MEDICALISATION OF SADNESS,

DEPRESSION AND SPIRITUAL DISTRESS

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ABSTRACT

A qualitative study was conducted amongst 57 practising Catholics in Spain: students, priests, and contemplative monks and nuns. Through semi-structured interviews, participant observation and ethnography their understanding of severe sadness and the difference with pathological sadness, coping mechanisms and help-seeking behaviour were explored. The participants clearly differentiated between sadness in response to a cause, sadness that "made sense", and cases where sadness was not explained by the context, sadness that "did not make sense". The former was seen as a normal reaction to adversity which should be resolved by the individuals' social, cultural and religious resources, while the latter was likely to be conceptualised as pathological, along the lines of depression, warranting psychiatric consultation.

It was also found that religion played a crucial role in the way sadness was understood and resolved: symptoms that otherwise might have been described as evidence of a depressive episode were often understood in those more religiously committed within the framework of the "Dark Night of the Soul" narrative, an active transformation of emotional distress into a process of self-reflection, attribution of religious meaning and spiritual growth. A complex portrayal of the role of the spiritual director and the parish priest in helping those undergoing

sadness and depression emerged, containing positive aspects and criticisms of some priests' lack of commitment and mental health training. This study emphasises the importance of taking into account the context of depressive symptoms, as the absence of an appropriate context is seemingly what made participants conceptualise them as abnormal. It also warns about the risks of medicalising normal episodes of sadness and raises questions about the lack of face validity of the current diagnostic classification for depressive disorder, which exclusively uses descriptive criteria. The thesis concludes by making some suggestions regarding differentiating normal from pathological sadness and how to incorporate existential issues into clinical practice.

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SECTION 1

INTRODUCTION

1.1. CONTEXT OF THE WORK

According to the World Health Organization, depression will be the second biggest disease burden by 2020 (Murray & López, 1996). However, some of this increase may be due to misdiagnosis. A decline in the assessment of patients' personal experiences and their cultural and social contexts (e.g. Andreasen, 2007; Dalal & Sivakumar, 2009; Jadhav & Littlewood, 1994) is likely to produce diagnoses overly based on symptoms with the subsequent labelling of normal human experience as disorder. In the current study, my aim is to build on the critique of the failure of the current psychiatric diagnostic classification to distinguish depressive disorder from a normal distress reaction in the face of loss (e.g. relationship, financial or health losses). I argue that the current decontextualised diagnostic criteria for diagnosing depressive disorder (since the DSM-III, in 1980) do not differentiate between abnormal sadness (sadness without an identifiable cause) and normal sadness (sadness with a clear cause) (Horwitz & Wakefield, 2007).

The growing medicalisation of normal human sadness fits well with our current social and medical landscape: society's increasing conceptualisation of physical and psychological suffering as a medical problem with a clinical or pharmaceutical solution; modern medicine's tendency to medicalise life's emotional difficulties; the pharmaceutical industry's economic interests; and finally, doctors succumbing to the pressures of overstretched health services that tend to favour the use of antidepressants rather than more costly psychotherapeutic treatments (Donohue, Berndt, Rosenthal, Epstein & Frank, 2004; Zuvekas, 2005), pressures that augment the use of medication as a response to emotional difficulties (Conrad, 2005).

1.2. RATIONALE OF THE STUDY

Normal and pathological sadness

Since 2006, I have been interested in the study of sadness, its conceptualisation, help-seeking behaviours, and the factors underpinning whether it was considered within the normality or whether it was thought to be pathological. Of the research projects I have carried out in this area, there were two - undertaken with highly religious samples - that compelled me to pursue the present broader research; they were also decisive as regards to the choice of participants. In this section, I will draw on other relevant studies on this topic, to which the design of my study is indebted, as well as on my two previous studies. I will explain how

the current project has been built on these studies in an attempt to both deepen our existing knowledge, and to tackle some of the questions that they left unanswered.

My first study was an ethnographic study based in a Spanish monastery of contemplative nuns (Durà-Vilà, Dein, Littlewood & Leavey, 2010). This study indicated that symptoms that otherwise might have been described as pathological and likely to meet diagnostic criteria for a depressive disorder were considered by the nuns to be normal and valued experiences, understood within the framework of the so-called "Dark Night of the Soul"[1] narrative: an active transformation of emotional distress into a process of self-reflection, attribution of religious meaning, and spiritual growth. This narrative of severe emotional distress was seen as a normal response to losses experienced by these deeply religious women (e.g. loss of personal religious beliefs, loss of certainty in their religious vocations, and the shrinking monastic community owing to secularisation in modern Spanish society). In the religious context of a monastery, the failure of the diagnostic classification to differentiate between the normal reaction to loss of faith and depressive disorder becomes apparent. Conceptualising their episodes of deep sadness as psychiatric disorders would not have made sense for them: their Dark Nights of the Soul needed to be explained (and resolved) in terms of their religious existential frameworks.

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[1] The origin of this expression comes from the title of 16th-century Spanish literary work, "La Noche Oscura del Alma" (Dark Night of the Soul), a poem and its theological commentary, written by the Carmelite priest Saint John of the Cross. In this book, he described the arduous path which the soul travels to reach mystical love. The participants' conceptualisation of the Dark Night is explained in detail in the "Findings", section 4.2.2.).

I also undertook a population survey in Spain (Durà-Vilà, Littlewood & Leavey, 2011) that was based on the critiques of the validity of the DSM diagnostic criteria for depressive disorder. Specifically, I attempted to empirically test Horwitz's and Wakefield's (2007) argument that these diagnostic criteria failed to differentiate between abnormal sadness or depression (sadness without an identifiable cause) and normal sadness (sadness with a clear cause). The sample, made up of 344 participants, was a highly religious one, as they were recruited from adult education centres associated with the Catholic Church. Participants were given a questionnaire containing questions regarding two hypothetical case vignettes portraying individuals experiencing deep sadness. Both vignettes fulfilled criteria for major depressive disorder (DSM-IV), one with a clear cause, the other without an identifiable cause. In summary, the study found that participants statistically significantly differentiated between the sadness-with-cause vignette, seen more frequently as a normal response to the vicissitudes of life, and the one portraying sadness without a cause, which was seen as pathological (and in particular, as a form of mental illness, along the lines of a depressive episode). The help-seeking behaviour recommendations followed this distinction: a medical option was statistically significantly more common when there was no obvious cause for sadness. This study emphasises, as did the previous one, though using a very different methodology, the importance of taking into account the context in which depressive symptoms occur, as it seems that the existence of an appropriate context that explains the symptoms makes people conceptualise them as normal. It also raises questions about the lack of

face validity of the current diagnostic classification for depressive disorder, which exclusively uses descriptive criteria.

Therefore, I set up the present study to further explore the conceptualization of deep sadness and help-seeking behaviours within a highly religious Spanish sample in an attempt to test and deepen my previous findings. I decided to investigate people's experiences of sadness with and without cause with a qualitative research approach and to considerably increase the diversity of the religious sample by including people in other monastic and religious settings, such as monks, nuns, priests and lay religious people. As ethnographic studies on nuns and monks are scarce (Hillery, 1992; Reidhead, 1998, 2002), I decided to obtain detailed anthropological data portraying their way of life, as well as biographical information from all the participants. An additional benefit of collecting and presenting this data here has been to provide a richer description of the participants, so as to contextualise the findings and conclusions of the study.

In contrast with the decontextualised diagnostic criteria generally used in psychiatric clinical practice, I decided to start from the micro-level of fieldwork and interviews, aiming to understand in depth the individual and the small group processes involved in normal and abnormal sadness. At the same time, however, the diversity of the sample was chosen in an attempt to reach conclusions that could be useful for the macro-level. I wanted to take the journey from the emic perspective - the "insider" perspective, taking into account the individual

sufferer's view - to the etic perspective - the "outsider" universalist position, focusing on medical categories - using a methodology that would be clinically relevant and contribute to building a person-centred psychiatric practice. My aim is to advance a conceptual framework - with testable and applicable notions - to distinguish pathological from normal deep sadness, transcending this religious Catholic sample. Without assuming uncritically the universality of the framework and without dismissing beforehand the cultural relativist worries, this framework should permit investigation through subsequent studies with non-religious participants.

Clergy as a resource for mental health

In my earlier study, which used a vignette-based structured questionnaire (Durà-Vilà et al., 2011), most participants viewed their parish priests as legitimate providers of help for normal and pathological sadness (but more so when it was considered normal). It was also quite striking that, for the sadness-with-cause scenario, seeking help from relatives and friends achieved virtually the same percentage (almost 70%) as seeking the support of a priest. Conceptualising sadness as due to a misfortune was also a predictor for advising the support of a priest: interestingly, the priest was seen particularly as having a role in helping people come to terms with life's tragedies and challenges, and as a central figure in their social support network. Most participants indicated that the alleviation of sadness was an integral part of their priest's duty of pastoral care and would

recommend relying on his help even in the secular experience of sadness (no information was given regarding the characters' religious background and there was no religious content in their symptomatology).

The above findings regarding the clergy influenced my decision to include a sub-sample of priests in the present study in order to address issues related to the boundaries of their pastoral care, their explanatory models for mental illness, their training, and their ability to recognize serious mental illnesses and to liaise with psychiatric services. Most of the literature supporting the clergy's role in assisting the mentally ill comes from the United States where community based clergy there have significant contact with people who suffer from mental health problems, many of whom prefer the help of the clergy rather than psychiatric professionals (Larson, Hohmann & Kessler, 1988; Mollica & Streets, 1986; Weaver, Flannelly, Flannelly & Oppenheimer, 2003). The National Comorbidity Survey determined that almost a fourth of the people seeking care for mental health problems obtained services exclusively from clergy, and almost 40% sought help for mental health problems from both clergy and a doctor or mental health professional (Wang et al., 2005). Along these lines, my two population surveys in Spain showed that devoted Catholic lay people would recommend both medical and religious help in times of severe psychological and emotional distress: the counsel given by the doctor and the priest were not seen so much as mutually exclusive, but rather as complementary (Durà-Vilà et al., 2011; Durà-Vilà & Hodes, 2012).

Few studies have investigated, from a qualitative perspective, the point of view of the clergy and their parishioners in this regard. In the UK, Leavey carried out interviews with clergymen investigating their role as a resource for mental health care in the community, their beliefs regarding mental illness, and the type of help offered to those affected (Leavey, 2008; Leavey, 2010; Leavey, Loewenthal & King, 2007). However, to my knowledge, there are no studies in Spain that have examined the views of the clergymen themselves or those of monks, nuns and lay religious people. Gathering the opinions and experiences of the participants who were not members of the clergy could be enlightening as they were the ones most likely to have sought the help of the clergy and would thus be in a position to offer first-hand accounts of their experiences.

The existing qualitative literature on the clergy and mental health influenced the design of the study. Firstly, most studies examined the clergy's attitudes about mental illness as a whole. I felt this concept to be too broad and opted to focus solely on depression, hoping to obtain clearer and more meaningful findings. Another potential benefit of studying depression was that, as it is the most common mental illness, the priests would have been more likely to have experience in dealing with it. Moreover, in Leavey et al.'s study (2007) clergy distinguished between psychosis and depression, with the latter being perceived as less threatening, more amenable to change, and offering them a better possibility to play a role. Secondly, as there seems to be considerable heterogeneity in clergy's views within the Abrahamic religions - even within different branches of Christianity -, I thought that by concentrating on a more

homogenous sample in terms of ethnicity and religion (all being Spanish and Catholic) I could make more sense of the participants' understanding of mental health matters in pastoral care. Thirdly, I included participants from inner-city areas as well as from rural areas, as their concerns may differ (most previous research had recruited priests from urban settings).

1.3. AIMS OF THE STUDY

Firstly, I wanted to provide rich anthropological data on the participants and their contexts so as to portray their ways of life and contextualise the findings of the study; secondly, to explore how religious people conceptualise and differentiate pathological sadness from normal but profound sadness, looking for what signs, symptoms, experiences and behaviours they consider evidence of pathology; thirdly, to investigate the participants' coping strategies and help-seeking behaviours used for both normal and abnormal sadness; fourthly, to study the clergy's understanding of the above concepts, the care they offer to those experiencing sadness or depression, the training they may or may not have received, and their views regarding psychiatric care and collaboration with mental health professionals (the views on the role that the priests play in helping those suffering from sadness would also be sought from the non-clerical participants); and finally, to propose a framework for distinguishing pathological from normal deep sadness, or at least to open up new horizons in pre-existing

theories in an attempt to suggest universal concepts of disordered sadness that can transcend this particular context.

The main research questions that I wanted the study to find answers for could be summarised in three main ones: how my religious participants distinguish normal deep sadness from dysfunctional sadness; how this distinction influences the way they cope and resolve their sadness; and what role the clergy play in helping those undergoing both non-disordered and abnormal sadness. The research questions, including additional subquestions, are presented in more detail in the "Method", section 3.1. The "Findings", section 4, is divided according to the aims, with each subsection being devoted to answering the first four aims in the same order as they have been presented above. The final aim, which consists of proposing a framework for distinguishing pathological from normal deep sadness, will be presented in the "Discussion", section 5.6., due to its clinical implications.

1.4. CLARIFICATION OF TERMS

Contemplative and active-life religious orders

Contemplative nuns and monks are cloistered, leading a life devoted to prayer, and are secluded within the walls of a monastery or a convent. Conversely, active-life monks and nuns work outside their communities in the service of

others, for example, as nurses in hospitals, teachers in schools or as missionaries abroad. The nuns and monks where I conducted fieldwork belong to contemplative religious orders. Five of the priests associated with Sant Josep's Catholic theological college that I interviewed belonged to active-life religious orders. A detailed description of the participants is included in the Findings ("Participants and their contexts", section 4.1.).

Diocesan priests and religious priests

Priests in the Catholic Church are categorized as either diocesan or religious. Although both types of priests have the same priestly faculties, acquired through ordination by a bishop, there are important differences between them. Religious priests belong to a religious order, such as for example the Cistercian Order, which is the one the participating monks belonged to. They undertake three public vows, committing themselves to live in poverty, chastity and obedience to their Abbot, and they live in community sharing material goods. Moreover, the money they earn through their work is given to the community and what they individually need is provided by their order's superiors. In contrast, the diocesan priests take oaths of celibacy and obedience to the bishop of their diocese, but not of poverty. They receive a salary from the bishopric as payment for the service offered to a parish. They often live on their own in the parish house. They can also live with a relative (e.g. a single sister or their mother) or share a flat with other priests (Sada, 2008).

In the thesis, unless I specify otherwise, when I employ the term "priests" or "clergy" (as well as "members of the clergy" and "clergymen"), I am referring to diocesan priests. The study's sample includes twenty-one priests: nine of them were religious priests and twelve were diocesan priests. Of the nine religious priests, four were contemplative monks belonging to the Monastery of Sant Oriol and the remaining five belonged to active-life orders. Therefore, unless specified otherwise, for purposes of clarity, when referring to the study's participants, the term "priest" will exclude the four religious priests from the Monastery of Sant Oriol, who lead a life of contemplation secluded in a monastery. Similarly, when I use the word "monk", I am talking about all the contemplative cloistered monks of the Monastery of Sant Oriol, where I conducted fieldwork, whether they were ordained as priests or not.

Monastery and convent

Although in English, the words "convent" (or "nunnery") and "monastery" imply a difference in genders (the former being used in the case of nuns and the latter in the case of monks), the participants of my study used these terms in a different way: "monasterio" was used when it was located outside of a city, town or village and "convento" when it was in an urban setting. Some, although located inside towns, were still called monasteries, because although they were originally built in the countryside, the town had grown to engulf them. I have

employed these words as the participants did to be consistent with their use. Moreover, the Dictionary of the Royal Academy of the Spanish Language (2001) seems to be in agreement with the participants' definition of "monasterio" (from the Latin "monasterĭum") as a house where nuns or monks live in community, generally outside a town. The participating nuns and monks used the word "monasterio" to refer to their homes. In the case of the Monastery of Sant Oriol, where the fieldwork with the monks took place, the definition clearly applies, as it stood alone surrounded by mountains.

Mental health professionals

When I asked participants about their views on mental health professionals, they spontaneously referred to psychiatrists more often than to psychologists or psychotherapists. While some seemed to use these terms interchangeably, others clearly differentiated between roles, with a few specifically referring to different modalities of psychotherapy (e.g. psychoanalysis). When reporting the findings I will use the terms used by the participants themselves.

SECTION 2

LITERATURE REVIEW

2.1. DEPRESSION AND THE MEDICALISATION OF SADNESS: CONCEPTUALISATION AND HELP-SEEKING

2.1.1. Conceptualisation of sadness and depression

Medicalisation of sadness and suffering

Modern society does not seem to accept that the human condition has always been intrinsically linked to a certain degree of suffering. Nowadays, there is a preference to define any type of severe distress as a disease (Paris, 2010b). Andrew Solomon (2002), the author of "The Noonday Demon, an Anatomy of Depression", argues that humans are now treating as illnesses certain aspects of themselves that were previously understood along the lines of troubled mood states or personality faults, due to the emergence of new ways of ameliorating them. Conrad (2007) calls this process "medicalisation", pointing out several practical reasons for converting psychological suffering into a medical concern; for example, this medicalisation legitimizes unpleasant states of mind with the

consequence that government or private insurance companies might be required to pay for their treatment.

The validity of the current diagnostic classification for depressive disorder, which uses descriptive criteria exclusively, has been seriously questioned. It has been argued that the decontextualised DSM definition of depression wrongly encompasses both a natural reaction to life events and adversity, and serious mental disorder, thus blurring the distinction between normal sadness and the kind of depression that can lead to severe dysfunction and require medical involvement (Horwitz & Wakefield, 2007; Parker, 2007; Solomon, 2002; Summerfield, 2006). Moreover, economic inequality is an underacknowledged source of mental illness and distress: there is robust evidence that greater income inequality in rich societies is associated with a greater prevalence of mental illness and drug misuse (e.g. Pickett & Wilkinson, 2010). Summerfield (2006) questions the existence of depression as a universally valid pathological entity warranting medical intervention. He argues this to be a serious distortion which distracts attention from the lack of human rights and the miserable conditions that so many are living in, and he denounces the pharmaceutical industry as the main beneficiary in the biologisation of the human predicament. There is a pressing need to resituate individual and social suffering in their cultural and historical contexts and to examine the causes and contexts of depression more critically, as depressive symptoms are likely to be a reflection of wider social problems attached to certain aspects of modernity that need to be faced (Gone & Kirmayer, 2010; Kirmayer & Jarvis, 2005).

The discourse highlighting the importance of taking patients' aetiological models into account is not a new one (e.g. Kleinman, 1981; Kleinman, Eisenberg & Good, 1978). Clearly, individuals have a tendency to try to make sense of their experiences, particularly when these experiences have significance in terms of their effect on themselves or others. The significance or meaning that individuals give to their experiences is often contextualised by their occurrence in the midst of antecedent objective events. Thus, it is generally considered acceptable that people who have experienced a defined loss (e.g. bereavement, relationship breakdown, diagnosis of a serious illness, etc.) may become withdrawn, silent and tearful. Contrarily, we might consider it very odd if people in similar circumstances were to act in a cheerful, upbeat manner. Experience and cultural factors provide the benchmark for what is understandable or acceptable behaviour and influence attitudes and beliefs about illness, which in turn determine help-seeking behaviours (Kleinman, 1981).

Interestingly, lay people's causal views on depression tend to differ from the biomedical model. A British survey examining the attitudes of more than 2,000 lay people towards depression and its treatment showed that depression was portrayed in terms of emotional problems, was believed to be caused mostly by social and contextual factors, and did not warrant medical treatment (Priest, Vize, Roberts, Roberts & Tylee, 1996). In another British study looking at explanations of depression among Irish migrants, the belief that their depression was provoked by clearly demarcated life events such as bereavement or domestic abuse strongly appeared (Leavey, Rozmovits, Ryan & King, 2007). My

own population survey in Spain emphasized the importance of taking into account the context in which depressive symptoms occur, as it seems that the absence of an appropriate context explaining the symptoms was what made people conceptualise them as abnormal (Durà-Vilà et al., 2011).

Conceptualising sadness as a mental illness entails negative reactions and consequences beyond the obvious stigmatisation. The doctor's words explaining that a depression is "chemical" are indeed powerful, as they tend to be followed by words that diminish the personal responsibility that the patient has for the causation and perdurance of their depressive symptoms. In Solomon's words: "The word 'chemical' seems to assuage the feelings of responsibility people have for the stressed-out discontent of not liking their jobs, worrying about getting old, failing at love, hating their families" (Solomon, 2002, p. 20). Moreover, the elimination of normal sadness through psychopharmacological agents may also deprive the individual of the opportunity for beneficial change. There is a growing body of literature arguing the value of sadness for psychological and emotional maturation as well as for artistic creation, with many artists having created their best works out of their experiences of emotional darkness (e.g. Moore, 2004/2011; May, 2004). Going through periods of sadness and distress forces people to consider alternatives that in happier times might not have occurred to them; these alternatives are part of life's natural cycle, providing staging grounds for reflection and growth; however, nowadays we no longer think in terms of passages and transitions, and these

meaningful moments of sadness are wrongly interpreted as medical problems (Moore, 2004/2011).

The role of culture

Almost half a century of worldwide research has demonstrated that cardinal symptoms of depression can be found in all the cultures that have been explored (Sartorius, Jablensky, Gulbinat, & Ernberg, 1980; Weissman et al., 1996). Nevertheless, people's culturally shaped notions and their core values will clearly influence the clinical presentation of depression as well as its course (Kirmayer, 2002). There is wide variation in depression's symptomatic expression, its conceptualisation and the social response to it across cultures: what is labelled as depression in the West is given a radically different form of cultural canalization and expression in most other parts of the world, with people interpreting symptoms related to depression not as psychiatric problems, but rather along the lines of social or moral ones, and they are likely to reject medical or psychological treatment options which are rooted in culturally unfamiliar systems (Kirmayer, 1989, 2001; Kleinman & Good, 1985).

Besides the clinical variance amongst cultures, cross-national comparative community studies of depression have shown marked variation in their prevalence figures: for example, in Weissman et al.'s study (1996), the prevalence of depression in Lebanon was 19.0%, while in Taiwan it was only

1.5%. Moreover, the nonexistence of locally developed culturally appropriate measures leaves important questions unanswered, such as whether those people identified in the diagnostic interviews used in the epidemiological studies as suffering from mild and moderate depression would be treated differently and more effectively than as if they had been suffering from a psychiatric disorder (Kirmayer & Minas, 2000). Mainstream psychiatry research is not well-equipped to study the cultural attribution of meaning to sadness and distress because it tends to simplify the richness of the narratives to a box-ticking of symptoms. There is a need for epidemiological research informed by ethnography to identify clinically relevant cultural variation in depression (Kirmayer, 2001). In contrast with alien medical categories, idioms of distress offer a culturally appropriate way of wording and expressing distress and suffering that makes sense in their social and cultural contexts. There are cultural idioms of distress that are related to depression and sadness, such as the Latin American idiom "soul loss", which refers to a common experience of everyday distress that is thought of in terms of the loss of something essential which has been taken out of the self (Littlewood, 2002).

The social response to being diagnosed with depression is also influenced by cultural factors. Even in the United States and Canada, it implies some sort of personal weakness, a lack of fortitude, while somatic symptoms related to depression are considered more socially acceptable, being perceived as less stigmatising. This is particularly relevant in the case of Japan: the greater social acceptability of suffering from anxiety than from depression may explain the

low levels of clinical diagnosis of depression and the infrequent use of antidepressants for patients presenting depressive symptomatology (Kirmayer, 2001). Another interesting example is Kleinman's (1986) research in China: patients fulfilling diagnostic criteria for DSM major depressive disorder were diagnosed instead with neurasthenia, and their symptoms were chiefly attributed to the devastating consequences of the Cultural Revolution. Similarly, for the Ashanti and the Yoruba, the constellation of symptoms operationalised as depression in Western society was understood as existential issues, a natural product of the vicissitudes of life (Kleinman & Good, 1985).

Moreover, culture also varies in the value given to sadness and suffering. Japanese culture has traditionally attached value to melancholy (Watters, 2010). Cultures that have an appreciation for sadness and the benefits that can derive from undergoing times of emotional darkness are more likely to see these periods as non-pathological, while in the West, with its culture of happiness and avoidance of dysphoric moods, these periods, even in their mildest forms, may be diagnosed as depression. An example of the former case is that of cultural groups that give a spiritual dimension to suffering, such as the Spanish Catholic nuns of our previous ethnographic study that understood their times of intense sadness as non-pathological, as a normal and valuable part of spiritual growth, expressing it through the idiom of distress: Dark Night of the Soul (Durà-Vilà et al., 2010). In Buddhist Sri Lanka, Obeyesekere (1985) explained that depressive symptoms were defined in existential and religious terms and not as an illness. He argued that the unpleasant affects that accompanied this existential condition

were expressed in and perhaps even resolved by a variety of activities and meanings provided by the Buddhist orientation of the culture (e.g. achieving a heightened realisation of one's transitoriness). Thus, in situations as in the examples above, it would be meaningless for psychiatrists to persuade these people that they are suffering from a mental disorder known as depression. When considering the role of culture in psychiatry, we need to take into account that psychiatry itself is a cultural institution, with psychiatrists' views about illness often being different from that of their patients or the communities in which they practice (Kirmayer, 2001). For example, the campaign created by the Royal College of Psychiatrists (1992) in the UK entitled "Defeat of Depression", whose aim was to heighten awareness, raised serious concerns regarding the absence of anthropological considerations because of its dominant ethos of popularising the biomedical concept of depression (Jadhav & Littlewood, 1994).

The role of religion

Some religious people are reluctant to be labelled as suffering from depression, but prefer to attribute religious meaning to their distress, seeking inspiration from the experiences of sadness and desolation of mystics, many of whom left carefully written accounts of their sufferings (Álvarez, 1997). Due to psychiatry's reluctance to incorporate or relate to the religious beliefs of their religious patients - for whom a search for religious meaning and a transcendental dimension may be essential parts of their suffering - there is a danger of ending

up seeing spiritual quests as pathological, diagnosing them inappropriately, and offering inadequate treatment plans (Abramovitch & Kirmayer, 2003). There is a need for the DSM-V to continue considering religion as a cultural factor and for the ICD-11 to develop a similar category to that in DSM-IV, "religious and spiritual problems" (Abdul-Hamid, 2011; Allmon, 2011). Thanks to the latter, religion has evolved in the DSM from pathology to a cultural consideration (Allmon, 2011), and there have been included clinically useful examples of distressing experiences involving loss of faith, problems associated with conversion to a new faith, or questioning of spiritual beliefs (American Psychiatric Association, 2005).

Depression and the Dark Night of the Soul

Some religious people refer to periods of intense sadness and distress using the idiom "Dark Night of the Soul" to describe a spiritual process of undergoing deep transformation so as to liberate oneself from attachments and to deepen one's relationship with God. The three most important contemporary authors who have contributed to the study of the Dark Night, each having a book dedicated to this phenomenon, are Font (1999), May (2004), and Moore (2004/2011). May's book, "The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth", argues that experiencing a Dark Night is not exclusive to very holy people or to the mystics,

and that it can appear not only as a single unique experience, but in various ways throughout people's lives.

Moore emphasises that the Dark Night is a profound learning experience that invites the individual to surrender control and to accept uncertainty, to rely on something beyond human capacity: that is, on faith and those resources that are beyond rational understanding. He proposes that the Dark Night be considered as out of the ordinary but not aberrant, arguing against labelling difficult emotions as pathological. These authors all agree in highlighting the positive contributions of the Dark Night to the individual's maturation. May describes the Dark Night as an opportunity for one to be transformed from within, and as a valued experience that brings about positive change, more personal freedom and spiritual growth. Similarly to my findings with the nuns (Durà-Vilà et al., 2010), these authors also described in their works the crucial aspect of the Dark Night as a source of giving meaning to people's lives.

However, in spite of the beneficial aspects of the Dark Night, none of these authors seek to minimise the pain and suffering that accompanies it. They certainly do not romanticise this time of despair, nor offer an idealised naïve portrait of it. The Dark Night can be profoundly unsettling: they unanimously agree on the resemblance between the Dark Night and a depressive disorder, with the attendant risk of confusing the two. May (2004) attempts to clarify the distinction between the Dark Night and depression in modern psychological terms, arguing that a person's sense of humour, general effectiveness, and

compassion for others tend not to be impaired in the Dark Night as they are in the case of depression. Moreover, in spite of the suffering, those undergoing the Dark Night, deep down, would not really trade their experience for a more pleasurable one: at some level they feel the rightness of it. In another earlier book of Moore's (1940/1994), the bestseller "Care of the Soul", he argues that nowadays many Dark Nights are labelled as depression. He calls for a different way of understanding and dealing with this experience, one that deals with the very meaning of life, insisting that depression is a label and a syndrome, while the Dark Night is a meaningful event.

Despite the differences between the Dark Night and depression, all three authors warn about the risks of the Dark Night. The benefits of the Dark Night are only perceived once the darkness passes: "They [the benefits] come with the dawn" (Moore, 2004/2011, p. 3). People may not always get through the darkness, and it thus might not invariably lead to personal discovery and growth. Some people may succumb to depression or to some other illness (May, 1982, 2004; Moore, 2004/2011). Therefore, during the Dark Night, it is essential to have an accompanying personal relationship with an experienced spiritual director or confessor who is skilled in differentiating between a depression and a genuine Dark Night. Besides watching out for the possible dangers linked to this time of spiritual darkness, the spiritual director can also offer spiritual guidance, companionship and be a source of hope (Font, 1999). May abandoned his post as a psychiatrist to fulfil this role: "This is the curse of a health-care system dedicated to only fixing problems, a system too streamlined… frustrated, I found

myself gradually leaving the practice of medicine and dedicating myself more to the art of spiritual companionship. Here the priorities are reversed; we continue to care about easing suffering, but the meaning is what's most important" (May, 2004, p. 6).

I would like to end this section by placing my discussion of the Dark Night of the Soul within a more contemporary framework, taking into account the comprehensive analysis undertaken by Zagano and Gillespie (2010) of Mother Teresa's Dark Night. These authors argued that in spite of the severity of her sadness there was no real evidence of her suffering from clinical depression and that her profound prayer life - no matter how arid and confusing it became at times - not only sustained and nourished her missionary zeal but also prevented her from reaching emotional collapse. Moreover, they also threw light on her experiencing spiritual angst, proposing that it might have been conditioned by a childhood event: the assassination of her father, an Albanian nationalist, poisoned by the Yugoslav police. When years later Mother Teresa experienced God's absence, the loss of her father might have psychologically influenced this experience. In the Dark Night, the suffering is not over the loss of God but rather the loss of prior-held notions of God. Thus, if the suffering of Teresa in her childhood is somehow reflected in the Dark Night of her adult life, it is that as a woman she is invited to release the "fatherly" image she might have of God in order for resolution to appear.

"Cristianisme i Justícia" - a Spanish interdisciplinary research centre devoted to social and theological reflection - published two monographic numbers on this topic entitled "Believing from the Dark Night" (Cristianisme i Justícia, 1994, 1998). They include the testimonies of the Dark Nights of 19 men and women from very different social, educational and cultural backgrounds. The triggers of their darkness are very diverse with their suffering being caused by being severely ill, experiencing the death of loved ones, having spiritual crises and religious doubts, or undergoing unemployment, social exclusion and marginalisation amongst others causes. The common denominator of all of them is "their hope in the middle of their hopelessness" (Cristianisme i Justícia, 1994, p. 2). Their narratives richly portrayed a broad range of feelings such as fear, pain, loneliness and failure, as well as their need for feeling understood, loved and accompanied by God and those close to them. Their willingness to undergo their suffering from a faith perspective seemed to help them not to try to escape their sadness but to enable them to face it and achieve some resolution.

Salutary and pathological religious depression: the legacy of Font

I am dedicating a separate section to Jordi Font i Rodon's seminal contribution to this topic. My research is indeed indebted to the theoretical framework that he developed in his book "Religion, Psychopathology and Mental Health" (1999), which contains a life's work in the field of religious psychopathology. His findings are based on decades of in-depth exploration of religious people's

psychopathology (he led a clinic in Spain which offered consultations and treatment to religious people, mostly to monks and priests). Font (born in 1924) is a prestigious Spanish psychiatrist and psychoanalyst who held the chair of psychiatry in Barcelona University's Medical School for almost 20 years. Besides his medical career, he graduated in philosophy and theology in Frankfurt. He is also a Jesuit and a priest. Font's work - with his scientific and humanistic background united to many decades of clinical work - offers a unique insight into the field of religious psychopathology.

In his book, Font uses two adjectives, salutary and pathological, to precede the term "religious depression" in order to make an important distinction between two concepts: salutary religious depression (or the so called griefs, desolations, or Dark Nights of the Soul) and pathological religious depression, which is in the domain of psychiatry. The detailed descriptions of his clients' Dark Nights fitted well with the narratives of the nuns that I encountered in my ethnographic research in the Monastery of Santa Mónica (this is a pseudonym in order to keep the anonymity of the nuns) (Durà-Vilà et al., 2010).[2]

Font explains that the salutary religious depression can present with multiple symptoms such as: an unbearable vital deep sense of unease and a healthy guiltiness - to be differentiated from pathological guiltiness - that causes loving

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[2] I conducted fieldwork from July 2006 to June 2008 in seven visits approximately four months apart to the Monastery of Santa Mónica in Spain. The visits lasted an average of two days each. In addition to these, I attended a ceremony of profession of perpetual vows of one of the Sisters and held a collective meeting once the analysis of the data was completed to validate the findings (Durà-Vilà et al., 2010).

feelings to repair the evil caused. Anxiety and suffering often accompany the depressive symptoms and in each individual case, either the anxious or the depressive feelings tend to predominate. Other symptoms can be loss of interests and satisfaction, sadness, disappointment, lack of volition, feelings of emptiness, inhibition and anhedonia; a negative self-evaluation is dominant. Although there is a feeling of uneasiness on the part of those suffering these symptoms due to their awareness of their own personal limitations, the key difference with their pathological counterparts is a clear wish to recover completely, even if they feel without the strength for it. Along with tearfulness and crying, the somatic symptoms of depression are also present: loss of appetite (with possible loss of weight), tiredness, insomnia, waking up at night and especially early morning wakening. Other somatic complaints include: hypersomnia, vertigo, headaches, migraines, dysmenorrhoea, and dyspepsia, amongst other physical symptoms.

People suffering from salutary depression are characterised by passivity and slowness in action and speech. Even the most ordinary daily activities may seem unachievable to them. They may search for solitude or look for frequent and brief contacts. In contrast to the pathologically depressed, those going through the Dark Night do not avoid social interaction. On the contrary, community life is well maintained in spite of the inner suffering. Moreover, as they advance in this process of spiritual maturation, their interpersonal relationships and attitude of service towards others increase and become more spontaneous and sincere. In the suffering of the Dark Night, the psychological depressive process has, par excellence, the qualification of salutary, as this process starts with the conscious

search for the object of love (God), a search that becomes a radical and progressive sacrifice of all that is narcissistic in order to be united to God.

An essential difference with the pathological religious depression is that in the Dark Night of the Soul the individual never ceases to feel hope; nor does it lead to suicide. In the pathological depression - in contrast with the salutary one - there is a feeling of hopelessness; using Font's own words regarding the experience of the Dark Night of the Soul: "even if the little light is so tenuous that it seems to have gone completely out, in spite of everything, it can be seen without being apparent; it is through the absence of longing for anything that one finds it all" (Font, 1999, p. 105). The depressive tone of the Dark Night is a salutary expression of the pain provoked by the radical search for God. The experience of God might be felt to be alien or absent. Instead of a God of love, there is darkness, a painful emptiness, the "no res" (a Catalan phrase difficult to translate: "absolutely nothing" or "the void"). Apostolic activity does not suffer either from this Dark Night. In some cases, full activity - ideological as well as external action - is preserved.[3] Nevertheless, praying may become difficult and arid: a struggle to abandon one's own egocentric interests to obtain the love of God.

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[3] Many theological and psychological studies found that those undergoing a Dark Night presented a significant difference from those suffering from depression: their functioning being maintained. Amongst many testimonies of saints, mystics and religious figures keeping up their apostolic activity throughout the Dark Night; a recent example is that of Mother Theresa of Calcutta. In spite of the aridity of her spiritual life, she managed to present an apparently joyful exterior life and led a very active working life as she was totally convinced that her work with the poor was God's work (Kolodiejchuk, 2008; Zagano and Gillespie (2010).

Besides the salutary depression explained above, religious experience can also lead to a pathological religious depression that fits the criteria for a depressive episode. Font identifies two possible causes for the development of mental illness in the context of the religious experience: either the previous existence of an underlying psycho-pathologically depressive structure or the intensity of the conflict and the fragility of the subject.

2.1.2. Help-seeking and coping with sadness and depression

Antidepressants

The state of affairs

In the treatment of depression, the benefits of cognitive therapy, as compared to those of medications, have been well documented (DeRubeis et al., 2005; Hollon et al., 2005). The National Institute for Clinical Excellence (NICE) does not recommend the prescription of antidepressants as the primary intervention in mild and moderate cases, recommending instead psychotherapy as the first line treatment (National Institute for Clinical Excellence, 2004). However, antidepressant medication continues to be the standard treatment for all depression, regardless of the degree of its severity and in spite of recent studies throwing serious doubts on the efficacy of these medications. In contrast to the discomforts of the older antidepressants, the mildness of the side-effect profile of the modern antidepressants, selective serotonin reuptake inhibitors (SSRIs), may

have played a key role in their widespread use: "Prozac is so easily tolerated that almost anyone can take it, and almost anyone does… Even if you are not depressed, it might push back the edges of your sadness and would that not be nicer than living with pain?" (Solomon, 2002, p. 26-27). Thus, the relative innocuousness of SSRIs encourages overstretched doctors to offer these drugs perhaps too liberally and indiscriminately for long periods of time, leading to overprescription (Dowrick & Frances, 2013; Paris, 2010a). More importantly, there is currently no way of knowing what the consequences on the brain are of using them long term (Sodhi & Sanders-Bush, 2004). In the United States, somewhere between 25% and 50% of college students seen in counselling or health centres are taking antidepressants (Kadison, 2005). In Spain - where the study of this thesis took place - 745 million euros per year are spent on antidepressants (Magán & Berdullas, 2010). In England, an analysis of the data from the Prescription Cost Analysis from 1998 to 2010 found a clear trend: antidepressant prescriptions increased by 10% per year on average; this was double the increase seen for antipsychotic medication (Ilyas & Moncrieff, 2012).

Pharmaceutical companies, jointly with other social forces, may have led a movement to broaden the diagnostic criteria for depression to include everyday life problems, as they have a vested interest in promoting the diagnosis and pharmacological treatment of depression (Metzl & Angel, 2004; Summerfield, 2004). Healey (1997) suggests in his influential book, "The Antidepressant Era", that without the emergence of antidepressants, depression would not have become as prevalent as it is today, arguing that the pharmaceutical industry with

its marketing of antidepressants has had much to do with the prominence and establishment of the psychiatric diagnosis of depression. Thus, public views are likely to have been gradually influenced and shaped so as to agree with the need to recognise and diagnose depression, and with the effectiveness and benignancy of antidepressant medication. A recent national survey carried out in Australia clearly showed that over the past sixteen years public belief in the likely helpfulness of both antidepressants and mental health professionals has increased; similarly, beliefs regarding the likely harmfulness of antidepressants have decreased (Reavley & Jorm, 2012). A similar earlier survey undertaken in the UK of lay people's attitudes revealed a different picture: 78% of the participants perceived antidepressants to be addictive and as being likely to mask rather than solve the problem (Priest et al., 1996). However, whatever the public's attitude toward antidepressants might be, considering these drugs as capable of solving on their own something as complex as depressive phenomena seems rather naïve: "We would all like Prozac to do it for us, but in my experience, Prozac doesn't do it unless we help it along" (Solomon, 2002, p. 29).

Moreover, research evidence has emerged questioning the effectiveness of antidepressants. Recent meta-analysis revealed that a placebo was as effective as antidepressant medication in reducing depressive symptomatology except when the symptoms were very severe, and only in this latter case were antidepressants more effective than a placebo (Fournier et al., 2010; Khan, Leventhal, Khan & Brown, 2002; Kirsch et al., 2008). A review was conducted by Pigott and colleagues (2010) which analysed four meta-analyses of efficacy trials submitted

to America's Food and Drug Administration (FDA). Besides these FDA trials, they also analysed the largest antidepressant effectiveness trial ever conducted, known as the Sequenced Treatment Alternatives to Relieve Depression (STAR*D). Regarding the FDA trials, the authors concluded that antidepressants were only marginally effective when compared to placebos, and documented profound publication bias has inflated their apparent effectiveness. They also noted a second form of bias in which researchers failed to report the negative results for the pre-specified primary outcome measure submitted to the FDA, while presenting in published studies positive results from a secondary or even a new measure as if it were their primary measure of interest. Pigott and colleagues' analysis of STAR*D showed that if its authors had taken into account the progressively increasing drop-out rate across each phase of the trial, the effectiveness of antidepressant therapies would probably have been even lower than the modest one that was reported (Pigott, Leventhal, Alter & Boren, 2010).

Do antidepressants affect the self?

Despite the remarkably widespread use of the new generation of antidepressants, almost everything we know about their effects comes from animal studies or clinical trials in which the sole parameter of interest is depressive symptomatology. Almost nothing is known about the effects that antidepressants have on what we think of as the self, with a number of authors from different

academic backgrounds, such as from the fields of ethics, philosophy and theology, having raised concerns about the likelihood of antidepressants having significant effects on personhood. Gold and Olin (2009) expressed their astonishment at the fact that the most popular medication in the United States and Canada should be one that manipulates brain chemistry, arguing that 25 years ago the idea of taking a drug daily that would alter global brain chemistry would have seemed to most people like a science fiction nightmare, triggering concerns as to what this would do to people's minds. Kramer (1993/1997), in his book "Listening to Prozac", highlights the impact that SSRIs may have on one's sense of self through the changes they make to people's personalities. In this book he introduced the term "cosmetic psychopharmacology", as these drugs, while ignoring our existential dilemmas, can be applied as "make-up" in order to achieve psychic enhancement, to make our personalities more attractive, and to make us more socially confident. Kramer provides depictions of people who were taking Prozac - although they were not clinically depressed - and who experienced positive changes in their personalities. It is interesting to note that from a Japanese perspective, the widespread use of Prozac in the West as a drug that alters personality is linked to the highly competitive nature of the United States and Canadian society (Kirmayer, 2002). On a different note, Svenaeus (2007), using a phenomenological approach, suggests that the effect of these drugs on the self needs to be thought of in terms of changes in self-feeling.

Kirmayer (2002) argues that medications change the narrative self through the attributions we make for our actions as we start conceptualising our behaviour as

being chemically determined, thus coming to the conclusion that we could not function without the medication. Solomon's (2002) quote reflecting on his own experience of taking long-term antidepressants illustrates this point well: "Taking the pills [antidepressants] is costly - not only financially but also psychically. It is humiliating to be reliant on them… And it is toxic to know that without these perpetual interventions you are not yourself as you have understood yourself. I'm not sure why I feel this way - I wear contact lenses and without them I am virtually blind, and I do not feel shamed by my lenses or by my need for them… The constant presence of the medications is for me a reminder of frailty and imperfection…" (p. 60).

Besides the potential effects on the psychological integrity of people, taking antidepressants may also have an impact on people's religiosity and spiritual lives. In a paper entitled "The Gospel according to Prozac", Barshinger and colleagues (1995) argue that antidepressants can trigger dilemmas and tensions in devout religious people as they are confronted by questions that challenge their beliefs, such as: what does it signify that praying and faith do not relieve depressive symptoms and antidepressants do? Perhaps even more disturbing, what does it signify when antidepressant medication seems to improve their spiritual life and experience of God? (Barshinger, LaRowe & Tapia, 1995). Chambers (2004) in his chapter "Prozac and the sick soul", illustrates the troubling nature of this subject, describing how a medical student recently consulted with him about a female patient who had been involuntarily admitted to the psychiatric ward. Her presenting complaint was that she was praying

unceasingly and there were concerns that she was not able to take care of herself. Both Chambers and the medical student were troubled by the idea that medication might cure the woman of her religiosity and might stop her praying. They thought that in a different interpretative context, her behaviour might have been considered as valued, as a spiritual experience. Chambers concludes his chapter saying that his main concern regarding the effect of antidepressants on religiosity is that pharmacological transformation may limit spiritual and psychological diversity. Thus, in his view, the value that we should be concerned with is not so much authenticity but rather diversity.

Religious coping and health

Religiosity's influence on health and depression

Although there are several ways in which religious beliefs and practices can have a negative influence on people's physical and mental well-being, religion can also have a positive impact by mediating between the social and individual dimensions of well-being (Van Ness, 1999). There is evidence that some aspects of religion are positively associated with mental health (Dein, 2006; Kang & Romo, 2010; Koenig, McCullogh & Larson, 2001; Levin, Chatter, Ellison & Taylor, 1996).[4] Religious communities are sources of social support and

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[4] However, many studies which have examined the relationship between religion and health are poorly constructed and theorised, and are problematic in terms of the definition and measurement

companionship, and faith equips the individual with coping strategies to deal with adversity and suffering (Grosse-Holforth et al., 1996; Krause, 1995; Tix & Frazier, 1998). Along these lines, Koenig (1997) identified three main mechanisms by which religion might promote mental health: firstly, through a system of beliefs that provide hope, comfort and a mental attitude of obtaining something good from every situation by trusting God; secondly, through increased social and emotional support from others; and thirdly, by emphasising a focus on God and on helping those in need as an attempt to transcend the self, forgetting one's own troubles.

There is research evidence supporting the notion that people who are religiously involved have more positive attitudes towards life and experience greater life satisfaction (Koenig et al., 1994). A large survey undertaken in Spain found that over half of those who described themselves as "very happy" had faith in God (Tristán, 2008). A Canadian study confirmed the association between attendance at religious services and lower levels of distress (measured using the General Health Questionnaire): the "no declared religion" group had the highest level of distress of all the groups (Jarvis, Kirmayer, Weinfeld & Lasry, 2005). An American study using data from the General Social Survey showed that people who declared themselves as religious reported themselves to be happier and to

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of religion and spirituality. For instance, attendance at church may not reflect "genuine" religious faith. The mechanisms that link religion and positive health effects are not well understood: they may be explained by religion forbidding certain behaviours, such as Muslims banning alcohol consumption and Catholics prohibiting sexual relationships outside marriage, or by the social support and companionship that religious communities provide.

enjoy better health regardless of religious affiliation, religious activities, work and family, social support, or financial status (Green & Elliot, 2010).

Turning our attention to depression, reviews of the literature strongly suggest that religion may be a protective factor for depression: being religious was associated with a lower incidence of depressive symptoms and depressive episodes as well as with a speedier recovery if suffering from depression (Dein, 2006; Koenig, 2001). Self-esteem arising from religious belief may act as a protective factor for depression: over half of the studies examining the relation between religion and self-esteem reported greater self-esteem among the more religiously involved (Dein, 2006). For example, a study conducted in Michigan with older adults found that feelings of self-worth tended to be lowest for those with little religious commitment, while those who relied on religion to cope had very high levels of self-esteem (Krause, 1995). There are also some studies replicating this positive association in the younger age groups, such as the study by Kang and Romo (2010) among Korean American adolescents that found that higher levels of church engagement were linked to stronger personal spirituality, which in turn predicted fewer depressive symptoms.

Similarly, the positive impact that being religious has on those suffering from a physical illness was confirmed by several studies. A study of patients diagnosed with cancer revealed that those patients who attributed greater control over the illness to God were rated by their nurses as having higher self-esteem and as adjusting better (Jenkins & Pargament, 1995). Koenig and colleagues (1992)

showed in a study of hospitalised physically ill men that the only characteristic that predicted lower rates of depression six months later was not the level of support from family or friends, physical health status, or income or education level but rather the extent to which they relied on their religious faith to cope. Another large study by the same author found that people who attended church frequently had lower rates of depression (Koenig, George, Meador, Blazer & Dyck, 1994). This association between attending church and less likelihood of suffering from depression was replicated in many studies in different areas of the United States and Canada (Koenig, 1997).

Religious interventions in secular medicine

At best, most medical doctors see religion as harmless, but largely irrelevant to clinical practice, and religious issues are usually not addressed during a medical visit unless they interfere with medical treatment (Koenig, 1997). In many religious groups, psychiatry and psychology are considered as being dismissive of dogma and God's existence. Therefore, turning to a doctor may express a lack of faith in God. There is evidence that religious people are less satisfied with a non-religious clinician than with a religious one. Patients may perceive doctors as failing to understand their religious beliefs and even ridiculing them (Dein, 2004). Thus religious people suffering from mental health problems may seek the advice of the clergy rather than secular professionals (Wang, Berglund & Kessler, 2003; Weaver et al., 2003). There is a considerable overlap between the

roles of spiritual directors and mental health professionals with regards to providing care to those undergoing severe emotional and psychological distress (Font, 1999; May, 2004; Moore, 2004/2011).

There has been a recent controversy that appeared in psychiatric publications over the appropriateness of certain religious interventions, such as doctors praying with their patients: while some psychiatrists were in favour of the benefits of this practice, others strongly voiced their concerns, arguing that such interventions breached professional boundaries (e.g. Davies, 2011; Haley, 2011; Poole & Cook, 2011; Sarkar, 2011). Although taking into account patients' spiritual needs in their care plans seems to be a less contentious issue for psychiatrists, asking clergy's advice or being in a position where the patient might enquire about the psychiatrist's own religious beliefs are sources of concerns, as they are perceived to be potentially harmful and in conflict with the General Medical Council guidance (Poole & Cook, 2011).

King and Leavey (2010) warned against the effects of such academic polemics, as they deflect attention from the importance that spiritual and religious factors play in psychiatric practice, factors which should not be ignored. For example, some of the most powerful evidence for religion's positive effects on mental health comes from studies that have successfully used religious interventions in the treatment of emotional disorders (Koenig et al., 1994), such as the one undertaken in Oregon by Propst and colleagues (1992), which compared the effectiveness of two types of cognitive-behavioural psychotherapy (the standard

version versus one with an additional Christian religious content) in the treatment of clinical depression in religious people. Their findings indicated that those receiving the religious version recovered quicker from their depression than those in the standard psychotherapy or control groups (Propst, Ostrom, Watkins, Dean & Mashburn, 1992). In Font's (1999) extensive psychiatric experience of caring for religious patients, simple religious practices such as the repetition of a few words or verses from the Psalms were found to be important sources of calm and relief that could be of value when trying to sooth religious patients' distress. Using religious imagery and messages in cognitive-behavioural therapy with religious patients may be more effective than therapy lacking this imagery (Propst, 1993; Propst et al., 1992).

2.2. THE ROLE OF THE CLERGY IN THE MANAGEMENT OF SADNESS AND DEPRESSION, AND THEIR COLLABORATION WITH MENTAL HEALTH PROFESSIONALS

In order to provide a context for the findings of the interviews regarding the Spanish priests' involvement in the care of those suffering from deep sadness and depression, I am presenting the relevant studies in this section. I have focused on the literature concerning the Western Christian context, and Catholicism in particular. A different picture is very likely to have emerged if the study would have taken place in a more religiously oriented socites (e.g. Kuruppuarachchi & Lawrence, 2006; Durà-Vilà, Hagger, Dein & Leavey,

2011). I start by looking at psychiatrists' attitudes and views regarding clergy's involvement in mental health care and the factors that may underpin them; this is followed by a depiction of the role that the clergy plays in the care of people suffering from mental health problems (paying particular attention to depressive disorder) and the dilemmas faced in this enterprise. I then offer an overview of the existing collaboration between mental health professionals and the clergy, the obstacles encountered and the conditions perceived to be needed for a fruitful collaboration to take place. Finally, I will look at what pastoral care entails, focusing on two key ministerial activities - spiritual direction and the sacrament of confession - which are considered in terms of the similarities shared with psychotherapy.

2.2.1. Psychiatrists' attitudes regarding clergy's involvement in mental health care

Although lately there seems to have been a growing interest and acknowledgement from mental health professionals of the role that spirituality and religion play in mental health (e.g. Royal College of Psychiatrists, 2004), members of the clergy are not considered as collaborators by the majority of mental health professionals, being often regarded with caution and suspicion (Koenig, 1988; Larson et al., 1988). For example, it has been argued that the social help initiatives existing within churches are motivated by proselytization rather than genuine altruistic reasons (Leavey, Durà-Vilà & King, 2011).

However, the vast but seldom quantified amount of long-standing social and health work quietly undertaken by the clergy and faith-based organisations addressing the unmet needs of those more vulnerable are often ignored, as are the various social justice campaigns championed world-wide by individual clergy and their institutions (e.g. liberation theology, black civil rights issues, and campaigns against capital punishment and apartheid) (Adriance, 1991; Leavey et al., 2011).

The negative attitudes towards the clergy are linked to many factors. Clergy are felt to be the representatives of religion, and their reputation has been - understandably - very much affected by recent sexual and financial scandals. Moreover, certain religious beliefs sustained by some members of the clergy - such as belief in demonic possession and exorcism - are not acceptable to secular values and are clearly a matter of contention among mental health professionals (Leavey, 2010). If religious patients were supported by their clergy in their beliefs regarding the supernatural origin of a psychiatric illness, this could have implications for pathways to care and compliance with the secular treatment proposed by their mental health team (Leavey & King, 2007). A significant number of mental health experts have even argued that religious beliefs and practices have a negative effect on the individual's psychological welfare, leading to psychiatric disorders and symptomatology (e.g. fomenting obssessionality and guilt) (Ellis, 1988; Freud, 1927; Watters, 1992), albeit others - being less openly critical - have considered religion to be irrelevant to health and clinical management (Koenig, 1997).

Another potential area of conflict with secular medical services is likely to be the clergy's use and application of a religious model to understand and cope with human suffering (Mollica & Streets, 1986). Even within a religious Christian context, critical voices have been raised suggesting that psychologically-informed pastoral care need not rely solely on biblical narratives and religious knowledge and have highlighted the clergy's lack of formal training and supervision in the area of mental health (Gilbert, 2007; Larson, Greenwold, Weaver & McCullough, 2000; Weaver, 1995). A study investigating clergy's knowledge of psychopathology found that clergy - from several denominations - scored lower than clinical psychologists, psychology undergraduates, and graduate students in clinical psychology and counselling (Domino, 1990). The deficiencies in the psychiatric and psychological knowledge of priests have also been frankly acknowledged by the priests themselves: many studies have consistently shown their dissatisfaction with the level of training they receive, a training that does not prepare them to assist mentally ill parishioners and their families (Farell & Goebert, 2008; Kaseman & Anderson, 1977; Leavey et al., 2007; Louden & Francis, 2003; Lowe, 1986; Virkler, 1979; Winett, Majors & Stewsrt, 1979;). For example, this need for receiving more training was clearly shown in a survey of 2,000 Protestant clergy from across the United States: practically all agreed that they would benefit from more training in pastoral counselling (Weaver, Flannelly, Larson, Stapleton & Koenig, 2002). Another study amongst Hawaii's Protestant clergy revealed that over 70% admitted to

feeling inadequately trained to recognise mental illness (Farrell & Goebert, 2008).

2.2.2. Clergy as a resource for mental health

The clergy has a long history of involvement in health care and has been favourably compared with psychiatrists as they are regarded as knowledgeable, caring and willing to help those in need of long-term support (Cinnirella & Loewenthal, 1999). Being popularly perceived within the community as trusted points of reference to consult in times of distress may give the clergy a pivotal role to play in initially assessing those suffering psychological difficulties, since they are in a position to advocate secular and spiritual interventions (Littlewood & Dein, 1995). They are sought out not only to help individuals with socio-emotional problems (e.g. bereavement, marital problems, etc.) - tasks more consistent with the training received - but also to provide support to those suffering from serious mental health problems (Stansbury, Harley & Brown-Hughes, 2009; Taylor, Ellison, Chatters, Levin & Lincoln, 2000; Young, Griffith & Williams, 2003). Moreover, many faith-based organisations are of particular importance amongst ethnic minority communities (Cinnirella & Loewenthal, 1999; Garro, 2003; McCabe & Priebe, 2004; Leavey et al., 2007).

There is considerable Western research evidence - predominantly from the United States - showing that community-based clergy have significant contact

with people with mental health problems, who sometimes opt to seek the advice of clergy rather than mental health professionals (Larson et al., 1988; Mollica & Streets, 1986; Weaver et al., 2003).[5] Approximately 40% of Americans with mental health problems resort to the clergy (Weaver, 1995), with some American studies showing that the clergy are more likely than psychiatrists and psychologists combined to be contacted for assistance with these difficulties (Hohmann & Larson, 1993; Veroff, Kulka & Douvan, 1981). The latter study found that clergy's guidance was even valued amongst those who were not highly religious: a sixth of participants who described themselves as "seldom attending religious services" and "not religiously active" still reported seeking assistance from the clergy for personal problems.

Religious-based beliefs about mental illness are likely to influence help-seeking behaviour (Chadda, Agarwal, Singh & Raheja, 2001; Cinnirella & Loewenthal, 1999; Cole, Leavey, King, Sabine & Hoar, 1995), determining from whom to seek help. My own studies undertaken in Spain found a strong association between the level of religious practice and the recommendation to seek the help of the clergy when suffering from deep sadness (Durà-Vilà et al., 2011) or when undergoing the distress described by the Hispanic idioms "nervios", "ataque de nervios" and "susto" (Durà-Vilà & Hodes, 2012). In both studies, amongst a religious sample, priests were seen as legitimate sources of help when facing

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[5] This might be related to economic factors and the lack of availability of free health care; thus the clergy plays a significant welfare role (e.g. Christian churches with predominantly African-American congregations in the United States).

emotional and psychological distress (around 70% of Spanish participants recommended the help of a priest when dealing with deep sadness, and 30% - 50% of Spanish nationals and Hispano-American migrants did so when suffering from the above mentioned idioms of distress).

Leavey and colleagues (2007) conducted a qualitative study in London consisting of 32 interviews with male clergy of different denominations (Christian ministers, rabbis and imams) with the aim of exploring the barriers and dilemmas that they faced in caring for those suffering from psychiatric disorders. Although clergy seemed to play an important role, they were not confident in managing people with mental illness and that a combination of fear, anxiety, lack of training and resources, as well as stereotyped attitudes about the mentally ill, prevented them from expanding and formalising their function further. The requests for mental health support seemed to be met by most participants with caution, reluctance and at times with rejection. An additional concern highlighted in the interviews was the perceived danger of moving away from spiritual guidance into a more secular way of helping. They feared a dissolution of their own religious vocations if they were to formalise further the task of helping those suffering from mental illness: becoming - as one of the participants pointed out - "a social worker in a dog-collar".

Another study by Leavey (2010) looking at Christian clergy's beliefs and attitudes to supernatural explanations in regards to mental illness revealed a complex and at times contradictory pattern of negotiation of these beliefs.

Although liberal and mainstream Christian clergy tended to be sceptical about a supernatural explanation for mental illness, other more traditional participants considered the devil to be the main source of illness and suffering. The possibility of mental illness being caused by religion, per se, was rejected by all the participating clergy. Nevertheless, they were aware of the attraction and shelter that religion can provide for people with emotional or psychological problems and seemed able to distinguish pathological religious beliefs from normal ones. Interestingly, some of the clergy were able to encompass both medical and spiritual interpretative frameworks about mental illness, considering them to be not mutually exclusive. Wang and colleagues (2005) determined from the National Comorbidity Survey conducted in the 1990s that almost 40% of people sought help for mental health problems from both clergy and a doctor or mental health professional. On these lines, my studies in Spain amongst a highly religious sample showed that devout Catholic lay people would recommend both medical and religious help in times of severe distress: medical and pastoral advice did not seem to be mutually exclusive alternatives, but rather complementary ones (Durà-Vilà et al., 2011; Durà-Vilà & Hodes, 2012).

The role of the clergy in the treatment of depressive disorder

A minister participating in Leavey et al.'s study (2007) drew an interesting distinction between psychosis and depression: in the latter, without denying its severity, the scope for reflection and intervention seemed to be perceived as

greater than in the former. Depression may be seen as less threatening (in this study the perceived risk of violence was greater for those with psychosis) and more amenable to change by the clergy, with religious beliefs concerning hope and meaning appearing particularly pertinent to someone who may be suffering from hopelessness, emptiness and low mood, among other depressive symptoms. Moreover, if depression is conceptualised along the lines of a moral disorder by parishioners, they may expect their clergy to become more categorical when assisting them through their depression (Leavey & King, 2007). The following three studies presented in this section are concerned with ministers' understanding of depression and their views about their contribution to its resolution and management.

Payne (2008) undertook a qualitative analysis of sermons from ten African-American Pentecostal preachers. Examination of the comments that they made in the pulpit about depression, sadness, and grief suggested that they saw long term depression as a weakness, advocating the opinion that "saints don't cry". Another theme emerging from the analysis was their scepticism about resorting to psychiatrists and taking psychotropic medication. A survey of over 200 Protestant pastors conducted in California explored variations in their perception of the aetiology of depression by ethnicity and religious affiliation (Payne, 2009). The findings indicated that these variables significantly influence how pastors understand - and manage - depression. White American pastors more often agreed with depression being a biological mood disorder, while African-American pastors more frequently agreed with depression being a moment of

weakness when facing life's adversities. Mainstream Protestants more often disagreed with a spiritual causation for depression than Pentecostals and non-denominational pastors.

Kramer and colleagues (2007) undertook focus groups with a dozen White and African-American clergy of a Southern, Christian and primarily urban background (Central Arkansas) to explore their explanatory models of depression, the barriers and facilitators to care, and their views on management. Ministers often felt themselves to be the front-line responders for those suffering from mental health problems, acting as natural helpers within a community as well as gatekeepers to more formal treatment. Regarding depression's aetiology, they held multiple biological, psychological, spiritual and cultural/social beliefs which were not seen as mutually exclusive, suggesting a complex multifaceted understanding. Although they talked about depression along the lines of an illness - allowing for the need of medical intervention in severe cases - they also mentioned many contributing factors such as the high importance society places on material wealth, the disruption of the family, high professional and personal expectations, long working hours, and lack of self-care. Having a relationship with God and belonging to a spiritual community were seen as playing protective roles as well as being sources of help for those already suffering from depression.

Although using a very different methodology from the previous study (Payne, 2009), cultural differences were also found amongst the ministers, with African-

American participants being more likely to attribute depression to social inequities such as unemployment, lack of access to services, and incarceration. Interestingly, this study also found that most parishioners themselves asked the minister for assistance with marital or family conflicts, financial problems, or other life concerns, without specifically acknowledging that they might be depressed. Sometimes, it was a family member or other parishioner who would approach the minister with their concerns about someone being depressed; in some other cases, the minister himself or herself would directly ask a parishioner about their well-being. Ministers differentiated four potential situations: 1) a mental health crisis (which might include psychiatric symptoms such as suicidal ideation or psychotic symptoms); 2) a life crisis (which in most cases is clearly preceded by a particular stressor or misfortune); 3) a spiritual crisis (e.g. loss of faith); 4) a social crisis (e.g. homelessness, unemployment). The management plan proposed tended to incorporate both spiritual and secular interventions: faith-based interventions such as praying, frequent worship, guided Biblical readings, and pastoral counselling were recommended, as were formal psychiatric treatments, such as medication and psychotherapy, and social interventions such as housing or employment. The ministers emphasised their responsibility to promote adherence to psychiatric treatment: encouraging doctor's appointments and continuation of medication.

Finally, the participating clergy members identified far fewer sources of help for depression care for their parishioners than obstacles. The conditions contributing to their better care which appeared most often in the interviews were: 1) having

connections with mental health professionals (especially if they were parishioners); 2) the existence of easily accessible on-site groups; 3) availability of mental health resources (e.g. self-help books, leaflets, videos). Conversely, the main obstacles encountered by the clergy which hindered the care of their parishioners suffering from depression were: 1) clergy's lack of training and expertise in the mental health arena (only one minister was familiar enough with the diagnostic criteria for major depressive disorder to adequately assess it); 2) their perceived conflict between their pastoral and counselling roles; 3) feeling overwhelmed by their parishioners' mental health requests; 4) difficulties encountered in locating, collaborating with and accessing mental health services; 5) their parishioners being afflicted by multiple social concerns contributing to their mental health problems; 6) the stigma of suffering from depression and the fear of being labelled as mentally ill; 7) lack of trust among patients, clergy and mental health professionals, with psychiatric treatment being perceived to be less accommodating to faith practices and to the involvement of the clergy.

2.2.3. Collaboration between clergy and psychiatrists

Factors affecting collaboration between clergy and mental health professionals

As discussed in section 2.2.1, psychiatrists do not generally see clergy members as collaborators in mental health care nor are they likely to refer their religious

patients to them. Indeed, the relationship between psychiatry and religion is one characterised by mutual suspicion (Bhugra, 1997). The clergy are also reluctant to refer their parishioners who may be suffering from mental illness to psychiatric services (Farrell & Goebert, 2008; McMinn, Runner, Fairchild, Lefler & Suntay, 2005). Clergy admitted to referring only a small minority of the parishioners they counselled to mental health services (Lowe, 1986; Mollica & Streets, 1986). A study, in which clergy members were given two vignettes depicting individuals suffering from mental health problems, revealed an interesting - as well as worrying - apparent contradiction: more than 40% of the clergy members who admitted to a lack of adequate training to assess and treat mental illness stated that they would still counsel the person portrayed in the vignettes (Farrell & Goebert, 2008).

Lack of training seems to be one of the best documented reasons hindering the development of a more collaborative relationship between psychiatrists and clergy: psychiatrists' lack of training in spirituality and the religious aspects of medical and psychiatric training (e.g. Durà-Vilà et al., 2011), and clergy members' need for education concerning mental health in the seminar (e.g. Leavey et al., 2007). A lack of familiarity with psychiatric referral criteria may make the clergy uncertain about which symptoms warrant a psychiatric referral: almost half of the clergy participating in Virkler's study (1979) stated that they did not receive any training in referral criteria.

Besides the obvious deficiency in training, what other reasons are behind clergy's reluctance to refer to psychiatric specialists? There is some research evidence showing that clergy place great importance on the mental health professional's religious beliefs, or lack thereof, firmly preferring to refer their parishioners afflicted by mental illness to those professionals who are religious as well. This is interesting, as several studies have suggested that psychiatrists are more likely than the general population to be atheists (Curlin et al., 2007; Neeleman & King, 1993). A study amongst Protestant clergy in Hawaii showed that having shared religious beliefs between the psychiatrist and the patient was considered important by over 40% of the clergy, and essential by almost a sixth (Farrell & Goebert, 2008). Another study investigating factors affecting clergy-psychologist referral patterns similarly found that clergy showed a preference for psychologists who identified themselves as Christian and used scripture and prayer in their practice (McMinn et al., 2005). Some clergy even specifically mentioned as a facilitator for collaboration that the mental health professional be a parishioner in their community (Kramer et al., 2007). The strong preference on the part of the clergy to refer parishioners to mental health professionals with the same faith may be linked to the concerns expressed by some clergy members that psychiatric specialists may look down on their parishioners' religious beliefs (Mannon & Crawford, 1996).

The teachings of the Catholic Church about what is expected from a Catholic doctor also throw light on explaining the importance placed by the clergy on there being a common faith with the medical professional for a collaboration to

take place between them. The Church encourages doctors not to separate their faith from their medical role, but to allow their religious beliefs to illuminate their medical practice. Pope Benedict XVI (2008) encouraged doctors in the opening address of a conference to take into account not just the physical dimension of the patient but also the spiritual one, encouraging them to see their medical role as a "gift" to the patient. Monsignor Martinelli (2009a) - a member of the Vatican's Congregation for the Doctrine of the Faith - argued that Catholic doctors' spirit of abnegation and great dedication to their patients are a testimony of Christ's love for the ill. He exhorted them to resort to their faith when confronting death and pain, emphasising their obligation to use not only medical cures but also spiritual resources to alleviate suffering and to facilitate the request for the administration of sacraments (e.g. confession, communion and the last rites). Martinelli also reminded Catholic doctors to become conscientious objectors when asked to contradict the divine law (e.g. abortion), to be aware of being an instrument of God's love and mercy, and to always remember that healing ultimately comes from God.

What is the impact that psychiatrists' religious beliefs have on their collaborating with the clergy? In the light of the evidence presented above, it seemed logical that those psychiatrists who are religious would be more forthcoming about recommending the help of the clergy when caring for religious patients. Along these lines, several studies have suggested that religious beliefs of medical staff influence the likelihood of collaborating with the clergy (Neeleman & King, 1993; Curlin et al., 2007). Nevertheless, the association

between psychiatrists' beliefs and seeking the help of the clergy in caring for patients was not apparent in my qualitative study with a predominantly religious sample of psychiatrists working in London (Durà-Vilà et al., 2011). My findings add to the complexity of the relationship between psychiatrists and the clergy, showing that religious psychiatrists seemed to struggle to hold both medical and religious beliefs in treating their patients. Their reluctance to bring religion into their clinical practice was not due to their personal rejection of the supernatural, but rather to the difficulty in combining these two very different models. Although religion and spirituality were seen by most of the participants as important areas in terms of working with patients, none of them had ever liaised with clergy or other religious professionals in their practice in the UK (neither had they routinely inquired about these areas while assessing their patients, nor incorporated them in their management plans). A significant difference emerged in the interviews with the psychiatrists who had immigrated to the UK concerning the difference between their practice in their home countries and in the UK: in their religiously oriented countries of origin, they incorporated their patients' religious beliefs and regularly liaised with religious professionals. The main reasons offered by these psychiatrists to explain their different behaviour in the UK were their fear of being perceived as "anti-modern", "unscientific" and "unprofessional" by colleagues and supervisors, and their wish to fit in and be accepted by the British medical community and secular society.

Current landscape

Jung (1932/1969) considered the clergy's interest in the psychological dimension of the person as a totally legitimate one, firmly believing in the possibility of a fruitful collaboration between both disciplines in spite of their points of conflict; in his own words: "The doctor and the clergyman undoubtedly clash head-on in analytic psychology. This collision should lead to cooperation and not enmity" (p. 353). However, most of the evidence presented goes against Jung's wishes: neither has the partnership between the two professions been fulfilled nor have their differences in standpoints been brought closer.

The role of the NHS chaplain clearly illustrates the current strains that the clergy-doctor working relationship is facing. Julia Head (2011) is a Specialist Chaplain in South London and Maudsley NHS Foundation Trust and is a fellow in Pastoral Theology and Mental Health within the Trust. She argues that chaplains and medical professionals are both responsible for the lack of cooperation amongst themselves: they hold narrow-minded attitudes about one another and do not focus on the common goal towards which they should be working together (restoring the patient to health). She explained how chaplains, albeit employed by the NHS, struggle to feel accepted within NHS settings, not feeling valued or taken into account by doctors. She gave many examples of the lack of cooperation and respect towards chaplains. For example, she referred to an occasion when - although she is not a minister - a doctor told her to go back to her parish, or the case of another chaplain who, when visiting a patient with

whom she had been working for a long time, found that the patient had been discharged from the ward (no one had informed the chaplain of the patient's discharge). Moreover, NHS chaplains have recently been facing much criticism and controversy in the media about being funded by the NHS, with some stating that, in the current climate of cuts on services, religious groups should be the ones to pay for their presence in hospitals and not the NHS (e.g. BBC News, 2009).

Faith-based organisations and clergy members may indeed play a key role in the lives of many people, and could be used further by health and welfare providers. Nevertheless, the nature of this relationship is still poorly understood: there is not a clear path to integrate them within existing statutory provisions, and there are obstacles that are often underestimated (Leavey & King, 2007). Although the effectiveness of this collaboration remains to be seen, there are some anecdotal examples of positive collaboration between the clergy and mental health professionals, such as the involvement of three chaplains in a residential treatment programme for posttraumatic stress disorder (PTSD) at a medical centre in Ohio (Sigmund, 2003). The clergy members ran a clinically-focused group called the "Spirituality Group" through which spiritual issues emerged such as anger at God, letting-go, and forgiveness. This group was integrated into the overall treatment package provided by the clinical team with the aim of providing a more holistic care. Interestingly, a reciprocal learning experience was achieved: clergy provided training to clinical team members on spirituality, and clergy in turn learned about psychiatric disorders. Although there is a clear

need for controlled studies to demonstrate the usefulness of incorporating spirituality into the management of PTSD, the author suggested that, based on the experiences of these clergy members, the exploration of trauma-related existential conflicts in patients with PTSD was beneficial.

2.2.4. Pastoral care

A comparison between spiritual direction and psychotherapy

Providing spiritual direction is a key aspect of priests' pastoral care. Spiritual direction differs from other ministerial tasks such as administering the sacraments, moral guidance, preaching or pastoral counselling (though having affinities with them) in its very specific aim, which is to assist individuals in developing and deepening their personal relationship with God. In order to achieve this goal, the priest - also known in this role as the spiritual director - may resort to prayer, religious reading, journal writing, worship and other religious practices (May, 1982). Although the main focus of spiritual direction is on the spiritual aspects of the parishioner's life, the spiritual director is also concerned with the whole person, taking a holistic view: discussion of other issues is welcome, as they are seen as having an influence on the individual's spiritual development (Merton, 1960).

Spiritual directors need to have appropriate personal characteristics and a broad range of skills to successfully fulfil this task, such as being compassionate (Rogers, 2002), being seriously committed not just to helping others on their path of spiritual maturation but also to working on their own spiritual growth (Benner, 2002), and being a good and caring listener (Barry & Connolly, 1982). It is important for the spiritual director to be skilled not only in spiritual matters but also in the psychological aspects of the self (Benner, 2002). The call felt by some clergy to become more psychologically informed and skilled is likely to derive from the deep influence that authors such as Freud, Jung, Rogers, Frankl, May, and Laing, among others, have had on the Christian ministry (Nouwen, 1980; Spiegelman, 1984).

Spiritual direction and psychotherapy share similarities in spite of their different methods and goals. Benner (2002) offers a rather simplistic distinction between both: while spiritual direction is spirit-centered, psychotherapy is problem-centered (one could argue, what happens when the problem is of a spiritual nature?). A particular case that makes the waters of distinction between psychotherapy and spiritual direction particularly murky is that of a Christian client seeing a Christian psychotherapist. Christian psychotherapists and spiritual directors may see the goals of healing in a different light than their non-Christian counterparts (Moon, 2002). The faith of a Christian psychotherapist is likely to colour how mental health is conceptualised, thus influencing how psychotherapy is practised (McMinn & McRay, 1997).

Leaving aside the religious beliefs of the psychotherapists, Julian (1992) studied the aspects that insight-oriented psychotherapy and supportive psychotherapy had in common with spiritual direction, as well as the points of divergence amongst them. Being warm and empathetic are necessary skills for the psychotherapist and the spiritual director in order to establish a sound therapeutic relationship. Their ability to manage resistance, transference, and countertransference is also essential in all three modalities. A difference noted by Julian is that for spiritual direction and supportive psychotherapy - in contrast with insight-oriented psychotherapy - the development of transference is not fostered. Regarding the criteria for selecting clients, insight-oriented psychotherapy is closer to spiritual direction: the best candidates are those who are psychologically minded, want a lasting change in themselves, have good coping skills, are able to sustain long-term close relationships and are willing and able to commit to the therapy/direction. Supportive psychotherapy may be more appropriate for those who are in times of crisis, in need of emotional support or lacking the previous characteristics.

Barry and Connolly (1982) offered a key distinction between spiritual direction, psychotherapy and counselling within a Christian context, and other forms of pastoral care such as confession and preaching: the fundamental goal of spiritual direction is to assist people in developing and deepening their personal relationship with God. Sperry (2001) highlighted three areas of divergence between psychotherapy and spiritual direction: the intervention used, the aims sought and the clientele. While psychotherapists tend to use several

psychotherapeutic interventions and techniques, the spiritual directors tend to resort to instruction through spiritual practices. The aims of psychotherapy are secular ones, such as improving functioning, decreasing symptomatology and modifying some aspects of personality; in contrast, the goals of spiritual direction are of a spiritual nature, firmly focusing on spiritual maturation and growth. Finally, the clients targeted by both activities are also different: those seeking psychotherapy are more likely to suffer from psychopathology while spiritual seekers are more likely to be relatively healthy individuals. Some might argue that another difference between spiritual directors and psychotherapists is that the former are recognised by the religious community due to their special spiritual attributes (Barry & Connolly, 1982), implying the achievement of some level of moral and spiritual superiority.

The sacrament of confession

Parallels have been drawn between this Catholic sacrament and psychotherapy, and between the role of the priest acting as confessor and the psychotherapist. This section starts by offering an explanation of what this sacrament entails before focusing on its rich psychological and moral aspects.

The sacrament of confession also receives the names of the sacrament of penance or reconciliation. The Catholic Church believes that through the celebration of the sacramental rite of confession God grants the forgiveness of

sins and that this forgiveness is considered to be a testimony of God's mercy and love for humankind (Martinelli, 2009b). Confession is seen as the necessary link between one's sins and receiving God's forgiveness. Historically, Judaism set aside a day in which the offender made a confession to someone who he had previously offended and from whom forgiveness was desired. The practice of confession came into full bloom in the sixth century as the Catholic Church further elaborated, expanded and clarified this sacrament (White, 1952). The following requirements are needed for the penitent to be absolved of his/her sins: having feelings of sorrow for the faults committed ("contrition"), disclosure of the sins to the priest ("confession"), and compliance with the priest's request to perform some task ("penance") to make amends for the committed sins (e.g. saying a prayer) (Estepa et al., 1992).

The priest has a key role in this sacrament: he is the mediator between God and the penitent. Moreover, he acts in a jurisdictional role imposing a penalty ("penance") for the committed sins (White, 1952). While some authors have considered this sacrament as having some useful value for emotional well-being (e.g. Jung, 1932/1969), others have emphasised its oppressive nature (e.g. Arruñada, 2009). "La Regenta" (Clarín, 1885), considered one of the most important 19th century Spanish novels, offers a critical portrayal of the most abusive and exploitative aspect of confession: the clergy's control of important men in society gained through the frequent confession - and manipulation - of their wives. Arruñada (2009) argues that confession is a complex form of achieving moral enforcement through the priest acting as an agent between God

and the faithful. The influence that this one-to-one interaction with the confessor has on the penitent was highlighted in his study which found that those who confessed more frequently were observed to comply more with the Church's moral code. Interestingly, no association was found between the latter and frequency of attendance at mass. Frequent confession - even of minor sins known as venial - is strongly recommended and endorsed by the Catholic clergy, as this sacrament is believed to have many spiritual and emotional benefits, such as increasing grace, strengthening virtue, and liberating the penitent from feelings of guilt, thus allowing the penitent to receive "the gift of serenity and peace" (Martinelli, 2009b).

The consideration of the potential positive and negative psychological effects of the sacrament of penance on the penitent is further complicated by the general disagreement within the Church itself as to the level of involvement that the confessor should have in the personal problems of the individual seeking confession. Most priests would agree that confession should primarily focus on the redemption of one's faults and that hearing and offering advice about life's trials and personal issues should be considered secondarily, if at all. More dogmatic priests may argue that emotional difficulties should be dealt with outside the confessional, while less conservative priests might not separate this sacrament from pastoral counselling, seeing the penitent's sins as intrinsically linked with the psychological and emotional aspects of the self (Worthen, 1974).

A comparison between confession and psychotherapy

Several authors have turned their attention to the similarities that Catholic confession and psychotherapy share. The task of easing human distress and guilt often falls upon the shoulders of the clergy and psychotherapists. Both of them deal with people's feelings of guilt, assisting them to overcome unhealthy tendencies and offering guidance towards wholeness (Worthen, 1974). Jung was amongst the first to critically examine how the role of the priest hearing confession differed from the psychotherapist's. The positive aspects of both disciplines were described in detail in his article "Psychotherapists or the clergy" (1932/1969). On the one hand, Jung considered confession to be a valuable - albeit temporary - tool to alleviate stress. He also praised the rich symbolic component of the ritual of confession, which he argued appealed to the unconscious mind, making it more accessible. On the other hand, he argued that psychotherapy did not offer moral judgements nor condemnation of any behaviour, and was more objective and simpler due to its comparative lack of ritualism. Moreover, Jung argued that psychotherapy could appeal to almost everyone - at one level or another - while confession only appealed to a limited number of religious people.

Worthen (1974) believed that the interpersonal relationship established between the individual undergoing psychotherapy/confession and the psychotherapist/ confessor had a key similarity: the one-to-one interaction is needed for the process of positive change to take place. Jung in his article "Psychoanalysis and

the cure of souls" also stressed the healing nature of the colloquy carried out between the two in an atmosphere of total confidence (1928/1969). The psychotherapist and the confessor also have in common being strictly bound to confidentiality. Thus, there is a strong sense of confidence that the content of the psychotherapy session/confession will not leave the therapist's office/confessional. Nevertheless, the level of secrecy demanded from the confessor is much higher than the therapist's; the latter has exemptions on which confidentiality can be overruled, such as when there is risk towards the individual or others. In contrast, the Catholic Church's teachings leave no doubt regarding the extreme level of the confessor's secrecy as stated in the Code of Canon Law (Canon 983, 1): "The sacramental seal is inviolable; therefore it is absolutely forbidden for a confessor to betray in any way a penitent in words or in any manner and for any reason" (Vatican, 2013a). A priest must keep his penitents' sins secret "without any exceptions" and "even at the cost of losing his (the confessor's) own life" (Martinelli, 2009b).

Worthen (1974) pointed out some more differences: those seeking confession follow an almost universally accepted format, while psychotherapists do not have a common procedure. They also diverged in their aims: the ultimate goal of confession is to obtain forgiveness for one's misdeeds with the priest acting as a judge of subjective moral rightness or wrongness. Conversely, the psychotherapist is not concerned with moral offences and no judgements are involved in the psychotherapeutic process.

Distinction between pastoral care and pastoral counselling

Pastoral care comprises all the tasks and duties associated with the ministerial role, including the two activities considered above (administering the sacrament of confession and offering spiritual direction). When examining the literature on pastoral care, a concept coloured by controversy emerges: pastoral counselling. One the one hand, it is a concept that is not easily differentiated from pastoral care, and on the other hand, while some authors see it as part of pastoral care, others consider it to be outside this realm.

In spite of the similarities, it seems that most clergy would differentiate between pastoral care and pastoral counselling: associating pastoral care with a generalist approach and pastoral counselling with a specialised area (Clinebell, 1984). A recent qualitative study with 18 African-American clergy was set up precisely to capture the clergy's perspectives on pastoral care and pastoral counselling. The main finding was that although acknowledging the existence of some overlap between both concepts, the majority of the clergy viewed them as fundamentally different (Stansbury, Harley, King, Nelson & Speight, 2010). Pastoral care was defined by the participants as providing spiritual guidance and nurturance to their parishioners. While they feel comfortable and prepared to fulfil this duty, they stressed the need of undertaking additional training in psychological techniques to engage in pastoral counselling. Most of them felt apprehensive and not prepared to provide the latter, preferring to act as gatekeepers to formal mental health services. Only two of the clergymen participating in Stansbury et

al.'s study believed that pastoral care and pastoral counselling were interchangeable concepts. Their views were more in line with another study which found that pastoral care and pastoral counselling were more similar than different (O'Connor, 2003).

SECTION 3

METHOD

3.1. RESEARCH DESIGN AND ANALYSIS

As explained in the "Rationale of the study", section 1.2., my goal is to build on the literature in this area as well as on my previous research to further explore the understanding of deep sadness and consequent help-seeking behaviour amongst practising Catholics in Spain using a qualitative methodology. Methodological triangulation was used in the study; triangulation is a method to explain more fully the variation and complexity of human behaviour by studying it from more than one standpoint (Cohen & Manion, 2000). I employed several methods to gather data - semi-structured interviews, participant observation and ethnography - in four groups of people on different religious pathways in an attempt to increase the credibility and validity of the results and to give a richer and more balanced portrayal of the phenomenon under study. The reticences and challenges that I encountered in the course of this research and the ways I used to deal with them are discussed in the "Reflexivity", section 5.1.

Sampling and recruitment

In order to considerably expand and diversify the samples of my initial studies in this area, different levels of religious commitment and religious pathways in the context of the Catholic Church in Spain were included: lay theological students, priests, and contemplative cloistered nuns and monks. Polkinghorne (1989) recommends that phenomenological researchers interview from five to twenty-five people who have experienced the phenomenon under study (in the present case, the experience of deep sadness). Thus, in order to obtain in-depth information and to be able to include a diverse spread of socio-demographic characteristics, taking into account time and resource constraints, I set out to recruit twenty priests, twenty lay theological students and a minimum of five contemplative nuns and five contemplative monks. The latter lower number was due to the scarcity of contemplative religious communities, the difficulties in accessing them and the fact that these communities are becoming smaller due to the lack of new entrants.

Two sites for conducting fieldwork amongst contemplative nuns and monks were identified: a retreat house where nuns in training of the Order of Saint Augustine were gathering for an educational course accompanied by some of their Mother Teachers, and a male monastery of Cistercian monks. The lay theological students and the priests were recruited from a theological college in La Ciudad - Sant Josep's theological college - which has satellite centres in surrounding towns (detailed information regarding the college and its running is

provided in "Participants and their contexts", section 4.1.1.). The participating students attended either the college in La Ciudad or one of its rural centres.

The priests that took part in the study were also associated with the college: most of them were local facilitators of the college, as in every centre two or three parish priests acted as links between the college and the parishioners who expressed an interest in attending a course. Those who did not fall under this category were either members of the teaching staff of the college or individuals who were put in contact with me through the college's personnel office. Information sheets were distributed in the theological college in La Ciudad explaining the project to the students. Those students and priests interested in the study were contacted to allow them to ask questions and to arrange a meeting if they wished to be interviewed. As there were more participants willing to take part in the study than the needed number, they were selected taking into account two main objectives: firstly, obtaining as broad socio-demographic representation as possible (considering gender, age, level of education, profession and marital status) and secondly, giving preference to those with a personal experience of undergoing deep sadness or to those with a professional experience in assisting those suffering from emotional and psychological distress. Although all of those contacted agreed to take part in the study - twenty lay theological students and twenty priests - , three priests were not interviewed as they had to cancel the scheduled meeting due to family sickness in one case and professional emergencies in the remaining two; thus, in the end, seventeen priests were interviewed.

In summary, the study sample was made up of four groups, making a total of fifty-seven participants:

(1) Twenty lay theological students (eleven female, nine male).

(2) Seventeen priests (living in the community, not in monasteries).

(3) Ten contemplative monks belonging to the Cistercian Order (four of them were ordained priests) and who lived in the same monastery.

(4) Ten contemplative nuns of the Order of Saint Augustine belonging to five different monasteries; seven of them - the nuns in training - were from Kenya, adding cultural and ethnic variation to the sample.

Ethnographic fieldwork

Ethnographic fieldwork was conducted twice in Spain in the summer of 2010: the first with contemplative nuns, and the second with contemplative monks. In keeping with the ethnographic approach, data collection methods included participant observation, writing down field notes, and interviews (Gray, 2003; O'Reilly, 2005). Besides the one-to-one semi-structured interviews carried out with the nuns and monks, multiple informal conversations - spontaneous chats and questions that arose during our exchanges - were held with them. These chats were not only important sources of information, but also contributed to building a relationship of confidence and trust, facilitating the interaction and the openness of the semi-structured interviews.

I spent two weeks in the Monastery of Sant Oriol, whose community was made up of ten Cistercian monks. I was invited to attend their communal prayers and daily mass in the church of the monastery. Although I was given a sitting room in the monastery where I interviewed the monks individually, I did not have free access to the monks and their guests' quarters. On a few occasions I was taken by the monks to other parts of the monastery: they showed me a small wooden chapel which had been hand-made by Brother Xavier, a couple of sitting rooms to receive visitors, and the garden. On one occasion, my last evening amongst them, I was shown the graves of Brother Antoni and Brother Andreu, which were located in a more private area of the monastery. As the community does not allow women to stay in their guesthouse, the monks kindly found me accommodation in a small guesthouse nearby whose owners they knew - a short walk from the monastery - where I had my meals and stayed overnight.

The second site of fieldwork was the retreat house located on the outskirts of a Spanish city where the nuns in training (novices and postulants) of the Order of Saint Augustine, accompanied by some of their Mother Teachers, gathered to attend a five-day training course. Like the nuns, I arrived the day before the start of the course and left the day after. I had permission to share all their activities: communal prayers and the daily mass, lessons, meals, break-times, walks in the garden and the party they had on the last evening of their stay. I was given an individual room on the same floor as the nuns.

Interviews

I carried out individual semi-structured interviews with all 57 participants. The interviews lasted an average of an hour, and were all audio-recorded and transcribed verbatim (see appendix 3 for the "Interview Schedule"). Interviews were conducted without an interpreter in Spanish and in Catalan. All the interviews with the monks of the Monastery of Sant Oriol were in Catalan. The interviews were conducted in four stages, from July 2010 to September 2011:

    (1) First stage: interviews with ten contemplative Augustinian nuns.

    (2) Second stage: interviews with ten Cistercian contemplative monks.

    (3) Third stage: interviews with twenty lay theological students.

    (4) Fourth stage: interviews with seventeen diocesan priests.

O'Reilly (2005) describes three main types of interview styles: structured interviews (survey style with no room for extra questions), unstructured interviews (more free-floating conversational style) and semi-structured interview (combining elements of both styles with the researcher being able to explore ideas with the participants as well as getting fixed answers for some criteria). In my one-to-one interviews with the nuns and monks, although still covering all the questions of the interview schedule, my style of interviewing seemed to lean, at times, to the unstructured interview style. Re-listening to the audio-recordings of the interviews, it became apparent that the interviews with the nuns and monks were more conversational, with the answers flowing more

naturally, than with the priests and lay theological students. The reason behind this difference is simple: in the case of the nuns and monks, the interviews were an additional method to complement the participant-observation and informal conversations of the ethnographic fieldwork. The topics covered by the interview had already been explored in a more informal way with the nuns and monks in the course of my stay with them, so during the interview we were able to consider the questions more rapidly, with less need for prompting or redirection. Moreover, the time spent with the nuns and monks enabled me to become familiar with them, whereas the actual interview was the first time the lay theological students and priests met me in person. Finally, with the latter there were more constraints and pressure to cover all the points during the one-off interview, while with the nuns and monks the interview could develop at a more leisurely pace, as there was the option of meeting later to finalise it.

I opened the interview by asking the participants to describe a time when they were feeling deeply sad as a way to elicit a narrative (part of the participant's life history), in order to explore their understanding of sadness, their coping strategies and help-seeking behaviour. After posing a question aimed at inducing a narrative, Wengraf (2002) recommends that the interventions by the interviewer be limited to facilitative noises and non-verbal support. I tried to cut down my verbal interventions and prompting to enable their narratives to unfold as spontaneously as possible. Seidman (1998) described three modes of in-depth phenomenological interviewing. I pursued his third mode, consisting of asking the interviewee to reflect on the meaning of their experience: in my interviews, I

strove to make the participant reflect on the personal meaning that the experience of deep sadness had for them.

The location where the interviews took place varied amongst the four groups of participants. The interviews with the nuns and the monks took place in the retreat house and in the Monastery of Sant Oriol, respectively, in sitting rooms specifically given to me to carry out the interviews. Most of the lay theological students were interviewed in an office at Sant Josep's theological college in La Ciudad, and a few of them in the centre that the college has in their own towns. The majority of the priests were interviewed in the sacristy of their parish churches. I let the students and the priests choose the location, offering to meet them in their towns if this option was more convenient (for the exact numbers on where the interviews took place for these two groups, see Table 1).

TABLE 1

Locations of the interviews for the lay theological students and the priests

Priests		Female lay theological students		Male lay theological students	
Sant Josep's college (La Ciudad)	Sacristy of their parish church	Sant Josep's college (La Ciudad)	College's centre (participant's town)	Sant Josep's college (La Ciudad)	College's centre (participant's town)
4	13	7	4	8	1

Research questions

I set up this research project to answer the following two main questions: how people differentiate between non-disordered sadness and dysfunctional sadness; and what role the clergy play in assisting those afflicted by normal and abnormal sadness. There were many additional questions that I needed to ask to be able to answer the above two questions; the most important questions are presented below and, for clarity, have been grouped according to the main topics I brought up with the participants (for a detailed list of questions see the "Interview Schedule", appendix 3):

(1) Distinction between non-disordered sadness and dysfunctional sadness

- Do religious people differently conceptualise sadness without cause and sadness with cause?

- Is the help-seeking behaviour associated with sadness perceived to be without cause different from that of sadness with cause?

- Given the option, will people opt to numb the experience of normal sadness by taking medication? And in the case of abnormal sadness?

(1.a.) Depressive disorder in religious people

- How is depressive disorder conceptualised and manifest (attributed causality, narratives, symptomatology)? Do they equate this disorder with abnormal sadness?

- What are their coping strategies and help-seeking behaviours - both psychiatric and non-medical - to deal with depression? What are their views regarding the effectiveness of antidepressant medication and psychotherapy?

(1.b.) Spiritual distress and the Dark Night of the Soul

- How do religious people conceptualise sadness with spiritual causation (e.g. doubting one's faith or experiencing uncertainties regarding one's religious vocation)? Do they use the Dark Night of the Soul narrative?

- How is the Dark Night conceptualised and manifest (attributed causality, narratives, symptomatology)? Is monastic life a pre-requisite for experiencing the Dark Night?

- What are the shared symptoms and the key differences between the Dark Night and depressive disorder?

- What are their coping strategies and help-seeking behaviours to endure and resolve the suffering intrinsic to the Dark Night?

(1.c.) Spiritual pathology (as distinct from the valorised path of the Dark Night)

- Do religious people have notions of spiritual pathology? How do they distinguish between spiritual phenomena, such as the valorised Dark Night, and spiritual pathology?

- How is the spiritual pathology conceptualised and manifest (attributed causality, narratives, symptomatology)?

- What are their coping strategies and help-seeking behaviours to endure and resolve spiritual pathology?

(2) Role of the clergy

- How do the priests conceptualise and recognise cases of depressive disorder, Dark Night, and spiritual pathology? How do they differentiate between them? What help do they offer to those undergoing them?

- What training have they undertaken in mental health?

- Have they liaised with mental health professionals in the case of parishioners suffering from a psychiatric disorder?

- What are their views regarding psychiatrists and standard psychiatric treatment for depressive disorder?

Analysis

I undertook thematic content analysis of the transcripts of the semi-structured interviews and the field notes (Coffey & Atkinson, 1996). Their semantic and metaphorical content was examined, while paying special attention to the emerging narratives. The transcripts of the interviews and the field notes were carefully read several times, and statements or phrases signifying relevant concepts, ideas, behaviours, beliefs and attitudes were highlighted and coded. Themes were derived from those statements, which were thoroughly compared across transcripts and field notes to identify recurring themes that were

subsequently categorised. These themes represent the key findings of the study. Particular attention was given to undertaking inter-group comparisons, with differences amongst the nuns, monks, priests and lay theological students becoming increasingly more evident as the analysis progressed; intra-group variation was also rigorously noted. In order to facilitate immersion into the participants' views, the reading of the transcripts and field notes was combined with listening to the interviews' audio-recordings. I held regular meetings with the primary and subsidiary PhD supervisors, in which I presented and interpreted the emerging themes and sub-themes.

In the "Findings", section 4, the themes are accompanied by excerpts from the transcripts in order to illustrate them and to provide abundant original evidence to support the conclusions reached. Each quotation has been labelled according to the following characteristics: (1) sub-sample (nun / monk / priest / layman or laywoman); (2) age; (3) marital status (for the lay person only); (4) ethnicity; (5) profession (when relevant).

3.2. EPISTEMOLOGICAL POSITION

I used a phenomenological approach to the qualitative research undertaken here. I will start this section by briefly presenting what I understand by this: a phenomenological study aims to describe the meaning for several people of their lived experiences of a particular concept or phenomenon, focusing on what all

the informants have in common (Creswell, 2007). The main aim of phenomenological research is to encapsulate individual experiences of a phenomenon in a description of universal essence; to obtain, in van Manen's (1990) words "a grasp of the very nature of the thing" (p. 177). Data collection in a phenomenological study often consists of in-depth interviews from individuals that have undergone the phenomenon. This data is then analysed highlighting significant statements which are grouped into themes (for a description of how I analysed the data, see the previous section, "Analysis"). Finally, a depiction of the essence of the experience for all the participants is provided in an attempt to portray what their experiences have in common; in other words, the underlying structure of their experiences (Creswell, 2007). Besides providing this description, phenomenological research also carries out an interpretative process in which the researcher interprets the meaning of the lived experiences (van Manen, 1990).

Moving on to the present study, I adopted a phenomenological stand to ascertain how the participants' experienced and perceived deep sadness, attempting to understand their subjective experience and how they made sense of it, and paying attention to the shared meaning within their varying religious contexts. Broadly applying the above words from van Manen to my study, there were two "things" whose "very nature" I wanted to grasp: pathological sadness and normal sadness. I adopted a two-fold approach: firstly, the in-depth semi-structured interviews carried out with all the 57 participants, and secondly, the ethnographic fieldwork with the nuns and monks. Both methods enabled me to

learn about the participants' lives from their own perspective. Moreover, the fieldwork allowed me to do so from within the context of the participants' own lived experience, and to pursue some degree of shared experience with them. I considered the latter to be a legitimate methodological tool for exploring their subjective experience. It soon became clear that in order to understand their actions and views a balancing act was required of me: I had to try to put myself in their shoes, trying to somehow experience their thoughts and emotions while at the same time maintaining the necessary amount of objectivity to be able to critically reflect on the experience (these processes will be explored in the "Reflexivity", section 5.1.). Therefore, the ethnographic method of participant observation was very valuable, as living amongst them and participating in their daily activities and religious rites allowed me to gain deeper insights into their experiences and points of view, which complemented the information collected through the interviews.

Kapaló and Travagnin (2010) warned against the risk of classical phenomenological ethnography of religious groups being limited to providing theory that could only be deployable within the field itself. As explained in section 1.2. ("Rationale of the study"), I strove to go beyond this notion of phenomenological study to identify universal concepts of disordered sadness that could transcend these particular Catholic contexts. Along these lines, I also considered Horwitz and Wakefield's (2007) criticism of anthropologists focusing on the presumed cultural relativity of human responses, with no definitions of disordered sadness being possible outside the particular culture

where the study was conducted. However, these authors also argued that anthropologists are in a privileged position to study which aspects of human sadness are culturally influenced and which belong to normal human functioning in the face of adversity and loss. The aspects of sadness that are likely to be culturally influenced in the highly religious sample studied here might be those related to the religious attribution of meaning to the participants' suffering and the religious nature of their coping strategies and help-seeking behaviours Moreover, in the case of the contemplative participants, the configuration of the self might also be culturally influenced (Kirmayer, 2007) being more sociocentric - contrasting with the egocentric self more prevalent in modern Western societies - as the monks and nuns might define the self by their belonging to their monasteries and religious communities.

3.3. ETHICAL CONSIDERATIONS

Ethical approval to undertake the study was granted by University College London, Research Ethics Committee in July 2010 (see appendix 2). In order to gain permission to conduct the fieldwork, approval from seven senior members of the participants' orders was obtained. Initially, I approached the Mother President of the Order of Saint Augustine and the Prior of the Monastery of Sant Oriol to explain the project and answer their questions. Following their consent, the Mother President explained that as the nuns participating in the study

belonged to five different monasteries, I also had to seek approval from the Mother Superiors of each; thus written information was sent to them.

On my arrival at the fieldwork sites, I explained the project to the nuns and the monks in a joint meeting, giving them the chance to ask questions both collectively and individually. All of them were supportive and helpful with my research, making time to talk to me and to be individually interviewed. I made clear from the start of my fieldwork that although their superiors had granted me permission to carry out research amongst them, they should not feel under any obligation to agree to an audio-recorded interview with me. Approval was also sought from the head of Sant Josep's theological college. Besides providing written information, before the start of the interview, the study was explained to the students and the priests when they were contacted, both over the phone and face-to-face, giving them the possibility to ask for further information regarding the project.

Informed consent was obtained from each participant of the study. They were all fully aware of the purpose of the project and my intention to write the findings as a PhD thesis and to subsequently submit them for publication in scientific journals. In order to ensure anonymity, pseudonyms have been used for the names of the participants, the monasteries, and the theological college and the city in which it is located (such colleges with the particular aim of training lay members of the Church are rare so identifying it if the city was known would not be difficult). Moreover, because of the personal data obtained from the nuns and

monks, and the fact that the increasingly scarce number of contemplative communities in Spain might facilitate their identification, the locations of the monks' monastery and the retreat house where the nuns' course took place are withheld. Similarly, no identifying information has been provided regarding the priests' parish churches.

Attention was given prior to the start of the research to the potential negative consequences that it could have for the participants and consideration was given to ways to address them if they arose (the potential benefits of the research are discussed in the Reflexivity, section 5.1.3., p. 343-345). I was aware that some of the questions regarding the participants' experiences of deep sadness and depression could be sensitive. Therefore, great care was taken in formulating them in a delicate and gentle manner and in case of noticing that a particular question caused any distress to the participant, I would move to another question or end the interview if necessary. I also reminded participants that they could refuse to answer any questions or withdraw from the interview at any time and without giving a reason. As a practising psychiatrist, I have experience in managing patients suffering from emotional distress and mental health problems; thus if during the course of the study any matter of concern had arisen regarding participants' mental health, I would have encouraged them to seek advice from their general practitioner.

Moreover, it was never my intention in the least to question or challenge the participants' faith and religious beliefs and I was determined to take great pains

to avoid any possibility of my research provoking any possible spiritual doubts in them; however consideration was given to this possibility and was discussed with my supervisors. As before, to avoid this risk questions were carefully formulated and I was alert to detect any such signs of distress from the participants which would have been managed by moving to another question or finishing the interview, and recommending them to consult with their spiritual directors, parish priests or the Mother Superior or Prior of their communities (the latter in the case of the contemplative participants).

SECTION 4

FINDINGS

This section contains the participants' answers to the study questions and is divided into four subsections in line with the aims of the study: each subsection is devoted to one of the aims the research was set up to explore. The first subsection provides a description of the participants of the study and their different settings, as in phenomenological research it is important that a description of the context and the participants themselves be provided because these will have influenced how the participants experienced the phenomenon under study (i.e. sadness) (Creswell, 2007; Moustaka, 1994). The three further subsections tackle each the following aims, exploring: 1) how sadness and depression were conceptualised by the study's highly religious participants, 2) what coping strategies and help-seeking behaviours were used to deal with sadness and depression, 3) what role the clergy played in the care of those undergoing sadness and depression, and their collaboration with mental health professionals. In each subsection, the themes emerging from the analysis of the interview transcripts are explained and illustrated with the participants' narratives and quotations (the findings have been summarised at the end of the section in Table 23). The fifth and final aim of the study - proposing a

framework to differentiate normal sadness from depression - has been presented in the "Discussion" (section 5.6.) due to its clinical implications.

4.1. PARTICIPANTS AND THEIR CONTEXTS

The description of the participants of the study and their different settings has been divided into four groups: lay theological students, priests, monks and nuns. The information regarding the lay theological students and the priests was obtained from semi-structured interviews, while the data gathered for the monks and nuns was collected during fieldwork through multiple informal conversations, participant-observation, and extensive fieldwork notes, as well as individual semi-structured interviews. Thus the information provided about the monks and nuns and their ways of life is more detailed and comprehensive.

4.1.1. Lay theological students

Socio-demographic characteristics

Semi-structured interviews were conducted with 20 lay adults studying in a Catholic theological college. All the participants were Spanish and, as expected, described themselves as practising Catholics with almost all of them going to mass at least once a week. The age range was 38 to 71 years with a mean age of

almost 50 years. Eleven of them were women and nine were men. Besides their current studies in theology, half of them had a university degree. Two of them were medical doctors: one was a general practitioner, the other a psychiatrist. The latter was undergoing a course to become a lay spiritual director and considered his experience as a psychiatrist a valuable contribution to this new role. Just over half of them were married and had children. Almost half were unemployed, including pensioners and housewives. Although four participants lived with their parents, most of the rest owned their own homes. Half of them lived in rural areas and the other half in urban ones (for a breakdown of the socio-demographic details of each lay participant, see Tables 2 and 3).

TABLE 2

Socio-demographic characteristics of the male lay theological students

Lay men	Age	Education*	Employment	Civil status	No. of children	Living arrangements	Urban/rural[□]	Frequency of worship[♦]
Isidro	38	Secondary education	Secretary	Single	0	Living with parents	Urban	Frequent
Andrés	40	University (philosophy)	Teacher	Married	3	Owned/mortgaged	Rural	Frequent
Pedro	40	Secondary education	Unemployed	Single	0	Living with parents	Rural	Occasional
Sergio	40	University (medicine, psychiatry)	Psychiatrist	Married	2	Owned/mortgaged	Urban	Frequent
Pascual	46	University (architecture)	Lecturer	Married	2	Owned/mortgaged	Urban	Frequent
Martín	55	University (business studies)	Early retirement	Married	2	Owned/mortgaged	Urban	Frequent
Lamberto	57	University (medicine, neurosurgery, GP[•])	GP[•]	Married	2	Owned/mortgaged	Urban	Frequent
Rafael	67	Secondary education	Retired	Married	3	Owned/mortgaged	Urban	Frequent
Jaime	71	University (chemistry)	Retired	Married	3	Owned/mortgaged	Rural	Frequent

* Not taking into account their current studies in theology.
[□] Whether the participant lived in an urban or rural setting.
[♦] Frequency of worship: frequent (going to mass daily or weekly), occasional (going to mass at least once a month).
[•] GP: abbreviation for general practitioner.

TABLE 3

Socio-demographic characteristics of the female lay theological students

Lay women[♦]	Age	Education*	Employment	Civil status	No. of children	Living arrangements	Urban/rural[□]	Frequency of worship[♦]
Fátima	38	Secretarial course	Secretary	Married	1	Owned/mortgaged	Rural	Frequent
Rosario	39	University (engineering)	Unemployed	Single	0	Living with parents	Rural	Frequent
Leonor	41	University (English philology)	Teacher	Separated	0	Owned/mortgaged	Rural	Frequent
Magdalena	45	Secondary education	Receptionist	Single	0	Living with parents	Urban	Frequent
Paula	47	University (law)	Housewife	Separated	2	Owned/mortgaged	Urban	Frequent
Amparo	47	Secretarial course	Secretary	Single	0	Owned/mortgaged	Rural	Frequent
Antonia	50	Secondary education	Housewife	Married	1	Owned/mortgaged	Rural	Frequent
Eulalia	55	University (Spanish philology)	Lecturer	Married	2	Owned/mortgaged	Rural	Frequent
Julia	58	Secondary education	Housewife	Separated	3	Owned/mortgaged	Urban	Frequent
Alejandra	60	Primary education	Housewife	Married	2[•]	Owned/mortgaged	Rural	Frequent
María	62	University (nursing), secretarial course	Nurse	Single	0	Owned/mortgaged	Urban	Frequent

* Not taking into account their current studies in theology.
[□] Whether the participant lived in an urban or rural setting.
[♦] Frequency of worship: frequent (going to mass daily or weekly), occasional (going to mass at least once a month).
[•] One of her children had passed away.

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Sant Josep's Catholic theological college

The college was founded in 1988 with the main objectives of providing theological training to the lay members of the parish churches of the diocese of La Ciudad and equipping them with the necessary skills to be able to carry out their pastoral work in their local churches. The college filled a gap in the religious education of the lay people who were actively involved in their parishes; for example, as catechists, biblical instructors or liturgical assistants. Unlike the priests and the members of religious orders, they had not received any formal theological training to undertake their tasks. The college has an average of a 1,000 students per year, and a staff of 40 teaching members.

All the students were required to take a "core module", a "biblical-theological section"[6] comprising five subjects, involving 180 hours of classes spread over three academic years. Depending on the student's individual needs, there was the possibility to choose several optional courses (involving from five teaching sessions to one academic year) or to undertake a pastoral speciality. For example, those who wished to become biblical instructors in their parishes had to take an additional three-year course (for the academic programme, see Table 4).

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[6] In the original Spanish,"tronco común" and "sección bíblico-teológica".

TABLE 4

Academic programme of Sant Josep's Catholic theological college

Biblical-theological section (compulsory)	Optional courses
- Faith and culture	- Introduction to ecclesiology ("Lumen Gentium")
- Sacred texts	- The Church in the modern world ("Gaudium et Spes")
- Dogmatic theology	- Introduction to Christology
- Moral theology	- Secularity, fundamentalism, multiculturalism, atheism, agnosticism
- History of the Church	- Liturgy and Eucharist
Pastoral specialities	- In-depth study of the New Testament
- Teaching of the catechism	- Second Vatican Council
- Liturgical assistant	- Teachings of John Paul II and Benedict XVI
- Pastoral of welcoming	- Living the Gospel in the family context
- Pastoral of the family	- Prayer workshop
- Pastoral of health	- Mary, prophetic woman
- Pastoral to assist the marginalised	- Sects and new religious movements.
- Pastoral of the young	- Songs and music in the liturgy
- Teaching religion in schools	- Sexuality and Christian morality
- Social doctrine of the Church	- Pastoral of the elderly
- Christian spirituality and prayer	- Ecumenicalism and inter-confessional relationships
- Biblical instructor (additional three-year course)	- Pastoral of missions
- Ecology	- Biblical workshop

4.1.2. Priests

Socio-demographic characteristics

As with the lay theological students, semi-structured interviews were conducted with 17 priests. They were all Spanish, with a wide age range spanning from 31 to 91 years old and a mean age of almost 60 years. All of them had university education, as they had studied theology in the seminary, and over half of them had an additional university degree. Two of them studied psychology and the other two were trained as medical doctors (one was trained as a psychiatrist, the other one as a general practitioner). Amongst the sample, several professions were represented: parish priest, hospital and prison chaplain, school teacher, college lecturer, psychiatrist, missionary and accountant of the cathedral. Most of the priests combined their work in their parishes with additional responsibilities, often complaining of feeling stressed and lacking time for the pastoral care of their parishioners and for themselves. Besides their regular occupations, they frequently had to substitute for other priests in neighbouring towns and villages who had to take planned or unplanned leave (e.g. sickness, family deaths, holidays). Many attributed the demanding nature of their roles to the shortage of priests in Spain, with seminarians becoming increasingly scarce.

The five religious priests included here lived in flats owned by their religious orders and formed a community with other members of the order with whom they shared accommodation, but - unlike the Cistercian monks and Augustinian

nuns of the study - they worked outside their religious communities as, for example, teachers and parish priests. In contrast, the diocesan priests did not live in a religious community: they lived alone in a flat or house attached to the parish they served, and Father Daniel lived with his mother. Ten of the priests lived in urban areas, while the remaining seven had their homes in small towns or villages in rural areas (for details on their socio-demographic details, see Table 5). I am going to provide below a brief description of seven priests that stood out due to their professional trajectories.

TABLE 5

Socio-demographic characteristics of the priests (non-contemplative priests)

Priests	Age	University career/s	Profession/s	Years of priesthood	Diocesan/religious	Urban/ rural[¤]
Tomás	31	Theology , computer science	Parish priest, school teacher	5	Diocesan	Rural
Anselmo	39	Theology	Parish priest, prison chaplain	14	Diocesan	Rural
Enrique	44	Theology, classic philology	Hospital chaplain, church assistant	11	Diocesan	Urban
Alberto	46	Theology, biology	Parish priest, school teacher, lecturer*	22	Diocesan	Urban
Daniel	47	Theology	Parish priest	15	Diocesan	Rural
Nicolás	51	Theology, medicine (general practice)	Parish priest, lecturer*	7	Diocesan	Rural
Eusebio	55	Theology, philosophy	Prior, gives spiritual retreats	25	Religious (Augustinian)[+]	Urban
Miguel	60	Theology	Head pastoral for migrants office[•]	35	Religious (Comboniano)	Rural
Francisco	65	Theology, psychology	Prior, gives spiritual retreats	41	Religious (Dominican)	Rural
David	63	Theology	Parish priest, lecturer*	37	Diocesan	Urban
Pablo	63	Theology, psychology, philosophy, pedagogy	Parish priest	39	Diocesan	Urban
Gerardo	64	Theology	Parish priest	38	Diocesan	Urban
Manuel	66	Theology , sociology	Parish priest, lecturer*	38	Religious (Jesuit)	Urban
Jesús	73	Theology, pedagogy	Parish priest	40	Diocesan	Rural
Guillermo	74	Theology	Cathedral accountant, lecturer*[♦]	52	Diocesan	Urban
Víctor	83	Theology	Church assistant, head missionary office[•]	60	Diocesan	Urban
Esteban	91	Theology, medicine (psychiatry)	Retired, formerly a consultant psychiatrist	60	Religious (Jesuit)	Urban

* Lecturer at the Sant Josep's Catholic theological college.

[♦] Besides being a lecturer at the Sant Josep's Catholic theological college, he also lectured at the university in theology.

[•] Formerly they were missionaries.

[¤] Whether the participant lives in an urban or rural setting.

[+] As opposed to the Augustinian nuns of the study who were contemplative, there are no Augustinian monks devoted exclusively to a contemplative life. Father Eusebio, like the rest of the Augustinian monks, is an active-life monk.

Priests trained in psychology

Father Francisco and Father Pablo studied psychology at university after they were ordained as priests. It was precisely the experience of working as priests that made them become conscious of the gaps in their training and encouraged them to pursue this subject, both to help their parishioners - especially those undergoing psychological or emotional distress -, and ultimately, to become better priests. Their training in psychology came in useful in several aspects of their pastoral care: in their provision of spiritual guidance, in the administration of the sacrament of confession (as it deepened their understanding of people's cognitions, emotions and behaviours), and in assisting those who were under psychological distress or mentally ill (because they felt empowered to directly approach them). They also stressed how useful having a good grasp of psychotherapeutic techniques was in helping their parishioners in their daily trials.

Father Pablo explained how he "made up for the deficiencies of the seminary" by taking degrees in three other subjects: psychology, pedagogy and philosophy. Interestingly, he qualified this by saying that he studied them in "the civil university" (not in a Catholic university). He vividly recounted how his parishioners reacted with apprehension to his decision of pursuing further education: "of course, I sought all this training to serve them better, but they said to me, 'Father, are you going to leave us?'. I replied 'no, I am *not* going to leave you, but I want to be able to serve you *better*. Thus, I need more training!'"

Besides psychology, the study of pedagogy and philosophy made him more resourceful as a priest: the former improving his teaching skills, and the latter deepening his thinking.

Father Francisco is a religious priest belonging to the Dominican Order, whose expertise is meditation and eremitic spirituality: he leads spiritual exercises and retreats in Spain and abroad, and is well-known within Catholic circles as a master of contemplative prayer, with several books published in this field. His name was spontaneously mentioned by some of the monks of the Monastery of Sant Oriol when talking about their contemplative practices and the importance of silence in advancing them on their spiritual paths. As in Father Pablo's case, his additional studies gave him a better understanding of normal psychology as well as making him more confident and skilled in psychopathology. He described several cases of people he had assisted who suffered from severe mental illness and to whom he was confidently able to provide help and advice. He had a holistic approach to his pastoral care: "I provide spiritual and psychological accompaniment, depending on the individual's needs… mind, body and spirit are all interrelated".

He founded a place with several "chapels" (little wooden houses furbished with great austerity: a bed, a table and an altar) where he leads groups that wish to have an eremitic experience. He refers to this as "a desert experience", and it consists of spending a minimum of eight days in silence and solitude. External distractions are minimised: electronic machines such as mobiles, computers,

watches and books are not allowed. The participants gather together only once a day to celebrate a very simple mass without songs and without even a sermon. All their meals are eaten in strict solitude. He also meets briefly twice a day with everyone individually. The object of this experience is to "find oneself in the deepest part of the self: self-knowledge" as "solitude and silence remove your securities and make you feel naked". Father Francisco explained that, in general, most people go through a "crisis of crying and insecurity" on the second, third or fourth day; he saw this as a normal, necessary stage of the transformative experience of the "desert". Once more, his psychological background assisted him in confidently managing these "crises", which he argued were often accompanied by "psychosomatic symptoms", as the overwhelming experience of solitude and silence was initially manifested in physical complaints (e.g. headaches and stomach aches).

Medical priests

Father Esteban and Father Nicolás were both working as doctors when they "received God's call". The former is a religious priest, a Jesuit, and the latter is a diocesan priest. Another difference between them is that Father Esteban combined his medical career - that of a consultant psychiatrist - with his vocation as a priest and a Jesuit, while Father Nicolás permanently left his job as a general practitioner when he entered the seminary.

Father Esteban founded a clinic in a Spanish capital 52 years ago to provide psychiatric care for priests, seminarians and monks. Ten years later, the centre also accepted referrals for nuns. Besides assessments, they also provided - when needed - long-term psychiatric treatment, including psychotherapy and medication. This was the first medical centre in Spain to specialise in providing psychiatric and psychological care for these religious groups. Father Esteban headed a team integrated by another doctor and three psychologists (most of the members of the staff were members of religious orders). Although they accepted self-referrals, the vast majority of referrals came from three sources: firstly, from Abbots and Mother Superiors requesting that a member of their community be seen; secondly, from bishops asking for an assessment of one of their diocesan priests; and thirdly, from directors of seminaries regarding a seminarian. Father Esteban worked in this clinic for 43 years, retiring at the age of 80 (at the time of the interview he was 91). Under his leadership the team assessed over 8,000 cases: almost 5,000 were priests, seminarians and monks, and the remaining 3,000 were nuns. He talked at length about the need to have a genuine vocation, firmly based on a mature personality, as a basis for their mental well-being. He stated that having either an immature personality or a weak or insincere vocation (e.g. entering a monastery as an escape from difficulties or to please others) could be confounded with mental disorders. Thus his team's main task was "differentiating a vocational problem from a mental disorder".

Father Esteban was able to combine his psychiatric expertise and his religious vocation in a long and fruitful career. He explained the gap that his centre filled:

from his clinic's first beginnings, they were inundated with referrals, and he argued that this was because the secular psychiatric services did not have the religious knowledge or sensitivity needed to fully understand this population. He even received referrals from abroad, making long stays in several countries, invited by directors of seminars and bishops to conduct multiple consultations. Clearly his long career as a psychiatrist contributed to reinforcing his religious vocation: his perception of having played a key role in supporting the mental health of priests and members of religious orders filled him with a sense of having been extremely useful to the Church.

Before Father Nicolás became a priest at the age of 44, he had been a general practitioner for 25 years. When I asked him about the particulars of, in my own words "his late vocation"[6], he bluntly - although kindly - replied "Glòria, no, it was not a late vocation, it is God who calls you whenever he wants". However, God had had a central part in his personal as well as in his professional life well before his ordination. He integrated his faith and religious beliefs in his medical practice, resorting to praying with his patients and their relatives and providing religious meaning and hope when they were facing illness and death.

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[6] One of those moments while conducting interviews when I wished I could have rephrased a question better.

Hospital chaplain

Father Enrique is currently a diocesan priest and the chaplain of a big urban hospital, but until two years ago he had spent fourteen years as a Carthusian monk. When he was diagnosed with a rare autoimmune disease that relegated him at that time to a wheelchair, his Abbot suggested that he leave the monastery, which he did only reluctantly, as he was "humanly and spiritually fulfilled" as a monk. He could not receive the appropriate treatment in the remote area where he was living nor could he, because of his illness, cope any longer with the physically demanding way of life of the Carthusian Order.[7] Later on, in section 4.3.1., I will provide a depiction of the painful process that Father Enrique underwent when he had to leave the monastery, where he had thought he was going to spend his whole life. The bishop of his diocese offered him the post of hospital chaplain once his functioning started to improve, thanks to the intensive pharmacological treatment he was receiving. It is interesting how Father Enrique uses both his experience of having being severely ill and his experience of God in his work as a hospital chaplain: when visiting patients, he often shares with them his very personal narrative where both aspects - being seriously ill and being a firm believer - are integrated.

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[7] The Carthusian Order is an eremitically oriented religious order. In contrast with the Cistercian monks of Sant Oriol, with their many communal activities (see Table 8 for their detailed timetable), they spend most of their time alone, secluded in their cells. Father Enrique explained that they can only talk amongst themselves for one hour and a half on Sundays after lunch (which is the only meal that they eat together). Their sleep is divided into two periods: they sleep from 19:30 to 23:00, and from 2:00 to 6:30 (and they pray in between). They eat two simple meals a day, at 11:30 and 18:00, alone in their cells.

Missionary priests

Father Miguel belonged to the Comboniano missionary order. He had spent 20 years as a missioner in the Peruvian Andes and he was at the time of the interview in charge of the diocese's provision of pastoral care to migrants. Father Víctor was a diocesan priest who had spent most of his life as a missioner in Africa, the Americas and India. At the time of the interview he was 83 and leading the regional office of missions as well as helping in a parish church.[8] The years these two priests spent as missionaries had a marked influence on the ways in which they face their own suffering and misfortunes as well as how they helped others. They both described many examples from their missionary days in which they had witnessed, in Father Miguel's words, "situations impossible to resolve". However, when the afflicted person or their relatives had faith in God, some sort of resolution was achieved: "when they opened themselves to God, you don't know how, but the person overcomes it [the adversity]. I am totally convinced of this possibility, yes, yes, I have experienced it!"

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[8] Father Víctor died seven months after I interviewed him. I still remember, when I walked into his office, how he was on the phone energetically trying to get funding for a mission. He was paid tribute in the local press and was remembered in many masses throughout the city for a life devoted to the missions.

4.1.3. Cistercian contemplative monks

In this section, I am going to provide background information about the monks and their monastery followed by a depiction of the level of their religious education, their daily life in the monastery and the hierarchical organisation. Due to the unconventionality of Brother Terenci's and Brother Joaquim's religious vocations, I will end with some biographical notes on these two monks. The information presented here was obtained in the course of my fieldwork in the Monastery of Sant Oriol through participant observation and multiple conversations held with the monks. Some of the more detailed and personal biographical data was gathered in the individual interviews.

The monks

The Monastery of Sant Oriol belongs to the Cistercian Order and was founded by four monks 45 years ago. The community is currently made up of ten monks with four of them having also been ordained as priests. Since the founding of the monastery, two monks have died: Brother Antoni, in 2009, and Brother Andreu, who was one of the founding monks of the monastery, in 2003. They are both still vividly part of the community, frequently being referred to in conversations. A very strong connection with them has been maintained after death: at a physical level, as their two graves are in the garden separated from the choir where the monks sit by the wall of the church, and at a spiritual level, as the

monks include them in their prayers, asking them for guidance and advice. Many monks have even attributed the vocation of Brother Terenci to "the work of Brother Andreu", as he died not long before Terenci joined (the last monk to enter the monastery before him had done so 23 years earlier).[9]

The age range of the community is very wide, spanning from 35 to 89 years, with a mean age of just over 64. It is interesting to note that there is a 22 year gap between the youngest monk, Brother Terenci, and the next youngest monks, Brother Arnau and Brother Joan. Brother Terenci noted in one of our conversations, when I asked him about the age difference between him and the rest of the community, that his own father was younger than any of the monks (in section 4.3.4. I will elaborate some of the tensions that he suffered due to the consequences of this age difference). The increasing age of the community would seem to foretell a gloomy future for the continuance of the Monastery of Sant Oriol and it is a real source of worry and uncertainty for the monks.

The monks' number of years of religious life ranges from four years to sixty-six, with a mean of almost thirty-five. Most of them joined the Cistercian Order in their twenties and thirties, with the exception of Brother Joaquim and Brother Gregori who did so later, in their fifties and forties, respectively. Most of them felt an inclination towards a religious life in their late adolescence or early twenties, with two exceptions: Father Pau and Father Arnau, who reported

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[9] Brother Joaquim entered the Monastery of Sant Oriol after Brother Terenci. The former joined four years before and the latter seven.

having wanted to become priests from a very early age, when they were around ten years old, and then communicated this resolution to their families. After making up their minds to become monks, most of them undertook more or less tortuous searches - lasting from a few months to several years - until finally entering the Monastery of Sant Oriol. The majority of the monks who were also priests started their religious paths in the seminary, with the call for priesthood preceding the call for a contemplative life. It was common for the monks to have had trial periods in several monasteries of the same Cistercian Order as well as in other religious orders. They used similar terms to express the relief of having found the monastery where they wanted to spend their lives: "this is it! I've found my home", "I felt like finally coming home", "I knew it, I knew it, as soon as I saw the cross on the front door, I knew it [that this monastery was the place for him]".

Regarding their level of education, the priests and the two monks who had joined the monastery most recently had university degrees: the priests had studied theology, Brother Joaquim had studied journalism, and Brother Terenci had studied music and theology (the latter after he had entered the monastery). Brother Gregori had secondary education and the rest of the monks had primary education only (see Table 6). The difference in their level of education was not apparent when the monks dealt with one another at an individual and communal level. We need to take into account that studying and reading is an intrinsic part of their daily routines, with the monks frequently spending time in their well-stocked library with internet access and with new books being regularly ordered.

Moreover, the monks were remarkably well informed about national and international news: they received daily newspapers, which they read carefully, and listened to the radio while doing manual work. When conversing about politics with Brother Xavier, I praised their up-to-date knowledge, and he laughed saying: "Glòria, *we* are definitely *in* the world!" (he might have been reacting to the involuntary surprised tone of my praise). In my fieldwork with nuns, I often heard the expression - especially being used amongst the older nuns - "when I was in the world", referring to the time before they became nuns, implying that somehow by entering the monastery they had left the world outside its walls. It is interesting that amongst the monks I did not hear this expression emphasising their separation from the world being used - not even once - except for Brother Xavier's above ironical comment. Also, the Abbot periodically organised conferences and courses in the monastery for the monks about a varied number of subjects such as theology, arts or history.[10]

Moreover, they seemed to be good at sharing knowledge amongst themselves; for example, when the monks told me about books they had read and enjoyed, they often immediately added that a certain brother had recommended it to them. Brother Terenci - the youngest monk of Sant Oriol - was currently a PhD candidate in theology, and so needed to dedicate more time to studying, at the expense of manual tasks. Rather than this creating rivalry or resentment amongst

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[10] The Prior asked me to give them a lecture on my research on religion and psychiatry, suggesting a presentation on my previous research with the nuns. As I did not want to influence the monks in any way, I declined - as graciously as I could - but agreed to do so at a later stage, once my research had been concluded.

the rest of the monks, they seemed to take particular pride in Brother Terenci's achievements, as if they belonged to them all. They liked to talk to me about the content and progress of his PhD (more often than Brother Terenci did so himself) in a tone similar to that of a father or grandfather proudly commenting on the gifts of a dear child or grandchild.

The majority of the monks came from small towns or villages (only two came from large cities): their fathers had run small businesses or farms, and their mothers were housewives. Most of their parents were deceased, which is not surprising due to the monks' ages. All the monks, with the exception of Brother Terenci, came from religious families, with their mothers having played a key role in the transmission of faith to their sons (e.g. praying the rosary as a family when they were little, encouraging them to say their prayers before bedtime, and taking them to catechism and to mass on Sundays). Only two of the monks acknowledged having had a relationship with a woman before becoming monks: Brother Terenci had a girlfriend and Brother Joaquim had been married (for a breakdown of the monks' ages, level of education and years of religious life, see Table 6).

TABLE 6

Monks' ages, level of education and years of religious life

Monks	Age	Level of education	Years of religious life
Terenci	35	University education (music and theology)	7
Arnau[•]	57	University education (theology)	24
Joan	57	Primary education	31
Joaquim	60	University education (journalism)	4
Gregori[▲]	64	Secondary education	23
Jordi[•]	66	University education (theology)	42
Xavier	68	Primary education	48
Robert[▲]	68	Primary education	43
Lluc[•]	78	University education (theology)	58
Pau[•]	89	University education (theology)	66

[•] These monks were also priests, and their names will be preceded by the word "Father" (instead of "Brother" as for the rest of the monks).
[▲] These monks had decided not to undertake "solemn vows": Brother Robert was an "oblate" and Brother Gregori had only undertaken "simple vows".

The foundation of the Monastery of Sant Oriol

The Cistercian Monastery of Sant Oriol was founded in 1967 by a group of four

monks: Father Pau, Father Lluc, Brother Xavier and Brother Andreu (the latter

died in 2003). These monks' monastery of origin - the Cistercian Monastery of

Sant Jordi - was one of the largest and most majestic monasteries in Spain: it is a

UNESCO world heritage centre containing a 12th-century church, a fortified

royal residence, royal pantheons and multiple masterpieces. Inspired by the opening up and change brought about by the Second Vatican Council, Father Pau - who was then the Abbot of the Monastery of Sant Jordi -, with the support of Father Lluc, Brother Xavier and Brother Andreu, decided to leave behind the magnificent Monastery of Sant Jordi to start a simpler community, finding the place to do so in a mountainous area where a small church with a rectory stood almost in ruins. The monks spent the first years restoring the small church (which dated from the 18th century) and expanding the rectory to accommodate the community. The community referred to these four monks, in a reverential and admiring tone, as "the foundational monks".

The principal aim motivating their foundation was to seek a more austere way of life far from the sumptuousness of the Monastery of Sant Jordi, a life in which the monks could forge closer bonds amongst themselves than were possible in their previous, much larger, community. They also wished for their monastery to become a centre of peace and silence, with a community of open and approachable monks, where visitors and guests in need of spiritual guidance could feel welcome. When listening to the monks' narrations of the foundation of their monastery, especially from one of the three monks who took part in it, I was reminded of my pre-fieldwork readings about the history of their Order and of those medieval Cistercian monks - such as Bernard of Claraval and Robert of Molesmes - who abandoned their rich monasteries to create new communities in remote places to resurrect the old monastic ideals of poverty and simplicity (for a description of the history of the Cistercian Order, see appendix 1, "Saint

Benedict and the origins of the order"). I wondered how much of a conscious or unconscious process of identification with those early renovators of the order took place amongst the monks.

I was told that the months preceding their departure from the Monastery of Sant Jordi, especially when their plans of leaving were disclosed to the community, were full of tensions and uncertainties, as well as active opposition from some senior members of the order. They clearly needed a great deal of courage and determination to leave such an important monastery and to start another from scratch. The many obstacles and difficulties they encountered were still very vivid in the minds of these three monks (the fourth foundational monk, Brother Andreu, died in 2003). The similarities between the descriptions given by the non-foundational monks and those who lived it firsthand were striking: the story of the foundation seemed to be a favourite one, being frequently referred to amongst the monks as well as narrated to their guests and visitors, and it was given in an intrepid and adventurous tone. There was a particularly moving moment in their narrations, which I heard from several monks repeating exactly the same words as said by Father Pau - who was their Abbot and the eldest among them - to the other three monks when, after having left their previous monastery, they stood for the first time, on a cold snowy winter morning (they did not have heating then), in front of the rundown church and rectory which was going to be their home: "my sons, where have I brought you?"

Religious vows

The monks understood their three religious vows as the expression of the complete surrender of their whole person to God. The vow of chastity consists of their free choice to give up loving and being loved physically. The vow of obedience implies the sacrifice of making their own decisions about life and being obedient to their Abbot. The vow of poverty means giving up personal possessions and sharing all goods with the community. Each monk was personally responsible for keeping these vows and, only in case of a clear failure to respect a vow, would the Abbot intervene with advice. The monks promised to live a life of chastity, poverty and obedience to the Abbot and to the whole community in a ceremony known as "the profession of the vows".

The monks generally undertake the vows in two ceremonies - "simple" and "solemn profession" - which take place in the course of their religious formation. I will now proceed to describe the main characteristics of every stage of religious training as they were explained to me by the monks, starting with the postulancy, which is the lowest level, lasting one year. This early stage is the beginning of their religious lives. Its main goal is testing the sincerity and strength of their vocations and their suitability for a cloistered life of contemplation. Once they have successfully overcome this first level, the monks enter the novitiate, lasting two more years. The training during these two stages is closely supervised by the Prior and the Father Teacher. In the mornings,

besides receiving lessons from them, they have time scheduled for studying and reading. They are expected, at the end of their novitiate, to have gained a good knowledge of the Rule and Constitutions of the Cistercian Order, the history of their order, the liturgy and the bible, as well as to have broadly read about the teachings and history of the Church. At the end of the novitiate, the Abbot and the solemnly professed members of the community decide if the monk has acquired the necessary knowledge and, more importantly, if he is spiritually ready to undertake a deeper commitment and thus proceed to take his first vows - known as "simple vows" -, which bind him to live in the monastery for three years. There is also a change in the monk's external appearance, as he will be given the habit of the Cistercian Order which is white with a black chasuble (postulants and novices were normal clothes).[11]

The monk is then known as a "simply professed monk" and, during the next three years, his aim will be to prepare himself to take the "solemn vows", which is the ultimate level of commitment that a monk can undertake, as these vows are - unlike the "simple vows" - not of a temporary nature, but rather a promise to live in the monastery for life. Although academic learning will continue, there is more emphasis on becoming a more active member of the community, working alongside perpetually professed monks. In this last level of formation, they concentrate on preparing themselves spiritually for the total surrender of their lives to God, confronting any final doubts or reservations that they may still

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[11] Due to the colour of their habits, Cistercian monks are popularly known as "White Friars" (while Dominicans are popularly called "Black Friars" and Franciscans, "Gray Friars").

have before committing themselves to live in the community until death. Again, the monk who wishes to proceed to take the "solemn vows" will do so only with the consent of the Prior and the "solemnly professed" members of the community. The "solemnly professed" monk is a full member of the community with the right to vote on all the important decisions of the monastery including the election of the Prior. The ceremony of profession of "solemn vows" is considered to be the most important moment in their religious lives: it is regarded as the culmination of all the years of preparation for undertaking the highest degree of commitment to God. The monk's relatives and friends are also invited to attend the ceremony. It is a very emotional time, not just for the professing monk, but also for the whole community. Brother Terenci, who was the last monk to have undertaken these final vows, told me that once the ceremony was over, all the monks, one by one, gave him a hug and that most of them had tears in their eyes when they embraced him.

The religious formation of the monks is not a rigid, mechanical kind of training. Although the finality is clearly the profession of "solemn vows", some degree of flexibility is allowed. For example, in terms of the duration, if a monk does not feel ready - or is not considered to be ready - to advance to the next stage of formation, the stage that he has been on can be prolonged; or contrarily, if a monk advances more rapidly, the duration can also be shortened accordingly. Moreover, there is the possibility of opting out of the standard formation path presented above and remaining indefinitely in one stage if the monk does not

wish to proceed further (for an outline of the monks' level of formation see Table 7).

TABLE 7

Monks' levels of religious formation

Stage	Duration	Changes
Postulant	1 year	Wears normal clothes
Novice	2 years	Wears normal clothes
S I M P L E V O W S		
Simply professed monk	3 years	Wears the Cistercian habit
S O L E M N V O W S		
Solemnly professed monk	For life	No changes in habit, right to vote, to break the vows a dispensation from the Vatican is required

All the monks of the monastery were "solemnly professed" except three: Brother Joaquim, Brother Robert and Brother Gregori. Brother Joaquim had just recently taken his "simple vows" and was preparing to do his "solemn profession" in two to three years time. But the other two monks were rather different cases: Brother Gregori, who had been in the monastery for 23 years, had only undertaken "simple vows" and Brother Robert, who joined the community 43 years ago, was an "oblate", meaning that he was not a "professed monk", not having ever undergone a ceremony of profession of vows. However, the latter was committed to living a contemplative life in the monastery bound by a personal promise ("private vows"), which he individually renewed with the Prior once a year. Both monks voluntarily chose not to advance further along the path culminating in the profession of "solemn vows", arguing that they did not feel "comfortable" and "capable" (these words were used by both of them) of, in the case of Brother Gregori, committing himself to living in the monastery until death and, for Brother Robert, undertaking the studying and lessons required in the formal training of the postulancy and novitiate.

Nonetheless, they and the other members of the community stated that, in spite of their different ecclesiastical status, they were full members of the community. The only practical difference between them and the "solemnly professed" brothers was that, as they were not committed for life, they did not have the right to vote in the decisions affecting the future of the monastery, such as the election of a new Prior, but they were allowed to participate in other matters that affected them, such as choosing where to go on holiday. Another area of divergence was

regarding the steps to be taken when a monk wanted to leave the monastery: Brother Robert and Brother Gregori could break their commitment in a much more straight-forward manner, needing only to get a dispensation from their Prior, while for the "solemnly professed" monks this process would be much more complicated, involving applying for a dispensation from the Holy Office in the Vatican.

Daily activities

The monks' daily duties are linked to the posts they hold in the community. Four of the monks had also been ordained as priests and thus have the task of administering the sacraments to the community. The main posts of responsibility in the community are: the Abbot, the teacher, the accountant and the council (made up of three monks). The posts of Abbot and teacher, and the members of the council, are democratically elected every four years by the "solemnly professed" monks (each monk has one vote). The Abbot chooses the monk to undertake the accountant's role. A necessary requirement to be elected into any of these posts is to be "solemnly professed". Besides this condition, the Abbot also needs to be a priest.

The Abbot is the most important authority figure in the community: he has the power of making the final decisions on every aspect of their communal life, generally in consultation with the council. In communities of less than twelve

monks - as it is the case of the Monastery of Sant Oriol - the Abbot receives the name of Prior. Sant Oriol's Prior is Father Lluc, who was elected when Father Pau became too old to carry out this task (at the time he was 89 years old). Father Pau had held this role since the beginnings of the monastery, and was still respectfully referred to as "Father Abbot" by the monks (they explained that they could call him so in spite of the small size of their community, as he originally was the Abbot of the larger community of the Monastery of Sant Jordi, and was thus allowed to retain the title).[12] The monks insisted on the autonomy and independence of their monastery from other authorities of the Church in Spain. Listening to the monks, it became very clear that they certainly did not want any external meddling with their internal affairs from the local or national bishops. When I asked about the specifics of their hierarchical structure, in case of internal problems arising, they reiterated that the first authority figure was their Prior, followed in second place by the Abbot of the local Cistercian congregation. Third was the General Abbot of the Cistercian Order, who lives in Rome, and finally, in the last instance, the Holy Office in the Vatican. It was interesting to note that there were three layers of authority belonging to their own religious order before reaching the highest authority of the Church, thus completely bypassing the Church hierarchy at a local and national level.

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[12] This different terminology was indeed convenient for avoiding confusion between the two monks: when they referred to the "Father Prior", I knew they meant Father Lluc, the current head of the community, and when they referred to the "Father Abbot", I knew they were talking about Father Pau.

Brother Xavier, Brother Joan and Father Arnau made up the council, to which the Prior turned for advice in the running of the monastery. Father Jordi was Sant Oriol's Father Teacher, having been recently in charge of the training of Brother Terenci and Brother Joaquim during their postulancy and novitiate, and he was still supervising, jointly with the Prior, the overall formation of Brother Joaquim until his profession of "solemn vows". The accountant post was nominally held by the Prior, with Brother Gregori acting as his assistant, but as was acknowledged by the monks, it was the latter who kept the books, as he was "good at computers and numbers" (he would have needed to be "solemnly professed" to hold this post).

The old Benedictine principles of the Rule (see appendix 1, section 2.1.) were very much alive in Sant Oriol, with their daily routine being governed by their maxim "ora et labora": as their timetable shows (Table 8), the monks' time was divided mainly between praying and working. Besides the specific times that the monks devoted exclusively to meditation and prayer, they described the experience of having a continuing, uninterrupted conversation with God, a feeling of being accompanied by God, not only during their prayers, but also while doing manual work. The Rule's advice against idleness was followed, with a strong emphasis amongst the monks on not wasting their time, with every moment of their day being accounted for. Nevertheless, there was one notable exception to their strictly adhering to their timetable: when someone visited them requesting their advice, they made time to sit and listen to the visitor. This

service took priority over other tasks that were considered less important: for example, Brother Terenci illustrated this by saying that it was better for windows to wait to be cleaned than for a distressed person to wait to be comforted. They also made an exception with me, generously setting aside a considerable amount of their time to being interviewed, as well as to having more informal conversations.

As the timetable of the monks' daily activities shows, the time spent together as a community was dominant, especially due to their following of the "Liturgy of the Hours" - also known as the "Divine Office" - which is a compendium of prayers that they recited communally at fixed hours of the day. Regarding their manual tasks, they did all the housework themselves, taking in turns the different tasks, with the exception of the laundry, which used to be done by the late Brother Andreu but was currently taken care of by a reliable woman from a neighbouring village. Father Arnau was the cook, and was assisted by another monk (the kitchen assistant role was also done in rotation). Brother Joaquim was in charge of cataloguing the library's books, counting at times on the help of some fellow monks.

TABLE 8

Timetable of the monks' daily activities

Time	Activity
5.00	Waking-up, dressing
5.30	Matins*
6.00	Personal time, individual meditation
6.45	Lauds*
7.15	Chapter: reading of the Rule of Saint Benedict, Prior communicates news relevant to the community (e.g. visits, family news such as births and deaths, etc.)
7.30	Personal time: shower, breakfast
8.45	Terce*
9.00	Personal time: taking off the habit to prepare for work
9.20	Work
12.45	Personal time: washing up and putting on the habit
13.00	Angelus and Sext*
13.10	Lunch (the first half is in silence, listening to a monk reading a religious text; in the second half they are allowed to talk)
14.15	None*
14.30	Siesta
15.00	Work
17.00	Formative time: studying, reading
18.00	Eucharist (at 10.00 on Sundays)
18.45	The monks go outside the church to meet and chat with the people who have attended mass
19.10	Vespers*
19.40	Personal free time except for those monks whose turn it is to lay the table and serve the dinner
20.00	Dinner (in silence, listening to a music recording of mostly classical sacred music)
20.45	Compline* and Angelus
21.00	Night rest

* Prayers belonging to the "Liturgy of the Hours".

The community was self-sufficient, sustaining themselves through various activities, the most important of which was the binding and restoration of books and documents by hand (they had a workshop in the monastery). The monks also received guests - only men, they did not accept women - who wanted to have a monastic experience of contemplation and meditation for a maximum of two weeks. These guests had access to the monks' communal rooms (unlike the monasteries of the nuns participating in the study, they did not have a grille).[13] Moreover, they welcomed their guests to join their prayers and had all their meals with them. Lunch time was an opportunity for the monks and their guests to socialise and to get acquainted as they were allowed to talk during the second half of the meal (during the first half they were in silence, listening to a monk reading a religious text). Furthermore, the monks were available to meet individually with their guests, to listen to them and to provide advice; this was completely optional and it was up to the guests to ask for a private talk, as they had no obligation to do so (I will explain this pastoral dimension of the community in section, 4.3.4.). They did not charge their guests a stipulated fee for their accommodation and meals, but instead accepted from each whatever they gave voluntarily, according to their means. They also had an orchard and garden that supplied them with fruit and vegetables.

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[13] The grille, in the case of the nuns' monasteries, separated the monastery's entrance hall from the cloister, to which only the nuns had access. They talked and exchanged objects (e.g. the meals for the guests) through an aperture in it.

Silence played an essential role in their lives of contemplation, since they considered it as an inner attitude of focusing their minds on God. They had two moments of "recreation" daily, when they could talk freely amongst themselves and their guests: besides the second half of their lunch period, after mass the monks came out of the church to greet the people who had attended the mass and to chat with them. Their recreation times were extended on special occasions such as the celebration of their saints' days, their birthdays and the silver and golden anniversaries of their professions of vows (the 25th and 50th year anniversaries, respectively). As a community, they also looked forward to celebrating Christmas and the Day of Saint Benedict. Besides having more time to chat, on these special days they also had "a special meal" for lunch accompanied by spirits and dessert. The monk who was being honoured (whose name day, birthday or anniversary of vows it was) chose the "special meal" that they all had, which was his favourite meal. In these celebrations and on Sundays, they had a longer after-lunch conversation with "real coffee" (differentiating it from instant coffee). Curiously, they drank wine with all their lunches and dinners but only enjoyed "real coffee" on Sundays. The monks were not allowed to smoke; if they were smokers before joining the monastery they had to give it up (in contrast, many of the priests participating in the study were heavy smokers).

They had a one-week holiday each year in the summer, which only half of the monks took at the same time so the worship could continue in the monastery. They normally stayed in a country house in the mountains or by the sea which

was offered to them by neighbours or people who had been their guests. From these homes they organised short excursions and walks. They also periodically watched a film together, or a documentary of interest to the community, followed by a discussion.

Two unconventional monks

After twenty-five years without having had any new vocation, they have had two in the last seven years: Brother Joaquim and Brother Terenci. Besides bringing hope for the future of their community, these two men have also challenged preconceptions about what entails a normal path to a contemplative life, as well as being perceived as evidence that, in their own words, "everything is possible through God".

    Brother Joaquim

Brother Joaquim was once married and had been a successful journalist. He explained that in his youth he had felt an inclination to leading a contemplative life, but although his family was religious, because he was an only child, his parents did not want to hear about a possible religious vocation. Although God continued playing a central role in his life, he married, had a daughter and led a

busy professional and social life. Those early feelings calling him for a monastic life that he had put aside for years came alive again when he separated from his wife, but then he had to take care of his adolescent daughter and later on, his elderly mother. After his mother passed away and with his daughter married, he decided to finally fulfil his contemplative vocation. He met the community of Sant Oriol through a common friend and, after a brief stay with them, he realised that this monastery was "his place". He joined the monastery four years ago at the age of fifty-six.

The community of Sant Oriol was very open and accepting of Brother Joaquim's special circumstances, especially taking into account that, according to the Catholic Church, marriage is for life. He was thus considered as being still married when he asked to be admitted to the monastery. The monks supported him in applying to the Vatican for a special permit, which was granted, allowing him to take the vows. His daughter and grandson often visited him in the monastery and were warmly welcomed by the rest of the monks, who jokingly told me on many occasions how very cute the grandson was, adding that "the little one is the grandchild of us all!"

Until his entrance into the monastery, Brother Joaquim had enjoyed a very active social life: he went to the cinema and the theatre weekly with friends, frequently dining out, travelling and entertaining his extensive group of friends at home. Therefore it seemed likely that he, in comparison with other monks, would have been especially vulnerable to bouts of loneliness and boredom. However, he

seemed just as well adapted to the monastic rhythm as any of the other monks who had been there most of their lives. He denied missing his life outside the monastery much, arguing that all of those aspects had been filled by a continuing feeling of God's presence with him.

Brother Terenci

Brother Terenci joined the community of Sant Oriol seven years ago, when he was twenty-eight years old. Although he had been baptised at the insistence of his grandmother, he did not receive any other sacraments, being brought up without religious beliefs. He had always been critical of religion: "I thought that religion was a big fat lie, I could not understand how religious people could be fooled in such a way", "I knew for sure I was never going to be a Christian, certainly not a Catholic!" He remembered having reproached his parents for consenting to his christening as a baby to please his grandmother without waiting to take into account his views on the matter. When asked about his life before becoming a monk, he responded that he felt "privileged" and "happy": he had studied music at college and had a job he enjoyed as a music teacher in a school. He was close to his family, had a good group of friends and had had a stable relationship with a woman. However, he described himself as having had "occasional moments of feeling that something was missing… life, death, suffering, happiness… and of wondering about what was the meaning of it all? What was the meaning of life? Who *was* I really?"

One year before joining the monastery, his best friend - "like a brother to me" - who was studying history of art and specialising in Romanesque art, proposed that Terenci travel with him around Spain and France, visiting Romanesque monasteries and churches. His friend's views about religion were similar to Terenci's, thus the motivation for these trips was not a religious one, but purely motivated by a desire to see art. Their travels gave Terenci his "first glimpse of monastic life", and he remembered how touched he was by the simplicity and kindness of the monks he met. He relived a conversation he had with his friend while driving back home, asking him: "can you imagine if it were true, that God existed?" Six months after these travels, while he was at home one night looking at the stars, Terenci had a sudden and overwhelming "experience of God" that made him change his life drastically and that led to his entrance into the monastery. The following quotations are taken from his responses to my questions, explaining this experience: "it is difficult to explain it with words, but I felt that love was surrounding me and was calling me by *my* name making me feel loved, it was coming not just from the outside but from my inside: someone was dwelling in me", "an irruption of God that marked a 'before' and an 'after' in my life", "that night God certainly opened my heart to allow me to know him".

His experience that night "changed *everything*" having the certainty that he had to "completely give his life to him [God]". Terenci himself pointed out that somehow his faith started at the same time as his religious vocation. He felt compelled to spend many hours every day in silent meditation - an activity

completely new to him - trying to find out what to do next. He also read books from different religions feeling "more comfortable" with those texts belonging to the Christian tradition, such as accounts of the lives of saints and the Gospels; his preference was possibly influenced, as he acknowledged, by the knowledge he had acquired in his visits to Romanesque monasteries and churches. Finally, he felt while meditating one day in the early morning that "God wanted me to be Christian", describing that feeling as an "intuition". He explained that, as he had known ever since having that "experience of God" that he had wanted to give his life entirely to God, once he decided that he wanted to be a Christian, the call to a monastic religious life naturally followed. From then on, everything happened very fast: he found a priest "by chance" to whom he opened his heart and who recommended the Monastery of Sant Oriol. He trusted this priest - "it all felt right and easy" - and asked the same friend with whom he had explored Romanesque art to drive him there (needless to say, Terenci's plans came as a shock to his friend). When the monastery was in sight, he asked his friend to leave him there and to drive away, as he wanted to arrive alone at the door: "it was precisely at that moment, before ringing the bell, that I had the certainty that this place was the place where God wanted me to be. I did not have to search any further!"

He described his arrival at the monastery as "fairly original" leaving the monks "a little taken aback". He decided to tell them about his intentions straightaway: "from the very first moment, with total transparency, I told them that I was not there for any discerning or trial period, that I was there to be a monk of Sant

Oriol". The monks' surprise continued to grow when he explained that he had not taken the holy communion nor been confirmed (he received those sacraments in the following months). Father Jordi, who was the first monk to greet Terenci, still vividly remembered his initial thoughts - shared by the community - about him: "this boy is mad or this has something to do with Brother Andreu" (who had recently passed away). In our conversations, Brother Terenci praised the open-minded and non-judgmental attitude the monks displayed towards him from the beginning. Terenci's cheerful personality provided a real injection of optimism and energy to the community, coming at a particularly low moment for them, as they were mourning the first death in the monastery since their foundation. Moreover, they had not had any new entrants for over 20 years.

Brother Terenci seemed well integrated in the community and was clearly much loved by the monks, who were all at least 22 years his senior (I heard Father Pau, the old Abbot, call him sometimes "the little one"). Although he had reached the final level of commitment with the monastery, having taken his "solemn vows", the monks still loved telling funny anecdotes from his early days at the monastery that they found hilarious, which were triggered by his ignorance of liturgy and religious matters, such as when he bluntly asked them why they were kneeling in front of "that box" (referring to the tabernacle).[14] Understandably,

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[14] A tabernacle is a box-like vessel, normally located on the altar, where the consecrated hosts left from the mass are kept. The Catholic Church believes in transubstantiation (i.e. that the bread and wine are transformed into the body and blood of Christ) and thus that Christ's presence perdures after the consecration (this is why the monks kneel in front of the tabernacle, as well as

his family and friends initially reacted with great surprise and disbelief to Terenci's religious vocation. However, he explained that he has won their respect - even if some do not understand it - as they have seen how happy and settled he is there (his parents visit him frequently).

4.1.4. Augustinian contemplative nuns

In this section I am going to provide socio-demographic and background information about the nuns, a description of the training course they were attending, and a brief summary of their lives in their monasteries of origin. This information was obtained during my fieldwork, which consisted of multiple conversations, participant observation and individual semi-structured interviews, in the house of retreat where the nuns had gathered to attend this course.

The nuns

Ten nuns belonging to the Order of Saint Augustine attended the course: one was a postulant (Sister Teresa), six were novices (Sister Claudia, Sister Raquel, Sister Elvira, Sister Elena, Sister Sofía and Sister Irene) and the three remaining nuns were Mother Teachers (Sister Carmen, Sister Mercedes and Sister

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directing their prayers to it). Priests take the hosts from it when visiting those who had not been able to receive the communion in the mass (e.g. the sick and the elderly).

Carolina). The course was part of the training the nuns received in their postulancy and novitiate, and they were accompanied by some of their Mother Teachers, as these senior nuns were seen as assuming overall responsibility for their training and well-being (jointly with their Mother Superiors). They came from five different Augustinian monasteries that the order had in Spain. My previous fieldwork had taken place in one of these monasteries, the Monastery of Santa Mónica, though only Sister Carmen had been there at the time.[15] The nuns belonging to the same monastery were as follows: Sister Raquel and Sister Teresa; Sister Elena, Sister Carmen and Sister Irene; Sister Mercedes and Sister Sofía; Sister Carolina and Sister Elvira (Sister Claudia was the only one from her monastery attending the course).

The age range of the nuns was - as had been the case for the monks - very wide: the youngest nun was 23 and the oldest one, a Mother Teacher, was 73. But in contrast with the monks of Sant Oriol, their mean age was just over 36 years (the majority of the nuns were in the earliest stages of religious life), while that of the monks was over 64 years. Regarding their ethnicity, all the nuns in training were Kenyan and the Mother Teachers were Spanish. The nuns from Kenya belonged to four different tribes: Kamba (Sister Raquel, Sister Teresa and Sister Elvira), Luo (Sister Irene and Sister Elena), Luhya (Sister Sofía), and Kikuyu (Sister Claudia); their first languages varied depending on the tribe they belonged to: Kikamba, Dholuo or Luo, Luhya, and Kikuyu respectively.

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[15] My fieldwork in the Monastery of Santa Mónica was conducted from July 2006 to June 2008 in seven visits (see sections 1.2. and 2.1.2. for further details).

As expected, there was a great disparity in the number of years of religious life between the nuns in training and the Mother Teachers: the former had joined their monasteries not more than three years ago while the latter had been nuns an average of thirty-two years. The majority of both groups of nuns felt drawn towards a religious life for the first time in their late adolescence, joining the order in their twenties. The exception is Sister Carmen, who experienced the call later, entering the monastery in her mid-thirties. As was the case with the monks, it was common amongst the nuns not to have followed straightforward paths to their current monasteries, since they had previously tried other religious orders and monasteries. Moreover, the Kenyan nuns had to overcome additional obstacles - such as the bureaucracy required for their applications to Spanish monasteries, which often involved long waits and paperwork - before setting off to Spain.

Only two of the nuns had university degrees, and both were Spanish and Mother Teachers: Sister Carmen studied chemistry and Sister Mercedes was a qualified teacher. The majority of the remaining nuns had only completed primary education. Most of the Spanish and Kenyan nuns came from small towns or villages located in rural areas, and were from devout Catholic families. The economic resources of the Spanish and Kenyan nuns differed greatly: the former came from middle-class families, whereas the latter provided many testimonies of the precariousness of their lives back home, where they often lacked basic necessities such as food, running water, electricity and medicines. Several of the nuns had gone out with boys or had had boyfriends before entering the

monastery. Two nuns - one Kenyan, the other Spanish - explained that they had been torn between the love for their boyfriends and their love for God, finally deciding to give up human love in order to become "God's brides" (for a breakdown of the nuns' ages, level of education, ethnicities and years of religious life, see Table 9).

TABLE 9

Nuns' ages, level of education and years of religious life

Nuns	Age	Level of education	Ethnicity[♦]	Years of religious life
Raquel	23	Primary education	Kenyan (Kamba)	3
Irene	23	Primary education	Kenyan (Luo)	2
Claudia	26	Primary education	Kenyan (Kikuyu)	3
Teresa	26	Primary education	Kenyan (Kamba)	<1[•]
Elena	29	Primary education	Kenyan (Luo)	2
Elvira	31	Primary education	Kenyan (Kamba)	3
Sofía	34	Secondary education	Kenyan (Luhya)	6
Mercedes	45	University education (teaching degree)	Spanish	25
Carmen	53	University education (chemistry)	Spanish	18
Carolina	73	Primary education	Spanish	54

[♦] For the Kenyan nuns their tribes are given in brackets.
[•] Sister Teresa entered the monastery five months ago.

The course for the nuns in training

This course had been organised specifically for the postulants and novices as part of their formative process. Having one course for all of them served several purposes: from a practical perspective, having all the novices from each monastery attend the same course saved both time and resources, and it also provided an opportunity for establishing bonds amongst these young women, who were in the same stage of formation. The course lasted five full days, from Tuesday to Saturday, with the nuns arriving from their different monasteries on the Monday afternoon and going back to their respective monasteries on Sunday morning.

The house of retreat where the course took place was located on the outskirts of a Spanish capital and was run by nuns who did not belong to the Order of Saint Augustine, but rather to an active-life order. The Augustinian nuns just rented the facilities: bedrooms, a lecture room, a small church and dining and sitting rooms. They also had permission to walk in the garden. The active-life nuns welcomed the Augustinian nuns on their arrival, showed them to their rooms and cooked and served all the meals, but they did not join them in any of the lectures, prayers or meals, leaving their Augustinian guests most of the time to themselves. The decision to hold the course in a house of retreat and not in one of their monasteries had a two-fold purpose: on the one hand, it would have meant a lot of work for the hosting monastery to provide meals and accommodation (this concern was based on previous experiences), and on the

other, this house was located fairly equidistant from all the monasteries, making the journey convenient for them all.

The programme of the course scheduled daily morning and afternoon lessons and intercalated the "Liturgy of the Hours" and the mass. Two lecturers gave the lessons: an Augustinian priest - Father Pedro - who taught the first three days, and a lay female theologian, Paula, who taught the final two days. Every day had a general theme, with all the lessons of that day being linked to it. The Tuesday was devoted to "the search for God in their community", paying particular attention to Saint Augustine's texts and suggesting ways to achieve "one soul and one heart". On the Wednesday, Father Pedro focused on "the reciprocal forgiveness of offences", taking inspiration from the words of the prayer "Our Father": "forgive our trespasses as we forgive those who trespass against us". He emphasised the importance of this topic in view of their commitment to spend their lives together. Father Pedro entitled his final day of teaching (Thursday) "contemplative life according to the Rule of Saint Augustine". Once more he extensively drew from Saint Augustine's literary legacy to illustrate his points, encouraging the nuns to "fall in love with its spiritual beauty" and to carry out their tasks "with love for God and for their Sisters".[16] Paula took over the teaching during the remaining two days with the following themes: "towards a greater understanding of religious life" and "towards a better communal life". She talked about the positive aspects of a contemplative life, but also about its

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[16] For a general depiction of Augustinian spirituality, in line with Father Pedro's teaching, see appendix 1.

challenges and difficulties, giving practical advice on, for example, how to deal with disagreements in a constructive manner and how to create space within the community for establishing productive dialogue.

The pace of life in the house of retreat was much more relaxed than in one of their monasteries where I conducted my first fieldwork. They got up half an hour later and went to bed at least one hour later than in their monasteries of origin (see Table 10 for a general timetable of the nuns' daily routine in their monasteries). The two most striking differences that I noted were their dispensation from keeping silence for the duration of the course and the fact that I had much greater access to them, as there was not a grille separating us.[17] I was given an individual bedroom in the same corridor as the nuns (I had stayed in the monastery's guest house in my previous fieldwork). Moreover, there was a festive feeling throughout the week, chatting during mealtimes and in the corridors, and taking walks in the garden after dinner. Their time together culminated in a party that the nuns in training offered to their Mother Teachers on the final night. The nuns of the house of retreat were also invited to join the party, and they provided non-alcoholic drinks, home-made cakes and biscuits. The party took place in the garden where chairs were arranged in a circle, started right after dinner and ended around midnight. Wearing colourful shawls that they had brought from Kenya on top of their habits, the nuns in training performed traditional Kenyan songs and dances, accompanied by a drum that they played in turns. They had rehearsed every day in their spare time, looking

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[17] See Note 14 for a definition of "grille".

forward to this entertainment with much excitement. There was lots of laughter and all the nuns seemed to genuinely have a good time. In one of their last numbers, they danced and sang, making a row for a while and eventually they tried to pull in some of the other nuns who were sitting around them to join the dancing row: although some gracefully refused, several middle-aged Spanish nuns from the hosting monastery as well as two of their Mother Teachers, Sister Mercedes and Sister Carmen, joyfully joined them amongst laughter and blushes.

TABLE 10
Timetable of the nuns' course

Time	Activity
7.00	Waking-up
7.30	Prayer
8.00	Eucharist, Lauds*
9.00	Breakfast
9.45	Terce*
10.00	Lesson
11.00	Break time
11.30	Lesson
12.30	Break time
13.00	Sext* and readings
13.45	Lunch (permission to talk)
15.30	None*
16.00	Lesson
18.00	Singing practice
19.00	Vespers*, individual prayer
21.00	Dinner
22.30	Compline*
22.45	Night rest (festival on the final day)

* Prayers belonging to the "Liturgy of the Hours".

Way of life in their monasteries of origin

As noted above, there were some considerable differences between the nuns'
behaviour during the course in the house of retreat and during my previous
fieldwork in the contemplative Augustinian Monastery of Santa Mónica.
Although I did not comment on these differences, the nuns knew about my
earlier fieldwork and somehow guessed that I was making this comparison,
commenting on how special and out of the ordinary the current circumstances
were as a justification for their different way of conducting themselves. In
particular, Sister Carmen, the Mother Teacher who I knew from my days at
Santa Mónica, often alluded to the contrast between what I was experiencing
there and the silence and austerity that I had observed in her monastery.
Although I provided elsewhere a detailed portrayal of the way of life in the
Monastery of Santa Mónica (Durà-Vilà et al., 2010), I am going to present in
this section as well some of the core aspects of their religious life, as I had the
chance to contrast them with nuns belonging to four other monasteries.

As in the case of the monks, the nuns undertook a triple commitment through
their religious vows to live in chastity, poverty and obedience. Another common
aspect was that the nuns followed similar levels of formation, with their first
vows being temporary - "simple vows" and their final ones - "solemn vows" -
being for life. The nuns also underwent, as they progressed on their religious
paths, some external changes in their appearance: wearing the habit rather than

normal clothes, changing the colour of the veils and receiving a ring which is normally made of gold and a gift from their families, which they wear on their ring fingers (see Table 11 for the nuns' levels of religious formation with their external characteristics).

TABLE 11

Nuns' levels of religious formation

Stage	Duration	Changes
Postulant	1 year	Wears normal clothes
Novice	2 years	Wears the Augustinian habit and a white veil
S I M P L E V O W S		
Simply professed nun	3 years	No changes in habit, still wears a white veil
S O L E M N V O W S		
Solemnly professed nun	For life	Black veil and ring, right to vote, to break the vows a dispensation from the Vatican is required

The main posts of responsibility in their monasteries were: the Mother Superior, the Mother Teacher, the Mother Accountant and the council (made up of three or four nuns). They were all democratically elected by the "solemnly professed" nuns except for the Mother Accountant, who was chosen by the Mother Superior. Having undertaken the "solemn vows" was a necessary requirement for being appointed to any of these posts. The Mother Superior, in consultation with the council, was in charge of the day-to-day running of the monastery. As the monks had stressed before, each monastery was autonomous, striving to keep themselves free from the influences of external Church authorities.

The nuns had very similar timetables in all five monasteries, dividing their time principally between work, prayer and study, the latter being especially the case for the nuns in training (see Table 12 for their general timetable). Their work mainly consisted of the cleaning and maintenance of the monastery and the guest house, as well as attending to their small vegetable and flower gardens. Most of the monasteries had little guest houses attached to them where they provided meals and accommodation for individuals and groups - both men and women were accepted - who wanted to retreat there for a few days. As in the monks' guest house, the guests paid whatever they voluntarily wanted to give. The care of the elderly and infirm nuns was a very important task for the community, and took priority over other occupations. As every monastery had at least one or two nuns in their eighties or nineties, with a few of them suffering from Alzheimer's, this emotionally and physically demanding task occupied a significant amount of the younger nuns' time.

The nuns were expected to maintain silence - including during their meals - and were only allowed to chat amongst themselves during two daily periods of "recreation", after lunch and dinner, lasting half an hour each. During these times, they engaged in diverse activities such as chatting, watching television together (the news or a selected programme), playing table games or going for a walk in their garden. As the monks did, they also extended their "recreation" on special occasions, such as the celebration of their name days, birthdays and the silver and golden anniversaries of their professions of vows. Each monastery had its own traditions: one shared by all of them was the celebration of the Epiphany on the 6th January, when some of the younger nuns dressed up as the Magi and delivered one present to each of the nuns. They also celebrated the Saint Days of Saint Augustine and Saint Monica (Saint Augustine's mother). The nuns also made the meals served on those days special, for example, baking a cake.

TABLE 12

Timetable of the nuns' daily activities

Time	Activity
6.30	Waking-up, shower, dressing
7.00	Matins*, individual prayer and Lauds*
8.45	Terce*
9.00	Breakfast
9.30	Work
12.00	Angelus
13.00	Sext*
13.30	Lunch (in silence, listening to one of the Sisters reading a religious book, or to a tape-recorded religious lecture)
14.30	Communal recreation time (they were allowed to talk among themselves)
15.00	Rest and free time
16.00	Personal prayer, None* and praying of the Rosary
17.00	Formative time: studying, reading, teaching of the postulants and novices by the Mother Teacher
18.00	Vespers*, Eucharist and individual prayer
19.45	Formative time: studying, reading, teaching of the postulants and novices by the Mother Teacher
20.45	Dinner (in silence, listening to one of the nuns reading a religious book, or to a tape-recorded religious lecture)
21.30	Communal recreation time (they are allowed to talk among themselves)
22.00	Compline*, communal prayer
22.15	Night rest

* Prayers belonging to the "Liturgy of the Hours".

4.1.5. Differences between the monks and the nuns

As seen above, there were many similarities between the nuns and the monks, with contemplation and silence dominating their way of life and with their common strong emphasis on a life-long commitment to their monastery and their community. However, I also observed significant gender differences regarding their backgrounds, organisation and understanding of some aspects of their religious lives, which will be presented here and are summarised in Table 13. The gender differences between the nuns and the monks in their ways of coping with sadness and depression and their help-seeking behaviours will be described in section 4.3.4.

In spite of both monks and nuns being in similar stages of formation and having a daily routine rooted in the "Liturgy of the Hours", with the mass being the central event of their day, there seemed to be more scope for flexibility in the monks' lives. A look at certain areas of their lives will illustrate this point, starting with their stages of religious training: for example, the monks - but not the nuns - made allowances for those who progressed faster, shortening the duration of a stage accordingly. Such was the case of Brother Terenci who, in spite of having to receive two sacraments (holy communion and confirmation) and to familiarise himself with basic notions of the Catholic faith for the first time, had his postulancy shortened for him as he was progressing fast at a theoretical and spiritual level. Moreover, all the nuns were expected to invariably follow a sort of routine mechanical training towards the "solemn

profession" of vows, whereas there were two monks who had completely opted out of this normal path (Brother Robert was an oblate and Brother Gregori, a "simple professed" monk). Another illustration of the monks' flexibility was the case of Brother Joaquim: although he was ecclesiastically married when he approached the monastery, he was nonetheless accepted by the community. I heard about a case of a woman separated from her husband for many years who requested to have a trial period in one of the nuns' monasteries; unlike the response of the monks of Sant Oriol to Joaquim, she was firmly rejected (with some of the senior nuns being taken aback by her boldness in aspiring to become one of them). I wonder if the importance given by the nuns to their virginity, so as to be worthy of being "God's brides", could be behind their attitudes.

The monks were allowed out of the monastery on their own for their daily walks in the mountains surrounding the monastery while the nuns walked in their monastery's garden and had to ask for permission from the Mother Superior to go out and never did so alone, but accompanied by at least one other nun. The monks also had more practical views regarding their habit: they wore normal clothes while working or when going out for a walk, they had a more simple grey habit that they wore on weekdays, and reserved the more delicate Cistercian white and black habit - jokingly referring to themselves as "dressing up as penguins" - on Sundays and special occasions (e.g. professions of vows). Conversely, the nuns wore their official habit even when they were doing their domestic tasks, only taking it off to go to bed. Other differences were that the monks listened to the radio when working, while the nuns worked in silence, and

that the monks drank wine with all their meals - spirits for special celebrations - while the nuns were not allowed to drink alcohol, this being very much frowned upon.

There were significant gender differences regarding their level of education: over half of the monks had university education while most of the nuns had primary education only. But even more importantly, the monks had a strong emphasis on keeping themselves up-to-date regarding national and international news and on spending time cultivating themselves intellectually, setting aside daily periods for reading. They were able to discuss current affairs with their guests and to give an opinion, and even boasted about the community's friendship with certain politicians, with whom they had discussed politics (e.g. a few monks proudly referred to having heard firsthand about a particular change in the government before it was published in the press). The nuns concentrated their study and reading times on their training stages and, once their formal education was completed, they tended to focus on their prayers and domestic tasks. They did not seem very interested in what was happening in the secular world, being more occupied with issues regarding their community, their order and the Church. This difference may be explained by the monks considering themselves part of the world - in Brother Xavier's words, "citizens of the world" - while the nuns' conversations often highlighted their separation from the world.

The level of contact with the guests was much more restricted for the nuns: they met and talked with the guests through the grille, and the guest houses were physically separated from their quarters. A difference with the monks was that the nuns provided accommodation in their guest houses for both men and women. The monks explained that the reason for this was that their guests lived in their monastery with total access to the monks themselves, which was not the case in the nuns' monasteries (with their grilles separating them from their visitors). Moreover, the monks ate with their guests, readily agreed to have individual meetings with them and greeted those attending their daily mass in the little square with benches outside the monastery. Another area of divergence with the monks was that the nuns were not keen on engaging in any small enterprises (unlike the monks, who received regular contracts for binding and restoring books). They feared that it could get out of hand, becoming a source of worry, stress, and ultimately disturbing their peace. Although the nuns' monasteries had little guest houses, they were mindful of not accepting too many or excessively large groups in order not to disrupt their life of contemplation. An example of this was their decision of paying for a house of retreat to have the course rather than having it in one of their monasteries.

Another obvious difference between the male and female communities concerned their ethnicities: while the monks' community was culturally very homogenous, with all the monks being not just Spanish and white, but also Catalan (they had very strong nationalistic views; Catalan was the main language used in the monastery with Spanish hardly ever being spoken), the

nuns' community was made up of Black Kenyan nuns in training and White Spanish senior nuns. They also differed in their reliance on people from outside the community for performing their religious practices: the nuns had to rely on a priest who visited them on a daily basis to celebrate the mass and heard their confessions on a regular basis. The monks were more independent of any external interference, as they had four ordained monks in their community who performed these tasks.

Probably, the most striking gender difference I found was regarding their conceptualization of the profession of "solemn vows": although both the monks and the nuns saw it as their final formative stage and as the achievement of the strongest level of commitment between themselves and God, the nuns experienced it very differently, believing that they were becoming "God's wives", and held many romantic notions about it, whereas the monks experienced it in a much more pragmatic and concrete way. It was interesting that the nuns did not consider themselves as single women, but as married ones, while the monks clearly saw themselves as single men. It was extraordinary how the nuns used the analogy of the wedding again and again to explain their religious path, comparing it with a couple who were going out together, getting to know and trust each other, facing and overcoming challenges, and eventually deciding to commit to each other forever. Externally, a married woman and a "perpetually professed" nun have in common that both wear a ring on their fourth finger. The nun would prepare herself for the special day of the profession of "perpetual vows" with great care and excitement - as the bride would also do

for her wedding day - and both would become "wives" and would receive a ring on that day. Equally, just as the bride wears a special dress for her wedding, the nun changes her white veil for a black one.

TABLE 13
Differences between monks and nuns: participants and context

Monks	Nuns
More scope for flexibility - in their stages of religious formation - walks: allowed out of the monastery - habit: normal clothes for working - meals: wine drunk daily, spirits on special occasions	**More rigid adhesion to the rules** - adherence to the training stages - walks: in the garden, inside the monastery - habit: always wore habit during the day - meals: alcohol was not allowed
More highly educated - many had university education - importance on being well informed regarding national and international news, ongoing reading and studying, with conferences being organised for them	**Less educated, less cultured** - most of them primary education - more emphasis on manual domestic work - studying condensed in the training stages - not so much interest on what happened outside
Feeling part of the world - stronger emphasis on being "part of the world"	**Feeling separated from the world** - stronger emphasis on being "different" and "outside"
Guests had close contact with the monks - no grille, individual meetings with men and women - the monks greeted visitors outside the church - guest house was inside the monastery	**Guests had a more restricted access to the nuns** - a grille separated the nuns and their guests - the nuns did not go outside to greet visitors - guest house separated from the monastery
Ethnically homogenous community - all the monks were Catalan	**Culturally diverse community** - mixture of Kenyan and Spanish
Community was self-sufficient - no dependence on external priest as four of them were ordained priests	**External dependence on a priest** - needed to administer sacraments, visit daily to perform the Eucharist
Besides the guest house, they had small business - workshop to bind and restore books	**Reluctant to engage in any small business** - concerns about additional stress disturbing their peace
Solemn vows: ultimate level of commitment - they considered themselves single men	**Solemn vows: marriage with God** - they considered themselves married women: "God's wives"

4.2. CONCEPTUALISATION OF SADNESS AND DEPRESSION

4.2.1. Normal sadness and pathological sadness: conceptualisation and distinction

The personal experience of a time of deep sadness was universal to all the participants. They all provided a detailed description of a time of intense sadness that they had been through in their lives. Several of them acknowledged to have suffered from depression, talking at length about their experience in the interviews. Those who had not undergone depression themselves were able to express their views, as they had had friends or relatives affected.

Sadness is understood as a normal reaction to the vicissitudes of life

All participants considered sadness as an unavoidable part of life. Moreover, it was considered as a totally normal and expected reaction to one's adversities and misfortunes, needing to be resolved outside the realm of medicine. Many of the participants reclaimed the "right" to feel sad when shaken by life's obstacles and were critical of the generalised hedonistic outlook of modern society. Being sad during times of sadness was considered not only in terms of normality but also, as will be seen later on, as having an intrinsic positive value for personal growth.

Critical voices were common amongst the participants, warning of the risk of masking genuine normal sadness as abnormal, with a possible subsequent medicalisation along the lines of depression in the midst of a society focused on pleasure and having a good easy time. Certain aspects of antidepressant medication were seen as problematic, with many arguing that they were being frequently administered in an unnecessary and rather indiscriminate manner beyond real clinical need. Using a pharmacological solution to deal with the experience of deep sadness, which was conceptualised as being "natural" and "intrinsically human", was seen as playing a significant part in the transformation of sadness into something pathological.

The testimonies of the two lay doctors participating in the study, Lamberto and Sergio, are particularly significant, as they had had firsthand experience of caring for mentally ill people and of prescribing antidepressants. Both agreed that "normalising emotions" was an important part of their clinical work, arguing that "on many occasions, what the patients experienced was adaptive phenomena, emotional reactions to adverse situations". They stressed the importance of explaining this view to their patients: "often I try to help them to realise that the emotions they are experiencing are normal, that they are not sickly[19]; for example, in cases of grief or any other loss, I ask them 'how do you expect to feel otherwise when you have lost something that you really valued?'; doing so may decrease their anguish".

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[19] The Spanish word used was "enfermizas".

Showing empathy to these patients, drawing from their own personal experiences of distress and sadness, was also seen as a crucial part of the doctors' role. Lamberto, a general practitioner, stated that those cases of deep sadness responding to life's adversities needed to be resolved outside the medical world: "antidepressants are not the answer, these situations [of sadness] are part of life that need to be overcome with one's maturity, with one's will power… a life's episode is never a pathology". Moreover, he added that a high percentage of his patients were not suffering from a recognisable medical illness: "over 50% of all my consultations don't pertain to medicine, but to sociology; they are social problems, family problems, emotional problems…"

Sergio, a psychiatrist, also reflected critically on his own clinical practice. He even candidly acknowledged that he had had a certain degree of responsibility for the medicalisation of his patients' normal emotions when, at times, he had prescribed antidepressants for them, responding to other than strictly medical needs. He justified doing so by blaming the strong pressures he was under, such as his patients' insistence on obtaining a prescription, his work within the public health system, and his hectic clinical schedule, all of which rendered alternative treatments unfeasible:

> Of course, you know that you are dealing with symptoms, with discomforts… that they are part of normal emotions… but they [patients] demand that you give them something to alleviate them, you know, they are users, they are clients that demand you to give them something, and also I work in the public health system… if I was in my own home [he means working in the private health sector] I would have more freedom… but, at the end of the day, I am a government employee… Apart from that, if I am not going to give them a pharmacological help,

then I have to offer them something else, maybe a weekly appointment, in which the person can feel listened to and where you can contain them emotionally… but in my case I don't have the time to do so… so the situation I am facing is that if they [patients] want the drug, and I don't give it to them, I don't have any other alternative available to give them.

[Sergio, layman, 40, married, White Spanish, psychiatrist]

Besides the above criticisms regarding antidepressants, other areas of concern regarding these medicines also emerged in the interviews. Firstly, many participants raised the possibility of antidepressants being over-prescribed, wondering about the apparent ease with which people seemed to get a prescription. Some suspected the pharmacological companies' powerful economic interests as being partly behind their apparent indiscriminate use. Secondly, some viewed with critical eyes the "artificiality" of these drugs as a way to deal with what in many cases was a "natural" phenomenon. Finally, others warned about antidepressants' "numbing" effect on the individual's ability to confront life's vicissitudes, describing this as an "escape". These themes were repeatedly expounded throughout the interviews:

[Taking antidepressants in cases of normal sadness] I see it as a way to escape, I believe in looking for the root of the problem… Sometimes I tell God: "Why are you sending me so many people asking me to help them with their problems [psychological and emotional problems]?"… but what can I do? Send them to a psychiatrist to be prescribed little pills? I could not do it for my own peace of mind.

[Enrique, priest, 44, White Spanish, hospital chaplain and church assistant]

Taking tablets [for normal sadness] is something artificial, we must not resolve our problems with tablets, you need to find out the causes of your sadness… faith will help you to resolve your problems, faith will help me to overcome my sadness much more than tablets because faith will help

> me to find myself… tablets are like a way out from your problems, you can't resolve your problems running away from them because they will come back… tablets will not solve anything. I am afraid you need to work yourself, there is not another easier way!
>
> [Elvira, nun, 31, Kenyan, novice]

Undergoing episodes of intense sadness in the course of one's life was thought to be an intrinsic and almost inevitable part of being human by virtually all participants. However, a majority of them stressed that there was also an element of freedom in the way people dealt with those times of suffering and, as will be elaborated upon later, they make use of them as an opportunity for learning and maturing. Moreover, other participants put forward the view that accepting and integrating life's painful setbacks as normal and natural phenomena - while trying to resolve or alleviate their concomitant suffering when possible - was a sign of "living life to the full", of embracing life "with all its joys and sorrows".

Depression is understood as a mental illness, as abnormal

In contrast with sadness which was considered as a normal way of reacting towards life's vicissitudes and trials, depression was practically unanimously categorised as "abnormal", "pathological" and belonging to the realm of mental illness. Therefore, for many of the participants, resorting to medical treatment and consulting with mental health professionals was seen not just as an acceptable option but also as the most advisable course of action.

However, many participants warned that a significant number of the instances of so-called depression nowadays were in fact perfectly normal occurrences of normal - non-pathological - intense sadness. A clear distinction emerged throughout the interviews between "true depression", considered as a serious mental illness, and "normal deep sadness", thought of as a response to life's problems and difficulties, with many participants raising concerns about today's tendency to make of normal sadness a disease called "depression". Some attributed this state of affairs to people's preference to look for medical explanations and solutions for sadness and other unpleasant emotions (anxiety and stress were also mentioned). Others blamed the frenetic pace of modern life, arguing that it impaired the possibility of taking the time to slow down and reflect during life's normal cycles of distress, such as in episodes of sadness, grief or existential crisis.

Some participants felt that "depression" had become a "fashionable" term which was frequently used inappropriately to express normal everyday setbacks. In these instances, the term "depression" loses its severe pathological connotation, not having a clear meaning unless the symptoms and individual circumstances are revealed, since it could be used to refer to both the impairing psychiatric illness and the distress over some trivial matter, such as "one's football team losing".

Sadness has a cause: "it makes sense"

All the participants were asked to describe a time in their lives when they suffered from deep sadness. As I explained in the Method section (pp. 89-90), I opened the interview by asking the participants to describe a time when they were feeling deeply sad as a way to elicit a narrative in order to explore their understanding of sadness, their coping strategies and help-seeking behaviour. I did not provide the participants with any definition of what I meant by "deep sadness" and let them freely choose whichever episode of sadness in their lives they wanted to share with me. The vast majority of them were rather quick in doing so. As will be presented in this section, although the events responsible for their sadness and the level of severity of their suffering varied amongst them, most of the chosen times of sadness were the most intense, significant or meaningful ones they had undergone to date.

All their narratives of sadness included a depiction of the cause or causes to which they attributed their state of sadness. Interestingly, a description of the events explaining their distress came naturally as part of their narratives with many of them actually starting their recollections with an explanation of the reasons behind their sadness. The suffering emanating from their accounts "made sense" in the face of the adversities and tribulations faced.

The events provoking their sadness were varied, with some of them having a clear spiritual nature while others were predominantly secular. The following

spiritual causes stood out in the interviews: having spiritual doubts about their faith or concerns about their relationship with God, disenchantment with some aspects of the Church and its hierarchy, and a cooling of their desire for a religious vocation (the latter being the case for some of the clergymen and contemplative participants). These experiences of suffering with a spiritual causation were referred to as having undergone a Dark Night of the Soul by several priests, monks and nuns as well as a few lay participants (section 4.2.2. will be devoted to an explanation of this concept). A wide-range of secular causes also emerged in the interviews, with the most frequent ones being: the death of a loved one, a severe illness (their own or of someone close to them), serious financial or professional trouble, the breakdown of their marriage or close friendships, or the witnessing of human suffering due to marginalisation, injustice and poverty. There were no significant gender differences in the causes to which they attributed their sadness with one notable exception: clergymen and monks highlighted celibacy as a source of suffering, while for the nuns it was giving up motherhood that caused them suffering.

Depression may lack a cause or may provoke a reaction that is too intense or prolonged in duration: "it does not make sense"

When participants talked about their own experience of depression or about someone's close to them, unlike in the case of sadness, there was a sense that the symptoms suffered did "not make sense" to them and those around them. Some

were perplexed by the lack of an apparent cause to blame for their suffering; in other words, there seemed to be a lack of a context supporting those distressing symptoms, with expressions along the lines of the following appearing frequently in their narratives of depression: "it did not make sense, I had a loving family, a good job, a house… still I did not want to get out of bed, I felt awful all the time when I really had no reason for feeling this way". Although this absence of causality for the sadness was the most common explanation found amongst the participants for tilting the balance towards conceptualising it as pathological, another pattern also emerged in their accounts of depression: sadness was also considered abnormal in spite of being able to attribute it to a clear event, when the symptoms displayed by the individual were thought to be disproportionate in their severity or duration to their aetiology.

Expressions pointing out that the symptoms were too severe, exaggerated, long-lasting or not changing with the passage of time were also present in their testimonies. Some of these cases actually started as cases of normal sadness, being perfectly understandable reactions to adversity and presenting symptoms which were proportionate to the severity of the cause ("it made sense" at least initially). However, these pictures of normal sadness could develop into illness, along the lines of depression, with the severity and duration of their symptoms becoming disproportionate ("it did not make sense any more") due to the following reasons: the individual's lack of social support (including here spiritual support in the shape of a religious community or a spiritual director; this was highlighted as an important part of the individual's support network to

face life's challenges and misfortunes); the lack of personal and religious resources to call upon to cope during difficult times; the existence of subjacent personality problems, or the presence of an underlying mental health problem. It was striking how the participants engaged in a qualitative judgement of the symptoms of sadness as part of their narrative accounts in order to decide if the symptoms were contained within the limits of normality or not.

Sadness has a value: it can help you to grow, mature and be more in touch with those who suffer

Depression was presented by the vast majority of the participants as being destructive and damaging to the individual suffering from it. The risks attached to this mental illness, such as suicide, deliberate self-harm, harming one's physical health and the consequent alienation of relatives and friends, were highlighted in the participants' narratives. However, normal sadness was seen in a much more positive light, offering the opportunity for personal and spiritual growth and beneficial change. Moreover, undergoing profound sadness was thought to promote empathy and heighten one's sensitivity for the suffering of fellow human beings. It was striking how participants strongly engaged in a process of attaching meaning and value to their normal experience of sadness in contrast with the lack of meaning and value attached to depression. Nevertheless, in spite of sadness being highly regarded by many of the participants, its accompanying suffering was not minimised, trivialised and

certainly not sought after ("sadness just happens to you as part of life, you don't look for it!").

The majority of participants insisted that undergoing sadness did not necessarily bring about benefits, insisting that its potential for maturation lay with the individual making a conscious decision at some point during their period of sadness, to "use their times of sadness well". Accepting the suffering caused by sadness as being part of God's plan - commonly phrased as "God's will" and the "divine providence" - rather than trying to escape or numb it was seen as a key aspect of this process. Moreover, "taking responsibility" for the sadness and being willing to seriously "reflect" on the experience were commended, and preferred to adopting a passive victim-like stand. Having a critical outlook regarding one's own contribution to one's state of sadness and a determination to resolve it through personal change was given much importance, and participants warned against the tendency that humans have of blaming others for their personal suffering. Finally, resorting to God's help in multiple ways (e.g. praying, retreating, seeking the help of their religious community or spiritual mentor) was endorsed by most of the participants as an extremely valuable asset to successfully learn from their episodes of sadness.

In contrast with the overwhelming majority of participants who praised the positive value of normal sadness, a few individuals reflected on the potential value of depression, as a result of having suffered from this mental illness themselves or having seen a loved one do so. However, this more positive

evaluation of the value of depression was made retrospectively and in spite of depression's far more numerous negative aspects. The positive gains of depression were linked to the experience of being ill rather than to the symptoms of sadness per se, benefits such as having feelings of gratitude for having had the help of God, a loving spouse, or a supportive religious community, relative or friend; a resulting feeling of strength for having been able to recover from it; and a deeper understanding of and empathy for the desolation felt by those suffering from this mental illness.

Depression carries potential risks for the individual: hopelessness, self-harm, substance abuse, suicide, and severe lack of functioning

In contrast with depression, those suffering from sadness did not have the risks attached to the more severe forms of depression, such as self-harm or suicide attempts. Moreover, in their narratives of sadness there was an absence of despair, and their hope was kept alive through various beliefs and strategies for coping, both of a religious and secular type, such as the belief that God will sustain them or the reliance on their families' help (participants' ways of coping will be explored in depth in the next section). Losing hope was probably considered as the most alarming and worrying symptom, which tipped the balance from severe sadness into the realm of the pathological and markedly increased the risk for the individual and brought about the need for psychiatric intervention. Sister Carmen, a 53-year-old nun and Mother Teacher of her

monastery, witnessed the experience of hopelessness in someone close to her who suffered from a severe depressive episode, and saw such an episode as "an inner death". Martín, a 55-year-old layman, linked his brother-in-law's recent suicide with "totally having lost hope". Paula, a 47-year-old laywoman, denied having ever lost hope during the break-up of her marriage, which she regarded as the saddest time of her life, in the following manner: "I never lost hope; if I had lost hope, I think I'd have killed myself".

Finally, the functioning of those undergoing a depressive episode was thought to be likely to be severely affected. Some examples of depressed people's incapacity to meet common daily tasks were given in the interviews, such as not being able to comply with the demands of their jobs or to take proper care of themselves (e.g. having a shower, cooking a meal or shaving). Conversely, the functioning of those suffering from normal deep sadness was not so severely affected: in spite of their suffering, they continued to carry out, to a greater or lesser extent, the most important of their duties towards themselves and others. A detailed account of the symptoms of sadness and depression, their commonalities and differences, can be found in Table 14.

TABLE 14

Symptoms that sadness and depression have in common, and symptoms which are distinctive of depression as described by the participants (they saw the latter as indicative of abnormality per se, not being present in normal sadness).

SYMPTOMS THAT SADNESS AND DEPRESSION HAVE IN COMMON
Psychological

Confusion	Anxiety	Poor concentration
Shame	Self-doubt	Fear
Vulnerability	Feeling trapped	Guilt
Distress	Feeling overwhelmed	

Physical

Tearfulness	Lack of energy	Poor sleep
Poor appetite	Tiredness	Crying

**SYMPTOMS THAT ARE
DISTINCTIVE OF DEPRESSION**

Helplessness	Suicide risk	Social isolation
Losing touch with reality	Self-harm	Hopelessness
Severe lack of functioning		

Holding of combined spiritual and secular models

In spite of the highly religious backgrounds of the participants, they were not immune to the secularisation process: spiritual explanatory models were combined with the medical, psychological and social in their narratives. The use of religious and spiritual explanations was not mutually exclusive, with many participants engaging in a process of existential construction of meaning to explain the occurrence of sadness and depression, consistently using both secular and religious resources.

Many of the clergy and contemplative participants, and to a lesser extent the lay theologian students, considered the secularisation process to be responsible for a high prevalence of depression. The generalised lack of faith in today's modern society was given as one of the main reasons behind people's "loss of life's meaning". Lamberto, a secular general practitioner, endorsed this view: "the increase in neuroses is linked with the decrease in people's religiosity… people have abandoned religious practice - and the Church has to accept some responsibility for it… it has let them do so - people can become ill due to many reasons, one is losing their joy of life, I think that the Church has had a very important role in helping people not to lose it".

Having faith in God was seen as playing a crucial part in keeping depression at bay to the extent that, although several participants said that depression was an illness that could affect anyone including those who were religious, more

participants felt that having depression was incompatible with having real faith in God. A couple of priests paraphrased Saint Anselm to argue this latter view: "if there is an authentic and mature faith, it is very difficult, if not impossible, to fall into depression". The participants opposing this more prevalent view tended to be those who, in spite of being seriously committed to their various religious paths, were more critical regarding the clergy and the Church. Father Alberto was very much against this opinion, qualifying it as "completely unacceptable" and using it as a reason to highlight the pressing need for the clergy to receive more training in mental health. He explained how much dismay he felt when he heard a fellow priest saying to his parishioners in a dominical sermon that "depression was a sin".

Father Esteban, a retired psychiatrist with over half a century of clinical practice, stated categorically that depression could never be a sin, as the depressed individual lacked freedom: "if there is no freedom, there can not be sin; this needs to be made completely clear, that in those cases [he was talking about what he called "endogenous depression"] there is no freedom at all!" María, a secular participant with a long nursing background, was also of the same opinion: "even if you have faith, you can still fall into a depressive illness and you shouldn't reject the help of medicines if you need them". She explained that she had personally known cases of deeply religious people, such as priests, who suffered from this mental illness. Sister Carmen, drawing from her experience of having a close friend with bipolar-affective disorder, censured the comments made by some religious people who argued that having true faith excluded the

possibility of suffering from depression; she attributed this opinion - as Father Alberto did - to their lack of knowledge of mental health matters: "I have sometimes heard [within religious settings] that if so and so is depressed, it must be because he doesn't have enough faith… I don't think so, no, no… it is their ignorance that makes them talk like that". A layman, Martín, whose brother-in-law committed suicide less than a year ago, pointed out that he was a religious man - "a man of faith, very involved with his parish church" - to illustrate that depression could affect anyone regardless of their beliefs.

In addition to lack of faith, other religious causes for the occurrence of deep sadness and depression were neglecting one's spiritual life, having significant religious doubts, loss of religious meaning and values, and abandoning religious observance and practice. Only one clergyman, Father Enrique, believed that demonic forces could cause clinical pictures that mimic depression and other mental illnesses. He was training to become an exorcist and he insisted on the need for priests to have enough training in both areas, demonic possession and mental health, to be able to differentiate between a case of possession by the devil and a genuine mental illness: "you need to be able to discern between one thing and the other". He illustrated this point describing several cases that he had cared for. For example, he was asked to see a young man who had been diagnosed with such severe depression that he had occasionally been admitted to a psychiatric ward. However, he was not responding to any medical or psychological treatment. He believed the case to be one of demonic possession and so provided him with the spiritual care he thought was warranted: a

combination of exorcist practices and spiritual guidance. Conversely, he also mentioned other cases where the opposite occurred: although he had been asked to perform exorcisms, he considered them to be clear cases of mental illness and consequently advised the patient to consult a psychiatrist.

Father Eusebio offered an outlook on demonic possession and the role of exorcism that was based on his experience of assisting one of the most important internationally renowned exorcists, a man considered an authority in this area (in order to protect the confidentiality of the participant and the exorcist in question, no details regarding where his practice was located are provided here). He argued that the overwhelming majority of the cases brought to them were "psychiatric cases" and not cases of genuine demonic possession, adding that "nowadays the psychiatrist is the one who removes the devils that we have inside". María, a senior lay nurse, spontaneously brought up a television programme on exorcism, in which an exorcist priest was interviewed, to emphasise the overlap between demonic possession and psychiatric pathology as well as to point up an example of excellent collaboration between the clergy and psychiatrists: the clergyman stated that he had never agreed to perform an exorcism without previously having had the possibility of mental illness ruled out by a psychiatrist.

The most frequent secular causal explanation mentioned amongst the participants was a biological one consisting of an alteration of the brain chemistry. Several participants mentioned a "disregulation" in the levels of

serotonin as playing an important role in the aetiology of depression while others compared this illness with other "physiological imbalances" such as the excess of glucose (i.e. diabetes), high cholesterol or lack of vitamins. Aetiologies of a social and psychological nature were also put forward, such as suffering from high levels of stress, poverty or marginalisation, as well as being selfish or having an excessive self-centred attitude. Further aetiological factors for depression appearing in the interviews were "the excess of comfort" in today's world, where personal effort and the work ethic were not inculcated in the young, and an "excessive reliance on technology, with people spending more time with computers and mobiles than with their loved ones". Not having an active occupation due to retirement or unemployment was also seen as contributing to depression. Concerning the latter, Jaime, a retired lay participant leading a remarkably busy life, being involved in volunteer work, had much to say: "I see amongst many of my retired friends, who had lived for their work, that they now have an existential void which in some cases is tremendous, and they often try to fill it in very poor ways… I know lots of friends who spend their days in front of the telly watching westerns… one of the worst things for people's mental health is not having anything to do; they don't find meaning in their lives, a reason to get up in the morning, to shave".

Suicide was considered as the most dramatic consequence of severe depression and was seen by the majority of participants not as a sin, but as the result of a fatal combination of mental illness and social problems. There was a unanimous view that those who died by their own hand should not be denied Christian

burial, participants arguing that this practice was "a thing of the past". For example, Father Alberto referred to the depression and subsequent suicide of a young man in the village where he worked as a parish priest. He pointed out that the stigma and alienation from the community that the young man felt because of his being homosexual was the main cause of his desperation. Magdalena, who worked as a receptionist in a tall building where several people had committed suicide jumping from the roof terrace, conceptualised it as the result of severe depression. She described these people as "being very ill" and sympathised with them, drawing from her own experience of having undergone several severe depressive episodes - as part of her bipolar-affective disorder - when she also strongly felt that she wanted to die.

4.2.2. The Dark Night of the Soul: a case of non-pathological religious sadness

It is a normal, non-pathological phenomenon with an intrinsic value

All participants coincided that the Dark Night was not a mental illness, but a normal and valuable spiritual experience that offered them the possibility to mature spiritually. Besides carrying eminent spiritual benefits, there was a sense that the Dark Night ultimately made people better persons through perfecting their personalities. For example, Father Francisco stated that "undergoing a Dark Night is a privilege, as it makes you grow", and Father Alberto, a biologist as

well as a theologian, used an animal metaphor to explain both the tension and suffering intrinsic to the Dark Night and its normality: "these spiritual crises are a way to mature; a crisis implies a rupture, without crisis there is no growth… it is a natural part of your trajectory… as in the case of many snakes and arthropods, who also need to break their external casing to grow". Andrés and Sergio, two 40-year-old lay participants with extensive experience in spiritual direction, commented on the need for one's spiritual life to experience this darkness: "you need to undergo a crisis of faith for your faith to grow" (Andrés), "the Dark Night is a moment to leap into a mature spiritual life… the Night is a purification of your faith or of your relationship with God" (Sergio).

This view was linked with the belief, firmly expressed by virtually all participants, that suffering was an invitation from God to mature in their spiritual lives. They considered it a powerful source to "purify their imperfections" and "let go of baggage". However, they also readily made clear that accepting their suffering from a faith perspective did not mean that they looked purposely for suffering, arguing that one needs to do as much as possible to overcome it. Father Pablo provided a good example of this belief, having suffered from a chronic heart condition for many years, which had warranted several surgical interventions and hospital admissions. Although he did "not like suffering" nor "want to suffer" but "rather live happily and have coffee and beers and catch up with my friends and parishioners", he resolutely added - drawing from his own experience of illness - that "if God sends it [suffering] to me… I think as a

believer and as a Christian that suffering brings redemption" explaining that his illness had been "the best master of my life"

Nevertheless, in spite of the Dark Night being considered a normal experience with many beneficial aspects, the clergy and contemplatives warned about the possibility that someone undergoing an authentic Dark Night could, at some point, fall into a depressive episode, as was the case for normal sadness of a secular nature. At that point, the individual's experience was no longer conceptualised as the Dark Night, but as a mental illness, as the Dark Night was always considered a healthy phenomenon. The main reasons given for the transformation of the Dark Night into depression were mainly the following: the severity of the spiritual conflict being too intense, or the individual's personality or spiritual life not being strong enough to cope with the experience of darkness, or not having a spiritual mentor skilled enough to deal with this complex spiritual stage.

Both the Dark Night and a depressive episode expressed themselves in severe sadness and had many similarities in their manifestations. However, the same symptoms that differentiated between normal and abnormal sadness described earlier in this section are applicable here. The absence of hopelessness in the Dark Night was particularly highligthed as an important difference with depression. Father Miguel commented on someone in the midst of a Dark Night to whom he was providing spiritual direction: "she has always maintained hope; in spite of her deep suffering, she has continued praying, she has continued

having hope, trying to fulfil God's will... she has always maintained her hope firmly, she has a very mature faith". Similarly, Sergio, a lay participant training to become a spiritual director, argued that: "hope is not lost [in the Dark Night], although I can not deny that there is a lot of suffering at a psychological level; at a spiritual level, they [those undergoing the Dark Night] have light… and that light, in their spiritual lives, is perceived strongly by those around them". Severe lack of functioning, persistent insomnia, and behaviours posing risks to the individual, such as not eating, were also indicative of a turn from the normal experience of a Dark Night towards pathology (the symptoms and concerns of the Dark Night of the Soul are summarised in Table 15).

TABLE 15

Symptoms and concerns during the Dark Night of the Soul

Symptoms			Concerns	
Psychological		**Physical**	**Social**	**Spiritual**
Confusion	Fear of not overcoming it	Tearfulness	Finding the right spiritual director who would be able to understand and support them	Giving up their religious vocations
Anxiety	Distress	Crying	Fear of not being understood	Doubting their own faith
Poor concentration	Disappointment	Poor appetite	Fear of not being believed that one is undergoing a genuine Dark Night ("nonsense", "self-importance")	Doubting the truthfulness of the Dark Night
Self-doubt	Frustration	Tiredness	Need to gain support from the community to cope with the darkness	Need to prove the strength of their vocation
Guilt	Vulnerability	Poor sleep		

Great importance was placed on the need of counting on an experienced spiritual director during the Dark Night in order to differentiate, due to the overlap in their symptomatology, between a genuine Dark Night and a depressive episode. This was considered to be one of the important roles of the spiritual director. Moreover, their skills were also required, while guiding someone undergoing a true Dark Night, to avoid the possible deviation of this normal religious experience into something pathological. It was argued that in these instances a different approach was required, probably warranting a psychiatric consultation.

Those who had more experience in providing spiritual direction, the priests and the monks, acknowledged that this distinction was at times not straightforward: "it is sometimes difficult to figure out whether someone is going through a Dark Night or through something pathological", "having an experienced spiritual director is key, as the life of the spirit is very complicated and to have someone able to discern what you are experiencing is fundamental". In order for the spiritual director to be in a position to do so, they insisted, on the one hand, on the importance of being knowledgeable about the manifestation of mental illness and of depressive disorder in particular and, on the other hand, on the need for carefully assessing each case individually, taking a detailed history and getting to know the person in great depth at a psychological and spiritual level. Sergio, a psychiatrist undertaking training in spiritual direction, emphasised the important role that spiritual directors could play in preventing the medical profession's tendency to conceptualise the Dark Night as pathological, warning about the dangers of doing so: "it [the Dark Night] could be diagnosed as depression, even

as a severe depression… if we medicalise it someone could lose a very important opportunity to grow. This is why it is so important to have available, in those moments, true spiritual mentors, because this medicalisation [of the Dark Night] is still happening, but they [those in a position to provide spiritual direction, referring mostly to priests] need to have had training that is as complete as possible, and that includes a psychological dimension".

The following quotations from two religious priests with extensive experience in spiritual direction, Father Francisco and Father Miguel, illustrate two other important tasks of those offering spiritual accompaniment[19] during the Dark Night: a supportive role, giving strength and fostering hope, and a formative role, guiding the individual to maximise the Dark Night's learning potential.

> When you are going through the Dark Night, you don't feel anything, you don't see anything, you are surviving only on pure faith… you need someone to help to sustain you….Going through the profound sadness of the Dark Night, if you are well accompanied [by a skilled spiritual director], can become an authentic lesson.
>
> [Francisco, religious priest, 65, White Spanish, theologian and psychologist, prior of his community, who is frequently in demand to give spiritual retreats]
>
> Having a spiritual director is indispensable, totally indispensable for them [for those undergoing a Dark Night], he is the one that guides them... he needs to be someone objective and with a great deal of experience to be able to accompany them well... he is the one who guides them, the one who gives them strength, who accompanies them, who

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[19] In Spanish: "acompañamiento espiritual". The participants mainly used two terms to refer to this process of spiritual guidance: "spiritual accompaniment" and "spiritual direction". The implications that using one or the other term had with regard to the spiritual director's level of authority are discussed in section 5.6.3.

gives them direction, who can help them to discern what they are living... discerning this experience can never be done alone.

[Miguel, religious priest, 60, White Spanish, head of the office providing pastoral care for migrants, formerly a missionary in South America]

The contemplative participants and the clergy adhered to a conceptualisation of the Dark Night with a strictly spiritual causation while lay participants attributed it to secular causes

The contemplative participants followed by the clergy were those who held a more classic conceptualisation of the Dark Night, attributing it to a spiritual cause such as having doubts about God and their faith, undergoing a vocational crisis, and feeling disenchanted with the Church, its hierarchy or their own religious community. They saw the Dark Night as a "test" sent by God to strengthen and deepen their faith and spiritual life, as a "spiritual purification" and as a "stage of their spiritual life". Moreover, many of the participating nuns, monks and priests brought up the mystic tradition when talking about the Dark Night, referring to examples of mystics and saints from the history of the Catholic Church, such as Saint John of the Cross, Saint Theresa of Jesus and Saint Thérèse of Lisieux or more recent ones such as Mother Theresa of Calcutta.[20, 21] They modelled their own experience of the Dark Night in them, turning to their testimonies to find ways to cope with their darkness:

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[20] Following publication of the book "Come, Be My Light", which contained Mother Theresa of Calcutta's correspondence with her spiritual directors in which she described a 40-year period of struggles with faith, doubts and a sense of abandonment by God, there was a media reaction

> [During the Dark Night] you feel down, you feel disappointed, you can't see any horizon in your life, you only see darkness, but that's fine, you just have to look at our mystics, they have clearly told us: man, in the Dark Night, do not move at all, stay still, wait because it will pass.
>
> [Guillermo, priest, 74, White Spanish, cathedral accountant and lecturer]

> Saint Thérèse of Lisieux is very useful [to read when undergoing a Dark Night], she said that she herself sometimes felt like a little chick in the midst of a storm unable to do anything. She said that when you are in the middle of a storm you can't do anything… just bear it because the storm will pass, you will see that it will pass… I am like a little chick standing still, still, reminding myself that the sun will rise, I know that the sun will rise… this is what you need to have clear in those very hard moments, even if you don't see a way out, you don't lose hope... you don't despair.[22]
>
> [Mercedes, nun, 45, White Spanish, Mother Teacher]

Several monks, nuns and members of the clergy explained that there were certain requirements for someone to experience a Dark Night. They stated that it could not happen to "just anyone who believed in God" being reserved to those who were highly committed to their spiritual life and who had reached "a very advanced state in their spiritual development". Those who had gone or were going through the Dark Night were seen as spiritually superior; their comments clearly implied that it was a religious experience exclusive to a spiritual elite:

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calling Mother Theresa a "fake", a "pretender" and a "liar". Van Vurst (2007) attributed this media reaction to a lack of knowledge of the mystics' experiences of the Dark Night of the Soul and an unfamiliarity with the language of the spiritual life.

[21] I studied the accounts of the Dark Night of the Soul of five important religious figures - Saint Augustine, Saint Theresa of Jesus, Saint Paul of the Cross, Saint Thérèse of Lisieux and Mother Theresa of Calcutta - through the analysis of original texts such as private letters, diaries and books that they left, as well as biographies (Durà-Vilà & Dein, 2009).

[22] Sister Mercedes referred to the autobiography of Saint Thérèse of Lisieux (1897/1926) called "The Story of a Soul".

[In order to experience a genuine Dark Night] they need to follow a serious path of prayer, to take their spiritual life very seriously… it is impossible for there to be a Dark Night in the case of an ordinary Christian, do you know what I mean?, a true Dark Night will only occur in people who are following a path of perfection.

[Enrique, priest, 44, White Spanish, hospital chaplain and church assistant]

The Dark Night of the Soul is something very special, very extraordinary, reserved to only a few.

[Miguel, religious priest, 60, White Spanish, head of the office providing pastoral care for migrants, formerly a missionary in South America]

Secular participants were more likely to consider the Dark Night as a metaphor for their experience of sadness in general. In contrast with the experience of the contemplatives and clergymen, their suffering was not necessarily triggered by a spiritual or religious cause, but was more often attributed to adversities of a secular kind, such as an illness, the death of a loved one or the breakup of a relationship. Although the nature of the causes for the Dark Night was different for secular people and those more religiously committed - contemplatives and clergymen - with the former being more secular and the later more spiritual, both embarked in a process of attributing religious meaning to their suffering, interpretating it through the religious framework of the Dark Night of the Soul.

4.2.3. Religion as a cause for pathological sadness

Existence of spiritual pathology

Most participants accepted the possibility of spiritual beliefs and religious practices turning into something harmful for the individual's mental health and well-being. However, they promptly added that this was the case only when religious beliefs were not well understood or when religious observance became excessive. The most frequently mentioned instances of religiously motivated pathology were: obsessive-compulsive symptomatology, scruples and guilt when enjoying in moderation healthy pleasures of life. Those participants who provided spiritual accompaniment to others - mostly priests and monks - were confident of being able to elicit these pathological cases. Moreover, they thought themselves in many cases to be in an excellent position to prevent them from occurring, as they knew those under their spiritual care well and followed their spiritual development closely.

It was also argued that the church attracts individuals undergoing mental, physical and emotional distress, people who are thus somewhat more susceptible to developing mental health problems. The priests, monks and a few nuns described examples of people in distress who approached them not so much seeking pure spiritual assistance, but rather guidance to solve problems of a clear secular nature such as marital breakdowns, financial and professional difficulties, addictions to illicit drugs and alcohol, and communication problems

with grown-up children or other relatives. A few priests said that their parish churches were also "havens" for people with intellectual disabilities, as they felt safe and welcome there. For example, Father Alberto paraphrased what an elderly priest - who was his mentor in his early days as a priest - used to tell him regarding the latter: "do you know why all the fools of the village [referring to those with intellectual disabilities] spend so much time in the sacristy? Because it is the only place that they are not chucked out… they tell them 'go away' at their home, at the bar... they get rid of them because they bother them. So if they are in the sacristy, I tell myself: 'it is a good sign!' If these people come to me, hey! it is a good sign that I am doing ok!"

Father Esteban ran a busy clinic in a Spanish capital that provided psychiatric care to priests, seminarians, monks and nuns. Due to the fact that he had a long career, extending over half a century, he was able to offer an interesting overview of the evolution of psychiatric manifestations that he encountered amongst his patients. He differentiated two main types of pathological scenarios: cases of "scruples" dominated the first decades of his clinical practice. He explained that they were "obsessive neuroses", which were more prevalent in nuns and manifested as a severe preoccupation with one's sins, leading to low self-esteem, dysfunction in their lives and relationships, and symptoms of anxiety. Gradually, cases of scruples were substituted by those of depression, which ended up becoming the most common complaint amongst his patients. He referred to this mental illness as "the great epidemic of the 20th century", from which his religiously committed clientele were not immune. Reflecting on the

clinical manifestation of the latter, he distinguished between cases of "authentic depression", which he thought to be "the worst existing illness", and those of normal sadness. He argued that the former was the domain of psychiatry and was likely to require pharmacological treatment and even hospitalisation in the most severe cases. Therefore, he emphasised the necessity of conducting a thorough assessment to differentiate between the two (this distinction and the implications for treatment will be further elaborated in the forthcoming section 4.3.2.).

Religiously motivated pathology as a result of poorly understood faith and lack of religious formation

The potential for religious beliefs and practices to lead to spiritual pathology was acknowledged by the participants. However, they stressed that this was due to misinterpretating these beliefs, ultimately blaming the widespread lack of religious education in the cases of many practising people. Many clergy and monks were critical of the poor religious knowledge of a number of lay religious people, arguing that many of them still held the same beliefs that they learned at their catechism when they were children and had an image of a punitive repressive God that was invariably finding fault with them. Some even extended this critique to members of the clergy and religious orders (particularly to female cloistered orders, which were more likely to be isolated and to have less access to religious training). Childish beliefs and misconceptions of the teachings of the Church, as well as religious fanaticism and fundamentalism, were seen as

responsible not just for excessive zeal damaging people's well-being, but also for many people drifting away from the Church. In contrast, it was frequently reiterated that "balanced" and "well understood" religious beliefs and observance had a positive effect on the individual, as they were liberating and conducive to health and happiness.

Several participants were able to reflect critically on the role that the Church and the clergy in particular had played in not equipping their parishioners with a stronger theological knowledge as well as not challenging those who might hold inaccurate beliefs, such as having a negative punitive image of God, excessive rigidity in their religious convictions, exaggerated piety or engaging in superstitious practices. Even some of the clergy interviewed went so far as to blame the more conservative sectors of the Church for having inculcated those beliefs that carried negative consequences for parishioners' psychological and emotional health, such as obsessively insisting on people's sinful nature, on "their nothingness". They warned that such beliefs could have serious consequences for people's psychological well-being, as Father Enrique explained: "I have found people who were crushed psychologically, who were bitter, without joy, wallowing in their sins… fair enough, sin does exist, but you also need to talk to them about God's love, that Jesus had died for you to liberate you from sin", "these people [who worried excessively about their sins] are full of scruples, they have even told me that they believed that having good self-esteem was against Christianity!".

A "too narrow sexual morality" preached by the Church was also highlighted as responsible of "creating many traumas" and "sexual scruples". This criticism was made predominantly by the older male participants, who saw this problem as belonging to the past, since only the most conservative priests and religious movements still currently hold to those negative views about human sexuality. Some participants talked about how they personally questioned and replaced those views with more open-minded balanced ones through seeking religious training and through their own life experience. The following quotation exemplifies this:

> You are young, but people from my generation have suffered the Church's narrow morality regarding sexuality… we all suffered from it… they [the clergy] insisted a lot on the problems brought about by sexuality, masturbation and so on… causing a lot of tension and feelings of excessive culpability in people, provoking countless scruples. Back then, the Church even talked about how women should take a shower without taking their nightgown off… to avoid touching themselves, everything was considered an inappropriate touching; back then all the religion was based from the waist down… this has caused lots of traumas in people of my generation… a situation of lack of joy, of guilt, that we all had to somehow find a way to overcome in the best way we could… I am convinced that all these sexual scruples have deeply disturbed lots of people, especially women.
>
> [Jaime, layman, 71, married, White Spanish, retired teacher]

4.3. COPING AND HELP-SEEKING FOR SADNESS AND DEPRESSION

4.3.1. Co-existence of religious and secular coping strategies and help-seeking behaviours

Multiple coping strategies and help-seeking behaviours to deal with sadness and depression were used by the participants with a pattern emerging in their narratives in which religious and secular strategies were not mutually exclusive, but co-existed comfortably and appeared together in their accounts. However, those participants who had a higher level of religious commitment tended to rely more strongly on religious resources, referring to them more often and with more intensity. Table 16 summarises the main coping strategies and help-seeking behaviours found in the interviews which will be elaborated in this section.

TABLE 16

Coping strategies and help-seeking behaviours to deal with sadness and depression

Religious
Interpreting their suffering as worthwhile and beneficial for the self and others, as it leads to: - spiritual maturity and growth - spiritual purification - an invitation to reflect on their lives - being more sensitive to the suffering of others Learning to experience God's presence in their times of sadness through: - prayer - contemplation - establishing an intimate conversation with God Seeking the help of a spiritual director, parish priest or religious community to: - promote hope - strengthen their faith in God - get individualised spiritual advice - receive practical support Resorting to their faith in God which provided: - solace - comfort - hope - absence of mortality sorrow Reminding themselves of those who became closer to God by enduring their sadness and through placing their trust in God: - mystics' and saints' narratives - other monks' and nuns' examples

Secular	
Practical resolution of the problem responsible for their sadness (e.g. getting a new job)	Distracting themselves from their feelings of sadness (e.g. doing voluntary work or finding a new hobby)
Seeking the help and support of friends and family	Looking after their own physical health (e.g. playing sports, healthier diet)
Seeking the help of a mental health professional to engage in psychotherapy	Seeking medical help (psychiatrist or GP) to be prescribed antidepressant medication or hospitalisation in the most severe cases◆

◆ These help-seeking behaviours appeared when the sadness was considered pathological along the lines of depression.

Religious coping and help-seeking

Attribution of religious meaning to suffering

One of the most common coping strategies found amongst the participants was their attribution of religious meaning to their sadness. Interpreting their sadness in a spiritual light allowed them to transform it into a meaningful experience as it was seen as worthwhile and beneficial for the self and others. They firmly believed that their experience of sadness could lead to spiritual growth and positive change in their lives as well as making them more in tune with and sensitive to the suffering of others. Engaging in a process of religious search for meaning helped them to accept their sadness as God's invitation to pause and reflect on their lives. Transforming their suffering into a meaningful experience filled with religious significance played an important role in maintaining hope, as they believed that they were not going to face the suffering alone, but with God sustaining and helping them. The religious attribution of meaning to their sadness allowed for the varied coping strategies of a religious nature to evolve during the participants' times of sorrow (these multiple religious coping strategies will be depicted in detail in the present section).

Prayer

Praying was one of the most common coping activities in times of deep sadness used by the participants. They learned to experience God's presence through frequent prayer, which was often described as having a conversation with God. Although the vast majority of participants directed their prayers to God and Jesus, many also mentioned directing them to the Virgin Mary and less frequently to a particular saint that they were particularly devoted to. The participants attributed to praying many positive effects for their well-being. They explained, drawing on examples from their own lives, how useful prayer had been in restoring their emotional, spiritual and psychological balance after a serious adversity left them submerged in a state of distress. I have grouped prayer's beneficial aspects in five main types (for a summary of these, see Table 17). Firstly, most participants found in prayer a restorative, comforting and calming power:

> God healed me through prayer... For me, prayer is very healing, prayer is what frees you, what really heals you, cleans you, empties you.
>
> [Mercedes, nun, 45, White Spanish, Mother Teacher]

> Praying gives you so much peace, I have never seen little lights in my prayers… what I mean is that I have never had let's say any mystical experience, in inverted commas… my experience of praying is the same as any other Christian… praying has especially helped me when I have been going through my times of depression because it gave me peace and light, a little or a lot of them, sometimes just to bear it until the following day or just to bear the present moment, but nevertheless that peace and light was enough to keep sustaining me.
>
> [Jordi, monk and priest, 66, White Spanish]

> What helped me the most [during a particularly distressing time in her life] was to seek refuge in the Virgin [Mary]… I tried, with all my might, to put in practice what Saint Bernard said, to invoke Mary when your little boat is being shaken by the tempest… I was so full of anguish at the time, but Mary filled my soul totally, Mary fed my need for affection completely, filling my life with her sweetness… I took refuge in her as much as I could.
>
> [Magdalena, laywoman (she had previously been a cloistered nun), 45, White Spanish, receptionist]

Two lay participants, Fátima and Pedro, were even able to use the calming effect of prayer to reduce their anxiety levels, using it as an alternative to taking the sedative medication - "Valium" - which had been prescribed by their doctors. However, they used different modalities of prayer in order to achieve the same relaxing effect. Fátima, a 38-year-old married secretary, found praying alongside a record of the rosary, with its repetition of prayers, "extremely soothing", helping her to reduce the stress caused by having three non-operable hernias located at the base of the brain. Pedro, a 40-year-old single unemployed man, found a remedy for his insomnia by "giving vent to his worries": when worrying prevented him from falling asleep, he told the Virgin Mary about his concerns instead of "bottling them all up" as he had done before. Besides prayer's calming effect, several participants described episodes of "crying and praying". It seems that crying and praying together also had a soothing effect, becoming a physical outlet for venting their distress and offering considerable physical relief.

Secondly, prayer was also commonly sought as a source of strength and courage to confront adversity: "what you need more is prayer because without prayer you cannot have the courage [needed to cope with the suffering]", "I went to pray

and I felt how praying was filling me up with strength… how the Lord was making me stronger". Eulalia, a 55-year-old lecturer in Spanish philology, provided one of the strongest narratives of prayer sustaining her and her husband through their son's severe illness. Interestingly, her testimony emphasised the key role that her parish community and religious friends played for her through being a source of prayer and not so much through offering social support (the latter, seeking social support as a way of coping, will be developed in the following section: "Secular coping and help-seeking"). Eulalia's son was at the time in remission from a "malignant lymphoma, Burkitt's type", which he had been diagnosed with three years earlier, at the age of 25. Although he was still subject to regular medical checkups, he had recovered well and was back to the life he led before the illness. Eulalia described in detail her son's illness, the long road they travelled until the diagnosis was made and the taxing treatment he underwent, being moved to tears at several points during the interview. She often used the plural form "we" in her narrative, referring to herself and her husband, who shared her high level of religious belief and practice. The doctors broke the news of the diagnosis to the parents, giving them a dramatic prognosis: "they told us that they did not have anyone in the hospital's records who had survived this diagnosis beyond six months... they told us that this particular type of lymphoma is the rarest and the most lethal one". Eulalia and her husband resorted to those close to them with a specific request to pray for them. In her own words:

> We sought help from our parish and all our friends, who we knew were believers, asking them to pray for us so they all started to pray. He also

> had masses celebrated for him in several churches praying for him to have enough strength to bear it, and he had a mass in the cathedral specifically praying for him to endure it all: the illness, the chemotherapy and being isolated in hospital [to protect him from infection].

They seemed to have coped remarkably well with the uncertainty of the illness, the unpleasant treatment and the long stay in hospital. Eulalia and her husband showed great fortitude and self-possession in front of their son "never crying in front of him", and with those around them. People were taken aback by the fact that "we kept functioning... I presented myself as usual, I dressed in the same way, put my make-up on in the morning". While being devoted to their son's needs, they endeavoured to carry on with their professional routines, only missing one day of work (the day their son was operated on), as well as keeping up with their family traditions (e.g. celebrating their birthdays, watching a film together once a week, etc.). Their son was made aware by his parents of the seriousness of his condition from the start. His mother explained with pride, becoming tearful while doing so, that her son never complained about his illness or treatment, never questioning or rebelling against God. Moreover, he showed gratitude to his parents and doctors for caring for him, even showing concern for other fellow patients. His doctors, as well as the hospital's chaplain who regularly visited him, repeatedly congratulated the parents for their son's fortitude.

In addition to their firm belief that God actively assisted them in response to their friends' prayers, it seems that the knowledge that so many friends were having them present in their daily prayers also played a key role in their coping,

comforting them immensely and helping them to go on. Eulalia described how they made a point to inform him about who was praying for him daily - lay friends, priests and a monastery of Carmelite nuns with whom the family had a close relationship - as well as the masses that were given for him:

> Yes, yes, we always told him, he knew, he knew that they were all praying for him, we told him, we told him: 'today at 7.00 a mass was given in a certain church for him'… he knew all along that the nuns were praying for him, that a certain priest was praying… even a priest who is very dear to our family who also had cancer and was having chemotherapy in the same hospital, he is dead now, we know for a fact - as he himself told us - that he was offering his sufferings for our son's recovery.

Eulalia and her husband seemed to be genuinely surprised at the courage the three of them had, and felt absolutely certain it was a direct consequence of having so many people praying for them, rather than being due to personal merit:

> I'm telling you, our strength was not normal, going to hospital every day, working, keeping an eye on his wife [his son had just married when he became ill and his young wife was born abroad and had no relatives in Spain], making sure she was not alone at night … you know what I mean? Such strength!... we are completely convinced that we were able to bear it all because there was a community behind us, praying for us, supporting us… Even at night, thinking of all the people praying for us kept worry at bay, I knew that he was in God's hands so I could stop worrying and fall asleep easily.

Thirdly, prayer helped them to maintain hope. There were many examples of participants resorting to praying when they felt that there was no solution for their suffering. They described a sense of feeling God's presence and being sustained by him protecting them from hopelessness and despair. Sister Mercedes answered my question "did you ever lose hope?" (referring to a

particularly distressing time in her life) with the response: "no, no, I prayed... I remember saying to myself: 'Lord I can't see a solution but you are here'... while praying I felt how the Lord was with me".

Fourthly, prayer provided the necessary space and time to reflect on the problems responsible for their sadness, enabling them to decide on the most convenient way forward to try to resolve them when possible or at least alleviate them. This positive effect of prayer was highly valued amongst the participants especially in times of emotional turmoil: "I prayed to see how to overcome it, what to do", "I was so muddled up, I didn't know what to do… I told God everything, my problems… it helped to see the light in the darkness and I knew I had to face it!", "it [praying] helps clarify your inner mess".

Finally, several participants - especially those participants with experience in spiritual direction - had much to say about how beneficial prayer was as an avenue to externalise problems and negative feelings and to favour rationality and objectivity. A few participants confessed to not having opened up to anyone about their suffering except to God. As the following quotations show, praying gave them the opportunity to share their sadness and concerns with God:

> I tell God about my sadness, my problems... I tell him what I feel, like having a one-on-one dialogue... for example, I tell him: 'I am not feeling too good today, I don't understand myself' and doing so [talking to God] I feel very much at peace.
>
> [Elvira, nun, 31, Kenyan, novice]

Prayer can achieve everything… some days I wake up feeling blue, in a bad mood, so I sit in front of the tabernacle and tell God all that is happening to me.

[Raquel, 23, nun, Kenyan, novice]

TABLE 17

Beneficial aspects of praying when suffering from deep sadness

Positive effects of praying
1. Restorative, comforting and calming power   *"Prayer is very healing, prayer is what frees you, what really heals you, cleans you, empties you"*   *"Praying gives you so much peace"; "It [praying the rosary] is extremely soothing"*
2. A source of strength and courage to confront adversity   *"What you need more is prayer because without prayer you cannot have the courage [needed to cope with the suffering]"*   *"I went to pray and I felt how praying was filling me up with strength... how the Lord was making me stronger"*
3. Feeling God's presence while praying protected them from hopelessness and despair   *"[Did you ever lose hope?]: no, no, I prayed... I remember saying to myself: 'Lord I can't see a solution but you are here'... while praying I felt how the Lord was with me"*
4. Giving them the space and time to reflect on the problems responsible for their sadness, enabling them to decide on the most convenient way forward to resolve them   *"I prayed to see how to overcome it, what to do"*   *"I was so muddled up, I didn't know what to do... I told God everything, my problems... it [praying] helps to clarify your inner mess"*
5. An avenue to externalise problems and negative feelings and to favour rationality and objectivity   *"I tell God about my sadnes, my problems... I tell him what I feel, like having a one-to-one dialogue... for example, I tell him: 'I am not feeling too good today, I don't understand myself' and doing so [talking to God] I feel very much at peace"*   *"Some days I wake up feeling blue, in a bad mood, so I sit in front of the tabernacle and tell God all what is happening to me"*

Trusting that God will look after them

Placing one's trust in God's hands was one of the most common religious coping strategies found in the interviews. Many participants explained that once they had done as much as they could to tackle the root of their sadness, it was "up to God to do the rest", as Raquel, a 23-year-old Kenyan novice explained: "God can achieve it all… when I can do no more, I trust it all to God, he can do anything, so I place it all [problems, sadness, worries, etc.] in God's hands and my faith tells me that God can [resolve it], and whatever happens to me, with my faith, God will help me to overcome it". This way of coping was especially important for those participants who could not actively remedy their problem: transferring the responsibility to God brought them peace and solace. Jaime and Antonia are good examples of unconditionally placing their trust in God's providence, as they could not solve the cause of their sufferings: the former had an aortic aneurism which in case of rupture was likely to cause his death, and the latter's only daughter was diagnosed with a moderate intellectual disability. The following testimony of Antonia illustrates this key religious coping strategy:

> There was a time, way back, when I used to ask myself "what will happen to her when I am not here [to look after her daughter], she has no siblings, what will happen to her?"... but now this doesn't bother me anymore, I have reached the conclusion that we are in his [God's] hands… yes, yes, I am sure that God will look after her… I am sure that he is not going to allow anything bad to happen to her, I do know it!
>
> [Antonia, laywoman, 50, married, White Spanish, housewife]

Seeking the help of a spiritual director, parish priest and community

Seeking the help of their parish priest or a spiritual director was a common religious help-seeking behaviour amongst the lay people, the clergy and the contemplative participants. The individualised spiritual advice and personal care that parish priests and spiritual directors were able to offer was highly valued by the participants. Besides promoting hope and strengthening the faith of the individual in need, they could also offer practical support at times (e.g. arranging medical appointments, mediating in marital problems, etc.). The help provided by the clergy in supporting those suffering from severe sadness and depression will be explored in depth in the following section of the "Findings", 4.4., which deals exclusively with this subject.

Several lay participants emphasised the important role that the parish community could play in helping to alleviate one of their member's suffering. The help provided by the community could be divided into two types: one being of a secular nature, acting as a social network of support offering practical help, and the other being clearly religious, reinforcing their faith and facilitating a religious attribution of meaning to their suffering. Some participants talked about having a "communitarian faith", insisting that maintaining their faith individually was much harder than doing so as part of a community. However, there was not a clear consensus regarding the supportive role that parish communities did in reality play amongst the lay participants: while some described their communities along the lines of "being a close-knit family", in

which everyone cared for and helped each other, especially when a member was undergoing a difficult time, others regretted the lack of a supportive community in their churches. Many blamed today's individualism and the pressure of time for this lack, arguing that: "the parishioners of my church are like 'islands'... we don't know each other, we just show up for mass on Sunday and go straight back home… we do not take the time to talk to people, to get to know them… we should communicate more with one another, to offer help if we think something is troubling them".

Some more critical participants saw the closed nature of certain groups within their parish churches (e.g. Neocatechumenal Way, Opus Dei, etc.)[24, 25] as an obstacle to having genuine communities, as these groups cared more for their own members than for the parish community as a whole. Others saw the "old-fashioned", "non-inclusive" and "judgemental" nature of certain parishioners as problematic for the coexistance of the different members of the community, as Paula, a 47-year-old separated woman, explained: "I find some people [of my

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[24] The Neocatecumenal Way is an itinerary of Catholic formation approved by the Vatican and also, a tool of Christian initiation for those adults who are getting ready to receive baptism. The aim is to gradually deepen people's intimacy with Jesus and to transform them into active members of the church so they will propogate his message in the world. The training takes place within their parish church, in small communities composed of people of every age and social status. It was founded by the Spanish painter Kiko Argüello after his conversion to Christianity in a deprived peripheral area of Madrid in the early sixties (Vatican, 2002).

[25] Opus Dei is a personal prelature within the Catholic Church whose whole name is "Prelature of the Holy Cross and Opus Dei". It was founded in 1928 by the Spanish priest Josemaría Escrivá de Balaguer with the aim of providing a way to achieve sanctity through ordinary life in all sectors of society and particularly in one's own work (Gran Enciclopedia Larousse, 1990a, p. 8024).

parish] a little behind the times. I've been much criticised in my parish church, especially by the older people, because I have my own way of dressing: I wear mini-skirts".

Those participants who met regularly, not counting at the Sunday mass, were the ones who praised the positive effect that their parish community had in helping them to cope with life's adversities. They belonged to a parish group which provided a particular service to the parish (e.g. catechists) or to a certain movement within the Catholic Church (e.g. Neocatechumenal Way). These meetings gave them the opportunity to get to know each other at a deeper personal level, to develop friendships amongst themselves, and even to meet outside the church for dinner parties or birthday celebrations. The supportive role of the religious community for the contemplative participants will be addressed in section 4.3.4. and the role of the parish community in supporting the priest in sections 4.3.5. and 4.4.1. Amongst the lay participants, Leonor, a 41-year-old separated teacher, provided one of the strongest testimonies in favour of the important role that her community played in her life. She belonged to a prayer circle which consisted of a group of people - mostly laymen and women - who met once a week to pray together. She was very happy with the two years she had been part of this group. She considered the members to be her "spiritual family" and talked extensively of the help she received from them with warmth and gratitude. She mentioned three main benefits that belonging to this group had brought her: she deepened her faith and her relationship with God through the experience of regular communal prayer; she received emotional,

spiritual and practical support from her fellow members during distressing times, such as her parents' severe illnesses or when she was facing serious professional uncertainties; and she felt that she had grown as a person, since she had been encouraged to face her limitations and weaknesses. Although her friends and relatives initially professed disbelief and were suprised when she joined this group, as she was not "a very religious person at all", they have since commented on her increased happiness and well-being. She insisted that being part of the "circle" did not entail distancing herself from those who did not belong to it. On the contrary, she argued that she had more joy and love to give to them than before.

Relying on their faith in God

Most participants highlighted the importance of having faith to cope with suffering. The concept of faith that emerged from the interviews was rich in meaning and certainly went beyond merely believing in the existance of God. There were two dimensions of faith that stood out as playing key roles in coping with life's trials: having faith in God entailed, on the one hand, accepting adversity and suffering as being God's will and, on the other, having a firm belief in resurrection. Having faith positively influenced people's mood and the way life's problems were faced. Many stated that they could not imagine how they could have endured misfortunes and sadness without the solace, comfort and hope they found in their faith. Several participants used Christ's own words

- "Father, if you are willing, remove this cup from me. Nevertheless, not my will, but yours, be done"[26] - to capture that continual trust in the providence of God, conceptualising their suffering as God's plan. Interestingly, advocating the acceptance of one's suffering as being God's will was not incompatible with actively asking God to spare them the suffering as Jesus did. For example, Sister Carmen, a Mother Teacher, exhorted her novices in the following manner:

> You need to look at Jesus, at his life, I mean that he does the Father's will, he didn't ask him [God] "why are you allowing my death on the cross?" instead he does his will and although it is a very difficult moment for him [Jesus] and he did ask God to remove this cup from him, he did say that his will be done. Thus… I need to tell myself that God is God and that I am his daughter, his child, therefore I have the liberty to ask him [to stop my suffering], even to argue with him, even to get cross with him… however, I must always end up abandoning myself to his hands and doing so will bring me peace and light.
>
> [Carmen, nun, 53, White Spanish, Mother Teacher]

Moreover, they firmly believe that if God allowed their sadness to go on, it was for their "own good", as it ultimately came from him. This was the case even if they could not see the apparent benefit to themselves due to their "limited understanding". With time, some participants were able to find the positive aspect of an event that caused them considerable suffering, such as in the case of Antonia, whose daughter had the intellectual disability. When the psychologist explained the diagnosis to her, she felt overwhelmed by sadness, anger and concerns: "I did rebel against it… I did ask God why this was happening to me… how did he allow this to happen to me?" However, she gradually

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[26] "Father, if you are willing, remove this cup from me. Nevertheless, not my will, but yours, be done" (Luke 22:42). "My Father, if it is possible, may this cup be taken from me. Yet not as I will, but as you will" (Matthew 26:39).

rephrased her daughter's disability into something eminently positive that she

cherished and valued in the following terms:

> My faith in God helped me to change, to have hope, to value her [her
> daughter], to ask myself "why should it *not* have happened to me?", who
> am I to tell him [God] such thing?... if I can not live without her, she is
> my everything!, she is the best thing he has given me, I don't stop
> thanking him for her, she is the greatest gift I have [she stopped talking
> here as she was moved to tears]… yes, yes, I am sorry to cry but she is
> indeed the best thing I have been given and I know she was given to me
> for a reason… and I do feel deeply sorry for having had those thoughts at
> first complaining about why this had happened to me… she brings joy
> wherever she goes, she was born with a gift… she is something special,
> truly special.

> [Antonia, laywoman, 50, married, White Spanish, housewife]

The clergymen and the contemplative participants often referred to the need to

have had an "unconditional faith in God" to keep persevering with their

vocations, especially during the difficult moments encountered on their religious

paths. Moreover and importantly, faith was seen as the perfect antidote to

hopelessness: "thanks to my faith, I can feel disconcerted but not desperate; how

can I feel desperate if I believe in God?", "I can feel very low, and I don't like

feeling this way… but I don't lose hope because I tell myself that even if I can

not see any solution… there is someone [God] who supports me, so I don't

despair!" Many participants, as was elaborated in section 4.2.1., thought that

having faith was a protective factor for depression, as it prevented falling into

the alarming loss of hope found in severely depressed individuals. They stated

that "faith and hope do go together for those who believe in God"; thus if one

truly had faith, one would not experience hopelessness. The following quotations

illustrate the importance of having a solid faith to cope with life's trials:

> I didn't rebel [against God] because I think that deep down there is someone who surpasses me and that keeps things under control, that things are not out of control… This is what faith means to me: even if I see everything bad, beyond my judgement, there is somebody else whose judgement is superior… I can not know everything, I can not tell God: "Why do you allow this?" It would be absurd!
>
> [Mercedes, nun, 45, White Spanish, Mother Teacher]

> Without faith, it would have been so difficult to go through life's adversities: without faith there is the void, the lack of meaning, the absurdity of life.
>
> [Anselmo, priest, 39, White Spanish, parish priest and prison chaplain]

Some participants clarified that the usefulness of one's faith to cope with sadness was dependent on the quality of one's faith, as adversity really put faith to the test. Although a strong faith could be "given to someone", as a "gift" or a "grace" in an apparently effortless way, in most cases it was felt that it was the result of years of seriously working oneself at a spiritual level. On these lines, Father Lluc explained that faith was not just something one received spontaneously but that, in most cases, having faith, especially in times of despair, had an important component of personal will and choice. For him, maintaining his faith and looking at adversities through a faith perspective was a conscious and active decision rather than a passive gift received from God: "to have faith you also need to have will because despair challenges your beliefs, it pulls you down". A profound faith achieved through introspection and strong will was the one that many participants argued could see you through any life crisis. It was described metaphorically as an "anchor" or a "rock", or even as "a little flame, no matter how faint, that never leaves you in total darkness".

Conversely, a weak faith based on childish beliefs and routine practices could not be expected to sustain someone when confronted with severe adversity and suffering. Two main types of this "shallow faith" emerged: having faith in God only when "everything was fine" and losing it if misfortune struck, and turning to God exclusively during adverse times in order to ask him to remedy them. Father Alberto criticized the latter type arguing that they "used God as a medicine" in an "addictive way" as "opium", and Father Miguel talked about many people having a "very commercial faith", meaning a "very selfish, always-acting-in-his-own- interest type of faith... so when they have suffered a severe setback, then they directly complain to God and, if he [God] does not sort it out, they want nothing to do with him anymore". The following longer quotations also illustrate in more depth this "faith without strong foundations":

> She [referring to a woman of her acquaintance who sometimes visited her in the monastery] practised [in the sense of attending weekly mass] for the sake of it, she went to a nuns' school and she would say that she practised because she has done it all her life… she, as many people like her, lived their religion in a very superficial way… they go to mass on Sundays but they go as a social act, she acknowledged that she liked going [to mass] to dress up, to show off her new outfits... so when she was in real trouble [serious financial problems] her faith was of no use to her.
>
> [Mercedes, nun, 45, White Spanish, Mother Teacher]

> It [being confronted by deep suffering] is the real test of one's faith. I think that deep down the problem is that we don't have a strong faith… it seems that we think that if we believe in God, everything needs to go our way. We say: "Lord, why are you sending me this [adversity]? if I have tried to be good, this is how you reward me for my good deeds?"… I think this is not having genuine faith, it is what I called an utilitarian faith... what I mean is that [some people believe that] if they behave well [following the Church's rules and advice] then God will reward them [by sparing them suffering, as a reward for their good deeds] so when they

have behaved well and bad things happen to them... then they believe that God is not being fair... and then they stop believing in him.

[Carmen, nun, 53, White Spanish, Mother Teacher]

Absence of mortality sorrow

The vast majority of the participants firmly believed in resurrection following death and the life ever after. The following quotations encapsulate this belief: "Christ through his Passion, death and resurrection has opened the doors of heaven for us all", "death is not a bad thing because Christ has redeemed it", "dying is going to the Father's house", "death is a beginning, is reaching eternal life". Several participants provided rich testimonies of having coped remarkably well with the deaths of friends and relatives. They were able to maintain a relationship with their deceased loved ones, frequently talking to them and asking for their help and intercession with their problems. The monks and nuns kept a strong connection with their fellow Brothers and Sisters after their death: both physically (the monks' and nuns' graves were in the garden) and spiritually (they were included in their daily prayers). They attributed positive events to their intercession, such as the entrance of Brother Terenci to the Monastery of Sant Oriol, which was thought to be thanks to Brother Andreu, who had died not long before Terenci's arrival. Similarly, Father Miguel's faith was crucial in helping him to overcome the unexpected death of his mother: "faith gave me a new way to live the relationship with my mother [she had recently passed away], I know she is with me and that she is part of my life, I count on her". One of the

most convincing testimonies of coping with the death of a loved one came from

a laywoman, Alejandra, whose 20-year-old son had been run over by a car

twelve years ago. She found a new way to relate to him after his death based on

her firm belief in resurrection and in God always watching over her:

> [When she was told by the doctors that her son had died] I felt a voice
> inside me telling me that God had never abandoned me and never will
> abandon me, I felt at peace… I felt a great inner certainty that God was
> with me then, so I stayed with my pain but it was a pain which could not
> destroy me… so I was able to tell the doctors to use his organs as they
> could be useful to someone else and not to him anymore; the doctor told
> me that they had never seen a mother with such fortitude… he [the
> doctor] took my hand and told me "I wish I could have a faith like
> yours!"
>
> I had to start getting dressed to attend his funeral but I was still in bed…
> then I heard his voice in my mind, in my mind, I've never heard voices…
> telling me "mum, what are you doing in bed? Look, I am in heaven and
> you can't imagine how pretty the Virgin Mary is, I want you to know that
> I am well"… and I believed him… since then I have incorporated him
> into my life or the Lord has incorporated him into my life in such a way
> that I feel him, I am not separated from him, I obviously can't see him
> but I tell him what's going on in my life and he answers me with his
> voice but in my mind… he has told me so many things in my mind so
> clearly: "I am with you, I am very happy where I am… although you
> can't see me, I am with you"… "I am in God and God is in you"… I used
> to do something before that I do less now: I used to close my eyes and
> open my arms and although I didn't see him, I felt his hug, his warmth.
>
> [Alejandra, laywoman, 60, married, housewife]

The participating doctors offered an interesting insight on the impact that

believing in resurrection had on their practice and on the way their patients

confronted death. Father Nicolás, who worked as a general practitioner for 25

years before being ordained as a priest, stated that "there was no terrible

diagnosis" he could give to a patient, as death for him meant "eternal life". As he

had done as a doctor, he continued avoiding the use of the word "death" as a

priest. He did not use this word when conducting funerals; instead he opted for addressing the deceased person rather than the congregation. He gave the example of a recent funeral he conducted for a woman who was leaving several children, in which he "talked to her" in the following manner: "look, now you have to continue working from heaven, you have to help your son to pass his exams, your other son to marry well…" His belief in resurrection was an antidote to hopelessness. He explained that hope meant "having the certainty that tomorrow I will be in heaven", adding that "tomorrow can be in five minutes or in eighty years". To my question whether he believed in the existence of hell, he replied that this was only reserved for those people who "having been given every single opportunity to love, chose not to love". He argued that everyone else would go to heaven, although some would have to go through purgatory first, which he described as "a summer school where everyone passes at the end and goes to heaven".

Another doctor, Lamberto, a secular general practitioner, commented on the difference he found between those patients who believed in God and those who did not in regards to how they reacted when confronted by a serious illness or death: "I think that the difference is fundamental [between believers and non-believers]: believers accept illness and death with much more greatness of spirit than those who do not believe; having said that, people who are agnostic or atheist can also accept these situations, but they don't endure them so well… believers accept them with trust in God… knowing that God is going to receive them [in heaven] for sure." Similarly, believing in an after-life was a dominant

theme in the narratives of those participants who had suffered or were suffering from serious health concerns. Father Pablo's account of the way he confronted his three heart attacks illustrates a lack of fear of death; he related his most recent one in the following manner:

> I was on my way home when I started sweating and sweating, I thought "Oh, my God, I am having another heart attack!" I had the pain in the arm, the chest pain, feeling so dizzy, sweating lots and lots… I did not go home, I told myself: "let's get a taxi [to go to hospital]", I was waiting for a taxi for 20 minutes!, during those 20 minutes I kept telling the Lord: "am I going to see your face?, are you calling me?, am I going to die?" Praise God! I had no fear at all, even the cardiologists from the hospital could not believe how calm and peaceful I was… I could hardly breathe, I was completely covered in sweat from head to toe but I kept telling the Lord with so much peace: "are you calling me?, am I going to see your face?" [To my question on how he achieved that security] Thanks to my faith, my faith… if I would not have had this faith, I think I'd have died, I'd have become so panicky!
>
> [Pablo, priest, 63, White Spanish, parish priest]

Several participants praised the sacrament of the last rites, differentiating two instances in which it could be administered: when someone was dying - its more widespread use - and when facing a difficult medical intervention or a severe illness. In the former, the goal was to prepare someone to die fostering hope, calmness and confidence in God's watching over them, and in the latter, to give them the necessary strength to cope with the suffering, as had been the case for María, a secular nurse, who praised the positive effect that receiving this sacrament had on her when she underwent a surgical procedure.

Previous experiences of receiving God's help

Accumulating experience of coping with, and successfully overcoming episodes of sadness using the religious coping strategies explained above, acted as a powerful aid to confront future suffering. Many participants talked about the importance of acquiring an experiential knowledge of "being cared for by God" when undergoing difficult times, as it gave them the trust and security that God would support them again when confronted by new challenges. Sister Carmen, the Mother Teacher of her monastery, strove to inculcate this certainty into her novices. The more adversities she overcame by placing her faith in God, the easier and less distressing future ones were, as she could look back to remind herself how God had helped her:

> It is so important to gather the feeling, little by little, that you are not alone when facing an event that you don't understand, that makes you suffer, that saddens you… I've learned to have the confidence that the Lord is with me, that he is conducting my life, so even if I don't understand it [the negative event], if I don't want it, well… I accept it, if God allows it to happen, he knows what is best for me.

[Sister Carmen, nun, 53, White Spanish, Mother Teacher]

Religious readings

Religious readings were also mentioned by several participants as being helpful resources to cope with suffering: besides bringing them comfort and bolstering their faith, some of these readings also provided practical advice on how to

address personal difficulties from a religious perspective. Most of the books they referred to had been recommended by their spiritual directors, parish priests or a fellow member of their religious communities. The biographies of saints, mystics and other fellow monks and nuns were frequently mentioned by the participants: reading about how they had become closer to God by enduring their sadness with faith helped them to face their own suffering. A few participants referred to the casual finding of a particular sentence in the Gospel or a religious publication that was felt to apply directly to them and was interpreted as a "sign from God". Such occurrences seemed to have been decisive in helping them to overcome their distress, as had been the case for María:

> Look, we [María and her sister] went to the parish church [trying to find comfort for the grief caused by the death of their parents, which had happened very recently] and when we got there - I will never forget it - we saw the parish bulletin, and on the cover there was a young man with a backpack going up a mountain and the title said "The Lord took them to rest". And I told her [her sister]: "this is what God has done for us" [taking their parents to rest after very long illnesses]… we felt so sustained by the Lord, at that moment and always.
>
> [María, laywoman, 62, single, White Spanish, nurse]

Religiously motivated gestures

Some physical actions and gestures with a religious intent were used, especially amongst the nuns, as a way of coping with distressing feelings; for example, "clutching the crucifix", "holding the rosary in their hands" and "holding it [a small cross] tight". These actions seemed to remind them of their faith when

they needed it most: "I could not see a way out… I only had my faith left… I clenched my little cross, and asked him [Christ] to give me strength". A laywoman, Amparo, also resorted to this gesture while attending the funeral of a close friend who died young of cancer leaving a dependent sister behind: "I had a little wooden cross in my hand, and when I left the church, I had my nails marked in my hand as I was pressing the cross so strongly".

Secular coping and help-seeking

Also found in the interviews of the vast majority of the participants were many secular coping strategies that were used in conjunction with religious ones. Two of the most frequent ones were: striving to find a practical resolution to the problem which was causing their sadness (when there was a clear cause triggering the sadness that could be resolved, such as by finding a new job to deal with a financial crisis due to unemployment) and trying to distract themselves from their feelings of sadness (for example, focusing on their work, being in contact with nature or finding a new hobby).

Several participants recommended helping others in their suffering as a good way to remedy one's own sadness. Although this way of coping has been included amongst the secular strategies, it was often imbued with religious meaning. It was thought to be useful for two main reasons: firstly, it helped them to stop obsessing about their problems and gave them an active occupation and

sense of purpose, and secondly, it put their own personal tribulations in context by comparing them with the serious adversities faced by those who they were trying to assist. For example, Jaime, a 71-year-old retired layman, contributed to a voluntary organisation who provided personal care, mentoring and supervised accommodation to people suffering from AIDS and mental illnesses (other altruistic endeavours undertaken by the participants have already been mentioned earlier in section 4.1., "Participants and their contexts"). Jaime explained that spending time amongst the ill helped him immensely to make his daughter's intellectual disability and his own health problems relative: it gave him a way to get out of himself by filling the day in a meaningful way. When describing his voluntary role further it became apparent that it could not be separated from his religious beliefs:

> When I was nursing a man with AIDS who looked bad enough to make you run, I was asked by him why I was doing this for him. I answered that because he and I were children of God and therefore we were brothers… there is nothing else to add, there is no other reason behind it… it is like that anecdote when someone who was watching Theresa of Calcutta caring for someone told her "I would not do what you are doing for a million dollars" and she replied "me neither!"… the other day a volunteer who had recently joined asked me "don't you love looking after people with AIDS?" I answered him by saying "you are crazy! I love being in a tennis club drinking a vermouth and looking at pretty women, I am here because in all conscience I have to do something, I want to help them, not because I enjoy doing it!"

> [Jaime, layman, 71, married, White Spanish, retired teacher]

María, a single 62 year old woman, also illustrated this coping strategy: she overcame her feelings of sadness and void by becoming a volunteer in a local care centre for children with severe intellectual disabilities: "I started going there

[care centre] not feeling good about myself, feeling really low, feeling bad, as I had been left without a path to follow [she was made redundant from her job as a secretary, which she had carried out for over 20 years] but it was there that I started feeling better, I found the satisfaction and the joy I had lost. Being useful to those who needed me made me so happy, it fulfilled me totally". Moreover, her experience there inspired her to pursue nursing training and to become a qualified nurse: "I discovered the sick there… I am convinced that it [being a nurse] was my mission in life".

As we have seen in the previous section, many participants approached their parish priest, their spiritual director or their religious communities in order to find solace and help in coping with their sadness and depression. Regarding their social support network, resorting to their families was often mentioned as one of the most common sources of help, followed by close friends. Their close relatives were seen as the most important port of call for seeking help and support when confronted with sadness and despair as well as in cases of depression, since there was a sense that one's own family knew "best how to help as, contrary to other people, they could see things from the inside" being "able to really understand the person's worries and sadness". Being able to "pour your heart out" to someone caring and empathic was considered as playing an important role in the healing process. One participant found another way of externalising his feelings and concerns: writing them down in a diary became a cathartic activity that helped her enormously in the ten years that she had been

"totally devoted to looking after her parents" (her mother suffered from cirrhosis and her father from Alzheimer's).

Several participants also consulted mental health professionals. They sought the help of psychologists, psychotherapists or psychiatrists with the intention of engaging in psychotherapeutic work. Some referred to specific modalities of psychotherapy, such as cognitive-behaviour therapy or psychoanalysis. The latter type of psychotherapy was generally seen in a critical light, as it was seen as incompatible with religious beliefs and therefore as potentially harmful for the individual's spiritual life, as well as being very costly.[27] A few participants who were thought to be in need of antidepressant medication - some of them mentioned "Prozac"- consulted with their general practitioner or a psychiatrist. The majority of participants considered taking antidepressant medication to be an appropriate help-seeking behaviour when the sadness was considered pathological and along the lines of a depressive illness. Pharmacological treatment was thought to be warranted when the severity of the symptoms worsened, when they persisted in time or when alarming physical symptoms emerged, such as severe weight loss or incapacitating insomnia. Most of the participants faced non-pathological cases of sadness and used religious and social resources while those who had undergone depression used these resources in addition to pharmacological treatment and psychotherapy.

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[27] There is a noticeable exception to the predominant negative view held towards psychoanalysis: Andrés, one of the layman participating in the study, succesfully combined psychonalysis and spiritual direction to overcome anxiety and depression (his testimony is explained in more detail later on, p. 301).

Antidepressant medication was not seen by the vast majority of participants as an appropriate way to address normal sadness. Moreover it was frequently seen in negative terms, being described as "a passive way to cope", "an escape" and as "running away from the root of the problem". They recommended instead facing the cause or causes responsible for the sadness using the secular and religious coping strategies described above. Many warned about the possibility that taking this medication could lead to a medicalisation of the experience of sadness, consequently jeopardising its positive aspects of self-reflection and personal and spiritual growth. It was also felt that antidepressants might prevent people from overcoming their sadness through their own personal efforts and inner resources, thus depriving them from cultivating "a thirst for overcoming difficulties" and "a conqueror spirit", which could lead to a "healthy pride" and "security in themselves". Sister Carmen summarises this view:

> Feelings [of sadness] are real stuff… pills don't solve problems; if I am sad, I must not run way, I have to face it and I have to find a way to deal with it, resolving my problems is the natural way forward, taking pills is artificial… [To my question of whether she would take antidepressants if she was in a state of severe sadness but could not discern an apparent cause for her sadness] If I don't know the cause then I have to take the time to find the cause and learn why I'm feeling sad. Instead of taking tablets, I believe I can find the solution for my sadness… tablets won't help me, they suppress growth.

> [Carmen, nun, 53, White Spanish, Mother Teacher]

Other criticisms regarding antidepressant medication found in the interviews were their lack of efficacy and their side-effects, including potentially unknown ones. A few participants were concerned about pharmaceutical companies' economical interests influencing the overprescription of these drugs by

professionals, as well as shaping the public opinion in their own interest through marketing campaigns.

A few participants - especially those with more knowledge of mental health matters - distinguished between "endogenous" and "reactive" depression (in Spanish: "endógena" and "reactiva"). They stated that taking antidepressants was a legitimate option, even a necessary one, in the case of someone suffering from the former type. As I will explain in detail in the following section, "endogenous" depression was thought to be an illness with an organic cause in contrast with the sadness which was the natural and normal response to adversity. Sister Carmen's long lasting friendship with a woman suffering from bipolar-affective disorder influenced her views regarding depression (she qualified it as "endogenous"). She held a biomedical explanatory model for her illness, arguing for the convenience of using medication: "the brain has shortages of certain substances and what the medication does is to balance this; thus taking medication is helpful… if this lack is creating an imbalance, you can't sort it out by, let us say, strong will; you need to take medication to physiologically regain the balance and recover".

I will illustrate the experience of taking antidepressants with the narratives of two laywomen, Magdalena and Rosario, who were diagnosed with mental illnesses and prescribed antidepressants. Although they had many distressing symptoms in common, their perception of what was occuring to them was fundamentally different: while Magdalena felt that she was genuinely sick,

Rosario attributed her symptoms to being an understandable reaction to adversity. Magdalena, a 45-year-old single receptionist, had been a contemplative cloistered nun two decades before. She was diagnosed with a depressive disorder after being in the convent for six years. She described having felt that she was "sinking into total despair" and that she "just wanted to die". She firmly advocated the need of using medication - back then, she was put on antidepressant medication - as she felt that the resolution of her illness was out of her voluntary control. She explained that she wanted to continue pursuing her religious life in spite of her mental illness, as she had already taken the perpetual vows (these vows committed her to a cloistered contemplative life until death). However, her Mother Superior and spiritual director thought that it was best for her mental health to leave the convent. Her Mother Superior played a crucial role in securing her exit from the convent: "she facilitated my exit… she told me I could not carry on like this, that a contemplative life was not for me… that you can love God anywhere". She finally abandoned her religious life relunctantly and in a great deal of distress: "I left [the convent] very unhappy… feeling totally broken, I felt that I was failing God".

In contrast with Magdalena, Rosario, a 39-year-old unemployed engineer, considered her symptoms to be a "reaction to my external circumstances, I was not suffering from any illness". She attributed her sadness to unexpectedly losing her job and her long-term boyfriend breaking up with her, both events happening in a short space of time. She was diagnosed as suffering from a depressive disorder and was prescribed antidepressant medication by her psychiatrist.

Although she took the medication for over six months and experienced a mild initial improvement in her anxiety levels, she never placed much confidence in the therapeutic potential of the medication, but rather in her religious resources: "well, I always thought that the medication was a temporary palliative measure and that I needed something else. Maybe an agnostic or an atheist doesn't think like me, and they settle on just relying on the medication until the problem goes away… but that's just papering over the cracks… for me the medication was a patch, the real help was my faith, the best way to face my problems was through my faith, finding a different way to cope… I never thought my problem was organic… I knew that facing my problems using my faith could make me grow".

As has been explained before, it was interesting that a different picture from the one seen for antidepressants emerged for the case of psychotherapy: this modality of treatment was seen by many participants as useful for both normal sadness and depression. The requisite of being ill did not apply for psychotherapeutic work as it did for taking antidepressants. Psychotherapy was often not seen as a medical treatment but as a valuable tool to deal with feelings of distress and sadness, as well as for personal development. Many more participants valued positively psychotherapy than psychiatric medication. Many comments appeared in the interviews along the lines of the following examples: "psychiatric drugs have risks, there are more natural ways [to help those suffering from sadness and depression]… psychotherapy helps people to improve themselves helping them a lot, much more than taking pills [referring to antidepressants]… I really don't have much faith in these drugs", "I did not want

to take antidepressants, no, no,… a psychologist helped me a lot… she [the psychologist] helped me so much to organise my life, to organise my thoughts… I was so confused… she was brilliant, she set up tasks and homework for me to do, I saw how I was improving week by week". It is worth noting that in the Spanish health system, most of the psychotherapeutic work does not take place in the national health system but privately and in charitable and volunteer organisations.

Three narratives of religious coping

Three narratives of sadness and distress will follow here to illustrate many of the religious coping strategies described above: two individual narratives, Father Enrique's and Sister Mercedes's, and another more collective narrative, a group of priests' account of the unprecedented secularisation of priests that occurred after the Second Vatican Council, which affected many of the participating priests.

Father Enrique

Father Enrique, currently a diocesan priest and the chaplain of a big urban hospital, had been a Carthusian monk for fourteen years. His narrative of sadness illustrates many of the above religious coping strategies. He had to leave his

monastery, with great relunctance, due to being diagnosed with a rare and severe autoimmune disease two years before. His Abbot took great pains in making him understand that he could not cope any longer with the physically demanding way of life of the Carthusian Order nor could he receive the necessary treatment in the remote area where the monastery was located (see section 4.1.2., "Hospital chaplain", for further biographical details on Father Enrique, and see Note 8, page 117, for a brief depiction of the Carthusian spirituality). He gave one of the most enthusiastic testimonies that I have encountered in my fieldwork amongst monastic communities of how much joy and fulfillment a contemplative way of life could bring. He talked with great affection and in a clear tone of nostalgia about "the immense happiness" of the years he spent in the monastery. He especially had much to say about his experience of feeling God's love while he was living there:

> I have felt God's love in my monastery… feeling that God loves you is feeling a great sense of peace, you have the certainty that God is loving you, you see it in your life, in concrete facts, in everything that happens to you… all day long, you are always in the loving presence of God, while you are working, studying… it's like being with the person that you love most, working together, feeling a connection… an intimacy between the two of you.

He had always taken for granted that he was going to die as a Carthusian monk. The possibility that an illness or other circumstance would force him to leave the monastery had never occurred to him before. He experienced great distress when he had to abandon his chosen monastic path and his monastery, which he still regarded as his true home. He provided a rich narrative of the painful process

that he underwent in the months following his departure from the monastery as well as the ways in which he coped with and overcame his feelings of sadness and desolation. His initial reaction was one of rebellion and anger towards God:

> I had such a tough time when I left the monastery, so tough, so tough! I rebelled against the Lord, I did not lose my faith, no! But I did rebel against him, I told him: "Lord, I don't understand why you do this to me after fourteen years [of being a monk]." I spent several weeks cross, very cross, with the Lord.

In addition to the above feelings of anger towards God, he reported that for over a month he had felt deeply sad, apathetic, lacking in energy and having frequent bursts of crying. He had also been very worried, as he could not see any future for himself outside the monastery. His spiritual life was affected too during this distressing time; for instance, praying, which had previously been such a natural and effortless activity, often became an arduous task "requiring the use of all my willpower". However, he persisted in keeping up with daily moments of prayer as they not only brought him alleviation of his suffering but also its final resolution. In one of these times of prayer, he distractedly opened the Bible and came across a passage from the Gospel which was decisive in helping him to come to terms with having had to give up his monastic call. It triggered one of the key coping strategies described in this section: he was able to accept God's will trustingly, putting his life in his hands. He vividly recalled this important moment:

> I was in a state of darkness, I don't know how to explain it, I could not see anything... I was still rebelling against the Lord, but there was a moment that somehow the Lord wanted to talk to me: I opened the Gospel and happened to set eyes on the passage about the birds, the lilies

> from the fields, that they don't spin or weave but God looks after them and how is he not going to look after us, being so much more worthy than them?[28]… and well, it was in that moment reading this that I told myself: "you [referring to God] love me and you are my father and you want what is best for me, therefore I am putting myself in your hands" and then a feeling of peace filled me up. I felt sustained by God's love. I was overcome by a feeling of great peace, a peace that made me abandon myself to his will.

When his health improved through an intensive pharmacological regime, he took the post of hospital chaplain. His firsthand experience of having felt the desolation and powerlessness brought on by his illness and of having succesfully overcome these feelings through his faith in God were invaluable tools for his work. He argued that they made him more empathic, resourceful and in-tune with the patients for whom he cared spiritually.

Sister Mercedes

Many of the religious coping strategies came together in the narrative of Sister Mercedes, a 45-year-old nun and Mother Teacher of her community. When she was asked to describe an episode of severe sadness in her life, she described the

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[28] Father Enrique refers to the following passage in Matthew 6:25-32: "Therefore I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more than food, and the body more than clothes? Look at the birds of the air; they do not sow or reap or store away in barns, and yet your heavenly Father feeds them. Are you not much more valuable than they? Can any one of you by worrying add a single hour to your life? And why do you worry about clothes? See how the flowers of the field grow. They do not labor or spin. Yet I tell you that not even Solomon in all his splendor was dressed like one of these. If that is how God clothes the grass of the field, which is here today and tomorrow is thrown into the fire, will he not much more clothe you - you of little faith? So do not worry, saying, 'What shall we eat?' or 'what shall we drink?' or 'what shall we wear?' For the pagans run after all these things, and your heavenly Father knows that you need them."

split that her community suffered due to the behaviour of a fellow nun. She explained how this nun, the Mother Teacher at the time, was reponsible for all the novices, who were four in number, leaving the monastery. She remembered those days as full of distress and sadness:

> It was very hard because I could see how the community was being torn apart, the community was been split; I could clearly see the cause but I could not say anything because the cause really was the Mother Teacher, she made life miserable for all the novices, provoking their departure from the monastery. She planted the seeds of division in the community… I could see how she was destroying a community that had always lived with great unity… it was very hard to see the four novices leave, people who you had seen joining with so much excitement… we are talking about four lives that, when they left [the monastery], were broken. It was a terrible drama that caused so much suffering… she [the Mother Teacher] used to accuse some of us [those who did not support her], and the Mother Superior was the one that suffered the most: I had to see how the Mother Teacher accused her, how she was psychologically squeezing her… to hear her crying desolately… this situation caused me so much anguish.

In spite of the intensity of her suffering, she stated that it was also the time "when she had more strongly felt God's strength". She employed various religious resources to endure those distressing months. Praying became a "necessity" for her, as it gave her courage and hope as well as being an avenue to experience God's presence:

> I was having lunch with all of them [her fellow nuns] and I could not hold back my tears, I was eating and crying… when the meal ended I went to pray [to the chapel] and I felt how praying was filling me up with strength… I felt that he [God] was with me… I felt a sensation of freedom invading me... I used to go to the chapel to pray feeling completely defeated, feeling that I could not bear it any longer, but while praying I felt how the Lord was with me, how the Lord was making me stronger, I even once left [the chapel] feeling like singing!... feeling that he was with us, feeling calm as he was with us.

Sister Mercedes's strong faith in God's providence helped her to accept without questioning "his plans" even when they caused her great suffering. She relied on God resolving the problems her community was going through. This was of key importance in enabling her to cope, as she explained she felt "totally powerless" and couldn't see a feasible solution to their situation. Giving God the responsibility to "save the community" brought her peace and a sense of control and meaning. Moreover she trusted that God wanted the best for them even if they themselves could not see it with their "limited understanding":

> If you have faith, you know that God is taking your hand, he is with you, what I mean it that no matter how terrible things are, God is not losing it, he knows what he is doing… I have this certainty - this is what I think having faith means - to be able to say: "look, my Lord, I don't know what is going to happen, but you know what you are doing… this is also having hope, yes, yes, that although I could not see any way forward, deep inside me, I had the conviction that nothing could spoil God's plans. I could not see any solution, any benefits... However, I was convinced that God's plans surpassed my intelligence and if he allowed it to happen, he had his reasons… the secret is to trust him even if you only see darkness.

> If God allows it [suffering] to happen, he will bring good from evil even if you don't know what good can come from it all, don't rebel! as there is someone [God] who surpasses you and is in control.

Retrospectively she was, on the whole, pleased with the outcome of the problems that shook her community during those days, arguing that they became a channel for beneficial change. She rephrased the experience along the lines of a "purification" that helped them to mature. The Mother Teacher finally left the monastery and the remaining nuns formed a more tightly knit community than before: "going through this experience resulted in a great deal of pain but the

community emerged really healed and became much more united; since then we have learned to value our union greatly".

Clergy's coping with mass secularisation[29]

As a final example of religious coping, I will briefly present here the clergymen's firsthand experience of the unprecedented process of secularisation of priests that took place in the Catholic Church during the late 1960s and throughout the 1970s, focusing on the main ways of coping used both at an individual level and as a collective (the contribution of the Second Vatican Council to the severe crisis that parish priesthood was facing and the reaction of eminent theologians has been developed in "Catholic clergy", appendix 1). Many of the participating priests - both religious and diocesan - were caught up in this phenomenon when they were in the seminars or shortly after being ordained. Their accounts presented many similarities. They described witnessing how fellow priests and seminarians left the Church in great numbers. Moreover, they were confronted by an increasing number of people, from outside as well as from inside religious circles, who argued that the role of the parish priest was obsolete, being no longer valid for the present times and therefore in urgent need of revision and update.

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[29] Secularisation here refers to the process undertaken by priests in which they seek authorisation from the Holy Office in the Vatican to become a lay person, thus they are dispensed from their religious vows (Gran Enciclopedia Larousse, 1990b, p. 9975).

The priests often brought up those years when asked to describe hard moments in their lives. The widespread secularisations posed a serious threat to their vocations, which were thoroughly challenged. This was particularly the case for those who were seminarians at the time: they recalled having entered the seminary with high hopes and enthusiasm, only to find that the priesthood, as an institution, and priests, as individuals, were under attack, a situation they found to be "utterly demoralising". Although several of them had nourished the wish to become priests since boyhood, others were still dealing with their own doubts regarding their vocations.

They frequently referred to those years as "turbulent times": they felt that the seminaries were in the "eye of the hurricane" and felt torn by powerful external and internal pressures. Many of the external pressures they faced came from certain sectors of the media and the Spanish society, which were seriously questioning the role of priesthood. Their own well-meaning families, most of them devout Catholics, were also a source of stress, as the majority were concerned that the seminarians make a success of their vocations. Thus these future priests felt obliged to reassure their families and underplay the gravity of the situation that their seminaries were in. And if this were not enough, the internal pressures were even more painful and difficult to endure: on the one hand, they witnessed the voluntary departure of many of their fellow seminarians with whom they had shared a "common vision", but who could no longer see the validity of the role of the priest and, on the other hand, they felt pressured by the seminary's teachers and mentors, who strongly urged them to resist and to be

faithful to their vocations. Father Jordi, who stated that since the age of eleven he had been determined to become a priest, was an 18-year-old seminarian when the massive wave of secularisation occurred. He provided an excellent depiction of the uncertainty of those times, using the analogy of its being "like a virus" to explain how his fellow seminarians were leaving on a daily basis: "they were rushing out of the seminary, one going this way, another the other way!" All the seminarians who entered the seminary two years before him left their training: "not one was left from that class group!" He often wondered when his turn would come to "get the bug" (that would make him leave too). The situation became "so desperate" that the senior priests in charge of his seminary decided to move the remaining seminarians away from the city to a remote house in "the middle of the mountains... for a change of scene, because the situation was like being exposed to a virus".

The priests coped with this period of religious upheaval in a variety of ways. In order to deal with the vocational doubts triggered by the secularisations, the majority of them resorted to reminding themselves of the original reasons they had had for taking this path, trying to keep them in mind and firmly holding to their initial call. There was also an implicit heroic air in their decision to carry on. They explained that Christ and the Church needed them to have a strong faith to save the priesthood, and alluded to previous critical times in the history of the Church:

> [To my question of why he stayed in the seminary] I was conscious of having a vocation, of having received a call from God… it was a matter of fidelity… I wanted to live coherently and to be faithful to God, that's it, I thought that it [continuing with his training to become a priest] was my little contribution… my answer to the lack of fidelity because there was no fidelity amongst them [referring to the seminarians and priests that gave up their religious call].

> [Jordi, monk and priest, 66, White Spanish]

Most of the religious coping strategies seen above also appeared in the priests' testimonies, strategies such as resorting to their faith in God supporting them, intensifying their moments of prayer and meditation, confiding in their spiritual directors for guidance, and searching for inspiration and solace in religious readings such as the Gospels or writings from admired priests from the past. In more practical terms, many of them opted to keep a low profile and avoid situations or people likely to criticise or challenge their life option. Most of the participating priests saw this period in vastly negative terms; however, a few of them, those who had held more critical views about the Church, saw the crisis of priesthood as a welcome opportunity to renovate the role of the priest. They argued that it had to become more in tune with the conclusions of the Second Vatican Council and strongly advocated for the priest to adopt an attitude of more service and approachability.

4.3.2. Medical help-seeking behaviours were more often advocated when there was an absence of causality for the sadness (lack of context)

Seeking the help of their general practitioner or a psychiatrist, taking antidepressant medication, and being admitted to a psychiatric ward were the main medical help-seeking behaviours found in the interviews. These sources of help seemed to be associated with those cases of sadness in which there was an absence of an apparent cause explaining it (when sadness "did not make sense"). Participants were likely to pursue medical advice themselves (when they were the ones experiencing this type of sadness) or to recommend it (when they were offering support or guidance to someone). Thus, when the experience of deep sadness was not seen in a context explaining it, participants were much more likely to see it as pathological. Moreover the resolution was placed within the realm of psychiatry.

One of the most dramatic examples of this lack of apparent causality was the suicide of Martín's brother-in-law, which took place only one year previously. Martín clearly attributed it to his relative's mental illness, which he called "depression". He pointed out that although "he [his brother-in-law] had lost the meaning of life", it did not make sense to those who knew him well, as "he did not lack anything, he was happily married, [he had] two lovely daughters, both are well-married to two good chaps… one [daughter] is a doctor… the other one is an engineer". His whole family agreed upon the need for intensive psychiatric care to treat his depressive illness: he received pharmacological treatment and

was admitted to the psychiatric ward of his local hospital several times. Conversely, when a cause was identified for the sadness, dealing with the cause, rather than opting for a medical and pharmacological route, was an integral part of the narratives. The resolution of understandable sadness (sadness that "made sense" in the context of adverse circumstances) was to be resolved from within one's personal and spiritual resources, counting on the help of both religious and secular figures (such as a priest, friends and family or even a psychotherapist).

As was mentioned in the previous subsection, a few participants used the terms "reactive" and "endogenous" to differentiate between two types of depression. The former was understood as a normal reaction to misfortune; thus the depressive symptoms were seen as a natural and understandable response to the adversity faced by the individual (this was equivalent to the normal sadness of most of the participants). Conversely, the latter was considered to be a mental illness and was qualified in much stronger terms, such as "pathological", "unhealthy", "the authentic depression", and "the worst existing illness" (this equated to the abnormal sadness without an apparent cause that most of the participants differentiated from the previous case). Moreover, endogenous depression was thought to be caused by an organic dysfunction: a chemical imbalance in the levels of neurotransmitters (a reduction in serotonin was specifically mentioned by several participants). This type of depression was associated with hopelessness, a symptom regarded as particularly alarming by many participants, and with higher risk for the individual's life. The distinction between reactive and endogenous depression implied an important difference in

the help-seeking behaviour considered appropiate and necessary to resolve the distressing symptoms. Pastoral care and religious coping were thought to have a clear role in helping those undergoing reactive depression. However, it was argued that their role was secondary, merely supportive, in the cases of endogenous depression, for which the main curative role was given over to psychiatrists, who could prescribe medications to remedy the brain's chemical imbalace, which was responsible for the symptomatology. Father Esteban, who had worked as a psychiatrist for over 50 years, illustrates this view: he was adamant that neither faith nor psychotherapy could cure endogenous depressions and stated that the only ways forward were subjecting the patient to pharmacological treatment to treat the illness and close monitoring to manage suicidal risk:

> In these cases [of endogenous depression] you sometimes need to admit them [the patients] to hospital; an endogenous depression is a depression written with a capital letter… you need to watch them closely, as they may jump out of the window or slash their wrists…
>
> [Esteban, religious priest, 91, White Spanish, retired, formerly a consultant psychiatrist]

The following quotations from Father David and Father Esteban illustrate the recognition of the limited role of religious belief and faith in the case of endogenous depression:

Well, when a depression is an illness [referring to endogenous depression] then I considered that it is very difficult for religion to be able to calm them [people suffering from this illness] in a more or less permanent way; maybe it can only give them a temporary injection to raise their morale.

[David, priest, 63, White Spanish, parish priest and lecturer]

In these cases [of endogenous depression], faith has no role whatsoever. Why? Because there is no faith or anything else, there is no faith, no love, nothing whatsoever!

[Esteban, religious priest, 91, White Spanish, retired, formerly a consultant psychiatrist]

4.3.3. The impact of the individual's personality on their coping strategies and help-seeking behaviours

In the case of many participants, the individual's personality, with its strengths and limitations, was seen as playing a key role in the way they coped and sought help to alleviate sadness. Moreover, as was explained in the previous section, an episode of normal sadness or even a Dark Night of the Soul could turn into a depressive disorder due to subjacent problems in the person's personality.

Participants with experience in providing spiritual care - mostly clergymen and monks - were the ones to go into more detail regarding the interplay between personality and ways of coping. They stated that in order to successfully help those suffering from deep sadness these people had to be motivated to change those aspects of their personalities that might be contributing to their suffering.

Although the spiritual directors saw themselves as having an important role in helping those in distress, they considered the individuals to be responsible for overcoming their own problems and for achieving positive change in their lives.

Several spiritual directors talked about how different types of personalities influenced people's coping. Those with a more negative view about themselves, God and the world, and those who tended to blame others for their problems were thought to be more likely to have maladaptive coping strategies, to seek inappropriate help or even, when the right source of support was offered, to not be able to use it effectively. Conversely, other people had a more positive attitude in the face of adversity and were more resilient in their ways of dealing with sadness.

4.3.4. Gender differences between nuns and monks in coping and help-seeking

In general terms, the women participating in the study were more prone to devotional and pious practices, such as praying the rosary or to a saint, than the men. Although most of the participants described having a personal relationship with God that involved sharing their daily joys and tribulations with him, women tended to talk more about their emotions while describing their relationship with God while men did so in a more factual descriptive and less sentimental manner. Jaime, a retired chemistry teacher who had been the head of a prominent Church

charity for decades and was at the time of the interview working in a voluntary organisation which provides support and accommodation to people suffering from AIDS and mental illnesses, was a good example of a prototypical male way of talking about his religiosity:

> I am a religious person, deeply religious, but not devout. I am not fond of praying the rosary, going to the church all the time, going on retreats; you might say I have a cold religiosity, not a sentimental one… I like what Saint Matthew says, that not by just saying "Oh my Lord, oh my Lord!" will one enter into the Kingdom of God… the actions are what matters.[30]
>
> [Jaime, layman, 71, married, White Spanish, retired teacher]

In spite of the many similarities shared by the participating monks and nuns in their ways of life, striking gender differences were found between them. Although they shared many of the coping strategies detailed above, the following significant differences between them were observed (for a summary of these differences, see Table 18).

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[30] "Not everyone who says to me, 'Lord, Lord,' will enter the kingdom of heaven, but only the one who does the will of my Father who is in heaven" (Matthew 7:21).

TABLE 18

Differences between monks and nuns in the ways they coped with sadness

Differences in coping	
Monks	**Nuns**
Sadness is faced alone	Sadness is shared with the community
Making themselves useful through direct contact with guests, offering guidance and help	Making themselves useful by providing guests with food and accommodation
They cope with the sadness of the crisis of vocations in a spiritual way: accepting God's will and praying	They cope with the sadness of the crisis of vocations in a more pragmatic way: bringing young women from different continents and actively promoting their vocation
Process of mimesis: - they suffer from sadness *like* Christ: they identified with him and his suffering on the cross - identification with intrepid, adventurous monks from the past	Process of mimesis: - they suffer from sadness *with* Christ: they share and accompany him in his Passion as his "wives" - identification with abused holy women

Role of the community: the monks faced sadness alone while the nuns sought

help from the community

A remarkable difference emerged in the way male and female communities coped during their times of sadness: while the support from the community played a key role in alleviating sadness for the nuns, in the case of the monks, sadness was faced alone, not shared with the community.

When the nuns were asked about how they coped with periods of sadness, they answered that they first sought God's help and then, their community's help. The nuns highlighted the key role that the community played during these times. They sought comfort from their fellow nuns, and in most cases shared the causes of their sadness with them. Besides receiving advice, the nuns recounted instances of physical comfort too, such as being hugged, or having others keeping vigil with them during the night. Most nuns insisted on the need for being able to relax and confide in their fellow nuns: "in the community one needs to feel like one is at home".

The novices particularly emphasised the importance of sharing their worries and anxieties with their Mother Teacher. It was obvious, in many of their testimonies, that there was a high degree of trust and intimacy with this senior nun who was in charge of their training and spiritual well-being. Many alluded to the healing, solace and comfort that sharing their problems with their community brought them. Undergoing suffering provided them with the opportunity to feel more strongly their fellow sisters' affection towards them; in Sister Carmen's words: "suffering makes us experience the love of our community, sorrows unite us more than joys, joys also unite us but undergoing sorrows actually makes you value more the love of those surrounding you, makes you value having them at your side". Sister Sofía had much to tell about her experience of revealing her sorrow and its cause to her sisters. She explained that when she shared it simultaneously with her Mother Superior and Mother Teacher: "they ended up crying and hugging me"; later on she also opened up to

the rest of her community, who also offered her their support: "I have experienced their sympathy because before I was like a stone".

However, within the male monastery the monks did not share their sadness or seek help from the other monks, but rather bore their sufferings in private. In Brother Xavier's words, referring to a painful period he went through: "alone, prostrating myself in front of the Cross, alone". Even when they saw that a monk was feeling sad, they would pray for him (and "suffer with him") but not openly address the problem with him or acknowledge that they had noticed his suffering. It is interesting that several monks mentioned that when they had been in need of a spiritual director in times of despair they had sought it outside their monastery. Although four monks were ordained as priests, several monks chose to have confession with priests not belonging to their community. In contrast to the nuns, maintaining privacy within the community was important for the monks. The majority of the nuns were spiritually mentored by senior nuns from the same community: the Mother Superior was in charge of the spiritual well-being of all the nuns and the Mother Teacher kept a close eye on the novices' and postulants' spiritual development. However, several monks insisted on the importance of having a spiritual director outside the monastery in order to be able to express themselves with total trust and freedom, and to guarantee objectivity and impartiality from him as the following quotation illustrates:

> [In answer to my question if he would seek spiritual direction from a fellow monk] Oh, no, no, not a chance, no, no!... having someone from outside [the community as a spiritual director] for me is unquestionable, you need to be able to explain yourself freely… because, at some points, it has been precisely the community that has been causing the suffering, the community may be the problem, no?, listen, I do love them all [his fellow monks] but it needs to be someone from outside, right?
>
> [Jordi, monk and priest, 66, White Spanish]

Brother Terenci, the youngest monk in the monastery, offered a contemporary critical view from within the monastery, the view of a man in his thirties who had received a modern education, in contrast with the older more "traditionally male" monks. The lack of emotional sharing and communication amongst the monks upset him. Once, when another monk was distressed, he felt unable to openly approach him to ask what was wrong, and instead went discreetly into his cell to give him a hug and words of comfort. Besides blaming the old-fashioned education that men received in the past when "talking about your problems or admitting to be suffering was thought to be a sign of weakness", he also attributed their attitude to "the lack of training in the monasteries regarding affection and sexuality" and the "conservatism" of monastery life.

Focusing on helping others with their sadness: the monks offered personalised care to those who visit the monastery while the nuns did not have individual contact with their guests

Both monks and nuns emphasised the importance of keeping themselves occupied when feeling down. Caring and trying to help the people who visit their monasteries provided them with a way of coping with their sadness: on the one hand, they had to focus on some else's suffering rather than their own struggles, which often appeared insignificant compared to those of their visitors, and on the other hand, it was a welcoming respite and source of distraction from their troubles.

As has been explained in the previous section 4.1., "Participants and their contexts", both monks and nuns offered accommodation to those who wanted to go on retreat in their monasteries. However, their level of contact with the visitors was dramatically different. The monks had a much more direct and personal contact with their guests: not only did the guests share the monks' facilities, their bedrooms were in the same building and they had their meals together (in the case of the nuns, the visitors slept and ate their meals in a guest house attached to their monastery). They were also given the opportunity to meet individually with a monk who could provide personalised advice and spiritual care.

The nuns had a strict criteria for accepting guests: they were expected to be practising Catholics and the purpose of their visit had to be of a clearly religious nature (e.g. seeking some days of silence and solitude in order to pray and meditate). In contrast with the nuns' requirements, the monks were much more open: they prided themselves on welcoming "all sorts of people... practically anyone who wants to experience first hand our way of life"; it was not necessary for them to be Catholic, to practise a religion or even to believe in God. The spectrum of people who had stayed with the monks over the years was certainly broad: religious men in search of time to meditate and pray; influential men with powerful jobs, such as politicians and businessmen who longed for the monks' advice, mentally ill people suffering mostly from depression and anxiety, those trying to give up a drug addition, and many people who were undergoing life's crises or were distressed by problems of any kind (e.g. financial difficulties, job tensions, undergoing a relationship breakdown or a divorce, struggling to end an extra-marital affair, etc.). They once even had a group of prisoners spending the day with them: they shared their meals with them and met individually with those who wished to do so. From time to time, they also got phone calls from people who described themselves as atheists or agnostics who wanted to spend some days of peace and quiet in their monastery away from their hectic lives. There were some testimonies in their guest book - visitors had the chance to leave a written record of their stay in this book - coming from their non-believer visitors expressing gratitude and surprise at having being welcomed in spite of their lack of faith and at not having been subjected to any attempt of proselytization. In the words of Father Jordi, the monk in charge of greeting the

guests and showing them their rooms and the monastery's facilities: "we have this wonderful experience of having had amongst us such a wide range of people: from those who are mentally ill, undergoing life's crises, overwhelmed by problems… we have opened our doors to people of every shape and form and we welcome them all equally, it comes naturally to us, we listen to them and understand them… we know what is wrong with them by just looking at their faces".

There are a few possible reasons which might explain some of the differences observed in the way nuns and monks negotiated their level of contact and involvement with outsiders, such as the monks' general level of knowledge far exceeding that of the nuns. Although both had time for studying and reading scheduled in their daily routines, the monks had remarkably up-to-date information about national and international news, while what was available to the majority of the nuns was rather limited. The monks placed great importance on following the news through the radio, the television and the newspaper they received daily; they frequently brought up in our conversations topics outside the religious realm, such as politics, literature or the arts, something that was much rarely done by the nuns. The nuns subscribed to religious publications and the little time they spent watching television or listening to the radio was devoted to programmes of a religious content.

As I explained in section 4.1.5., while I at times heard nuns using the expression "when I was in the world" to refer to the time before they entered the monastery,

the monks rejected this expression that emphasised the separation between them and the world. The monks insisted on "being *in* the world" and on not being scandalised by any problem that their guests might bring to their attention, such as drug misuse, divorce, extramarital affairs and abortion. There were also significant gender differences in the level of formal education achieved: six out of the ten monks had received university education while only two out of the ten nuns had a university degree. Five monks had obtained degrees in theology while none of the nuns had done so. The monks' higher level of education could partly explain why they appeared more confident and at ease in arguing and backing up their religious beliefs than the nuns and why they did not find being questioned by their guests on these matters daunting. Several monks and priests were critical of the nuns' knowledge on theological matters and seemed genuinely concerned about it, advocating the need for giving them more training. However, even more than their lack of formal education, what worried them most was the nuns' isolation and lack of openness, as this could lead to holding narrow-minded, simplistic and judgmental attitudes regarding many aspects of modern society and the challenges faced by people nowadays.

Ways of dealing with the crisis of vocations: the monks took a more spiritual approach while the nuns were more pragmatic

The lack of entrants into their monasteries, with the subsequent increase in the age of the community, was one of the main sources of worry and sadness for the

contemplative participants, as this not only threatened their survival but also brought into question the validity of their life option in the Spain of today. The nuns and monks coped with this situation in very different ways. Although they both prayed daily for God to send them new vocations to secure the continuance of their communities, the nuns adopted a more pro-active approach than the monks. The nuns not only brought young women from abroad to become postulants in their communities, but also advertised their monasteries in religious publications and even on the internet (e.g. one of the Mother Teachers interviewed, Sister Mercedes, recently organised an open day in the monastery for women who might have been considering consecrating their lives to God, and advertised it on Facebook).

The monks did not feel comfortable with such initiatives, arguing that the best way forward for them was to try to live their contemplative vocations in the most coherent way possible and ultimately accepting God's will, even if that meant that the monastery at some point could not remain open. Moreover, they had many reservations about bringing young men from completely different cultural backgrounds into their community. Based on cases they knew of from other monasteries, they argued that the foreign monks could pose many challenges to the cohesion of their community as well as bringing their own problems: in addition to the difficultues of adapting to a contemplative life, these young people also had to integrate into a new culture, being in many cases unable to communicate as they did not speak Spanish.

Identification with religious figures from the past: the monks identified with Christ and brave holy men, and the nuns with being "Christ's wives", the Virgin Mary and battered holy women

The main figure that both monks and nuns actively engaged with in a process of identification was Christ and the pain and desolation experienced in his Passion. Their sadness became their own "Cross", increasing the meaning and purpose of their own suffering and providing them with a sense of hope: Christ's resurrection followed the suffering on the Cross. However, there was an important gender difference in the way they identified with Christ. The nuns suffered *with* Christ, sharing and accompanying him in his Passion as "his wives"; their goal was not to resemble him, but rather they saw their role as one of lovingly offering comfort and support to Christ. The monks suffered *like* Christ, trying to assume his feelings and attitudes, and aiming to react in the way Christ himself would have done. Moreover, the monks often identified with the human side of Christ, as "he was the son of God but also truly a man" thus he - like them - also suffered due to having human experiences such as desolation, loneliness and disappointment (e.g. on the Mount of Olives, Saint Peter's negations, Judas' betrayal, etc.).

The Virgin Mary was the nuns' supreme female model and they strove to resemble her in her purity and submission to God's will. They often referred to examples from her life, relating them to their own experiences, such as the case of Sister Raquel who, when describing a time of suffering, made hers the words

of the Virgin Mary: "I am the servant of the Lord. Let it be done to me as you say".[31] The nuns' strong identification with the Virgin Mary contrasted with its absence amongst the laywomen participating in the study. Alejandra was the only laywoman who also reported having experienced this identification with the Virgin. Interestingly, Alejandra's identification was triggered by the fact that both were mothers who suffered the death of their sons. Alejandra remembered, becoming tearful in the interview, what she felt when the doctors informed her of the unexpected death of her son: "like the Virgin Mary I also felt how a painful sword pierced my soul… Mary was told by Simeon when she presented Jesus in the temple that a sword would pierce her soul. I felt it, I felt it! Like her, I felt that sword!"[32]

Besides Christ and the Virgin Mary, there were other holy men and women from the history of the Church that the monks and nuns also identified with, though the qualities of these figures were admired differently by them. The monks, especially when relating the foundation of their monastery, identified with the intrepid and adventurous monks that preceded them and that played an important role in the origins of their order; men such as Robert of Molesmes and Bernard of Claraval (for more details on these monks, see appendix 1: "Saint Benedict and the origins of the order"). In contrast with these brave monks, the nuns often

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[31] "'I am the Lord's servant,' Mary answered. 'May your word to me be fulfilled.' Then the angel left her" (Luke 1:38).

[32] "Then Simeon blessed them and said to Mary, his mother: 'This child is destined to cause the falling and rising of many in Israel, and to be a sign that will be spoken against, so that the thoughts of many hearts will be revealed. And a sword will pierce your own soul too'" (Luke 2:34-35).

identified with women from the history of the Church who were psychologically and physically abused by their husbands and who were canonised by the Church; women such as Catherine of Genoa and Monica, the mother of Augustine. The nuns used these women as exemplary testimonies of undergoing suffering when talking about how sadness should be endured with hope and faith in God. They had heard and read about them, and strived to imitate them during their own times of sadness.

4.3.5. Clergy's share their sadness with their fellow priests

Many priests explained that sharing their sadness and worries with other fellow clergymen helped them to cope. Several priests specified that they would only share their sufferings and tribulations with another fellow member of the clergy. Two main reasons were found for this preference. Firstly, their belief that another priest, with whom they had in common their vocation and who was likely to face similar challenges, could understand them better. Father Anselmo, one of the youngest participating priests, 39 years of age, was amongst those priests who would only share his problems with another clergyman: "I *only* discuss my worries with another priest". When I asked him to explain this choice of confident, he was prompt in his reply: "*only* another priest can *truly* understand another priest".

Secondly, they considered that keeping clear boundaries with their parishioners was essential, as they needed to present an image of strength and feared that a revelation of their suffering to their congregants could have been seen as a sign of weakness; their role was to assist them in their trials and not the other way round. It also became apparent that a disclosure of their feelings could make them somewhat vulnerable. The priests' relunctance to open up to their parishioners bore a resemblance with what I observed among the monks: the clergy also felt it was important to maintain their privacy and to hide their problems and distress from those closer to them (as has been explained above, the monks kept their suffering from the rest of the monks they lived with). In contrast with these views, there were also a few priests who were happy to open up to some trusted lay members of their community, with whom they tended to work on the parish's projects, and to their families and lay friends during times of suffering.

4.4. THE ROLE OF THE CLERGY IN THE CARE OF SADNESS AND DEPRESSION, AND THEIR COLLABORATION WITH MENTAL HEALTH PROFESSIONALS

Most of the findings presented here are extracted from the clergy's interviews, as this area of inquiry was a key part of their interviews. The priests were asked many questions in order to explore in-depth the help they provided to those of their parishioners who were undergoing profound sadness and depression. Their

opinions were also sought on the care offered by psychiatrists and other mental health professionals, as well as on their experiences of jointly working with them (see appendix 3, "Interview schedule"). The first and the third subsections (4.4.1. and 4.4.3) mostly compile the priests' views, while the middle subsection (4.4.2.) captures the monks', nuns' and lay people's opinions regarding the role that clergy played in assisting in cases of sadness and depression. This latter subsection attempts to complement the priests' testimonies with those most likely to seek their help in times of despair.

4.4.1. Pastoral care is provided for both sadness and depression

Most clergy saw providing help to those suffering from sadness and depression as an important part of their pastoral role

Commonly, clergy insisted that caring for those undergoing normal deep sadness as well as depression was an "essential part of their pastoral care". When I enquired in detail about how they provided this help, a broad variety of approaches and techniques employed emerged in their interviews which have been summarised in Table 19. Being a source of hope and meaning was one of the most prevalent themes: virtually all the priests stressed the importance of offering hope and religious meaning to those suffering from both normal sadness and depressive episodes. Integrating people's suffering into a religious narrative and encouraging them to live this suffering in the light of their faith was thought

to help them to transform their sadness into a meaningful experience. The priests often reminded them of Christ's own suffering, aiming to gently promote an identification with him. They also insisted on the value of sadness for achieving spiritual purification and maturation. They often suggested that people "offer their suffering" in order to achieve a favour from God (e.g. enduring one's sadness with hope and faith in exchange for the healing of a loved one). The following quotation from Father Anselmo illustrates the above:

> It is essential to accompany those who are depressed, those who are suffering from life crises, personal conflicts… Any period of sadness lived with faith gives fruit. The priest accompanies from a faith perspective, he gives hope, reassuring them that it is going to be good for them, that they can learn from it.
>
> [Anselmo, priest, 39, White Spanish, parish priest and prison chaplain]

The priests highlighted the importance of actively listening to those who approached them for help and of having an empathic and caring attitude towards them. They resorted to spiritual resources such as prayer, acts of worship, pilgrimages and religious readings. They were also alert to detect those cases in which the individual's dysfunctional religious beliefs and practices were responsible for the sadness, cases such as scruples, excessive guiltiness or holding a punitive image of God (pathological religious sadness has been addressed in section 4.2.3.).

They adopted a pragmatic approach with those people whose sadness was the result of a clear cause (e.g. family problems, health concerns or vocational crises): firstly, they normalised these feelings as an understandable consequence

of the adversity confronted and secondly, they tried to find a solution, when possible, for their sadness. Several priests were also willing to offer practical help, such as providing financial assistance, a daily meal to the poor or advice to find employment. One priest provided rehabilitation for drug addicts. Spiritual direction and confession were highlighted as two key avenues that they had to care for those undergoing sadness and depression.[33]

Generally, priests appeared confident in differentiating between normal phenomena, such as understandable sadness or religious experiences like the Dark Night of the Soul, and mental illnesses, like depressive disorders or psychoses. However, a different view emerged regarding their role in caring for those suffering from mental illnesses: while they almost unanimously argued that they could effectively help those undergoing depression, they did not feel confident in caring for those suffering from a psychotic disorder. In cases of psychoses, the priests saw their role as mainly supportive, first to the ill person and their families, and then to the psychiatrist who was considered as the main figure in the treatment; several actively encouraged engagement with and adherence to psychiatric treatment (e.g. reminding their parishioners of appointments or giving them a lift to the psychiatric clinic).

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[33] Besides explaining later on in this present subsection how the clergy used confession and spiritual direction to help their distressed parishioners, I have covered several other aspects of these two pastoral activies elsewhere in the thesis: a comparison between confession and psychotherapy was made in section 2.2.4. and the discrepancies found with regard to the sacrament of confession and to the spiritual director's level of authority were discussed in section 5.6.3.

The clergy saw themselves as playing a crucial role in accompanying those undergoing a Dark Night of the Soul. The contemplative participants and the priests were those who most often highlighted the importance of trusting their spiritual directors and of being "docile", accepting their advice on coping and making the most of this period of spiritual darkness. As we have seen previously, in section 4.2.2., the first task of the priest was to ensure that his parishioners were experiencing a genuine case of Dark Night and not a depressive disorder. Once they were convinced of the absence of mental illness, their care focused on normalising their parishioner's intense sadness and on being a source of hope and meaning. They explained that it was essential to advocate for adopting a patient attitude throughout the Dark Night in order to wait for the darkness to clear. Several participants referred to a quotation of Saint Ignatius of Loyola when talking about the need of not making drastic decisions during this disquieting spiritual stage, but rather to being patient and holding firm to their beliefs: "In time of desolation, never to make a change".[34] Father Enrique spoke about the case of a woman, who at the time of the interview was going through a Dark Night and to whom he was offering spiritual care, and reproduced some of the advice he had given her:

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[34] This is the beginning of the fifth rule of Saint Ignatius of Loyola's "Spiritual Exercises" (1548/1920, p. 328), the full quotation being: "In time of desolation never to make a change; but to be firm and constant in the resolutions and determination in which one was the day preceding such desolation, or in the determination in which he was in the preceding consolation. Because, as in consolation it is rather the good spirit who guides and counsels us, so in desolation it is the bad, with whose counsels we cannot take a course to decide rightly."

I keep telling her: "don't worry, don't worry… you are in a process… you have told the Lord that you were aiming to achieve holiness; well, the Lord is purifying you and the only thing you need to do is to let yourself be purified, there is no other option, don't rebel against the darkness, let the Lord act in you… this is part of a normal process, nothing strange is happening to you, this is happening precisely because the Lord loves you". I even try to cheer her up by telling her: "take it like the Lord is trying to elevate you and that he is purifying you in the measure he wants… let him act in you, you know that God loves you, let him act in you and especially don't force yourself to feel when you are praying what you used to feel before… if now you don't feel anything, so be it, resign yourself to it, don't force yourself… let yourself go and God will give you what you need".

[Enrique, priest, 44, White Spanish, hospital chaplain and church assistant]

TABLE 19

Clergy's ways and strategies employed to help those suffering from sadness and depression

Clergy's answers to the question: "how do you help those suffering from sadness and depression?"
- Installing hope and meaning, integrating their suffering into a religious narrative (e.g. Jesus's Passion)
- Active listening, empathic and caring attitudes, not giving up easily
- Using spiritual resources such as prayer, acts of worship, pilgrimages and religious readings
- Detecting cases in which the individual's religious beliefs and practices are responsible for the suffering (e.g. scruples, punitive image of God, excessive guiltiness)
- Normalisation of their sadness, trying to find the causes behind their suffering (e.g. family problems, health concerns, vocational crises)
- Offering practical help (e.g. providing financial assistance, a daily meal to the poor or helping to find employment)
- Helping to rehabilitate drug addicts
- Differentiating normal sadness and religious phenomena (e.g. Dark Night of the Soul) from mental illnesses (e.g. depressive disorder, psychosis)
- Encouraging the keeping of psychiatric appointments and adherence to psychiatric treatment in cases of severe mental illness
- Through confession and spiritual direction

The clergy encountered many barriers while trying to fulfil this role

The barriers that hindered priests in assisting those undergoing deep sadness and depression were varied (the main obstacles encountered by the clergy have been summarised in Table 20). Many priests blamed the growing secularisation of today's Spanish society for erecting these barriers, arguing that people nowadays were reluctant to entrust their psychological and emotional problems to them and instead preferred to seek help in a secular context (e.g. psychiatrist, psychotherapist), whereas in the past the clergy would have been their first port of call. Besides the secularisation process, recent scandals affecting the clergy have damaged the image and credibility of the Church as a place of solace and safety for those suffering from distress and sadness. Another obstacle mentioned by many clergymen was the poor or inexistent collaboration with psychiatric services; they felt that mental health professionals did not consider them to be in a position to contribute to the care of those suffering from depression. They regretted this lack of joint work, arguing that they were losing an "excellent chance to do good together".

Father Miguel and Father Víctor longed for the "coexistence between doctors and the clergy" that they had witnessed during the many years they had worked as missioners, in the Peruvian Andes and in Africa, and in the Americas and India, respectively. They explained that the local priest of the villages and small towns was routinely contacted by the doctors to administer the sacraments to their patients or to support their treatment plans. A religious conceptualisation of

suffering and a way of coping filled with religious meaning was fostered and supported by the sick, their relatives, the parish priest and most of the medical staff caring for them: "religion is everywhere there, here [Spain] it is being lost". They also agreed that sadness was often understood as a result of adversity, that depression was diagnosed by doctors far less often than in Spain and, when it was diagnosed, the cases were more severe.

Some participating priests held the Church itself as being partly responsible for hindering the pastoral care they could offer to those suffering from sadness and depression. Considerable ideological diversity was found amongst the clergy, with some making a very critical assessment of the current state of the Church and priesthood, while others had more conservative and less critical views. Their lack of training in mental health was most commonly recognised as the main barrier that held them back from providing care. None of them had received formal training in the assessment and management of mental illnesses nor in psychotherapeutic techniques during their formative years. They worried that the current training provided in the seminary ran the risk of producing priests who could "just apply recipes" and whose practice was "full of reductionism". Thus they argued that the training provided in the seminary was in need of a "drastic reform" and proposed a more "holistic" and "pragmatic" approach to their training, something "less minimalist", "simplistic" and "patchy", which would give priests both a good grasp of psychology and basic psychotherapeutic skills. The frustration and sense of urgency transmitted in their responses regarding the inadequacy of their training was not translated into the expectation that

something might change in the near future. They seemed to have resigned themselves to the seminary's teaching programme continuing as it is for quite some time, as they were not optimistic about the proposed changes taking shape soon, blaming "the static nature of the Church".

Finding a satisfactory balance between being caring and intruding into the private matters of their parishioners stopped several clergymen from offering support to those suffering from deep sadness and depression. While some priests felt more at ease directly approaching a parishioner who appeared to be sad or depressed, others did not feel comfortable doing so and waited for their help to be requested by the individual or the family. A few priests warned that certain members of the clergy used their lack of training in mental health as a reason - "an excuse" - for not getting involved with those who suffered from psychological and emotional distress. They argued that if a priest felt in need of further training to be able to completely fulfil his pastoral responsibilities it was his duty to pursue additional training to gain the needed skills. They were critical of priests "hiding behind their poor training", and argued that this might mask the lack of a truly caring and compassionate attitude towards those around them.

However, admitting to the inadequacy of their training did not seem to stop most of the priests from helping their parishioners who were undergoing deep sadness or depression, as they strongly felt this to be part of their pastoral duty. The clergymen's determination not to lose any more power and influence over people still willing to seek their advice emerged strongly in their testimonies.

They were clearly reluctant to hand over the care of those afflicted by sadness or depression to mental health professionals. They were quick to stress the importance of faith as a powerful healing agent, which helped compensate for the shortcomings of their training. Offering a faith perspective to their parishioners' suffering was thought to be something "truly therapeutic"; they provided many examples of people they had helped to endure their sadness by encouraging them to place their trust in God. In Father Jesús' words: "faith is such a good therapy! You can achieve so much through faith!" They felt equipped to help many of their congregants through their trials and tribulations by skillfully applying the Gospel's teachings; they relied confidently on its therapeutic potential to respond to the psychological needs of their parishioners: "you have very useful resources in the Gospel's revelation", "I find ways to help [those in distress] from the wisdom emanating from the Gospel".

Besides mental health, two other areas of deficient training were identified which hindered the clergy in assisting their parishioners in spiritual and emotional crises. Several priests thought that the clergy nowadays needed to be more skillful in explaining their faith in order to be able to sustain a dialogue about religious beliefs with lay people; they were critical of some priests expecting their parishioners to invariably agree with their views and to follow their advice without question ("always saying 'yes' to the priest"). Helping their parishioners with their matrimonial and intimate relationship difficulties was the other area that some clergymen admitted to struggling with: the deficiency of training in this area was accentuated by their celibacy.

Priests' lack of time often emerged in the interviews as an important obstacle to offering a more personal pastoral care to their parishioners; they frequently felt overwhelmed by other ecclesiastical duties that took much of their time, such as administering the sacraments (some explained that they had to cover more than one church due to the current shortage of priests and had to travel considerable distances to other villages and towns). There was a sense that although they considered offering this individualised pastoral care very important, they had to "find the time" for it in the midst of responding to many other demands. A few priests argued that relying more on the lay members of the parish church could free priests of some of their pastoral tasks by allowing them to be more available to offer spiritual care on a one-to-one basis.

Most lay participants saw an increase in their participation in church matters as something positive and enriching for the life of the parishes. For example, Amparo, a 47-year-old secretary, received excellent feedback from her fellow parishioners regarding her role as "extraordinary minister of the holy communion"[35], an activity that allowed her to take the communion to the sick of her parish: "many elderly people had told me 'Amparo, I prefer you to come [to

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[35] An "extraordinary minister of the holy communion" is a lay person committed to the Catholic Church who helps the priest in the mass and has the specific task of administering the consecrated host to the parishioners. It is implied that the lay person will undertake the necessary training to undertake this task. This role was stipulated in the canon 230 of the canonical law and was introduced by the liturgical reform that followed the Vatican Second Council through the pontifical document "Immensae caritatis" in 1973. It specifies the cases in which an extraordinary minister should be used: firstly, when there is not a priest available to administer the communion; secondly, when the priest can not do so because he is ill or elderly or has to attend to other ministerial tasks; and finally, when the great number of parishioners waiting to receive the communion would lengthen the mass excessively or when the parishioners need to receive the communion outside the church (e.g. when they cannot get to the church due to being sick or elderly) (Vatican, 2013b).

bring the communion], I wish Father Teodoro[36] [the parish priest] would not come, I'd rather have you coming to see me because I can't explain anything to Father Teodoro, the only thing I can do with him is confession… talking to you [when Amparo brings her the communion] does me a lot of good!' You see they tell me for example that they have argued with their children or whatever is bothering them... I am not in a rush".

However, a few priests and a small minority of lay participants took a dim view of the increasing participation of the lay people in the parishes. These priests feared that it could mean a relinquishment of their control and power over the running of their parishes: "it could get out of hand". The reasons offered by the lay people to justify their reluctance regarding lay participation in the church were mainly two-fold. Firstly, some argued that the priest was the one who was more prepared and in a better position to attend to the needs of his parish: "the shortage of vocations for priesthood scares me a lot because having the church in the hands of lay people scares me a lot… I think that some lay people seem to think that they know everything. We are all prepared to help in the church but for me, the priest is the one who has the authority, who can help you best… they have a special vocation". Secondly, a few were critical of the priests delegating some of their tasks to their lay parishioners for the sake of their own convenience: "if there were no priests in my parish church, I would understand it [relying on the help of lay people] but we have four priests! Four priests! And we have lay people in my parish doing lots of the things priests used to do, for

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[36] This is a pseudonym to keep the priest's identity confidential.

example, they have asked some lay people to take the communion to the sick…
and I don't agree with this… I think they [the priests] are growing a little too
comfortable".

Those priests who had consistently showed a more critical attitude towards the
Church and priesthood throughout their interviews identified the following three
barriers. Firstly, the lack of emotional well-being of certain members of the
clergy and their rather widespread feelings of loneliness were thought to hinder
the emotional availability necessary to help others. Many priests recognised that
feeling lonely was one of the hardest parts of their vocation to endure. A couple
of priests particularly referred to the "loneliness felt on Sunday afternoons" as a
good example of their loneliness, as the parish was closed then - the mass being
celebrated in the morning - and the priest was left alone. The importance that
maintaining and cultivating the links with their families and friends had for their
emotional and psychological well-being was often highlighted. Several priests
stated that the best remedy to keep feelings of loneliness at bay was to spend
their free time with their families or with the "big family of the parish church"
rather than alone in the vicarage. A few priests mentioned that they regularly
joined their families or members of their congregation for meals or other
recreational activities (e.g. having lunch on Sundays, taking their nephews and
nieces to a museum).

Secondly, some denounced what they called the "professionalization of
priesthood", meaning that being a priest was becoming more a "job" than a

"vocation". They condemned some sectors of the clergy for their lack of social commitment to those who suffered, for not having the necessary motivation to reach today's society, and for having grown "too comfortable". Some older priests were critical of the younger generation of priests as they felt that they were more interested in the ritual aspects of their role, such as administering sacraments and participating in religious processions and festivals, than in serving those who needed them most: "they [some young priests] love the sacristy, the table-cloths, the incense… rather than being committed to the poor!" Moreover, those participant priests who were actively involved with social causes (e.g. helping in prison, providing daily meals to migrants, rehabilitating drug addicts) felt they were frowned upon or even openly criticised by other fellow members of the clergy who had more restricted views regarding the role of the priest. Amparo, a laywoman who was very committed with her parish church, also denounced some younger priests' shortcomings; she gave the specific example of her parish priest: "older priests tend to have more gentleness and are able to respond to their parishioners' needs better than the younger ones… they [the latter] don't want to face difficulties, they don't want trouble… for example, my parish priest, who is a young man, has told me that he can't visit the sick, I would tell him, please make an effort, but he would become white, pale, he would feel sick just by seeing them".

Finally, some priests complained about not having a support network in place within the Church to help them in their multiple tasks. They argued that the parish priest often ended up doing most of his work in isolation, unable to count

on the help of senior priests who could share their knowledge or lay members who could assist him with many practical aspects of running the parish. This lack of companionship and guidance was higlighted as a contributing factor to "the current tiredness of the priests". Moreover, several priests were concerned about the absence of official supervisory structures and missed not having regular supervision sessions with experienced priests from whom to seek advice, especially when dealing with challenging aspects of their work.

When the clergy were specifically asked about what avenues to receive supervision they had in place to support their pastoral care, virtually all of them answered that they did not have anything formally arranged for them and that it was up to them to arrange it for themselves if needed. They explained that the individual priest had to take the initiative to seek and request the help of a trusted more experienced colleague. As Father Daniel said: "you need to sort it [supervision and support structures] all out yourself". Many priests commented how beneficial it could be for them to have ready access to supervision structures already set up, rather than having to look for them themselves. They particularly felt the need for this when they faced tensions, disagreements and divisions within their parishes or when caring for their parishioners made them feel "out of their depth", such as when they tried to help them with mental health problems or with matrimonial or family crises. Several priests were of the opinion that having regular supervision should be compulsory for the junior members of the clergy, as they argued there was a big gap between the theoretical formation that they received in the seminary and the reality they

encountered in their parishes. A few priests were critical of the lack of support provided by their local bishops, in Father Víctor's words: "the problem is that bishops are not shepherds anymore! They [bishops] have left priests [he was referring particularly to those involved in missionary work] abandoned and forgotten!"

Father Jesús: a narrative of social commitment

Father Jesús illustrated many of the points mentioned above offering one of the most compelling narratives of social commitment found amongst the clergy. Although he was not amongst the youngest priests participating in the study - he was 73 years old and had been a priest for 40 years -, he prided himself on "being a priest in tune with the needs of a 21st century parish". He was a priest with a strong personality and was certainly blunt in his critical analysis of the current state of the Church and the clergy. He thought that providing individualised care to his parishioners who were going through distressing times was a key part of the priest's pastoral duties; the importance he felt for this task was reflected in the words he chose to describe it: "for me, it's a true sacrament". He set up a service to help drug addicts to rehabilitate themselves with the help of a married couple who had experience in this field. Interestingly, it was Jesús himself who took the initiative to approach this couple and request their help, as they had previous experience in helping drug addicts, which he

lacked. This service filled a gap in the community, as it was the only one of its kind in town.

He was a good example of a priest from on older generation who managed to adapt to the needs of his community and to establish a fruitful collaboration with lay people: "we [referring to the lay couple he worked with] are a great team!" They helped more than a hundred drug addicts over the years; He described several cases to illustrate their commitment, many of them involving desperate phone calls, often in the middle of the night, from parents whose son or daughter were withdrawing from a drug (mostly from heroin). He responded to these calls for help by getting out of bed, going to their home to "see what I could do for them". Besides providing personal accompaniment and support throughout their rehabilitation process and in particular in the difficult withdrawal stage - "sometimes you just have to hold them in your arms, there is no point in giving them a spiritual lecture" -, he also offered practical help to reintegrate them into society: paying their debts with money collected in the parish or even with his own money, using his influence and contacts to find them employment, and encouraging non-addicted young people from his parish to befriend them and ask them out.

He was also one of the priests who expressed more critical views regarding the excess of self-satisfaction and lack of social commitment of some of today's clergy: "priests need to leave the sacristy and commit themselves to social issues; less incense and more social commitment!" However, many of his fellow

priests did not support his way of living his priesthood and censured it: "many of my colleagues tell me that I am mad, that why do I have to get myself into these scrapes [helping drug addicts]?" He answered them in the following manner: "OK, maybe it's madness but it is a blessed madness!" or "very well, you go on blessing the old devout women in your parish and I will continue with my work, but I am telling you that you are stuck in the Council of Trent and I have moved on to the Second Vatican Council!"[37] Once more Father Jesús emphasised that he was up to date with the new winds of change in the Church, stirred by the Second Vatican Council and, more importantly, that he was responding to the problems afflicting today's society, while the priests who criticised him still maintained the views held by the Church in the past, as illustrated by the 16th century Council he referred to.

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[37] For more information about the Council of Trent and the Second Vatican Council, see appendix 1.

TABLE 20

Barriers that the clergy encountered when they tried to help those suffering from sadness and depression

What are the barriers faced by the clergy when trying to help those suffering from sadness and depression?
- The growing secularisation of society and people's reluctance to trust the clergy with their psychological and emotional problems, preferring to seek help in a secular context (e.g. psychiatrist, psychotherapist)
- Recent scandals affecting the clergy that have damaged the image and credibility of the church as a place of solace and safety
- Poor or nonexistent collaboration with mental health professionals
- Lack of training in the assessment and management of mental illnesses, psychology and basic psychotherapeutic techniques
- Difficulties in finding a balance between being caring and intruding into the private matters of their parishioners
- Lack of time and feeling overwhelmed by other ecclesiastical demands (e.g. administering sacraments in more than one church)
- Their own lack of emotional well-being and feeling lonely
- Professionalization of their vocation: lack of motivation to serve those who are suffering
- Priests who are more socially committed are negatively perceived by other members of the clergy who have more restricted views regarding the role of the priest
- Feeling isolated: lack of a support network and supervisory structures to help the priest with the demands of his parish

Spiritual direction and confession are considered effective ways to help those undergoing psychological, emotional and spiritual distress

In general terms, the priests maintained two types of relationships with their parishioners. They cared for the majority of them by administering the sacraments, such as celebrating the weekly mass, christening and giving the first communion to the children, marrying couples and giving the last rites to the dying. However, they could also offer a much more personalised care to those with whom they regularly met on a one-to-one basis in order to provide spiritual direction, or during confession (those who just confess sporadically were not included here but in the first type of relationship). Administering the sacrament of confession and providing spiritual direction were considered essential aspects of their pastoral care. Moreover, most of the priests particularly cherished and enjoyed these tasks, as they found them very fulfilling. The priests explained that these activities allowed them to gain a deeper knowledge of their parishioners and gave them the chance "to do more good" by developing a more personal relationship with them.

When I asked the priests to explain what the sacrament of confession (also known as the sacrament of penitence or reconciliation) entailed, it became clear that there was not a unanimous agreement amongst them. Their explanation had in common the three main requirements of penitents in order to have their sins absolved by the priest: experiencing contrition for the faults committed, disclosing them to the priest and finally undertaking the "penance" given by the

priest to make amends for the sins, such as saying some prayers. However, most priests added a new dimension to this sacrament by offering spiritual accompaniment to those who approached their confessional. They argued that this could have positive effects in the penitent's spiritual, psychological and emotional well-being that went beyond the feelings of peace and relief that followed the forgiveness of sins. They insisted that for this sacrament to have therapeutic value the priest had to move from listening to the penitent's faults and setting a penance to providing a serious spiritual mentorship that could foster beneficial change and growth. Many priests insisted on the importance of making those undertaking this sacrament feel accompanied, supported and understood by their confessor. They strongly felt that the priest should create in the confessional an atmosphere of trust in which the dialogue taking place there could flow like an intimate conversation in which the penitent could find solace and understanding as well as sound advice and an objective perspective from "a senior spiritual brother who knew you inside-out" and "cared for you deeply". Father David illustrated this view:

> Well, in confession you tell your sins to the confessor, fulfill the penance and receive the absolution… however, I soon realised that what people needed was not just this, but also someone willing to listen to them and someone that understood them even if not necessarily agreeing with them... they could get someone else's views and feel accompanied and supported. I think that this is an auxiliary function of confession: not just being absolved from sins but also, at the same time, receiving the human support that the person needs.
>
> [David, priest, 63, White Spanish, parish priest and lecturer]

Moreover, hearing their parishioners in confession offered the clergy an excellent opportunity to assess their state of mind and to know when they were going through a time of deep sadness or suffering from a possible depressive episode so they could accompany and support them. Several participants went beyond praising the therapeutic potential for maintaining mental well-being in the kind of confession that also included spiritual mentorship to suggest a possible cause-and-effect relationship between people's currently moving away from the sacrament and the perceived increase in emotional and psychological problems in today's world. They argued that many of life's tribulations and psychological afflictions, which had been effectively dealt with through frequent attendance to the confessional, were nowadays taken to the medical arena, consulting psychiatrists and other mental health professionals:

> Since people do not come to the confessional and do not seek spiritual direction, many problems of emptiness and depression have appeared, as people do not have spiritual support.
>
> [Jesús, priest, 73, White Spanish, parish priest]

Although adding a layer of spiritual direction to the sacrament of confession was the most prevalent view, several priests and a few contemplative participants vehemently insisted that the sacrament of confession and spiritual direction should not take place together. Moreover, they actively discouraged any diversion from the penitent's sins during confession, such as attempts at conversation: "confession is confession, if you want to talk then we will meet later". They worried that engaging in spiritual accompaniment could lead to losing focus of the main aims of the sacrament: disclosing ones faults, receiving

forgiveness and being willing to try not to fail again. They insisted that spiritual direction and other more informal ways of communicating with the priest (e.g. seeking advice about their problems, letting him know about some important changes in their lives) should happen outside the confessional.

When I asked the participants who were at the receiving end of the sacrament of confession - lay people, nuns and non-ordained monks - which type of confession they preferred (with our without spiritual accompaniment), a predominant view clearly emerged. Although they did not deprecate the sacramental value of the confession and the positive feelings of peace and relief triggered by the forgiveness of sins, the majority much preferred a confession which was open to a spiritual accompaniment in which they could "pour their hearts out to the priest" and talk to him about their spiritual as well as secular concerns rather than making a routine enumeration of their sins. Contrasting with the vast majority of the lay participants who were not bothered about the barriers between confession and spiritual direction becoming blurred, a laywoman, Paula, stood out, as she supported a more rigid conception of this sacrament:

> Although I may seem very modern in many areas, I am very traditional with regards to confession… for me, really, kneeling down in the confessional, in front of a priest who, of course, is acting in the name of Jesus and is forgiving me for my sins is something utterly incredible!

> We do need to differentiate between the sacrament of confession and spiritual direction… they are two different things: during confession you tell your sins, your faults, and you receive the absolution, it's great, isn't it? And then, once the confession is over, if you want, you ask to talk to the priest to receive spiritual direction.

[Paula, laywoman, 47, separated, White Spanish, housewife]

Although the priests explained that the spiritual accompaniment offered to their parishioners varied depending on the willingness and the needs of each individual case, most of them differentiated a more formal type of spiritual direction from the more casual one that took place in the course of confession. This more intense type of spiritual direction warranted a much higher level of commitment in terms of time, trust in the spiritual director and adherence to the process of spiritual growth. Moreover, prior to the start of the spiritual direction, they had to reach an agreement regarding the regularity of their meetings, the specific times for the appointments, and the overall length of the process. Although this type of spiritual direction tended to take place outside the confessional (often in the priest's office), confidentiality was also maintained by the priest.

Several priests and monks made a further distinction amongst those seeking to engage with this more formal type of spiritual direction: those who approached the priest mainly for spiritual and emotional help during life crises that rocked their faith and religious beliefs, and those whose primary goal was to mature spiritually. The priests provided examples of men and women to whom they had offered spiritual direction to illustrate both types. Father Lluc's ongoing spiritual

direction to two sisters served as an illustration of the latter type. These women had undertaken private vows to remain celibate while working actively in the chemist shop they owned.[38] He knew them very well, as he had been meeting them individually, once a month, for many years. His main role was to help and guide them in the long term to achieve their spiritual potential. He praised their commitment to perfect their spiritual lives and the high level of trust and understanding their relationship had gained through the years.

Andrés, a lay participant, also illustrated this modality of spiritual direction, but in this case he was the one receiving the spiritual accompaniment himself: he met regularly with a priest for many years. He explained that in the initial sessions they set up spiritual goals to work on, one of the main ones consisting in restructuring his "negative and demanding image of God", which was causing him great distress and anxiety. The long-term help provided by his spiritual director was key in changing this image of God, which was deeply embedded in him: "I had to let go of my old image of God… now my image of God is much more free, he [God] accepts me unconditionally regardless of what I do… it is

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[38] Religious vows have been explained in sections 4.1.3. and 4.1.4. (for the monks and nuns respectively), including the difference between "solemn vows" and "simple vows". The monks' and nuns' vows are "public vows" meaning that they are regulated by the church. As has been described, they attached great importance to the ceremonies of profession of vows which are also attended by their relatives and friends. Conversely, the religious vows of these two women whose spiritual director is Father Lluc were "private vows", personal promises made by the individual on their own terms (Arzobispado de Valencia, 2013). Similarly, Brother Robert was committed to living a contemplative life in the monastery bound also by "private vows" which he individually renews with the Prior once a year. Brother Robert - as well as these two sisters - do not need to apply for a dispensation from the Holy Office in the Vatican if they wish to break these private vows unlike those who were "solemnly professed".

OK to try to help others but he doesn't demand that I change the world… my image of God is now much more liberating". Regarding the other type of spiritual direction (the one motivated by life adversities), the priests provided many examples of the reasons given for requesting their spiritual assistance, such as the unexpected deaths of loved ones, severe illnesses, serious financial trouble and marital and family problems.

The priests acknowledged that not all their experiences of providing spiritual accompaniment had satisfactory outcomes. The main causes for spiritual direction to fail were lack of engagement with the process, not attending and not following the priest's guidance: "there are some people that, as soon as you start disagreeing with them and advise them to change, just disappear". The priests explained that those whose main motivation for undertaking spiritual accompaniment was to deepen their relationship with God were more likely to be succesful than those who pursued it to cope with life's misfortunes. The former tended to be more committed to perfect their spiritual lives and to unreservedly place their trust in their spiritual director. The individual's personality was also thought to play an important role in the success of the spiritual direction: being more mature, having adaptive coping strategies and being able to sustain deep and lasting personal relationships facilitated the process.

Many participants stressed the importance of finding the "right person" for the role of spiritual director, as they argued that it was essential to find someone

who could truly understand and help them. Much thought and effort was generally devoted to this task: some asked for the opinion of someone who knew the spiritual director well while others advocated the need of meeting several priests before choosing one. However, a few participants opted to leave this selection in God's hands; such was the case of how Leonor found her spiritual director:

> I went to the cathedral [she was trying to relieve her distress following the break-up of her marriage and wanted to find a priest to help her], I well remember that I kneeled down there, I saw the confessional... I asked the Lord, "shall I confess or not?" [it had been a long time since her last confession] so I told God, "send me a sign". I closed my eyes asking him, "what sign are you going to send me?", I felt like I was losing my head… how was he really going to send me a sign there just because I asked him… it sounded mad.... well, he did!, as soon as I turned around I saw that the priest in the confessional was reading the same book - "With New Eyes" -[39] that I had just finished reading. Look, there are so many many many books in the world, and he was reading that particular book!... well it gave me goose pimples… I knew he was the priest who could help me.
>
> [Leonor, laywoman, 41, separated, White Spanish, teacher]

Being spiritually advanced and having psychological knowledge were characteristics highly regarded in a spiritual director, as Andrés, layman, explained: "I started several spiritual accompaniments, I was not happy with any of them… it was not easy, it took me a while to find the right person who understood me: he was experienced spiritually and had the science too, he was a

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[39] This autobiographical book, "With New Eyes: The Story of her Return to the Fold", written by the aristocrat Alexandra Borghese relates her years distanced from the Catholic faith and how she rediscovered God, which led to a radical change in her life (Borghese, 2006).

trained psychologist". Some participants apply their concerns regarding the clergy's lack of psychological training, explained in the previous section, to the particular cases of confession and spiritual direction: they lamented that the mainly theoretical knowledge received in the seminary did not equip them to confront the many challenges that confession and spiritual direction posed. The following quotation illustrates this with regards to confession:

> You are taught the theoretical part of the sacrament of penitence but nothing on how to treat the person; we need much more training on this… the training only focuses on the sacramental dimension, the liturgical side… we are taught how to administer the sacrament but nothing on the most important things: how to listen to the person, how to make the person feel understood… we are only taught the technical part of the sacrament.
>
> [Miguel, religious priest, 60, White Spanish, head of the office offering pastoral care for migrants]

Two lay theological students, Andrés and Sergio, offered a possible "solution" to the lack of specific training to undertake spiritual direction. Andrés was a teacher and Sergio was a psychiatrist, both were 40 years old, married and with children. They both brought up in their interviews that they were attending a three-year-course in spiritual accompaniment run by several monks of the Franciscan Order (it became apparent that they were referring to the same course). They were in the first year of this course, as it started a year ago. Only 25 students were admitted into the training, with several candidates being turned down because there were not enough openings to accommodate them. There will be a new call for entrants in two years time when the first year students conclude their training. The academic programme covered the three domains thought to be

essential when guiding people through their spiritual journeys: the spiritual, the psychological and the existential. It also included the study of the Church's tradition of spiritual direction, paying particular attention to three mystics: Saint Theresa of Jesus, Saint John of the Cross and Saint Francis of Assisi. There was an important practical component, and students were encouraged to discuss their cases, which were supervised by their teachers, in the workshops set up for this purpose (they had a strict confidentiality code). This course was open not only to priests, monks and nuns, but also to laymen and laywomen. Andrés and Sergio strongly felt that "providing spiritual accompaniment was not an exclusive ministry of the clergy". They believed that lay people, with the necessary training, could fulfil this role in their parishes as satisfactorily as the priest and could even add a valuable dimension to it as "we lead ordinary lives, and are in the world with our spouses, job, children… we are placed in an excellent position to undertake this task". They both used the word "vocation" to describe their willingness to become spiritual directors; in Sergio's words: "this [training] has given me the opportunity to strongly fulfil my vocation as a lay person because I used to feel that not being a priest or a monk I was missing something… but now I can see my future in the Church, providing spiritual accompaniment". When I asked them about how they foresaw lay spiritual directors being received in their parishes, they bluntly responded that they were unsure about the reaction of the parish priest and parishioners and admitted that it was likely to take time for them to be fully accepted.

4.4.2. Views on the clergy's pastoral care from the perspective of contemplative participants and lay people: benefits, critique and comparison with the monks

Clergy's pastoral care at its best can have a very positive effect on those suffering from sadness and depression

As I have detailed previously, the majority of participants considered most cases of normal sadness and depression - with the exclusion of the more severe forms of depression - resolvable within people's religious, social and cultural resources, and especially with the ongoing support of their families and spiritual director, confessor or parish priest. Lay theological students, the monks and the nuns, repeatedly stated that good devoted pastoral care could be extremely useful in helping people suffering from deep sadness and depression to cope with and resolve it. Visiting the sick and the dying was also regarded as a central part of priests' pastoral care, which involved not only bringing the communion to those who were not able to go to church, but also spending time by their bedside providing comfort, hope and warmth. Convincing testimonies of positive experiences of clergy's pastoral care were given by some of the participants. They praised it in the following eloquent manner: "they create spaces of life where there wasn't any life" or paraphrasing Saint Francis' words "where there is sadness, they bring joy, where there is despair, they bring hope".

Having a parish priest who was willing to listen to their feelings and worries sympathetically and who could advise them wisely was highly appreciated. The following attributes in a priest were much valued: their empathy, fraternity, sensitivity, their ability to make others feel safe when talking about very personal matters and their unconditional regard for those in need. Being available when needed was the most valued characteristic of the clergy. In contrast with mental health professionals, a devoted parish priest did not help others "for the money" or for its being "their professional duty", but rather for their "vocation of service", something inherent to the priesthood; thus their motivation to help others "came from God", as God called them to become priests in the first place. Similarly, Father Víctor drew a categorical difference when comparing both professions, arguing that unlike mental health professionals, "priests were God's instrument".

When lay and contemplative participants were asked to describe how priests had supported them when they had suffered from deep sadness or depression, several similarities were found with the clergy's descriptions of the ways they used to help those under their spiritual care. Most importantly, the priests helped them to find meaning to their suffering, which made it easier to endure, since they thought of it more as an invitation for spiritual purification and personal growth. They gave them hope and reminded them of their faith in their moments of doubts and confusion. The priests often referred to religious narratives of saints and martyrs, and particularly to Jesus's own pain during his Passion and crucifixion as examples of trusting God when one was subjected to great distress

and adversity. Encouraging sufferers to pray and to receive the sacraments frequently were activities often recommended by the clergy as they believed that those in need could particularly find solace in the mass and in the sacrament of confession. Priests' home visits with the specific aim of comforting and accompanying people in their suffering were highly valued and tended to happen when they were very unwell, such as in the case of a severe depressive episode in which the individual was unable to go out.

Those participants more religiously committed, particularly the contemplative participants, regarded the spiritual accompaniment provided by their spiritual directors to be the most comprehensive and intense avenue to receive individualised guidance to successfully face and overcome their times of sadness and depression. This was the case of Father Jordi, a 66-year-old monk from the Monastery of Sant Oriol, who had suffered from several "bouts of depression". He explained that he felt "very ill" and believed that he had had a predisposition for "suffering this illness" since he was a young man: "this [illness, referring to depression] is something I have that comes and goes". According to current psychiatric classifications, his symptomatology would have likely fulfilled criteria for a moderate depressive episode: he clearly remembered having suffered from low moods, lack of energy, insomnia, poor self-esteem, despondency, deep sadness and anhedonia; each "bout" lasted for a period of at least a month and up to a year. His narrative differed from most of the other narratives of depression that unfolded in the course of the interviews: although he used a medical model to conceptualise his suffering and considered that he

was undergoing an illness and consulted with a psychiatrist once and with his general practitioner a few more times, he never pursued a medical help-seeking path. He sought neither psychotherapy nor took antidepressants, and instead opted for "putting himself in the hands of his spiritual director". He argued that he could not have shared the spiritual aspects of his illness, such as for example the impact that it was having on his vocation or on his relationships with his fellow monks, with a mental health professional as he could with his spiritual director. He talked extensively about this man whom he completely trusted, who he said was very knowledgable about the "mind and the spirit" and knew him (Father Jordi) deeply. Father Jordi described his help as having been crucial over the years in helping him to cope with and resolve his episodes of depression.

The actual care provided by the clergy to people undergoing sadness and depression often fell short of what it could have ideally been

Some non-ordained participants were sceptic about the clergy's pastoral care being able to make a real difference to the lives of their parishioners. The more critical participants argued that the majority of parish priests did not meet fully their parishioners' spiritual and psychological needs, and that the care they could feasibly offer to their parishioners suffering from deep sadness or depression was limited. Idealised depictions of priests were scarce, and the majority of participants held realistic views of the clergy's limitations and weaknesses.

When the lay people, the monks and the nuns were asked about the reasons behind clerical pastoral care falling short of what it could ideally be, many similarities were found with the barriers recognised by the priests themselves (barriers to pastoral care encountered by the clergy have been described in section 4.4.1.). The main ones highlighted by both parts were clergy's lack of time for meeting the individual needs of the congregants and their lack of psychological training. Regarding the former barrier, many lay and contemplative participants were ready to excuse the deficiencies of the clergy's pastoral care in the light of their many duties. Regarding the latter, although criticisms of the priests' lack of psychological knowledge were widespread amongst the participants, only a few questioned the clergy's ability to fulfil their roles without acquiring these skills and appealed to their personal responsibility to remedy it by seeking additional training. Those participants with specific training in mental health worried that the priests' limited instruction did not equip them with the necessary skills to rule out mental illness and to discern "how far they could go before referring someone to a [mental health] professional"; these participants were amongst those expressing a stronger urgency in introducing remedial measures in the clergy's formal training. Martín's quotation illustrates this common concern:

> For me there are three subjects that are fundamental in the clergy's training: theology, philosophy and psychology. Regarding the third one, if you take their training programme, there is very little, very little… the priest's mission here is to serve, and in order to serve he must know about psychology, he must be able to get close to people, and I do sometimes rebel against their lack of skills to do so… because I see certain priests, I see certain parish churches… and I rebel against how little they [priests] approach people… a priest should be able to assess a

> person's state of mind… he is in a position to see who amongst his parishioners looks downcast, who is feeling sad… And he should then try to approach that person.
>
> [Martín, layman, 55, married, White Spanish, he worked in a bank before taking early retirement]

The case of confession illustrated well some of the limitations of clergy's pastoral care: many lay participants regretted that confession was often "rushed", as priests did not have the time for more than going through the ritual aspects of the sacrament (listing one's sins, being given a penance and being absolved). There was a sense of a "lost opportunity" in what happened in the confessional, as many participants would have wished it to be a more conducive space for a more personal interaction with their confessor in which they could bring up their problems (examples of secular and religious problems they would have liked to share in the course of confession were given, such as relationship difficulties or spiritual doubts). Requesting a later meeting with the priest, separate from the confession, to allow this to happen was not always easy due to the hectic timetable of the priest. Magdalena considered her confessor to be "exceptional", she regarded him as a model of patience and compassion. She explained that he spent "hours and hours listening to people" and called him "a saint" and "a martyr of the confessionary". In the way she praised him there was an implicit criticism of those priests who did not possess these qualities: "his forbearance is infinite, he has so much patience, he is understanding, sweet, he puts up with so many people that others [priests] would send packing".

A few lay participants and monks had much to say about priests' lack of commitment towards their parishioners. They felt that they had become "too comfortable", in that some priests hid behind their many occupations purposely to avoid "headaches". They argued that in such cases it was not so much a genuine lack of time but a lack of having an attitude of service. They described cases of priests who, although they were very busy, found the time to help their parishioners in need. For example, Amparo, a single laywoman, praised her priest's availability:

> I always say that he is a priest for 48 hours a day not for 24 hours, what I mean is that it doesn't matter at what time you call him, he will be there for you... whatever the time he is available and on top of everything. He is not only a teacher in the local school, but also the poor man runs two parishes and even managed to study anthropology at university two years ago… and he still has time to be with us, and help us… however, you do find other priests who are far less busy than him who don't have the time to meet with you when you are not working and are only available to see you during office hours when you can't make it because you are at work.

> [Amparo, laywoman, 47, single, White Spanish, secretary]

Along these lines, some participants argued that some priests needed to "rethink their priorities" and give more importance to being available to their parishioners and to offer them more individualised care, particularly when they were going through distressing times. The following quotation from Sergio, a lay psychiatrist, captured this demand: "they [priests] should be there when their parishioners need to talk, need to be consoled, comforted, when they need some advice… they should dispense with other commitments which are not really top priorities. For me, personal contact should be a fundamental task for the clergy… I would even go as far as to say that they should cut down the number

of masses they celebrate!" Several participants felt let down by their parish priests' lack of help in their times of need. For example, María and her sister - both very devout and committed to their parish - were disappointed and saddened by the fact that they did not receive any visits from the two priests of their parish when both their parents became terminally ill and were admitted to hospital (the sisters practically "lived at the hospital" for over a month as they accompanied their parents until their death). These two single women were involved in many of the activities of the parish - from being catechists to cleaning the church - and "could not understand" why the priests did not make the time to visit them during those incredibly anxious and distressing weeks.

Those most critical amongst the lay participants and the majority of the monks referred to the clergy's lack of spiritual maturation, as their commitment to spiritual growth took a back seat to their other parish duties. In contrast with the parish priests, the monks devoted most of their time and efforts to their spiritual maturation, as they did not have all the work involved in running a parish. Some lay men and women argued that although priests had enough "intellectual knowledge" and "education", they could be lacking in "spirituality". Clergy's commitment to their own spiritual development was considered crucial: "if a priest has knowledge and is also a man of deep spirituality, a man of prayer, something special flows from him, you notice it... he will do a great deal of good to those around him". Father Francisco, a religious priest belonging to the Dominican Order with an expertise in meditation and eremitic spirituality, talked

extensively about the importance for the clergy to work seriously on their own

spiritual maturation in order to be able to help others:

> Acquiring self-knowledge, getting acquainted with the deepest part of yourself, spending time in silence… it's so important! For being able to create space in yourself, for welcoming God's mystery and your fellow brothers and sisters, you have to reach the deepest part of yourself and empty it of yourself, if you have not reached your inner self and created a space for God and those around you, how are you going to have space to take others in? You have to get rid of your own baggage first.
>
> [Francisco, religious priest, 65, White Spanish, theologian and psychologist, prior of his community, he is frequently in demand to give spiritual retreats]

Father Eusebio was critical of both priests' and monks' emotional and spiritual

maturation: he voiced his concern that for many of them, the accumulation of

theoretical knowledge was not accompanied by true personal maturation. Father

Eusebio, a religious priest belonging to the Augustinian Order, was the head of

his community. His religious order was not a contemplative one like the one the

monks from Sant Oriol belonged to, but an active life order.[40] He held a job as a

lecturer in theology and shared a flat with other members of the order. He

explained that he had first-hand knowledge of the state of the spiritual and

affective well-being of priests and monks, as he was often asked by them to

conduct spiritual retreats. He stated that their formative years did not prepare

them to meet the affective and emotional demands of their future life. Thus he

advocated offering routine psychotherapy sessions to those training to become

priests and monks throughout their formative years in order to support their

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[40] As opposed to the Augustinian nuns of the study who were contemplative, there are no Augustinian monks devoted exclusively to a contemplative life.

emotional and psychological development and to help them discern if a religious and celibate life was the right path for them. He even recommended those who wanted to become priests or monks "to fall in love before entering the seminary or the monastery", as he thought it was crucial for them to have experienced what having an intimate relationship was like before they could fully commit to being celibate for life.

The monks of the Monastery of Sant Oriol expressed their concerns regarding the loneliness suffered by many diocesan priests and their lack of supportive relationships, which could cause an "affective void" and render them susceptible to emotional difficulties. In contrast with the clergy, they not only shared their lives with their fellow monks of the monastery, but also had strong links with monks from other monasteries who belonged to their religious order. Several monks spoke sympathetically about today's clergy, explaining they felt they suffered from a kind of "burned out syndrome" and had "widespread feelings of disillusionment", feelings they attributed, at least partly, to the excess of parish work they were subjected to due to the current shortage of priests. They argued that their excessive work load was responsible for their neglecting their spiritual growth and recognising the need to nourish personal relationships.

When I asked the monks to share their thoughts about clergy's pastoral care, they spontaneously compared it with the spiritual care they offered to those who visited them (for a summary of the comparison between the clergy and the monks from the perspective of the latter, see Table 21). The outcome of these

comparisons was, almost invariably, to give a clear advantage to the monks. Firstly, they felt themselves to be more spiritually mature, as they devoted much more time and effort to their own spiritual development and were thus better equipped to help those undergoing emotional and spiritual distress. Secondly, they argued that they were more available to meet their guests individually, as they did not have to attend to parish duties and could count on the support of their fellow monks to free up their time. Thirdly, they considered themselves to be in a better emotional state to help, as living in community kept feelings of loneliness and isolation at bay. Finally, they believed that the monastery provided an inviting and trustful space for people to open up to them. The peace and stillness that emanated from the monks contrasted with the hectic pace of many priests, who were often rushing around in order to meet their many pastoral duties.

The following quotations from a monk and from a lay psychiatrist illustrated the above comparative analysis between monks and priests, in which the former emerged with greater merit:

> First of all, priests are very busy so people cannot really go to their parish priest and say to him: "I would like to talk to you", just like that, no, they can't. But here [in the Monastery of Sant Oriol], it is different, they [the guests who live in the monastery] are here, they have more time to reflect, we have more time, the peaceful spiritual atmosphere helps too, it is conducive to having a deep conversation that otherwise could not be arranged hastily.

> [Jordi, monk and priest, 66, White Spanish]

> The religious orders have a solid heritage of spiritual accompaniment… I would rather ask a monk for spiritual guidance than a parish priest because priests are packed with tasks… monks always have more time and are likely to have more spiritual education… many religious orders, such as the Jesuits, provide much more spiritual accompaniment to people than what the clergy can offer…I also think that monks have a more developed inner life… the experience of faith is more developed amongst contemplatives.
>
> [Sergio, layman, 40, married, White Spanish, psychiatrist]

It was interesting that the fact that four of the monks were also priests did not alter their critical views about the state of today's clergy. When they were asked specifically about how they handled their two identities - being both a monk and a priest - a predominant view emerged: all of them, with the exception of Father Jordi, stated that they felt that the contemplative monastic identity prevailed over the clerical one ("I am a monk above all!"). They decided to be ordained as priests as a "service to the community" and explained that a religious community could not function without some of its monks also being priests, as they needed the latter to administer the sacraments and particularly the daily mass (it was convenient to have several priests amongst them so they could share the ministerial tasks). In contrast with his fellow ordained monks' unanimous answer, Father Jordi started his response by comparing my question to another one in a joking tone: "your question, Glòria, is like when you ask a child whom do you love more your mother or your father? You can't ask such question!" He strongly felt that his role as a monk and a priest were knitted together in his religious vocation and could not be separated one from the other. In spite of the ordained monks' conceptualisation of their priesthood as a service towards their fellow monks, it transpired during the course of the fieldwork that the non-

ordained monks were critical of the inequalities that existed between them, such

as the condition that a monk, in order to be elected head of his community, had

to also be a priest. The latter was particulary upsetting for many of the monks

who considered that their order should change this rule to allow the access of

non-ordained monks to this post.

TABLE 21

Comparison between the clergy and the monks from the perspective of the monks

Monks	Priests
More spiritually mature as they invest more time and effort in their spiritual development	Do not devote enough time to work on their spiritual growth
More available to help those undergoing emotional and spiritual distress	Lack of time and availability to help others as they are overwhelmed by their parish duties
They have the support of their religious community to free time to meet people individually	Isolation and lack of a support network; they work alone without the backup of a religious community
They emanate peace and stillness, creating a welcoming and trustful space for people to open up to them	They are unable to provide a serene space to meet their parishioners as they often have to rush to meet their many pastoral tasks

4.4.3. Clergy and mental health professionals: overlap, rivalry and collaboration

Overlap between the work of the clergy and mental health professionals

The clergy often held the similarities between their works and those of mental health professionals as being responsible for the suggested competitiveness they felt existed between the two professions. This rivalry was accentuated by the fact that both were approached by people experiencing desolation and distress. Many participants, especially those with a medical or psychological professional background or those who had suffered from mental health problems, were more aware of the overlap in the work of clergymen and mental health professionals. Several remarked on the fact that mental health professionals and priests "both work with words" as their main therapeutic tool; this was applicable to psychologists and psychotherapists but also to psychiatrists as, although prescribing medication was considered by the vast majority of the participants to be their main treatment, they did not necessarily have to resort to it to help their patients. Lamberto, a lay general practitioner, was quick to point out what he thought was the shared domain: "priests and doctors have facets in common… the main facet in common is that both treat the soul; the doctor treats the body and treats the soul, and we could say, talking in very simplistic terms, that the priest treats the soul… this is what they have in common".

Andrés' testimony was notable as he was able to succesfully combine the help of a spiritual director and two mental health professionals (initially a psychiatrist and more long term, a psychoanalyst) in addressing his own severe anxiety and depression. His case highlights the complementary nature of these two disciplines as he resorted to both of them to solve his suffering. This 40-year-old married teacher explained that, although he was receiving regular spiritual direction, he decided to consult a psychiatrist: "I realised that although the spiritual accompaniment was helpful, it was not enough and I needed a different type of support [from the psychiatrist]". After a few sessions with the psychiatrist, in which he was prescribed medication, the psychiatrist referred him for psychotherapy to a psychoanalyst, whom he saw twice a week for a year. He discontinued the psychoanalysis once he felt better, since he was struggling to afford it, but continued with regular spiritual guidance - which was free - for many years until his spiritual director left Spain. During the one year that he was under the care of both the spiritual director and the psychoanalyst, he considered their roles as "complementary", explaining that although "the spiritual and the psychological dimension are close, they are not the same" and therefore he was in need of both. He did not find any tensions between the two, who were aware of the other's involvement, as "they were both very respectful with each other". Other participants endorsed using both the help of a priest and a mental health professional, and they expressed the help of the latter in religious terms along the lines of the following quote: "psychiatrists, medication... are all means that God has put in our way to be used".

Clergy's pastoral care and psychiatric care: rivalry and comparison

Many of the priests compared the pastoral care they provided to those suffering from deep sadness and depression with the service provided by mental health professionals. The outcome of this comparison was undoubtedly positive for the clergy (their critical views of psychiatric care will be presented in the following section). They saw mental health professionals as competitors and often made remarks that betrayed a sense of rivalry in this respect. Many clergymen spoke in a tone of regret and nostalgia about people nowadays preferring to consult psychiatrists, psychologists and psychotherapists when afflicted by emotional and psychological distress rather than consulting them.

The main argument put forward by the clergy to explain the current preference that people had for mental health professionals was the growing secularisation of Spanish society. The consequent gradual loss of religious observance and values was often seen as being responsible for the rise in existential dissatisfaction, emotional and psychological problems, and mental illnesses, particularly depression and anxiety disorders. They regretted the lack of influence that the clergy had on people's lives and explained that people used to rely on their parish priest to help them with their existential crises and life tribulations, which were resolved within a religious context through frequent confession, spiritual direction or simply by seeking clergy's advice (see Figure 1 for a graphic representation of these aetiological links).

FIGURE 1

Diagram showing an aetiological link between the decrease in the influence of the Church and the increase in mental illness, as seen by the participating clergy

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                    ┌─────────────────────────────────┐
                    │         Secularisation:         │
                    │   loss of religious observance  │
                    │  and values in today's Spanish  │
                    │             society             │
                    └─────────────────────────────────┘
                            ╱                  ╲
                           ╱                    ╲
  ┌──────────────────────────────┐   ┌──────────────────────────────┐
  │ Increase in existential      │   │ Decrease in clergy's         │
  │ dissatisfaction, emotional   │   │ influence in people's lives  │
  │ problems and mental          │   │ (e.g. fewer people going to  │
  │ illnesses, particularly      │   │ confession, or seeking       │
  │ depression and anxiety       │   │ spiritual direction or       │
  │                              │   │ advice)                      │
  └──────────────────────────────┘   └──────────────────────────────┘
                          ╲                    ╱
                           ╲                  ╱
```
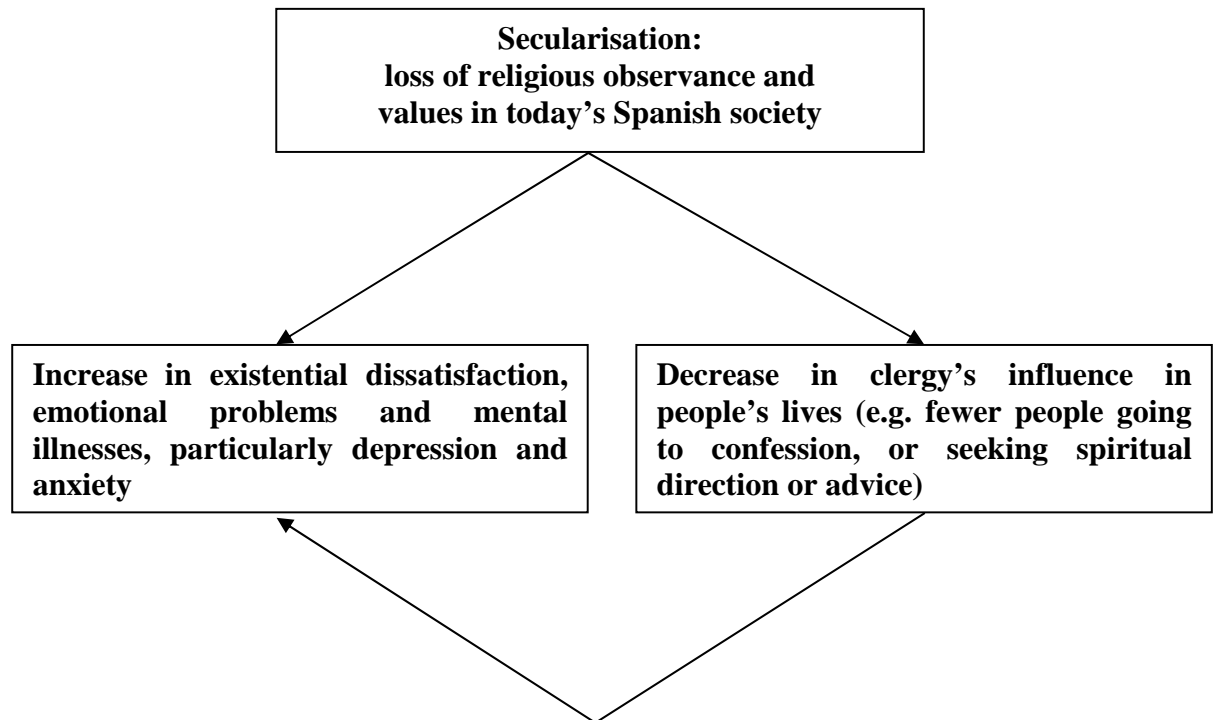
Many participants considered - at least at a theoretical level - that collaboration between the clergy and mental health professionals could be beneficial to the religious mentally ill patient, such as in the case of someone suffering from depression. Most of the clergy readily acknowledged that severely depressed people - especially when they were a risk to themselves - "have need of faith but also of science: they are not separate". However, those participants who longed for this collaboration regretted that this was far from a reality, as the pride and

insecurities of both professions tended to get in the way of their seeking help

from one another. The following quotations from a religious priest and a

laywoman illustrate these attitudes:

> Both professions [psychiatrists and priests] believe themselves to be
> absolutely autonomous: the spiritual director feels that he can play the
> psychiatrist, and the psychiatrist feels that can play the spiritual director.
>
> [Francisco, religious priest, 65, White Spanish, theologian and
> psychologist; prior of his community, he is frequently in demand to give
> spiritual retreats]

> Each one [the psychiatrist and the priest] has their own field, and they
> don't want to know anything about the other's field… I think that a priest
> with a deep experience of God can be very beneficial [to someone
> suffering from depression] but this doesn't mean that the other field is
> not needed.
>
> [María, laywoman, 62, single, White Spanish, nurse]

The clergy's critical views of mental health care

Critical voices regarding the care provided by mental health professionals were

widespread among the participants, and negative comments undermining their

work were abundant in the interviews. The priests were the most emphatic in

their criticisms and their arguments were more thoroughly elaborated. The

mental health specialist that received the strongest and most frequent criticisms

was the psychiatrist, followed by the psychotherapist - and particularly those

offering psychoanalysis[41] - and finally the psychologist. The priests critical assessments of many aspects of mental health professionals' work compelled them to offer help to their mentally ill parishioners in spite of having to acknowledge candidly their own lack of training, even in cases where they felt uncomfortable and out of their depth.

They were mainly critical of three aspects of psychiatric practice. Firstly, the clergy argued that psychiatry held a compartmentalised and narrow view of the person that focused mostly on physical aspects; thus it relied too much on the biological model of illness while neglecting other essential aspects, such as the spiritual and the inter-relational. Regarding the latter, they argued that the supportive role that the family, friends and religious community could play was key for the individual's recovery; thus they strived to foster the social domain as part of their pastoral care. Medication was considered to be the main treatment tool used by psychiatrists, which the clergy argued was often over-prescribed. Conversely, the clergy explained that they combined both medical and religious beliefs when helping their parishioners who suffered from sadness and depression, as they held a holistic view of the person. They explained that, in contrast with psychiatrists' over-reliance on prescribing antidepressants and sedatives, their main "healing tools" consisted of listening, talking and encouraging the use of religious resources, such as praying, attending acts of worship and appropriate religious readings. Father Manuel shared this criticism:

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[41] This type of psychotherapy, as will be explained later on, was often seen as markedly anti-religion as well as unaffordable to the majority. See Note 27, on p. 224, for a brief commentary about a participant contesting this view.

> They [mental health professionals] think they know the human mind and its real mechanisms but what they end up doing most of the time is to mess people up… I would say that in 80% of the cases they mess them up… even if you found a trustworthy and good psychiatrist who does not mess you up too much and tries to help and gives you a pill, you do know that a pill is not going to take the problem away!
>
> [Manuel, religious priest, 66, White Spanish, parish priest and lecturer]

Secondly, psychiatrists' medicalisation of sadness as a mental illness - along the lines of a depressive illness - was seen as the source of many problems; for example, the potential of psychiatric treatment to make the problem chronic, leading to stigma, social exclusion and even institutionalisation. They contrasted this with the approach of the clergy, who strived to normalise sadness as the result of the vicissitudes of life, and to foster hope and meaning through interpreting the sadness as a religious narrative full of potential for catharsis and beneficial change. Moreover, they argued that being helped by the parish priest did not lead to further marginalisation and isolation but, on the contrary, could increase the individual's sense of belonging, as it was seen as socially acceptable and even laudable by the congregation.

Thirdly, the role of the psychiatrist was compared critically with that of the clergy. A psychiatrist's time is rigidly limited, and his work is based on knowledge and plagued with financial and social prestige incentives. Conversely, the clergy talked about their role in very different terms to the ones used to describe that of mental health professionals. They described their role along the lines of being: "a vocation", "a life-long commitment", "a call from God to do this work" and "an altruistic service". Their skills were not just based

on following an academic career, but also on "being". In contrast with the psychiatrists' adquisition of "mere knowledge", they had to work on their personal and spiritual maturation. It was clear that the clergy saw their role as carrying a certain degree of inner wisdom and of moral and spiritual superiority.

Some differences between the psychiatrist-patient relationship and the priest-parishioner one were also pointed out. The former was argued to be rather rigid and full of boundaries, as it was subjected to the observance of a number of explicit and implicit rules, such as the professional's duty to violate the patient's confidentiality in cases of risk, or to expect his compliance with pharmacological treatment. The clergy considered their relationship with their parishioners to be "totally different". The divine component of their relationship made them see those who approached them as "children of God" and themselves as "representatives of Christ". Thus they felt compelled to persist in helping them, and to refuse to give up on them. They were also able to resort to behaviours and attitudes which would have been censured as unprofessional or unorthodox in psychiatric practice (such as adopting paternalistic attitudes or taking parishioners out for lunch or for a walk). Moreover, the priests could provide a stronger reassurance regarding the safety and intimacy of what was disclosed to them, as in the case of confession, in which there were no exceptions to maintaining confidentiality.[42]

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[42] There are no exceptions that could allow a priest to reveal his penitent's sins as has been explained in section 2.2.4., "A comparison between confession and psychotherapy".

In addition to these differences, the clergy did not receive remuneration from those whom they helped. Conversely, consulting with a mental health professional might involve the payment of fees which could be rather costly, especially when the individual wanted to avoid medication and opted for psychotherapy instead (the latter is mostly available in the private sector in Spain). Father Francisco, who was also a trained psychologist, illustrated some of these differences with an example of his own: he offered "spiritual and psychological accompaniment" to an oncologist who had undergone many years of psychoanalysis as he struggled with long-term feelings of sadness and generalised anxiety. The oncologist complained about the burden that the psychoanalysis had placed on his family finances and about the strict boundaries that governed the interaction with his analyst, for example, regarding the duration of the sessions: "you [Father Francisco] give me the time I need, you don't count the minutes… you don't tell me that the time is up!" Table 22 summarises the outcome of the clergy's process of comparison between the care they provided to those undergoing sadness and depression and that of the psychiatrists.

TABLE 22

Comparison between the roles of the clergy and psychiatrists in helping those undergoing sadness and depression from the perspective of the clergy

CLERGY	PSYCHIATRISTS
Holistic view of the person and approach to care, they take into account social, psychological and spiritual aspects of the individual; they often have knowledge about the person and the family and provide continuity of care	**Narrow view of the person and compartmentalization,** as they focus on the physical aspects, not including the relational aspects of the individual, often patients are seen by different professionals
Able to hold both medical and supernatural beliefs when assessing and managing sadness and depression	**Unable to combine medical and supernatural models;** the latter is ignored when assessing and managing sadness and depression
Healing through listening, talking and religious resources such as praying, worship and religious readings	**Over-reliance on medication;** the prescription of medicines such as antidepressants and sedatives is their main treatment tool
Family and religious community are fostered as they are considered important resources	**Individualistic approach to care,** not appreciating the supportive role of the family and friends
Being sources of hope and meaning through incorporating the sadness into religious narratives and encouraging beneficial change	**Psychiatric diagnosis and treatment may make the problem chronic** and may lead to hopelessness and even institutionalisation

CLERGY	PSYCHIATRISTS
Normalisation of sadness as the result of the vicissitudes of life	**Medicalisation of sadness** as a mental illness along the lines of a depressive illness
Receiving help from the clergy is socially accepted as it increases their sense of belonging to their religious community	**Psychiatric care may lead to stigma and social exclusion,** it may increase feelings of marginalisation and isolation
Priesthood is a vocation which comes from God, their motivation to serve others is altruistic and they are commited to priesthood for life	**Being a psychiatrist is a profession**, their motivation is less generous (e.g. financial, prestige and social status) and lasts until retirement or a change in career
Their skills are based on being, their role implies inner wisdom, and moral and spiritual superiority	**Their skills are based on knowledge** through extensive academic and practical training
Their service is free, no remuneration is received from those whom they help	**Psychiatric care may be expensive** particularly when opting for psychotherapy (mostly available in the private sector in Spain)
Unconditional regard for the people they help, they are regarded as "children of God", they are willing to persist in trying to help someone in need not giving up easily	**Psychiatrist - patient relationship is conditional to the observance of a strict set of rules** such as compliance with treatment, attendance to appointments, payment of fees
There are no exceptions to violating confidentiality in the case of confession, there is a stronger assurance of safety and intimacy	**There are exceptions to maintaining confidentiality,** information is shared with supervisors, the multidisciplinary team, other agencies and even with relatives when the risk is high

Negative attitudes towards mental health professionals were supported by stereotypes and assumptions as well as by past negative experiences

As we have seen in the previous sections, many clergymen resisted recommending those under their spiritual care to consult with a mental health professional unless the pathological nature of their symptoms made it absolutely necessary. Instead they chose to provide help themselves even if doing so caused them considerable anxiety, which was especially the case of those priests who acknowledged their lack of training in mental health. In addition to the clergy's rivalry with mental health professionals and the critical views about psychiatric care presented above, the following negative attitudes also shed some light on the clergy's reluctance to refer parishioners to them.

Many priests not only regarded mental health professionals as competitors, but also felt they posed a threat to the pastoral care they offered to their parishioners. They worried that the advice given by mental health professionals might be in conflict with theirs because they viewed these professionals as being anti-clerical and anti-religious. The priests feared that mental health professionals could cause harm to their depressed patients by allowing their personal negative views about religion and the Church to influence the advice given to them (e.g. discouraging them from religious attendance, ridiculing their faith or undermining and contradicting their parish priest's advice), thus depriving them of a source of hope and meaning. This concern was frequently found in the

interviews and was most prevalent amongst the clergymen, followed by the nuns and monks, and to a lesser extent amongst the lay participants.

Psychiatrists and psychoanalysts were the mental health specialists who received most criticisms, as they were seen as being more likely to take an active stand against their patients having a religious faith and to discourage them from attending acts of worship. They were therefore thought to have the greatest potential for worsening people's mental health. Moreover, psychiatrists were specifically criticised for strictly adhering to a biological model of illness and for over-relying on medication, while psychoanalists were censured for their lack of practicality: elevated cost, intense frequency of sessions and long duration. A few participants even stated that psychoanalysis was incompatible with having a religious faith. In contrast with this view, Father Enrique, a priest and a psychiatrist, praised another modality of psychotherapy - logotherapy - for its similarities and compatibility with religious beliefs. He had personally met its founder, Viktor E. Frankl, and explained that logotherapy's ethos of searching for meaning was "a non-religious interpretation of life, however very close to a religious one".

When I looked at the evidence given by the clergy to support the strong wariness felt particularly for psychiatrists, two response patterns emerged: while some priests and devout religious participants seemed to simply presume the antipathy of psychiatrists towards religion, describing their reasons in terms of intuitions, feelings and fears, others presented convincing objective evidence to support

their views. Although in the case of the former their opinions seemed to be based on subjective negative attitudes and stereotypes regarding secular hostility within the institution of psychiatry rather than an identifiable phenomenon, it was remarkable how deeply embedded those attitudes and stereotypes were. I tried to gently challenge them, inquiring if they could conceive of the existence of atheist psychiatrists who were respectful towards their patients' religious beliefs and who might even be willing to incorporate spiritual aspects into their clinical management and to collaborate with the clergy. Most participants could not imagine it to be possible and when I mentioned that I actually knew of some, they looked astonished. The response pattern of the second group was very different, as their perception of psychiatrists' stand against religion was predicated on evidence coming from real cases. Several other participants showed a combination of both patterns, with the description of objective accounts being interspersed with the occasional disparaging generalisation of psychiatry as being invariably against religion.

The objective evidence provided by the clergy that supported their negative views towards psychiatrists could be divided into two groups. Firstly, they described cases in which psychiatrists had told their parishioners not to continue seeking advice from their priest or had challenged their religious beliefs and practices: "he [the psychiatrist] dared to recommend to her [his parishioner] that she abandon her faith and stop listening to me [her parish priest], and that it was better not to have anything to do with religion, to stop going to mass, to stop praying". Moreover, they gave good examples of psychiatrists' scornful

comments about religion, made in clinical settings, such as: "religion is no good, it oppresses you!" The priests strongly argued that psychiatrists should not interfere with religion. Most of them, while sharing these experiences, clearly showed their feelings of upset, frustation and anger towards those psychiatrists. Secondly, virtually all the clergymen criticised the fact that mental health professionals did not consult with them, or recommend that the patient do so, even when the patients' symptomatology had a clear religious content (e.g. depressive symptoms being triggered by a spiritual crisis). It was interesting that the clergy took the latter as further proof of psychiatrists' dismissal and contempt for them rather than just mere indifference.

In addition to the clergy's experiences of mental health professionals' opposition to religion, several lay participants described times in which they had witnessed these professionals making disrespectful comments towards their patients' religious beliefs or supressing any of their attempts to bring up religious matters. This, for example, was the case of Amparo, a 47-year-old single secretary diagnosed with a brain tumour a few years ago. She had much to say about her psychologist's pejorative views about her religious beliefs. The neurosurgeon who closely monitored the progression of the tumour had told her that it was likely she would have to undergo brain surgery in the near future. Besides relying on her family's and friends' support, her main ways of coping were of a religious nature, such as her faith in God, her strong belief in an afterlife, the help of her spiritual director and of the community of her parish church. She seemed to cope with her uncertain prognosis very well and, to the extent she was

able, tried not to let her illness modify her life style and strove to carry on with

her normal daily activities: "I am determined not to let it [the tumour] spoil my

happiness, it is not going to take over my life!" She even showed a remarkable

sense of humour in the way she referred to the tumour, calling it "the tenant",

and in the manner she addressed God: "I am very well here, I am not in a hurry

at all, I am looking forward to seeing you [God] but I am not in a hurry at all, so

let me stay here for a long while, I am very well here… when I pray, I prayed for

my loved ones, for those who need help, and at the end, I ask God for 'the

tenant' to continue remaining dormant". She was offered a chance to meet with a

psychologist to help her to cope with the initial diagnosis (this was part of the

routine medical package that her hospital provided to patients in her situation).

She talked about her psychologist in the following critical manner:

> The psychologist was awfully anti-religion, such an atheist, you could
> not believe to what extent!... I was not fond of psychologists but after
> meeting him… I am not even sure there are a handful of psychologists
> who are actually normal... he [her psychologist] was so odd… he
> dismissed everything I told him about my beliefs… imagine if I had told
> him or a psychiatrist all the things I have told you [about how her faith
> helped her to cope with the uncertainty of having a tumour], I do think
> they would have locked me up!
>
> [Amparo, laywoman, 47, single, White Spanish, secretary]

Several participants brought up the subject of abortion, particularly the fact that

for a woman to be allowed to have an abortion in the Spanish medical system

she needed to undergo a psychiatric assessment. This contributed further to the

perceived anti-religiousness of the psychiatric profession, as the participants

shared the firm stand against abortion held by the Vatican. They viewed the

"conformity of psychiatrists towards abortion" with consternation: "if the mother says that she is depressed or that she doesn't feel she has the capacity [to cope with the pregnancy]… the psychiatrists are happy to sign! [to allow her to have an abortion]".

As has been described previously, many lay participants offered a critical outlook regarding the clergy's training, arguing that mental health matters were overlooked. Similarly, the training received by doctors was also criticised by several participants. For example, Lamberto, a general practitioner, censured the total exclusion of "any training in humanities, culture, religion… in the medical schools' teaching programmes". He explained that neither himself nor his daughter, who recently graduated, had received any. María, a lay nurse, stated that "the most important things are not taught to them [medical students]". On the one hand, she denounced the failure of the medical training to equip their doctors with strategies to cope with dramatic situations and to be able to separate their work from their family life; and on the other hand, she condemned the total disregard for religious matters, especially when treating religious patients. Regarding the latter, she described several cases in which her intervention had been crucial in administering sacraments to dying patients: such as giving the last rites to a patient who was about to die or the christening of a premature baby who was not likely to survive. She explained that on such occasions the families were often too distressed to think about arranging for the administration of sacraments, and thus she often took the initiative to ask the relatives if the patient was a believer and if so she offered to call the priest herself.

Lack of collaboration between the clergy and mental health professionals

Although the majority of the priests argued that the care they provided to those suffering from normal deep sadness and depression was sufficient, they did advise seeking the help of a mental health professional, mainly a psychiatrist, for those people suffering from a more worrying and impairing depressive episode, especially when it was accompanied by suicide risk, marked weight loss, deliberate self harm, or a feeling of unremitting hopelessness, or when the episode did not improve over time. In spite of psychiatry being the mental health speciality of which the clergy was most critical, it was also the one most often recommended to their parishioners. This was the case in the more severe cases of depression, for which the clergy might have to seek the psychiatrist's involvement, and which might warrant interventions that the priests themselves could not offer, such as the prescription of medication or even hospitalisation. In addition to severe forms of depression, the priests mentioned other types of mental illnesses for which a referral to psychiatric services was considered necessary: psychoses and the more severe forms of obsessive-compulsive disorder and drug abuse.

Some priests were more pro-active than others in their suggestion to seek mental health advice: while some just gave a verbal recommendation to the individual or the family, others went much further than this and recommended a certain professional, booked the appointment themselves and even offered to drive or accompany parishioners to the clinic. Once the patient agreed on a treatment

plan with the psychiatrist, most of the clergymen would show interest in their progress and, if they considered the treatment appropriate and beneficial - not going against their faith or religious beliefs -, they would also encourage the keeping of appointments and adherence to the treatment. Being under the care of a psychiatrist did not imply a discontinuation of the clergy's assistance, as the parishioners frequently continued to see their priest for ongoing guidance and support and to share the outcome of the psychiatrist's consultation. Several priests explained that, when they had explicitly recommended a psychiatric consultation to a parishioner, the recommendations given by the mental health professional were often in tune with their own: "Father, the psychiatrist has told me the same as you did". For example, both professionals might agree on the need to establish certain boundaries with a family member or to take psychiatric medication to get better.

The unilateral nature of the clergy's relationship with psychiatrists really bothered some of the priests: the fact that the vast majority of psychiatrists did not reciprocate and recommend their own assistance infuriated them, especially in those most obvious religious cases in which they claimed to have a legitimate role to play (e.g. when the pathology had a religious content or the patient was deeply religious). They explained, in a tone of clear irritation, that although they had referred parishioners to psychiatrists, it was "never the other way around". Father Jesús pointed out the exception to this, arguing that psychiatrists would advise patients to seek their parish priest's help "as a last resource", when no

other intervention had worked, and as an easy way to "get rid of a patient" who was not likely to make progress. His quotation illustrates this point:

> I've had people who had gone first to the psychiatrist and when the psychiatrist had extracted lots of money from them and they could neither afford it nor cope anymore, and the psychiatrist did not know what to do with them, he told them: "go and talk to your parish priest".
>
> [Jesús, priest, 73, White Spanish, parish priest]

Two possible "solutions": the religious psychiatrist and the priest with mental health training

Concern regarding the training and skills of psychiatrists and priests was widespread throughout the interviews. Moreover, the participants' criticisms were strikingly similar regardless of their different backgrounds: while the priests condemned the psychiatrists' lack of ability to address their patients' spiritual and religious needs, they themselves were criticised for their lack of mental health training and psychotherapeutic skills. The lack of spiritual resources on the side of the psychiatrists, and psychological, on the side of the priests, was much lamented, as it hindered the potential to help the distressed individuals who approached them. As one lay participant put it: "if only the psychiatrist could behave a little like a priest, and the priest could behave a little like a psychiatrist!"

The term "good psychiatrists" or, less frequently, "good doctors" appeared in the interviews to refer to medical professionals who were practicing Catholics. The priests felt safe in referring their parishioners to them, as these doctors would not cause their parishioners harm: unlike anti-religious doctors, these devout ones would not make them doubt their religious beliefs, threaten the clergy's authority, or judge or ridicule their faith. One obvious solution for psychiatrists' neglect of religious aspects and for the lack of mental health training of most priests was to unite both facets - being a priest and a mental health professional - in one individual. Many lay participants highly praised those priests who were knowledgeable in mental health matters and psychotherapeutic techniques and were therefore able to provide a holistic pastoral care to their parishioners that included the psychological and spiritual world. A few participants used the term "good priests" to refer to this type of clergy, those who combined these two dimensions. Interestingly, the preceding adjective "good" was used to qualify those psychiatrists and priests who united the characteristics of the other: the "good psychiatrist" was the doctor who incorporated the patient's spiritual dimension, and the "good priest" was the priest who took into account the psychological needs of the parishioner.

The "good priest"

The study sample provided four examples of "good priests": priests who successfully used the skills achieved through having undertaken psychiatric or

psychological training in their pastoral care. These priests' specialised knowledge of mental health brought benefits not only to their parishioners' well-being, but also to the priests themselves. Their additional skills enriched their religious vocations and gave them a deeper sense of fulfilment, since they significantly increased their ability to do good to their parishioners. Such were the cases of Father Francisco and Father Pablo who, after being ordained as priests, pursued a university career in psychology in order to be better equipped to help their parishioners, and of Father Esteban and Father Nicolás, who were both working as doctors when they decided to become priests (for more biographical details regarding the above four priests, see sections "Priests trained in psychology" and "Medical priests" in section 4.1.2.).

Father Nicolás chose to permanently leave his job as a general practitioner when he entered the seminary. However, he fit the description of a "good priest", since he continued to use his clinical knowledge of, and experience in mental health to assist those for whom he cared spiritually. Interestingly, before becoming a priest, he would have also made a "good doctor", as he used his faith and religious resources to help his patients during his long medical career; for example, he was such a firm supporter of the benefits of prayer that he regularly prayed with his patients even when they were not religious or belonged to a different religion: "when as a doctor I did not know what else to do, I stayed at the patient's bedside to pray". He did not see doctors praying with their patients (or using other religious resources) as problematic or as overstepping their professional boundaries. He adopted a pragmatic approach and argued that

doctors should use any resources available to them, religious ones included, to help their patients. He denied having ever offended anyone by resorting to prayer or other religious practices in his clinical work and said that his patients were respectful of his faith. When I inquired about his professional relationships within the medical community, he replied the following: "I didn't have any problems with atheist doctors but I did have problems with those who were anti-clerical and anti-Church".

Father Esteban, unlike Father Nicolás, combined his work as a doctor - he was a consultant psychiatrist - with his religious vocation. He was the founder of a clinic that provided psychiatric care for priests, seminarians, monks and nuns, which is still functioning. He led this clinic for 52 years until his retirement. Besides Father Esteban's clinic, there were two other similar ones in Spain: each one covered a different geographical area and provided psychiatric consultations and treatment to the clergy and the members of religious orders. They also were led by two psychiatrists who were priests; the real name of Father Esteban and the names of these two other priests came up several times in the interviews of the clergy and contemplative participants. Father Esteban argued that the vast majority of secular psychiatrists would not have been able to undertake this work, as they lacked the knowledge of the context and complexity of religious life needed to assess the mental state of this specific population. When a patient was referred to him, his key task was to discover whether he was dealing with a vocational problem or with a mental illness, as they bore some similarities in their manifestations. He explained that some religious vocations were not

genuine, as the motivation behind them was "immature" or "childish", and was considered to be "an escape from the world", "due to family problems" or "from a fear of going to hell".

Interestingly, Rafael, a 67-year-old married participant, explained in his interview that he had been under the care of Father Esteban 40 years ago when he was a monk. At the time he was undergoing a "very hard time", as he was questioning his religious vocation. He described being torn between the loyalty he professed for his fellow monks and the growing uncertainty and doubts he felt regarding his future as a monk. His religious conflict led to feelings of intense sadness and guilt. He was grateful for the support and accompaniment received from Father Esteban during that difficult time and talked about him in very complimentary terms. Father Esteban reassured Rafael about the normality of "the period of anguish" that he was going through, and conceptualised it as being caused by a vocational crisis and not by a mental illness. Father Esteban played a key role in helping him to make a decision: "he never pressed me in any way… he helped me so much, encouraged me to make up my mind, never telling me to go this way or the other, he helped me to think, to face my doubts even if I did not want to do so… it was a very tricky situation, to break with what had been my life up till then, to disappoint my family and friends". Moreover, once he left his religious community, he still received further assistance from Father Esteban to adapt to a secular life.

The "good psychiatrist"

Many priests placed great importance on psychiatrists' religious beliefs and attitudes towards the Church and the clergy to the extent that, in order for them to recommend a certain psychiatrist to those under their spiritual care, they needed to be sure that the psychiatrist shared their religious faith. This prerequisite emerged in the light of the clergy's concerns regarding psychiatrists' anti-religious views impacting their clinical practice. Those "good psychiatrists", religiously sound and trusted by the clergy, were often members of their congregation or had been recommended by other fellow clergymen. The youngest priest participating in the study, 31-year-old Father Tomás, wished to have a "list" of the names of some psychiatrists he could safely refer to (i.e. those whose religiosity he could be sure of).

The majority of the participants who had seen a psychiatrist - as patients themselves or accompanying a relative - regretted the strictly secular approach of mainstream psychiatry that excluded religious aspects in the care of their patients. For example, in Father Lluc's words: "if only the psychiatrist was willing to open himself up to the patient's spiritual dimension, he would help so much!" María, a lay nurse who worked in a big hospital, was asked by a priest - who was also a friend - to recommend a psychiatrist, as he thought himself to be suffering from depression. There was an implicit assumption that the psychiatrist had to be religious in order to be able to help: "I talked to this particular psychiatrist [to ask for an appointment for the priest] because I knew

that she was a person with solid religious principles… I explained the case to her and she saw him very quickly". I asked her if she would have referred him to a psychiatrist who, although not religious, was an excellent and compassionate professional. She responded in the following way: "well, I know lots of good professionals that I could have referred him to… but I thought it was important that they share the same faith, and that she [the religious psychiatrist] could help him more… faith and beliefs provide a different outlook, which allows you to see things from a different perspective".

Magdalena was in a position to compare the experience of being under the care of a religious psychiatrist and a secular psychiatrist. She was diagnosed with bipolar-affective disorder when she was a nun (she left the monastery many years ago). Her Mother Superior arranged for her to be seen by a psychiatrist who, although he was a layman, was well-known within Church circles for being deeply religious. She described her current psychiatric care, which was provided by a secular professional, as being entirely devoid of any religious consideration; for example, any attempts to bring up her former life as a nun were brushed aside by the psychiatrist. She preferred her previous religious psychiatrist: not only was she able to discuss her spiritual concerns with him, but he also integrated a religious dimension with her overall care. In contrast, she found her current psychiatric care to be "superficial", as she was not able to "talk about what matters to me most [her faith]", and said that it was mainly focused on discussing her medication regime: "she [the psychiatrist] just tells me to take this tablet, or this other one". Similarly, Rosario, who was diagnosed with a

depressive disorder, had been under the care of two lay professionals, a psychologist and a psychiatrist. She met with the former several times and once with the latter, who prescribed antidepressants. She described her psychiatrist's care as "merely scratching the surface" and "just papering over the cracks". However, she achieved resolution thanks to the help of her psychologist, who was religious, and "who united both dimensions, faith and psychology… she [the psychologist] helped me to grow in both aspects, the spiritual and the psychological, in my faith and as a person".

Amongst the lay participants, I found two good examples of what some participants, especially the clergy, meant by the term "good doctors": a 40-year-old psychiatrist, Sergio, and a 57-year-old general practitioner, Lamberto. They both worked in busy clinics within the public health system, were married with children, were deeply religious and highly committed to their parish churches. As will be shown below, their testimonies highlighted the gains brought about by adding a religious dimension to their clinical practice. However, they also described the tensions and difficulties caused by trying to find a balance between the religious and secular aspects of their work and the maintenance of professional boundaries.

Although Segio and Lamberto concurred on many of the points they made, there were also significant areas of divergence between them. They both agreed on the similarities shared with the clergy. In addition to the more apparent commonalities which were pointed out by other participants, such as helping

people through their times of need and distress, two new areas of coincidence were pointed out by these two doctors. Firstly, they considered their work to be "a vocation" and themselves to be "God's instruments when trying to help one's neighbour". Lamberto even referred to the Bible to support the divine dimension of his work: "as a doctor I have the chance to help others... I am a doctor thanks to God, being a doctor is so much more than the scientific knowledge you have… the Ecclesiasticus encapsulates this well by asking you to respect the doctor because the doctor is following God's orders".[24] Secondly, they strongly relied, like the priests, on their religious beliefs and resources to cope with their professional challenges. They argued that religious doctors were less likely to suffer from professional burn out, as their faith added meaning to their tasks, thus acting as a protective factor against the despair caused by daily exposure to human suffering. Moreover, they argued that their faith contributed to making them "better doctors": more compassionate and committed to their patients. Lamberto's quotations integrated these points:

> I am convinced that believing in God and placing trust in him makes doctors better, yes, definitely makes doctors better, yes, because they do things that otherwise they wouldn't do [if they were not believers]; for example, without wanting to boast about myself, I sometimes make house calls when the patient does not expect me, beyond my professional duty, I do so without any doubt as an act of pure Christianity… it [having faith] improves one's humanity… it helps you in your [clinical] practice… it helps you not to lose hope; for example, there is something I do in a routine way: when I leave patients who are in critical states, in irreversible situations, knowing in all conscience that I have done

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[24] Ecclesiasticus 38:1-3: "Treat the doctor with the honour that is his due, in consideration of his services; for he too has been created by the Lord. Healing itself comes from the Most High, like a gift received from a king."

> everything I could to save them, I pray an Our Father[25] as I am leaving them, while going down the stairs, I leave them in God's hands… this makes me feel better, I also thank God for allowing me to help them.

> Young people dying, accidental deaths… no one understands these kinds of deaths… but somehow you have to accept them by holding on tight to your faith… you can't see any sense but you have to accept them as being part of God's plan… and that is all… it's horrible but it's this way and you know that God is going to welcome them [in heaven] so you do need to resort to your faith to cope [as a doctor]... if not, what? after death we enter the void, that is horrible!

> [Lamberto, layman, 57, married, White Spanish, general practitioner]

Thirdly, similarly with the priests, these doctors encouraged religious coping strategies when helping those undergoing sadness and life's adversities, which they illustrated with examples from their patients. They upheld the view - based on their clinical practice - that religious faith and beliefs could play a key role in helping those patients afflicted by depressive symptoms such as feelings of sadness, emptiness, and lack of meaning, purpose or hope. They considered that the "constellation of supports" for patients suffering from depression should include - in addition to their relatives and friends - the priest and the parish. Interestingly, both clarified that for those cases of depression that were "too severe" or "endogenous", psychiatric treatment was preferred over religion as the best way forward.

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[25] "Our Father" (also called the "Lord's Prayer") is a central prayer in Christianity. It appears in the New Testament in two forms: in the Gospel of Matthew (6:9-13) and in the Gospel of Luke (11:2-4). The liturgical form is the one from Matthew which is the following one: "Our Father in heaven, hallowed be your name. Your kingdom come, your will be done, on earth as it is in heaven. Give us this day our daily bread, and forgive us our debts, as we also have forgiven our debtors. And lead us not into temptation, but deliver us from evil."

In spite of agreeing on the above points, they differed in the way they addressed the inclusion of religion in their clinical practices. On the one hand, Sergio explained that he did not directly ask patients about their religious beliefs nor did he try to promote religious meaning without "receiving some clear signs" from them that they were believers, which he clarified were a very small proportion of his patients. He felt he had to follow this more careful approach due to the clear secular ethos of the public health system he worked for, which was particularly marked within his speciality: "I am really mindful that, in psychiatric practice within the public health sector, bringing up religious beliefs is frowned upon". Nevertheless, he stated that when he saw patients who were openly religious and were willing to use their faith in their recovery, he did not hesitate to actively incorporate a religious dimension in their treatment:

> I do go for it and use their faith alongside medication and everything else; even at times, their faith becomes the most important part of their treatment, which makes me feel very weird as I am a psychiatrist working for the public health sector… even at times, in addition to prescribing and doing the usual, I do a little spiritual accompaniment with the patient… which makes me feel weird, but I feel I have to do it because I have someone in front of me whom I think I can help more this way.
>
> [Sergio, layman, 40, married, White Spanish, psychiatrist]

Sergio shared many of the concerns of the participating priests about mainstream psychiatry's anti-religiousness and about the risk of psychiatrists acting on their religious prejudices when treating their patients; thus he completely sympathised with the clergy's reluctance to recommend a psychiatric consultation to their parishioners. He argued that the majority of his colleagues were atheist, and that

a significant proportion of them were openly critical of religion and the clergy. Drawing from his clinical experience, he denounced a possible tendency to pathologise religious patients, as he explained that religious phenomena "are seen suspiciously as something that can end up being classified as psychotic… there is a systematic suspicion of everything that has to do with religion [within mainstream psychiatric practice]".

In contrast with Sergio's initial apprehension to incorporate a religious dimension to his clinical practice - only doing so when his patients clearly brought out their religiosity - and the tension this caused in him due to the secular nature of his employer, Lamberto considered faith to be "a therapeutic tool" and he brought it up without waiting for a cue from patients regarding their religious beliefs: "I talk to my patients about faith, God... whether they give me an opening or not". Lamberto justified his generalised inclusion of religion in his clinical practice in the following manner: "talking to my patients about faith is good for them... faith improves the prognosis for sure… faith is therapeutic, faith is also analgesic, no one with half a brain would question this!" He also provided another reason for introducing a religious element which was not strictly therapeutic: he felt compelled to do so in order to strengthen his patients' faith, especially in those who were more ambivalent about their religious beliefs: "many patients are on the boundary between belief and disbelief… so you can do them a great favour by tilting them to the side of belief". Lamberto candidly admitted that he had had some patients who had rejected any talk about faith, and a few that had even become upset with him. When I questioned him in this

regard, he said: "they are agnostic or atheist patients, or those who simply have had little to do with God... recently, I saw a paraplegic octogenarian man and I tried to introduce a little the topic of faith as, well, he was very old, with a bad prognosis, he probably did not have much time left… but he rejected God's presence, even getting rather upset; he thought that everything was God's fault".

Although Lamberto was also working within the public health sector, he did not feel Sergio's conflict of interest when he incorporated religion into his clinical practice. This might be at least partly explained by the fact that Lamberto, as a general practitioner, did not experience amongst his primary care colleagues the hostility towards religion that Sergio felt amongst his fellow psychiatrists. Lamberto never received any criticisms from the other partners who worked in his surgery regarding his personal religious views, which he had openly shared with them. In contrast with the majority of Sergio's psychiatric colleagues who were atheist and anti-religion, there was a much more varied spread of religious beliefs amongst Lamberto's fellow general practitioners: believers who were very religious (one belonged to the Opus Dei)[26], believers who practice weekly or less often, non-practising believers, agnostics and atheists; regarding the latter he clarified that they were "respectful about religious matters".

In spite of their willingness to incorporate religious aspects into their clinical practices, neither Sergio nor Lamberto had ever prayed with their patients. However, they often prayed for their patients' recovery and encouraged them to

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[26] For a definition of Opus Dei see Note 25, p. 208.

pray. Moreover, Lamberto explained that he had successfully integrated prayer in the management of psychosomatic disorders, which represented an important proportion of his consultations. He gave the example of "vertiginous syndrome": "95% of the cases I see are psychosomatic". In order to prevent his patients from making rapid postural changes, which he explained triggered the symptomatology, he gave them the following advice: "look, when you are lying down, before standing up, sit first and pray one Our Father[27] or, if you are agnostic, count until 15, but praying the Our Father will take you the same time and will probably do you more good". In addition to prayer being beneficial from a medical point of view as a way of slowing down patients' transition between postures, Lamberto used this example to insist once more on the importance he gave of using every opportunity available to him to bring up religion when helping his patients: "[by suggesting to them that they pray before standing up] you are talking to them about religion… yes, this is good, let me tell you something, I do think that religion, the Church needs to start thinking of better ways to sell themselves... how to be more out there".

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[27] For an explanation of this prayer see Note 44, p. 328.

TABLE 23

Summary of findings: main themes and sub-themes extracted from the participants' interviews

A. CONCEPTUALISATION OF SADNESS AND DEPRESSION
Normal sadness and pathological sadness: conceptualisation and distinction
Sadness is understood as a normal reaction to the vicissitudes of life *Depression is understood as a mental illness, as abnormal* *Sadness has a cause: "it makes sense"* *Depression may lack a cause or may provoke a reaction that is too intense or prolonged in duration: "it does not make sense"* *Sadness has a value: it can help you to grow, mature and be more in touch with those who suffer* *Depression carries potential risks for the individual: hopelessness, self-harm, substance abuse, suicide, and severe lack of functioning* *Holding of combined spiritual and secular models*
The Dark Night of the Soul: a case of non-pathological religious sadness
It is a normal, non-pathological phenomenon with an intrinsic value *The contemplative participants and the clergy adhered to a conceptualisation of the Dark Night with a strictly spiritual causation while lay participants attributed it to secular causes*
Religion as a cause for pathological sadness
Existence of spiritual pathology *Religiously motivated pathology as a result of poorly understood faith and lack of religious formation*

B. COPING AND HELP-SEEKING FOR SADNESS AND DEPRESSION

Co-existence of religious and secular coping strategies and help-seeking behaviours

Religious coping and help-seeking

- Attribution of religious meaning to suffering transforms it into a meaningful experience
- Prayer
- Trusting that God will look after them
- Seeking the help of a spiritual director, parish priest and community
- Relying on their faith in God
- Absence of mortality sorrow
- Previous experiences of receiving God's help
- Religious readings
- Religiously motivated gestures

Secular coping and help-seeking

- Finding a practical resolution to the problem which was causing their sadness
- Distracting themselves from their feelings of sadness
- Helping others in their suffering
- Resorting to their social support network (families and close friends)
- Consulting mental health professionals
- Antidepressant medication when the sadness was considered pathological (i.e. depressive illness)
- Psychotherapy, considered useful for both normal sadness and depression

Medical help-seeking behaviours were more often advocated when there was an absence of causality for the sadness (lack of context)
The impact of the individual's personality on their coping strategies and help-seeking behaviours
Gender differences between nuns and monks in coping and help-seeking *- Role of the community: the monks faced sadness alone while the nuns sought help from the community* *- Focusing on helping others with their sadness: the monks offered personalised care to those who visit the monastery while the nuns did not have individual contact with their guests* *- Ways of dealing with the crisis of vocations: the monks took a more spiritual approach while the nuns were more pragmatic* *- Identification with religious figures from the past: the monks identified with Christ and brave holy men, and the nuns with being "Christ's wives", the Virgin Mary and battered holy women*
Clergy's share of their sadness with their fellow priests

C. THE ROLE OF THE CLERGY IN THE CARE OF SADNESS AND DEPRESSION, AND THEIR COLLABORATION WITH MENTAL HEALTH PROFESSIONALS
Pastoral care is provided for both sadness and depression *- Most clergy saw providing help to those suffering from sadness and depression as an important part of their pastoral role* *- The clergy encountered many barriers while trying to fulfil this role* *- Spiritual direction and confession are considered effective ways to help those undergoing psychological, emotional and spiritual distress*
Views on the clergy's pastoral care from the perspective of contemplative participants and lay people: benefits, critique and comparison with the monks' *- Clergy's pastoral care as its best can have a very positive effect on those suffering from sadness and depression* *- The actual care provided by the clergy to people undergoing sadness and depression often fell short of what it could have ideally been*

Clergy and mental health professionals: overlap, rivalry and collaboration
 	
- Overlap between the work of the clergy and mental health professionals
- Clergy's pastoral care and psychiatric care: rivalry and comparison
- The clergy's critical views of mental health care
- Negative attitudes towards mental health professionals were supported by stereotypes and assumptions as well as by past negative experiences
- Lack of collaboration between the clergy and mental health professionals
- Two possible "solutions": the religious psychiatrist and the priest with mental health training
        The "good priest"
        The "good psychiatrist"

SECTION 5

DISCUSSION

This section starts with an explanation of the challenges that I encountered in the course of this research and the ways in which I dealt with them - "Reflexivity" - which is followed by a consideration of the limitations of the study. I then proceed to revisit the aims of the study and to discuss some of the key findings in the ligth of the existing literature in the field. Thus, the following subsections are devoted to the problems caused by the medicalisation of deep sadness paying particular attention to the Dark Night of the Soul; religious coping with sadness and depression and the gender differences found between the contemplative participants; and the role that the clergy play in supporting those afflicted by sadness and depression. Finally, the thesis ends by tackling the last aim of the study: proposing a framework for distinguishing pathological from normal deep sadness.

5.1. REFLEXIVITY

It is important for researchers using a phenomenological approach to reflect on their own experiences as well as on their role (Moustakas, 1994; Creswell,

2007). In this section, I am going to provide a personal reflection on the main challenges that I faced while navigating through the intrinsic uncertainties of conducting qualitative research amongst highly religious individuals and groups. Firstly, I will start by describing how I negotiated the "insider - outsider" position, eventually finding a satisfactory balance between the two, and contrasting my experience with other researchers who have undertaken fieldwork with monastic religious groups. I will continue with some considerations regarding my role in the fieldwork and interviews, and by presenting the process of comparison that my presence amongst the nuns triggered. Finally, this section will end with some thoughts regarding the potential positive effects that the research may have had on the participants.

5.1.1. The "insider - outsider" dilemma

The "insider - outsider" position became challenging and somewhat tense in the course of the research: it was certainly difficult at times to find a balance between being an "outsider" while gradually becoming an "insider" and developing personal and emotional links with the participants. The tension between these two positions has been addressed by several researchers who undertook research in monasteries and other highly religious groups. Kapaló & Travagnin (2010) proposed two seemingly opposing positions: on the one hand, the researcher may choose or feel forced to conform and play a role in the field,

becoming religious in order to gain access; on the other hand, one may embrace one's "otherness", resigning oneself to the exclusion that might derive from it.

Drawing from his research in Japanese ascetic practices, Lobetti (2010) argued that ethnographic fieldwork needed to recognise the fluidity of the relationship between the "I" and the "other", as the identity of the researcher became blurred through participation in the informants' lives. In the course of my fieldwork, I became gradually aware that certain aspects of my enquiry could only be understood by developing a shared human experience. I thus joined the nuns and monks in their religious rites and prayers and other secular activities, such as meals and walks, trying to access their subjective world of emotions and cognitions while at the same time maintaining objectivity and my stand as a researcher. I agree with Lobetti's view that objectivity does not depend on maintaining physical, emotional or intellectual distance from the object of study. My involvement in the nuns' and monks' daily activities brought me two main benefits: it offered me the means of recreating in myself a glimpse of their subjective experience while at the same time giving me the necessary proximity to allow trusting social relations to develop.

Although sharing some aspects of the participants' cultural and religious background may cause some difficulties and challenges for the researcher (Trzebiatowska, 2010b), I also felt privileged for the advantages that it brought me. My upbringing in the Catholic faith enabled me to understand and access the mindset of the participants more easily, as well as allowing me to participate in

their religious services, since I had a prior knowledge of the liturgy and sacraments. Moreover, in the case of the nuns, being a woman was an essential requisite, as they would have never allowed a man to acquire the same level of liberty, trust and access. An area that concerned me - before and during the course of the research - was the possibility of being directly asked by the religiously committed participants about my religious beliefs and practice. Interestingly, although they were curious about my personal and professional life in London, asking many questions in this respect, not one person amongst the four groups of participants inquired about my religious beliefs. I strongly suspect that they might have assumed that I was a practising Catholic and that I agreed with their beliefs, as I was respectful and knowledgeable about their faith and doctrine. I identified with the compromise Irvine (2010) reached in his fieldwork in a male Benedictine monastery, describing it as "imitation without commitment": while he was not a monk, he carried out the activities of one. Therefore, I resolved to struggle to find a point of equilibrium between being both an "insider" and an "outsider", embracing both, and trying to obtain the benefits that my mixed identity opened for me.

Although the benefits of the "insider" position may seem more obvious, my inevitable "otherness" - being a married professional woman and an emigrant in London for almost ten years - also played a valuable role, as it helped to create a dialogue between their religious world and the secular world that I represented, creating interesting dynamics, such as the process of comparison that my different life choice triggered in the nuns (this comparison is described in the

next section). One aspect of my "outsider" status that became particularly useful was being a practising psychiatrist. Firstly, it allowed me to give something back to the participants, as I received requests to provide psychiatric consultations, which are of course bound to confidentiality and therefore not discussed in this thesis. Secondly, my clinical experience in interviewing patients within a therapeutic context assisted me in making the participants feel at ease while I attentively listened to their narratives of sadness. Thirdly, their knowledge of my professional background might have contributed to the atmosphere of trust and openness achieved in the interviews, in spite of the presence of the digital recorder, due to an implicit assumption that I was experienced in hearing distressful accounts. Finally, their knowledge that I had previously conducted research in a monastic contemplative setting might have also inspired confidence, maybe more than my being a psychiatrist, as they might have felt that I was in a position to understand them.

5.1.2. Becoming an object of comparison

As had happened in my previous research with the nuns of the Monastery of Santa Mónica, I also felt in the present fieldwork with nuns that in spite of the many differences existing between us, the similarities that we shared - such as being a woman with a Catholic upbringing - seemed more or less unconsciously to trigger a process of comparison in the nuns. I wondered, as I had done before, how much my choice of life in the "outside world" caused them to think of or

consider alternative life choices. At times I perceived this as a conscious task, with the aim of providing arguments to support the validity of their life option, while at others it struck me that much of this could be an attempt to quell the insecurities that my presence there might have awoken in them. I would like to stress here that this process of comparison was indeed compatible with being treated by the nuns with friendliness and kindness and it did not affect the sincerity and openness of their relationship with me.

Interestingly, I perceived this process of comparison to be more salient in the current study than it had been in my initial fieldwork. I could venture two possible reasons explaining why the comparison process might have been accentuated. On the one hand, the ages of the nuns in training were much closer to mine than in the older community of Santa Mónica (the latter's mean age was 20 years older than the present sample of nuns). On the other hand, unlike the nuns of Santa Mónica, most of whom were perpetually professed, the majority of the current study's nuns were in the initial stages of their training and had not yet undertaken the solemn vows; thus, it was possible that they still might have been dealing with their own vocational doubts. The main area of comparison was between the divine nature of their marriage and the human nature of mine: the nuns in training were preparing a marriage to God - who is by definition perfect and permanent, always faithful and available - while mine was to a man and therefore temporal and subject to imperfections and weaknesses.

Looking back at my two experiences of conducting fieldwork with contemplative nuns, I realised that although I perceived this process of comparison to be stronger in the study presented here, I felt more at ease than in my days at Santa Mónica. Besides the obvious argument that this time this process did not take me by surprise, I very much identified with Irvine's analogy of comparing ethnography to a "craft", with the fieldworker being an "apprentice" gradually developing the necessary set of skills, and maturing through practice and experience.

5.1.3. Potential positive effect of the research

Conducting qualitative research may have a transformative effect in the researcher due to the personal interaction with the participants and the sharing of intense life experiences provided by the fieldwork and the in-depth interviews. From the experience of vulnerability and uncertainty so intrinsic to the face-to-face encounter with the "other", I certainly learned about my own ways of handling these negative emotions, becoming more aware of my strengths and weaknesses. Moreover, I was inspired, touched and humbled by many of the narratives of sadness and hope that the participants shared with me. I felt very grateful for their generosity and willingness to take part in my research.

I was indeed mindful of the many positive effects that undertaking this project had had on me at an academic and personal level and I often wondered if the

participants obtained something positive from my research. Firstly, at a more superficial level, the vast majority of them seemed flattered by my interest in them and reported that they had truly enjoyed either having me amongst them (in the case of the nuns and monks) or having been interviewed by me (in the case of the priests and lay theological students). Secondly, they might have also experienced a sense of validation by my interest in them, giving them a voice, in the midst of the current crisis of religious and clerical vocations in Spain and with the level of religious practice amongst lay Catholics decreasing.[47]

Thirdly, sharing their experiences of sadness and distress might have made them feel useful, in that they were contributing to making clinical practice more human. Along these lines, several authors have argued that qualitative research may have positive effects in and of itself for the participants: apart from some reporting that they felt pleased to be heard, others said they felt a sense of usefulness, as their experiences could be of benefit to others (e.g. McKeown, Clarke, Ingleton, & Repper, 2010). Finally, on a rather more practical note, my role as a psychiatrist and my willingness to provide psychiatric consultations when I was asked to by the participants could also be considered as my most explicit contribution to them.

Beyond the potential benefits mentioned above, I found it rather striking that many of them reported after the interview had taken place how they kept

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[47] Detailed figures taken from recent population studies looking at religious practice in Spain are provided in appendix 1 ("The religious scene in Spain").

reflecting on the subjects raised by my questions, seeming genuinely grateful for some deep introspection that I triggered. Some of the nuns and monks had more to add to their answers in the days following the interview, after "taking your questions to meditation" or simply "after sleeping on them". Some even praised my style of questioning or the questions themselves: "what you are asking are key questions!"; "your questions really hit the nail on the head!"; "you aren't satisfied with a general superficial answer, you want me to think harder and look deeper into myself, and I am up for the challenge!"

5.2. LIMITATIONS OF THE STUDY

As explained in the "Method" (section 3.1.), I used a qualitative method to undertake an in-depth exploration of the conceptualisation of severe normal and pathological sadness, coping strategies and help-seeking behaviour amongst practising Catholics in Spain. Although it is often argued that generalisability is not the purpose of qualitative research, several authors have argued that if qualitative research is not considered to be generalisable, then its use is limited (e.g. Morse, 1999; Morse, Barrett, Mayan, Olson & Spiers, 2002). I was concerned with the generalisability of the present work, as it would impact the potential of my research for theory development. Popay and colleagues (1998) argued that the generalisability of a qualitative study refers to the extent to which theory developed within that particular study could be exported to provide

explanatory theory for the experiences of other people who are in a similar context (Popay, Rogers & Williams, 1998).

The following efforts were made to increase the credibility, trustworthiness and validity of the findings. Firstly, in order to capture the diversity of the religious landscape of the Catholic Church in Spain, four groups of people were selected, each belonging to a different religious pathway - lay theological students, priests, and contemplative cloistered nuns and monks - making a total of 57 participants. Secondly, methodological triangulation was employed with several methods being used to gather the data - semi-structured interviews, participant observation and ethnography - in order to understand more fully the variation and complexity of the area under study, since it was explored from more than one standpoint. Thirdly, regular meetings with my two supervisors took place during the data collection and analysis to discuss emerging themes (I also sought advice regarding challenges and difficulties posed by the research process).

Nevertheless, in spite of these efforts, I certainly cannot guarantee that, without comparative studies, there are similarities between the participating Catholics' understanding and resolution of deep sadness and depression and those of Catholics or Christians of different denominations living in other Western countries. Similarly, my findings may considerably differ for people belonging to other religions and cultures. Moreover, although I endeavour to recruit a diverse sample with regard to the participants' demographic and social backgrounds (e.g. gender, broad age range, urban and rural, married and single,

with children and without, employed and unemployed, different levels of educational attainment), many of them were likely to have a higher level of religious education than most Catholics, which may limit further the generalisability of the findings to other less educated sectors of the Spanish Catholic Church. This is explained by the sampling method I used: the lay participants and the clergy were recruited through a theological college where the former were studying theology and the latter were lecturers or acted as links between their parishioners and the college. However, in spite of their theological formation, the sample encompassed - as the findings clearly show - people who held a wide spectrum of religious views ranging from open-minded and critical with the Church and the hierarchy to mainstream and highly conservative.

Because it was never my intention to select a study sample that would match the Spanish population at large - as one would have tried to do in the case of a quantitative study - I would certainly discourage any extrapolation of my findings to the Spanish population. The general level of religious practice of my participants was clearly not nationally representative, as they were significantly more religious than the general population. Having said that, a recent national survey undertaken by the Centre of Sociological Investigations (Centro de Investigaciones Sociológicas, 2009a) showed a higher level of religious practice (excluding those occasions related to ceremonies of a social kind such as weddings or funerals) than I anticipated: over a sixth of the population had a high level of attendance (from several times a week to once weekly) and almost

a quarter attended with some regularity (from at least once a month to several times a year).

Finally, the findings were based to a great extent on the retrospective accounts of the participants' periods of deep sadness and depression. Although those who said they had suffered from depression had been diagnosed by a psychiatrist or a general practitioner, a more formal confirmation of their diagnoses was not sought and I took the participants' word for it. These are also limitations of the study, since the presence or absence of a genuine depressive disorder, especially in those cases where the participants stated they were suffering from normal sadness, could have influenced the way they made sense of their experience, their coping strategies and help-seeking behaviour. However, in spite of the methodological limitations mentioned here, I was reassured that many of the findings - as shown in the "Discussion" section - were generally consistent with those studies that have looked at religious coping styles in the face of adversity and with previous research undertaken with clergy samples that have explored their understanding of mental illnesses and the pastoral care offered to those afflicted by them, as well as with my previous research on the field.

5.3. THE MEDICALISATION OF SADNESS AND THE DARK NIGHT OF THE SOUL

In this section the problems caused by the medicalisation of deep sadness are discussed in the light of the study findings and recent publications in this field. Particular attention is paid to the Dark Night of the Soul, as this culturally mediated way of conceptualising deep sadness as a normal phenomenon richly infused with religious meaning highlights this problem area. Moreover, the Dark Night offers a counterpoint to the modern tendency to resort to the biomedical model of depression to understand and resolve normal intense sadness and acts as a reminder of the risks involved in transforming the latter into something pathological, which could endanger the cathartic process of attributing meaning to suffering consistent with the participants' social and cultural context.

5.3.1. Modern tendency to define severe distress as disease

Medicalisation of sadness as depression

Suffering does not seem to have a place in the modern Western world. It might seem as if 21st century men and women suffered from a new "disorder": "happiness-deficit disorder" (Kelly, 2011). Depression and unhappiness are becoming more and more entangled, as many people feel entitled to be happy at all times no matter what is going on around them; when they fail to feel happy,

its absence is interpreted as evidence that something is medically wrong with them. In contrast, although my participants did not look for suffering gratuitously and tried to resolve or alleviate it when possible, they fully accepted as normal the suffering caused by life's misfortunes and adversities and argued that the human condition has always involved a degree of suffering.

However, their discourse was far more complex than a mere acceptance of suffering based on the old religious adage that life was "a vale of tears". On the one hand, they argued that there were certain things in life which were "worthy of suffering", such as the sadness triggered by secular causes (e.g. falling in and out of love, losing someone very dear to them) as well as by spiritual ones (e.g. undergoing a Dark Night of the Soul, confronting doubts about their contemplative vocation). On the other hand, they discerned a positive side to suffering, as they explained it had the potential to bring beneficial changes to the individual, such as emotional maturation and spiritual growth. Moreover, accepting and bravely enduring one's trials allowed one to bestow an act of sheer generosity to a loved one or unknown people through offering one's own suffering to God in exchange for the alleviation of someone else's, such as a relative who is ill or the victims of a natural disaster.

Defining any form of severe distress in pathological terms seems to be the current trend. Many depressive symptoms are no longer consider "facts of life", but objects for medical treatment, as an increasing number of people expect a pharmacological fix for almost every negative psychological symptom (Conrad,

2007; Paris, 2010b). But should antidepressants be offered to everybody who feels unhappy, no matter what the cause? I rebel against the expectation - or even the demand - that psychiatrists use their expertise to treat pharmacologically those who, lacking a genuine mental illness, complain about feeling unhappy. Surely the absence of happiness is not a mental disorder. I would propose that the main tasks of the psychiatrist when confronted by such requests are to normalise this sadness, to suggest ways of coping that are within the patient's cultural and social resources, and to encourage positive life changes that might increase their personal fulfilment. However, the over-inclusiveness of the current diagnostic criteria for depression does not facilitate these tasks, as it legitimises resorting to psychiatric drugs to deal with the whole spectrum of normal emotional discontent: if people understand their sadness as the result of an illness called depression, then a pharmacological solution easily follows.

Reasons underpinning the medicalisation of sadness

I have often wondered how we have got to the current widespread medicalisation of troubled states of mind. Leaving aside the obvious influence of the "Big Pharma", the reasons underpinning the current state of affairs are certainly complex and diverse and cannot be simplistically analysed. There are some practical financial reasons that cannot be overlooked, such as the government or private insurance companies being more likely to cover the cost of the treatment if one gets a diagnosis of depression (Conrad, 2007), or overstretched national

health systems favouring the prescription of antidepressants instead of psychotherapy as the main treatment for depression on the grounds of cost.

However, I would argue that the following much more personal reasons might well be as powerful as the previous ones. Accepting a prescription for an antidepressant might feel easier, quicker and less threatening for the "patient" than confronting his or her own "demons". Moreover, people are freed from guilt and responsibility for the problems and failures in life that are behind their emotional discontent when their sadness is rephrased as a disorder called "depression" that is caused by a neurochemical imbalance (Solomon, 2002, p. 20). The above is clearly indicated by the fact that seeking help for depression in the medical realm has become widely accepted. The striving of individuals to be seen as modern and progressive has necessarily brought a change in their beliefs about illness and pathways to care (Bhugra & Mastrogianni, 2004). This might well be the case for depression, as there is research evidence indicating that people's beliefs in the likely helpfulness of antidepressants and mental health professionals have increased over recent years (Reavley & Jorm, 2012).

Several authors have pointed to other possible causes of a more disturbing nature as they seriously contemplate to what extent the pressing social problems of the modern world are responsible for the climbing rates of diagnoses of depression. They wonder about the powerful role that this diagnosis and its pharmacological treatment seem to be playing in masking the material deprivation and human disconnectedness that afflict our modern societies. Converting these social

problems into a disease with an organic cause that warrants medication to be resolved diverts responsibility and attention from the government, whose duty should be to resolve these issues through social and political initiatives (Kelly, 2011). Marked economic inequalities, the fast pace of life with its technological slavery, people's increasing loneliness and alienation, and the breakdown of traditional family structures and systems of belief might all have significantly contributed to the epidemic of low mood and existential void (Solomon, 2002, pp. 31-32; Kirmayer & Jarvis, 2005; Gone & Kirmayer, 2010; Pickett & Wilkinson, 2010).

So far I have only referred to one main rationale that moves people to take antidepressant medication, consisting broadly of the alleviation of a large constellation of depressive symptomatology. A new "use" of these drugs needs to be added to the former: people are also willing to take them to compensate for weaknesses in their personalities so as to make themselves more socially competent. Kramer (1993/1997) used the analogy with plastic surgery and introduced the term "cosmetic psychopharmacology" to refer to this latter use of antidepressants. Disability theory can throw some light on this: modern Western society is increasingly less accepting of people who are socially less skilful or who are going through a state of intense sadness. People feel they have to present themselves as upbeat, strong, happy and gregarious to convey the kind of successful image that will enable them to succeed socially and professionally.

5.3.2. Contextualisation of sadness: atrribution of meaning and the Dark Night of the Soul

Problems associated with the decontextualised diagnostic criteria for depression

The findings of my study emphasise the importance of assessing the context in which depressive symptoms occur, as it was precisely the absence of an appropriate context making sense of the distress that led participants to consider the symptoms to be pathological. As can be seen in the literature review (section 2.1.), many other authors have seriously questioned the validity of the current diagnostic criteria for depressive disorder because of its being purely descriptive, and which they feel "ineptly defines depression as the presence of five or more on a list of nine symptoms" (Solomon, 2002, p. 20). The diagnostic classification's neglect of the context in which the depressive symptoms occur is responsible for the lack of discrimination between a natural reaction to adverse life events and a serious mental disorder (e.g. Summerfield, 2006; Horwitz & Wakefield, 2007; Parker, 2007). The lack of understanding of behaviour seems to play an important part in people's perception of abnormality: when a behaviour is understood, it becomes more likely to be seen as normal (Ban, Kashima & Haslam, 2010).

I have been critical of the fact that the DSM-IV's criteria for major depressive disorder only considered depressive symptomatology to be normal in cases of

recent bereavement, since other causes also capable of producing great distress in the individual - such as the break-up of a meaningful relationship, a threatening illness or the loss of a fulfilling job - were ignored. However, I could not help receiving with dismay the new DSM-V's removal of this exemption, which even further decontextualised their already decontextualised diagnostic criteria and left the path open to making grief a medical problem as well. Greenberg (2013) believed that the motivation behind the DSM's elimination of this clause in the new version was simply because it had become an embarrassment: on the one hand, it challenged the idea that depression invariably had a biological aetiology and on the other, it led critics to ask for the inclusion of other external factors (like the examples I mentioned before).

My study revealed that not only academics and mental health professionals were critical of the way depression was currently diagnosed through the application of the diagnostic manuals, but lay people too raised several problems which mirrored the concerns of the former. Participants in my study criticised the imposition of the medical model to deal with intense sadness, and felt it was likely to lead to the labelling of normal episodes of sadness as pathological, and the prescription of pharmacological treatment. It clearly emerged in the interviews that the face validity of depression, as defined in the diagnostic systems, was lacking. Participants argued that in many cases psychiatrists gave a diagnosis of depression to a normal and understandable reaction to life problems and that this could be avoided if the individual's unique circumstances were taken into account. Many of them bluntly stated that doctors often used this

diagnosis and the prescription of antidepressants as "an easy escape" from taking the time and effort to gain an understanding of the patient's experience and context, which could facilitate a resolution within the patient's socio-cultural resources.

My own population survey in Spain also highlighted the importance of taking into account the context when assessing depression and highlighted the lack of face validity in the diagnostic criteria: when people were shown different scenarios of individuals presenting depressive symptomatology, all of which met the criteria for major depressive disorder, it was the absence of an appropriate context explaining the symptoms that made people conceptualise them as abnormal (Durà-Vilà et al., 2011). An example that clearly exposes this problem area is the current movement to screen adolescents for depression, which has brought about an increase in diagnosing amongst this age group. These initiatives have been questioned, as the diagnostic criteria does not take into account adolescents' tendency to react with high levels of negative affect and distress in response to stressful events, however situational these episodes may be (Horwitz & Wakefield, 2009).

The participants' narratives not only highlighted the lack of face validity of the diagnostic criteria for depression, but its cultural validity was also much criticised. While there is some evidence that the core symptoms of depression co-occur as a cluster in many cultures, it is equally obvious that culturally shaped notions of the person and the way sadness and suffering are valued will

impact the clinical syndrome of depression (Kirmayer, 2002). Although my participants accepted the existence of depression as a severe mental illness that significantly impairs functioning and that could have dramatic consequences for the individual, they argued that many people who received this diagnosis were not "truly ill" but were going through normal times of sadness in the face of adversity.

In the case of deeply religious participants, whose sadness had a clear spiritual motivation and content, it was conceptualised as a Dark Night of the Soul. They advocated that both normal "secular" sadness and the Dark Night should be "allowed by the doctors" to be resolved outside the medical world through cultural, religious and social strategies. My findings with regard to the way that sadness was understood amongst Spanish Catholics bore striking similarities with the observations made by Kirmayer (2002, 2004) and Obeyesekere (1985) in other distant cultures. The former noted that Japanese people - in common with my participants - were accepting of sadness and depression, as it offered them the opportunity to confront their own impermanence, losses and imperfections, which could lead to a heightened awareness of the transient nature of the world. They consider antidepressants to be damaging to their moral personhood and spiritual development, as they numb the person's ability to experience sadness. Obeyesekere's findings amongst Buddhist practitioners in Sri Lanka also resonate with mine: many depressive symptoms were not seen as disabling there either, but were cultivated and valued due to their potential for wisdom and spiritual transformation.

Religious contextualisation of sadness: the Dark Night of the Soul

The participants used the term "Dark Night of the Soul" to describe the experience of angst and desolation in one's life associated with profound spiritual suffering. They placed their suffering in a wider context than that offered by psychiatry and medicine in general, one that involves a connection to God and to the history of the Church, as many saints and mystics had experienced this period of spiritual angst. The Dark Night of the Soul made obvious the problems of the decontextualized diagnostic criteria for depression discussed above, as it would almost certainly been considered pathological if the criteria was applied to the experiences detailed by my participants. Moreover, the Dark Night highlights the important part that attributing meaning to sadness plays in the way it is perceived and resolved.

The participants did not see the Dark Night as a pathological phenomenon but, on the contrary, they made sense of this experience in the light of their religious beliefs and faith, and were able to transform their psychological suffering into an active process of self-reflection and an opportunity for spiritual and personal growth. I found the Dark Night's potential of having positive consequences for the individual to be one of the most fascinating aspects of their narratives. They described a broad range of benefits that undergoing it could bring them, the most frequent being the resolution of inner conflicts, the "purification" of certain

negative aspects of their personalities, greater fulfillment and depth in their spiritual lives and more compassion for those suffering around them.

Batson and Ventis' (1982) views with regard to spiritual experiences being problem-solving processes resonate with my participants' accounts. These authors explained that these experiences, which are often triggered by existential crises involving emotional and cognitive stress, could end with an important reduction of the level of tension the individual was under (Batson & Ventis, 1982). May (1982, 2004) explained that when assisting those going through the Dark Night of the Soul he often felt that they would not trade that experience for more pleasure as they sensed at some level the rightness of it. Similarly, my participants considered the Dark Night to be a "good thing", and insisted that it was not a disease but, on the contrary, a natural stage of their spiritual development and an invitation for maturation and for becoming closer to God. At some points in their narratives, the Dark Night seemed to be a rite of passage which helped them to achieve a kind of "spiritual adulthood": it became a journey that took them from a more immature spiritual stage to a more advanced one as "light" triumphed over "darkness". Their religious communities and spiritual directors contributed to this rite by offering powerful communal rituals, symbols and shared narratives of spiritual darkness.

The participants' accounts of experiencing the Dark Night themselves or witnessing and supporting others through it confirmed the concerns I raised in my initial studies with regard to the risks involved in giving a diagnosis of depression, with its pharmacological solution, to someone who believes to be

undergoing a Dark Night. I disagree with May's (2004) position encouraging the prescription of antidepressants to those going through a Dark Night, which he based on his enthusiasm for the therapeutic potential of these drugs[48]: "… the presence of the dark night should not cause any hesitation about treating depression. Because of recently developed medications, depression is now recognized as a very treatable disorder, and it is a crime to let it go unattended." (p. 157). Leaving aside what to me seems a phenomenological impossibility - that an individual might experience at once both a Dark Night and a depressive episode - by giving a diagnosis of a depressive episode to the Dark Night of the Soul psychiatrists may delay - or even prevent - the attribution of meaning from taking place. This attribution of meaning to the experience of psychological suffering is the crucial element acting as a cathartic agent. Therefore, the resolution of a person's suffering through its transformation into the Dark Night of the Soul may be hindered (a simplification of this is represented in Figure 2).

I share the views of Gone and Kirmayer (2010) when they argue that the very act of diagnosing a given pathology in an individual conceals the potential to modify the individual's experience (Gone & Kirmayer, 2010). I am convinced that a medical professional assertively telling their "patients" that they are suffering from a disease called depression has the power to jeopardise the attribution of meaning - religious meaning in the case of my participants - that could bring

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[48] Research evidence has emerged which seriously questions the effectiveness of antidepressants; see section 2.3.2. (e.g. Fournier et al., 2010; Kirsch et al., 2008; Khan, Leventhal, Khan & Brown, 2002; Pigott et al., 2010).

about or at least facilitate the endurance and resolution of their distress. Rather than people embracing the empowering and cherished narrative of the Dark Night, a narrative validated by their communities and by centuries of tradition, which offers hope and is a religious and cultural source of help, we could end up with "patients" accepting an illness narrative instead, adopting the sick role and seeking the resolution of their sadness through passively taking antidepressants.

Another positive aspect of the Dark Night is that experiencing it was not only meaningful and worthwhile for those undergoing the darkness, it was also socially accepted - even highly valued - within the religious contexts in which the participants dwelt. Those undergoing the darkness were not judged or alienated, as may be the case of those diagnosed with a depressive episode, but rather were respected and supported by their spiritual directors and religious communities. Some even achieved a higher spiritual status, since only individuals with a deep spiritual life were challenged by this darkness. This contrasts with the stigma nowadays some people feel is associated with depression and taking antidepressants, and that can possibly lead to greater isolation. The Dark Night was a safe avenue for voicing the sadness and suffering triggered by the problems and adversities they encountered in their spiritual paths, such as having doubts about their contemplative vocations.

FIGURE 2

Flow diagram showing the resolution of the feelings of deep sadness through the process of attribution of meaning that takes place in the Dark Night of the Soul in contrast with the functional impairment that may follow the psychiatric diagnosis of depression
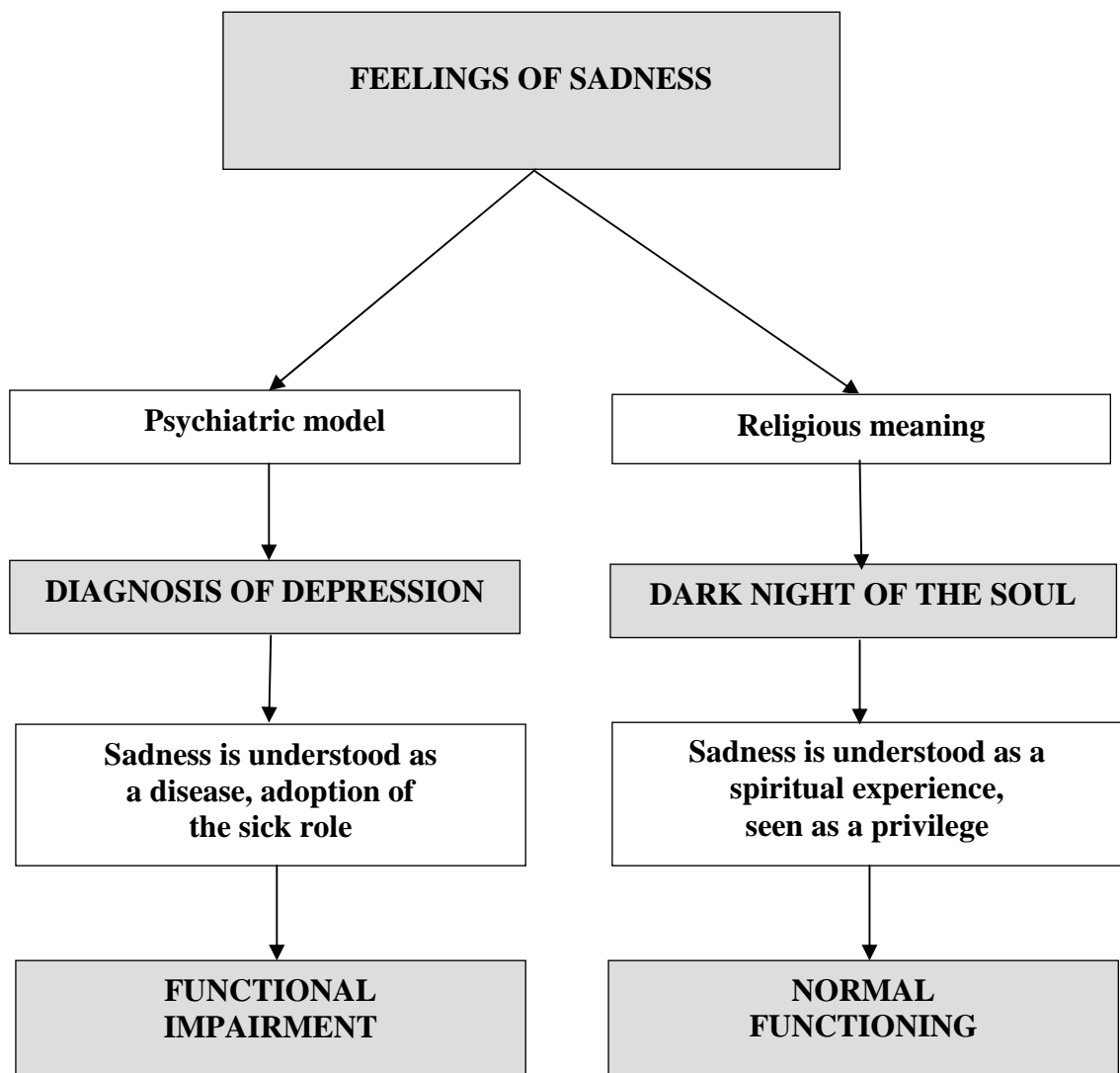
5.4. RELIGIOUS COPING WITH SADNESS AND DEPRESSION

This section starts with a discussion of the main religious coping strategies deployed by the participants - in particular, prayer - and continues with a critical analysis of the main gender differences found in the way the nuns and the monks coped with suffering. It ends with some considerations regarding the role of the clergy in caring for those afflicted by sadness and depression. All the above points are placed in the context of the existing literature.

5.4.1. Religious coping strategies

The participants' descriptions of times when they had been shaken by life's trials and misfortunes provided convincing testimonies of the key role that their faith played in helping them to cope with deep sadness: at a personal level, their religious beliefs infused their suffering with meaning, which protected them from having feelings of hopelessness and emptiness; at a social level, religious communities, parish priests and spiritual directors provided them with a supportive network, as well as being sources of guidance and direction during times of emotional turmoil. Their faith and religious practices contributed to give them a sense of purpose, trust, belonging and self-worth, which led to resilience in the face of adversity (their coping strategies have been described in detail in

section 4.3. of the Findings). This is in keeping with the existing literature that has reported greater self-esteem amongst those more religiously committed (Dein, 2006) and positive correlations between religiousness and feeling more hopeful and optimistic about the future (Koenig et al., 2001). The mechanisms by which religion might promote mental health, proposed by Koenig (1997), appeared consistently in the participants' narratives: first, their system of beliefs provided them with hope, comfort and a mental attitude of obtaining something good from adverse situations by consciously deciding to "turn a situation over" to God; second, their religious community or parish provided them with increased social and emotional support; and third, their activities emphasised a focus on God and on helping others in need (e.g. lay participants' charitable work, monks' attending to their distressed visitors, etc.), transcending the self and forgetting their own difficulties (e.g. poor health, relationship difficulties).

The religious practices the participants undertook to find solace when afflicted by sadness and suffering were in accordance with those found in studies looking at religious coping in times of adversity; for instance, reading inspirational scriptures, talking to a priest or praying (Koenig, 1997, pp. 23-72; Koenig et al., 2001, pp. 17-23). The latter stood out amongst the multiple ways of coping used by the participants to endure sadness: in addition to prayer being one of the most common religious activities, widely used regardless of the participant's level of religious involvement, it was much praised and favored due to the many benefits

they attributed to it. Prayer helped them to have a more optimistic attitude as they trustingly placed the resolution of their problems in God's hands. Moreover, it was an excellent avenue to externalize their negative thoughts and feelings by sharing them with God, which in turn enabled them to be more aware and in control of them. As has been described in the "Findings", praying for the participants was much more than saying prayers, as a significant amount of the time they devoted to prayer was taken up by "pouring their hearts out to God": sharing their problems and experiences as if conversing with an intimate and trusted friend. Prayer even had a positive impact on their physical well-being - particularly on their anxiety levels - as the soothing repetition of prayers (e.g. praying the rosary) helped them to relieve stress, calm down and take their minds off their worries. In consonance with this, a large study designed to look into which aspects of religious observance influenced mental welfare found that the relationship between mental health and religion was likely to be linked to the way people use prayer to deal with stress: people who prayed frequently were less likely to suffer from anxiety and depression (Maltby, Lewis & Day, 1999). The authors argued that personal prayer was much more likely to have a positive effect on mental well-being than going to church for social reasons. This suggests that those who are religious at a personal deeper level might be more protected against mental illness than those who engaged in religious practices for superficial or less genuine reasons, such as social convention.

5.4.2. Gender differences between the contemplative participants

One of the most remarkable gender differences found in the way male and female contemplatives coped with sadness was with regard to the role that the community played: while the support from the community had a key role in alleviating sadness for the nuns, in the case of the monks, sadness was faced alone and was not shared with the community (for more details see section 4.3.4., "Gender differences between nuns and monks in coping and help-seeking"). Moreover, the nuns - in addition to relying on the support of their community to overcome spiritual and worldly obstacles - were also keen to seek guidance and advice from their senior fellow nuns and spiritual directors.

To some extent the nuns' social way of coping appeared dissonant: they chose a retreat towards human contact and compassion, while the monks' choice of facing distress alone seemed more consistent with the pursuit of solitude intrinsic to their renunciation of human attachments. However, in the latter's response, an apparent indifference to the suffering of their fellow monks appeared as a failing (e.g. Brother Terenci's testimony on p. 248). While privacy and respect were given as motivations by the monks for neither seeking nor offering compassion to their fellow brothers in the midst of their suffering, such detachment suggested similarities to old masculine patterns of competitiveness, fear of intimacy and weakness: keeping quiet about one's distress in order to avoid the perception of

spiritual failing. Moreover, offering to help a fellow monk might have posed a challenge to one's own vocation and beliefs, opening the possibility of stirring up inner doubts. Attending to the suffering of those on the outside was a safer channel for compassion. Thus, assisting a layman in his suffering triggered by, for instance, marital or professional difficulties was too removed from the monks' life to be perceived as threatening.

The monks' resolution to keep their suffering from the rest of the monks they lived with bore a resemblance to some of the clergymen's reluctance to open up to their parishioners: in common with the monks, these priests also felt that maintaining their privacy and hiding their problems and distress from those close to them was important. They feared that a revelation of their feelings to their congregants could have been seen as a sign of weakness and render them somewhat vulnerable; moreover, they felt they were the ones who should offer support to the parishioners and not the other way round. On these lines, the findings of several studies undertook with clergymen resonated with our own. Such was the case of a study that interviewed 30 Judeo-Christian clergy, a study set up to explore how they coped with personal crises (Proffitt, Cann, Calhoun & Tedeschi, 2007). Similarly to the monks and the priests in our study, some clergy found themselves to be subjected to "social constraint": a perception that those around them did not welcome emotional disclosure and the sharing of their problems with them. They also felt that their parishioners expected them to have

an unshakable faith, firm religious beliefs and a strong fruitful relationship with God. The authors argued that these social constraints could be quite real since congregants might not welcome expressions of doubt about the search for meaning from their parish priest, as they expected him to have achieved clarity on these issues. Therefore, clergy may need to seek social support outside of their usual social networks, which can delay their return to a sense of well-being after a life crisis.

Another study that conducted in-depth interviews with 24 Catholic parish priests looked at the impact that being obliged to lead a life of celibacy had on their mental health (Hoenkamp-Bisschops, 1992). The author suggested that several aspects of their celibate vow seemed to lead to detrimental consequences for their mental health. On the one hand, the irrevocability of the vow becomes a considerable source of pressure: the decision to remain celibate which was taken earlier in their lives may no longer make sense decades later. On the other hand, priests tend to stop themselves from having close friendships in order to protect their celibacy, thus depriving themselves of an important source of emotional and psychological welfare. This is of relevance, as research evidence has found associations between well-being and having supportive social relationships when dealing with adversities and stressors (Ryff, Singer & Palmersheim, 2004, p. 90-123); conversely a link has also been found between feeling restrained from

sharing life problems with the people close to one and a greater struggle to regain

well-being (Lepore, Silver, Wortman, & Wayment, 1996).

The monks and nuns of my study, when enduring times of darkness, engaged in a

process of mimesis - an effort to imitate or identify with spiritual people from the

past (Young, 2007) - which also had marked gender differences. The monks

aimed to imitate the feeling, attitudes and reactions of the intrepid monks that

started their order,[49] while the nuns identified with battered holy women who had

suffered mainly at the hands of men. Moreover, the monks identified with Christ

as they strived to face and accept their suffering on their own "like Christ". In

contrast, the nuns embraced their condition of "Christ's wives", although they

felt deeply unworthy of it (see section 4.3.4. of the "Findings" for a detailed

description of the nuns' and monks' process of mimesis).

These gender differences resonate with those noted by May (2004) between the

spiritual journeys of two of the most revered mystics in the history of the

Church, Saint Theresa of Jesus and Saint John of the Cross: in keeping with the

monks' spiritual experience, Saint John started on his path full of confidence and

self-reliance while Saint Theresa's, like that of the nuns, began from a humbler

position, doubting herself and putting her trust in others (pp. 166-167). It is likely

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[49] For a description of these monks, see appendix 1, section 2.1. ("Saint Benedict and the origins of the order").

that the nuns and monks of my study would have read the writings of these saints in some depth, triggering a wish to model their lives with those of Saint Theresa's and Saint John's respectively.

Kirmayer's (2007) cultural configurations of the self can also be applied to the contemplative participants: while the nuns' tended to be more sociocentric, the monks' was more egocentric. For the former the self was defined by their belonging to their monastic communities, and they resorted to their fellow sisters for spiritual and emotional healing and often used a polyvocal voice in their narrations about themselves; for the latter, the self was defined by personal achievements, their locus of agency was the individual monk, they relied on their own resources in their times of need and the mode of their narrations was rarely polyvocal, being much more often univocal.[50]

I would like to end this section on gender differences between the contemplative participants by acknowledging that some of the differences found between monks and nuns could well be related to the significant differences existing in their cultural backgrounds, ages and education levels rather than their gender *per se* (for a detailed description of these differences see section 4.1.5. of the Findings, pp. 158-163).

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[50] Kirmayer (2007) clarifies that these ways of construing the self can co-exist - they are not mutually exclusive - and can be in a state of ongoing tension with one another.

5.5. THE CLERGY'S ROLE IN ASSISTING THOSE SUFFERING FROM SADNESS AND DEPRESSION

5.5.1. The study findings in comparison with previous qualitative studies on the clergy

Few studies have investigated, from a qualitative perspective, the point of view of the clergy regarding their beliefs on mental illness and the help they provided to those suffering from psychiatric disorders. To my knowledge, there are no studies in Spain that have examined the views of the clergy in these areas with which to compare and contrast my findings. The studies that are most relevant to mine are the ones conducted by Leavey and colleagues in the UK: they also conducted in depth qualitative interviews with clergymen (Leavey et al., 2007; Leavey, 2008; Leavey, 2010). Although many of their findings resonated with mine, some areas of divergences also appeared that could be explained by the differences in the sample and methods of our respective studies. Besides being carried out in different countries, Leavey's participants came from urban settings (my study included a mixture of urban and rural priests) and his earliest study included non-Christian clergy (my participants were exclusively Catholics). Moreover, Leavey's studies were set up to explore the clergy's views on mental illness as a whole while I, as explained in the "Method" section, focused on the most common mental illness, depression. I would argue that the latter difference in the design of our studies was in great part responsible for the variance in some

of the findings. Although both sets of participants frankly recognised their lack of knowldege of mental health and the insufficient training received in this area, the way they reacted to requests for mental health support differed. Most of Leavey's participanting clergymen tended to meet these requests with caution, reluctance and at times rejection. However, the majority of the priests - and monks - in my study were confident in assisting their parishioners undergoing depression - excluding the most severe forms - and generally only shared the anxiety, fear and inadequacy of their counterparts in Leavey's studies in the case of those suffering from a psychotic illness. In addition to their deficient training, the reluctance of Leavey's participants to help people with mental disorders could be attributed to the fear of the risk they might at times pose to the order of the parish, as the priests talked about feeling "vulnerable" and "intimidated" by those suffering from mental health problems. These fears and feelings were absent from my participants' narratives of pastoral care, as they were focused on the help provided to depressed individuals.

Another difference was the concern voiced by Leavey's participants regarding a possible dissolution of their religious vocations if they were to expand their role into helping those suffering from mental illness. This concern was not echoed by my participants, as they saw their role of helping those going through a depressive episode as being an intrinsic part of their priesthood; one priest even referred to it as being a "sacrament". Again, this difference may be due to the fact that my participants could easily accomodate helping someone suffering from depressive symptomatology as part of given spiritual guidance: the clergy

could use their faith and religious beliefs as antidotes for the hopelessness and emptiness so prevalent amongst depressed individuals, antidotes that were not that pertinent - or indeed useful - in other types of mental illnesses. The religious resources used by the clergy to help in normal cases of deep sadness - such as severe life adversities or the Dark Night of the Soul - were applied to cases of depression as well. Leavey's participants preferred to act as gatekeepers to the formal mental health system; for ours, this was the case mainly for those suffering from psychoses and the most severe forms of depression, since the clergy seemed at ease helping those suffering from mild and moderate forms of depression, which were not associated with suicidal risk. Interestingly, Leavey et al.'s study (2007) seemed to suggest that their participating priests also made a similar distinction to my participants between psychosis and depression with regards to their potentiality to help. A brief comment in this respect appears in their paper explaining that the clergy raised the possibility of playing a more important role in caring for people suffering from depression, as these cases were perceived as less threatening and more amenable to change.

5.5.2. The clergy's view of psychiatrists: rivalry and opposition

The problems that have hindered a potential collaboration between the clergy and psychotherapists are further complicated when these professionals are viewed as being in opposition, or when the work of either is considered to be superior to the other (Julian, 1992). Many of the priests and to a lesser extent the

monks spontaneously compared themselves with psychiatrists, psychologists and psychotherapists when asked about the pastoral care they provided to those suffering from deep sadness and depression. The point of this comparison was undoubtedly positive for the clergy (for a detailed summary of this comparison, see Table 22). An overlap between the work of the clergy and mental health professionals may naturally cause rivalry between them; in Worthen's words, "the problem of easing human anguish and guilt most often falls upon two categories of individuals - psychotherapists and the clergy" (1974, p. 275).

Moreover, in our secular society, clergy may feel threatened by mental health specialists: in the interviews, the participants often commented that people go to psychotherapists rather than to the clergy, just as Jung (1932) noted 80 years ago. These remarks by our participants - especially the clergy - were made in a tone of regret and nostalgia. There was a sense that mental health professionals had experienced a rise in clientele at the expense of the clergy. The priests were not blind to the tendency of people nowadays to opt for secular help when facing emotional and psychological distress - resorting to mental health professionals - rather than resolving these problems within a religious context, such as through frequent confession and spiritual direction, as was formerly the case in Spain some decades ago. Participants blamed the growing secularisation of Spanish society and the gradual loss of religious values for the decrease in the influence of the Church and the priests in people's lives as well as for the greater incidence of mental illness (especially of depression). Again, it was remarkable how similar the views expressed in the interviews were with Jung's opinions: he

argued in his paper "Psychotherapists or the clergy" (1932) that owing to the loss of religious belief and worship, and the belief that the spirituality of the past was no longer valid, neurosis had become more frequent for modern man.

In spite of the vast majority of the priests recognising their lack of mental health training and their anxiety and insecurity when dealing with high risk cases, most of them stated that they still would try to help. Their attitudes are along the lines of Farrell's and Goebert's (2008) findings: over 40% of the participating clergy would assess and manage mentally ill parishioners even if they did not feel adequately prepared to do so. Why were the priests willing to help their mentally ill parishioners in spite of feeling untrained and out of their depth, rather than referring them to mental health services straight away? Why is the clergy so resistant to recommending that those under their spiritual care seek the advice of a mental health professional? Clearly there must be some weighty reasons keeping the clergy from resorting to psychiatric services when this behaviour does indeed cause them considerable worries and troubles. The priests, as well as the majority of the rest of the participants, were critical of the compartmentalised, narrow view of the person that is held by psychiatry, a view which focuses on physical aspects - thus relying too much on medication - while ignoring other essential aspects of the self, such as the inter-relational and spiritual. Nevertheless, this criticism does not seem sufficient to explain the clergy's strong reluctance to refer to mental health professionals, which was what became evident in the interviews. The clergy's wariness of psychiatrists was deeply embedded and likely to be supported by attitudes and stereotypes as

well as by past negative experiences that they themselves or other fellow priests had had in their encounters with mental health professionals. From our conversations, it became clear that the two main reasons behind the priests' views were, on the one hand, a determination not to cede to psychiatrists any more power and influence over people's lives (especially for those still willing to seek clergical advice) and, on the other hand, their perception of psychiatrists as being anti-clerical and anti-religious leading them to fear that mental health professionals might cause greater harm to an already distressed individual.

Regarding the latter reason, there is research evidence supporting the view that psychiatrists are more likely than the general population to be atheists (e.g. in the UK: Neeleman & King, 1993; in the US: Curlin et al., 2007). However, many of the participating clergymen perceived them not simply as atheists, but as taking an active stand against religion. This is a different case than psychiatrists ignoring religious aspects in their clinical practice (Durà-Vilà et al., 2011) or considering them irrelevant to health (Koenig, 1997), in that it implies that not only do they have a negative opinion of religion and those practising it, but that they are at least somewhat influenced by those beliefs when providing clinical care to religious patients. Some clergy participating in Mannon's and Crawford's study (1996) also expressed their worry that mental health specialists might undermine or show contempt for the faith of the parishioners who were referred to their care. My findings are consistent with theirs: there was a strong concern that psychiatrists' negative views on religion and the clergy would be reflected in the treatment of their patients (e.g. ridiculing their religious beliefs,

discouraging them from attending acts of worship, or even recommending that they not follow their parish priest's advice), thus depriving depressed individuals of a source of hope and meaning, and leading to further deterioration of their mental state.

This serious concern was a constant theme in the interviews, being especially frequent amongst the priests, followed by the nuns and monks, and to a lesser extent by the lay theological students. When I asked those expressing these views if there could exist atheist psychiatrists who were respectful towards their patients' religious beliefs and even willing to incorporate spiritual aspects in their clinical management and to collaborate with the clergy, most participants looked utterly bewildered by such a possibility. It is not completely clear from the interviews that the participants' perception of psychiatrists' stand against religion was predicated on evidence coming from real cases or whether their fears were an anticipation of secular hostility within the institution of psychiatry. In other words, do the clergy (and devout religious people) simply presume the antipathy of psychiatrists to religion, or is it actually an identifiable phenomenon?

When a fuller exploration of this was attempted, two response patterns emerged: while some clergy provided good examples of psychiatrists' scornful comments about religion made in clinical settings, even going so far as to recommend to their patients that they abandon their faith, others failed to supply objective evidence for their negative views and avoidance of psychiatrists, other than the

occasional disparaging generalisation of psychiatry as being actively against religion. Commonly, unless prompted by me, this latter group described their reasons in terms of intuitions, feelings and fears. All the priests noted the lack of consultation they received from mental health professionals even when someone's low mood seemed to be triggered by a spiritual crisis, taking this as further proof that psychiatrists' critical views of them were worse than mere indifference.

From these fears and concerns, the clergy's requirement that psychiatrists be religious before collaborating with them naturally follows. My study showed that the priests placed great importance on the religious beliefs of the psychiatrists, as had been found in previous studies (Farrell & Goebert, 2008; McMinn et al., 2005; Kramer et al., 2007; Mannon & Crawford, 1996). However, it seems rather naïve to assume that religious psychiatrists will be keen to do so, as my previous study amongst religious psychiatrists has shown this not to be the case (Durà-Vilà et al., 2011). This study found that the psychiatrists' apprehension was not due to their personal rejection of the supernatural, as our participants argued, but more probably due to the difficulty in combining such different models: the supernatural model with the medical one.

Farrell's and Goebert's quantitative study (2008) found that the amount of training received in mental health was not related to the clergy's views on whether shared beliefs were essential. Although this study used a very different

method from mine, it seems to suggest - as mine indicates - that the reluctance of the clergy to consult psychiatrists about the mental health of a parishioner may be triggered by something more ingrained and subjective, in the realm of attitudes, stereotypes and fears, than their simple lack of knowledge about mental health. An obvious solution to reconcile these two roles is to unite them both - that of a priest and of a mental health professional - in one individual. The names of three Spanish psychiatrists who were also priests and members of a religious order came up repeatedly in the interviews (one of them participated in our study). They had provided - they are currently retired - psychiatric consultations and treatment to clergy, seminarians, monks and nuns. These men were able to maintain their religious calling while practicing psychiatry (one of them was also a psychoanalyst), successfully combining the two professions: using their first-hand knowledge of religious life in their clinical practice to assess and treat fellow members of religious orders and priests.

This is not unique to the Catholic Church in Spain; several of the larger churches throughout the world have "in-house" mental health professionals to treat parishioners (Kramer et al., 2007). St Marylebone Healing and Counselling Centre in London, started by the Anglican Church, is a good example of integrating both professions: the director, the Rev'd Chris MacKenna, is an Anglican priest and a psychoanalytic psychotherapist. The centre offers psychotherapy and, although it is open to all, their publicity clearly states the Christian orientation of their psychotherapists (St Marylebone Healing and

Counselling Centre, 2011).[51] Nevertheless, it may not be an easy task to combine such different frameworks in one joint life project. As the Jungian analyst J. Marvin Spiegelman (1984) argues, many clergy have given up their religious vocation in favour of exclusively pursuing a career as psychotherapists. In spite of the resulting greater independence and freedom from institutional constraints, Spiegelman - as the clergy members and monks of our study did - regarded such a choice as leaving a greater vocation for a lesser one.

The findings from the interviews with the priests and monks of my study posed an apparent paradox: although they fully acknowledged their deficiencies in mental health knowledge and the insufficient training received in this area, they still saw their role in assisting those suffering from profound sadness and depression as superior when subjected to a comparison with the role of a mental health specialist (as has been shown in the "Findings", section 4.4.3.). Above all, this task was considered by the majority to be an integral part of their religious vocation which came from God, an altruistic life-long endeavour, firmly contrasting this with the professional, remunerated and temporal nature of the mental health professional. There was a strong sense in them - particularly in the monks - that the spiritual development achieved through their lives of service, prayer and self-sacrifice could somehow provide the wisdom needed to help those emotionally and psychologically disturbed, compensating for their lack of scientific knowledge.

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[51] The centre offers psychotherapy on a pay-fee basis, but the fee is negotiable depending on the individual's income and circumstances (St Marylebone Healing and Counselling Centre, 2011).

In a recent conference organised by the Royal College of Psychiatrist's Spirituality and Psychiatry Special Interest Group (2011) entitled "Doctors, Clergy and the Troubled Soul: Two Professions, One Vocation?", a member of the audience - formerly a psychiatrist and currently an Anglican minister - explained that for her the main difference between both roles was that she now had the freedom to listen to the person without the pressures of her past medical role (e.g. asking many questions to form a diagnosis, complying with the bureaucracy, having to come up with a management plan, etc.). Listening to her it became apparent that hanging up the white coat in favour of the cassock seems to have been a liberating experience, that her desire to help those psychologically and emotionally distressed was better addressed as a minister than as a doctor, and that she found her task more personally fulfilling now. However, one could argue that all those years of psychiatric training and clinical experience might have been crucial in equipping her with the necessary skills to be able to deliver such a fulfilling level of pastoral care.

5.5.3. Clergy's explanatory models for depression and possible repercussions for their pastoral care

I wanted to explore the clergy's explanations for mental illness and for depression in particular, as they would influence the help they offered to their parishioners as well as the latter's own understanding of what was happening to them. Two main conceptualisations emerged in the priests' interviews:

while in the case of psychotic disorders - the word schizoprenia was frequently used - they tended to discount a supernatural explanation and clearly favored a biomedical model, in the cases of depression and anxiety disorders more complex, multifaceted and at times contradictory explanations emerged. Spiritual aetiological explanations for depression, such as lack of faith and religious values, coexisted with mainstream psychiatric ones, such as neurochemical imbalance (several mentioned the role of serotonin in the causation of depression). This accommodation of non-materialistic explanatory models - e.g. spiritual, social, cultural beliefs - with biomedical ones was not exclusive to the clergy: it was also found in the other participating groups (monks, nuns and lay people). These findings show that even highly religious Catholics have not been immune to the secularisation process that modern Spanish society has undergone, and resonate with Leavey's studies amongst the clergy in the UK (Leavey et al., 2007; Leavey, 2010) and Kramer's in the US (Kramer et al., 2007).

The belief of a malign supernatural presence in psychiatric presentations was extremely rare amongst the participating priests. This finding might be explained by their good education level - they had links with a theological college where several of them were lecturers - rather than their being a particularly liberal sample, which was not the case: they were all mainstream clergy holding a wide spectrum of views ranging from conservative to open-minded and critical. This finding suggests that arguments supporting supernatural interferences in mental illness causation - such as the devil being

responsible for illness and overall suffering - with a subsequent endorsement of spiritual healing modalities are likely to be received with similar degrees of disbelief and sceptism not only by mental health professionals, but also by mainstream and well-educated clergy. This possibility has also been pointed out by other authors (e.g. Bhui & Bhugra, 2002; Dein, 2002).

Only one clergyman, Father Enrique, believed that demonic forces could cause clinical pictures that mimic mental illnesses and that cases of demonic possession were often mistaken for psychiatric disorders. He provided several examples of the latter and had much to say about the role that he had played in discovering the "real nature of the problem". He explained that in such cases psychiatric treatment was invariably doomed to fail and argued for the need to perform exorcisms. He himself was in training to become an exorcist and strongly felt that priests should have adequate training to be able to differentiate between a case of possession by the devil and a genuine mental illness (for more details about this see pp. 181-182). However, most of the priests felt uncomfortable with the practice of exorcism and stated that the vast majority of the so-called cases of "possession" were in fact mental illnesses, mainly psychotic disorders, that warranted a psychiatric and not a religious solution. This more prevalent view would certainly facilitate the communication with and the possibility of a collaboration between the clergy and mental health professionals, since Father Enrique's views are not only unacceptable to secular beliefs but could - more importantly - obstruct the access of mentally ill people to psychiatric care and jeopardise their

compliance with the treatment advised by their mental health team (Leavey &

King, 2007; Leavey, 2008, 2010).

Many participants - especially the clergymen, monks and nuns - not only

argued that believing in God played a crucial part in keeping depression at

bay, but also felt that having depression was incompatible with having true

faith in God and considered those who succumbed to this illness as having a

faith lacking in maturity and depth. In addition to having a "fragile faith",

which was the main spiritual cause of depression and deep sadness, other

spiritual causes were also found: neglecting one's spiritual life, having

significant religious doubts, suffering loss of religious meaning and values,

and abandoning religious observance and practice. I believe that the moral

interpretation that the clergy made of depression is the main barrier that

would have to be removed before a collaboration between the clergy and

mental health professionals could take place.

More importantly, the argument of depression being incompatible with

having true faith in God would be likely to have a detrimental effect on those

afflicted by sadness and depression, since it would, on the one hand, further

accentuate their feelings of guiltiness and lack of self-worth, especially when

coming from their parish priests or spiritual directors, and on the other hand,

create obstacles to religious people's pathways to mental health care, their

engagement with psychiatric services and adherence to the recommended

treatment, outcomes that would be particulary worrisome in those cases of

severe depression associated with higher risk. Unfortunately, my findings in this instance were not an isolated case; other studies concerned with clergy's understanding of the aetiology of depression also found that they saw people undergoing this illness in a critical and judgmental light, considering them to be weak when confronted by life's adversities (Payne 2008, 2009).

Without underestimating how problematic these views are, I think that there is still scope for hope, as the picture emerging from the interviews was a complex one in which seemingly contradictory views were often held by the same priest without any apparent discomfort or even awareness of those views being in conflict with each other. As we have seen in the "Findings" section, supernatural and biological explanatory models for depression naturally coexisted. Moreover, although the priests might have thought that their parishioners' poor faith was to be blamed for their depression, one would certainly hope that common sense and compassion would prevail in most cases and that they would not explicitly share their beliefs with their already distressed parishioners. This would be in keeping with the main strategies used by the clergy to help those afflicted by deep sadness and depression, such as reminding them of God's unconditional love, and their firm views on religious faith and observance would be conducive to optimism and self-worth. It is also important to stress that a significant minority of the priests - especially those with training in mental health - strongly opposed this view and considered it to be completely unacceptable, stating furthermore that it was an example of the pressing need for the clergy to

receive adequate training in mental health. These priests could play an important role in enlightening their fellow priests regarding depression causation from within the Church, as it would be perceived as less threatening than if secular psychiatrists were to undertake this formative task.

5.5.4. Clergy's pastoral care for sadness and depression

The participants' reliance on seeking help from their parish priests could be explained by their highly religious backgrounds. Religious-based beliefs about mental illness are likely to influence the choice of whom they seek help from (Chadda et al., 2001; Cinnirella & Loewenthal, 1999; Cole et al., 1995). Two other studies that I undertook amongst highly religious samples in Spain, in which a quantitave methology was used, found strong associations between the level of religious practice and the recommendation to seek the help of the clergy when suffering from deep sadness and distress (Durà-Vilà et al., 2011; Durà-Vilà & Hodes, 2012).

Virtually all the participants agreed that clergy's pastoral care at its best could be a crucial resource in helping those suffering from deep sadness and depression, and would both resort to it themselves and recommend it to others. However, in spite of this general agreement regarding the clergy's potentiality to help, there was not a clear consensus regarding the level at which this was actually achieved. Some of the participants provided convincing first-hand accounts of

such valuable assistance, while others considered it to be a "missed chance" for the clergy in general, as they regretted their priests' lack of commitment towards those in need of emotional and psychological help. In this subsection I am going to discuss three attributes of the priests that may be key in enabling them to care effectively for religious people afflicted by sadness and depression; followed by three problem areas that may hinder it.

Well-placed to assist those suffering from normal sadness and depression

The findings from this study indicated that spiritual directors and parish priests could play an important part in supporting those under their spiritual care when battling with normal sadness - such as the Dark Night of the Soul - as well as when suffering from a depressive episode. The priests and the monks explained that some people had initially approached them asking for help with relationship tensions, spiritual concerns, professional difficulties or other types of life problems without specifically referring to the possibility that they might be suffering from depression. These spiritual guides are respected and well-placed at a community level, in their parishes and monasteries, to perform this double task: on the one hand, to help those who are sad and distressed and, on the other, to support those who are mentally ill and in need of psychiatric care. The "social discomfort" associated with a psychiatric consultation (Solomon, 2002, p. 23) is avoided, as asking for the advice of a spiritual director is culturally accepted, well-considered and encouraged within the participants' religious settings.

Spiritual directors and parish priests may be in an excellent position to offer help that is culturally sensitive and consistent with the religious values and the way of life of those consulting them. They have a broad range of resources - not all of a religious nature, as has been described in the "Findings", section 4.4. - that they resort to when assisting those who are afflicted by suffering. The cultural concept of the person held by mainstream psychotherapy is based on Euro-American values of individualism (Kirmayer, 2007). This could be problematic for some of the participants, especially for the contemplative ones - particularly the nuns - and for some lay participants who were very committed to a religious group. Spiritual directors and parish priests can go beyond the individualistic and egocentric concept of the person and incorporate others, such as a more sociocentric one that, for example, sees the person in relation to the monastic community. Moreover, their own spiritual experience equips them to fulfil a role others could not perform to such an extent. The clergy may be more open to the potential benefits of a life crisis than lay people even in those cases when they feel tested or abandoned by God; their long-term connection to God may help them to endure those feelings which could become too unsettling and an obstacle to growth for those less spiritually experienced (Proffitt et al., 2007).

The role of the spiritual director is a complex and multifaceted one that goes beyond providing personalised spiritual guidance and support for those under their care so they can reach their maximum spiritual potential (see section 4.4. for a description of this role). Another important - and less obvious - pastoral task came up in the interviews: bringing to light religious beliefs and practices

that could lead to or contribute to mental illness, and trying to rectify them. The most commonly cited beliefs and behaviours were the following: childish religious beliefs, such as having an image of a punitive God who invariably found fault with them, religious fanaticism and fundamentalism, excessive rigidity in their religious convictions, exaggerated piety, engaging in superstitious practices and holding negative and repressive views on sexuality.

Although the potential of religion to cause negative consequences for one's psychological and emotional health was widely and openly acknowledged, the opinions of the participants were somewhat divided as to the extent of the problem. Those holding more liberal views were more blunt about this possibility and even reflected critically on the responsibility that the Catholic Church and the clergy in particular had played in creating and perpetuating those beliefs and practices. They were thought to be at fault for not equipping their parishioners with a stronger theological knowledge and for not challenging inaccurate beliefs and obsessive practices. A few priests and monks blamed the more conservative sectors of the church for actively inculcating these beliefs in the first place by insisting on people's sinful nature and ignoring "the message of liberation contained in the Gospel". However, in spite of the participants' awareness of religion's potential for harm, I need to stress that they did not side with the views of prominent mental health experts who have argued that religious beliefs and practices have a negative effect on people's psychological well-being and that they could cause psychiatric disorders and psychopathological symptoms (e.g. Ellis, 1988; Freud, 1927; Watters, 1992).

They strongly reiterated that this was the result of a poor understanding of faith and a lack of religious education, and further argued that well-informed and balanced faith and mainstream religious beliefs and observance had a positive effect on the individual and were conducive to health and happiness. Therefore, they considered an important part of the clergy's pastoral care to be quick to identify and correct those negative religious beliefs in order to protect and foster their parishioners' emotional well-being.

Ability to support genuine cases of the Dark Night and to differentiate them from depression

In section 5.3., the risks of medicalising normal sadness and particularly, of pathologising the Dark Night of the Soul were discussed. I have advocated that the latter be treated outside the medical model through a religious framework and under the guidance of an experienced spiritual director, as I consider the Dark Night to be a case of non-pathological religious sadness. Although I uncovered fundamental differences between a depressive episode and the Dark Night, it is important to acknowledge the possibility that a genuine case of depression could be mistakenly taken for a Dark Night as, in spite of their differences, they also have many similarities in their presentations (see section 4.2.2. for a description of the differences and commonalities between them). Therefore, spiritual directors need to be alert to identify a possible spiritualisation of depression and to be aware of the presence of signs of this

illness so appropriate mental health care can be sought. This is certainly not a new concern: two prominent 16[th] century mystics, Saint John of the Cross and Saint Theresa of Jesus, also shared this worry. They both had extensive experience in acting as spiritual directors and looking after the members of their communities; their writings captured their determination to differentiate and treat accordingly those suffering from "melancholia" or "bad humours" and to not confuse them with the Dark Night (May, 1982, 2004).

We are facing a very different problem nowadays: while mental illnesses were much more likely to be spiritualised and attributed to supernatural forces in these mystics' time, normal human experience such as deep sadness or the Dark Night is running the risk of being medicalised in the 21[st] century Western world. However, the case of highly religious people living within secular modern societies - as may be the case for isolated monastic communities - might resemble the mystics' situation in that they might tend to spiritualise depression using the framework of the Dark Night, as this is more acceptable - and even valued - within their religious communities. There is evidence that ethnocultural groups frequently express depressive symptomatology in different ways so as to fit in with their communities by somatising certain symptoms (Raguram, Weiss, Channabasavanna & Devins, 1996). That our highly religious participants seemed to spiritualise their sadness rather than somatise it might be explained by the tendency, existing amongst the more conservative sectors of the Catholic Church, to despise the body in favour of the exaltation of the spirit.

Sharing the same religious language to express distress

People suffering from depressive symptomatology often resort to metaphors and allegory to describe what they are going through (Solomon, 2002, p. 16), and those selected by deeply religious people are likely to differ from those chosen by others. Many of the narratives of intense sadness that the participants shared with me contained metaphors, symbols and images filled with religious meaning. However, the majority of them felt that - in a clinical setting - they were expected to describe their intense sadness in purely medical terms and they consciously avoided any reference to the religious significance their distress had for them in order to avert embarrassment or even judgement, since there was a widespread concern that psychiatrists were antireligion. Religious people are likely to employ strictly secular language in their interactions with mental health professionals in order to fit in with the medical model in which the latter operate. Thus, their sadness and existential angst were more easily phrased in terms of illness, along the lines of depression, as their accounts were purged of any meaningful religious attribution. The style of clinical presentation largely depends on the patients' symptom attribution and their strategic decision as to which aspects of their distress they consider appropriate to present to the clinician (Kirmayer & Robins, 1996).

However, when the participants were in the presence of their confessor, spiritual director or parish priest, their religious narratives naturally unfolded as they felt completely at ease expressing themselves in religious terms and attributing

spiritual meaning to their sadness. Identification with the powerful religious narratives of suffering accumulated throughout centuries of the history of the Church could take place, which allowed their accounts of woe to be transformed into meaningful religious experiences. In contrast with the cathartic value of these religious stories and metaphors of sadness, the current medical model of consultation does not invite these attributions of personal meaning - religious or not - to occur and the suffering of the individual is presented as a collection of symptoms without any meaning, potential or finality.

Moore (2004/2011) argued that the great cultural stories and myths of suffering provided examples of human struggle that could help and inspire the individual in their personal suffering. He believed that conveying the experience of the Dark Night using powerful images or compelling stories had a therapeutic value. Participants referred to a number of religious stories to voice their experiences, such as the Calvary, the Mount of Olives and the Resurrection, and also resorted to metaphors, such as that of Father Alberto who, drawing from his love of nature, compared the tension and struggle of the Dark Night to the snake's need to shed its skin to be able to grow.[52] Moreover, in contrast with the negative connotations of hopelessness, stigma and sick-role attached to the word "depression", couching one's suffering in terms of "Dark Night of the Soul" had in itself an intrinsic therapeutic value - even an aesthetic value - as it summons many positive associations, such as the triumph of light after the darkness of the night or the examples of many revered saints who have been transformed by it. It

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[52] The full quotation of Father Alberto's words is in section 4.2.2., p. 181.

became clear that spiritual directors were not only receptive to these images, narratives, metaphors and religious terminologies, but also welcomed them in order to foster hope and meaning for those under their spiritual care who were torn by sadness.

Unsuitable spiritual directors make the quest for a "good" one necessary

The crucial importance of the spiritual director in times of spiritual darkness is reflected in the emphasis that the participants give to finding the "right one" and not settling for someone more convenient, such as one's own parish priest. They talked about the need to "shop around" until "the person who could truly understand and help you" was found. They were willing to embark on an arduous journey to find the mental health professional or the priest who was right for them. The time and effort devoted to this search was considered worthwhile, as so much was at a stake: their emotional, psychological and spiritual well-being.

Interestingly, the participants' concern was also shared by Saint Theresa of Jesus and Saint John of the Cross, as their writings show (May, 2004, p. 25). Being under the spiritual care of unsuitable directors caused Theresa great suffering. Some of her directors even attributed her mystical experiences to the devil. She explained going from one director to another until she finally met an ascetic Franciscan friar called Pedro of Alcántara. He gave her the understanding she

longed for and reassured her of the validity of her experiences. Unlike my participants who invariably referred to male spiritual directors[53], John found the spiritual companionship he needed in a woman, Saint Theresa of Jesus, whom he affectionately gave the name of "spiritual mother". Both saints warned of the dangers involved in putting one's spiritual life in the hands of the wrong spiritual director. They recommended selecting a director who, in addition to being knowledgeable from an academic and scriptural perspective, was experienced in their own life of prayer. In order to avoid the harmful consequences that misdirection could have, they encouraged people to meet with more than one potential director if in doubt (May, 2004, p. 169-173). The following quotation from Theresa's autobiographical book captures the suffering caused by inappropriate spiritual directors (Saint Theresa of Jesus, 1565/1991, chapter XXV, p. 314):

> Not a fig shall I care then for all the devils in hell: it is they who will fear me.... I am quite sure I am more afraid of people who are themselves terrified of the devil than I am of the devil himself. For he cannot harm me in the least, whereas they, especially if they are confessors, can upset people a great deal, and for several years they were such a trial to me that I marvel now that I was able to bear it. Blessed be the Lord, Who has been of such real help to me!

In the notion of the "good and bad spiritual director" there was an implicit critique of the clergy, as it tolerated the existence of the latter.[54] Although the level to which the participants took their critical analysis of the clergy varied, the

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[53] When referring to their spiritual director, the participants used the masculine ending ("director espiritual" or "directores espirituales") or preceded their names with "Father" or "Brother".

[54] Similarly to spiritual directors, the participants also differentiated between "good and bad psychiatrists" (see section 4.4.3.)

old idealised image of priesthood in which the priest was considered incapable of fault was replaced by a more "down-to-earth" and "realistic" one; this was also found in Leavey's (2008, 2010) studies on the clergy. The religiosity of the lay participants and the love and admiration that the "good priest" inspired in them did not keep them from clearly seeing and pointing out the shortcomings of today's priests. Clergy's positive attributes - such as having unconditional compassion, a strong caring and service attitude and unshakable moral standards - were not taken for granted anymore and were praised in those who had them. Their studies in theology might have empowered them to be more confident in expressing their critical views with regard to what they considered unacceptable in the clergy from a theological perspective.

The clergy's lack of availability to help their parishioners was one of the most common criticisms and was particularly frequent amongst the lay participants who were highly committed to the running of the parish (while at the same time meeting the demands of their jobs and families). Moreover, it negatively affected the quality of the relationship between the parish priest and the people integrating the parish community. A study looking at different criteria for what makes a "successful" parish found that the relationship between the parish and the priest was the key for a parish to work (Ryan, 1997). The interviews also left no doubt about the capacity that the clergy had for self-criticism, as blunt and sharp criticisms were the norm in many of the priests' testimonies. Many provided compelling narratives of the frustration and pain that they felt when they witnessed a lack of commitment in other members of the clergy. The

severity of their criticisms might have been fuelled by having a deeper insight into the real state of the Church and by the fact that the existence of the "bad priest" posed a threat to their own vocation.

Discrepancies in attitudes to the sacrament of confession and to the spiritual director's level of authority

Although the participants regarded highly the sacramental value of confession through its forgiveness of sins, the majority preferred it when a layer of spiritual accompaniment could be added. Besides giving an account of their faults, they wanted to be able to talk openly to their confessor about their spiritual and secular worries. However, a minority of the participants strongly stated that the sacrament of confession and spiritual direction should not take place together. Worthen (1974) argued that in spite of the general disagreement within the Church itself as to the level of involvement that the confessor should have in the personal problems of the individual seeking confession, the predominant view held by the clergy was one defending that confession should primarily focus on the forgiveness of one's sins and that listening to and offering advice about personal trials should be considered as secondary, if at all. The three decades that separate the priests that Worthen wrote about from those in my study and the high educational level of my clergy sample could explain the discrepancy between their opinions about confession. However, Worthen made an observation which was corroborated by the findings of my study: the more

dogmatic priests were the ones more likely to defend the view that emotional difficulties should be dealt with outside the confessional, while less conservative priests might not have a problem with this, as they considered the penitent's failings to be intrinsically linked with the emotional and psychological aspects of the self.

My findings showed considerable disparity with regard to the participants' description of their ideal parish priest and spiritual director. Their views ranged from those who preferred him to have a high level of authority and a paternalistic attitude to those who advocated greater proximity and equality to those he helped. Interestingly, the participants of my study - priests and non-members of the clergy - who held the minority view that confession should be strictly about the redemption of one's sins were also the ones whose ideal spiritual director was highly authoritative. These differences of opinion were reflected by the importance given to the word used to describe the priest in charge of helping with one's spiritual progress. A few participants felt very uncomfortable with the use of the terms "spiritual director" or "spiritual direction" due to its implying high authority and superiority, and opted instead for using the terms "spiritual accompaniment", "spiritual brother" or "spiritual guide". Conversely, some of the more conservative priests felt equally unhappy with the latter terms and did not shy away from the terms "director" or "direction", as they argued that those in a position to guide someone spiritually had to be able to "direct" them through their spiritual darkness and challenges and needed to be wiser and more spiritually advanced than those they served.

This lack of agreement is consistent with the literature in the field. Rogers (2002) argued that spiritual directors' authority was linked to the task they were at times called upon to perform, such as being a "soul physician" or a "confessor". In contrast, spiritual directors who adopted a low level of authority and who saw their role as walking alongside their directees to help them find God's path were more at ease being described as "a trusted friend", "God's usher" (Merton, 1960) or "a spiritual friend" (Benner, 2002).

Lack of affective and spiritual maturity

Moore (2004/2011) - like most participants - highlighted the key role that priests could potentially play in helping the individual to find meaning when confronted by periods of spiritual suffering. He also warned that religion had often avoided the dark and had tried to hide it with false reassurances and platitudes, which led to the infantilisation of one's spirituality rather than facilitating the spiritual adulthood that the Dark Night could bring about. The participants often complained about those clergy - as well as about monks and nuns - who were "immature" at two levels: at a spiritual one, having "childish beliefs" and "poor spiritual lives", and at an emotional one, which led to problems in regulating their emotions and impaired their relationships with others. These priests were not in a position to offer guidance to someone through their spiritual journeys and Dark Nights, as they lacked the spiritual subtlety and intuition required. A call for priests who took their own spiritual life very seriously, who were not

only compassionate and caring but also intelligent, deep, reflective and emotionally stable and mature, strongly emerged in the interviews. Similarly, Thomas Merton (1998), a Cistercian monk with vast experience in spiritual direction and in looking after those new to the contemplative life, emphasised the importance of the latter: although he valued a good education level in his novices - he recommended that they finish secondary school or get a university education before entering the monastery -, he left no doubt about what he considered far more crucial than academic attainment: their affective maturity.

This deficiency in the clergy was particularly pointed out by the monks in the first place and by the priests themselves in the second place and was held responsible for many of the problems that the clergy faced, such as feeling unfulfilled by and disenchanted with their priesthood, suffering from loneliness, lacking an attitude of service and commitment to their parishioners, and being unable to offer a deep and meaningful spiritual direction (see section 4.4.2. for a detailed description of this problem area in the clergy). Clergy's lack of spiritual maturity was seen as a significant obstacle that hindered their ability to effectively support those undergoing a Dark Night of the Soul. Their neglect of their own spiritual development meant for many participants that the actual care they provided to people who were highly devoted to their spiritual growth in their times of darkness fell short of what they really needed.

5.5.5. Final reflections on pastoral care

The reality of many parish priests - who were overwhelmed by sacramental duties, bureaucratic demands and by the added pressure caused by the fall in the number of new priests being ordained - contrasted with the monks'. While these clergymen had hectic life styles and struggled to find time to devote to their own spiritual growth and to provide personalised pastoral care to their parishioners, the monks led lives of prayer, reflection and silence, which they explained equipped them with the necessary qualities to be able to be sensitive and responsive to the suffering and needs of other human beings. The monks saw themselves as an alternative to the parish priest in the task of helping those who were emotionally and psychologically disturbed or going through a spiritual crisis. Moreover, the support structure and division of work provided by the monastic community made it possible for the monks to free up time to meet individually with their guests and visitors who wished to do so. Thus, their monastery was presented as a "sanctuary" for distressed people in need of advice, solace and sympathy. However, in spite of the stress parish priests were under, their lack of time and the uneasiness caused by their limited mental health knowledge, there was a strong sense in most of them that being a source of support and hope for those who were suffering from intense sadness and depression was an integral part of their religious vocation.

An important barrier encountered by some of the participating priests in their provision of spiritual direction to those suffering from sadness and depression

was the isolation they felt in facing the demands and challenges intrinsic to this task. They complained about the lack of support networks and supervisory structures to assist and help them. However, this complaint contrasts with the wealth of resources available to them. These clergymen seemed to be ignorant of the professional networks and training programmes existing for spiritual directors that could have enabled them to overcome or at least reduce this barrier. There are indeed a constellation of associations devoted to them to help in the development of their practice as spiritual directors as well as to facilitate links with other spiritual directors. These organisations offered a broad range of training opportunities such as publications, events, courses, outreach programmes and workshops for spiritual directors. Moreover, they emphasised the importance of not working in isolation, thereby providing those involved in spiritual care with the means to connect with one another and to become part of supervision groups.[55]

The romantic depiction of the selfless priest invariably willing to go the extra mile to help their parishioners and who was always helpful and sympathetic was challenged by the participants. The priests who took the time to get to know the human being behind the parishioner with their particular personal and social

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[55] Examples of such learning communities are the "Spiritual Directors International" which has a large membership of more than six thousand people on six continents including forty-five spiritual traditions, and "The London Spirituality Centre" which also serves spiritual directors' well-being and development drawing upon Christian spirituality and contemporary psychological insight (Spiritual Directors International, 2014 and The London Spirituality Centre, 2014, respectively). Probably the one more relevant to the participating clergymen is "Catholic Spiritual Direction"'. It utilises the expertise of trained, practising Catholic spiritual directors and provides supervision and training through the internet, by e-mail and by telephone to those who are unable to have the benefit of direction face-to-face. The latter could have fitted well with the busy schedules of many of the participating clergymen (Catholic Spiritual Direction, 2014).

circumstances were considered to be exceptional. A powerful narrative emerged in the study reflecting how priests were often losing the battle to provide empathic and personalised assistance to those they care for due to feeling obligated to fulfil less important tasks. They felt trapped by the demands of professionalisation and bureaucracy and overwhelmed by the fast pace of life (this is indeed applicable to other professional groups too, such as doctors). However, in spite of priests being seen as capable of succumbing to these "modern devils", some of the testimonies contained in this thesis depicting experienced, intuitive and caring priests, whose religious vocation was manifest as a life-long altruistic commitment to serve those who suffer, served as reminders of the possibility of breaking with these constraints.[56]

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[56] The constraints the clergy were under reminded me of the "iron cage": a sociological concept introduced by Max Weber. He argued that people, especially in Western capitalist societies, are trapped by this "iron cage" as they become subjected to systems based on efficiency, control and rational calculation. The demands of bureaucracy and the adherence to the system's rules are seen as playing an important role in limiting individual freedom (Lassman & Speirs, 1994).

5.6. A FRAMEWORK TO DIFFERENTIATE NORMAL SADNESS FROM DEPRESSION

Looking back at the origins of the study

I will start the last section of the thesis by presenting a reflection on the origins of this research and the motivation for embarking on this project. I was intrigued by the findings of my initial research on the field of culture and depression with regard to the potential of the Dark Night of the Soul - an experience of sadness deeply rooted within a particular cultural and social context - to act as a "magnifying glass" to clearly reveal the problems of the current decontextualised diagnostic criteria for depressive disorder that fails to differentiate normal from abnormal sadness. My first ethnographic study in a monastic setting opened my eyes not only to the theoretical pitfalls of the diagnostic system but also, and more importantly, to the risks associated with the medicalisation of a normal experience of sadness - the nuns' Dark Night -, since this medicalisation endangered the attribution of powerful religious meaning and the use of rich social and cultural coping resources, both of which were clinically relevant (this has been discussed extensively throughout the thesis, sections 4.2., 4.3., 4.4., 5.3.). With this in mind, I set up a study which was the first, to my knowledge, to use ethnography to explore in-depth the experience and conceptualisation of deep sadness and the coping strategies and help-seeking behaviours amongst a sample of Spanish Catholics who reflected the diversity of the Catholic Church.

Moreover, I wanted the research of my PhD both to go beyond offering a theoretical critique of the diagnostic criteria for depression - which, as shown in the "Literature Review", section 2.1.1, has been thoroughly done by many authors - and to have a clinically meaningful dimension. Thus, I will end the thesis by proposing a framework that could allow a differentiation between normal deep sadness and its pathological counterpart, depression. This framework is based on the rigorous analysis and synthesis of the participants' narratives of intense sadness. This was the fifth and final aim of the study (the rest of the aims have been addressed in the "Findings" section).

Rationale of the framework

My study revealed an alternative configuration of deep sadness and distress as a normal phenomenon that encompassed the social, cultural and religious resources of a religious sample and included the indigenous category of the Dark Night of the Soul in the case of those more spiritually committed. The accession of hope and meaning attached to the participants' religious understanding of sadness should neither be dismissed by mental health professionals nor endangered by medicalising it. The beliefs and behaviours of participants run counter to the overgeneralised current diagnostic criteria for depression, as they argued that many of the cases diagnosed as such were in fact the normal experience of human sadness. They were disturbed by the current widespread

pathologisation of normal intense sadness, including religious phenomena such as the Dark Night of the Soul, as depression, and the subsequent imposition of a medical model which leads to the overprescription of antidepressant drugs. The framework I am presenting here adds some key aspects ignored by the diagnostic criteria that the findings illustrate, and thus enables a distinction between pathological and normal sadness that made sense to the participants. By "protecting" normal sadness from receiving a diagnosis of depression, the framework may allow people to attribute meaning to their experiences of sadness, loss, demoralisation, void and disenchantment with life choices which are likely to be infused with existential meaning.

Although I support the call of many authors to change the diagnostic classifications with regard to depressive disorder due to their inability to tease out normal from pathological forms of sadness, this is unlikely to happen. As has been extensively discussed in the thesis, too much is invested in the diagnostic systems: they are embedded in all aspects of psychiatric research and practice, so any modification is inevitably going to be faced with firm opposition. My framework is far less ambitious than a change in diagnostic systems: it is a practical solution, a clinical suggestion for those working in mental health, that could be used within one's clinical practice when assessing someone for depression. As seen in the "Literature Review", this framework has similarities with the solutions proposed by other scholars in the field (e.g. Horwitz & Wakefield, 2007).

Many professionals may already put in practice much of what I propose in my model as part of performing a mental state examination and taking a thorough history. However, I would encourage them to keep this framework in mind when deciding whether to give a diagnosis of depression and to restrain them from giving too hasty a diagnosis. It could also be useful to counteract the tendency of doctors to apply a strict medical model when conducting a psychiatric assessment - particularly in the case of medical specialists outside the mental health field - in which symptoms are gathered from the patient's history and from various examinations and tests, which lead them to make a diagnosis without giving sufficient consideration to the patient's personal, social and cultural dimensions. As a trainer of medical students, general practitioner trainees and junior psychiatrists, I have often witnessed this tendency to simplify the diagnostic process for depression to a box-ticking of symptoms.

Assessment of deep sadness and help-seeking behaviours for normal sadness and depression

The synthesising effort that allowed the creation of this framework was facilitated by the fact that - in spite of the heterogeneity of my sample, which covered a wide range of socio-demographic and religious backgrounds - there was much agreement in the participants' way of distinguishing normal sadness from depression. The need to take into consideration the following three areas in the assessment of people suffering from depressive symptomatology strongly

emerged in the interviews: firstly, the context in which the symptoms occur; secondly, the impact on the individual's functioning and finally, the level of risk (the process of differentiation between normal and pathological sadness has been summarised as a flow diagram in Figure 3).

The second and third areas to include in the assessment of a potential case of depression - level of functioning and risk - were more in tune with what any responsible mental health professional would make sure of covering. However, the area the participants thought to be most neglected by the professionals - an in-depth exploration of the existence or absence of a context or cause that could explain the sadness experienced by the individual - was the one they considered paramount, as it would allow the psychiatrist to differentiate between, as they often worded it, "sadness that made sense" *versus* "sadness that didn't make sense". They had much to say about how important it was for doctors to try to understand their patients' sadness before prematurely labelling it as depression.

The many hours spent listening to the participants' narratives of sadness made me very much aware of the great importance that making sense of one's suffering had for the phenomenological experience of sadness. The participants' narratives of normal deep sadness contained a spontaneous and often detailed description of one or more causes that were held responsible for their suffering. It seemed important to them to make me see, even to convince me, that their sadness was an understandable consequence of adversity. The opposite was also true: in their accounts of their own or others' depressive episodes, they shared

their puzzlement over the lack of a context sustaining the suffering (e.g. "he had everything going for him, it [his sadness] didn't make any sense!").
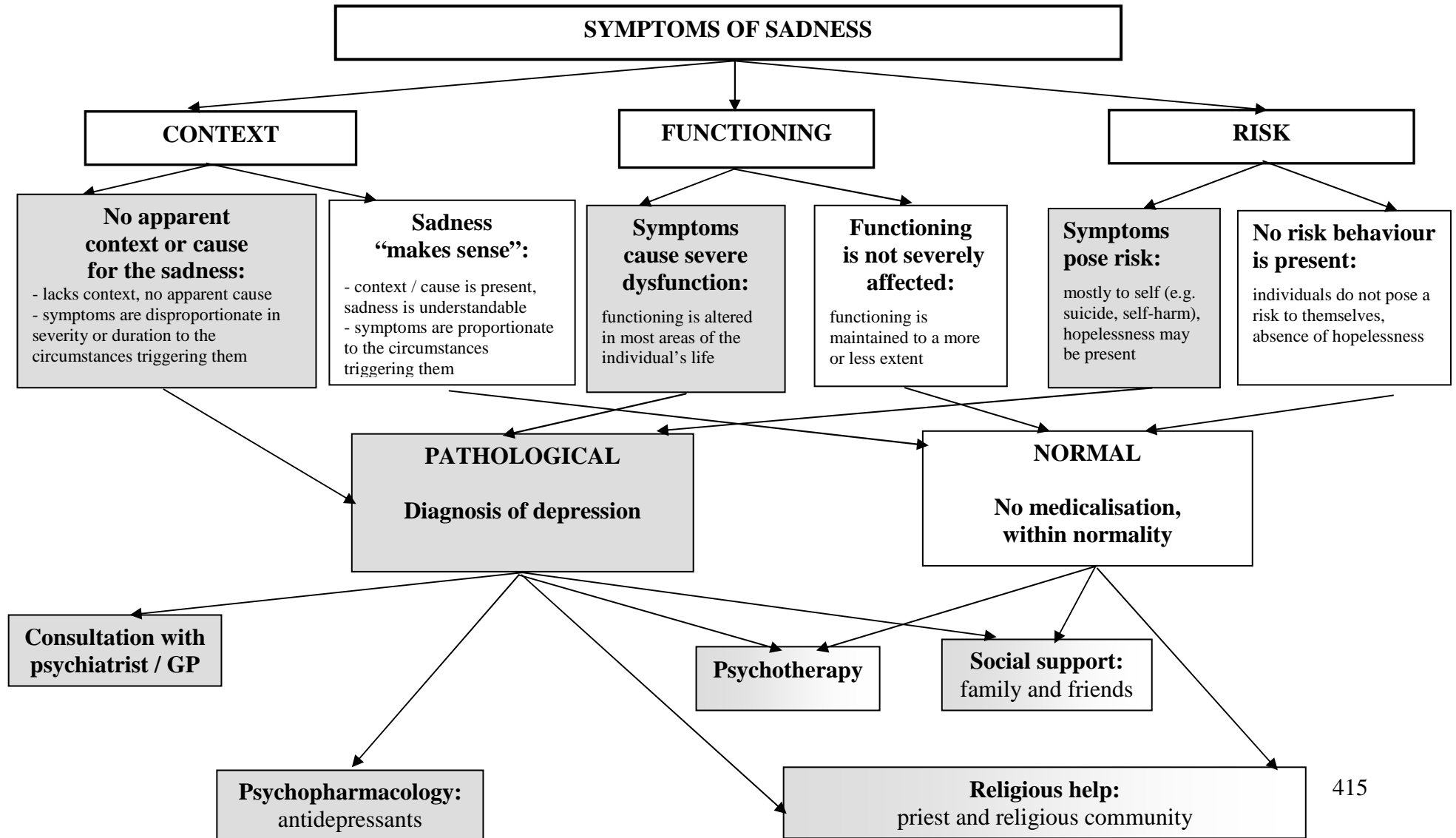
The application of diagnostic criteria for depression that disregarded the need for contextualising sadness was rejected by the participants; as one participant put it: "it made no sense at all!" Therefore, a study of the context in which sadness occurs is essential when evaluating emotional and psychological distress. However, identifying a cause for the sadness did not mean that it was invariably considered normal, as one more aspect needed to be taken into consideration when deciding if the symptoms of sadness "made sense or not", this being a qualitative assessment of the symptomatology, so symptoms which were disproportionate in severity or duration for the circumstances triggering them were considered pathological - again "they didn't make sense" - and those which were appropriate and proportionate, given the cause, tended to be seen as normal - "they did make sense".

These three areas of assessment - context of the sadness, the impact on functioning and the risk - constitute the core of the proposed framework for differentiating between depression and sadness. In summary, it was considered evidence for the sadness to be conceptualised as pathological and as likely to warrant a diagnosis of depression when the symptoms: 1) "did not make sense", when no apparent cause was found to support them or when, in spite of having a context explaining the sadness, they were disproportionate in severity or duration to the circumstances triggering them, 2) caused severe dysfunction,

with the individual's functioning being altered in many areas of life (e.g. personal, professional, spiritual), and 3) posed considerable risk to the individual, mostly to self (e.g. suicide, self-harm). Conversely, an episode of sadness was likely to be understood within the bounds of normality when: 1) the sadness was explained by a context or a cause and was proportionate to the circumstances triggering them, 2) the individual's functioning was not severely affected, and 3) risk behaviours were not present.

An in-depth assessment by mental health professionals of the experience of sadness requires an understanding that goes beyond the current descriptive criteria used to diagnose depression. In addition to carefully considering the impact of the symptoms on the individual's functioning and evaluating the level of risk, the exploration of the context in which the sadness occurs and the meaning the individual attributes to it, should become a central part of the assessment. The outcome of this assessment - the consideration of the symptoms of sadness as being normal or abnormal - is crucial, as it was clearly found that it will determine the help-seeking behaviours that the individual will resort to (as the flow diagram, Figure 3, shows).

FIGURE 3

Process of differentiation between normal and pathological sadness, and help-seeking behaviour

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                        │         SYMPTOMS OF SADNESS             │
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CONTEXT	FUNCTIONING	RISK

No apparent context or cause for the sadness:
- lacks context, no apparent cause
- symptoms are disproportionate in severity or duration to the circumstances triggering them

Sadness "makes sense":
- context / cause is present, sadness is understandable
- symptoms are proportionate to the circumstances triggering them

Symptoms cause severe dysfunction:
functioning is altered in most areas of the individual's life

Functioning is not severely affected:
functioning is maintained to a more or less extent

Symptoms pose risk:
mostly to self (e.g. suicide, self-harm), hopelessness may be present

No risk behaviour is present:
individuals do not pose a risk to themselves, absence of hopelessness

PATHOLOGICAL

Diagnosis of depression

NORMAL

No medicalisation, within normality

Consultation with psychiatrist / GP

Psychotherapy

Social support: family and friends

Psychopharmacology: antidepressants

Religious help: priest and religious community

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Secular and religious help-seeking behaviours co-exist in this framework. Interestingly, there was much overlap in the behaviours the participants used for both normal sadness and depression: only two help-seeking behaviours - consultation with a general practitioner or a psychiatrist, and taking antidepressants - were exclusive to the case when the sadness was considered pathological and received a diagnosis of depression. As noted in the "Findings", section 4.3., the requisite of being ill, necessary to justify the use of antidepressant medication, did not apply to psychotherapeutic work, as this was seen as potentially beneficial for both normal sadness and depression: it could help not only to deal with feelings of distress and sadness but also for personal development. The use of social sources of support - friends and relatives - and the religious ones - parish priest, spiritual director and religious community - to cope with and overcome normal sadness were also seen as useful when the sadness was abnormal and were added to the previous medical options.

The findings of this study underline how crucial it is to acknowledge, before medical professionals rush to apply biomedical and psychological treatments for depression, that non-medical forms of healing consistent with local beliefs and values may provide cost-effective treatments for depression and related common disorders (Kirmayer & Jarvis, 2005). My study showed that the participants used a wealth of culturally mediated ways of coping with sadness which effectively helped them to endure suffering and to regain a state of well-being. Adaptive coping strategies such as seeking relief in prayer, in the guidance and support offered through spiritual direction or in the liberating effects of confession and

penitential rituals should not be undermined or ridiculed by medical and mental health professionals.

The role of assessing hope in distinguishing the Dark Night of the Soul from depression

Those participants who had suffered from depression themselves could without hesitation distinguish it from times when they went through normal intense sadness; as a participant bluntly put it when referring to a time of normal sadness due to severe hardship: "I knew I was totally screwed but not depressed!" Similarly, Solomon (2002) described his certainty that he was suffering from depression: "no one has ever been able to define the collapse point that marks major depression... when you get there, there's not much mistaking it!... you are simply absent from yourself... the meaninglessness of every enterprise and every emotion, the meaninglessness of life itself, becomes self-evident. The only feeling left in this loveless state is insignificance" (p. 15-19).

The participants emphasised the great importance of assessing hope not only in order to determine the level of risk of those suffering from depressive symptomatology, but also as a way to set normal sadness, and the Dark Night of the Soul in particular, apart from depression, as in the former hope was always preserved through the firm belief that God would sustain them until "the light overcame the darkness". Their narratives of depression revealed the important

role that the loss of hope seemed to play in the phenomenology of depression and in distinguishing it from normal deep sadness. The participants considered the absence of hope as a clear indication of pathology; moreover they saw it as a sign of the most severe and dangerous form of depression, as it was clearly associated with a marked increase in the level of risk, with the threat of suicide becoming a serious concern.

In contrast with depression, the experience of losing hope was totally absent from the participants' descriptions of normal intense sadness no matter how profound their angst was, and its presence was denied when I specifically asked about it. Losing hope was often seen as incompatible with believing in a god who would always provide and care for them regardless of how gloomy their future looked. Their faith in God seemed to act as an "antidote" against hopelessness, as even in the worst scenario - death - they believed that resurrection and heaven would be awaiting them. The preservation of hope was particularly marked and even accentuated in the case of the Dark Night of the Soul. The Dark Night offered the participants an alternative structure for dealing with distress that integrated their religious and cultural values, in which their trust in God fostered the maintenance of a hopeful attitude throughout their suffering, allowing an outlook which might offer a better social course and outcome than the medical diagnosis of depression.

Concerns with regard to the possibility of mental health professionals' medicalising the Dark Night as depression were found in the interviews. This is

the case as, in spite of the Dark Night being described in spiritual rather than psychological or medical terms by their sufferers, it is likely that at some point or another those going through the Dark Night will have contact with mental health professionals due to the significant overlap of its symptomatology with depression.[57]

 Thus, medical and mental health professionals who encounter people who appear to be undergoing this period of spiritual darkness - especially if they are under the care of an experienced spiritual director - should perhaps resist diagnosing depression and prescribing antidepressants and to opt for careful watching instead. It is important to emphasise here that when the participants with experience in supporting those undergoing a Dark Night were asked about the risks that it posed for the individual, they unanimously agreed that it did not lead to hopelessness, suicide or other high risk behaviours in spite of the intensity of the suffering that the individual might be experiencing (see section 4.2.2 for a detailed description of the Dark Night and its differences with depression, especially in terms of risk). This coincides with the findings of other scholars of the Dark Night such as Font (1999) and May (1982, 2004).

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[57] Those participants with experience in providing spiritual direction acknowledged that the distinction between the Dark Night and depression was at times not straightforward. For example, Sergio, a psychiatrist undertaking training in spiritual direction, was one of the participants who emphasised the possibility of the Dark Night being diagnosed as a depressive episode: "it [the Dark Night] could be diagnosed as depression, even as a severe depression" (for the full quotation, see section 4.2.2., pp.185-186.

Applicability to a secular context

Although many of the participants' attributions of meaning, coping strategies and help-seeking behaviours were infused with religious significance and were rooted in a Christian tradition, I would argue that the theoretical and practical postulates developed here could have some resonance and applicability in other secular and religious contexts.[58] While highly religious settings such as the ones I studied are places where it is more likely to find episodes of emotional distress being transformed through the attribution of religious meaning, this analysis also has relevance with regard to the world outside monasteries, parishes and theological colleges. The participants' religious paths are not prerequisites for developing the type of emotional distress described in the thesis; diverse individuals can define their feelings of sadness and dissatisfaction in existential terms, relating to other vital narratives outside a faith framework. This is important as the ways in which the person interprets the depressive symptoms play an important part in the perpetuation of the symptomatology, as these interpretations fuel the negative cognitive processes of depression (e.g. conceptualising them as being one's fault, or blaming others for one's suffering). Conversely, understanding one's sadness as normal and as fulfilling a purpose can only help with the resolution of the cognitive aspects of depression.

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[58] With regard to the potential to translate my findings to other religions, in section 5.3.2. ("Contextualisation of sadness: attribution of meaning and the Dark Night of the Soul"), I described the striking similarities that these findings bore with the observations made by Kirmayer (2002) and Obeyesekere (1985) in other distant cultures (Japan and Buddhist Sri Lanka respectively) where the experience of sadness was also highly valued due to the potential for personal growth.

The Dark Night could provide explanatory theory for the experiences in other individuals who are facing sadness and void. This process of attribution of meaning to one's suffering, whether religious or secular, can help people to normalise it, so that it ceases to be pathological and produces adaptive reactions that can instigate transformation of the negative aspects of their lives. It is important to note that there is only one strictly religious aspect - the help offered by the clergy and religious communities - in the framework proposed here to assess and help those undergoing deep sadness. I argue that a sensitive appraisal of the existential nature of the symptoms and a clinical management that is consistent with such analysis is vital to provide the best possible treatment for all patients whether they are religious or not.

The feedback I got when I first presented the findings of my initial ethnographic research in an international conference made me aware of the potential of the Dark Night framework for being translated to secular contexts.[59] Some of my colleagues, although coming from an academic and atheist backgrounds, strongly related to the nuns' testimonies and shared with me episodes of deep sadness in their own lives that had triggered key decisions and positive changes. The nuns' experience of darkness also reminded them of artists and thinkers who had also used their distress and angst in a cathartic way to stir up their creativity, such as Mahler and Shostakovich, or to alter their theories, as was the case of J.

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[59] The findings of my initial ethnographic research in a female monastery were presented for the first time at the II World Congress of Cultural Psychiatry in Norcia (Italy) in 2009.

S. Mill who broke with his father's thought after undergoing a long period of

intense sadness.[60]

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[60] Although completely devoid of any religious meaning, J. S. Mill's long period of intense sadness - which is richly documented in his "Autobiography" (1873/1989) - led him to break with his father's postulates and create his own theories. The cognitive tension and emotional turmoil induced by the darkness he was under reminded me of that of the nuns, which led these women to make far-reaching changes in their spirituality. This echoes the creative and existential crisis that is explored and resolved in Mahler's last three symphonies, and the creative act as catharsis seems to lie behind the hidden meanings and enigmas in much of Shostakovich's later music.

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APPENDIX 1

THE CATHOLIC CHURCH AND MONASTICISM

This appendix contains a literature review to add further context to the findings. I start this section by looking at the current state of the Catholic Church in Spain in order to assist the understanding of the reality and the challenges faced by the participants of the study. I move on to provide a historical overview of local monasticism, focusing on the two religious orders the contemplative participants belong to, which shows how the beliefs and narratives relating to suffering that the study has explored are in fact the product of many centuries' thinking and nurturing. Finally, I offer a review of ethnographic research carried out with nuns and monks which shows the scarcity of such studies.

1. THE STATE OF THE CATHOLIC CHURCH

1.1. The religious scene in Spain

The sample of the study was purposely selected from highly religious Catholic contexts and is clearly not representative of the religious level of the nation itself, which is experiencing a sustained decline in church-going and an overall

process of secularisation. Moreover, increasingly critical and negative views of the Church have grown, with a proliferation of books and articles criticising religion and questioning the existence of God; for example, Dawkins's (2006) "The God Delusion".[61]

Recent clerical sexual abuse scandals, particularly widespread in the Catholic Church, have also rocked that idealised perspective of religion as representing purity, goodness and a place of safety, and provoked feelings of disillusionment and alienation from the Church. Even within the Catholic Church, critical voices have been asking for liberal reforms and renovation of the Church - reforms such as optional celibacy for priests, acceptance of homosexuality and the ordination of women - which are very much opposed by the Church's more conservative sectors and the ecclesiastical hierarchy.

A recent survey undertaken in Spain, amongst those of Spanish nationality, showed that the majority of them, 76.0%, declared themselves as "Catholic", 13.0% as "non-believers", 7.3% as "atheists" and 2.1% as "believers of other religions". However, when those who defined themselves as Catholic or believers of other religions were asked about the frequency with which they went to mass or other religious services, without counting those occasions related to ceremonies of a social nature, such as weddings, communions or funerals, the percentages were much lower, with 50% of them responding

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[61] Several participants alluded to this book of Dawkins's (2006) as an example of "bad press against religion", voicing their concerns about how it might have affected people's religious views.

"almost never", and the remainder answering: "almost every Sunday and church holiday", 18.0%; "several times a year", 17.7%; "at least once a month", 11.3%; and "several times a week", 2.4% (Centro de Investigaciones Sociológicas 2009a, 2009b). In addition to this decrease in religious observance, the Church is also facing a severe decline in religious vocations: priests, nuns and monks are not being replaced by new members, causing a subsequent increase of the work burden of existing priests and the frequent closures of monasteries throughout Spain. Although there are no figures specifically for Spain, the Vatican has published statistics, from 2000 to 2006, acknowledging a reduction in the number of nuns, monks and priests in Europe, while Asia and Africa are experiencing a rise in their numbers (Catholic News Agency, 2008; Kandra, 2008).

What are the factors behind this decline in religiosity in Spain? Pérez-Agote (2010) explains that while a fervently religious minority still believes that Spain is a Catholic society under the moral mandate of the Catholic Church, the majority of the population holds the view that Spain is a country with a Catholic culture no longer subject to the Catholic Church, and this view is especially prevalent among a younger generation that is rapidly moving away from the Church. Pérez-Agote attributes the religious changes that Spain has undergone to three broad social dynamics: the widespread process of secularization observed among the Spanish population, the separation between the Church and the state, and the recent arrival of a large immigrant population. Díez de Velasco (2010) argues that the increasing visibility of non-Catholic faiths in Spain is causing

fractures in a previously homogenous religious community, shaping a new religious heritage, and challenging what for centuries was taken for granted: that the one and only religion in this country was Catholicism (it was only three decades ago that Catholicism was the official religion).

1.2. Women and the Catholic Church

Women consecrated to the Church are much more numerous than men: the number of female religious members is almost double that of priests, and 14 times that of non-ordained monks (Catholic News Agency, 2008; Kandra, 2008). However, the running of the Church is in the hands of men, with women still remaining in a clear state of subordination and obedience to the male members of the Church, who occupy the posts of responsibility from which - today as it was in the past - women are excluded. The Catholic Church has not adapted to the improved status, visibility and participation that women have achieved in other areas of society (Casas i Tubau, 1994; López, 2011).

The restrictions imposed on the freedom of Catholic nuns - such as the contemplative nuns participating in the study - have not considerably lessened when compared to the lives of consecrated women in the past: they are still assigned very specific and restricted roles, depending on male priests to receive the sacraments, and having limited participation and influence in official Church structures. The decline observed in the number of Catholic nuns in the United

States and other Western nations is not surprising and can be explained, amongst other factors, by the general secularisation that has taken place in industrialised nations, and by the expansion of educational and occupational opportunities for women, which have reduced the attractiveness of taking the habit (Ebaugh, Lorence & Chafetz, 1996). The Head of the "Compañía de María", an active-life female religious institute, Núria Casas, denounces the absurdity in today's world of nuns being restricted to the roles of serving clergymen and monks, as was the case in the past (Casas i Tubau, 1994).

The formation of women in theology constitutes a challenge for the Catholic Church today: until recently, women were excluded from the theological educational centres, with the Bible being read and interpreted from an exclusively male perspective (Estévez, 1993). Many theologians - such as Augustine, Thomas Aquinas and Luther - have embraced negative theories about women, concurring with the female archetype of Eve the seducer, the one who brought evil into the world (Meyer-Winmes, 1997), with the subordinated status of women based on their "inferior nature" and with the patriarchal tradition of women's submission to men (Schüssler Fiorenza, 1996).[62] Lately there has been a call for more women theologians to emerge and for the Bible to be re-interpreted from a female perspective, questioning the hegemony of the unilateral discourse of religion made from an exclusive male perspective. In the

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[62] Women appear early in the history of Christianity as agents of Satan, as we can read in 2 Corinthians 11, 2-10 where the female archetype that has dominated and prevailed in the Western culture is described: Eve the seducer, the one who brought evil into the world through her transaction with the snake, and as a source of sin, who interposes herself between God and man (Meyer-Winmes, 1997).

past and even nowadays a great part of the theology made by women has resulted from experiences of inadequacy and impotence. Moreover, women who are fighting for a change and for the recognition of their own theological contribution - the number of women studying theology is growing - tend to receive very little support from official Church structures. They rarely form part of the theological colleges' teaching staff, and courses on feminist theology are not routinely included in the teaching programmes; all these facts lead to widespread feelings of isolation among female theologians (Ecumenical Council of the Churches, 1998; Bernabé, de Miguel, León & Ramón, 2002).

The Vatican is keeping a close watch on women who are asking for more equality and renovation within the Catholic Church, subjecting them to considerable censorship. For example, in March 2012, the Congregation for the Doctrine of the Faith (ex "Santo Oficio") scolded the Leadership Conference of Women Religious (LCWR) - which is an association of the leaders of congregations of Catholic religious women in the United States - subjecting them to a process of "doctrinal assessment", as the Vatican was concerned about "serious doctrinal problems" and "unacceptable views" expressed in their annual assemblies, such as getting pastorally closer to homosexuals, supporting "radical feminist statements" and advocating for the ordination of women, all of which

were described as "incompatible with Catholic teachings" (Leadership Conference of Women Religious, 2012; ABC, 2012).[63]

The Vatican's refusal to allow the ordination of women still remains one of the most polemical issues in the Catholic Church, evoking a great deal of anger, pain and frustration among people who coexist within the Church, but who hold opposite views on the matter. In spite of this subject being repeatedly closed by the Church authorities, some Catholic women have been ordained and are ministering to communities through an organisation created in the United States in 2002 called "Roman Catholic Women Priests", which has been condemned by the Vatican (Rue, 2008).[64] A woman theologian, Pilar Bellosillo (2004), criticises the paradoxical situation in which the Catholic Church finds itself by denying priesthood to women; on the one hand, the Church has recognised the radical equality between men and women, having repeatedly asked legislators to recognise women's equal rights but, on the other hand, the Church itself has not yet recognised this equality of rights by accepting the ordination of women.[65]

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[63] The Leadership Conference of Women Religious (LCWR) which was founded in 1956 has more than 1,500 members, but this represents institutions composing more than 80% of the 57,000 consecrated women in the United States.

[64] In the United States and Canada as of 2008, the organisation "Roman Catholic Women Priests" (RCWP) includes four bishops, twenty-eight priests, fourteen deacons and fourteen candidates. Although it was initially a movement in Europe and the United States and Canada, their aim is to become a global network (Rue, 2008).

[65] In order to understand the current conflict we need to look back at the history of the church: the battle against women's ordination started in the French Church in 511, when the bishops found out that two Breton priests were celebrating the mass with women co-hosts. Bishops became worried that these women could contaminate the sacrament - because of their menstruation - when offering the chalice to the parishioners. During the first quarter of the 6th century, French bishops could still be persuaded to ordain women as deacons; examples of these deacons were Helaria, daughter of the Bishop of Reims, and Saint Radegunda. Two Councils were key in preventing women's access to the priesthood: the Council of Orleans, which

1.3. Catholic clergy

During the late 1960s and throughout the 1970s an unprecedented process of secularisation of priests took place in the Catholic Church.[66] Many of the priests interviewed in my study - who in those times would have been in the seminars or recently ordained - frequently referred to those years as "turbulent times" and as being particularly challenging and demoralising in terms of their vocations and their roles (this will be further expanded in the "Findings", section 4.3.1., "Clergy's coping with mass secularisation"). The Second Vatican Council contributed to this phenomenon, as many priests felt profoundly disappointed because the changes they thought would follow the council did not materialise (Núñez, 2010).

There was no doubt that the parish priesthood was then in a state of severe crisis, as evidenced by hundreds of priests deciding to leave the ecclesiastical institution, and by a lack of new seminarians. In an attempt to remedy the situation, publications by eminent theologians emerged trying to redefine the role of priests. Amongst others, Rahner (1969) called for "resistance", urging

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disqualified women from undertaking this post, and the Council of Auxerre at the end of the 6[th] century, which declared women to be impure by nature. They therefore had to cover themselves with a veil and could not touch anything that was consecrated, which was completely incompatible with being a priest (Duby & Perrot, 2000). Menstruation was presented as a fatal impediment for woman to access the priesthood (Ranke-Heinemann, 1994).

[66] Secularisation in this context means the process undertaken by priests to seek authorisation from the Holy Office in the Vatican to be dispensed from their religious vows to become laymen (Gran Enciclopedia Larousse, 1990b, p. 9975). The personal experience of many of the participating priests who were caught up in this phenomenon have been described in section 4.3.1., "Clergy's coping with mass secularisation".

priests to remain at their posts, and Illich (1968) advocated ridding the Church of its immense bureaucratic apparatus, stressing the importance for priests of staying and trying to change the Church from within. Küng (1972), in an attempt to provide more meaning to the clerical vocation, published a book entitled "Why Priests?", redefining the role, advocating "service" rather than "ministry", and advancing the possibility of permitting the role to be temporary. Although publications, such as the latter, tried to courageously face the crisis by suggesting changes to the priesthood, they were also apt to add to the confusion and blurriness of the role, since they deeply disturbed some embedded assumptions of what being a priest entailed (e.g. that it is meant to be for life), assumptions that were especially prevalent in the less liberal sectors of the Church.

Núñez (2010) specifically investigated the renunciation of priesthood, conducting individual interviews amongst priests in the Barcelona diocese. This study tried to explore the causes that led to the unrest felt by the clergy during the late 1960s and throughout the 1970s. Núñez suggests that rather than being the result of a sudden crisis, it was the consequence of several processes that had been gestating for years. It is relevant to keep in mind that the Catholic Church in Spain had been closely associated with the Franco regime and that the regime was then in a state of crisis too. The interviews revealed that after the Second Vatican Council, the identity and the role of the priest had become blurred, with priests themselves not knowing anymore how to be a priest. Many of the participating priests acknowledged that they no longer knew what to preach to

their parishioners, since they were subjected to diverging voices in the midst of the institutional ecclesiastical upheaval. Moreover, a feeling of having fallen out of tune with the Church was rather widespread amongst them; they experienced a clash between what they really thought and what they felt they were supposed to think according to the Church's teachings. An additional contributing factor to the crisis was the unquestionable loss of prestige of the figure of the priest. Two intrinsic characteristics of priesthood gradually became discredited: their role as intermediaries between God and people, and being obligated to lead a celibate life.

I would like to end this section on Catholic clergy by turning our attention to the clergy's mental health. Hoenkamp-Bisschops (1992) conducted in-depth interviews with 24 Catholic parish priests, looking at the impact that being obliged to lead a life of celibacy had on their mental health, and exploring their experience of being celibate and the ways of dealing with it. The majority of the participants did not choose to have a relationship, since they tried to comply with the law. They tried to remain celibate with varying levels of success, as they acknowledged that leading a celibate life was very hard. The author suggested that several aspects of their celibate vow seemed to lead to detrimental consequences for their mental health. On the one hand, the irrevocability of the vow becomes a source of considerable pressure: the decision to remain celibate, which was taken earlier in their lives, may not make sense anymore decades later. On the other hand, priests tend to stop themselves from having close friendships in order to protect their celibate option, thus depriving themselves of

an important source of emotional and psychological well-being. Optional celibacy for priests is not permitted in the Catholic Church, in spite of its having been asked for repeatedly by many Catholics. There are indeed many organisations of married Catholic ex-priests across the world who are actively opposed to having to unwillingly renounce their priesthood in order to get married (e.g., in Argentina: "Movement of Married Priests and their Wives", in Spain: "Movement of Optional Celibacy", in Canada and the United States: "Corpus").

2. AN HISTORICAL OVERVIEW OF LOCAL MONASTICISM

The monks of the Monastery of Sant Oriol belong to the Cistercian Order, and the nuns participating in the study, although coming from various monasteries, all form part of the Order of Saint Augustine. In order to provide a historical context for the findings that will follow, I have included in this section a description of the beginnings of these two orders, an overview of Saint Benedict's and Saint Augustine's legacies, and an account of the most defining elements of the Cistercian and Augustinian contemplative paths - known as the order's "charisma" -, which differentiate them from other religious orders. The charisma of the order is often crucial when choosing one particular religious community over another. All religious orders ultimately aim to follow Christ through the Gospels, but each of them does so according to the particular

interpretation of their founder, which explains the immense diversity of religious orders and institutions in the Church (Monjas Agustinas Contemplativas, 2002).

Besides the charisma of the order that a monk or a nun belongs to, each monastery has its own "personality", which is considered by their members, in Thomas Merton's[67] words, as: "a special manifestation of the mystery of Christ" (1998, p. 8). Merton explains that this is why the monks and nuns consider themselves primarily members of a particular community, with all its advantages and limitations, and secondly members of the order they belong to. Therefore, the monk and nun will be a Brother or a Sister of the monastery where they took their solemn vows, committing themselves to live and die there and striving to "become a perfect disciple of Christ, a saint", "if the monk or nun were to achieve sanctity, it would be the sanctity of someone who has found Christ in a particular community and in a particular time in history" (1998, p. 8).

2.1. The Cistercian Order

Saint Benedict and the origins of the order

Saint Benedict was born in Nursia (modern Norcia, in Umbria, Italy) in 480 and died in Monte Cassino (south-east of Rome). As a son of a Roman noble, he

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[67] Thomas Merton (1915-1968) was a Trappist monk and author as well as a pioneer of interfaith dialogue.

could have pursued a prosperous career, but inspired by the Gospels, he abandoned his studies and left his home to lead a life of solitude in a cave in Subiaco for three years. There he became well-known and respected, aquiring a reputation for sanctity and of being able to perform miracles. As many people visited him wishing to receive his instruction, he built 13 monasteries for them, in one of which he lived. Although each monastery had its own Abbot, he remained the general Abbot of all of them (Saint Gregory, 2007). Saint Benedict's main contribution to monasticism was his book, known today as the "Rule of Saint Benedict", which contains recommendations and regulations for those who want to lead a life of contemplation while living in community. Since then, the Rule has been taken by religious communities willing to follow its norms as a practical interpretation of the Gospel (Merton, 1998). A Cistercian monk, Rafael de Pascual (1998), argues that Saint Benedict himself would have been very surprised to know that his book had originated a monastic order. In fact, it was not until the 19[th] century - under the mandate of the Pope Leo XIII - that the disciples of the Benedictine Rule were united in one confederation, although they have carefully maintained the independence of each community up to the present day.

A key moment in the evolution of the order took place at the end of the 11[th] century in a monastery in Molesmes (Burgundy, north-central France), where some monks felt that the norms that regulated their lives did not accord with the principles contained in the Rule of Saint Benedict. The old Benedictine maxim of "ora et labora" (pray and work) that had been governing their monasteries in

the previous centuries had become very unbalanced, with the monks spending most of their time in the divine office. The increase in the time dedicated to prayer was a result of the patronage given by some wealthy local families, which provided the monks with a comfortable existence, rendering work unnecessary. In 1098, a group of 21 monks under the authority of their spiritual father, Robert of Molesmes, abandoned their monastery in Molesmes looking for a place where they could devote themselves to the strict obedience of the Rule of Saint Benedict. They found an inhospitable place in the midst of a forest called Cister ("Cistellum" which means thicket: a deserted place that needed a great deal of work to make it habitable), where they settled to lead the simple life of prayer and work that they longed for; a life of loneliness, poverty and silence. The construction of a monastery in Cister was begun with the help of several powerful men of the region (particularly, two bishops and the Duke of Burgundy). This monastery was the scene where they put into practise their new monastic attitude, and thus it came to be known as "Novum Monasterium" (new monastery). The monks soon exceeded the accommodation available in the monastery, prompting the foundation of four new monasteries, known in Cistercian history as the "four sisters of the Cister", in Ferté, Pontigny, Claraval and Morimond. From these monasteries and the initial "Novum Monasterium", an extensive campaign of foundations of the Cistercian Order around Europe was initiated, with the female branch of the order also emerging (Bango Torviso, 1998; Kinder, 1998).

Bernard of Claraval was the monk that shaped the Cistercian monastic ideal in the first half of the 12[th] century. Through his prolific writing of sermons, treaties and epistles, he established the foundations for the return to the more radical monastic life conceived by Saint Benedictine and advocated by Robert of Molesmes and his followers. He denounced the monastic richness and idleness to which the monasteries had succumbed to, strongly censuring the monks who did not comply with the old Benedictine norms: "How can those monks say that they follow the Rule when they wear habits with lining? Monks who, even when they are healthy, eat meat or butter? who eat three- or four-course meals (which is strictly against the prohibition of the Rule)? Who do not engage in manual work as the Rule orders them to? And finally, who have disturbed, increased and diminished many of the observances [of the Rule] according to their fantasy?" (Díez Ramos, 1955, p. 836). Bernard was not just an intellectual figure in the Cistercian history; his radicalization of the monastic principles triggered a spirit of crusade in the monks who felt compelled to spread their way of life, founding a remarkable number of monasteries: 531 were founded in less than 90 years. This wave of foundations took place under the protection of the royal family (Bernard was well regarded by Alfonso VII and his family), bishops and members of the nobility (Bango Torviso, 1998; Díez Ramos, 1955).

During the second half of the 12[th] century, the Cistercian alliance with the powerful and wealthy caused, as it had in the previous century, a marked decline in the original ideals of monastic austerity and simplicity resurrected by Robert and Bernard (the latter died in 1153). These influential families wanted to have a

Cistercian monastery in which to rest for eternity. Therefore, the monasteries that were built to house their graves, tombs and funeral constructions were rich monumental buildings very far from Benedict's spirit of sobriety. The old principle of combining work and prayer was lost once again, with the monks spending most of their time praying. Manual work was abandoned, as the monks did not need to work to support themselves, due to substantial donations and the payment of expensive burial rights. Nevertheless, during the 13th century, there was a decrease in the number of donations and the monks were required to find other means to subsist. The financial problems suffered by some of the monasteries heightened in the 14th century, slowing down their constructions, with many of them never completing the initial designs. We can nowadays see a reflection of these spiritually and economically turbulent times in the architecture of the resulting monasteries, with their lack of functional and aesthetic unity. The financial difficulties were accompanied by a realisation - by both the monks and lay people - that the Cistercian contemplative life had become something other than what Saint Benedict and those first monks of the "Novum monasterium" had intended. In the following centuries and up until the present day, the Cistercian communities have been travelling a path of gradual recovery, as well as adapting to their particular historical and social context the foundational ideals that had been lost or distorted (Bango Torviso, 1998).

Cistercian spirituality

As we have seen in the previous historical account, the main objective of the Cistercian Order was not to propose a new monastic spirituality, but to return to the sources of that old spirituality emanating from the Rule of Saint Benedict, which had been adulterated. The "Novum monasterium" in Cister is considered as the origin of the Cistercian order, and those monks who founded it, with Robert of Molesmes as their Father Abbot, as the first Cistercian monks. Bernard of Claraval was indeed the key figure in shaping the new spirituality of the order: the Cistercian charisma. He strived to simplify their contemplative lives in all respects, taking poverty as a collective norm, wielding the least possible power in the organisation of the community, disdaining ornamentation in their books and buildings, and stressing the importance of the monks carrying out manual work to support themselves (e.g., "Cistercian farm", where the monks raised the crops and tended the animals) (Kinder, 1998; Jiménez Lozano, 1984).

Today's Cistercian way of life is still firmly based on the daily combination of work and prayer. Attending the divine office, working and reading sacred texts are to be appropriately balanced throughout the day so the monk is never idle. Reading the Bible is an integral part of their spirituality, which is transformed - as the monk grows spiritually - into a deep meditation on the texts. Their work needs to be simple enough to allow for an inner prayer to take place. The ideal is for the monk to reach a state of constant prayer: not in the sense of an incessant repetition of prayers but, while performing all his duties, being able to feel the

constant presence of God accompanying him. Their contemplative nature makes it necessary for them to live withdrawn from society in an atmosphere of peace and silence, humility and austerity, working and praying, in the same community until death. As the monk needs to learn how to achieve a balance between work and prayer, he also needs to learn how to combine the act of maintaining silence with a fraternal communication with his fellow monks (Merton, 1998; Molina Zamora, 2001; Rafael de Pascual, 1998). The promotion of silence within their monasteries, located in isolated places, is meant to firmly draw their attention to the "divine presence". This practice becomes a permanent way of life and prevents God from becoming just a vague memory amongst many other distractions and occupations: "... before the immensity of this Presence [God], the monk will spontaneously adopt an attitude of loving stillness, that little by little takes possession of his whole existence transforming it into prayer" (Merton, 1998, p.30).

Another important aspect of their communal life stressed in the Rule of Saint Benedict is the need for the monks to be subjected to the authority of their Abbot, whose main duty is to provide for every monks' physical and spiritual needs, taking into account their own individuality. The Abbot (a word that comes from the Aramaic "abba" which means father) is the "father" of the monastery, owing this position to the explicit will of the members of the community, who have elected him and who rely on his wisdom and experience to govern the monastery and to help them in their spiritual growth (Molina Zamora, 2001; Rafael de Pascual, 1998).

2.2. The Augustinian Order

Saint Augustine and the origins of the order

Saint Augustine was born in Tagaste (now Souk-Ahras) on 13th November 354 CE. Although his father was a pagan, his mother - Saint Monica - went to great lengths to convince him to be baptised. Augustine also received an early Christian education from his mother but, as a student of philosophy and literature, he underwent a spiritual crisis, leaving aside his religious beliefs. It was during this time that he started a relationship with a woman which lasted over ten years and with whom he had a son, Adeodato, in 372 CE. Once Augustine's education was completed, he taught grammar and rhetoric in Carthage, Milan and Rome, and was part of the Manichaean sect for ten years. His mother's influence, the teachings of the bishop of Milan (Saint Ambrose) and Augustine's careful reading of the Bible were deciding factors in his conversion to Christianity. Saint Monica arranged an advantageous marriage for her son shortly before his conversion, which led Augustine to break his long attachment to his mistress and to take with him their son (Herberman, 1907-1912). Nevertheless, he eventually opted out of his mother's marriage plan (Hill, 1994).

Augustine went to Africa in 388 CE, where he founded his first two religious communities: one in Tagaste and the other in Hippo. His son - whom he had taken with him when he abandoned the boy's mother - died in 390 CE. One year

later, Augustine was ordained as a priest, becoming Bishop of Hippo in 395 CE.

Several monasteries for men and women were established after his earliest

foundations. The invasion of the Vandals eventually brought about his death (he

died in Hippo in 430) and caused the disappearance of the Augustinian

monasteries from the North of Africa (Gavigan, 1962). In the following

centuries, there is evidence that many monasteries were founded throughout

Spain whose members followed the Rule of Saint Augustine, and that several

adaptations of the Rule were made for some communities of women, such as the

ones made by Saint Leandro and Saint Isidoro (Verheijen, 1953).

The Vatican brought together several hermitical groups who were following the

principles of the original Rule of Saint Augustine under the name of the Order of

Hermits of Saint Augustine in 1256. Currently, the order to which the nuns

participating in our study belong is known as the Order of Saint Augustine

(OSA). The way of life of Augustinian monks and nuns is regulated by the

Constitutions of the order, which describe the requirements that they have to

follow in their communities. The first Constitutions were written in 1290 and are

known as the Constitutions of Ratisbon. The centuries leading up to the mid-

1500s were marked by a decadence of the observance of the religious principles

set up by the Rule, such as the neglect of the communal liturgical prayers, the

non-observance of the cloister, and the vow of poverty, the latter leading to

striking inequalities amongst the members of the same community. The

restoration of the religious life in the light of its original principles was begun at

the Council of Trent (1546-1548) with the decree entitled "De regularibus et

monialibus" (on regulars and nuns). Added to this were those instructions of Popes Pius V and Gregory XIII that apply to the Augustinian nuns, which gave - amongst other aspects of their communal life - precise regulations regarding the cloister, the election of the Mother Superior, the practice of the sacraments, the age at which novices/postulates were allowed to take the vows, and the verification of the freedom of the woman taking the vows. The changes initiated in the Council of Trent triggered the growth of female Augustinian monasteries in the 17[th] century (e.g. in the Crown of Aragon alone, there were eight monasteries) (Monjas Agustinas Contemplativas, 2002; Gemma de la Trinidad & Alonso, 2002).

Augustinian spirituality

As with the Cistercian monks, I am going to devote this section to explaining the more distinctive characteristics of the Augustinian Order, their charisma, which is mostly contained in the "Rule and Constitutions of the Order of Saint Augustine". Although this is applicable to all monastic religious orders, Saint Augustine emphasised in a special way that the communitarian life of his monks and nuns needed to have the seal of true friendship, and that it should strive to imitate the unity of the first Christian community in Jerusalem (in the Bible, this

community is described as having one soul and one heart).[68] Thus, living in

perfect communion is singled out as the most important element of the monastic

Augustinian life in their Rule and Constitutions (Gemma de la Trinidad &

Alonso, 2002). The opening paragraph of the Rule is dedicated to their

communal life: "The first thing, for which you have become a community, is to

live together in the monastery, to have only one soul and only one heart for God"

(Regla y Constituciones de la Orden de San Agustín, 2002, no. 3, chapter 1, p.

13). Also, their Constitutions strongly emphasises this ideal, as the following

two quotations illustrate: in the first chapter, we see clearly stated that the

experience of fraternity and of authentic friendship characterises their

contemplative life and constitutes "... their specific testimony in the midst of the

People of God" (Constituciones de las Monjas Contemplativas de la Orden de

San Agustín, 1989a, no. 20, part 1, chapter 1, p. 41) and in the following chapter,

we read once again the allusion to the unity of the earliest Christian community:

"... in the monastery, the unity of love between all the Sisters must reign, trying

to make of all of them one soul and one heart" (Constituciones, 1989b, no. 51,

part 2, chapter 2, p. 54).

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[68] Acts 4:32-35: "And the multitude of them that believed were of one heart and of one soul:
neither said any of them that ought of the things which he possessed was his own; but they had
all things common. And with great power gave the apostles witness of the resurrection of the
Lord Jesus: and great grace was upon them all. Neither was there any among them that lacked:
for as many as were possessors of lands or houses sold them, and brought the prices of the things
that were sold. And laid them down at the apostles' feet: and distribution was made unto every
man according as he had need."

Besides the Rule and Constitutions, another book which has strongly influenced the Augustinian spirituality is Saint Augustine's "Confessions" (397-398), which is carefully read as part of the instruction of postulants and novices aspiring to embrace the Augustinian contemplative way of life. Although it is commonly regarded as an autobiography - some arguing it to be the first written example of this genre - Wills (2011) disagrees with this view, considering it not an autobiography but "a drama of sin and salvation", as a literary text extremely rich in symbolism, which almost totally neglects to mention details about key people in his life (it is this last point that goes against its being an autobiography). Saint Augustine resorted to the constant use of scripture in an attempt to acknowledge the blessings that made his life part of a sacred narrative, reliving his own salvation and journey towards God.

Other central Augustinian precepts are: their austerity, poverty and the sharing of all goods; not having any individual possessions; their life of contemplation through prayer, silence, inner withdrawal and intense penitence, and the preservation of the nun's personality and freedom (Gemma de la Trinidad & Alonso, 2002; Monjas Agustinas Contemplativas, 2002). This latter precept was not seen as being in opposition to the requirements for the vow of obedience, in that it is recorded in several numbers of the nuns' Constitutions: "The friendship with Christ not only invigorates personality but also increases the freedom of the community, in which a healthy openness of mind is promoted with every Sister enjoying enough autonomy to serve God better" (Constituciones, 1989c, no. 33, part 1, chapter 2, p. 46). Finally, two other aspects of a more practical nature

stand out in the Augustinian contemplative spirituality: the nuns are exhorted in the Rule and Constitutions to provide loving care to the members of the community who are ill and to make their comfort and needs a priority (it was even ordered in the Constitutions to give them the best food available) and to offer a charitable and warm welcome to the guests visiting the monastery (Gemma de la Trinidad & Alonso, 2002; Monjas Agustinas Contemplativas, 2002).

3. ETHNOGRAPHIC RESEARCH INTO MONASTICISM

Ethnographic fieldwork on nuns and monks is scarce, and there are few social scientists studying Christian monasticism. The demanding nature of the research methods required - such as participant observation and interviews - might be perceived as too intrusive by the monastic communities (Hillery, 1992), making the process of finding religious communities willing to open their doors to an ethnographer a difficult endeavour (Reidhead, 1998, 2002). A brief outline of monastic ethnographies is provided below.

Regarding research into female monastic communities, I will begin by presenting ethnographic studies of Catholic nuns, grouping them according to the continents in which the research took place. In America, Lester's (2005) research focused on postulants (first stage of religious training as nuns) in a convent in central Mexico to explore self-formation and embodiment, showing

how they aspire to reach an "authentic femininity" and view their religious transformation as a political stance against modernity. Claussen (2001) studied nuns in the Philippines, and argues that these women adopted the missionary Benedictine lifestyle as an attempt to reshape Philippino culture, gender norms and religious responsibility in the context of a rapidly globalising nation. Taylor's (2007) research looked at how several communities of environmentally active Catholic Sisters (popularly known as the "Green Sisters") throughout the United States unite their religious devotion with ecological commitment, linking the soil with the sacred. In Africa, Burke's (2001) ethnographic work on nuns provided a rich insight into their enculturation in the former Zaire. In Europe, Trzebiatowska studied nuns in several convents in Poland, analysing the significance of the nuns' habit through a Durkheimian lense (2010a); moreover, she used her research experience to reflect upon the emotional strain that fieldwork with religious participants places on the researcher, a strain that is particularly intensified when the researcher shares biographical characteristics with the participants of the study (2010b). My own study of the Monastery of Santa Mónica in Spain, inhabited by a community of contemplative cloistered nuns of the Order of Saint Augustine, explored the nuns' experience of emotional distress, their perception of its causes, and their coping strategies (Durà-Vilà et al., 2010).

Moving on to ethnographic research conducted in Orthodox female monasteries, we find three studies: Bakić-Hayden (2003) compared how three generations of nuns experienced their faith and their monastic vocations in a Serbian

monastery; Forbess (2010) studied the production and transmission of religious knowledge amongst the nuns of a Romanian monastery; and Burtea (2009) focused on the ways in which the nuns' subjectivities were reshaped in two Romanian monasteries. There are two more ethnographies of nuns not belonging to the Christian faith that need to be included in this overview: Gutschow (2004) undertook three years of fieldwork in a Buddhist nunnery in the Himalayan Kashmir, providing rich depictions of gender hierarchy and narratives of their struggle with the discipline of detachment, and Vallely (2002) conducted thirteen months of fieldwork in a Jain ascetic community in rural Rajasthan, offering a detailed portrayal and analysis of these women who have renounced their families and all material possessions for an ascetic life, making themselves symbols of renunciation and of the transcendent.

Turning our attention to male monastic ethnographies, the efforts of Hillery, and Reidhead and Reidhead, within Catholic monasticism excel. Hillery's (1992) participant observation of Trappist monasteries (and of one in particular) in the United States highlighted the important role that freedom, obedience and love played in bonding the community together. Reidhead abd Reidhead (2001) conducted research with both Catholic nuns and monks of the Benedictine Tradition (in three different monasteries). The first phase of their research consisted of non-applied ethnographic research aiming to gain anthropological knowledge on monasticism, and for the second phase they changed the methodology, adding a quantitative component with the objective of measuring

spirituality and religiousness, and of achieving predictive quantitative results. Also, in a Catholic context, Irvine (2010) used his experience of ethnographic fieldwork in an English Benedictine monastery to reflect on the role of imitation in ethnographic fieldwork ("playing at being a monk"), on the way in which he negotiated his role as an ethnographer in the community, and on his involvement in the monastery's activities. As a linguistic ethnographer, Bargiela-Chiappini (2007) used her fieldwork with a community of Benedictine monks as a basis for discussing and suggesting new methodological approaches when conducting research in segregated organisations. An example is the use of "conversatio"[69], a method that maximises the effectiveness of the limited face to face contact with participants, such as contemplative monks, to whom the researcher has restricted access.

Naumescu's (2010) research with Ukrainian Orthodox monks offered a depiction of such monastic practices as exorcism, which is both a way of serving those who are believed to be afflicted by demon possessions and a source of income. His findings also emphasise the importance of resorting to imagination in the monks' religious experiences. Finally, moving outside the Western world, Cook (2010) studied monks and lay nuns in a Northern Thai Buddhist monastery, providing an in-depth account of the phenomenology of meditation

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[69] "Conversatio" (from the Latin "conversari", the "act of living with", and "conversare" meaning "turn about with") emphasising the researcher's attitude of total involvement with the participant (Bargiela-Chiappini, 2007).

and ascetic practices, as well as exploring hierarchical structures and gender differences within the monastery.

APPENDIX 2

UCL ETHICS APPROVAL

UCL RESEARCH ETHICS COMMITTEE
GRADUATE SCHOOL OFFICE

Dr Gerard Leavey
Director of Research
Northern Ireland Association for Mental Health
80 University Street
Belfast
BT7 1HE

9 July 2010

Dear Dr Leavey

Notification of Ethical Approval:
Ethics Application: 1120/002: Medicalisation of sadness, depression and spiritual distress

I am pleased to confirm that in my capacity as Chair of the UCL Research Ethics Committee I have approved your project for the duration of the study (i.e. until July 2013).

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

    Reporting Non-Serious Adverse Events
    For non-serious adverse events you will need to inform Dr Angela Poulter, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

    Reporting Serious Adverse Events
    The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

I have been fascinated by this project and send Gloria best wishes for the continuation of her work.

Yours sincerely

Sir John Birch
Chair of the UCL Research Ethics Committee

Cc. Dr Gloria Dura-Vila;
    Professor Roland Littlewood, UCL Department of Mental Health Sciences

APPENDIX 3

INTERVIEW SCHEDULE

(1) DISTINCTION BETWEEN NON-DISORDERED SADNESS AND DYSFUNCTIONAL SADNESS

Research questions

(a) Do religious people differently conceptualise sadness without cause and sadness with cause?

(b) Is the help-seeking behaviour associated with sadness perceived to be without cause different from that of sadness with cause?

(c) Given the option, will people opt to numb the experience of normal sadness by taking medication? And in the case of abnormal sadness?

Interview questions

(a) Think of a time when you were feeling deeply sad

(a.1) Why do think you were sad? Was there are a reason behind your sadness?

(a.2.) Can you describe how you felt? Your thoughts? Was your functioning affected?

(a.3.) How did you cope at the time? What did you do to feel better?

(a.4.) Did you ask for help? To whom did you go?

(a.5.) What do you think your family/religiouscommunity/friends thought about your sadness (if they knew)?

(b) Have you ever been intensely sad *without* a cause? [if the answer is "no", go to (c)]

(b.1) Why do think you were sad if you could not identify a reason?

(b.2.) Can you describe how you felt? Your thoughts? Was your functioning affected? Was the way you felt and behaved different from when you were sad due to, for instance, a misfortune or some adversity? How was it different?

(b.3.) How did you cope at the time? What did you do to feel better?

(b.4.) Did you ask for help? To whom did you go?

(b.5.) What do you think your family/religious/community/friends thought about your sadness (if they knew)?

(c) Do you know of anyone who has been intensely sad without a cause? Ask (b.1.) to (b.5.) in the third person

(d) If the interviewee has not brought up spontaneously the role that their faith/religious beliefs play, ask:

(d.1.) What role did your faith/religious beliefs/God play at the time (when you were feeling sad)?

(d.2.) What role did your religious community (fellow brothers or sisters/members of your parish/fellow priests) play at the time?

(d.3.) Did you seek help from your parish priest/confessor/ spiritual director? Which help did he offer? What kind of help did you expect him to offer?

(1.a.) Depressive disorder in religious people

Research questions

(a) How is depressive disorder conceptualised and manifest (attributed causality, narratives, symptomatology)? Do they equate this disorder with abnormal sadness?

(b) What are their coping strategies and help-seeking behaviours - both psychiatric and non-medical - to deal with depression? What are their views regarding the effectiveness of antidepressant medication and psychotherapy?

Interview questions

(a) Why do you think people become depressed? What is the cause of depression?

(b) How do people with depression behave? How will you differentiate between these intense experiences (deep normal sadness/Dark Night/ spiritual distress *versus* depression)?

(c) What do they need to do to get better? What kind of help do they need

to seek?

(d) What do you think about psychiatric treatment for depression such as

antidepressants and psychotherapy?

(e) If they have not brought it up spontaneously: What role (if any) does

religion/faith/God play in the recovery from depression?

> (e.1.) Would you seek the help of your religious community?
>
> How would you think they might help?
>
> (e.2.) Priest/confessor? How do you think they may help? Which
>
> characteristics and training do you think they need to be helpful
>
> in these circumstances?

(1.b.) Spiritual distress and the Dark Night of the Soul

Research questions

(a) How do religious people conceptualise sadness with spiritual

causation (e.g. doubting one's faith or experiencing uncertainties

regarding one's religious vocation)? Do they use the Dark Night of the

Soul narrative?

(b) How is the Dark Night conceptualised and manifest (attributed

causality, narratives, symptomatology)? Is monastic life a pre-requisite

for experiencing the Dark Night?

(c) What are the shared symptoms and the key differences between the Dark Night and depressive disorder?

(d) What are their coping strategies and help-seeking behaviours to endure and resolve the suffering intrinsic to the Dark Night?

Interview questions

(a) Have you ever undergone a time of spiritual suffering/distress? (to differentiate from the previous questions about "sadness" - here the suffering has a spiritual cause/attribution, e.g. faith-religious doubts, concern with their relationship with God, feelings of spiritual emptiness, desolation, etc.)

(a.1.) Why do you think you were undergoing it?

(a.2.) Can you describe how you felt? Your thoughts? Was your functioning affected?

(a.3.) How did you cope at the time? What did you do to feel better?

(a.4.) Did you ask for help? To whom did you go?

(a.5.) What do you think your family/religious community/friends thought about your distress (if they knew)?

(b) Do you think spiritual suffering has any value? If so, explain.

(c) If they have not brought up spontaneously the term Dark Night of the Soul, ask:

(c.1.) What do you understand by it?

(c.2.) Have you experienced it? Do you know of anyone who has experienced it? If "yes", ask (a.1.) to (a.5.) in the third person

(c.3.) Who do you think can experience it? Nuns/monks? How about secular religious people, outside a contemplative life/ monastic setting?

(1.c.) Spiritual pathology (as distinct from the valorised path of the Dark Night)

Research questions

(a) Do religious people have notions of spiritual pathology? How do they distinguish between spiritual phenomena, such as the valorised Dark Night, and spiritual pathology?

(b) How is the spiritual pathology conceptualised and manifest (attributed causality, narratives, symptomatology)?

(c) What are their coping strategies and help-seeking behaviours to endure and resolve spiritual pathology?

Interview questions

(a) Do you think that people's religious experiences/beliefs can become abnormal or pathological in some way? Ask for examples, description, causal attribution, help-seeking.

(b) How do you differentiate between a healthy religious experience and pathology/abnormality?

(c) How will you differentiate between these intense experiences (Dark Night *versus* spiritual pathology)?

(2) ROLE OF THE CLERGY

Research questions

(a) How do the priests conceptualise and recognise cases of depressive disorder, Dark Night, and spiritual pathology? How do they differentiate between them? What help do they offer to those undergoing them?

(b) What training have they undertaken in mental health?

(c) Have they liaised with mental health professionals in the case of parishioners suffering from a psychiatric disorder?

(d) What are their views regarding psychiatrists and standard psychiatric treatment for depressive disorder?

Interview questions

(a) Do you have experience of assisting parishioners undergoing episodes of spiritual distress?

(a.1) How do you recognise that they are going through it?

(a.2.) What help do you offer? What help do they ask for/expect from you?

(a.3.) Do they ask for the help themselves/do their relatives? or do you offer to help without being asked?

(b) Do you have experience of assisting parishioners undergoing a depressive disorder?

Ask (a.1) - (a.3.)

(b.4.) Have you ever liaised with mental health professionals? Would you do so? What do you think of standard psychiatric treatment? Would you recommend seeking psychiatric help?

(c) Have you ever encountered cases where a religious experience/belief became abnormal/pathological? How would you differentiate between these intense experiences (Dark Night *versus* spiritual pathology?

Ask (a.1) - (a.3.) and (b.4.)

(d) What training have you received to assist your parishioners in the above cases? Do you think it is sufficient? Do you feel a need for more? Do you think it is part of your role as a priest?

(e) What characteristics do you think a priest needs to be helpful in these circumstances?

APPENDIX 4

LIST OF TABLES AND FIGURES

TABLES