Dedication

To my wonderful children, Josep and Mireia.
Acknowledgements

First and foremost, it is my great pleasure to thank the two titans whose shoulders helped mine to sustain the weight of this project, Gerard Leavey and Roland Littlewood. You would not be holding this book in your hands today without the inspiration, support and guidance I received from my much-valued mentors over many years. I would like to thank Gerry for being my anchor and compass while navigating the waters - at times turbulent - of academic research, and Roland for giving me the most unusual combination of fierce intellectual challenge and unfailing encouragement; I will always be indebted to both. I am very grateful to Laurence Kirmayer whose critical insights assisted me enormously in setting up the project. I would also like to thank Laurence for acting so generously in his role as editor-in-chief of the journal Transcultural Psychiatry; his advice and work has played an important part in shaping my research.

Many thanks, also, to Michael King, head of the Research Department of Mental Health Sciences at University College London, where this project was born and grew, for his interest and enthusiasm for my project, and to Bernadette Flanagan, Kate Loewenthal, Wayne Martin and Mitchell Weiss for their helpful suggestions. I have benefited immensely from participating and sharing my fieldwork experience at the medical anthropology seminars at University College London, and from attending the world congresses of cultural psychiatry, organised by the World Association of Cultural Psychiatry, which offered me a stimulating and nurturing environment in which to present and discuss my research with colleagues from all over the world. Two philosophers deserve my gratitude too: the sorely missed Peter Goldie, and my brother, Víctor Durá-Vilá; their incisive questioning and rigorous thinking made the foundations of the project deeper and stronger. As will become clear in the pages to follow, my clinical work has always being the torch that has guided the paths that my academic research has followed. The questions that I have attempted to answer through my research projects have been triggered in one way or another by my psychiatric practice. Thus, the many mental health professionals from two psychiatric training schemes in London, the Royal Free and St Mary’s, who formed me as a psychiatrist need to be acknowledged here. In particular I want to mention Matthew Hodes and Elena Garralda under whose lead I was clinical lecturer at Imperial College giving me the great opportunity to combine clinical and academic learning. I would like to extend my thanks to my consultant colleagues at Surrey and Borders Partnership NHS Foundation Trust and especially to those belonging to my continuing professional development (CPD) group for keeping this particular psychiatrist within the bounds of sanity.
I also owe a profound debt of gratitude to the 57 men and women who took part in the study portrayed in the book for sharing with me their narratives of sadness and hope. Their courage, resilience and altruism makes them the real heroes and heroines of the story. I can only hope to have done justice to the emotion and sheer beauty of their narratives which took my breath away on innumerable occasions during the interviews. I want to testify here to the immense respect I feel for all of them. The cherished memories of the intense days I spent amongst you will forever be with me. I would like to give special thanks to Jessica Kingsley for once more believing in me as an author and for accompanying me through the publishing journey with so much wisdom and kindness: it is an honour and a privilege to publish with her. Finally, I would like to end on a more personal note by expressing my love and gratitude to my parents, Mercedes Vilà-Pladevall and Miguel Durà-Marquès, for their faith in me, for never stopping me from spreading my wings to fly as high as I could dare; and to my husband, David Bentley, for nourishing my dreams and cherishing my ideas.
Preface

What is the book about?

Since 2006 I have been interested in the study of sadness, its conceptualisation and help-seeking behaviours. Within these vast topics, there were two areas that intrigued me the most: the role that culture and religion played, and the factors underpinning whether sadness was considered normal or whether it was thought to be pathological. I am a practising psychiatrist, so these areas of research fascinated me not only academically but also as a clinician whose practice posed challenging – at times terribly uncomfortable and uneasy – questions with regard to the way depression was diagnosed and treated in mainstream psychiatric practice. Questions – when one wants to find answers – inevitably lead to a search process and searching often involves journeys. This book you have in your hands is the result of one of those journeys in search for answers. I would like you to think of it as a sort of a diary of my travels, a witness to my experiences and to the lessons I learned along the way. Although it involved a fair amount of travelling and visits to many different places, the encounters I will be sharing with you are of a human kind: thus the transformative nature of my journey.

Building on the literature in this area as well as on my previous research, I set up a study to further explore the conceptualisation of deep sadness and consequent help-seeking behaviour using several qualitative methods to gather data among 57 practising Catholics in different parts of Spain. Among the religious resources that my participants may have used, I wanted to pay special attention to get an accurate account of the role that the clergy plays in assisting those afflicted by normal and abnormal sadness. I included four groups of people on different religious pathways – lay theological students, priests and contemplative nuns and monks – to increase the credibility and validity of the results and to give a richer and more balanced portrayal of the phenomena under study. In order to explain more fully the variation and complexity of their understanding of severe sadness, coping mechanisms and help-seeking behaviour, I decided to investigate these topics from more than one standpoint: I employed semi-structured interviews, participant observation and ethnography to gather data.

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 took the journey from the ‘insider’ perspective, taking into account the individual sufferer’s view, to the ‘outsider’ universalist position, focusing on medical categories and...
using a methodology that would be clinically relevant. I wanted this work to contribute to building a person-centred psychiatric practice: the book concludes by advancing a conceptual framework – with testable and applicable notions – to distinguish pathological from normal deep sadness. Without assuming uncritically the universality of this framework and without dismissing beforehand the cultural relativist worries, I strived for it to transcend this religious Catholic sample and to permit investigation through subsequent studies with non-religious participants.

Being able to hear the participants’ stories outside the constraints of my clinic felt liberating, allowing me to be reflective and curious in new ways, and somehow in the field my thoughts became clearer. Listening to people’s sadness in the context of my fieldwork and in my hectic psychiatric practice are such different experiences; let me try to express this difference using two images. In the first picture, imagine me in a room in the monastery interviewing a monk; no one is in a rush, there are no interruptions, the silence and stillness around us is only broken by the sounds of birds; the window is open and I can see, a short walk away, the cypresses scaling the mountains that surround us: there is time and space to listen and think. In the second picture, I am in my office at my clinic; there are noises of phones, traffic and chat from the waiting room – last night’s reality TV and the inevitable complaints about the state of the NHS. I am trying my best to listen to the patient in front of me and not to worry – ‘Yes, Google is very useful, but Jack doesn’t have ADHD’ – about the paperwork I need to complete, the growing waiting lists for treatment, the emergency – ‘Coffee? Yes, just milk please; no wait, I haven’t time’ – I have to attend to at some point – ‘reschedule it for next week, or the week after…’ – in spite of having a full clinic and a scheduled meeting in the afternoon – ‘…maybe we can squeeze him in next month’ – and where did I put my mobile…

The many hours I spent listening and living among the participants – as well as the many hours that, once back home, I devoted to listen to the tapes and to read and to analyse the transcripts and field notes – made apparent, as I will show in the pages to follow, that 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, whereas the latter was likely to be conceptualised as pathological, along the lines of depression, warranting psychiatric consultation.

I 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.

The narratives and arguments presented here emphasise 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. They also warn about the risks of medicalising normal episodes of sadness, raising questions about the lack of validity of the current decontextualised diagnostic classification for depressive disorder to people who are not mental health experts.

*Why did I embark on this research? The author’s motivation*

I have just told you what the book is about; now let me move to another key question that will take us to the origins of the study: what compelled me to undertake this research? When you want to go on a journey, such as the one that resulted in this book, before setting off you need to tackle this question in order to justify – to yourself as much as to your loved ones and colleagues – the time and effort that it will require. Why, in the middle of my already hectic clinical, academic and family life, did I get myself into this adventure? As you can already see – I hope – I want this research to be as much as possible a ‘shared experience’ with you.

The idea of the research project you are going to hear about came into my head in the months that followed the conclusion of my first ethnographic study in a monastic setting. This idea only happened to grow bigger and stronger as time went by through internal debate with myself as well as lively discussions with close colleagues and mentors (whose contributions have been gratefully acknowledged in the book). Moreover, I was taken aback by the interest that such a seemingly simple project – the result of my very first experience in fieldwork – received through its publication in *Transcultural Psychiatry* (Durá-Vilá et al. 2010) and the presentations in national and international conferences that followed. The emails and comments made by reviewers and colleagues from a satisfyingly broad range of disciplines – going beyond the more obvious fields of mental health and medical anthropology to those of theology, philosophy and sociology – reassured me that I was not alone in seeing the potential that my early findings had for future research. I was fortunate to receive helpful and encouraging insights from non-academic people too, mostly from members of the clergy of different denominations and those with an experience of suffering from depression. Two favourite examples of correspondence of the latter kind that especially moved me were the hand-written letter – accompanied by flowers – sent by a lady in her sixties who had suffered from
bouts of deep sadness, diagnosed as depression, throughout her life. In her note she opened up about
the lack of understanding she had found in the medical profession and how the nuns’ testimonies of
the Dark Night contained in my paper resonated with her experience, and added that she was grateful
to me as they had brought her ‘solace’ and ‘meaning’. The second example that comes to mind is the
email I received from an Anglican priest, a hospital chaplain working in palliative care, in which he
explained that the Dark Night framework echoed the sadness he saw in many of the patients he cared
for and made him want to use it to help them. I found it extraordinary that they had somehow
managed to find so much therapeutic value in an academic paper with all the many constraints this
kind of publication is subject to. As you can imagine, all of this just happened to add more and more
wood to an already smoldering fire.

I wish I could convey to you how intrigued I was 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. I witnessed how
this experience of sadness, deeply rooted within the nuns’ particular cultural and social context, acted
as a ‘magnifying glass’ to clearly reveal the problems of the current decontextualised diagnostic
criteria for depressive disorder, making obvious its failure to differentiate normal from abnormal
sadness. It was exciting to realise how the nuns’ experience of the Dark Night 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 – their 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 indeed clinically relevant (I have described and
discussed these processes extensively throughout the book).

With these thoughts boiling in my mind and the priceless support of those important to me, 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 among
a sample of Spanish Catholics who reflected the diversity of the Catholic Church. I very much
wanted this research project to complement and go beyond the theoretical critique of the diagnostic
criteria for depression – thoroughly done by many authors before me (Chapter 1) – and offer a
clinically meaningful dimension. Thus, as I have explained before, I will end this book by proposing
a framework that could allow a differentiation between normal deep sadness and its pathological
counterpart, depression. This framework was based on the rigorous analysis and synthesis of the
participants’ narratives of intense sadness.
The argument

According to the World Health Organisation, depression will be the second biggest disease burden by 2020 (Murray and 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 and Sivakumar 2009; Jadhav and Littlewood 1994) is likely to produce diagnoses overly based on symptoms with the subsequent labelling of normal human experience as disorder. 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 and Wakefield 2007). My study was inspired by 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. the breakdown of a relationship, financial difficulties or health problems) made by many authors before me. I will draw upon their work throughout the book.

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 et al. 2004; Zuvekas 2005), pressures that augment the use of medication as a response to emotional difficulties (Conrad 2005).

The aims of the study

First, 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; second, to look for what signs, symptoms, experiences and behaviours they consider evidence of pathology in order to find out how religious people conceptualise and differentiate pathological sadness from normal but profound sadness; third, to investigate the participants’ coping strategies and help-seeking behaviours used for both normal and abnormal sadness; fourth, to explore the clergy’s understanding of the above concepts, the care they offer to those suffering from sadness or depression, the training they may or may not have received, and their views regarding psychiatric care and collaboration with mental health professionals (I also wanted to seek the views on the role that the priests play in helping those experiencing sadness 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 extend beyond this particular context.

*In search of the participants*

In order to considerably expand and diversify the samples of my initial studies in this area, I included different levels of religious commitment and religious pathways in the context of the Catholic Church in Spain as well as a diverse spread of socio-demographic characteristics. Taking into account time and resource constraints, I set out to recruit 20 priests, 20 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.

I identified two sites for conducting fieldwork among contemplative nuns and monks: 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 which has satellite centres in surrounding towns (detailed information regarding the college and its running is provided in Chapter 4, ‘The Participants and Their Ways of Life’). The participating students attended either the college or one of its rural centres. The priests who took part in the study were also associated with the college: most of them were local facilitators of the college, as in every centre one or two parish priests acted as links between the college and the parishioners who expressed an interest in studying theology. 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.

I contacted those students and priests interested in the study 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 desired number, I selected them taking into account two main objectives: first, obtaining as broad a socio-demographic representation as possible (considering gender, age, level of education, profession and marital status) and, second, giving preference to those with a personal experience of undergoing deep sadness or depression, and 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 – 20 lay theological students and 20 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, I interviewed 17 priests.

In summary, the study sample was made up of four groups, making a total of 57 participants:

- 20 lay theological students (11 female, nine male)
- 17 priests (living in the community, not in monasteries)
- ten contemplative monks belonging to the Cistercian Order who lived in the same monastery (four of them were ordained priests)
- 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.

I use pseudonyms for the names of the participants, the monasteries and the theological college to ensure anonymity. Moreover, because of the increasingly scarce number of contemplative communities in Spain, a fact which might have facilitated their identification, I withhold the locations of the monks’ monastery and the retreat house where the nuns’ course took place. Similarly, I do not provide any identifying information regarding the priests’ parish churches and I give a pseudonym for the city in which the theological college is located and for the monks’ monastery of origin.

**Potential positive effect of the research on the participants**

I often wondered during the course of the study about the potential of qualitative research to have a transformative effect on the researcher and on the participants. Having conducted studies that used a quantitative research methodology (in contrast with qualitative research, which is based on narrative data, the latter collects numerical data), the main attraction that the fieldwork and the in-depth interviews had for me was that they provided plenty of scope for personal interaction with the participants and the sharing of intense life experiences. I will start with the easier task of thinking about the benefits that the research had on me before I tackle the trickier question about the participants’ obtaining something positive from my research.

As the positive effects that the research had on me at an academic level are obvious, I will tell you about those at a personal level. 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 was also deeply grateful and moved by the strength, generosity and trust that the participants
showed in their willingness to take part in a study that asked them to share with me the most distressing episodes of their lives.

I hope that as you are reading these lines, it is becoming apparent to you that carrying out this research was a wonderful and exciting experience for me; but what about the participants? Did they obtain something positive from taking part in my research? I found myself – while doing the interviews as well as when doing the analysis and writing up the findings – devoting time to trying to figure out some possible answers. Let me share them with you.

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 among 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). 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 among lay Catholics decreasing.

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 et al. 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 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 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 kindly 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!’
Part I

Setting the Literary and Historical Contexts

Looking back at the origins of the study

Journeys are triggered by your own past travels and experiences, as well as shaped by the intriguing adventures of others. My intention is to give you here an understanding of the roots of the research project you have in your hands: how it was built on previous studies undertaken by me and by other authors in an attempt both to deepen our existing knowledge and to tackle some of the questions that they left unanswered. If you are curious about finding out about the research to which the design of my study is indebted, don’t turn the page as I will proceed to briefly summarise these studies; otherwise, you can march ahead to Chapter 1.

Of the research projects I have carried out in the areas of sadness and culture, there were two – undertaken with highly religious samples – that compelled me to pursue the current broader research; they were also decisive as regards to the choice of participants. My first study was an ethnographic study based in a Spanish monastery of contemplative nuns (Durá-Vilá et al. 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 narrative. 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, the shrinking monastic community as a result of 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.

I also undertook a population survey in Spain (Durá-Vilá, Littlewood and 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 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-5), one with a clear cause, the other without an identifiable cause. The participants 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 more common when there was no obvious cause for sadness. These are the two main findings, both reaching a statistically significant level. 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 more likely to conceptualise them as normal.

Therefore, I set up the present study to further explore the conceptualisation of deep sadness and help-seeking behaviours within a highly religious Spanish sample 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 did not want to miss the opportunity to obtain detailed anthropological data portraying their way of life. I also aimed to collect biographical information from all the participants to put into context the findings and conclusions of the study.

In my earlier study, which used a vignette-based structured questionnaire (Durá-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 per cent – 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 participants’ 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 recognise 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 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 and Kessler 1988; Mollica and Streets 1986; Weaver et al. 2003).\(^1\) The National Comorbidity Survey determined that almost a quarter of the people seeking care for mental health problems obtained services exclusively from clergy, and almost 40 per cent 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 (Durá-Vilá et al. 2011; Durá-Vilá and 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, 2010; Leavey, Loewenthal and 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 and shaped the questions I asked in the interviews. First, 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

\(^1\) This might be related to economic factors and the lack of availability of free health care; thus the clergy plays a significant welfare role.
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. Second, as there seems to be considerable heterogeneity in the 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. Third, 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).
Chapter 1

Depression and the Medicalisation of Sadness

Conceptualisation and Help-Seeking

Following an overview on the literature concerned with the medicalisation of sadness, this chapter will turn to the role that cultural and religious factors play in the way sadness is understood, paying particular attention to the similarities and differences existing between depression and the Dark Night of the Soul. The chapter ends by reviewing the medical literature on sadness and help-seeking, looking at behaviours and coping strategies used to deal with sadness and depression, and critically analysing the use of antidepressants. I also discuss the literature written from a religious perspective such as religious interventions employed in secular medicine.

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 legitimises 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 and Wakefield 2007; Parker 2007; Solomon 2002; Summerfield 2006). Moreover, economic inequality is an under-acknowledged 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 and 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 in which so many are living, denouncing the pharmaceutical industry as the main beneficiary in the reduction of the human predicament to mere biology. 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 and Kirmayer 2010; Kirmayer and 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 and 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) 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 2000 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 et al. 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 et al. 2007). My own population survey in Spain emphasised 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 (Durá-Vilá et al. 2011).

Conceptualising sadness as a mental illness entails negative reactions and consequences beyond the obvious stigmatisation. The doctor’s words explaining that 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’ (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. May 2004; Moore 2011 [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 2011).

The role of culture and religion

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 et al. 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 canalisation 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 and Good 1985).

Besides the clinical variance among 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 per cent, whereas in Taiwan it was only 1.5 per cent. 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 and Minas 2000). Mainstream psychiatric 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, whereas 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 and 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, whereas 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 my previous ethnographic study who 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’ (Durá-Vilá 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 those of their patients or the communities in which they practise (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 and Littlewood 1994).

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 and Kirmayer 2003). The introduction of the category ‘religious and spiritual problems’ in the DSM-IV – which has been retained in DSM-V – was of key importance as it considers religion as a cultural factor (Abdul-Hamid 2011; Allmon 2011); moreover, it includes 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 (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 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 (Durá-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 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 (1994, first published 1940), 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, whereas 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, 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; Moore 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)

Zagano and Gillespie (2010) undertook a comprehensive analysis of Mother Teresa’s Dark Night. These authors argue that in spite of the severity of her sadness there is 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 throw light on her experiencing spiritual angst, proposing that it may 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 entitled ‘Creer desde la Noche Oscura’ [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 among 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 not to help them 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 *Religió, Psicopatologia i Salut Mental* [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 at 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 combined with 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 earlier ethnographic research in the Monastery of Santa Mónica (this is a pseudonym in order to maintain the anonymity of the nuns) (Durá-Vilá et al. 2010).

Font explains that the salutary religious depression can present with multiple symptoms such as an unbearable vital deep sense of unease and a healthy sense of guilt – to be differentiated from pathological feelings of guilt – that causes loving 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 they do not have 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, among 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. Nevertheless, praying may become difficult and arid: a struggle to abandon one’s own egocentric interests to obtain the love of God.

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:

---

2 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. Among many testimonies of saints, mystics and religious figures keeping up their apostolic activity throughout the Dark Night, a recent example is that of Mother Teresa 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).
for the development of mental illness in the context of the religious experience: either the previous existence of an underlying psychopathologically depressive structure or the intensity of the conflict and the fragility of the subject.

**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 with those of medications, have been well documented (DeRubeis *et al.* 2005; Hollon *et al.* 2005). 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, pp. 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 over-prescription (Dowrick and 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 and Sanders-Bush 2004). In the United States, somewhere between 25 per cent and 50 per cent of college students seen in counselling or health centres are taking antidepressants (Kadison 2005). In Spain, where the study presented in this book took place, 745 million euros per year are spent on antidepressants (Magán and 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 cent per year on average; this was double the increase seen for antipsychotic medication (Ilyas and 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 and 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 16 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 and Jorm 2012). A similar earlier survey undertaken in the UK of lay people’s attitudes revealed a different picture: 78 per cent 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 towards 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 et al. 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 with 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. The authors’ analysis of STAR*D showed that if they 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.

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, in his book *Listening to Prozac* (1997 [1993]), 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, from a Japanese perspective, that 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) view, 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… (Solomon 2002, 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 and 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.

Religiosity’s influence on health and depression

Religion can have a positive impact on mental health 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 and Romo 2010; Koenig, McCullogh and Larson 2001; Levin et al. 1996). Religious communities are sources of social support and companionship, and faith equips the individual with coping strategies to deal with adversity and suffering (Grosse-Holforth et al. 1996; Krause 1995; Tix and Frazier 1998). Along these lines, Koenig (1997) identified three main mechanisms by which religion might promote mental health: first, through a system of beliefs that provide hope, comfort and a mental attitude of obtaining something good from every situation by trusting God; second, through increased social and emotional support from others; and, third, 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 et al. 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 enjoy better health regardless of religious affiliation, religious activities, work and family, social support or financial status (Green and 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, whereas 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 which 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 and 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 et al. 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).

It needs to be acknowledged here too that critical voices have been raised arguing that some 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 of religion and spirituality (e.g. Flannelly, Ellison and Strock 2004).
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 and Kessler 2003; Weaver et al. 2003). There is a considerable overlap between the roles of spiritual directors and mental health professionals with regard to providing care to those undergoing severe emotional and psychological distress (Font 1999; May 2004; Moore 2011).

King and Leavey (2010) highlight 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 more quickly from their depression than those in the standard psychotherapy or control groups (Propst et al. 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 soothe 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).
Chapter 2

The Role of the Clergy in the Management of Sadness and Depression, and Their Collaboration with Mental Health Professionals

The 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 and 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 and 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 and Brown-Hughes 2009; Taylor et al. 2000; Young, Griffith and Williams 2003). Moreover, many faith-based organisations are of particular importance among ethnic minority communities (Cinnirella and Loewenthal 1999; Garro 2003; McCabe and 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 and Streets 1986; Weaver et al. 2003). Approximately 40 per cent 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 and Larson 1993; Veroff, Kulka and Douvan 1981). The latter study found that clergy’s guidance was even valued among 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 et al. 2001; Cinnirella and Loewenthal 1999; Cole et al. 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.
(Durá-Vilá et al. 2011) or when undergoing the distress described by the Hispanic idioms ‘nervios’, ‘ataque de nervios’ and ‘susto’ (Durá-Vilá and Hodes 2012). In both studies, among a religious sample, priests were seen as legitimate sources of help when facing 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 the 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 per cent 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 among 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 (Durá-Vilá et al. 2011; Durá-Vilá and 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 and 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, whereas 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 for 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 among 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 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 the care of their parishioners with depression 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 with the diagnostic criteria for major depressive disorder); (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) psychiatric treatment being perceived to be less accommodating to faith practices and to the involvement of the clergy.

Collaboration between the clergy and psychiatrists

Factors affecting collaboration between the clergy and mental health professionals

As has been stated previously, psychiatrists do not generally see clergy members as collaborators in mental health care nor are they likely to refer their religious patients to them (Bhugra 1997). The clergy are also reluctant to refer their parishioners who may be suffering from mental illness to psychiatric services (Farrell and Goebert 2008; McMinn et al. 2005). Clergy admitted to referring only a small minority of the parishioners they counselled to mental health services (Lowe 1986; Mollica and Streets 1986).

There is some research evidence showing that the 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 and King 1993). A study among Protestant clergy in Hawaii showed that having shared religious beliefs between the psychiatrist and the patient was considered important by over 40 per cent of the clergy, and essential by almost a sixth (Farrell and 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 and Crawford 1996).

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 and 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 (Durá-Vilá 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 the 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.
Jung 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’ (1969 [1932], 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 viewpoints 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 among 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 – even though 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 face 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 and 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.

**Pastoral care, spiritual direction and the sacrament of confession**

What does pastoral care comprise? The most straightforward answer will be: all the tasks and duties associated with the ministerial role, including offering spiritual direction and administering the sacrament of confession. 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, although 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 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 et al. 2012). Pastoral care was defined by the participants as providing spiritual guidance and nurturance to their parishioners. Although 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).

**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 and 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 the two: whereas spiritual direction is spirit-centred, psychotherapy is problem-centred (one could question, 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 to 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 and 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 between 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.

Whereas 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 whereas 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 and Connolly 1982), implying the achievement of some level of moral and spiritual superiority.

A comparison between confession and psychotherapy

Parallels have been drawn between this Catholic sacrament and psychotherapy, and between the role of the priest acting as confessor and the psychotherapist. Let’s start by offering an explanation of what this sacrament entails before focusing on its rich psychological and moral aspects. The sacrament of confession is also called 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 whom 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 penitents to be absolved of their 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). Although some authors have considered this sacrament as having some useful value for emotional well-being (e.g. Jung 1969), others have emphasised its oppressive nature (e.g. Arruñada 2009). *La Regenta* (Clarin 1992 [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, whereas 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).

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 (1969) was among 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’. 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 or 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 – whereas 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 (1969 [1928]). 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, whereas 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.
Chapter 3

Sketches on the Catholic Church and Monasticism

In order to add further context to the findings, Part I ends by offering a review of the literature of three relevant areas of the study. I start by looking at the current religious scene in Spain in order to assist the understanding of the reality and the challenges faced by the participants. I move on to provide an 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 provide a review of ethnographic research carried out with nuns and monks which shows the scarcity of such studies.

**The state of the Church and the clergy**

*The religious scene in Spain*

A recent survey undertaken in Spain, among those of Spanish nationality, showed that the majority of them, 70.6 per cent, declared themselves ‘Catholic’, 15.1 per cent ‘non-believers’, 9.7 per cent ‘atheists’ and 2.3 per cent ‘believers of other religions’ (2.3% not known/no answer). 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, first communions or funerals, the percentages were much lower, with 60.3 per cent of them responding ‘almost never’, and the remainder answering: ‘almost every Sunday and church holiday’, 13.8 per cent; ‘several times a year’, 14.9 per cent; ‘at least once a month’, 8.2 per cent; and ‘several times a week’, 2.0 per cent (0.7% not known/no answer) (Centro de Investigaciones Sociológicas 2015a, 2015b). 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, whereas 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 although 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 secularisation observed among the Spanish population, the separation between the Church and the state, and the recent arrival of a large migrant 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).

An historical overview of the Cistercian and Augustinian Orders

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 an 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 words, to be ‘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

3 Thomas Merton (1915–1968) was a Trappist monk and author as well as a pioneer of interfaith dialogue. He wrote more than 70 books, including his bestselling autobiography The Seven Storey Mountain.
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).

**Saint Benedict and the origins of the Cistercian 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 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, acquiring 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 19th 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 11th 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*’ 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 practice 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 who shaped the Cistercian monastic ideal in the first half of the 12th century. Through his prolific writing of sermons, treatises 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, 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 radicalisation 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; Diez Ramos 1955).

During the second half of the 12th 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

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 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 among 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 his
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).

Saint Augustine and the origins of the Augustinian Order

Saint Augustine was born in Tagaste (now Souk-Ahras) on 13 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 for more than 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 CE) 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 decline of the observance of the religious principles set up by the Rule, such as the neglect of the communal liturgical prayers and non-observance of the cloister and the vow of poverty, the latter leading to striking inequalities between 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 – among 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 17th century (e.g. in the Crown of Aragon alone, there were eight monasteries) (Monjas Agustinas Contemplativas 2002; Gemma de la Trinidad and 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 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). 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 and 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’ (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’ (Orden de San Agustín 1989, 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’ (Orden de San Agustín 1989, no. 51, part 2, chapter 2, p.54).

Besides the Rule and Constitutions, another book that 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, almost totally neglecting to mention details about key people in his life, a fact which certainly 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.

---

4 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.’
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 and 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’ (Orden de San Agustín 1989, 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 guests visiting the monastery (Gemma de la Trinidad and Alonso 2002; Monjas Agustinas Contemplativas 2002).

**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 – the 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 Filipino 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 (2010a) studied nuns in five convents in Poland, analysing the significance of the nuns’ habit using the accounts of their encounters with the lay public; 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 (Durá-Vilá 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 among 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 13 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 and 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. 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. 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 and ascetic practices, as well as exploring hierarchical structures and gender differences within the monastery.
Part II

Unfolding the Narratives of Sadness and Spiritual Growth

This second part of the book contains the findings of the study and in the following pages you will find out the participants’ answers to the study questions. It is divided into four chapters in line with the aims of the study; each chapter is devoted to one of the aims the research was set up to explore. In Chapter 4, I strive to equip you with a detailed description of the participants and their different settings to bring the findings to life. In Chapters 5, 6 and 7, I will answer each the following questions: (1) How were sadness and depression 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 did the clergy play in the care of those undergoing sadness and depression, and how did they collaborate with mental health professionals? In each chapter, 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 book in Appendix 4). I will tackle the fifth and final aim of the study – proposing a framework to differentiate normal sadness from depression – in Part III (Chapter 11) due to its clinical implications.

 Clarification of terms

Before I start telling you what I learned from the participants, let me clarify some terms I will be using in the forthcoming pages in order to avoid confusion.

 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 whom I interviewed belonged to active-life religious orders.

 Diocesan priests and religious priests

Priests in the Catholic Church are categorised 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 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 literature review, 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 21 priests: nine of them were religious priests and 12 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 gender (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, even when 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 monasterium) 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. Although 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.
Chapter 4

The Participants and Their Ways of Life

Fieldwork and interviews

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. I was given a sitting room in the monastery where I interviewed the monks individually. On the table of this room I always found a glass and a bottle of water and often a vase of fresh flowers from their garden. 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-built by Brother Xavier, a couple of sitting rooms to receive visitors, and the garden. On one occasion, my last evening among 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 so I often bumped into them in the corridor.

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
‘Research questions’ I asked the participants and the more detailed ‘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: interviews with ten contemplative Augustinian nuns (first stage), interviews with ten Cistercian contemplative monks (second stage), interviews with 20 lay theological students (third stage), and interviews with 17 diocesan priests (fourth stage).

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 receiving 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. Listening back 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, whereas 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 story, 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 among 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 4.1).

Table 4.1: Locations of the interviews for the lay theological students and the priests

How did I make sense of the hundreds of pages of interview transcripts and field notes? I carefully read them several times, and highlighted and coded statements or phrases signifying relevant concepts, ideas, behaviours, beliefs and attitudes. I derived themes from those statements, which I thoroughly compared across the transcripts and the field notes to identify recurring themes that I subsequently categorised. I examined their semantic and metaphorical content, while paying special attention to the emerging narratives. These themes represent the key findings of the study. I gave particular attention to undertaking inter-group comparisons, with differences between the nuns, monks, priests and lay theological students becoming increasingly more evident as the analysis progressed; I also rigorously noted intra-group variation. In order to facilitate immersion into the participants’ views, I combined the reading of the transcripts and field notes with listening to the audio-recordings of the interviews. I also held regular meetings with colleagues, in which I presented and interpreted the emerging themes and sub-themes. I have accompanied the themes with excerpts from the transcripts in order to illustrate them and to provide abundant original evidence to support the conclusions I reached. I have given at the end of each quotation the following information (unless this information was given in the text preceding the quotation): sub-sample (nun/monk/priest/layman or laywoman), age, marital status (for the lay person only), ethnicity and occupation (when relevant).
57 faces, 57 stories

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

**Lay theological students**

I conducted semi-structured interviews 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 4.2 and 4.3.

Table 4.2: Socio-demographic characteristics of the male lay theological students

<table>
<thead>
<tr>
<th>Lay men</th>
<th>Age</th>
<th>Education*</th>
<th>Employment</th>
<th>Civil status</th>
<th>No. of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isidro</td>
<td>38</td>
<td>Secondary education</td>
<td>Secretary</td>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Andrés</td>
<td>40</td>
<td>University (philosophy)</td>
<td>Teacher</td>
<td>Married</td>
<td>3</td>
</tr>
<tr>
<td>Pedro</td>
<td>40</td>
<td>Secondary education</td>
<td>Unemployed</td>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Sergio</td>
<td>40</td>
<td>University (medicine, psychiatry)</td>
<td>Psychiatrist</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Pascual</td>
<td>46</td>
<td>University (architecture)</td>
<td>Lecturer</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Martín</td>
<td>55</td>
<td>University (business studies)</td>
<td>Early retirement</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Lamberto</td>
<td>57</td>
<td>University (medicine, neurosurgery, GP*)</td>
<td>GP*</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Rafael</td>
<td>67</td>
<td>Secondary education</td>
<td>Retired</td>
<td>Married</td>
<td>3</td>
</tr>
<tr>
<td>Jaime</td>
<td>71</td>
<td>University (chemistry)</td>
<td>Retired</td>
<td>Married</td>
<td>3</td>
</tr>
</tbody>
</table>

* 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).
Table 4.3: Socio-demographic characteristics of the female lay theological students

<table>
<thead>
<tr>
<th>Lay women</th>
<th>Age</th>
<th>Education*</th>
<th>Employment</th>
<th>Civil status</th>
<th>No. of children</th>
<th>Living arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fátima</td>
<td>38</td>
<td>Secretarial course</td>
<td>Secretary</td>
<td>Married</td>
<td>1</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Rosario</td>
<td>39</td>
<td>University (engineering)</td>
<td>Unemployed</td>
<td>Single</td>
<td>0</td>
<td>Living with...</td>
</tr>
<tr>
<td>Leonor</td>
<td>41</td>
<td>University (English philology)</td>
<td>Teacher</td>
<td>Separated</td>
<td>0</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Magdalena</td>
<td>45</td>
<td>Secondary education</td>
<td>Receptionist</td>
<td>Single</td>
<td>0</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Paula</td>
<td>47</td>
<td>University (law)</td>
<td>Housewife</td>
<td>Separated</td>
<td>2</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Amparo</td>
<td>47</td>
<td>Secretarial course</td>
<td>Secretary</td>
<td>Single</td>
<td>0</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Antonia</td>
<td>50</td>
<td>Secondary education</td>
<td>Housewife</td>
<td>Married</td>
<td>1</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Eulalia</td>
<td>55</td>
<td>University (Spanish philology)</td>
<td>Lecturer</td>
<td>Married</td>
<td>2</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Julia</td>
<td>58</td>
<td>Secondary education</td>
<td>Housewife</td>
<td>Separated</td>
<td>3</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>Alejandra</td>
<td>60</td>
<td>Primary education</td>
<td>Housewife</td>
<td>Married</td>
<td>2*</td>
<td>Owned/mortgaged</td>
</tr>
<tr>
<td>María</td>
<td>62</td>
<td>University (nursing), secretarial course</td>
<td>Nurse</td>
<td>Single</td>
<td>0</td>
<td>Owned/mortgaged</td>
</tr>
</tbody>
</table>

* 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.

Sant Josep’s Catholic theological 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 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’ 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 (ranging from five teaching sessions to a whole academic year) or to undertake a pastoral specialism. 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 4.4.

5 In the original Spanish, ‘tronco común’ and ‘sección bíblico-teológica’.
Table 4.4: Academic programme of Sant Josep’s Catholic theological college

<table>
<thead>
<tr>
<th>Biblical-theological section</th>
<th>Optional courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(compulsory)</td>
<td></td>
</tr>
<tr>
<td>Faith and culture</td>
<td>Introduction to ecclesiology (‘Lumen Gentium’)</td>
</tr>
<tr>
<td>Sacred texts</td>
<td>The Church in the modern world (‘Gaudium et Spes’)</td>
</tr>
<tr>
<td>Dogmatic theology</td>
<td>Introduction to Christology</td>
</tr>
<tr>
<td>Moral theology</td>
<td>Secularity, fundamentalism, multiculturalism, atheism, agnosticism</td>
</tr>
<tr>
<td>History of the Church</td>
<td>Liturgy and Eucharist</td>
</tr>
</tbody>
</table>

| Pastoral specialities         |                  |
|-------------------------------|                  |
| Teaching of the catechism     | In-depth study of the New Testament |
| Liturgical assistant         | Second Vatican Council |
| Pastoral of welcoming        | Teachings of John Paul II and Benedict XVI |
| Pastoral of the family        | Living the Gospel in the family context |
| Pastoral of health            | Prayer workshop |
| Pastoral to assist the marginalised | Mary, prophetic woman |
| Pastoral of the young         | Sects and new religious movements |
| Teaching religion in schools  | Songs and music in the liturgy |
| Social doctrine of the Church | Sexuality and Christian morality |
| Christian spirituality and prayer | Pastoral of the elderly |
| Biblical instructor (additional three-year course) | Ecumenicalism and inter-confessional relationships |
| Ecology                       | Pastoral of missions |
|                               | Biblical workshop |

**Priests**

As with the lay theological students, I conducted semi-structured interviews with 17 priests. They were all Spanish, with a wide age range spanning from 31 to 91 years 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 as a general practitioner).

Among 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 4.5). I am going to provide below a brief description of seven priests who stood out due to their professional trajectories.

Table 4.5: Socio-demographic characteristics of the priests (non-contemplative priests)

<table>
<thead>
<tr>
<th>Priests</th>
<th>Age</th>
<th>University career/s</th>
<th>Profession/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tomás</td>
<td>31</td>
<td>Theology, computer science</td>
<td>Parish priest, school teacher</td>
</tr>
<tr>
<td>Anselmo</td>
<td>39</td>
<td>Theology</td>
<td>Parish priest, prison chaplain</td>
</tr>
<tr>
<td>Enrique</td>
<td>44</td>
<td>Theology, classic philology</td>
<td>Hospital chaplain, church assistant</td>
</tr>
<tr>
<td>Alberto</td>
<td>46</td>
<td>Theology, biology</td>
<td>Parish priest, school teacher, lecturer*</td>
</tr>
<tr>
<td>Daniel</td>
<td>47</td>
<td>Theology</td>
<td>Parish priest</td>
</tr>
<tr>
<td>Nicolás</td>
<td>51</td>
<td>Theology, medicine (general practice)</td>
<td>Parish priest, lecturer*</td>
</tr>
<tr>
<td>Eusebio</td>
<td>55</td>
<td>Theology, philosophy</td>
<td>Prior, gives spiritual retreats</td>
</tr>
<tr>
<td>Miguel</td>
<td>60</td>
<td>Theology</td>
<td>Head pastoral for migrants office*</td>
</tr>
<tr>
<td>Francisco</td>
<td>65</td>
<td>Theology, psychology</td>
<td>Prior, gives spiritual retreats</td>
</tr>
<tr>
<td>David</td>
<td>63</td>
<td>Theology</td>
<td>Parish priest, lecturer*</td>
</tr>
<tr>
<td>Pablo</td>
<td>63</td>
<td>Theology, psychology, philosophy, pedagogy</td>
<td>Parish priest</td>
</tr>
<tr>
<td>Gerardo</td>
<td>64</td>
<td>Theology</td>
<td>Parish priest</td>
</tr>
<tr>
<td>Manuel</td>
<td>66</td>
<td>Theology, sociology</td>
<td>Parish priest, lecturer*</td>
</tr>
<tr>
<td>Jesús</td>
<td>73</td>
<td>Theology, pedagogy</td>
<td>Parish priest</td>
</tr>
</tbody>
</table>
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 furnished 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, whereas 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 that also included 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: first, from Abbots and Mother Superiors requesting that a member of their community be seen; second, from bishops asking for an assessment of one of their diocesan priests; and, third, 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 more than 8000 cases: almost 5000 were priests, seminarians and monks, and the remaining 3000 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 seminaries 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’, he bluntly – although kindly – replied, ‘Gloria, no, it was not a late vocation; it is God who calls you whenever he wants’ (one of those moments while conducting interviews when I wished I could have rephrased a question better). 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.
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 14 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. Later on, in Chapter 6, 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 as a result of 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.

Missionary priests

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. He 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. The local press paid tribute to him and he was remembered in many masses throughout the city for a life devoted to the missions. 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. 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

6 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 4.8 for their detailed timetable), they spend most of their time alone, secluded in their cells. Father Enrique explained that they can only talk among themselves for one and a half hours 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.
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!’

*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. I obtained the information presented here in the course of my fieldwork in the Monastery of Sant Oriol through participant observation and multiple conversations held with the monks. I gathered some of the more detailed and personal biographical data in the individual interviews.

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).

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. The increasing age of the community would seem to foretell a gloomy future for the continuance of the Monastery of Sant

---

7 Brother Joaquim entered the Monastery of Sant Oriol after Brother Terenci. The former joined four years before and the latter seven.
Oriol and it is a real source of worry and uncertainty for the monks. I have elaborated some of the tensions that Brother Terenci suffered due to the consequences of the age difference and the ways the monks used to deal with the crisis of vocations in Chapter 6, in the section ‘Differences and peculiarities observed in the nuns, monks and priests’ (p.00).

The monks’ number of years of religious life ranges from four years to 66, with a mean of almost 35. 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 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 4.6). 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: ‘Gloria, we are definitely in the world!’ (he might have been reacting to the involuntary surprised tone of my praise). In my fieldwork with nuns, especially among the older nuns, I often heard the expression ‘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 among 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.⁸

Moreover, they seemed to be good at sharing knowledge about 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 among 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 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 4.6.

Table 4.6: Monks’ ages, level of education and years of religious life

<table>
<thead>
<tr>
<th>Monks</th>
<th>Age</th>
<th>Level of education</th>
<th>Years of religious life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terenci</td>
<td>35</td>
<td>University education (music and theology)</td>
<td>7</td>
</tr>
<tr>
<td>Arnau*</td>
<td>57</td>
<td>University education (theology)</td>
<td>24</td>
</tr>
<tr>
<td>Joan</td>
<td>57</td>
<td>Primary education</td>
<td>31</td>
</tr>
<tr>
<td>Joaquim</td>
<td>60</td>
<td>University education (journalism)</td>
<td>4</td>
</tr>
<tr>
<td>Gregori▲</td>
<td>64</td>
<td>Secondary education</td>
<td>23</td>
</tr>
</tbody>
</table>

⁸ 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 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 among 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 section ‘Saint Benedict and the origins of the Cistercian Order’ in Chapter 3.

* 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’.
I wondered how much of a conscious or unconscious process of identification with those early renovators of the order took place among 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 first-hand were striking: the story of the foundation seemed to be a favourite one, being frequently referred to among 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 – 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 Father Teacher and the Abbot or Prior (in communities of fewer than 12 monks – as it is the case of the Monastery of Sant Oriol – the Abbot receives the name of Prior). 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 wear normal clothes).  

The monk is then known as a ‘simply professed monk’. 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 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 most of them had tears in their eyes when they embraced him.

---

9 Due to the colour of their habits, Cistercian monks are popularly known as ‘White Friars’ (whereas Dominicans are popularly called ‘Black Friars’ and Franciscans ‘Grey Friars’).
The religious formation of the monks is not a rigid, mechanical kind of training. Although the
duality 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 4.7.

Table 4.7: Monks’ levels of religious formation

<table>
<thead>
<tr>
<th>Stage</th>
<th>Duration</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postulant</td>
<td>1 year</td>
<td>Wears normal clothes</td>
</tr>
<tr>
<td>Novice</td>
<td>2 years</td>
<td>Wears normal clothes</td>
</tr>
<tr>
<td>Simple vows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simply professed monk</td>
<td>3 years</td>
<td>Wears the Cistercian habit</td>
</tr>
<tr>
<td>Solemn vows</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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 straightforward manner, needing only to get a dispensation from their
Prior, whereas 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 at Sant Oriol has the title of Prior as the community has fewer than 12 monks. The Prior
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. 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. 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.

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. 

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 the monastery’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 section ‘Cistercian spirituality’ in Chapter 3 (p.00)) 
were very much alive in Sant Oriol, with their daily routine being governed by their maxim ‘ora et 
labora’: as their timetable shows (Table 4.8), 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 among 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 adherence 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 turns to perform 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, 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 4.8: Timetable of the monks’ daily activities

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

* 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\textsuperscript{10}). 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 the last section of this chapter). 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.

Silence played an essential role in their lives of contemplation, since they considered it an inner attitude of focusing their minds on God. They had two moments of ‘recreation’ daily, when they could talk freely among 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 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 meal that they all had. In these celebrations and on Sundays, they had a longer after-lunch conversation with ‘real coffee’ rather than instant coffee. Curiously, they drank wine with all their lunches and dinners but only enjoyed ‘real coffee’ on Sundays. The monks offered me coffee on many occasions which I readily accepted and I am pleased to be able to report to you that each time I was treated to the ‘real’ kind. They 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 and several smoked profusely during the interviews). 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

\textsuperscript{10} 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.
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 25 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 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 to play 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, which 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 56. 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 to be 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 or 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 joined the community of Sant Oriol seven years ago, when he was 28 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, and 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 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, 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-judgemental 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, sometimes call him ‘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
Understandably, 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).

**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.

Ten nuns belonging to the Order of Saint Augustine attended the training: one was a postulant (Sister Teresa), six were novices (Sister Claudia, Sister Raquel, Sister Elvira, Sister Elena, Sister Sofia and Sister Irene) and the three remaining nuns were Mother Teachers (Sister Carmen, Sister Mercedes and Sister Carolina). The course was part of the formative process 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. 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 Sofia; 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, 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),

---

11 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 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).

12 My fieldwork in the Monastery of Santa Mónica was conducted from July 2006 to June 2008 in seven visits (see sections ‘Looking back at the origins of the study’ (p.00) and ‘Help-seeking and coping with sadness and depression’ (p.00) in Part I for further details).
whereas 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. 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, whereas the latter had been nuns for an average of 32 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 among 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 4.9.

Table 4.9: Nuns’ ages, level of education and years of religious life

<table>
<thead>
<tr>
<th>Nuns</th>
<th>Age</th>
<th>Level of education</th>
<th>Ethnicity♦</th>
<th>Years of religious life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raquel</td>
<td>23</td>
<td>Primary education</td>
<td>Kenyan (Kamba)</td>
<td>3</td>
</tr>
<tr>
<td>Irene</td>
<td>23</td>
<td>Primary education</td>
<td>Kenyan (Luo)</td>
<td>2</td>
</tr>
<tr>
<td>Claudia</td>
<td>26</td>
<td>Primary education</td>
<td>Kenyan (Kikuyu)</td>
<td>3</td>
</tr>
<tr>
<td>Teresa</td>
<td>26</td>
<td>Primary education</td>
<td>Kenyan (Kamba)</td>
<td>&lt;1♦</td>
</tr>
</tbody>
</table>
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 among these young women, who were at 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 twofold 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’. 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 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, at 7.00, and went to bed at least one hour later, at 10.45, than in their monasteries of origin (see Table 4.10 for a general timetable of their courses which is a reproduction of the one the nuns in training were given on arrival). 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. 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 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

13 For a general depiction of Augustinian spirituality, in line with Father Pedro’s teaching, see Chapter 3.
14 See Note 7 for a definition of ‘grille’. 

86
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 among laughter and blushes.

Table 4.10: Timetable of the nuns’ course

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

* 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 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 whom 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 have provided elsewhere a detailed portrayal of the way of life in the Monastery of Santa Mónica (Durá-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 4.11 for the nuns’ levels of religious formation with their external characteristics.

Table 4.11: Nuns’ levels of religious formation

<table>
<thead>
<tr>
<th>Stage</th>
<th>Duration</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postulant</td>
<td>1 year</td>
<td>Wears normal clothes</td>
</tr>
<tr>
<td>Novice</td>
<td>2 years</td>
<td>Wears the Augustinian habit and a white veil</td>
</tr>
<tr>
<td><strong>Simple vows</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simply professed nun</td>
<td>3 years</td>
<td>No changes in habit, still wears a white veil</td>
</tr>
<tr>
<td><strong>Solemn vows</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solemnly professed nun</td>
<td>For life</td>
<td>Black veil and ring, right to vote, to break the vows a dispensation from the Vatican is required</td>
</tr>
</tbody>
</table>

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 4.12 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 among 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 6 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 4.12: Timetable of the nuns’ daily activities

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

* Prayers belonging to the Liturgy of the Hours

Notes

1 I undertook thematic content analysis of the transcripts of the semi-structured interviews and the field notes (Coffey and Atkinson 1996).
Chapter 5

Conceptualisation of Sadness, Depression and the Dark Night of the Soul

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 that they had 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 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 among 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 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 first-hand 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;\(^{15}\) 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.

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 per cent 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.

---

\(^{15}\) The Spanish word used was ‘*enfermizas*’. 

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. First, 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. Second, some viewed with a critical eye 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, 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’

I asked all the participants to describe a time in their lives when they suffered from deep sadness. As I explained in the section ‘Fieldwork and interviews’ in Chapter 4 (p.00), 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 I will present in this section, although the events responsible for their sadness and the level of severity of their suffering varied among 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 whereas 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 (the section, ‘The Dark Night of the Soul: a case of non-pathological religious sadness’ (p.00) 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, relationship 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, whereas 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 the experience of someone 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 among 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 and 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 that 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, which 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 noticeable how strongly participants attached 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 ‘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 experience of being sad 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 (I will explore in depth the participants’ ways of coping in the next section). Losing hope was probably considered 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 5.1.

Table 5.1: Symptoms that sadness and depression have in common, and symptoms that 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).

<table>
<thead>
<tr>
<th>Symptoms that sadness and depression have in common</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological</strong></td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Poor concentration</td>
</tr>
<tr>
<td>Shame</td>
</tr>
<tr>
<td>Self-doubt</td>
</tr>
<tr>
<td>Fear</td>
</tr>
<tr>
<td>Vulnerability</td>
</tr>
<tr>
<td>Feeling trapped</td>
</tr>
<tr>
<td>Guilt</td>
</tr>
<tr>
<td>Distress</td>
</tr>
<tr>
<td>---------</td>
</tr>
</tbody>
</table>

**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 experience, stated categorically that depression could never be a sin, as the depressed individual lacked freedom: ‘If there is no freedom, there cannot be sin; this needs to be made completely clear, that in those cases [of people suffering from depression] there is no freedom at all!’ Maria, a secular participant with a long background in nursing, 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. 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 out 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 among 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, whereas others

---

16 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.
compared this illness with other ‘physiological imbalances’ such as the excess of glucose, 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 among 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 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.

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’ or ‘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 highlighted 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 cannot 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 5.2.

Table 5.2: Symptoms and concerns during the Dark Night of the Soul

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological</strong></td>
<td><strong>Physical</strong></td>
</tr>
<tr>
<td>Confusion</td>
<td>Tearfulness</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Crying</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>Poor appetite</td>
</tr>
<tr>
<td>Self-doubt</td>
<td>Tiredness</td>
</tr>
<tr>
<td>Guilt</td>
<td>Poor sleep</td>
</tr>
<tr>
<td>Fear of not overcoming it</td>
<td></td>
</tr>
<tr>
<td>Distress</td>
<td></td>
</tr>
<tr>
<td>Disappointment</td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td></td>
</tr>
<tr>
<td>Vulnerability</td>
<td></td>
</tr>
</tbody>
</table>

104
Great importance was placed on the need to count 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\textsuperscript{17} 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 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

\textit{Differences in the conceptualisation of the Dark Night}

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 Teresa of Jesus and Saint Thérèse of Lisieux or more recent ones such as Mother Teresa of Calcutta.\textsuperscript{18,19} They modelled their

\textsuperscript{17} In Spanish: ‘acompañamiento espiritual’. The participants mainly used two terms to refer to this process of spiritual guidance: ‘spiritual accompaniment’ and ‘spiritual direction’. I discuss the implications that using one or the other term had with regard to the spiritual director’s level of authority in the section ‘Clergy’s pastoral care for sadness and depression: compliments and complaints’ (p.00) in Chapter 10.

\textsuperscript{18} Following publication of the book \textit{Come Be My Light}, which contained Mother Teresa 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
own experience of the Dark Night on them, turning to their testimonies to find ways to cope with their darkness:

[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.²⁰

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 for 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:

[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.

abandonment by God, there was a media reaction calling Mother Teresa 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.

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

Sister Mercedes referred to the autobiography of Saint Thérèse of Lisieux called The Story of a Soul (1926 [1897]).
Enrique, priest, 44, White Spanish, hospital chaplain and church assistant

The Dark Night of the Soul is something very special, very extraordinary, reserved for 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 break-up 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 on a process of attributing religious meaning to their suffering, interpreting it through the religious framework of the Dark Night of the Soul.

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 the 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 among 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 among his patients. He referred to this mental illness as ‘the great epidemic of the 20th century’, from which his religiously committed clientele was 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 Chapter 6).

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 misinterpreting 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 for ‘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
Coexistence 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 coexisted 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 6.1 summarises the main coping strategies and help-seeking behaviours found in the interviews which will be elaborated in this section.

Table 6.1: Coping strategies and help-seeking behaviours to deal with sadness and depression

<table>
<thead>
<tr>
<th>Religious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreting their suffering as worthwhile and beneficial for the self and others, as it leads to:</td>
</tr>
<tr>
<td>spiritual maturity and growth</td>
</tr>
<tr>
<td>spiritual purification</td>
</tr>
<tr>
<td>an invitation to reflect on their lives</td>
</tr>
<tr>
<td>being more sensitive to the suffering of others</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Secular</strong></th>
<th><strong>Religious coping and help-seeking</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical resolution of the problem responsible for their sadness (e.g. getting a new job)</td>
<td>Distracting themselves from their feelings of sadness (e.g. doing voluntary work or finding a new hobby)</td>
</tr>
<tr>
<td>Seeking the help and support of friends and family</td>
<td>Looking after their own physical health (e.g. playing sports, healthier diet)</td>
</tr>
<tr>
<td>Seeking the help of a mental health professional to engage in psychotherapy</td>
<td>Seeking medical help (psychiatrist or GP) to be prescribed antidepressant medication or hospitalisation in the most severe cases*</td>
</tr>
</tbody>
</table>

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

** Attribution of religious meaning to suffering**

One of the most common coping strategies found among 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 (I will depict these multiple religious coping strategies 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 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 6.2). First, 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 recording 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.

Second, 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 section ‘Secular coping and help-seeking’ (p.00)). 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). 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 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 their son 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.

Third, prayer helped the participants 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.’

Fourth, 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 among 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 6.2: Beneficial aspects of praying when suffering from deep sadness

<table>
<thead>
<tr>
<th>Positive effects of praying</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Restorative, comforting and calming power</strong></td>
</tr>
<tr>
<td>‘Prayer is very healing, prayer is what frees you, what really heals you, cleans you, empties you’</td>
</tr>
<tr>
<td>‘Praying gives you so much peace’</td>
</tr>
<tr>
<td>‘It [praying the rosary] is extremely soothing’</td>
</tr>
<tr>
<td><strong>2. A source of strength and courage to confront adversity</strong></td>
</tr>
<tr>
<td>‘What you need more is prayer because without prayer you cannot have the courage [needed to cope with the suffering]’</td>
</tr>
<tr>
<td>‘I went to pray and I felt how praying was filling me up with strength…how the Lord was making me stronger’</td>
</tr>
<tr>
<td><strong>3. Feeling God’s presence while praying protected them from hopelessness and despair</strong></td>
</tr>
<tr>
<td>‘[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’</td>
</tr>
<tr>
<td><strong>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</strong></td>
</tr>
<tr>
<td>‘I prayed to see how to overcome it, what to do’</td>
</tr>
<tr>
<td>‘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’</td>
</tr>
<tr>
<td><strong>5. An avenue to externalise problems and negative feelings and to favour rationality and objectivity</strong></td>
</tr>
<tr>
<td>‘I tell God about my sadness, 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’</td>
</tr>
</tbody>
</table>
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.

Terror 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 among 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 Chapter 7 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 among the lay participants: whereas 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.

Those participants who met regularly, not counting at the Sunday mass, were those 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 among 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 and the role of the parish community in supporting the priest will be addressed in the following section ‘Differences and peculiarities observed in the nuns, monks and priests’ (p.00).

Among 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 surprised 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 existence 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’ – 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

21 ‘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).
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 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 cannot 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 cannot see any solution…there is someone [God] who supports me, so I don’t despair!’ Many participants, as I described in Chapter 5, 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 cannot know everything, I cannot 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 criticised 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 12 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 into 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 regard 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 afterlife 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.

Maria, laywoman, 62, single, White Spanish, nurse

Religiously motivated gestures

Some physical actions and gestures with a religious intent were used, especially among 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 (e.g. 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 among the secular strategies, it was often imbued with religious meaning. It was thought to be useful for two main reasons: first, it helped them to stop obsessing about their problems and gave them an active occupation and sense of purpose, and, second, it put their own personal tribulations in context by comparing them with the serious adversities faced by those whom they were trying to assist. For example, Jaime, a 71-year-old
retired layman, contributed to a voluntary organisation that 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 in Chapter 4). Jaime explained that spending time among the ill helped him immensely to make 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 Teresa 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. [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 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 to play 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-behavioural 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.22 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, whereas those who had undergone depression used these resources in addition to pharmacological treatment and psychotherapy.

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 I have 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 of 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 away, 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’ economic interests influencing the over-prescription of these drugs by professionals, as well as shaping the public opinion in their own interest through marketing campaigns. Other participants – especially those with more knowledge of mental health matters – distinguished between ‘endogenous’ and ‘reactive’ depression (in Spanish: ‘endógena’ and ‘reactiva’). This was an old way to classify depression: the former was thought to be an illness with an organic cause in contrast with the latter which was considered to occur in response to adversity. As I will explain in detail in the following section, these participants stated that taking antidepressants was a legitimate option, even a necessary one, in the case of someone suffering from the endogenous type. 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

---

22 There is a noticeable exception to the predominant negative view held towards psychoanalysis: Andrés, one of the laymen participating in the study, successfully combined psychoanalysis and spiritual direction to overcome anxiety and depression (his testimony is explained in more detail in Chapter 7).
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 happening to them was fundamentally different: whereas 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 reluctantly 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
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. Psychotherapy was valued positively by many more participants than psychiatric medication. 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. 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.

Narratives of religious coping

Father Enrique

Father Enrique, currently a diocesan priest and the chaplain of a big urban hospital, had been a Carthusian monk for 14 years. His narrative of sadness illustrates many of the above religious coping strategies. He had to leave his monastery, with great reluctance, 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 ‘Hospital chaplain’ in Chapter 4 (p.00), for further biographical details on Father Enrique, and see Note 3 in the same chapter for a brief depiction of the Carthusian spirituality). He gave one of the most enthusiastic testimonies that I have encountered in my fieldwork among 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 14 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 more than 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?  

…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 first-hand experience of having felt the desolation and powerlessness brought on by his illness and of having successfully 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.

Clergy’s coping with mass secularisation

As a final example of religious coping, I will briefly present here the clergymen’s first-hand 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 the section ‘The Catholic clergy’ in Chapter 3 (p.00)). Many of the participating priests – both religious and diocesan – were caught up in this phenomenon when they were in the seminaries 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

23 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.’
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.

The priests often brought up those years when asked to describe hard moments in their lives. The widespread secularisation 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 Spanish society, which were seriously questioning the role of the 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 he had been determined to become a priest since the age of 11, 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 secularisation, the majority of them resorted to reminding themselves
of the original reasons they had had for taking this path, trying to keep those reasons 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 among them [referring to the seminarians and priests who 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 choice. 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.

Medical help-seeking behaviours and an absence of causality for the sadness

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 section, 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 appropriate 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 imbalance, 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

The impact of the individual’s personality

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 ways of 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.

**Focusing on helping others with their sadness**

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 with those of their visitors, and, on the other hand, it was a welcome respite and source of distraction from their troubles.

As has been explained in Chapter 4, 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 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 addiction; 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 extramarital affair). 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 proselytisation. 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 among 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, whereas 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 more 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 the section ‘Differences between the monks and the nuns’ in Chapter 4 (p.00), whereas at times I 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 of the ten monks had received university education whereas only two of the ten nuns had a university degree. Five monks had obtained degrees in theology whereas 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 judgemental attitudes regarding many
aspects of modern society and the challenges faced by people nowadays.

Ways of dealing with the crisis of vocations

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 choice 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 proactive approach than the monks. The nuns not only brought young women
from abroad to become postulants in their communities, but they 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 difficulties 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 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).

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.’

The nuns’ strong identification with the Virgin Mary contrasted with its absence among 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!  

Besides Christ and the Virgin Mary, there were other holy men and women from the history of the Church with whom the monks and nuns also identified, 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 who preceded them and 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 section ‘Saint Benedict and the origins of the Cistercian Order’ in Chapter 3 (p.00)).

---

24 "I am the Lord’s servant,” Mary answered. “May your word to me be fulfilled.” Then the angel left her’ (Luke 1:38).
Chapter 7

The Role of the Clergy in the Care of Sadness and Depression, and Their Collaboration with Mental Health Professionals

Most of the findings I present here are extracted from the clergy’s interviews, as this area of inquiry was a key part of their interviews. I asked the priests many questions in order to explore in depth the help they provided to those of their parishioners who were undergoing profound sadness and depression. I also sought their opinions 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 for the ‘Interview schedule’).

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 (they are summarised in Table 7.1). 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 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

25 ‘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
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 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): first, they normalised these feelings as an understandable consequence of the adversity confronted and, second, 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.26

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, such as depressive disorders or psychoses. However, a different view emerged regarding their role in caring for those suffering from mental illnesses: although 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 to be 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).

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

sword will pierce your own soul too’’ (Luke 2:34–35).

26 Besides explaining later on in this present section how the clergy used confession and spiritual direction to help their distressed parishioners, I have covered several other aspects of these two pastoral activities elsewhere in the book: a comparison between confession and psychotherapy is made in Chapter 2 in the section ‘Pastoral care, spiritual direction and the sacrament of confession’ (p.00) and the discrepancies found with regard to the sacrament of confession and to the spiritual director’s level of authority are discussed in Chapter 10 in the section ‘Discrepancies in attitudes to the sacrament of confession and to the spiritual director’s level of authority’ (p.00).
and making the most of this period of spiritual darkness. As we have seen previously, 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 to not make drastic decisions during this disquieting spiritual stage, but rather to be patient and hold firm to their beliefs: ‘In time of desolation, never to make a change.’

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:

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 7.1: Clergy’s ways and strategies employed to help those suffering from sadness and depression

<table>
<thead>
<tr>
<th>Clergy’s answers to the question: ‘How do you help those suffering from sadness and depression?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Installing hope and meaning, integrating their suffering into a religious narrative (e.g.</td>
</tr>
</tbody>
</table>

27 This is the beginning of the fifth rule of Saint Ignatius of Loyola’s Spiritual Exercises (1920 [1548], 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.’
<table>
<thead>
<tr>
<th>Jesus’ Passion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active listening, empathic and caring attitudes, not giving up easily</td>
</tr>
<tr>
<td>Using spiritual resources such as prayer, acts of worship, pilgrimages and religious readings</td>
</tr>
<tr>
<td>Detecting cases in which the individual’s religious beliefs and practices are responsible for the suffering (e.g. scruples, punitive image of God, excessive feelings of guilt)</td>
</tr>
<tr>
<td>Normalisation of their sadness, trying to find the causes behind their suffering (e.g. family problems, health concerns, vocational crises)</td>
</tr>
<tr>
<td>Offering practical help (e.g. providing financial assistance, a daily meal to the poor or helping to find employment)</td>
</tr>
<tr>
<td>Helping to rehabilitate drug addicts</td>
</tr>
<tr>
<td>Differentiating normal sadness and religious phenomena (e.g. Dark Night of the Soul) from mental illnesses (e.g. depressive disorder, psychosis)</td>
</tr>
<tr>
<td>Encouraging the keeping of psychiatric appointments and adherence to psychiatric treatment in cases of severe mental illness</td>
</tr>
<tr>
<td>Through confession and spiritual direction</td>
</tr>
</tbody>
</table>

**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 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.

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 among 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.28 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 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

---

28 Religious vows have been explained for the monks and nuns in Chapter 4, 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’.

148
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 successful 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.

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

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’.

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. Having a parish priest who was willing to listen to their feelings and worries sympathetically and who could advise them wisely was highly appreciated. 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 in 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’ 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 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
neither sought 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 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 knowledgeable 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.

Clergy and mental health professionals

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. 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.

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’.

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\(^{29}\) – 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.

They were mainly critical of three aspects of psychiatric practice. First, 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 interrelational. 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:

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 per cent 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

Second, 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

\(^{29}\) This type of psychotherapy, as will be explained later on, was often seen as markedly anti-religion as well as unaffordable to the majority. There is a brief commentary about a participant, Andrés, contesting this view earlier in the current chapter.
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.

Third, 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’ acquisition 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 that 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.30

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

30 There are no exceptions that could allow a priest to reveal his penitent’s sins as has been explained in the section ‘A comparison between confession and psychotherapy’ in Chapter 2 (p.00).
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 7.4 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 7.4: Comparison between the roles of the clergy and psychiatrists in helping those undergoing sadness and depression from the perspective of the clergy

<table>
<thead>
<tr>
<th>Clergy</th>
<th>Psychiatrists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Holistic view of the person and approach to care:</strong> 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</td>
<td><strong>Narrow view of the person and compartmentalisation,</strong> as they focus on the physical aspects, not including the relational aspects of the individual; often patients are seen by different professionals</td>
</tr>
<tr>
<td><strong>Able to hold both medical and supernatural beliefs</strong> when assessing and managing sadness and depression</td>
<td><strong>Unable to combine medical and supernatural models,</strong> the latter is ignored when assessing and managing sadness and depression</td>
</tr>
<tr>
<td><strong>Healing through listening, talking and religious resources</strong> such as praying, worship and religious readings</td>
<td><strong>Over-reliance on medication:</strong> the prescription of medicines such as antidepressants and sedatives is their main treatment tool</td>
</tr>
<tr>
<td><strong>Family and religious community are fostered</strong> as they are considered important resources</td>
<td><strong>Individualistic approach to care,</strong> not appreciating the supportive role of the family and friends</td>
</tr>
<tr>
<td><strong>Being sources of hope and meaning</strong> through incorporating the sadness into religious narratives and encouraging beneficial change</td>
<td><strong>Psychiatric diagnosis and treatment may make the problem chronic</strong> and may lead to hopelessness and even institutionalisation</td>
</tr>
<tr>
<td><strong>Normalisation of sadness</strong> as the result of the vicissitudes of life</td>
<td><strong>Medicalisation of sadness</strong> as a mental illness along the lines of a depressive illness</td>
</tr>
<tr>
<td><strong>Receiving help from the clergy is socially accepted</strong> as it increases sense of belonging to a religious community</td>
<td><strong>Psychiatric care may lead to stigma and social exclusion,</strong> which may increase feelings of marginalisation and isolation</td>
</tr>
<tr>
<td><strong>Priesthood is a vocation</strong> which comes from God: their motivation to serve others is altruistic and they are committed to priesthood for life</td>
<td><strong>Being a psychiatrist is a profession:</strong> their motivation is less generous (e.g. financial, prestige and social status) and lasts until retirement or a change in career</td>
</tr>
<tr>
<td><strong>Their skills are based on being:</strong> their role implies inner wisdom and moral and spiritual superiority</td>
<td><strong>Their skills are based on knowledge</strong> through extensive academic and practical training</td>
</tr>
<tr>
<td><strong>Their service is free:</strong> no remuneration is received from those whom they help</td>
<td><strong>Psychiatric care may be expensive,</strong> particularly when opting for psychotherapy (mostly available in the private sector in Spain)</td>
</tr>
<tr>
<td><strong>Unconditional regard for the people they help,</strong> who are regarded as ‘children of God’; they are willing to persist in trying to help someone in need</td>
<td><strong>Psychiatrist–patient relationship is conditional on the observance of a strict set of rules</strong> such as compliance with treatment,</td>
</tr>
</tbody>
</table>
Negative attitudes towards mental health professionals were supported 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. The following negative attitudes also shed some light on the clergy’s reluctance to refer parishioners to them.

Many priests felt that psychiatrists 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 among the clergymen, followed by the nuns and monks, and to a lesser extent among the lay participants.

Psychiatrists and psychoanalysts were the mental health specialists who received most criticism, 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, whereas psychoanalysts were censured for their lack of practicality: elevated cost, intense frequency of sessions and long duration. 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’.

Some priests presented convincing objective evidence to support their views. The objective evidence provided by the clergy that supported their negative views towards psychiatrists could be divided into two groups. First, 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, although sharing these experiences, clearly showed their feelings of upset, frustration and anger towards those psychiatrists. Second, 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 suppressing 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 lifestyle 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].’

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 he nor his daughter, who recently graduated, had received any. Maria, 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 traumatic 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 baptism 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, 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, usually 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 proactive than others in their suggestion to seek mental health advice: whereas 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
Part III

Stepping Beyond the Monasteries’ and Parishes’ Walls
The Medicalisation of Sadness and the Dark Night of the Soul

In this chapter I discuss the problems caused by the medicalisation of deep sadness in the light of the study findings and recent publications in this field. I pay particular attention 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.

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 that 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 over 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 and 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 and 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 (Gone and Kirmayer 2010; Kirmayer and Jarvis 2005; Pickett and Wilkinson 2010; Solomon 2002, pp.31–32).

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 used the analogy with plastic surgery and introduced the term ‘cosmetic psychopharmacology’ to refer to this latter use of antidepressants (1997 [1993]). 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.

**Contextualisation of sadness: attribution 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 on this topic in Chapter 1, many other authors have seriously questioned the validity of the current diagnostic criteria for depressive disorder because of its being purely descriptive, and because they feel it ‘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. Horwitz and Wakefield, 2007; Parker 2007; Summerfield 2006). 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 and 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 (such as the examples I mentioned before).

My study revealed not only that academics and professionals were critical of the way depression was currently diagnosed through the application of the diagnostic manuals, but that lay people too raised several problems which mirrored the concerns of the latter. 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 depression, as defined in the diagnostic systems, lacked validity for people who were not mental health experts. 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 (Durá-Vilá 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 among 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 and Wakefield 2009).

The participants’ narratives not only highlighted the lack of face validity of the diagnostic criteria for depression, but also revealed criticism of its cultural validity. Regarding the latter, although 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 among Spanish Catholics bore striking similarities with the observations made by Kirmayer (2002, 2004) and Obeyesekere (1985) in other 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 among 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 decontextualised diagnostic criteria for depression discussed above, as it would very likely have been considered pathological if the criteria were 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, 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.

The views of Batson and Ventis (1982) 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 and 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 rather 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 is observed 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:31 ‘[T]he 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 8.1).

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 and 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 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, but 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

31 Research evidence has emerged which seriously questions the effectiveness of antidepressants; see section ‘Antidepressants: the stage of affairs’ in Chapter 1 (p.00) (Fournier et al. 2010; Khan et al. 2002; Kirsch et al. 2008;
depression and taking antidepressants, which 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.

Pigott et al. 2010).
I start this chapter with a discussion of the main religious coping strategies deployed by the participants, in particular prayer, and then continue with a critical analysis of the main differences found in the way the nuns and the monks coped with suffering. I end the chapter with some considerations regarding the role of the clergy in caring for those afflicted by sadness and depression. All of the above points are placed in the context of the existing literature.

**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 Chapter 6). This is in keeping with the existing literature that has reported greater self-esteem among 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), 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,
The latter stood out among 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 favoured 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 externalise 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 Chapter 6, 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 and 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.
A Framework to Differentiate Normal Sadness from Depression

Rationale of the framework

I will end this book by proposing a framework that could allow us to differentiate 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 other aims have been addressed in the previous chapters). This framework is the main clinically meaningful contribution of the research.

As I have argued in the book, 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 over-generalised 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 over-prescription 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 I have extensively discussed in the book, 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. This framework has similarities with the solutions proposed by other scholars in the field which have been presented in Chapter 1 (e.g. Horwitz and 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.

**Distinguishing normal sadness and the Dark Night of the Soul from depression in clinical practice**

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: first, the context in which the symptoms occur; second, the impact on the individual’s functioning and, finally, the level of risk (I have summarised the process of differentiation between normal and pathological sadness as a flow diagram in Figure 11.1).

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 competent 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’ and ‘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. Symptoms that were disproportionate in severity or duration for the circumstances triggering them were considered pathological – again, ‘they didn’t make sense’ – and those that 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 11.1, shows).

Figure 11.1: Process of differentiation between normal and pathological sadness, and help-seeking behavior

Secular and religious help-seeking behaviours coexist 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 Chapter 6, 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 and 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, but when you get there, there’s not much mistaking it.... [Y]ou are simply absent from yourself... [T]he 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 that 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. 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 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 ‘The Dark Night of the Soul: a case of non-pathological religious sadness’ in Chapter 5 (p.00) for a detailed description of the Dark Night and its differences from 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).

**Applicability of the study 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. Although 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

---

32 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 ‘The Dark Night of the Soul: a case of non-pathological religious sadness’ in Chapter 5 (p.00)).

33 With regard to the potential to translate my findings to other religions, in Chapter 8 (section ‘Contextualisation of sadness: attribution of meaning and the Dark Night of the Soul’ (p.00)), I described the striking similarities that these findings bore with the observations made by Kirmayer (2002) and Obeyesekere (1985) in other cultures (Japan and Buddhist Sri Lanka respectively) where the experience of sadness was also highly valued due to the potential for personal growth.
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.

The Dark Night could provide an 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.34 Some of my colleagues, although coming from 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 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.S. Mill who broke with his father’s thinking after undergoing a long period of intense sadness.35

34 The findings of my initial ethnographic research in a female monastery were presented for the first time at the Second World Congress of Cultural Psychiatry in Norcia (Italy) in 2009.
35 Although completely devoid of any religious meaning, J.S. Mill’s long period of intense sadness – which is richly documented in his *Autobiography* (1989 [1873]) – 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. To take examples for the creative arts, 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.
Appendix 1

Ethical Considerations

Ethical approval to undertake the study was granted by University College London, Research Ethics Committee in July 2010. 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 additionally had to seek approval from the Mother Superiors of each; thus, written information was sent to them. Informed consent was also 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 for publication. As explained in the Preface, in order to ensure anonymity, pseudonyms have been used for the participants, the monasteries, the theological college and the city in which the latter is located.

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 among them, they should not feel under any obligation to agree to an audio-recorded interview with me. I also sought approval 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 opportunity to ask for further information regarding the project.

I gave attention prior to the start of the research to the potential negative consequences that it could have for the participants and I considered ways to address them if they arose (the potential benefits of the research are discussed in the Preface). I was aware that some of the questions regarding the participants’ experiences of deep sadness and depression could be sensitive. Therefore, I took great care in formulating them in a delicate and gentle manner, and in the event 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 the possibility of my research provoking any spiritual doubts in them; however, I sought advice from colleagues with experience in doing fieldwork in highly religious settings with regard to this possibility. As before, to avoid this risk, I formulated questions carefully 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).
Appendix 2

Finding the Questions to Get the Answers

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 in order 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. Following them, you will find the ‘Interview schedule’ for a detailed list of questions I asked the participants.

Research questions

1. Distinction between non-disordered sadness and dysfunctional sadness

Conceptualisation and help-seeking

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 a clear cause?

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

Depressive disorder in religious people

How is depressive disorder manifested and conceptualised (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?

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 manifested and conceptualised (attributed causality, narratives, symptomatology)? Is monastic life a prerequisite 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?

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?

Interview schedule

1. Distinction between non-disordered sadness and dysfunctional sadness

Conceptualisation and help-seeking

(a) Think of a time when you were feeling deeply sad.

(a.1) Why do think you were sad? Was there 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/religious community/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 you 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.)–(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? What help did he offer? What kind of help did you expect him to offer?

**Depressive disorder in religious people**

(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?

**Spiritual distress and the Dark Night of the Soul**

(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/attrtribution, e.g. faith/religious doubts, concern with their relationship with God, feelings of spiritual emptiness, desolation.)

(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?

2. **Role of the clergy**

(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?
(b.1) Ask (a.1)–(a.3).

(b.2) 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?
References


Dictionary of the Royal Academy of the Spanish Language [Diccionario de la Lengua de la Real Academia de la Lengua Española] (2001). Available at


Illich, I. (1968) ‘El cura, el clero y la burocracia clerical deben desaparecer’ [The priest, the clergy and bureaucracy must disappear]. *Correspondència* 52, 11–18.


Mollica, R.F. and Streets, F. J. (1986) ‘A community study of formal pastoral counseling activities of
the clergy.’ American Journal of Psychiatry 143, 3, 323–328.


Morse, J.M. (1999) ‘Myth #93: reliability and validity are not relevant to qualitative inquiry.’ Qualitative Health Research 9, 6, 717–718.


Popay, J., Rogers, A. and Williams, G. (1998) ‘Rationale and standards for the systematic review of qualitative literature in health services research.’ *Qualitative Health Research* 8, 3, 341–351.


Saint Ignatius of Loyola (1920) Ejercicios espirituales [Spiritual Exercises]. Madrid: Editorial Apostolado de la Prensa. (Original work published 1548.)


Saint Thérèse of Lisieux (1926) Historia de un alma [The Story of a Soul]. Barcelona: P.P. Carmelitas Descalzos. (Original work published 1897.)


*Vanguardia, La* (2011) ‘Católicas, el liderazgo que nunca llega’ [Catholic women, the leadership that never arrives]. 29 March, 26–27.


Weaver, A.J. (1995) ‘Has there been a failure to prepare and support parish-based clergy in their role as front-line community mental health workers? A review.’ The Journal of Pastoral Care 49, 2, 129–149.


