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Analysis of the Therapeutic Dynamics Working with Nuns

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Abstract

Psychotherapy has gained social acceptance as a means of providing support during mental health crises. Despite the growing number of publications on psychotherapy for different patient groups, scientific research on therapy for nuns (especially in Poland) remains scarce. The subject remains taboo; many nuns view emotional problems as a sign of weakness and a shameful topic - much like psychotherapy itself. This article therefore highlights significant challenges in therapy with nuns. We conducted a multiple case study to investigate the topic and work towards recurring patterns faced during therapy with such patients. The study is based on work conducted at the Day Treatment Unit for Emotional and Mood Disorders at the University Hospital in Krakow, Poland. Over a ten-year period, we collected and analyzed data from intake interviews and therapy sessions of twelve Catholic nuns (ages 38-53) diagnosed with major depressive disorder or mixed depressive and anxiety disorder. During psychotherapeutic treatment, the therapists mainly used clarification, interpretation, reflection, containment, and confrontation techniques. Our observations highlight the unique nature of resistance and counter-resistance in therapy with nuns, which hinders the establishment of an open therapeutic dialogue. Nuns undergoing psychotherapeutic treatment are a special group of patients due to their social roles. At the same time, however, they are "ordinary" people in terms of the emotions they experience, their daily concerns, crises, and difficulties that manifest in social interactions. Behaviors, reactions to stressful situations, and emotional states that appear to lack an adaptive function are often reinforced by the rules of religious life or develop based on generally accepted principles within the religious congregation. Therefore, the specific nature of therapeutic work with nuns requires consideration of their daily reality. The study revealed significant issues and challenges in the psychotherapy of nuns, underscoring the necessity of further research and exploration in this clinically understudied area in Poland.

Key words: nuns, resistance, counter-resistance, defense mechanisms, psychotherapy.

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Novelty and Significance

What is already known about the topic?

- An increasing number of nuns are seeking help from psychotherapists.
- One of the greatest challenges nuns face is dealing with repressed emotions.

What this paper adds?

- This is the first clinical research into therapy for nuns in Poland. It explores how living in seclusion within a religious community affects nuns' perception of the emotional issues they experience.
- The results show the specific difficulties of which psychotherapists should be aware when working with nuns.
- The study explores the phenomenon of resistance and counter-resistance in psychotherapy with nuns.

In the last decade, the importance of psychotherapy in treating mental crises has become increasingly socially accepted. Changing living conditions, greater access to information, and increased acceptance of various psychological difficulties allow for the discussion of life and psychological functioning among nuns as well, a trend reflected in an ever-growing body of recent publications (Abramowicz, 2017; Białkowska, 2023; Dżbik-Kluge, 2023). However, the scope of research and scientific literature that is applicable when accepting nuns into therapy remains limited.

In Poland, the topic of psychotherapy for nuns has not yet been addressed in academic or research work. All the polish cited works consist of interviews with nuns who have chosen to talk about their struggles, particularly in situations involving leaving the convent. It seems that the topic of therapy for nuns is still an unexplored area in Poland. The nuns themselves tend to view their emotional struggles as a sign of

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weakness and a source of shame, and they consider therapy itself to be a taboo subject that is best not discussed openly.

Within international literature this topic has been explored in more detail than in the domestic literature. Scott (1970) presented a clinical report based on a year-long group therapy program for a Catholic monastic community, comprising the mother superior and eight nuns. The results of this experience indicated significant benefits. Over the course of the year, the author observed that all the nuns matured, becoming more self-aware and gaining greater self-confidence. They also became more tolerant of themselves and others. The Mother Superior herself commented on this as follows: 'Group therapy is the best thing I could wish for my closest friends. I would wish it for every group of nuns, because bringing nuns together in one house artificially creates many problems that might otherwise remain unseen". This comment seems to demonstrate the Mother Superior's keen insight. However, therapy conducted within a single group living in a shared space is more akin to family therapy than to individual therapy within a group setting or individual therapy where each participant works on their own areas of conflict.

Researchers from Puerto Rico (Rodríguez Gómez & Molina, 2020) conducted an original study among a community of Catholic nuns. The results point to the need for mental health prevention and counselling within this group. Over half a century ago, in 1967, Ray Naar (2014) provided psychotherapy to a group of Catholic nuns. He treated a total of 180 nuns. In his book, he detailed the course of psychotherapy for six of the nuns, including reconstructed dialogue from case notes and his personal recollections. The sisters' situation was further complicated by years of isolation from the secular world, in addition to the psychological problems they faced. His work may be of interest to mental health and psychotherapy professionals working with nuns. It highlights the significance of emotions and relationships within the psychotherapeutic process for this specific, closed group of patients. Nowadays, a growing number of nuns are also leaving their religious orders in Poland. This phenomenon was first observed in other parts of the world (ex. USA) many years ago. To understand the causes of this trend, a study was conducted examining stress, psychological strain, depression and coping mechanisms among nuns (Rayburn, 1991).

Despite several decades of gender equality processes in society and the increasingly widespread application of justice-based social principles, gender equality for women and men serving as clergy in the Catholic Church remains virtually non-existent (Radzik, 2015; Szwed, 2015). The gender of clergy members is strongly linked to specific tasks. In the Catholic Church, a female clergy member still has a subordinate role to a male clergy member. This imbalanced definition of the relationship not only imposes certain duties on nuns, but also limits their privileges, thereby placing them in a unique and often challenging situation. The same behaviors and reactions displayed in social interactions are often interpreted as assertive in the case of male clergy and aggressive in the case of female clergy. Zuzanna Radzik (2015), a theologian, draws attention to the differences between Catholicism in Poland and Central and Eastern Europe, and Catholicism in North and South America. In Poland, the roles of male and female clergy seem to be even more clearly divided into male and female realms. This delineates the boundaries of nuns' daily lives, often confining them to the kitchen, kindergarten, school and administrative tasks relating to hierarchically superior male clergy.

Situations that, in a secular setting, would be viewed as difficult to accept -or even as infringing on the sovereignty of one gender over the other- constitute an accepted norm within the clergy. From a psychological perspective, the emotions or state of tension caused by relationships in which one gender -in this case, women- is the party whose autonomous boundaries are constantly violated and crossed, are not alleviated by the

fact that this is sanctioned due to the nature of the environment in question. Opposition to this prevailing norm may evoke a sense of guilt in the patient herself and could lead to disapproval and ostracism within the religious community. These phenomena have been described in detail by Hailparn and Hailparn (1994).

For therapists, this can raise uncertainty or anxiety. Nuns as patients are ordinary persons, experiencing similar emotional states, facing situations familiar to other people, feeling and thinking like other women (Ciarrocchi & Wicks, 2005; Osóbka-Zieliński, 2015), at the same time one cannot fail to consider the nature of a nun's specific social role. Problems, concerns, conflicts, and crises experienced in the context of their social role, their profession, or their life in accordance with the rules of the religious congregation add additional challenges for the therapist.

In Poland nuns facing mental health issues do not always have the opportunity to access individual or group psychotherapy, such as that offered at our outpatient clinic. However, there are opportunities to access such assistance within the church's own structures. The advantage and limitation of these opportunities may lie in the fact that they take into account the specific context of life in a convent.

The aim of this article is to broaden the understanding of the specific challenges in the psychotherapy of nuns in order to help other practitioners improve their approaches. We present our observations and draw on existing literature to put them in context. The therapeutic approach employed in our ward enables patients to recognize that the psychological issues and internal conflicts experienced by nuns are similar to those faced by laypeople. It is only the context of these experiences that differs. This enables patients to normalize the difficulties they face and experience a sense of community, rather than reinforcing a sense of uniqueness and isolation. After many years of living in seclusion, participating in a therapeutic group with laypeople can be beneficial for nuns, as it provides them with an opportunity to find their place within a broader community, which is something they are deprived of in their daily lives.

Method

Participants

The participants of this study were 12 nuns (aged 38-53), who enrolled in group therapy over a 10-year period (2010-2020), diagnosed with major depressive disorder (F32 or F32.1; n= 4) or mixed depressive and anxiety disorder (F32 or F32.1, and F41.2; n= 8) they attended the therapeutic group at the Day Treatment Unit for Emotional and Mood Disorders at the University Hospital in Krakow, Poland. The length of religious service of the participants ranged from 13 to 22 years. Regarding their religious lifestyle, they belonged to active religious orders; regarding their clothing, they wore habits (outside of therapy sessions). They performed caregiving, educational, maintenance, or sacristy duties. All the nuns admitted to the ward had been dealing with problems for several years.

At a certain stage of therapy, some nuns expressed their intention to leave the convent. Ultimately, after completing therapy, four sisters applied to church authorities for a one-year exclaustration; none of them left the order. Half of the nuns treated in the unit continued individual therapy after the group therapy ended.

Design

The presented study was conducted using a multiple case study approach. After the first nun participated in our regular group therapy sessions in 2010, differences

between this case from most other patients became obvious. A better understanding of the peculiarities of their context, became important to support treatment. It was decided to take on each case when a new potential participant joined the ward. The goal was to find both repeating patterns as well as differences from case to case to build a thorough understanding that could help practitioners in their work.

We applied the following methods to collect and analyze the data: First an intake interview based on the inclusion and exclusion criteria described in the previous section. The interview included a nosological and functional diagnosis and an evaluation of the nun's motivation to undergo therapy. Secondly, clinical notes taken during all activities with the patient. Finally, therapeutic session with the participants have been monitoring by a researcher. Gathered data has been evaluated in a multifaceted team.

Procedure and Setting

Therapeutic groups within the unit for emotional and mood disorders are heterogeneous, comprising both men and women aged 20 to 55. The standard therapeutic cycle spans 12 weeks. Patient admission to these groups is determined by an intake interview, which encompasses nosological and functional diagnoses, alongside an assessment of therapeutic motivation.

Admitted patients were screened for inclusion based on the presence of depressive or mixed anxiety-depressive disorders, alongside personal motivation and willingness to undergo treatment. Exclusion criteria comprised substance abuse, psychotic, and cognitive disorders.

Due to the low prevalence of religious sisters (nuns) within the sample, measures were taken to ensure standardization: no more than one nun participated in a single therapy group at any time. To minimize bias and integrate participants into the ward environment, these individuals refrained from wearing religious habits during therapy and were addressed by staff and peers using their given names instead of their religious titles.

Intake interviews were conducted by a psychotherapist. If there are reasonable grounds to believe that the therapy might be too demanding or impossible to complete for formal reasons, the patient will not be admitted. Aside from the patient's suffering, a key factor determining admission to the ward is the patient's internal motivation. The waiting period for admission ranges from a few weeks to several months. Upon admission, the patient is examined by a psychiatrist and participates in all scheduled activities from 8:30 a.m. to 2:00 p.m. from the first day onwards.

Group psychotherapy is conducted using a model that integrates various approaches: psychodynamic, cognitive-behavioral, and humanistic. The group is semi-open -consisting of 8 to 12 patients- with each therapeutic session lasting 120 minutes and performed four times a week by two therapists. Group therapy focuses on individual work within the group setting. Patients work on the issues they have raised, as well as on their own issues during the individual work of other group members.

No differential treatment was administered to the study participants compared to other patients during the course of the study. The intervention protocol was not adapted based on religious beliefs, and participants were integrated into heterogeneous groups alongside non-religious peers.

Therapy sessions within the ward were strictly supervised. Each group meeting was transcribed in real time by a non-participating observer. Additionally, sessions were broadcast live to a consultation room, enabling a multidisciplinary team of psychiatrists and psychotherapists to observe the dynamics and subsequently collaborate with the group leaders. Furthermore, an independent external supervisor monitored each patient's progress. This comprehensive approach -characterized by a focus on individual group

members, collective deliberation, and systematic clinical notes- minimized reliance on subjective clinician impressions, thereby facilitating a highly reliable, multifaceted assessment of the patient's mental state.

Intervention

The main intervention carried out was the participation in group psychotherapy sessions. This can be divided into an emotion sharing round and individual psychotherapeutic work (in front of the group). During the emotion sharing round, each patient shares insights from their therapeutic process and attempts to connect them with their current emotional state. The therapist provides ongoing feedback on their understanding of the patient's statements, using psychodynamic or cognitive interventions. In this way, changes in the therapeutic process were monitored and important issues raised by patients on a daily basis. During individual work, patients worked on internal conflicts that they themselves had chosen. However, all activities organized in the ward provide therapeutic material that were discussed and analyzed in a group setting. The therapists used well-known relationship-building techniques such as clarification, interpretation, reflection and containment. Confrontation became an important technique in the later stages of therapy. In addition, patients participated in daily psychoeducational and relaxation activities and are members of the therapeutic community.

Analysis of the Difficulties of Daily Life for Nuns

Nuns, like everyone else, experience stress related to the demands of their environment. In this section, we present an analysis detailing the psychological difficulties encountered by nuns undergoing therapeutic intervention and explore how their religious commitments intersect with emotional and interpersonal demands. The findings highlight tensions arising from the conflict between vocational obligations, adherence to strict obedience within the religious order, and the maintenance of personal autonomy. Key struggles identified include chronic loneliness, feelings of helplessness stemming from dependence on superiors, and the suppression of difficult emotions like anger and doubt, often intensified by external pressures such as anti-clerical sentiment or institutional constraints. The analysis underscores how these factors create an environment conducive to passivity, anxiety, and isolation, necessitating therapeutic intervention to help individuals reconcile their deep commitment to a prescribed life structure with fundamental needs for emotional expression and personal growth.

Work and Religious Responsibilities and their Impact on a Nun's Family Relationships

The work of nuns is inextricably linked to the risk of blurring the boundaries between professional duties and personal life. They are expected to maintain their professional persona not only during working hours but also outside of them. This expectation is expressed by laypeople but is also evident within the community of nuns themselves (Ciarrocchi & Wicks, 2005; Osóbka-Zieliński, 2015).

Observations by the therapeutic team indicated that a nun, who is, after all, also a daughter or perhaps a sister, from whom her loved ones expect a certain level of involvement and presence in family life, often finds herself in a difficult situation. Despite her intentions, as emphasized by the study participants, her involvement in this area depends on the permission, approval, and goodwill of her superiors. The nuns hospitalized in the ward spoke of the fact that they cannot challenge their superiors' decisions or adopt an assertive stance; they must be obedient, in accordance with the

vow of obedience they have taken. It happens that fear -the fear of receiving a negative response- not infrequently prevents them from taking any initiative. Infrequent visits to their family home and the resulting relinquishment of at least some of their family responsibilities can evoke feelings of guilt and helplessness, which they most often struggle with alone.

The functioning of nuns within the congregation is closely tied to the performance of specific tasks, just as it is for laypeople whose daily lives are tied to their profession or the work they undertake. One's place in the hierarchy and the tasks performed often influence the level of perceived tension, as well as emotions -whether consciously recognized or experienced unconsciously. The reported daily routine was most often centered around kitchen, preschool, school, and tasks of a domestic nature. The patients noted that interpersonal relationships within the religious order not only impose certain obligations on them but also limit their privileges, thereby placing them in a unique, often difficult situation. While expressing one's own will in social interactions in the secular world may be interpreted as assertive behavior, in the case of consecrated persons it is sometimes interpreted as a lack of obedience -the nuns noted. This may be all the more difficult, since, on the one hand, the subservient role of a nun in the Catholic Church seems to be commonplace, while on the other hand, opposition to this prevailing norm may evoke a sense of guilt in the patient herself and even lead to disapproval and ostracism within the religious community.

It seems significant that all of the participating nuns were raised in patriarchal families and thus, from an early age, experienced and observed women's dependence on men in their relationships.

Anti-clericalism

The social situation of clergy and consecrated persons is not easy in today's world. Difficult emotions and a partial undermining of the Catholic Church's role in response to widely publicized scandals and abuses involving the clergy have drastically eroded the authority it once enjoyed (Ciarrocchi & Wicks, 2005). The current state of public sentiment is often felt most acutely among lower-ranking representatives of the Church, such as nuns. Sometimes, as the most accessible figures in daily contact, they are personally identified with the unfavorable opinion weighing on the Church, which places a heavy psychological burden on them and may also raise doubts about their own place and role. Such a situation fosters isolation and the guarding of boundaries. Any critical stance toward consecrated persons or other representatives of the Catholic Church is taken very personally. Disclosing confidential information would harm the interests of the Church (Szwed, 2015). During group therapy, this is a significant problem as other patients can convey their negative opinions during therapy to the nuns as representatives of the Church.

Interpersonal Relationships and Context of Therapy

The nuns highlighted the difficulties they experienced in their relationships with others. Constant participation in social interactions induces considerable psychological stress. Furthermore, the difficulty in separating professional activities from personal time does not facilitate maintaining a certain distance that is essential for every person. Consequently, the accumulated tension derived from broader interpersonal dynamics -encompassing professional obligations, congregational life, and familial ties- frequently serves as the primary catalyst for seeking psychological and psychiatric help.

Institutionalized faith is a breeding ground particularly prone to the development of ambiguity (Ciarrocchi & Wicks, 2005). The emotional tensions that build up are usually hidden behind a mask of smiles and appearances. Nuns play a prominent role in our socio-religious context, serving as a moral model, an authority, representing an attitude that affirms certain principles and acts in accordance with them, and clearly distinguishing between what is desirable and what is undesirable. This is due to the need to maintain a certain specific image of Church representatives. The loyalty of consecrated persons to the system creates a certain difficulty in relationships, both in contacts outside the religious order and within the congregation. It seems to be a very difficult task to reconcile openness in therapy with the simultaneous effort to avoid revealing any conflicts. A high level of emotional tension creates space for the development of unconstructive, often destructive emotions, such as passive aggression. Passive aggression often manifests as a result of suppressing feelings of anger, which may be linked to an inability to identify this emotion at all. If, on the other hand, anger as an emotion is subject to judgment and defined in terms of evil, it will be difficult to accept. And such an understanding of anger appears to be an integral part of the image presented by the nuns (Ciarrocchi & Wicks, 2005; Osóbka-Zieliński, 2015). Suppressing a difficult, incomprehensible, and unaccepted emotion is, however, only a temporary and unproductive -though common- solution among the nuns receiving treatment at our facility.

Based on observations we concluded that nuns seeking therapeutic help are most often very lonely. They usually do not have the opportunity to share their work-related anxieties, emotional difficulties, doubts, concerns, or everyday worries in a safe environment. They believe that doing so would violate the principles to which they have subordinated their lives by deciding to enter a convent. This is all the more so because among consecrated persons, there is a widespread belief that the same principles apply to them in their interactions with the faithful as with their fellow sisters. Loneliness may also result from a failure to fulfill one's role. Maintaining relationships is further complicated by the fact that nuns frequently change their place of residence and work -as evidenced by the accounts of patients in our ward.

Financial considerations also play an important role in discussions about the loneliness of nuns. After all, a lack of adequate material resources determines and limits a nun's ability to function freely, intensifying her sense of alienation and isolation. Time is another factor. The lifestyle of nuns, which is subject to specific rules and a strict schedule, makes it difficult to find time to establish, develop, and maintain relationships.

The progressive process of a nun's isolation, influenced by the factors mentioned, may create a risk of depression and foster an attitude of excessive self-focus. Such a situation can lead to dysfunctional behaviors and the development of psychopathology.

Nuns seeking therapy highlight a sense of dependence that encompasses all areas of functioning (control over free time and work hours, tasks performed, activities, and attire), which keeps them in a state of uncertainty, intensifies anxiety and helplessness, and exacerbates alienation. Dependence on superiors, on the one hand, "relieves" them of the need to make independent decisions; on the other hand, it prevents the vast majority of free choices. This, in turn, intensifies feelings of anger and suppressed aggression, which are also subject to control, resulting in their suppression.

A major difficulty observed in many nuns who joined therapy is an attitude of passivity, helplessness, lack of autonomy, and an inability to identify their own needs. The reasons for this state of affairs can be found, on the one hand, in the specific nature of religious life, the necessity of submitting to governing rules, and, within that, submitting to external control. On the other hand, it seems that many nuns, out of fear of rejection, do not strive to develop their own autonomy; instead, by adopting an attitude of excessive dependence on others, they maintain unsatisfying relationships

whose advantage is the reduction of fear of alienation. Based on interviews with a dozen or so sisters, it is difficult to generalize this to a larger population, but it can be assumed that the sisters who approached us were already experiencing difficulties before entering the convent.

Nuns carried themselves as if the difficulties associated with functioning in society, which laypeople typically experience, do not seem to apply to them (Ciarrocchi & Wicks, 2005). It is as if the chosen path, once set, were meant to "protect" them from the reality of being an emotional individual, from the burden of interpersonal relationships in both professional and private spheres, and from experiencing moments of uncertainty, doubt, or the desire to reshape their lives. Interpreting all difficulties as a sign of weak faith (Osóbka-Zieliński, 2015) -a point frequently mentioned by the nuns- closes them off from the possibility of seeking help and accepting support, deepening their isolation and exacerbating the symptoms of their illness or disorder. Failed attempts to resolve their problems through prayer, participation in retreats, or self-mortification ultimately led them to seek therapy.

Nuns rarely sought therapy of their own volition. Typically, the severe nature of their problems -which significantly disrupts relationships within the congregation- lead their superiors to decide that the nun must undergo therapeutic treatment. The most common escalating difficulties in social functioning within the congregation include withdrawal from daily duties, a noticeable intensification of depressive and anxiety symptoms, the emergence of suicidal thoughts, communication problems with fellow sisters, and avoidance of communal activities.

Nuns admitted to group therapy most often cite the following motivations for seeking treatment: 1) they wish to be "better" nuns, improve their functioning within the order, and declare a willingness to change, and these changes often involve meeting the demands of their superiors, or 2) they are struggling with the decision to leave the convent and transition to secular life. It is worth noting that during the assessment and goal-setting phase, they do not explicitly state a desire to leave the order, become more assertive, or build greater independence for themselves. Patients in the first group typically have greater difficulty disclosing information about themselves and their religious life; they exhibit much stronger resistance than patients in the second group, who seem more willing and open to exploring certain areas but are also more likely to attribute any limitations to the order. Nuns who have doubts about remaining in the order also more frequently report suicidal thoughts and, in psychological tests, tend to show an exacerbation of symptoms.

The motivation to seek treatment and the goals nuns wish to work on in therapy differ in the initial stage of therapy from the goals formulated by other patients in the group. During therapy, the nuns most often reformulate their previously set therapeutic goals toward increasing their resources, developing their own interpersonal skills, and better understanding the psychological mechanisms of their functioning. It appears that therapeutic goals formulated in this way do not differ from those set by other patients participating in the therapeutic group.

Analysis and Observations from the Therapeutic Process

In this section, we explore the specific psychotherapeutic challenges presented by working with nuns. The analysis highlights that emotional difficulties - manifesting as anxiety, shame-based mood disorders, and complex guilt - are often deeply intertwined with cultural roles, institutional rules, and theological interpretations rather than solely being viewed through a secular psychological lens. We examine how these systemic factors contribute to significant therapeutic resistance, which frequently serves to maintain the

status quo by blocking access to core personal desires and emotional insight. Furthermore, we discuss the pervasive use of immature and narcissistic defense mechanisms (such as splitting and denial), demonstrating that effective intervention requires a specialized approach that simultaneously respects the unique cultural context while addressing underlying difficulties in self-integration and relational boundaries.

Emotional States in Therapeutic Work with Nuns

Clinical practice reveals that various emotional issues stem from an excessive need for social approval, a culture of chronic politeness, and perfectionist tendencies, often coupled with an inability to define personal needs and desires. The most prevalent manifestations include anxiety, mood disorders -marked by heightened shame- guilt, and suppressed anger. These observations align with existing literature in the field (Ciarrocchi & Wicks, 2005).

Anxiety is an emotional state that is a source of immense suffering for nuns, but at the same time sustains their functioning at the current level. Fear of negative judgment for failing to fulfill one's duties, fear of expressing one's needs, and a constant sense of guilt in situations that seem unjustified are the cause of intense emotional tension. Anticipation of change is often linked to the fear of disrupting the hierarchical relationships within the order and undermining the prevailing rules, which consequently keeps the nun trapped in her anxiety.

Mood disorders among consecrated persons are characterized by a deep sense of shame. Among this group of patients, this is of particular significance: Among nuns themselves, depression is sometimes understood as a kind of punishment for sins or as a sign of failure, accompanied by an unconscious belief that a person belonging to God would not succumb to emotions causing a depressive state, according to the logic: "if I trusted God, I would not need support."

Ciarrocchi and Wicks (2005) note that the basis for feelings of guilt may be conscience, both in psychological and theological terms. Religiously rooted guilt can evoke a sense of helplessness, if not surprise, in therapists. The barrier between cultural factors constitutes a religious divide that often separates therapists from clients. Furthermore, emotional guilt has no connection to logic. Sometimes these terms are interpreted differently by therapists and clergy. According to the authors (Ciarrocchi & Wicks, 2005), the psychological understanding of guilt involves experiencing emotions resulting from a betrayal of one's conscience. The philosophical-theological understanding of conscience is a moral judgment, an act of the intellect determining what is good and what is evil. Guilt perceived in this way may or may not be associated with emotions.

Observed Difficulties in Therapeutic Work with Nuns

The phenomenon of resistance in psychotherapy has been extensively studied and repeatedly described, taking into account differences in its understanding and the role attributed to it (ranging from classification as a disruptive or even change-preventing factor, through being an integral element of the change process, to the function of an ally) depending on the preferred therapeutic approach (Kottler, 2003). Resistance is associated with the client/patient. In insight-oriented therapy, paradoxically, it protects the patient from the change that they, on the one hand, strive for, yet on the other hand, unconsciously fear. On the therapist's side, however, the co-occurrence of counter-resistance is often observed, which is sometimes linked to the patient's conflict, thereby contributing -much like the process of resistance- to maintaining the status quo (Grzesiuk, 2005).

Resistance in the psychotherapy of nuns concerns many spheres of life and the functioning of this group of patients. It is linked to revealing almost everything that defines the specificity of the lives of consecrated persons: the situation within the order, emotions toward superiors (fear of portraying them in an unfavorable light), monastic rules (ambivalence or even rejection of them). In therapy, it is difficult to gain access to areas related to intimate relationships, the world of desires, thoughts, and fantasies of nuns. Furthermore, resistance most often also blocks access to issues concerning difficulties within the nun's generational family. Fear of social judgment, stemming from a sense of carrying out a mission and vocation, effectively hinders entry into the areas listed above, not only by the nun herself but also by other members of the therapeutic group. Attempts to maintain a certain status quo and adapt to the situation do not foster insight or change; rather, they reinforce resistance.

The participant nuns were diagnosed with depressive disorders or mixed depressive-anxiety disorders with a predominance of avoidant or dependent personality traits. The rumination, low self-esteem, and self-blame evident in the clinical picture of these disorders hindered therapeutic work and openness within the group. The source of countertransference -a phenomenon that hinders change in therapy- can be either the therapeutic group or the therapist themselves. Patients in a therapy group typically express their beliefs or expectations regarding Church representatives and those in religious ministry, just as they would in social interactions outside the group: "My world has fallen apart", "How can a nun think that way?", "Your parents are proud that you're a nun." They express their fears and concerns, but also their judgments and evaluations in a way that most often causes the nun to withdraw from the dialogue, from the group process of insight and understanding, and from shared reflection, thereby blocking her from speaking. In the therapeutic group, the phenomenon of a "split" in the nun's personality is also frequently observed, consisting of an emphasis on the aspect related to her role while simultaneously negating aspects of her humanity and denying her needs -which, after all, constitutes the core of the nun's own psychological difficulties.

Similarly, therapists reveal difficulties in addressing certain topics in the group, as if seeking to protect the nun from the reaction she will have to face, thereby simultaneously cutting her off from themselves and from the group, partially maintaining her unique position and image, and perhaps even deepening the distance. Difficult topics are more often "shifted" to individual sessions than in the case of other patients, which affects not only the nun herself but also how she is perceived by the therapeutic group.

In addition to the difficulties mentioned above, which stem directly from the nature of the resistance (the way she establishes a relationship with the therapist, seeking contact outside the group rather than within the therapeutic group), the resistance leads to further limitations in therapeutic work with this group of patients. The unique position of a consecrated person hinders her, and often even prevents her from achieving, or even improving, emotional insight. Interpretations by the therapist or the group are rejected, which is often accompanied by taking offense or experiencing therapeutic interventions as oppressive.

Many nuns often exhibit a tendency to shift responsibility for psychopathological symptoms or difficulties onto external factors: "From the very beginning, I felt that the convent would wear me down." They frequently adopt certain rules by which they act, the rationale for which they do not know, and it is not even clear whether anyone ever declared them binding. It is worth noting that the attitude of the so-called "social taboo" was observed nearly half a century ago by Stephenson (1967). In his study, he found how certain unspoken rules of functioning within a given group or community are maintained despite the lack of justification or adaptability to current conditions, solely based on their constant (often nonsensical) repetition.

It seems significant that, in the summary of group therapy, the nuns treated in our ward declared that the therapy gave them the opportunity to be understood and accepted, that they received significant support, and that group members expressed a desire to maintain relationships. During therapy, various defense mechanisms become apparent, which may intensify in their daily religious life. Based on the classification developed by Meissner (1989), the most frequently observed mechanisms were those of a narcissistic nature (denial, projection, distortion, splitting), immature mechanisms (acting out, blocking, hypochondriasis, somatization, passive-aggressive behaviors, regression), and neurotic mechanisms (repression, displacement, control), with mature defenses being less common. This overview indicates a predominance of defenses characteristic of lower levels of personality integration. It is also worth noting that the defense mechanisms exhibited by the nuns are not unique. Many other patients with depressive and anxiety disorders also exhibit the use of the described defense mechanisms.

Discussion

This study evaluates a limited cohort of hospitalized nuns, introducing methodological limitations that preclude broader generalization. Consequently, conclusions must be interpreted with caution. Nevertheless, clinical observations within this specific group offer valuable insights. This article aims to delineate the complexities of conducting psychotherapy with religious sisters, specifically addressing the influence of societal stereotypes -from which clinicians are not immune- on the perception of their psychological distress. Acknowledging that the present analysis may also be subject to such cognitive biases, this paper highlights several critical dimensions essential for guiding therapeutic interventions within this population.

Clinical experience highlights the unique nature of resistance and counter-resistance in therapy with nuns, which makes it difficult to establish an open therapeutic dialogue. A therapist's unfamiliarity with the manifestations of resistance can further compromise clinical efficacy. Crucially, these dynamics must be evaluated within the framework of the specific therapeutic modality utilized. Similarly, implementing group psychotherapy within this population requires a specialized understanding of group cohesion, institutional dynamics, and environmental influences.

Psychotherapeutic interventions with religious sisters necessitate a systemic comprehension of the consecrated life framework, with particular emphasis on parameters of loyalty, canonical confidentiality, obedience, and spirituality. A rigorous distinction must be maintained between spiritual or theological dimensions and the secular, objective focus of the therapeutic process. Consequently, behavioral patterns classified as adaptive or normative within secular environments may conflict with the functional and institutional demands of consecrated persons.

Notwithstanding the methodological limitations inherent in this study, the empirical evidence demonstrates that psychotherapy reinforced the participants' psychological resilience. The intervention facilitated the acquisition of novel adaptive strategies without compromising or conflicting with their vocational commitments.

As an exploratory investigation, these findings introduce novel clinical inquiries rather than definitive empirical conclusions. Future research should include the more structured collection and subsequent analysis of therapeutic material. Questionnaires could prove useful for this purpose. Likewise, evaluating the therapeutic process could reveal changes that patients notice during psychotherapy.

In summary, this original, longitudinal multiple case study delineates critical clinical dynamics and systemic challenges within the psychotherapy of nuns, synthesized from

a 10-year therapeutic perspective. The insights articulated herein offer a foundational framework and practical guidance, particularly for early-career clinicians navigating psychotherapeutic interventions with this specific patient population.

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