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Teaching the Christian OrthodoxMystery of Baptism to Adults with Moderate or Severe Intellectual Disability

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ABSTRACT :*Sevenadults at a residentialfacility of agesbetween 25 and 64 yearswithmoderate or severeintellectual and otherdisabilitieswereselected to betaught a simplified adaptation of the Christian orthodoxmystery of baptism in order to establish a basic understanding of religioussymbolism and a relationshipwith the priest of theirparish. This priestperformed all sessions, providing the enactments of baptism and explaining the symbolsused by asking the participants nine questions (graduallyin 3 sets of 3) and providingtheiranswers. A preferred snack wasgiven to each participant at the conclusion of every session. A withinsubject design wasused to show the acquisition of thisknowledgethrough the conditions of baseline, teaching, probing and generalization. All participants learnt to respond to the questions regarding the ritual of baptism. This knowledgegeneralized to different settings –achurch and a monastery. The goal of increasing the participants' engagement withtheir local communitywasalsoindirectlyapproached by this training, whichprovidedsomeskills and knowledge to become more active members of their local church and community. Such training of symbolsmightverywellfacilitate a greatersense of belonging and acloserrelationshipwiththeircommunity.*

KEYWORDS:*teaching, adults with intellectual disabilities, religious symbolism, generalization of knowledge, socialization.*

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I. INTRODUCTION

The relationship between religion and mental health has been debated for centuries. History shows that religious organizations were often the first to offer compassionate care to vulnerable groups in society, including the medically ill, the elderly and the disabled. The fourteenth century saw the advent of the first health institutions for people with mental health problems sponsored by the various Churches and managed by priests [1]. However by the end of the MiddleAges, leading religious practitioners began to suggest that rather than supernatural powers, biological mechanisms were responsible for mental illness [2]. Therefore historically the holistic approach of treatment of patients with mental disturbances and behaviors originated from religious scholars. The resulting practices benefited those individuals suffering from mental health behaviorism who were the recipients of medical care much like other human beings [3]. Hence, religion had played a significant role in shaping the moral and humane approach to mental health care.

Koenig, Larson, and Larson [4] investigated the association between religiousness and perceived well-being. The majority of these 100 studies reported that strong religious reverence was significantly related to higher life satisfaction, more positive affect and greater happiness and to less depression, suicidal thoughts and behavior, drug, alcohol use and abuse. These studies examined the relationship between religious beliefs and activities and adaptation to physical illness in patients with general medical conditions, neurologic disorders, heart disease, renal failure, AIDS, and a host of other physical disorders. The review of Koenig, et al. [4] demonstrates the widespread use of religion in coping with medical illness and provides circumstantial evidence for the possible benefits of this lifestyle factor. When people become physically ill, many rely heavily on religious beliefs and practices to relieve stress, retain a sense of control and maintain hope and their sense of meaning and purpose in life. Religious involvement appears to enable the sick, particularly those with serious and disabling medical illness, to cope better and experience psychological growth from their negative health experiences, rather than be defeated or overcome by them. It seems that individuals involved in organized religion, religious salience and intrinsic religious motivation are less likely or have a reduced risk of experiencing depressive disorders [5]. Finally, religious commitment may play a beneficial role in preventing

mental and physical illness, possibly by applying a "different" attitude and course in coping with albeit mental or physical illness [6].

Usually the positive impact of religious involvement on mental health is more robust among people under stressful circumstances (the elderly, and those with disability and medical illness). There is evidence that religious involvement is usually associated with better mental health [7]. Many studies have shown a strong positive association between devoutness and mental health across various populations, including samples of the young, adults, older people, general community residents, immigrants and refugees, college students, the sick, addicts, homosexuals, parents, individuals with mental health problems, and personality disorders [8], [9], [10], [11], [12], [13], [14], [15], [16], [17],[18], [19], [20], [21], [22], [23], [24], [25], [26], [64],[65].

Past research and reviews on the devoutness-health relationship tended to have focused more on the physically healthy populations, such as adolescents and youths, family members, college students and the general public [27], [28], [29], [30], [31]. Other studies have put more emphasis on the role of religiousness in alleviating emotional stress and enhancing the well-being among caregivers of disabled persons rather than to investigate the role of piety in influencing mental health of the disabled themselves. The majority of these studies revealed that caregivers of disabled individuals promoted their well-being reversing or at least reducing any negative feelings by helping them concentrate on religious involvement [11], [32].

Many studies commonly reported that religiousness is a powerful resource of hope, comfort, solace, meaning and purpose in life. These protective and beneficial effects are particularly strong in people with illness and disability [33], [34], [35], [16], [36]. Private religious involvement was a beneficial and protective factor for recently disabled men to fend off depression resulted in their functional disability [37]. In addition, Koenig, Cohen, Blazer, Meador, and Westlund [38] examined the beneficial effects of religiousness on depression in 850 older patients with disability and other chronic health problems. The survey of the sample showed piousness was significantly and inversely related to depressive symptoms even after controlling for a set of confounding variables. More notably, the interaction term between the extent of disability and religious coping was significant, which denoted the negative association between religiousness and depression was strongest for patient participants who were with more serious disability. According to Johnstone, Glass, and Oliver [39] religion is used by many individuals with disabilities to help them adjust to their impairments and to give new meaning to their lives.

Although there is a well-established literature on the positive relationship between religiousness and mental health, little is known about how people use religious beliefs and practices to establish meaning for and respond to a life with disability. Little is known about whether religious involvement would contribute to better adjustments and well-being among those with a disability who are religious. Furthermore, there has been limited number of explorative qualitative research available for investigating how disabled individuals employed their religious faith to cope with challenges and difficulties they encountered. A research conducted by Treloar [40]reported that religiousness stabilized the lives of the disabled, providing meaning for the experience of disability, assistance with coping and bolstering other benefits to the participants with physical disabilities. In addition, the participants reported that increased assistance by the church in promoting theological understanding of disability and religious support in using a continuing model of caring were important in keeping them feeling mentally healthy.

Religion in people's life with Intellectual Disability (ID, hereafter) can help to fill the vacuum created by this handicap. ID is a condition of impaired or incomplete development that does not permit the individual to compete in society. It is a condition diagnosed before age 18, usually in infancy or prior to birth, that includes below-average general intellectual function, and a lack of the skills necessary for daily living. ID is determined by individual standard assessment providing ratings below 70 (100 being the population average), and the impaired ability to adapt to the demands of normal life. ID affects about 1 to 3 percent of the population [41]. Many of these lives are being reshaped on the harsh anvil of disillusionment and frustration. Religion is very important in the individual's attempt to find a solution to the problem, because God is an inner source of support and solace [42].

Unquestionably, religious belief, faith systems and church involvement are often major sources of strength in dealing with the problem of ID in a family. The clergyman by his very presence can help through patience, visiting both parents together as well as separately, encouraging the family to express not only their feelings about their child's ID, but also all their positive or negative feelings, their hopes, expectations and fears [43].

The individuals with ID, even though they comprehend very little, they sense the projected faith of the congregational atmosphere of the emanated calmness and security. The persons with moderate or mild ID not only have the capacity of feeling the presence of God, but in greater or lesser degree they can comprehend when concretely illustrated certain abstract ideas about God, church and religion. Of all who participate in worship, in Sunday School, in receiving the sacraments or the church's social programs, the individual with ID undoubtedly receives as much satisfaction as does any other individual [42].

One of the finest motivations in the congregation is the interpersonal relationship that can be developed between persons with ID and the other members of the congregation. It is important for the person with ID to engage in social exchanges with the group of the other churchgoers, because both of them give a purity of love and devotion [42]. The individual with ID approaches the church and its people in perfect trust. This mutual understanding and trust can flourish the socialization of people with disabilities [42]. The role of religion in developing a personal life must find its outlet in developing relationships with others. Vogel, Polloway, and Smith [44] provided a review of the relevant literature on religious participation in faith communities for persons with disabilities and blended the limited data available on these topics with the perspectives of individuals whose efforts focus on these concerns. Topics explored are the implications of being part of the faithful community in terms of its impact on quality of life, the barriers to inclusion in such communities, strategies for overcoming these barriers, and special considerations for adults with intellectual or other developmental disabilities.

This specific attitude and condition guided the planning of the present intervention. People with severe ID living only within the confines of institutions, as were our participants, have but very few opportunities to increase their knowledge and experiences necessary for their personal development. This intervention aimed to provide our participants some social and symbolic knowledge of the local custom of baptism while establishing a supportive relationship with the priest of their parish. Since the participants occasionally visit their local church, we reasoned a baptism would be a more likely and approachable social event they might attend and a teaching program on the mystery of baptism might increase their future participation in church events as a vehicle for increased socializing with the rest of the congregation. This study was an educational intervention aimed to develop religious knowledge in people with severe ID at residential facility. The hope is that such knowledge will facilitate increased opportunities for inclusion and socialization with their community outside their residential facility through increased contact with their local church and priest.

The purpose of any special education program is to support people with Special Educational Needs physically, mentally, emotionally and socially, to promote them as far as their capabilities allow, and to integrate them in the social environment on conditions of parity, freedom, security and respect of their personality. In teaching persons with disabilities, we care about the quality, not the quantity, of information and a satisfactory outcome in every lesson. The aim is experiential teaching [45], the adoption of the basic teaching of the Church [46]and the gaining of experiences [47]. Each curriculum is adapted to the degree of difficulty of the student's problem. According to Anstotz [48] the teaching model that adapts to the student's personality is called adaptive teaching. In a case of serious ID, the curriculum is limited to simple skills [46]. According to Polychronopoulou [49] the purpose of education is not different from that of normal children. In special education, it is necessary for activities to have experiential character [50]. What is taught in the classroom it is also important to be used in everyday life of children with disabilities [46] in order to be effective and to benefit these children. Furthermore, an important prerequisite in order to maintain the students' interest, attention and active participation is to connect teaching with daily experiences of the students [48], [51], [52],[49] and to perceive it as part of everyday life.

The education of children with ID needs to have specific goals, such as sociability, independent living skills, confidenceand productivity [48]. Their training continues with the goals of integration as members of society, of their professional resilience and of practicing what was taught [53]. Systematic teaching with repetition is a good combination for a successful training approach for children with ID [52]. Moreover, the attitude of the teacher should be characterized by calmness, maturity [52], patience by methodical and unhurried instruction [48]. This study was a special education program for persons with ID in order not only to obtain basic knowledge about the Christian Orthodox mystery of baptism and its symbolism but also to be active members in their religious community.

II. METHOD

1. Participants

Seven adults 25 to 64 years old with moderate or severe intellectual and other disabilities from a residential facility participated in this study. All participants have limited expressive language and there is no available Greek-standardized test of expressive language ability we could use, thus we could only indirectly evaluate their linguistic ability via Verbal Scales of the Wechsler Intelligence Scales (WISC III). Participants were evaluated before the intervention on their mental capacity with the Wechsler Intelligence Scales for Children (WISC III). Table 1 shows the age and the mental scores of each adult.

Table 1. The ages and WISC III scores of all participants

NAMES	AGE	INTELLIGENCE QUOTIENTS WISC-III
GIORGOS	46	58
ANTONIS	25	34
BARBARA	49	53
JOAN	35	35
MARINA	60	34
VICTORIA	33	30
SOTIRIS	64	37

1.1. Setting

All experimental sessions took place where the participants resided. This facility is located at the outskirts of a coastal town in central Greece. There, a quite room was allocated for the whole duration of this intervention containing three tables arranged in a u-shape and eight evenly spaced chairs on the three exterior sides of the u-shaped tables. A video camera on a tripod was positioned at the open side of the tables facing the group of the participants. Allexperimentalsessionswereconductedduringlatemorninghours.

1.2. Materials

The independent variables of the present study were items used for the enactments of baptism: a baby doll, a baptismal font, a cross, olive oil, water, consecrated myrrh, two cards showing the dove and Jesus Christ, a New Testament (Holy Bible) and the presence of the priest presenting the process of baptism.

1.3. Procedure

During baseline sessions the process of baptism was presented to the participants and after every session each participant independently was asked nine questions and his/her responses were recorded.

During training the process of baptism was presented with the question for every step of the process and each answer, and again after every presentation each participant independently was asked nine questions and his/her responses were recorded.

There were two generalization probes conducted, one within the premises of a small church and the other within the premises of the large dining room of a monastery.

During all experimental conditions all participants were brought into the designated room and were seated around the tables. The experimenter turned on the camera and the priest started the representation of the mystery of baptism.

With the beginning of training the priest provided models of all questions and answers, and as training proceeded he provided models of appropriate answers only when the participants could not respond. Training was completed in 6 sessions. The questions and the answers were taught in this given order:

1) What prayer does the godmother confess since the baby cannot talk?

'She recites the Creed of Faith the prayer "I believe"'.

2) Why does the godmother put oil on the child to be baptized?

'To slip away from the difficulties and always be strong'.

3) Why does the priest put the child in water?

'To be cleansed, brightened, made cheerful'.

4) Where do we put oil on the child, which part of the body?

'The participants show and tell the body parts on their body'.

5) After baptism who will always be with the baptized child?

'God, Christ and the Holy Spirit will always be with the child'.

6) How did God become with us?

'Through the water, the oil and the chrismation God is anointed within us'.

7) What kind of gift does the child give to God?

'He offers some of his hair'.

8) What does the godmother sing when circling three times around the font?

'Anyone who is baptised is strong, because Christ is power, love and joy'.

9) What is the gift that the child receives in baptism?

'It is the Cross, because it represents strength, hope and resurrection".

Each session lasted approximately 25 minutes, that is, the time it took to complete one showing of the baptism procedure and the interviewing of each of the eight participants. For the whole duration of training verbal praise was given for appropriate responses. During all conditions of the intervention (baseline, training and generalization) a final reward was given to each subject for their good participation (bonbonier: a traditional

pouch with candied almonds given at baptisms). A week after the termination of training all subjects participated in the two above mentioned generalisation probes. During these two generalization probes no verbal models, corrections, verbal praise and final reward for good participation were available.

1.4. Experimentaldesign

A within-subject multiple baseline design across three questions through conditions of baseline, teaching, probing and generalization for the eight subjects was used to show the acquisition of the ability to obtain and maintain the taught responses.

1.5. Dependentvariablesandmeasurements

Data was collected and graphed individually for each participant. The dependent measure was the number of correct answers of each participant per session. As correct answers were counted any contextual exchanges (words, phrases or sentences) which were audible, comprehensible and completely independent. Data was also collected on untrained contextual answers, on partial answers and on non- contextual answers. Datacollectionandanalysislastedtwomonths.

1.6. Inter-observeragreement

All sessions were recorded on video and scored by two trained observers (the experimenter and another observer). Inter-observer agreement was scored for each response (point by point) and was calculated as the number of agreements, minus the number of disagreements, over the total number of responses. All session were scored for inter-observer agreement and the mean agreement found was 94%.

III. RESULTS

Results appear individually for each subject as the number of trained answers, shown with blackened circles, untrained answers with open circles, partial answers with blackened triangles and non-contextual answers with opened triangles across consecutive sessions during all experimental conditions. The abscissa represents consecutive sessions and the ordinate the number of correct answers. The vertical lines represent changes in experimental conditions between baseline, teaching, initial probe and generalizations probes. The names of the participants have been changed to conceal their identity.

Fig. 1 shows the number of correct answers of Antonis per session. Antonis during baseline reached a level between one and two partial answers in the second and third set of questions. During teaching Antonis' partial answers resisted decline and were maintained between one and two while his trained answers reached the level of two in the first and third set of questions and remained at the level of one trained answer in the second set. Antonis showed a level of one to two trained or untrained answers in the first generalization probe and increased to the level of two in the first set and three in sets two and three on the second generalization probe.

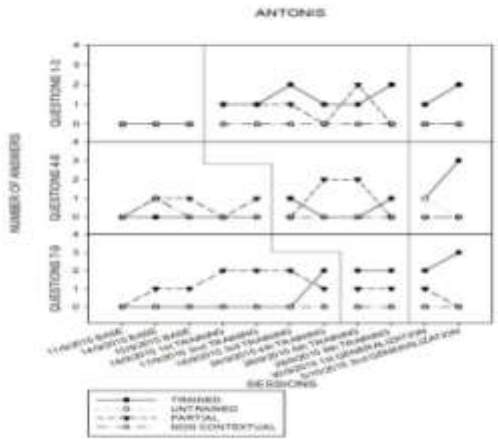

Figure 1. The number of correct answers of Antonis per session.

Fig. 2 shows the number of correct answers of Barbara per session. Barbara during baseline responded with one partial answer in the second and third sets of questions (4-9) and then learned all trained answers with the initiation of training. She showed acquisition of two correct answers of the last set of questions (7-9) the session before teaching was initiated for these questions that is on the seventh exposure to the baptism ritual. Barbara as well maintained knowledge of all the correct responses during both generalization probes.

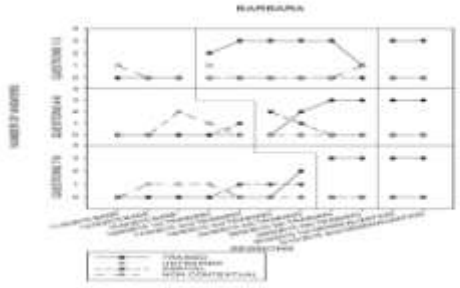

Figure 2. The number of correct answers of Barbara per session.

Fig. 3 shows the number of correct answers of George per session. George during baseline answered up to two questions per set mostly with partial and some untrained answers. These partial and untrained responses decreased to zero with the initiation of training gradually on all sets. He learned the correct answers increasingly faster within three sets of questions and for the last set (questions 7-9) achieved as Barbara the acquisition of these three answers during baseline condition. This effect happened after the fifth enactment of the baptism ritual and it was most likely due to the learning of the answers before initiation of teaching through observing the ritual. George maintained knowledge of all the correct responses during both generalization probes.

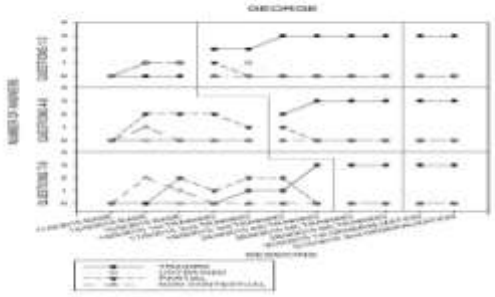

Figure 3. The number of correct answers of George per session.

Fig. 4 shows the number of correct answers of Joan per session. Joan during baseline likewise showed one to two partial answers in the second and third sets of questions. She also showed two trained answers on the seventh baseline session. During training Joan's trained answers gradually reached the level of two while her partial answers remained between one and three with a mixed tendency to decline in sets one and two and to increase in set three. During the generalization probes Joan again reached a level of two trained answers and maintained a level of one partial answer in the third set of questions, while in the second set she reached a level of three trained answers on the second generalization probes.

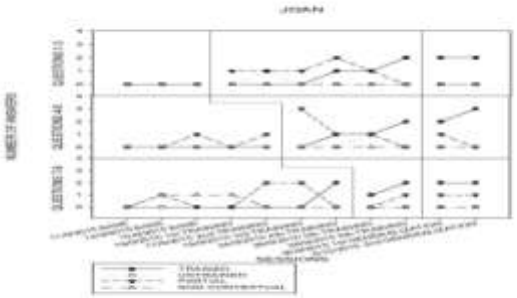

Figure 4. The number of correct answers of Joan per session.

Fig. 5 shows the number of correct answers of Marina per session. Marina during baseline had between one to two partial answers. During training Marina's partial answers declined to zero while her trained answers gradually reached the level of three per set. During the two generalization probes Marina responded with all trained answers in the first and the third set while she responded with two partial or trained answers in the second set. Her unsustainable performance in this second set of questions was also evident by her slow acquisition of the correct trained answers during teaching.

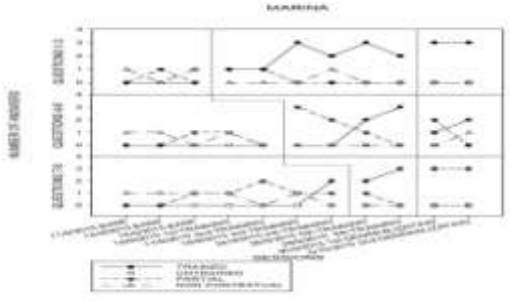

Figure 5. The number of correct answers of Marina per session.

Fig. 6 shows the number of correct answers of Victoria per session. Victoria during baseline had one to two non-contextual answers in the first two set which quickly declined to zero and she continued responding with an untrained answer in the second set and between one to two partial answers in the third set of questions. During training Victoria reached only the level of two untrained answers in the first and third set of questions while responded between one and three partial answers in the first two sets. She had a similar to training condition performance during the two generalization probes reaching the level of two trained answers.

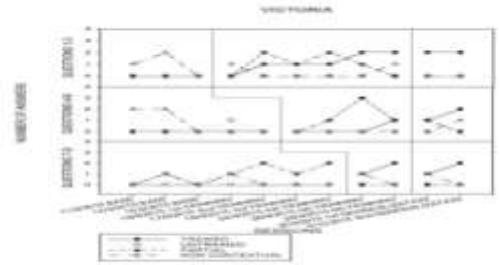

Figure 6. The number of correct answers of Victoria per session.

Fig. 7 shows the number of correct answers of Sotiris per session. Sotiris during baseline had an untrained answer. During training Sotiris' trained answers gradually reached the level of two and three while his untrained answers remained to one in sets two and three. During the generalization probes Sotiris again reached a level of three trained answers and diminished the partial answer in the third set of questions.

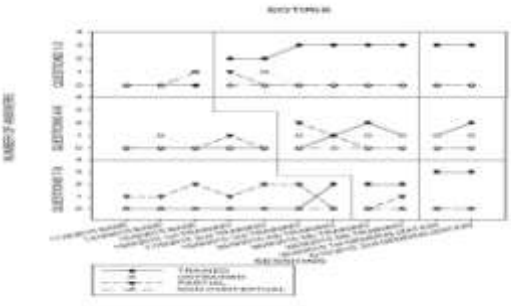

Figure 7. The number of correct answers of Sotiris per session

IV. DISCUSSION

The present study demonstrated that the participating adults with moderate or severe ID obtained basic knowledge about the Christian-Orthodox mystery of baptism and its symbolism and generalized this knowledge to new situations and new environments. More important to the participants was their new relationship with the priest of their parish, who was strongly motivated to establish a consoling relation with them. Before this intervention participants did not know about the mystery of baptism. The provided enactments, questions and answers on this religious ritual led to the acquisition of these responses and to a developing relationship with the local pastor.

Overall, these adults participated more during the novel situations of the generalization measures, possibly because these new situations were of more interest to them and presented conditions in which they could exhibit their newly acquired skills. Thus, generalization of learning by individuals with ID is feasible even with a brief but effective educational intervention.

This intervention was an opportunity for ID adults to participate and to better understand a religious mystery, but it was also an opportunity to gradually build their relationships with their religious community. Teaching people with ID appropriate social and interpersonal skills is one of the most important functions of special education. Thus, adults with ID learn to socialize, to cope up with life's demands and take care of themselves. They can be trained in religious mysteries and so can engage in them more actively.

According to Smith [54] moral order provides people's normative ideas about what is good and bad, right and wrong, worthy and unworthy, just and unjust, which go beyond an individual's own desires and standards, and could be conducive to the developments of oneself and the society as a whole. Learned competencies may enhance people's social skills and knowledge and contribute to their overall well-being and life chances. Concerning the socialization religious people could meet many other members in their religious communities who care about and give guidance to them. This constructive relational network would be helpful for human growth and developments in long run. Obviously, Smith puts more emphasis on the socialization process of religious involvement.

Pati and Parimanik [55] and Indrabhushan, Amool, and Akhtar [56] demonstrated that social development decreases with increasing severity of ID. That is why the necessity of training, managing and rehabilitating children with mental ID is of great importance. Social integration of people with disabilities is gradually becoming an even broader social welfare; its materialization, however, depends on the contribution and cooperation of the entire educational community. In such an effort the role of the Church becomes evident, more so nowadays when the social policy of the State seems to be developing tendencies of self-restraint.

The Orthodox Christian Church of Greece has traditionally promoted the overall work of ministration and charity, primarily towards people with disabilities. Nevertheless, self-sufficient action aiming at their social integration cannot be systematically organised. Dellassoydas [46, 597] reported that "their social integration cannot be the concern of the established church only; each one of us should have a share in the concern, to be expressed through our attitude and efforts. Consequently, the role of religious education in this particular orientation, that is, the formation of appropriate attitude and action, constitutes a major factor." Kampert and Goreczny's research [57] showed that community involvement and increased socialization are among the most common desires expressed by individuals with ID.

As more individuals with intellectual or developmental disabilities are physically included in community life, in schools, neighborhoods, jobs, recreation, and congregations, the challenge of going beyond physical integration to true social integration becomes more apparent [58]. Thus, churches should play a major role in fostering greater acceptance of and respect for the ID. Specifically, clergy can give sermons that highlight the dignity of all people, including ID children and adults, educational programs for church groups and for the public should be sponsored, providing information about the capabilities and needs of mentally handicapped people and about current programs for these people. Children and adolescents with ID should be integrated into religious education programs and be encouraged to join in church. Special classes for those not able to participate in regular classes should be provided. Finally, moral support for residential and work programs in community or neighborhood should be provided. This can be done at public hearings held to inform the community about programs that plan to locate in the area.

AbdAleati, MohdZaharim, and Mydin [59] showed that there has been an increasing interest in the role which spirituality and religion play in mental health. Furthermore, George, Ellison, and Larson [60] argued that religiousness affects positively people's health. Based on prior relevant studies, they proposed four psychosocial mechanisms through which religious involvement could promote positive health outcomes. These mechanisms are health practice, social support, psychological resources (e.g. self-esteem and self-efficacy), and belief structure (sense of coherence). They concluded that religiousness might facilitate and enhance these four mechanisms and that these four mechanisms could act as robust mediators to influence a variety of health and behavioral outcomes.

Religiousness can promote various resources, including spiritual, cognitive, psychological and social. Not only do these assets have unique positive effects on mental health, but they also interact and mutually reinforce each other. Therefore, more social resources, such as greater supportive social network derived from one's faith community, will further enhance one's religious involvement and in turn reinforce his/hers spiritual resources. Having a greater sense of belonging and a closer relation to the faith community, will make anybody more open to follow religious values, norms, teachings and traditions. In addition, through engaging in a faith community one also augments his/hers supportive social network and relationships by this contact and interaction with others in the community. Having a more cohesive and supportive social network and interpersonal relations will in turn enhance one's psychological and cognitive resources. It is evident that a social network will contribute to an individual by having similar psychological and cognitive characteristics [61], [62]. Therefore, people will learn to be more confident, optimistic and hopeful, and see the world less apathetic and more joyful, even when life stressors emerge. Religious involvement would result in a set of religious resources, such as spiritual, cognitive, psychological and social resources, which will mutually interact and reinforce one another. Religiousness is hypothesized to contribute to mental health of the believers through this process of mutual interaction and reinforcement.

"Although studies examining religion, spirituality, and mental health generally indicate positive associations, there is a need for more sophisticated methodology, greater discrimination between different cultures and traditions, more focus on situated experiences of individuals belonging to particular traditions and, in particular, greater integration of theological contributions to this area" [63, 852].

This study attempted to fill the gap between people with ID and religiousness. Its general potential is for the participants to approach and follow other religious values, teachings and traditions, which may in turn gradually develop their religious feeling, their spiritual realm and their experience of the transcendental.

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