland is predominately an ethnically and religiously homogenous country where one religion holds one dominant position – Catholicism. Regarding the number of believers (as captured in official statistics), Poland overtakes the other two homogenous Roman Catholic countries in Europe - Ireland and Hungary. Due to Poland's national and religious characteristics, "the Poland-centric and Roman Catholic Centric" views and systems of values dominate in Polish society. Data from 2022 from the Centre for the Survey of Public Opinion reports that 84% of Poles declare belonging (as believers) to the Roman Catholic denomination. This has been a consistent feature of Polish society for centuries, and around 40% of the respondents declared that they regularly practice at least once a week (Public Opinion Research Centre [Centrum Badania Opinii Publicznej, CBOS], 89/2022].

Furthermore, Pols tend to see religiosity as an integral feature of that society, and 48 % of Pols consider Catholic morality as an optimal morality. Yet half of them also, seeing the complexity of the current world, claim that they need to complement Catholic morality with other ethical principles. Those who accept the high standing of Catholic morality also claim that they try to follow the Church's teachings. The term Pol-Catholic indicates that Pols are very attached to Christian traditions and their practice. Despite the political, social and economic changes in contemporary Poland, the support for the institutional Church in Poland is still high, although, in recent years, it has seen a drop (CBOS, 105/2022). In the 2000s, it constantly oscillated around 69%, while it was even higher during socialism (around 80%). The recent departure is evident among young people and residents of bigger cities and intellectual groups who are critical particularly of the Catholic Church as an institution and of priests' conduct (CBOS, 105/2022).

The moral position of the Catholic Church in Poland is linked to the figure of Pope John Paul II, who was a spiritual leader but an important political figure for Pols in times of socialism and Soviet domination in Poland (Mishtal, 2015). In the time of socialism, both the priests and the Church as an institution experienced political-based oppression. Participation in the political resistance contributed to the high standing of the Catholic Church and priests during socialism. Yet, now, even though two-thirds of Pols accept the Church's public moral discourse, fewer accept the Church's involvement in shaping public law. Nonetheless, in the last decade, when the conservative right party ruled in Poland (called Law and Justice), Catholic institutions and religious groups have been extensively involved in political life in Poland, to the extent that priests even advise people how to vote (Gozdecka, 2012).

Furthermore, with the post 1989 Poland's transition to a neoliberal economy and the shrinking welfare state, the Catholic Church in Poland re-emerged as an essential actor fulfilling the socially

vital functions of delivering social services and addressing the gap in social assistance, including in the domain of psychiatry. During socialism in Poland, the state guaranteed universal health care to all its citizens[1], with a broad spectrum of services financed from the state budget (Sitek, 2008, p. 41). Yet, even during that time, the psychiatric service system, which was funded under the general healthcare system, was underfinanced when comparing to other medical fields. (Sokolowska & Moskalewicz 1987). Thus, services provided by the Catcholic Church are perceived as desirable not only because they respond to the religious needs of patients but also because they provide them with needed support in critical life moments. It is also because they fill the gap in services that the Polish government cannot or does not want to address despite the strong emphasis of the European Union on the social inclusion of marginalized populations in its Europe 2020 strategy and the ratification of the National Program of Mental Health Care. There are still problems with the implementation of the program both in community psychiatry and other services due to the government's insufficient funding. Thus, people with histories of psychiatric hospitalization need to rely on families and a community-support system that is available to them.

Furthermore, the ratification of the Concordat in 1993 provided the legal basis for fulfilling pastoral functions in state-run institutions, such as education or health care (Concordat, 1993). A concordat is a legal instrument the Holy See (Vatican) uses to regulate matters related to its mission on the territory of a foreign state. Unlike in many other countries where the doctrine of separation guides the relation between the state and the church/es (Eberle, 2011), in the Polish Constitution of 1997, the relationship between the state and the Catholic Church is defined as based on mutual autonomy and collaboration for the common good (Krukowski, 2010). In the signed Concordat, the Polish state guaranteed the freedom of realization of the Catholic Church's mission. It included separate jurisdiction and management of the Church's matters according to the Canonical law, as well as the church's involvement in health care. Article 17 points 1-3 of the Concordat states that the state will guarantee conditions for undertaking religious practices and accessing religious services by persons confined in correctional, youth socialization, health care facilities, and other facilities of this type. Access to holy mass, catechesis, and one-to-one religious services, aligned with the purpose of the individual's confinement in the facility, is seen as the realization of the aforementioned religious practices. To realize these services, the state signs contracts with delegates and clergy to fulfill this pastoral care. In effect, the state contracts these clergy as employees, pays them from the public budget, as well as imposes obligations on the health facility's director to maintain the catholic chapel together with a chaplain. Last but not least, while the Concordat created the legal infrastructure for the involvement of clergy and chaplains in the delivery of pastoral care across various sites, it also underscored in its Preamble "the significant input of the church in the development of a human being and strengthening of morality," and in the article 5, the Polish state guaranteed the Catholic Church free and public implementation of its mission. The integration of the Catholic Church into the Polish healthcare system reflects both ideological and institutional support, which is formalized in law. This legal framework not only provides funding for the Church's and priests' involvement in healthcare—including psychiatry—but also enables their role in supporting individuals with mental health needs.

---

[1] *In fact, during socialism, the right to universal health care included access to abortion and other reproductive technologies. In the first decade of the socialist regime in Poland, the state liberalized reproduction despite opposition from the church. For an excellent discussion of Poland's post-1989 transition with a specific focus on the reproductive rights of Polish women and the Catholic Church institution's formal and informal influence on their regulation, see the feminist ethnography authored by Joanna Mishtal (2015).*

3. Between a Madonna and a Whore: Religion, Psychiatry, and Gender Normalization

For decades, feminist scholars have argued that neither religious nor psychiatric discourse has ever been neutral. Both religion and psychiatry, as social institutions, have actively engaged in normalizing and disciplining gender, race, sexuality, and class (Daley et al., 2012; Ussher, 2011, 2017; Rimke, 2018; Chesler, 1972). Both institutions have and continue to treat women as the Other who must meet prescribed cultural and social norms that are continually regulated and enforced (Daly, 2007; Jasper, 2012).

Scholars have demonstrated that religious regimes are closely associated with gender regimes, where the 'doing' of gender is done simultaneously with the 'doing' of religion (Schnabel, 2018; Daly, 2007). In Genesis, through Eve's transgression, Satan's possession and caused-sinning have been already symbolically attached to women. Women are not only presented as sinful but also as potentially causing the trespasses of others. For instance, women's madness has evolved from the historical example of the witch trials in Western Europe starting in the 15th century when the combined church and state violently targeted women who threatened the patriarchal order with their medicinal knowledge (Rimke, 2018; Ussher 2005). Bipolar spaces that women symbolically occupy in the Catholic religion across countries – the whore (the transgressor) or the virgin (the norm upholder) have been and still are sites for disciplining women (Rimke, 2018; Jasper, 2012; Georgaca et al., 2023). The teaching of the Catholic Church makes women responsible for the survival of the family unit, even blaming them for violence and abuse that may occur towards them or in the family context.

With the emergence of the discipline of psychiatry, various forms of gender transgression have been psychiatrized and converted into medical pathologies (Daley et al., 2012). The pathologization and demonization of women—once framed as witchcraft—evolved into diagnoses like hysteria and moral insanity, confining women to asylums; today, this legacy continues through female-targeted personality disorders and psychopathology, which shift responsibility onto women for failing to conform to feminine norms while ignoring the social structures that contribute to their suffering and erode their autonomy (Ussher, 2017). This control through regulation and normalization is based on hegemonic and binary classifications such as normal/ abnormal, female/male, white/non-white, homo/hetero, and rich/ poor (Rimke, 2018, p. 24). Indeed, Bhugra aptly (2018, p. 230) accuses psychiatry of creating its own 'high church' where practitioners act as policing agents of normalization or deviancy. While in institutionalized religions, such as Catholicism, the relationship between people is mediated by the church, likewise psychiatry mediates the relationship between the person and their inner self, with both institutions aiming to restore the individual to its 'better self.'

The 'high church' of psychiatry's normalization is reinforced by the hegemonic 'religion' of neoliberalism. Oldale (2020, p. 2) describes neoliberalism as a 'shadow' patriarchy, an extension of the capitalist system's historical reliance on the exploitation of women and minorities. Privatization and deregulation in the neoliberal economy evolve from and intensify this exploitation, dictating societies' lifeworld systems and heightening inequality for global populations and ecosystems (Oldale, 2020). Individual responsibility, productivity and efficiency

are upheld as dominant values that reinforce free-market ideologies. This perspective focuses on personal reform rather than addressing broader social injustices. Within neoliberal knowledge systems, psychiatrized women and "undesirable" groups are pathologized and assessed for risk, often based on their perceived economic burden where they are subject to social control (Leblanc Haley, 2019; O'Leary & Ben-Moshe, 2019). The free market creates an illusion of choice while limiting support systems, where psychiatry then pathologies individuals based on a system of power rooted in oppressive capitalist systems (O'Leary &Ben-Moshe, 2019; Olddale, 2020). Within that oppressive system, biopsychiatry – and its scientific language, which focuses on cognition, hormones, and neurochemicals, is leant scientific authority- which creates a market for those who are marked as flawed or abnormal, thus perpetuating psyhegemony and depoliticizing the intersectional societal explanations for their so-deemed pathologies (Daley, Costa & Ross, 2012). By refusing to acknowledge the social causes of perceived abnormalities, biopsychiatry—especially within a neoliberal framework—turns mental illness diagnoses into mechanisms of individual responsibility, compelling consumers to seek and adhere to professional treatments; those who challenge the effectiveness of these interventions risk being re-pathologized. (Rimke, 2018; Cohen, 2016). Hence, the social control role of psychiatry and religion and their potential compounding effects on women when working in tandem are rarely acknowledged in the current literature on spiritual and pastoral involvement in psychiatric services.

When this literature pays attention to gender, it does so by narrowing its focus on women's religiosity or, even more so, the gender gap in religiosity between women and men. In this literature, it is argued that women are generally more religious than men in Christian religions (Schnabel, 2018; Fiori et al., 2006; Hvidtjørn et al., 2014; Vardy et al., 2022; Walter & Davie, 1998). This religious propensity among women has been attributed to their search for comfort, security, and coping mechanisms in patriarchal society and within the church (Schnabel, 2018; Fiori et al., 2006). Yet, it has also been evident in this scholarship that when it comes to the Christian church's attitude toward mental illness, including women's mental health diagnosis, these vary. While many clergy and church members may work from the biopsychiatric understanding of mental disorders (Magliano et al., 2021), others conceptualize mental illness as being demonically influenced, a cause of personal sin or lack of faith (Webb 2012; Wesselmann & William 2010; Lloyd & Panagopoulos 2022; Stanford 2007; Mercer 2013; Lloyd 2021). Subsequently, some Christian churches dismiss women's mental illness and discourage them from taking psychiatric medication or make them responsible for contributing to their mental health condition by transgressing established gender norms. In these cases, when these women seek resources or treatment from the church, they may be met with dismissal or demonization (Collins et al., 2008; Georgaca et al., 2023). In Christianity, particularly Catholicism, the unattainable ideal of the Virgin Mary—both virgin and mother—forces women into a perpetual pursuit of purification; their bodies are linked to earthly existence and bodily desires, making salvation an ongoing struggle (Walter & Davie, 1998). In trying to restore their 'sanity' and social position, and yet simultaneously seeking recovery, they may turn to religion as a guide to purify themselves from sins, transgressions and Satan's possessions (Collins et al., 2008; Webb, 2012) through the church and its conservative gender roles as a grounding identity, particularly in instances when their illness is associated with sexuality.

In the next section, we turn to the Polish case, highlighting the Catholic Church's extensive influence – through priests, clergy, and FBOs – within the Polish psychiatric system during a person's hospitalization and after their discharge. Consumer-based, first-person survivor accounts reflect a neoliberal, individualized perspective that risks overlooking the intersectional ways women are subjected to normalization, shifting responsibility onto them to overcome adversities beyond their full control. While religion can improve psychiatric service delivery and recovery, they are institutions involved in normalizing and policing practices that perpetuate patriarchy and are ingrained with the social relations of power and inequity.

4. God's Omnipresence? Multiple Entanglements Between Catholic Church in Psychiatric and Mental Health Systems in Poland

In contemporary Poland, the Catholic Church is involved in mental health care in multiple ways. These ways include pastoral care and involvement in the delivery of some services to patients of psychiatric hospitals during their stay and after discharge.

Regarding the pastoral care delivered to hospitalized psychiatric patients, the first author's empirical fieldwork in psychiatric facilities in a city in south-eastern Poland observations conducted therein provided evidence of a regular and extensive presence of Catholic chaplains in psychiatric secured wards. During that fieldwork, she observed not only the presence of Catholic symbols in hospital rooms but also the active involvement of clergy in pastoral care as well as in many other aspects of hospital life and patient care. Daily visits of a Catholic priest to the psychiatrist that lasted for an extended time, as well as their conversations with psychiatrists and judges (coming to the facility to adjudicate involuntary admission cases or other mental health law cases), were not unusual scenes in the facility where she conducted her fieldwork. As mentioned in the discussion of the Concordat, the state and, by extension, state-funded medical facilities are obliged to provide conditions for pastoral care to patients. For that realization of pastoral functions, the Church expects chaplains to meet with all patients and to meet with medical staff and collaborate with them in organizing relevant events. Thus, per the first author's observations, priests have a daily presence in psychiatric hospital wards in Poland and have regular access to patients. Furthermore, given that for many psychiatric patients, access to facilities (including chapels) located outside of the ward is often forbidden, the visiting priests may be the only point of contact with the institutionalized Catholic Church. The presence of pastors from other denominations was not observed. This may also be partially explained by the special arrangements that Catholic chaplains receive in Poland; they are hired as full employees whose salaries are covered by the medical facilities while those from other denominations are not. In some medical facilities, the position of Catholic hospital chaplain is inscribed in their founding by-laws. This raises serious concerns about patients' ability to access another kind of spiritual or religious support or, even more so, the denial of the need for that support.

Although the literature on this topic is scattered in relation to Poland, what has been observed by the first author and confirmed by that literature, is that the involvement of Catholic priests present in psychiatric wards extends beyond spiritual and religious counselling strictly speaking. The first author observed that priests were involved in co-organizing institutional events along with psychiatrists and local authorities. For example, an anti-stigma event that the facilities put together for the Day of the Sick, during which the local bishop was the keynote speaker, the mass was an integral element of the event, and the only artistic, music performance delivered by current psychiatric patients had a religious character as their songs were about the role of God in mental health recovery. Developed under the supervision and guidance of a chaplain, this music group is one of the typical activities that priests organize as an extracurricural activity in psychiatric wards. While it may be argued that in a highly underfunded mental health service system in Poland, any extracurricular activities delivered to persons kept in psychiatric facilities are of value. Here, the problem is that patients' options are limited to those extracurricular activities that have a religious character or are led by priests or chaplains. The first author noted that other opportunities for participating in extra-therapeutic activities were quite limited at her research site. This may correlate to the fact that the Catholic Church also dominated volunteering opportunities in the facility. The first author learned that the only way to volunteer in one of the facilities where she conducted her fieldwork was to become a volunteer on behalf of Catholic FBOs or church-related agencies.

Furthermore, although patient participation in these activities is voluntary, lack of involvement may have several significant consequences for them. Participation in extra-therapeutic activities, such as the priest-run music group, can facilitate the perception that they are compliant with treatment. By being proactive, demonstrating that they are active in trying to improve their mental condition and gaining 'insights' into their disease, patients can earn institutional privileges, such as permission to go outside the locked ward. Such participation can also matter legally. It may enhance patients' legal standing and chances for discharge when such extra-therapeutic participation is read as a sign of recovery and potentially evidence that the conditions justifying their initial admission have ceased, especially when it concerns the threat of violence that person poses to themselves and others (Mental Health Protection Act, 1994; Minister of Health, 2012).

The Catholic Church and FBOs also have significant oversight over patients' care and subsequent support when they transition into the community. Notably, priests serve on boards of directors or on the steering committees of organizations that provide social support for ex-patients, such as housing support, training opportunities, and social services to facilitate the integration of psychiatric patients into society. In terms of outpatient mental health services in Poland, Szmigiero (2016) reported on the ways the parish help centers provide spiritual help in an outpatient context for persons struggling with mental issues and the government's involvement in funding them. One such example of a registered charity is called Magnificat; located in Łódź, it received public funding from the Minister of Labour and Social Policy for a project Supporting the Primary Functions of Family through Psychological and Therapeutic Counselling which also included retreats that performed exorcisms (Szmigiero, 2016, p.39). Psychiatrists refer patients to this treatment when the national health provisions cannot afford other treatments. These spiritual counselling centers are supported by magazines, literature and self-help pamphlets, which pathologize

mental disease as a result of poor lifestyle choices and "acedia," which equates to sloth in the seven deadly sins. Furthermore, the Church and FBOs can secure housing or other social services for people in dire situations. Despite the European Union's strong emphasis on the social inclusion of marginalized populations in its Europe 2020 strategy, the Polish government has been reluctant to provide adequate support; as a result, people with histories of psychiatric hospitalization must rely on their families and any available community-support systems.

Through these forms of engagement, the Church and its doctrine create an omnipresence in these spaces, potentially imposing Catholic ideology within the context of in-patient and outpatient care, as well as supporting social services to psychiatrized persons in Poland.

5. 'War on Gender': Catholic Church's Evangelization Mission for Upholding Traditional Gender and Sexual Orders in Poland

When it comes to Poland, the teachings and the orientation of the Polish Catholic Church have been known to be very conservative on social issues, such as issues of marriage, gender equality, and women's bodily autonomy, when compared to the approaches adopted currently in the Vatican or other Catholic denomination and institutions in different countries (Bucholec & Gospodarczyk, 2024). Backed by the conservative Law and Justice party (governing Poland from 2015 to 2023), the Catholic Church has actively worked to revitalize Catholic morality in response to cultural shifts. Two prominent Polish feminist scholars, Hyciak & Koralczuk, 2016), argue that:

> In Poland, the democratization process and transition from a command economy to a neoliberal regime brought about significant changes within the cultural environment concerning gender order in general and the practices of parenting. It stimulated the revival of nationalism and increased the power of the catholic church, which in turn led to a local form of backlash against women's rights (p. 54).

Those discourses of women's rights have been seen as threatening to Polish traditional values and the gender order. Gender has also been presented as a cause of homosexuality and, as such, a practice directed toward Polish families. The term 'gender ideology' was coined and used by the Polish Church and right-wing Polish establishment to symbolize the moral degradation that is associated with cultural changes occurring in Polish society (Graff, 2014). Bucholec and Gospodarczyk (2024) explain that the meaning of gender ideology in Poland is broader than the one that is embraced by conservative discourses in the US and UK. In addition to the rejection of gender as a spectrum, it also includes beliefs about sexual behaviour, reproduction, family life and child-rearing (Bucholec & Gospodarczyk, 2024). Thus, the Polish Catholic Church's 'war on gender' focused on issues of abortion (Bucholec & Gosporadczyk, 2024), in vitro (Gozdecka, 2012), and parenting (Charkiewicz, 2014), including sexual education in schools, as normalizing the practice of

motherhood and establishing Catholic morality as public morality. Alongside those debates, the Church officials (and associated right-wing organizations were involved in actions against LGBTIQ persons) rejected of the ratification of international treaties that, in their opinion, override the rights of a family unit with the individual rights of their members, such as the Convention on the Prevention of Gender Violence (September 5, 2014, TVN24 News). Gozdecka (2012) talks about the Catholic Church in Poland as a semi-political organization that has a significant impact on processes of democratic deliberation, which also homogenizes the conception of femininity based on Catholic morality.

Another Polish feminist, Charkiewicz (2014), connects the Catholic Church's war on gender to the institutionalization of the new evangelization project that gained more visibility in early 2010, both in the Vatican and Poland. The new evangelization mission of the Church focuses on Catholics and Catholic families who, while their declaring beliefs, do not live according to the Bible and the Church's teachings. Hence, the Church is obliged to bring its followers on the right path so they can receive eternal salvation. For that to occur, the heteronormative and patriarchal family is the site of intervention. Thus, anything that contests that social order and the role of women in the reproduction of Catholic values is highly criticized and resisted by the Church via social, political, and legal means. One way this evangelization counters gender equality and women's rights to bodily autonomy is by promoting 'new feminism' – a strategy of gender normalization that upholds traditional gender roles while responding to societal changes. This so-called 'new feminism' does not question either the premises and values of the Catholic faith or the organization of the Church itself. Rather, it elaborates on the significance of women's roles in current societies, including their maternal roles, and recommends that their emancipation could be achieved by a deeper appreciation of their work for society and families, as opposed to trespassing on gender roles and occupying men's spaces (Borutka, 2004). Furthermore, the church must preach the word of God in every place and at every time to fight what the Church calls 'death civilization' (Charkiewicz, 2014).

In this context, the presence of priests and chaplains in psychiatric hospitals and spaces that deliver services to psychiatrized people, particularly women, should be considered highly consequential as it is a potential, yet very receptive, site for this new evangelization due to the vulnerability of psychiatrized women. It is crucial to recognize that the involvement of the Church in psychiatric care will bring with it a profoundly gendered ideology that can shape the meaning of female patients' understanding of mental illness and their roads to recovery. The expansion of the new evangelization beyond the Church's visible engagement into less publicly scrutinized spaces - such as psychiatric facilities – aims to further its re-moralization mission; especially in light of statistics showing a significant decline in the Polish Church's followers in recent years. Psychiatric spaces may also be crucial for that very mission, particularly in the shifting Polish political and governmental landscape, when those associated with the Church parties are not in power and the Church cannot exhibit its influence and reinstall its moral doctrine easily through policies and legal regulations.

Conclusion

This article problematizes an argument circulating within the recent psychiatric and public health literature that supports the broader involvement of clergy and faith-based organizations in advocacy and service delivery to people with mental illness, showing that in a specific cultural context, this kind of engagement may contribute to some normalizing practices towards patients. When located in a specific political and religious context of countries where one religion and institutional church hold a hegemonic position and engage actively in a moral evangelization mission, the call for clergy involvement in mental health services can be deeply problematic. Using the example of Poland, we showed how the sites of involvement of Catholic clergy and FBOs might also become sites of gender normalization and disciplining. While faith, religion, and church communities may indeed provide a source of strength to patients, it is crucial to recognize that the involvement of the Church can also bring with it a deeply gendered ideology. We argue that the collaboration between priests and psychiatrists can be profoundly consequential. It goes beyond the spiritual care model and chaplaincy observed in multi-religious countries, working as a site of intense control and normalization of women's behaviours according to religious gender norms. In this sense, the involvement of clergy can be seen as a site of oppression and suppression instead of spiritual wholeness and healing.

Both religion and psychiatry, as social institutions, have actively engaged in normalizing and disciplining gender, race, sexuality, and class and have acted as forces that policed women's adherence to prescribed cultural and social norms. From inscriptions in Genesis, through Eve's transgression, Satan's possession and caused-sinning have been already symbolically attached to women, through discourses of witchcraft, the church (along with the state) targeted women who threatened the patriarchal order. These bipolar spaces that women symbolically occupy in the Catholic religion across countries – the whore (the transgressor) or the virgin (the norm upholder) –have been and still are sites for disciplining women. As psychiatry developed as a discipline, its focus shifted from diagnoses like hysteria and moral insanity to modern female-targeted personality disorders and psychopathology. These frameworks place responsibility on individual women for failing to conform to feminine norms while overlooking the broader social structures that shape their experiences. Biopsychiatry can disregard the social causes of perceived abnormalities, particularly in a neoliberal context, and shift the responsibility of mental illness onto individuals, framing them as consumers tasked with seeking and adhering to professional treatments for their conditions, only to be pathologized at any sign of failure to comply. Moreover, when these systems work in tandem, such as when religious personnel and FBOs integrate into the mental health system, their compounded effects on women remain largely overlooked.

Given the increasing collaboration between religion and psychiatry in potentially reinforcing conservative gender norms further empirical research is needed. Future studies should explore the impact of religious involvement in mental health care, both in Poland and in other countries with similar conservative religious influences. For instance, given that the spiritualization of mental illness by the church as a source of support plays a significant role in patients' conceptualization of self and recovery, it will be informative to investigate how religious and

medical systems influence the normalization of gender, affecting patients' self-concepts and recovery. Discourses in recovery from serious mental illness, often involving religion and spirituality, provide hope and resiliency. However, both the church and psychiatry possess normalization values, which may have significant effects on the patient's conception of self when combined.

Furthermore, given the gender rhetoric of conservative Poland and the so-called gender ideologies, a threat to traditional values is seen through the policing of mothers and women's bodies, making the case of postpartum depression a site for scholarly attention one of particular importance. Within the framework of psyhegemony, this condition could posit abnormality or 'failure' of motherhood with very pointed traditionalist solutions on what it means to be a mother while dismissing the intersectional complications. There is great significance surrounding pregnancy and childbirth in religion, where procreation is often seen as the purpose of marriage, and the family unit is integral to traditional values (Cheadle & Dunkel, 2018). Attention should be placed on the widespread significance of postpartum depression on women and how closely related it is to gender. This scrutiny is particularly necessary as, under neoliberalism, the pregnant psychiatrized woman is not only subjected to increased medical surveillance but is also taught to internalize their own risk (Leblanc Haley, 2019).

The concern towards the institutionalization of religion and normative policing is also of growing concern in other political contexts, particularly in the US, where the influence of religion is evident. There also, the term "gender ideology" has become a powerful rhetorical tool, evoking fear of a political agenda that threatens traditional values (Butler, 2024) and reveals similar patterns as those seen in Poland. It functions as a broad, weaponized concept that frames gender as a destabilizing force, encouraging censorship and authoritarian governance under the guise of protection (Butler, 2024). Gender rhetoric has contributed to the support of Donald Trump, particularly among Christian nationalists, who advocate for a patriarchal "dream order" to be reinstated through strong state intervention at the expense of fundamental rights (Butler, 2024, p.12). This is demonstrated in the hundreds of bills which target women and people who are LGBTQIA+, the deprivation of healthcare, and the censorship of education (Butler, 2024). As Christian nationalism gains significant power in right-wing politics, religious institutions and corporations benefit with support for hierarchical, patriarchal gender roles (Whitehead & Perry, 2019). This is of particular concern when such policies restrict bodily autonomy, such as abortion and gender-affirming healthcare, where the area of psychiatry must also be closely monitored.

Acknowledgement:

Research resulting in this manuscript was partially funded by a fellowship from the Centre for Studies in Religion and Society at the University of Victoria, and by the University of British Columbia Aspire Research Fund (grant number Grant ID GR024024) received by AD. We extend thanks to two anonymous reviewers for the very constructive comments.

References

Bhugra, D. (Ed.). *(2018). Conclusions: Religion, mental illness, and mental health-the way to move forward. In Bhugra, D. Psychiatry and Religion: Context, consensus and controversies (pp. 231-232). Routledge. https://doi.org/10.4324/9780429490576*

Borutka, T. *(2004). Feminism a chrześcijańskie posłannictwo kobiet. Analecta Cracoviensia, 36, 2004. https://theo-logos.pl/server/api/core/bitstreams/7710cf3a-8a60-40dc-966d-791b24678262/content*

Breakey, W. *(2001). Psychiatry, spirituality and religion. International Review of Psychiatry, 13(2), 61-66. https://doi.org/10.1080/09540260120037281*

Bucholec, M., & Gosporaeczuk, M. *(2024). Feminist mobilization, abortion law, and political images of womanhood: Feminists as 'the worst minority.' In M. Bucholec (Ed.), Established-outsider relations in Poland (pp. 143–175). Palgrave Studies on Norbert Elias.*

Butler, J. *(2024). Who's afraid of gender? Canadian edition. Knopf Canada.*

Campbell, M. K., Hudson, M. A., Resnicow, K., Blakeney, N., Paxton, A., & Baskin, M. *(2007). Church-based health promotion interventions: Evidence and lessons learned. Annual Review of Public Health, 28(1), 213-234.*

Charkiewicz, E. *(na). Archeology of transformation: War against gender from an intersectional perspective [Archeologia transfomacji: wojna o gender w perspektywie intersekcjonalnej]. Vimeo. (uploaded March 25, 2014). https://vimeo.com/90066569*

Cheadle, A.C.D., Dunkel Schetter, C., & The Community Child Health Network (CCHN). *(2018). Mastery, self-esteem, and optimism mediate the link between religiousness and spirituality and postpartum depression. Journal of Behavioral Medicine, 41(5), 711–721. https://doi.org/10.1007/s10865-018-9941-8Collins, P.Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. Social Science & Medicine , 67(3), 389–397. https://doi.org/10.1016/j.socscimed.2008.03.013*

Cox, J.L. *(2018). Psychiatry and religion: A general psychiatrist's perspective. In D. Bhugra (Ed.), Psychiatry and religion: Context, consensus and controversies (pp. 157-166). Routledge. https://doi.org/10.4324/9780429490576*

Crawford, C. *(2004). Daughters of the Inquisition: Medieval madness: Origins and aftermaths. Tensed: Seven Spring Press.*

Daley, A., Costa, L., & Ross, L. *(2012). (W)righting women: Constructions of gender, sexuality, and race in the psychiatric chart. Cult Health Sex, 14(8), 955–969. https://doi.org/10.1080/13691058.2012.712718*

Daly, M. *(2007). The church and the second sex. In Women's Studies in Religion: A Multicultural Reader (1st ed.). Routledge.*

Deacon, G., & Tomalin, E. *(2015). A history of faith-based aid and development. In E. Tomalin (Ed.), The Routledge handbook of religions and global development (1st ed., pp. 68-79). Routledge.*

Doll, A. *(2017). Lawyering for the 'Mad': An institutional ethnography of involuntary admission to psychiatric facilities in Poland (Unpublished doctoral dissertation). University of Victoria, Victoria.*

Eberle, E.J. *(2011). Church and state in Western society: Established church, cooperation and separation (1st ed.). Routledge. https://doi.org/10.4324/9781315572024*

Fulford, K.W.M. *(2018). Religion and psychiatry: Extending the limits of tolerance. In D. Bhugra (Ed.), Psychiatry and religion: Context, consensus and controversies (pp. 6-29). Routledge. https://doi.org/10.4324/9780429490576*

Fallot R. D. *(1998). Spiritual and religious dimensions of mental illness recovery narratives. New Directions for Mental Health Services, (80), 35–44. https://doi.org/10.1002/yd.23319988006*

Fiori, K. L., Brown, E. E., Cortina, K. S., & Antonucci, T. C. *(2006). Locus of control as a mediator of the relationship between religiosity and life satisfaction: Age, race, and gender differences. Mental Health, Religion & Culture, 9(3), 239–263. https://doi.org/10.1080/13694670600615482*

Georgaca, E., Fenekou, V., Katsouli, A., & Kyriakou-Chatziapostolou, E. *(2023). Feminine sexuality, religiousness and psychotic distress: Tracing a pattern. Feminism & Psychology, 33(1), 144–162. https://doi.org/10.1177/09593535221105687*

Graff, A. *(2014). Report from the gender trenches: War against 'genderism' in Poland. European Journal of Women's Studies 21(4): 431-442.*

Gozdecka, D.A. *(2012). The Polish Catholic Church and the regulation of IVF in Poland: Polarized political discourse and the battle over 'proper' reproduction. feminists@law 2(1) https://journals.kent.ac.uk/index.php/feministsatlaw/article/view/26*

Haakenstad, A., Johnson, E., Graves, C., Olivier, J., Duff, J., & Dieleman, J. L. *(2015). Estimating the development assistance for health provided to faith-based organizations, 1990-2013. PloS one, 10(6), e0128389. https://doi.org/10.1371/journal.pone.0128389*

Heffernan, S., Neil, S., & Weatherhead, S. *(2014). Religion in inpatient mental health: a narrative review. Mental Health Review Journal, 19(4), 221-236.*

Hyciak, R.E. & Koralczuk, E. *(2016). At the intersection of gender and class: Social mobilization around mothers' rights in Poland. In K. Jacobsson& S. Saxonberg(Eds.), Beyond NGO-zation: the Development of social movements in Central and Eastern Europe (pp. 49-70). Routledge.*

Hvidtjørn, D., Hjelmborg, J., Skytthe, A., Christensen, K., & Hvidt, N. C. *(2014). Religiousness and religious coping in a secular society: The gender perspective. Journal of Religion and Health, 53(5), 1329–1341. https://doi.org/10.1007/s10943-013-9724-z*

Jasper, A. E. *(2012). Beauvoir and The Second Sex. In Because of Beauvoir: Christianity and the cultivation of female genius (1st ed., pp. 3–31). Baylor University Press.*

Jarvis, G. E., Whitley, R., & Leblanc, M. *(2021). Cultures of wellness and recovery: Exploring religion and chronicity in relation to severe mental illness. In A. R. Hatala, & K. Roger (Eds.), Spiritual, religious, and faith-based practices in chronicity (1st ed., pp. 221-246). Routledge. https://doi.org/10.4324/9781003043508-11*

Kehoe, N.C. & Dell, M.L. *(2021). Clergy-clinician collaboration. In: Peteet, J.R., Moffic, H.S., Hankir, A., Koenig, H.G. (eds) Christianity and psychiatry. Springer, Cham. https://doi.org/10.1007/978-3-030-80854-9_15*

Koenig, H. G., Al-Zaben, F., & VanderWeele, T. J. *(2020). Religion and psychiatry: Recent developments in research. BJPsych Advances, 26(5), 262–272. https://doi.org/10.1192/bja.2019.81*

Konkordat miedzy Stolica Apolstolska *I Reczpospolita Polska z 28 lipca 1993 roku [Concordat], Annuals of Law, 1998, no 51 position 318 chttps://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU19980510318*

Kramer, F. D. *(2010). The role for public funding of faith-based organizations delivering behavioral health services: Guideposts for monitoring and evaluation. American Journal of Community Psychology, 46(3-4), 342–360. https://doi.org/10.1007/s10464-010-9351-8*

Krzyzak, P. *(November 2, 2013). Egzorcysci maja u nas duzo pracy [Exorcists have a lot of work here]. Rzeczpospolita https://www.rp.pl/kosciol/art5309431-egzorcysci-maja-u-nas-duzo-pracy*

Krukowski, J. *(2010). Concordats with Central and Eastern European Countries. Teka Komentarzy Prawniczych OL PAN, 95-112.*

Leavey, G., Dura-Vila G., & King M. *(2011). Finding common ground: the boundaries and interconnections between faith-based organisations and mental health services. Mental Health, Religion & Culture, 15(4), 349-362, DOI: 10.1080/13674676.2011.575755*

Leavey, G., Loewenthal, K., & King, M. *(2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. Social Science & Medicine, 65(3), 548-559.*

Mental Health Protection Act of 19 August 1994 *[Ustawa O Ochronie Zdrowia PsychiczneDnia 19 Sierpnia 1994 Roku] ("MHPA"), in [1994] Journal of Laws (No 231, item 1375).*

Minister of Health (Poland)*. Decree pertaining to practices for involuntary admission and discharge from psychiatric hospitals of 13 July 2012. [Rozporzadzenie Ministra Zdrowia z dnia 13 lipca 2012 w sprawie szczegolowego postepowania w sprawie przyjecia i wypisania ze szpitala psychiatrycznego], in [2012] Journal of Laws (No 854).*

Mishtal, J. *(2015). The politics of morality: The Church, the state, and reproductive rights in postsocialist Poland. Athens: Ohio University Press.*

Oldale, B. *(2020). Neoliberalism: The new patriarchy. New Patriarchy. A literature review. Literature Review. Journal of Integrated Studies, 1(1). https://jis.athabascau.ca/index.php/jis/article/view/279*

Public Opinion Research Centre *(July 2022). Religious landscape-distant view. 89/2022, Warsaw.*

Public Opinion Research Centre *(August 2022). Religious landscape-distant view. 105/2022, Warsaw.*

Rimke, H *(2018) Sickening institutions: A feminist sociological analysis and critique of religion, medicine, and psychiatry. In: Kilty J.M, Dej E. (eds) Containing Madness: Gender and 'Psy' in Institutional Contexts. New York, NY: Palgrave Macmillan.*

Schnabel, L. *(2018). More religious, less dogmatic: Toward a general framework for gender differences in religion. Social Science Research, 75, 58–72. https://doi.org/10.1016/j.ssresearch.2018.06.010*

Sitek, M. *(2008). Politics and institutions in the reforms of health care in the Czech Republic, Hungary, and Poland. Polish Sociological Review 1, 39-53.*

Sokolowska, M. & Moskalewicz, B. *(1987). Health sector structures: The case of Poland. Social Sciences & Medicine 24(9), 763-775.*

Sperry, L. *(2017). Spiritual and religious concerns presenting in psychiatric treatment. In J.R. Peteet, M.L. Dell & W.L.A Fung (Eds.), Ethical considerations at the intersection of psychiatry and religion (pp. 60-73). Oxford University Press. https://doi.org/10.1093/med/9780190681968.003.0006*

Szmigiero, K. *(2016). Holy water or Prozac? How the Catholic Church in Poland sees mental disorders. In Muses, mystics, madness. Leiden, The Netherlands: Brill. https://doi.org/10.1163/9781848884328_005*

TVN24 *(September 24, 2014). Sejm nie ratyfikowal konwencji o zapobieganiu przemocy wobec kobiet [Sejm (the lower chamber) did not ratify the Convention on preventing and combating violence against women) https://tvn24.pl/polska/sejm-nie-ratyfikowal-konwencji-o-zapobieganiu-przemocy-wobec-kobiet-ra471476-ls3412971*

Ussher, J. M. *(2005). Managing the monstrous feminine: Regulating the reproductive body. London: Routledge.*

Ussher, J. M. *(2011). Labelling women as mad: Regulating and oppressing women. In The madness of women: Myth and experience (1st ed.). Routledge.*

Ussher, J. M. *(2017). A critical feminist analysis of madness: Pathologising femininity through psychiatric discourse. In Routledge International Handbook of Critical Mental Health (1st ed., pp. 72–78). Routledge.*

Vardy, T., Moya, C., Placek, C. D., Apicella, C. L., Bolyanatz, A., Cohen, E., Handley, C., Kundtová Klocová, E., Lesorogol, C., Mathew, S., McNamara, S. A., Purzycki, B. G., Soler, M., Weigel, J. L., Willard, A. K., Xygalatas, D., Norenzayan, A., Henrich, J., Lang, M., & Atkinson, Q. D. *(2022). The religiosity gender gap in 14 diverse societies. Religion, Brain & Behavior, 12(1-2), 18–37. https://doi.org/10.1080/2153599X.2021.2006292*

Whitehead, A. L., & Perry, S. L. *(2019). Is a "Christian America" a more patriarchal America? Religion, politics, and traditionalist gender ideology. Canadian Review of Sociology/Revue canadienne de sociologie, 56(2), 151-177. https://doi.org/10.1111/cars.12241*

Young, J. L., Griffith, E. E., & Williams, D. R. *(2003). The integral role of pastoral counselling by African-American clergy in community mental health. Psychiatric Services, 54(5), 688-692*