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ABSTRACT

Depression and the Catholic Church:
A Genealogy of Accommodation and Subject-Formation

by

Amanda Ziemba Randall

A genealogy of institutional Catholic discourse on depression reveals a strategic process of epistemic accommodation that supports the construction of the condition as a spiritual and moral problem. The hierarchy defends its stake in Catholic subject-formation through competition and complicity with psychiatric models of depression. Positing secular society as a risk to mental health, the Church proposes a cure for depression that is also a solution to the twin crises of ecclesial authority and postmodern culture. That is the evangelization of Euro-American culture through the resurrection of Catholic moral pedagogy and technologies of the self. Thus, depression serves as a discursive field for the operation of Catholic governmentality.
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Preface

This study of depression through the gaze of institutional Catholicism presents three issues that deserve discussion as a matter of method and of ethics. The first of these is the scope of inquiry. Depression is a topic of deep historical significance and broad interdisciplinary interest. Descriptive personal non-fiction accounts, psychiatric diagnostics and psychological therapies, popular self-help books, social histories, comparative phenomenological and epidemiological ethnographies, moral and medical etiologies are all counted among the contemporary genres of depression literature. In any study of depression the researcher is bound to encounter much interpenetration among discourses, and the present genealogy of Catholic approaches to depression is no exception. It would be fascinating and enlightening to examine the interface between Catholic accounts and other contemporary Christian literature on depression, for instance. But the chosen scope of this inquiry necessitates the placement of artificial restrictions on a recognizably permeable field. Relevant intersections will be addressed in so far as they help to further the main thrust of argument – such as references in Protestant Christian self-help literature to Catholic spiritual writers. Likewise, while there is a clear resonance between the Catholic position on depression and the anti-psychiatry movement, the precise parameters of this linkage are subtle and embedded in a historical relation that, while relevant, is beyond the immediate scope of this research.

The second issue is that of researcher reflexivity. The choice to write about depression almost always finds its impetus in personal experience. Much
of the popular literature on mood disorder begins with some first-person account
(See for instance Jamison 1996; Smith 1999; Solomon 2001; Thompson 1996;
Melancholy*, was in part a personal quest to understand the nature, origin,
prevention and treatment of depression. Depression is a topic of personal
interest and investment for me too. I am a Catholic who has experienced
depression. I am a depressed Catholic. It was my experience of depression that
first piqued my interest in this project five years ago. I was living under the
diagnosis of cyclic clinical depression when I finally began to formulate this
thesis. For a time I was convinced that my Catholic identity was at least in part
the source and certainly the idiom of my depression – a sort of Catholic culture-
bound syndrome (Hahn 1995). While the diagnosis of depression is understood
as universal, I believe the Catholic imagination causes adherents to live
depression in a unique way. From my own experience I know the condemning
judgment, the depth and the discourse of depression among religious people, my
own family included. I have a deep and painful investment in depression and the
Catholic Church. Within this thesis I find substantiation and validation of my
experience. It is the responsibility and risk of reflexivity to admit these things.
Biased, invalid, subjective - heroic, strong, brave; I anticipate the potential
responses of readers.

This is a study of depression and Catholicism, written by a Catholic who
has experienced depression herself, and analyzed through the perspective of
postmodern critique, a thought system judged depressive by the Catholic
Church. In this sense, one could say this is a depressive exercise at several levels. But whether it was the new diagnosis, new drugs, a new therapist, new self-knowledge, at some point in the research and writing I emerged from the abyss and stepped back from the edge. Does that change my perspective on the material? Does the material now affect my memory and current perception of my depressive experience differently? Yes. Yes. I think of my position toward Catholic depression as a sort of epistemic vertigo, an uncomfortable ambivalence. Much in the way Hugh Gusterson (1998) was converted from an anti-nuclear activist to assume a more central and complex position toward nuclear arms production, my study of depression has been a process of perspectival relocation. As I read and write about the indictment of postmodernism, the prescriptions of repentance and reframing, the risk and result of immorality for depressed persons, I cannot help but read my own experience into, out of and through this discursive field. I will not deny that it was therapeutic to study depression, but this thesis is not meant to be my confessional.

Both my personal identity and my training in anthropology inform my approach to the study of depression. For the anthropologist reflexivity is not simply a matter of ethics but also of method, the third issue concerning this thesis. It is a common mode of postmodern anthropology for the researcher not only to situate his or her subjectivity, but actually to draw on that positionality as an ethnographic resource in conversation with other voices (See for instance Fischer 2003; Kondo 1990; Marcus 1998; Pandolfo 1997; Taylor 1998). It would
be presumptuous to present my experience of depression as a Catholic as somehow paradigmatic. Indeed, when approaching the illness, both religious and scientific professionals acknowledge that the particular psychic and spiritual pain of this condition is unique for each sufferer, and can only be comprehended through personal experience. For this reason I have chosen to include several scenes of Catholic depression, drawn from my own life and narrated in the third person. However proximal or incomplete, the evocation of one Catholic’s struggle with depression is meant to raise the reader’s sensibility for the epistemic and emotional complexity of the condition.
I. Introduction

“You said you were depressed...I'm not sure this program would be right for you.” On the other end of the line, she choked. She had experienced this sort of rejection before; the belief that a depressed person could not thrive in a new environment, could not adapt, could not perform — above all, that depressed people pose a liability. To an organization, objectively depression represents risk. But this time the implication was different, was worse. The stigma of depression was not just a barrier to new experience and opportunity. She understood from past encounters, from her upbringing too, that this was a condemnation of her spiritual fitness, a rejection of her personality and her identity — of her very self. She sensed implicitly that the word “depression” on the health history section of the application triggered certain associations for the Sister: pessimism, self-centeredness, spiritual aridity, weak faith, lack of trust in God, absence of Christian joy, in a word, sin. Even after explaining that she was receiving medical and psychotherapeutic treatment, had not experienced an episode in nearly a year, that she was in fact a graduate student with a strong track record of success, had experience abroad to prove she was able to adapt, and above all, had been strongly involved in Christian activities — all this meant very little. She knew from the moment the Sister read the application that she had been judged unworthy, un-Christian, unfit for mission. She cried a deep, existential cry. Depression returned.

Paranoia?

She was accepted, hesitantly, and only after an interview with the Sisters’ private physician. Later she learned she was not the only applicant to be subjected to this pragmatic humiliation. Despite the hurt and indignation she felt, she tried not just to perform the part, but to truly imbibe and to live out a Christian identity. She became determined to prove the Sisters wrong, to change the perception of depression, one religious authority at a time. She must be an example that people with depression are not fundamentally incapable of loving action. But in the volunteer “formation” training her fears were confirmed. Right in the handbook read the statement: sin underlies depression. Hoping she had misread or misinterpreted, she red-facedly requested clarification. Yes, explained the Sister, sin, whether personal or as part of the person’s past, is the foundation of all depression. Reliving the condemnation, the dampening sensation returned and then morphed into anger. Force of will, frantic journaling, sincere Confession and Communion, and arguing and pleading with God got her through the three-week course. She had to prove to herself as much as to the Sisters that depression did not rule her, nor did it merit eternal or temporal condemnation. But even after successfully completing her two-months of service and continuing actively in domestic volunteer work, the stigma would not lift. Finally, she just gave up.

“If you are seriously considering leaving the One True Church, maybe your faith was not as strong as you thought.”

The most depressing thought of all.
In the Christian tradition, the emotional, mental and physical condition of depression is consistently associated with evil and sin. Whether it stems from guilt over unforgiven transgression, the unfortunate, universal inheritance of original sin, or from residual social sin, depression is a state that Christians learn to shun and condemn. Since the suicide of Judas Iscariot depression has appeared as a problem for Christian moral theology; depression was never not a part of the Christian imagination. Nor was it ever simply a case of science versus religion. For its part, the Catholic Church has never fully discredited biologicist theories of the ontology and etiology of depression. From humoral medicine to modern psychopharmacology, faith accommodates reason to mediate the confrontation between moral and medical interpretations of depression. Historically, depression’s status in the Church has shifted along a moral spectrum between existential crisis and amoral neurological illness. The mutual antagonism between the Catholic Church and psychiatry is well-documented. In the first half of the 20th century, Freudian psychoanalysis was the enemy of moral belief. Today, the conflict over depression takes place on a different front. As medical psychiatry dominates the modern imagination with brain images, DSM diagnostics, and psychopharmacological prescriptions, the Church is faced with the emerging problem of how to maintain the moral and spiritual significance of depression while still acknowledging the applicability of scientific advancements.

What is depression, exactly? No perspective is certain, no definition definitive. Within this ambivalence there opens a space for the institutional Church to assert its authority to interpret and to intervene in the condition through
its own totalizing vision. When it comes to the Church’s relation with the human sciences, truth is more than a matter of research evidence; it is a philosophical matter of defining the meaning of human life. The Catholic problematization of depression today is another iteration of the conflict between Christian humanism and scientific materialism. But the significance of depression for the Catholic Church is more than a philosophical controversy. Catholic authorities and observers read the incidence of depression and other emotional disorders in Euro-American society as a sign of the times, a sign of the cultural crisis of modernity coincident with a crisis of Church power and authority. These twin crises can only be mitigated through re-evangelization, mass conversion, and the revitalization of Catholic religious practice and belief in the public sphere. Thus the significance of depression for the contemporary Catholic Church is more than a matter of maintaining a moral stake in the meaning of human suffering. Depression is a discursive site for the revitalization of Catholic subject-formation.

This thesis concerns the problematization of depression emerging from and between Catholicism and psychiatry, two major knowledge-generating and knowledge-disseminating entities. We take as our object the historical ruptures and continuities of phenomenological descriptions, ontological definitions, etiological explanations and therapeutic prescriptions regarding depressive states over the course of Church history, in conversation with the nascence and development of various systems of medical and psychological knowledge. What this study reveals is an epistemic politics of complicity and competition: an interaction characterized by a process of recursive evaluation, selective alliance
and implicit resistance at the nexus of humanist and materialist philosophies. As such, it involves a strategic process of authorizing and de-authorizing knowledge as an operation of the investment of individuals in systems of power. This philosophical debate cum bio-political operation is directed toward the delineation and defense of realms of authority over ontological, etiological and phenomenological knowledge about disorders of the inner life. The history of the Catholic Church’s present investment in depression is, in short, a history of Catholic subjectivation.

**Genealogical Method**

In *Culture and Depression* (1985) Kleinman and Good call for, “a renewed emphasis upon clinical descriptive research on the phenomenology of depressive disorders by focusing upon the broadest issues of the individual in the life world” (Rubin 1994, 9). That is, researchers are encouraged to examine “the culturally organized patterns of perceiving time, space, body, and person, the symbolic organization of experience, the nature of ‘realities’ in the social and psychological life, and the forms of discourse and social interaction through which such realities are constructed” (Kleinman and Good 1985, 496). Rubin argues that in order to support this type of trans-disciplinary analysis of the life worlds of contemporary religious depressives, a history of ideas about depression, based in the historical method of Michel Foucault in the spirit of ethnopsychiatry is required (1994, 9). Following the works of Jackson (1986), Rubin (1994) and Radden (2000), the body of this paper comprises precisely such an epistemic genealogy of depression in the Catholic Christian tradition.
Though not an ethnography in the classical sense, the present study is an example of what Matti Bunzl has described as “neo-Boasian anthropology” (2004). This emergent mode of ethnographic research combines the Boasian conception of the past as the main site of anthropological inquiry with the genealogical method of Michel Foucault to produce a re-visioning of the anthropological project as the history of the present. Though based on published resources as opposed to interviewing and participant-observation, anthropology as history of the present relies on many of the same narrative and interpretive conventions as fieldwork-based ethnography. There are several excellent ethnographic precedents for this type of study. Paul Rabinow’s French Modern (1989) is constructed explicitly as a Foucauldian genealogy based primarily on textual sources: books, articles and archival documents through which his informants articulate the particular apparatuses in question. In Yoga in Modern India (2004) Joseph Alters similarly engages a large body of literature as a discursive field subject to a type of participant-observation. Alters’ simple, pragmatic, straightforward approach to the history of the present is a model for the successful navigation of the problematic relationship between texts unto themselves and in relation to what people say, an issue common to text-based genealogy. Finally, Joseph Dumit’s (2003) largely media-based studies of the effects of new visual and textual representations of mental health and illness - autobiographical, mass popular and scientific – provide a particularly apt methodological model for the present study.
The historical method of Michel Foucault revolves around the concept of the "apparatus" or dispositif, a system of relations that can be established between a heterogeneous ensemble of elements consisting of "discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions" (1980, 194). One may understand the task of the history of the present as the identification and genealogical study of the emergence and stabilization of apparatuses, focusing on the particular nature of interaction among their constitutive elements (Foucault 1980, 194; Rabinow 2003, 55). Typically arising in response to some pressing problem or need, the apparatus is fundamentally strategic in nature. (By strategic is understood a response tailored to a specific problem; it is not meant to imply self-conscious deliberateness or intentionality.) Further, whether it is discursive or non-discursive, the apparatus is always intimately connected with systems of knowledge and power (196). Thus depression, the object of the present genealogy, will be examined in terms of the interaction – the competition and strategic collaboration – between two different systems of power/knowledge: those of the discipline of psychiatry and the global institution of the Catholic Church.

For such a study of the interaction between distinct discursive apparatuses, the issue of interpretive description becomes salient. The hegemony of the bio-medical perspective creates the powerful temptation to discuss depression in the dominant medical idiom of diagnosis, symptomology, therapy, prescriptions, etc. But the scientific perspective is a recent addition to
the understanding of depression. Albeit extremely influential, in the full scope of history the medicalization of mental distress is a relatively small epistemological contribution. Between psychiatric rhetoric and the existential, moralizing interpretation favored by Catholic observers there is no clear neutral middle-road. One strategy, interpretively ideal but subject to misappropriation, is phenomenological description. The politics of phenomenology is apparent in its application as the purported perspective on depression of Church authorities. Meant to imply a semblance of objectivity, this usage is strongly nuanced by an underlying value system. A related approach, the one attempted here, is discourse analysis. The purpose of this thesis is to explicate how the distinct discourses of medical science, the psych-disciplines and institutional religion interact and appropriate one another over time and to what effect.

Ethnographies like Joseph Alter’s *Yoga in Modern India* (2004) and contributions from sciences studies (Elliott 1999; Shorto 1999) are instructive for navigating the discourses of depression between philosophy and science, spirituality and psychiatry. The hoped-for result is a historicizing narrative of the role played by the phenomenon of depression in the evolution and operation of Catholic power/knowledge.

In this treatment Catholicism is understood in two ways. First, contemporary religious apologists and cultural anthropologists alike recognize Catholicism to be cultural system and a distinctive worldview (Ciarrocchi 1995, Geertz 1973, Schepfer-Hughes 1979, Weigel 2004). Catholic culture is comprised of a body of beliefs, a way of life, and “an optic, a way of seeing
things, a distinctive perception of reality,” a “sacramental imagination” through which disordered mental conditions like depression are understood and experienced (Weigel 2004, 10). A distinguishing aspect of the Catholic worldview is what Weigel calls the “Catholic both/and”: revelation and tradition, “nature and grace, faith and works, Jerusalem and Athens, faith and reason, charismatic and institutional, visible and invisible” (Ibid, original italics). For the present analysis we are especially concerned with the complicity of faith and reason characteristic of the Catholic worldview.

The second way in which Catholicism is understood in the present treatment is as a supra-local religious institution, built upon the authority of revelation and tradition. It is a major knowledge-generating and knowledge-disseminating entity that articulates its totalizing world vision via a massive assemblage of discursive and non-discursive apparatuses, including sacramental ritual, communication technologies, and an ethical practice, all aimed at the creation and collusion of Catholic subjects. That is, Catholicism is a system of power/knowledge. In this genealogy the location and role of depression in the Catholic system of power/knowledge will focus on discursive apparatuses scattered throughout an array of historical sites. Contemporary Catholic discourse may be understood as a cumulative apparatus derived from and legitimated by discursive precedents including the Bible, writings of and about saints, including the early Church fathers, Canon Law and iterations of the catechism, papal encyclicals, apostolic letters and exhortations, and documents and resolutions of Pontifical Councils. In current institutional discussions of
depression the most immediate ecclesial reference is the Second Vatican Council. Convened in the mid-1960s, the purpose of this council was to define formally the Church’s response to the conditions of modernity. The modifications, clarifications and declarations that emerged from Vatican II are key to explaining the hierarchy’s current position toward depression as a mental illness and an existential crisis.

The Bible and the writings of the early Church Fathers – Augustine’s Confessions and Aquinas’ Summa Theologica for instance – serve as the ultimate historical resources of Church legitimacy. The Church documents that build upon original revelation and early tradition are arranged in a hierarchy of categories of authority:

At the top of the hierarchy of authoritative documents are apostolic constitutions and decrees issued by popes, such as the Second Vatican Council documents. The Catechism of the Catholic Church was presented by the apostolic constitution Fidei Depositum in 1992. These documents, along with the Code of Canon Law (1983) have binding authority on the entire Church. These are legislative documents, containing dogmatic or doctrinal elements (Hitchcock 2002).

After the apostolic constitutions and papal decrees come papal teaching documents, encyclicals, apostolic letters, apostolic exhortations, motu proprio documents, and instructions issued by Vatican Congregations and approved by the Pope that expound upon or explain existing Canon Law and other official legislative documents of the Church. At the national or regional level are official documents issued by bishops’ conferences and approved by the Holy See that explain how Church teachings apply to or are to be implemented within a given country or region.
The inspiration for the present study is the 2003 conference of the Pontifical Council for Health Pastoral Care (PCHPC) on the topic of depression. The proceedings of that conference were published as the 2004 issue of the PCHPC's journal, *Dolentium Hominum (DH)*. Such publications from particular Pontifical Councils are considered teaching documents. The array of Church teaching documents cannot be arranged into a neat hierarchy; they are categorized not on the basis of the level of authority, but according to their purpose (Gantley 2007). In the case of the PCHPC document, “the pronouncements of the various Congregations are an ever new attempt to enlighten reason with faith and to strengthen faith with reason according to the issues and problems on which they are called to express their opinion and to give their direction” (Girotti 1999, 9). These are not meant to be authoritative teachings, but are considered intrinsically valuable for the understanding of particular issues, like depression. The information presented in teaching documents is to be considered a reliable discussion of particular matters, proposals and perspectives “meant to be more persuasive than dogmatic” (Gantley 2007).

But Catholic discourse on depression is not produced solely at the top level of the hierarchy. As we shall see, popular Catholic spiritual and apologetic writings, pastoral guide manuals, Catholic psych-experts, and even a genre of Catholic self-help literature draw from Catholic tradition and secular science to contribute to the discourse. The authoritative religious status of these dispersed and specialized applications and interpretations of Catholic doctrine depends on
the obtainment of the “Imprimatur” seal. The “Imprimatur” and “Nihil Obstat” are official declarations that a text written by a Catholic religious on a subject pertaining to Catholic doctrine is free of doctrinal or moral error. The institution’s seals of approval, they are the most basic marker of inclusion in official hierarchy discourse. This does not imply, however, that those who have granted the Nihil Obstat and the Imprimatur agree with the content, opinions or statements expressed. Despite the compulsion to doctrinal concordance, there is a certain amount of flexibility to Catholic discourse not only regarding psychiatry and depression, but with respect to scientific knowledge in general.

The Catholic Church takes a particular doctrinal position toward scientific progress. Accommodation is a traditional ecclesial principle based on “the assumption that revelation and other divine institutions were adjusted to the capacity of men at different times to receive and perceive them” (Funkenstein 1986, 11). It is the idea that “the Scriptures speak a human language,” that rather than contradicting or containing secular or scientific knowledge the Scriptures “adapt themselves to the point of view of the multitude” (216). The principle had become secularized by the 17th century and now refers to the natural, God-directed progression of scientific knowledge. In acknowledging this adaptation of Scripture to advancements in human culture and knowledge, Funkenstein explains, the Church’s aim is not so much to preserve the literal meaning of the holy texts, as it is to protect its own authority (217). That is, accommodation has traditionally served to maintain the legitimacy of Church discourse in the face of all social transitions and scientific innovations.
Accommodation has been a consistent aspect of Catholic understandings of depression over the course of Church history. Of particular concern here is the Church’s response to the medical reconstruction of depression following the emergence of the modern human sciences in the late 18th century (Foucault 1994e). The genealogy of depression offers a window onto the various ways in which the Church has defended against the philosophical materialism of modern science. The legitimacy of the autonomy of the human sciences was reaffirmed in the Second Vatican Council; science’s only limit is the dignity of man (DH 70). Thus ecclesial accommodation of the human sciences ends at the boundary of Catholic humanism, the philosophical system, formally articulated by St. Thomas Aquinas, which documents and explains Christian beliefs about natural and moral law. The Catholic Christian interpretation of life, alternately called Christian humanism, Christian anthropology and Catholic realism (Weigel 2004), centers around the idea of the human person as a complex whole, a fundamentally communal and transcendental being thoroughly enmeshed in the cycles of life and death, suffering and pain. This dialectic constitutes the mystery that is the meaning of life, exemplified and redeemed in the life, death, and resurrection of Christ. The human person was created in the image of God and is called to freedom and responsibility to oneself, to others, and to God. Through the Incarnation we share in the humanity of God, and in turn God, the creator and lover of all life, is present in all creation. Thus human dignity and essential goodness derive from our own deification. Our redemption through a share in
the divinity of Christ and the unconditional love of God is nothing we can earn or
deserve. And yet God grants it; that is the ultimate mystery of divine grace.

This is necessarily a very abbreviated description of Christian humanism;
a doctrine built upon the entirety of Catholic tradition from the Bible to Benedict
XVI is understandably expansive and not easily summarized. But the
acceptance and internalization, if not the understanding, of this intricate and
mysterious truth about reality that is the Church’s unifying, totalizing vision of
human life are the mark of authentic belief and the condition of salvation. It is
through this vision that all Church discussions of the ontology, etiology and
treatment of depression are proposed, read and evaluated. The ethical and
interpretive task of moral theology and Christian anthropology, then, is to
compare the understandings and observations provided by the human sciences
with their worth for Christian interpretations of life (DH 85).

Given its unique position at the nexus of morality and medicine,
philosophy and psychiatry, depression in Church history is a paradigm of the
practice and stakes of accommodation. As an interdisciplinary concern, it
represents a meeting point for different forms of rationality, each bringing to bear
a unique set of assumptions that both shape sensibilities and provide knowledge
about the condition. In situating depression in the operation of ecclesial
accommodation and authority, the argument of this thesis will follow a path
illuminated by contemporary operations of Catholic power/knowledge, through a
genealogy of depression in Catholic discourse, and ending with a hypothetical
consideration of doctrinal dissemination and internalization with respect to
subjective experience and ethical practice. To begin this exploration of how knowledge about depression, past, present and potential, is constructed, substantiated, disseminated and ultimately embodied at the various levels of hierarchy and agency that comprise the Catholic Church, we first consider the contemporary discursive apparatus that inspired this study: the proceedings of the 2003 Vatican conference on depression. A close analysis of the assumptions, descriptions and prescriptions presented in this document will reveal a mode of Catholic epistemic politics operating through the ecclesial principle of accommodation. It will be shown that depression, understood by Church officials as an existential crisis and a social pathogen that poses a dire risk to (mental) health and life, plays a specific role in the exercise of ecclesial power. The curative prescriptions delineated in this teaching document correlate with the Church’s response to the conditions of postmodernity, of which depression is understood to be an unfortunate side-effect. In this way the contemporary problematization of depression at the top level of the Catholic hierarchy plays into and legitimates a larger Church discourse of crisis: the twin crises of postmodern culture and of Church authority in the modern world. The Church’s solution to the problem of modern depression involves the selective accommodation of current psychiatric knowledge in necessary combination with a moral conversion of individuals and society through a resurrection of Catholic pedagogical and ethical techniques of subject-formation. Ultimately it will be argued that for the Catholic Church, the stakes of defining and treating modern
depression is fundamentally a matter of maintaining a stake in Catholic subject-
formation.

Following the impulse of the 2003 Vatican conference on depression, the 
second chapter will present a genealogy of depression in the Catholic tradition 
that sets the significance of ecclesial accommodation and subject-formation in 
historical context. In that regard, two central questions form the crux of this 
genealogical study. First, how do Catholic theological and philosophical 
authorities combine insights from the disciplines of psychiatry, psychology and 
bio-medicine to create a picture of depression that is both scientifically and 
theologically valid? Practically speaking this is a question of which secular 
authorities are authorized to speak (literally or referentially) on depression in 
Catholic texts and forums. Further, how do top Church leaders mobilize non-
Catholic authorities on depression – science, other religions, philosophy, 
sociology, psychology, and psychiatry – to substantiate and add thrust to the 
traditional Christian humanist position? In other words, how does the principle of 
accommodation operate to secure the legitimacy of Catholic epistemology – to 
allow the hierarchy to say, ‘Yes, we knew all along!’?

The second major question raised by the 2003 Vatican conference and 
embedded in the genealogy of depression in Christianity is in regard to the 
implications of Catholic discourse on depression for the workings of pastoral 
power through the operation of religious and moral subject-formation. The Bible, 
Church history and Catholic tradition all provide precedents for the articulation of 
a Catholic perspective on depression as a moral state and a mental disorder.
Colluded within the 2003 Vatican discussion of depression are those historical religious foundations upon which the contemporary Catholic problematization of depression is based. The analysis of the 2003 Vatican conference thus sets the scene for a genealogy of depression as a discursive object of competition and complicity between the Catholic truth-claims and other epistemic systems. Thomistic philosophy erects the boundaries of secular accommodation as Church tradition and moral theology encounter, influence, contest or absorb various holistic and materialist understandings of a bio-psycho-socio-spiritual condition recognized throughout human history. It will be shown that depression plays a role in the evolution of Catholic moral imagination and practice as a problem in the articulation of moral theology. What emerges is a dual picture of depression. Depression is a spiritual crisis that is harmful to the soul, to the point of damnation. At the same time, depression holds the potential for conversion and redemption, keys to mystical union and ultimate salvation. What links these contrasting meanings of depression is the practice and experience of self-knowledge, both as a symptom of the malady and as the mode of therapy. Thus, in terms of Catholic subject-formation, the disordered state of depression presents an occasion for the development and implementation of techniques for the exercise and conversion of self-reflection and self-discipline, which in turn has implications for the operation of pastoral power.

Where the first two chapters are concerned with the present and the past of depression in institutional Catholic discourse and practice, the concluding chapter will entertain possibilities for the ethnographic study of emergent,
embodied instantiations of depression in the everyday lives of Catholics. Thus we turn from the development, legitimation and prescription of therapeutic technologies of the self to a critical consideration of the way these techniques are actually practiced and lived. Implicit here is the question of how and to what extent institutional discourse influences local beliefs surrounding depression, which in turn influence the individual experience of depression. This consideration of how Catholic believers define and position themselves toward depression opens a critical space in which one may raise questions about the impact, positive and negative, of Catholic religious belief and practice for the onset, course and cure of depressive illness.

Catholic Power/Knowledge

*There is no power that is exercised without a series of aims and objectives.*

- Michel Foucault, *The History of Sexuality, An Introduction*

Before proceeding to the substantive chapters, it is necessary to explicate certain theoretical concepts crucial to the interpretation of the meaning and significance of depression in Catholic discourse. Here the vital and strategic significance of depression in the history of the Catholic Church will be read through Michel Foucault’s analytics of power. In Foucault’s terms depression appears to serve as a field of competing, historically interrelated modes of governmentality, a discursive and practical space where technologies of the domination of others encounter technologies of the self (Foucault 1994d, 225). Where Foucault speaks of governmentality, he is referring not simply to the will and mechanisms of state government, or even to the general power techniques
of violence and consensus, but to a mode of power in which the subject comes to internalize or embody the techniques of discipline. Governmentality operates not only at the level of state politics and administration, but in the spheres of philosophy, religion, medicine and pedagogy as well. Child-rearing, spiritual direction, behavioral counseling and moral prescriptions overall – the soul, the sick, both individual and the collective – all of these fall under the heading of governmentality. In general it designates the way individual or group conduct is directed through strategic relations, techniques and procedures (Foucault 1994c, 88; Foucault 2000b, 341).  

Foucault’s critique of power is relevant to the present study not only theoretically, but substantively as well. Both early Christian institutions and institutions for the mentally ill are identified as significant sites of development of the individualizing and totalizing effects of power. Foucault’s idea of pastoral power in particular is crucial for an understanding of the political significance of depression for the Church, though not for the reasons one might expect (Foucault 1999, 2000b). While modern state power is based on that technique of power originating in Christian institutions, the ecclesial institutional aspect of pastoral power all but disappeared by the 18\textsuperscript{th} century. It was not the form, but the function of pastoral power that remained, multiplied, and spread. Pastoral power is contingent on the access to and accepted authority over the inner life. To gain such knowledge of and authority over individual consciences pastoral

\footnote{Though a full comparison is beyond the scope of this discussion, it may be noted that many substantive themes in Foucault’s work on governmentality clearly parallel Emile Durkheim’s treatment of moral education and subject-formation in \textit{Moral Education} (1961 [1925]) and \textit{The Evolution of Educational Thought} (1977 [1938]) (Ramp 1999).}
power operates through certain technologies of the self that are directed at the exploration and confession of the soul. Read as Foucault's concept of ethic, the government of the self and its attendant techniques emerged "between" pedagogical institutions and the religions of salvation, which in turn borrowed much from the philosophy and ethics of Hellenistic and Roman culture (Foucault 1994c, 88).

Technologies of the self are procedures "suggested or prescribed to individuals in order to determine their identity, maintain it, or transform it in terms of a certain number of ends, through relations of self-mastery or self-knowledge" (Foucault 1994c, 87). The imperative to know oneself as the means of caring for oneself is characteristic of Western civilization and is the foundation of self-governance or subjectivity. This is Foucault's concept of ethics: government of the self by the self in articulation and relation with others (88). Foucault has traced the evolution of a set of techniques of self-surveillance that derive from the Greeks and characterize the practices of Christian spiritual discipline, from monastic asceticism, through spiritual exercises and mysticism, and culminating in the Sacrament of Confession, also called the Sacrament of Penance or the Sacrament of Reconciliation. Made obligatory for all Christians by the Fourth Lateran Council in 1215, the Sacrament of Confession is precisely a method of self-examination, pastoral guidance, penitence and self-formation (Foucault 1990, 116; 1994a, 195). The eclipse of the practice of Confession after the Second Vatican Council is an indicator of the extent to which the ecclesial pastoral power of the Catholic Church has waned. Today the problem of modern
depression presents an opportunity for the Church to reinvigorate that lost pastoral power through the reinstitution of the practices and principles of the Catholic ethics as a mode of therapy.

The effectiveness of Christian forms of self-government lies in the intimate connection with truth, in two senses. First is the acceptance and practice of certain true or rational discourses, that is, the accession to and embodiment of a truth regime. This is the communeralizing confession of faith for Christians that entails submission or obedience to dogma, certain authoritative texts and authority figures. Second is the duty of self-exploration in the practice of technologies of the self for the purpose of producing the truth of the self in confession. Communal and individualizing obligations of truth are linked in confessional practice as the confessing individual trusts religious authorities to interpret the contents of confession and confer judgment and absolution.

Bearing witness against oneself permits the purification of the soul – and hence access to salvation – that is impossible without self-knowledge (Foucault 1994d, 242).

As with any form of governmentality, the exercise of power also necessarily involves freedom: it is not based in coercion, but is rather the “management of possibilities,” the “conduct of conducts” (Foucault 2000b, 341). “Power is exercised only over free subjects, and only insofar as they are ‘free,’” that is, in so far as they have several modes of possible action available (342). What makes power acceptable is that it is not only experienced as the force of prohibition, but that it “traverses and produces things, it induces pleasure, forms
knowledge, produces discourse” (Foucault 2000c, 120). In confession the individual becomes a subject of power through the belief that this mode of truth-telling about the self is both free - the belief that submission is freely chosen and not embedded in relations of power - and freeing, as it is in fact the condition of salvation (Foucault 1990, 60).

But the benefits of self-mastery are found not only in the afterlife. Pagan Greek and Roman philosophy first recognized in self-cultivation a “curative and therapeutic function” (Foucault 1994b, 97). Two millennia later this insight was assumed by late 20th century Catholic authorities with respect to states of depression and other emotional disorder (Sheen 1949, 90-91; Van der Veldt and Odenwald 1954, 202; DH 19, 40-41, 64, 88, 92-93, 102-103, 121-122, 125, 129, 143, 147-150). We find in current Vatican discourse on depression explicit reference to the therapeutic power of metanoia, the Biblical concept of repentance and conversion of consciousness and behavior through practices of self-truth-telling, which lead to self-mastery, self-transformation, and, for the spiritual elite, to self-renunciation (Foucault 1994d, 242). Regardless of the precise etiology of the illness, metanoia is always the preferred prescription of religious for those suffering from modern depression. The hierarchy legitimates its claims about the therapeutic effects of self-truth-telling and faithful obedience to the Church in three ways. First, Catholic officials point to historical precedents available within Church tradition. In order to convince the modern scientific imagination of the validity of Christian wisdom, exemplars of faith are linked with insights from the psych-disciplines. The second mode of legitimation is the
accommodation of those aspects of biologic or psychological models that are found to be therapeutically effective without threatening to undermine the principles of Catholic humanism. But the legitimation of therapeutic *metanoia* does not stop with accommodation. To solidify the case for *metanoia*, complicity with modern psychiatry and neurology allows Catholic discourse on depression to extend into the construction of risk. Not only is *metanoia* a rational approach to depression, living an unconverted modern life poses a direct risk to one’s mental and physical health. Understood in this way, depression appears as an emergent theater for the exercise of ecclesial biopower.

Biopower as *nosopolitics* involves the problematization of health and sickness of individuals and populations by way of explicit calculation (demography and statistics) in collaboration with institutional systems for the enactments of collective policing measures (systems of education and moral proselytism), the object of which is the instantiation of the value and methods of self-government (Foucault 2000a).

Biopower, we suggest, entails one or more truth discourses about the ‘vital’ character of living human beings; an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals work on themselves in the name of individual or collective life or health (Rabinow and Rose 2003, 1).

As biopower developed, its object shifted from the “troubled” or “troublesome” of society to the social body as a whole. In making “the imperative of health…at once the duty of each and the objective of all,” power/knowledge became “an agent of transformation of human life” (Foucault 2000a, 94; 1990, 143). In short, biopower entails “strategies for the governing of life” (Rabinow and Rose 2003, 1)
and as such is an essential objective and mechanism of political power in general.

Foucault makes an economic argument that the politicization of health emerged as an apparatus of production in early industrial society. This observation still holds true: the World Health Organization continues to measure population health, now including mental health, in terms of the burden of work disability (WHO 2001). We shall see that health statistics about depression serve a valuable purpose for the Catholic Church in its assertion that depression is a matter of moral and medical health risk that negatively impacts the whole of society. Social measurements including data generated by the WHO, European and American professional psychological and psychiatric associations are today integrated into the Church's top apparatuses of social policing. The Pontifical Councils, for instance, were established to observe social and cultural trends, including population health and illness, in order to make recommendations for the Church's position and response to these. It is perhaps no coincidence that the WHO's 2001 identification of mental health as an emergent problem of global health concern was followed only two years later by the articulation of depression as a specific crisis requiring a response of pastoral health care and cultural reform by the Pontifical Council of Health Pastoral Care. Furthermore, this Council commissioned its own statistical study of the social factors affecting mental health and illness – statistics derived from the experience of professional religion and which support the Church's legitimacy in speaking about this issue (DH 73-79).
Since its emergence in the 18th century biopolitical surveillance, measurement and discipline of individuals and populations has been exercised by religious groups, parishes, and charitable organizations as well as through state apparatuses. The primary traits of 18th century biopolitics - the focus on the management of the child and family and the “privilege” of institutional interventions like medicine, pedagogy, and of course religion – remain the hallmark of Catholic morality, rearticulated since the Second Vatican Council in the explicit terms of the protection of “life.” The paradigmatic text is Pope Paul VI’s 1968 encyclical *Humanae Vitae*, which forbids contraception, abortion, euthanasia, capital punishment and any other technology for the artificial manipulation of life, which are counter to natural law. Shortly thereafter Pope John Paul II’s “theology of the body,” formulated between 1979 and 1984, linked the Catholic sexual ethic with the spiritual and moral categories of free self-mastery (as opposed to the psychological category of “self-control”) and self-giving (Weigel 2004). This Catholic “culture of life” is painted in diametric opposition to the “culture of death,” coined and repudiated by Pope John Paul II as it extends into political discourse. Described by the Pontifical Council for Health Pastoral Care as “the greatest murderer of our times” (*DH* 6), now even depression is subsumed under the same category as abortion and capital punishment. It too is a matter of life and death, a prime case for the moral reformation of individuals and society. The moral education of youth, the support of “traditional” families as the primary locus of personal development, and
obedience to universalist Catholic moral codes in general are prescribed as the means of preventing and treating depressive states.

The inclusion of mental health and illness in the operations of biopower is by no means new. It is, after all, the foundation of modern psychiatry. Foucault has demonstrated the fundamental role of psychiatry in the medicalization of morality, with the assumption of sexual perversion – or pleasure, as it were – under the jurisdiction of biopolitical surveillance and management (Foucault 1990). Rabinow and Rose also argue that the rise of bio-medical psychiatry is a clear example of the workings of biopower, with its apparatuses of mental institutionalization, community-based mental healthcare, surgical and pharmaceutical intervention, and now brain imaging and genetic mapping (2003). Despite the open antagonism between Christianity and atheistic psychiatry since the 18th century, these competing truth regimes seem to share a common biopolitical project.

Modern biopower, like all operations of subjectivation, involves the process of normalization, that is, the construction and internalization of concepts of normality. Concepts of normality, in turn, are necessarily contingent on the construction and punishment of deviance. Erikson reminds us that the definition of deviant behavior is culturally relative. “Deviance is not a property inherent in any particular kind of behavior; it is a property conferred upon that behavior by the people who come into direct or indirect contact with it” (1966, 6, original italics). The sociology of deviance finds its deepest roots in the work of Durkheim. In The Division of Labor in Society he explains how deviance is
actually a normal and beneficial part of social life. When a person violates the community’s rules of conduct, the group comes together to express outrage at the transgression, and the ignition of the common sense of morality reinforces the social bond. Deviance is thus an essential aspect of defining, policing and reinforcing the boundaries of group identity (1997 [1893]). As a kind of culture the Catholic Church has constructed for itself an expansive and explicit cadre of deviant behaviors, all defined with reference to violations of Catholic moral codes. One might say that along with orthodoxy and orthopraxis, the Church also enforces a kind of “orthopathy.”

Deviance is not simply a matter of immoral outward behavior, but is a matter of the very identity of an individual. Through a historical study of Puritan society, Kai Erikson shows how, “We are still apt to visualize deviant behavior as the product of a deep-seated characterological strain in the person who enacts it.” We treat the one perceived as deviant “as if his whole being was somehow implicated in what is often no more than a passing deviant episode.” “To characterize a person as deviant,” was and still is, “to describe his spiritual condition, his calling, his vocation, his state of grace” (1966, 198). The stigma of such an indelible character flaw can be lifted only by a spiritual conversion or a clinical cure (205). The particular deviance of depression requires both. But depression is not simply associated with the deviance of an individual or subgroup. In the view of Catholic experts, it is the result of the waning morality of the whole of secular society – a “depressed society” (Anatrella 1993). It is a sign of
the deteriorating health and integrity of a whole social order, the decline of the civilization which the Church credits itself with creating.

As a marker of personal slippage into the general malaise of modern secular culture, depression is constructed as a form of deviance within the Church’s territorial discourse of Catholic “counter-culture.” Regardless whether depression is understood as a medical illness or an existential crisis resulting from moral deviance, individual or social, in problematizing the condition the Church finds an occasion in which to reaffirm the parameters of its vision of society. But while depression is discussed in the usual rhetoric of moral panic or crisis, Church authorities also incorporate a construction of deviance more typical to the operation of modern biopower, namely the constitution of the subject at risk. Several social theorists – most prominently Mary Douglas – have developed this concept to explain how Durkheimian and Foucauldian ideas of deviance and normalization have been supplanted by the objectification and articulation of risk in late-modern media, politics and the market as the principle dynamic of social relations (See for instance Douglas 1992; Douglas and Wildavsky 1982; Lianos and Douglas 2000; Vaz and Bruno 2003). The social construction of risk effects an emergent form of self-government built on the delineation not of present subversion but of calculable vulnerability factors that pose a pressing threat to the future of the whole population. In the operation of modern biopower, a temporal shift is made in the locus of deviance from a present threat to the projection of future danger. This “temporal gap” between the identification of deviance and its manifestation “opens up a space for
individuals’ action in the shaping of their futures” (Vaz and Bruno 2003, 274). In the field of medicine, for instance, individuals make themselves “patients before their time” (Vaz and Bruno 2003, 287), even perpetual patients – much as the institutionalized mental patient was socialized to become (Goffman 1961) – exercising self-control and restricting behavior for the sake of perceived health and well-being. It is also a space for institutions like the Catholic Church to propose the importance of its values and techniques for enabling individuals to achieve self-mastery for health and well-being.

Focus on the future has always been a characteristic of Christian spirituality in terms of the importance of self-discipline and obedience for the sake of salvation. Catholic moral theology is concerned with the risk that sin poses to the eternal fate of the soul. Meanwhile moral adherence also promises earthly health and happiness. The Church thus offers not only the means to salvation, but the key to life itself. The Catholic Church has not moved very far beyond its historical identification of sin, original, personal and social, as a risk factor for depressive states. Nor is the prescription of metanoia for the prevention and treatment of depression a new moral theological insight. We argue that the Church’s most recent evaluation of depression is also a strategic exercise of biopower that links what it deems a crisis of culture with the current crisis of ecclesial power. Facing the medical articulation of new genetic and biomedical risk factors for depression, the institutional Church, instead of opposing the medical model, adapts scientific knowledge and the language of risk to project the seriousness of moral factors of mental and physical illness. In this
way Catholic discourse may counter the hegemony of medical knowledge on the
same discursive plane while still maintaining the legitimacy of its existing truth-
claims about social morality and human reality. In the next chapter we will see
this strategic operation of accommodation played out at the top level of the
Catholic hierarchy: the 2003 Pastoral Council for Health Pastoral Care
conference on depression.
II. Impulse: The 2003 Vatican Conference on Depression

Faith in the risen Christ opens man up to hope, to the paschal joy, and to an optimism that generates a state of mind that is diametrically opposed to the state of mind of depression.

- Cardinal José Saraiva Martins, Dolentium Hominum

In November of 2003 the 18th International Conference of the Pontifical Council for Health Pastoral Care (PCHPC) was convened in Vatican City. The topic of discussion was depression. Experts from theology and the behavioral sciences attempted to set aside mutual suspicions in order to deepen their understandings of the nature of depression and to propose methods of relieving the suffering of depressed individuals and the "depressed society," that is, contemporary Euro-American society. Conference highlights and summaries of certain addresses were reported in Zenit and the Catholic News Agency, conservative international new agencies dedicated to reporting on events, documents, and issues that emerge from or otherwise concern the Roman Catholic Church (CNA 12 Nov. 2003; Zenit 12 Nov. 2003, 20 Nov. 2003, 23 Nov. 2003, 24 Nov. 2003, 28 Nov. 2003). Though the actual discussions were not documented, the conference proceedings were published in the 2004 volume of Dolentium Hominum (DH), the journal of the Pontifical Council for Health Pastoral Care. The 151-page issue documents the inauguration of the conference, including an address from Pope John Paul II; a section on the present state of depression the contemporary world; a subsequent section on "the light of faith in the world of depression," both Christian and non-Christian; and a final section to

address the practical question, “What can be done to escape depression?” This question would be answered in terms of the three theological virtues: faith, charity and hope, all of which are the fruits of grace. The international collection of contributors was comprised of seven Cardinals and Bishops, five of whom were members or heads of Pontifical Councils; ten experts in psychology, psychiatry, neuroscience, internal medicine and sociology; six Catholic religious trained in different branches of psychology and psychiatry; and five religious and/or scientific experts representing perspectives on depression from Judaism, Islam, Hinduism and Buddhism.

 Whereas religious expertise is grounded in a tradition of revealed truth and systematic theology, contemporary psychiatric knowledge tends to privilege materialist, amoral explanations of the biological or psychological origins of depression. Still there is substantial space between these two poles in which the spiritual-moral and the scientific-medical perspectives may meet. At the PCHPC conference the competition and cooperation between the biological reductionism of certain branches of the psych-disciplines and the holism of the Catholic humanist approach to depression is played out in the resonance and dissonance of the discourse of religious, scientific, and hybrid religious-scientific experts. Where the Dolentium Hominum document is a textual artifact of ecclesial accommodation, the cleric-scholars trained in both theology and psychology are the embodiment of that principle. Believed to represent the universality and contemporary validity of Christian tradition, this dual expertise makes for a doubly forceful truth-claim about the nature and significance of depression.
Overall the points of dissonance are subtle, buried or absent. This is in part due to the textual format of the conference proceedings as a series of twenty-nine papers, the interim discussions of which were not made available in publication. Overt dissonance also is mitigated structurally through the selection of particular secular scholars whose work represents a position that is clearly resonant with a Christian anthropology, most notably social psychiatry and existential psychology. In Bourdieu’s terms, this aspect of the discussion of depression at the top level of the Catholic hierarchy appears to be an exercise in the conversion of doxa into orthodoxy: the alignment of opinions and censorship of alternative interpretations to propose a view of depression that not only appears self-evident, but carries the force of doctrinal correctitude (Bourdieu 1977). What emerges is a biopolitical maneuver operating through the strategic assembly and accommodation of mental health data that reflects the Church’s position toward the modern world and serves to protect the Church’s stake in authority over the inner life. Specifically, depression is constructed as an indicator of the mental health risk of secular postmodern culture.

At the PCHPC conference, the strategic accommodation of medical and other scientific data operates in two basic ways. First, empirical research in sociology and the psych-disciplines provides the clinical descriptions, diagnostic criteria, therapeutic prescriptions, and statistics compiled by such authoritative bodies as the World Health Organization, the American Psychiatry, the US National Institute of Health, and other national and international health research institutions. Statistics in particular serve not only to confirm the crisis level of
depression, now the “common cold’ of psychiatry” (DH 26), they also provide proof of the real, underlying problem, namely the depressive influence of an un-Christian culture. Depression is shown to be widespread, diverse and indiscriminate, suffered equally by religious and non-religious, laypersons and expert caretakers alike. It is not limited to any particular social stratum. Significantly, however, statistics establish that depression is more prevalent in wealthy and Westernized countries (DH 51, 64, 145). The repetition of “dismaying” statistics on the growing rates of depression and suicide in Europe, North America and countries that have assimilated Euro-American values supports the construction of depression as a problem of postmodernity and a pressing health risk - together proof of the real and severe consequences of moral crisis for society and individuals (DH 16, 22-24, 29-31, 43-46, 47-50, 55-66, 73-79, 86, 99, 136, 139, 151).

Statistics and other devices of scientific discourse rationalize moral panic by converting it into a health panic. Still, religious representatives temper their reliance on medical statistics and explanations, lest the Catholic concept of modern depression as a moral/existential crisis become secularized (DH 127). Two modes emerge by which the PCHPC counters the medicalizing tendencies of contemporary psychiatry and the “invasion of psychological emergency units” (DH 35). First, discussions of bio-medical models of depression are frequently prefaced or followed by a disclaimer that the research methods and findings are largely unsubstantiated, neither verifiable nor refutable. Statistics and studies are cited that emphasize the limits or inconsistent effectiveness of
pharmacological and psychotherapeutic interventions. There are also studies that quantify the negative aspects of the medical approach such as misdiagnosis, recurrence, dangerous drug side effects, improper or insufficient usage, and the wide treatment gap between the number of persons believed to be suffering from depression and the number of those successfully treated (DH 29, 48, 55). Documented and undocumented uncertainty about the precise mechanisms of anti-depressants or the exact cause or processes of the development of depression helps to temper the dominance of the medical perspective (DH 29-30, 32, 48, 55, 57, 59, 133).

The second way in which the PCHPC resists the medicalization of depression is by relying on alternative psych-disciplines that resonate with the Church’s position toward modernity as well as the position of Christian humanism. The religious psych-experts tend to have their training in social psychiatry. Existential psychiatry, particularly the school of Viktor Frankl, offers a meaning-centered, moral approach to depression. Finally, the positive psychology of Maslow and Seligman, both inheritors of Frankl’s perspective, find their place in the list of citations. While positive psychology and social psychiatry are both experiencing a minor renaissance (Blazer 2005; Max 2007), each of these sub-disciplines still represents an “alternative” psychological approach to the dominant bio-medical model of depression (Frost 1985; Shorter 1997). But despite their datedness or relative remoteness, these scientific models offer clear resonance with Catholic evaluations of morality, modernity and the relation of these to depression.
The perspective of Christian humanism derived from Thomistic and Cartesian philosophies posits the spiritual dimension as an integral aspect of the human being that is separate from and integrated with the physical body and the psychic dimension of reason and emotions. While psychiatric treatment is considered an acceptable first-response to depression, it is vehemently argued that to neglect the spiritual dimension yields an incomplete understanding of depression that is insufficient for affecting a complete cure. Accusing the contemporary psych-disciplines of downplaying the spiritual aspect of depression (DH 38), the PCHPC insists that the essential existential nature of the human person must be addressed if depression is not to remain chronic. Anti-depressants and psychotherapy are instruments useful in the recovery of health, but one cannot attribute recovery to psychiatric treatment alone because ultimately depression is an inner disturbance prompted by a deleterious social environment. While drugs and therapy may relieve symptoms, only pastoral care can address the underlying problem, namely society’s erosive effect on the individual’s ability to bear suffering and shoulder one’s own responsibilities (DH 64, 86-87, 100-101, 131, 142, 145, 147, 151). Conversely, the spiritual dimension cannot be co-opted as a concern of medical health care. It is wrong, conference participants argue, to medicalize “problems of existence”(DH 32, 35, 56, 63, 90). The secularization of existential crisis and the emptying of depression of its spiritual dimension is a holistic health risk to be resisted.

Thus, although the biogenetic, philosophical and moral perspectives are all given voice, the overarching message of the conference is that depression is
a sign and symptom of the crisis of modern culture, the rectification of which lies in a revitalization of Christian religiosity and morality through the reassertion of Catholic Christianity in the public sphere. This conservative, sometimes alarmist position is typical of the institutional Church’s response to the conditions of modernity, exemplified, for instance, in the Vatican II document *Gaudium et Spes* (1965), and in more popular publications by Catholic apologists (See for instance Weigel 2002, 2004; Benedict XVI 1991; Benedict XVI and Pera 2006). The rhetoric of cultural or moral crisis is, generally speaking, the preferred mode of articulation of the problem of modernity and the correlated crisis of Church authority in secular, individualist societies. In the context of the Vatican conference, depression and the Church crisis are two faces of the same problem. Both are results and indicators of the moral, philosophical, epistemic and existential crisis of post-war, post-Vatican II and postmodern Western culture. While the maintenance or reinstatement of Catholic pastoral power is contingent on the Church’s resistance to the exclusive medicalization of depression, medical evidence of the incidence and seriousness of depression in Euro-American society works in the exercise of religious biopower. When biomedicine is coupled with social psychological and existential explanations, postmodern society may be posed as a risk to one’s physical and mental health, the only cure to which is the religious and moral conversion of depressed individuals and the “depressed society.”
Institutional Catholic Beliefs about Depression

Death is the depressed person himself or herself.

- Fr. Mariano Galve Moreno, Dolentium Hominum

Sadness
Inner disturbance
Melancholic mood with corporeal connotations and expression
Motor and psychic inhibitions, apathy, tiredness, exhaustion
Depressive mental contents or thoughts
Psychic pain, moral pain
Difficulty communicating
Difficulty with relationships
Agitated behavior, destructive impulses, withdrawal
Pessimism
Excessive worry, paranoia, anxiety, fear, guilt
Feelings of paralysis, exclusion, isolation, suffocation, frustration, impotence, failure,
   hopelessness, powerlessness, remorse, resentment, indifference, confusion
Meaninglessness
Distorted feelings of being trapped, misunderstood, unloved, unworthy, abandoned
   by others, even by God
Distorted sense of time, trapped in nostalgia, a “sick memory”
Feeling dismantled, crushed, drowned, inconsolable, empty
Sinking into the abyss, a “thick frozen covering”
An existential void, the spirit falls silent
Self-pity, self-doubt, “folding in on oneself,” ruined self-image, a false self
Loss of self-esteem, hope, confidence, trust, sense of transcendence
Loss of interest in the future, other people, things, the desire to live
Inability to discharge responsibilities, to accept one’s own existence
Wounded emotional state that devastates entire life
Rejection of life and freedom

Each talk at the PCHPC conference on depression includes some clinical
or metaphorical description of the various features and forms of depression. It is
presented as an affective state, a character style, or a chronic pathology of
variegated etiology that can be cured with appropriate, necessarily multilateral
treatment. Multilateral because the precise source of any one form of depression
cannot be reduced to one factor; rather depression is to be understood as a
complex bio-psycho-social-spiritual condition that involve the entire person. The
triggers and symptoms of depression are multiple, complex and intertwined. Key
aspects of depression, such as anxiety and isolation, can be both a cause and a symptom of the condition. Its etiology can be traced to one’s biology, psychology, personal history, or the social or physical environment. Not only the presence of risk factors, but also one’s perception or interpretation of these can affect the onset, severity and progression of the illness. As such, depression is of interdisciplinary interest. Neurobiology, psychiatry, psychology, philosophy and theology offer competing interpretations, none of which is fully representative of depression, and all of which are indispensable perspectives for an understanding its nature and cure (DH 16, 24, 31, 45, 47-50, 55-66, 72-73, 86, 90, 99, 127, 131, 136).

As a medical, psychological and existential condition depression is a universal pathology presented throughout human history (DH 16, 33). Still, one must take care to distinguish the pathology of depression from normal and appropriate expressions of sadness that come as a natural reaction to loss. The sadness of mourning, it is explained, is a mental condition only, with no serious physical or psychical disturbances. Unlike a depressed person, the person in mourning remains open to the future, retains a grip on reality and still finds meaning in life. Admittedly, however, it is difficult to distinguish between these two forms of sadness without having experienced one or the other oneself. In fact the definition of depression is relative and largely subjective (DH 16-17, 21, 25, 86). Therefore, it is emphasized that each case of depression must be understood according to the individual’s unique experience of it (DH 27, 33).
Not one of the conference attendees outright discards depression as a clinical category of psychiatry, but the discussion focuses primarily on additional subgroups of experience that extend the limits of clinical description (DH 16, 22-24, 38, 62-63, 90-91, 127). Following classic models of depression from psychology and psychiatry, the condition is discussed in terms of two basic types: endogenous or psychotic depression, which is considered chronic and severe, and reactive or neurotic depression, which is a milder, passing form. Both could arise at least partially as a result of some physiological disturbance related to heredity, family history, a change in brain functioning, or, as one participant puts it, a "genetic error," but endogenous depression remains even after the cause or trigger has been removed or relieved (DH 32). This type of depression is a "real," "authentic" clinical illness (DH 90). Yet it is emphasized that scientific proof still lacking as to exactly if and how genetics play a role in the onset of depression (DH 29-30, 32, 48, 55, 57, 59, 101, 133). In any case, the connection between physiological and psychological causality and symptoms is subtle and complicated. In contrast to the psychotic type, neurotic depression is limited to psychological suffering based in an extreme and inappropriate reaction to loss or other types of stress. This reactive type is transitory, characterized as a painful episode that can and should be overcome. Those who experience such "mild" cases are typically the ones who engage in help-seeking behavior, unlike those who suffer "severe" depression, who in contrast tend to accept the depressed state as a way of life (DH 16).
Then there is the proposal of a third type: existential or spiritual depression (*DH* 16, 32, 90). This form is diagnosable in anyone who experiences existential problems, that is, has difficulty giving meaning to life, especially in times of transition such as adolescence or the onset of problems for those advanced in age. In the PCHPC’s formulation existential depression is not just an independent diagnostic category. Rather, it is contended that all types of depression have implications for the inherent spiritual dimension of the human being: any depression is accompanied by an “existential crisis.” Depression is always a “spiritual trial” (*DH* 7, 19, 27, 38, 53, 55, 65, 71-72, 76, 125, 127, 130, 135). Unlike the psychotic or neurotic forms of depression, existential depression is a universal, essentially human experience that is not pathological in and of itself (*DH* 16-17, 33, 47). Psychologically speaking, the core of existential depression is anxiety stemming from imagined or real personal guilt and general fear about the world (*DH* 16, 22, 19, 34-38, 52, 67, 122, 131, 137, 142). In theological terms, depression comes from the “radical evil” of “separateness”: a loss of the sense of God and of values that results from permissiveness and leads to the false belief that one is separated from God and from others. It is described as a matter of social isolation, spiritual desolation and an overall rejection of the truth of human spirituality (*DH* 6, 19, 39, 75, 86, 94, 127). Connecting the psychological and the spiritual interpretations of depression, the conference posits that this state of “separateness” from the Other leads to feelings of abandonment and the fear of disappointment, leaving the person frozen with existential anxiety. If left unresolved, the ensuing sense of guilt or
non-reconciliation will cause not only personal unhappiness and inner conflict, but conflict with other individuals and with authorities like the Church (DH 13, 36, 67, 71).

The belief in a fundamental rupture between the perspective of the depressed person and that of the outsider is a crucial point for the Church’s description and evaluation of depression. The inner imbalance of depression is thought to result from the person’s inability to face up to or stay in contact with “reality” (DH 16, 62, 87, 138). The reality of which the PCHPC speaks is that of Christian humanism. From the Thomistic perspective of the institutional Church, objective reality or truth consists of the paradoxical mystery of life (DH 38-42, 87, 94, 96-97, 100, 103-104, 123-124, 128). The world is meaningful because God exists and loves unconditionally. The human person, in turn, is a complex whole, an unalienable part of which is the will to meaning and transcendence. Human life is governed by natural law and moral rules that derive from our communitarian nature and the fundamental dignity of human life. In this reality the world is recognized as basically good. In the cases where humanity disobeys natural law – war, abortion, genocide, etc – ultimately, “only religion can offer man an acceptable answer to these examples of irrationality” (DH 20). The promised outcome of a person’s full integration into the Christian religious community and worldview is joy, hope, optimism, a healthy sense of responsibility, indeed all of those values and qualities identified as lacking in the state of depression.
The idea of “folding in on oneself” frequently used to describe depression refers to a radical subjectivity or hyper-subjectivity, in opposition to some objective reality and the others who exist in it (DH 40, 67, 131, 139). This disproportional, paralyzing reaction to reality is thought to be a result of deprivation of “internal resources” that leads to the inability to admit the truth of oneself or of others. The false sense of reality refers not only to the present, but to the past and to the future as well (DH 127). Perfectionism is a particular type of break with reality that easily triggers depression. It is a lack of realism about one’s own limits, a hypercritical self-perception that makes one vulnerable to frustration and poor self-esteem. Subjectively this translates into a pathological response to guilt; inter-subjectively it manifests in the tendency to blame others for one’s own failures. That feeling of victimization and the lack of gratitude and generosity are posited by conference panelists as signs of the narcissism that underlies depression (DH 10-15, 33-35, 67, 70, 73, 77, 87, 92, 98, 102, 127, 129, 134).

The discussion of depression passes smoothly through the psychology of narcissism and agency to an explanation in terms of Catholic moral theology. According to the PCHPC, depression reveals a fundamental “human frailty” that is both intrinsic to the human condition – the residue of original sin – and the result of personal or social factors related to the moral crisis of postmodern culture. Regardless of the precise etiology, as an existential condition all depression is an indicator of inner psychological and spiritual weakness that burdens both the sufferer and others around him or her (DH 7-8, 32, 51, 71, 96-
97, 104, 129, 131). With regard to individual transgression, it is reiterated frequently that both the cause and the expression of depression involve choice and culpability at various levels (DH 14, 37, 64, 69, 86, 90-95, 97-98, 124, 146-147, 149). “It is an open secret that hidden and unforgiven sins easily lead a person to be depressed” (DH 148).

Deep psychological discouragement can lead to the mortal sin of suicide, the ultimate act of anti-humanism. In suicide not only does one fail to duly love oneself, but the person fails in his or her responsibility to others by declaring in self-destruction the meaningless of the world and of life. If meaning is ultimately relational, as Christian humanism contends, then by asserting a false autonomy, the act of suicide is a contradiction of the very meaning of life. As one moral theologian explains it, life is not a choice but is something in which we are integrated (DH 94). But even formal theology is not able to completely solve the mystery of self-annihilating behavior as an expression of human suffering, so the theologians turn to psychology to find a more complete understanding of the motivations of suicide (DH 43-46, 90-91). From that perspective the impulse to suicide is not founded in an actual desire for death, but rather in the desire for a solution to existential problems. Retaining the existential dimension, this explanation remains in concordance with the Council’s description of depression.

In addressing the feelings of guilt – both justified and distorted – that drive depression and suicide, it is contended that one must always make an ethical and conceptual distinction between objective moral reference points (the relational reality of sin) and subjective moral reference points (personal feelings...
of guilt). Such arbitration between two different forms of rationality is an ethical necessity for the understanding and treatment of depression, especially with respect to the Church’s prescription of confession as a curative practice.

Distinguishing the sin from the sinner is the foundation of the theology of the Sacrament of Confession. This is significant psychologically and theologically when one considers that the narcissistic guilt of depression is believed to arise from the mistaken association of the sin with the sinner. To confuse the feelings of guilt that are symptomatic of an involuntary disorder with willful sin can be devastating, causing painful and useless misunderstandings. Unfortunately the distinction between sin and guilt is not always clear to the sufferer, to the lay observer or to the specialist. Likewise unclear is the extent of one’s culpability. Catholic moral theology recognizes various levels in the illicitness of sin, divided between venial versus mortal or capital sin, and between active sin and sins of omission. But as St. Augustine observed, while you can judge a person by his outward actions, it is impossible to know the contents of his heart (DH 90-95).

Depressive guilt may indeed be prompted by personal sin. Even when the feelings of guilt are unfounded, depressed persons may act in sinful, self-destructive ways. In either case, the precise locus and level of sin in depression is not knowable to either the sufferer or to those with whom he or she interacts. To complicate matters further, there is also believed to be a strong influence of social sin in the onset of modern depression.
Homo Pavitus and the 'Depressed Society'

But in essentials, in my opinion, the whole of this post-modern mentality...in variingly explicit ways penetrates the cultural contents of contemporary society and provides us with a 'parology' of instability. We are referring here to the decline of thought, which is rightly called 'weak thought,' and which as such can only generate the horrendous culture of death. This culture provokes an uncontrollable fear and is openly expressed in a whole series of forms of depression.

- Cardinal Javier Lozano Barragán, Dolentium Hominum

The increasing incidence of depression demonstrated by the statistics and sociological surveys cited by the PCHPC is taken to suggest that the condition merits special attention from the Church. Modern malaise is “in fashion.” It is “the illness of our century” and the “symbol of modern times” (DH 6, 16, 38, 67). Clearly, the conference participants state, depression is a medical mental health concern – it is, after all, a topic for the Pontifical Council for Health Pastoral Care. But depression is also an individual and a social pathology that derives from an interrelated set of social crises - epistemic, cultural, moral, and above all religious. Assuming the views of social psychiatry, the conference contends that individual depression is induced, at least in part, by “aggravating factors” found in contemporary society. Poor moral education, the lack of a “real upbringing,” and fraught personal history are blamed for causing fissures in personal identity and the regression of the self, the weakening of personality and the hinderance of maturation and development. A lack of stability, strength, realism, and attachment to the world and to others are all aspects of depression thought to derive from the conditions of late modernity. Not only is modern man alone, homo pavitus is also characterized by the incapability of facing life's difficulties or of bearing any kind of suffering, and this has direct implications for the
conference discussion of the nature of depression (\textit{DH} 7, 14, 33-37, 41, 70, 85, 96-105).

The connection between depression and the conditions of late modernity has been a theme in Catholic thinking since World War II.\textsuperscript{3} Popular texts like Hilda Graff’s \textit{Modern Gloom and Christian Hope} (1959) criticized modern pessimism from the Christian point of view. For the PCHPC’s argument about social origins of the emergency state of depression, the most powerful resources of Catholic tradition are by far the pastoral constitutions, encyclicals, apostolic letters and exhortations, and catechetical writings produced during or subsequent to the Second Vatican Council. Together these documents contain the most recent, complete and specific articulations of the Church’s totalizing worldview, a Catholic humanism that is holistic and transcendental, and is in diametric opposition to depression. The Vatican II document, \textit{Gaudium et Spes} (1965), on the Church in the Modern World, has already been mentioned. After the documents of Vatican II, the encyclicals and apostolic letters of John Paul II, the most prolific pontiff in the history of the Church, play prominently in the conference’s articulation of the meaning and cure of modern depression. Among them, the pope’s encyclical letter, \textit{Veritatis Splendor} (1993), refutes the individualist conscience and subjective morality of postmodern culture. \textit{Fides et Ratio} (1998) offers a similar analysis of what the conference now describes as the “depressive” ideas present in various moral realms.

\textsuperscript{3} We do not argue that the categorization of depression as a postmodern illness is limited to Catholic discourse, only that this assessment supports a particular operation of pastoral power. For non-religious social scientific discussions of depression as a postmodern illness, see Awbrey (1999), Blazer (2005), Fee (2000), Levin (1987), or Morris (1998).
The two apostolic letters which have perhaps the greatest bearing on the topic of depression must be *Salvifici Doloris* and *Reconciliatio et Paenitentia*, both presented by John Paul II in 1984. The first of these speaks to the meaning of suffering as an unavoidable, meaningful human reality to be embraced, not rejected. Suffering must be understood as mysterious, redemptive, and an essential part of man’s transcendence. It must not be seen as evil in and of itself nor in its consequences. Rather, we can discover the meaning of pain through Christ; in realizing its meaning suffering can even be a source of hope and joy. The second letter outlines the mystery of sin and evil and their consequences, explaining suffering as the result of ruptures in relationships between the self and others, God and the environment. Citing the example of the Prodigal Son, reconciliation is to be understood as a reconnection and reestablishment of ruptured relationships, the natural outcome of which is the restoration of joy and hope.

The PCHPC combines these theological reflections on the depressive effects of modern society with social psychiatric analyses of the “virus of depression” (*DH* 39). Using a sort of dialectical reasoning, the conference characterizes modern society as a contagion of immorality that triggers individual depression, which in turn is passed throughout the rest of society. Otherwise stated, modern depression is an epidemic of social sin that is not just a burden on the individual but on those around that person as well. “Even the more intimate and private sin extends its evil to other human beings and structures surrounding the person, thus manifesting in a negative way the unity and
interdependence of humankind” (*DH* 98). Expressed in aggression toward others and toward moral systems, especially Christianity, depressive social malaise is represented as alarmingly contagious.⁴

The “depressed society” is said to have emerged from a lack of “points of reference” that stress the “values of life” (*DH* 11, 35, 127-128). More specifically, in the PCHPC’s diagnosis, depression is a symptom and result of the rise of secularism and the liberalization and individualization of religion (*DH* 38, 51, 131). In a cursory appropriation of a sociological term introduced by Durkheim (1979 [1897]; 1997 [1893]) and developed by Parsons (1937) and Merton (1957), modern depression is said to result from *anomie*: a lack of stable social norms and moral rules, yielding individual behavior that is unhealthy, inauthentic and threatening to social coherence (*DH* 96). The lack of concrete moral rules further incites existential loneliness and a disdain for life and its values, causing individuals to “turn in on themselves” for support that society does not provide (*DH* 40, 67, 131, 139). In this sense the eclipse of organized religion is not just a risk factor for spiritual and mental depression; in not supporting the integrating frameworks of marriage and family, and in denying the structuring worth of values and symbolic order, the dominance of secularism is a matter of society’s life and death (*DH* 70-71, 127).

Still, the PCHPC insists, depression is not so much a matter of not having moral rules, as of ignoring them (*DH* 127). Nor is depression just a matter of the poor transmission or integration of unified values (*DH* 32). It involves a

⁴ The concept of social sin smacks strongly of social contagion theory, though surprisingly this interpersonal explanation of the spread of depressive mood and symptoms appears nowhere in conference citations (Coyne 1976; Benazon and Coyne 1999; Joiner and Katz 1999).
fundamental shift in the thought content of contemporary Euro-American society, an epistemic crisis, as it were. According to the PCHPC, contemporary cultural references contribute to a distortion of individuals' "cosmic vision and manner of understanding and interpreting life" (DH 100, 123). Specifically, the cultural references at the base of all symptoms of depression consist of the deteriorated, "weak thought" of postmodernism. With its critique of meta-narratives and the corresponding preponderance of universal truth, postmodern thought expands to a general distrust of everything, in turn propounding "depressive ideas" and depression-inducing values. Catholic observers describe it as a flight from truth, from true reason, from any concept of the objective or absolute (DH 11-12, 14, 67-72).

The postmodern position is described as anti-family, anti-clerical, anti-state, anti-authoritarian, anti-religion, in a word, anti-human. Nietzsche, Vattimo, Heidegger, Wittgenstein, Lyotard, as well as Foucault, Lévi-Strauss, Sartre and Freud: intellectuals all indicted for their contribution to the depressive position that now characterizes, infects as it were, contemporary society (DH 68-70). The grouping of all these thinkers under the heading of postmodernism may seem strange. From the Church's perspective, however, they are unified not in theoretical perspective, but in their anti-humanism. Having seeped out of the academy into art, politics, economy and industry, even science and medicine, postmodern thought is the most insidious risk factor for modern depression (DH 13, 69-70).
The separation of faith and reason, science and morality, represents a crisis of rationalism constitutive of an "era of confusion in thought and feelings" that dominates and depresses the spirit (DH 127). The crisis of postmodern thought in turn incites a moral crisis. Atheistic rationality is accompanied by moral relativism and nihilism, what Catholic apologist George Weigel describes as the "new Gnosticism," or the latest iteration of the earliest heresy (2004). The epitome of heterodoxy, postmodern depression represents "a kind of radical Pelagianism which lacks trust in God" (DH 88). Liberalism, pluralism, syncretism, individualism and the narcissistic hegemony of subjectivity and affect – a "form of freedom that is not to be based upon objective truths and moral norms" – combine to confuse subjective perspectives and preferences with objective truths (DH 127). The fragmentary nature of postmodern culture means no limits and no unity, resulting in confusion and chaos. Consumerism commodifies love; hedonism confuses pleasure with true happiness. The superficial is taken for the real, distorting expectations, feeding competitiveness and obscuring any concern for the inner life.

Due to the destructive, depressive contagion of postmodern thought, "contemporary culture knows only how to reflect on the meaning of anxiety, guilt, suffering, and the evil inherent in the human condition" (DH 34). As such, modern depression is posited as the "rejection" of life and love (DH 32, 37, 92-93, 97, 128). Fundamentally opposed to natural order and moral order, indeed to all of that which forms the basis of Christian religion and Catholic moral dogma, modern depression is not just painful and tragic, it is fundamentally
dehumanizing (DH 100). Depression, like the unnatural, immoral acts of abortion, euthanasia, and suicide, is listed among the “inhuman” aspects of the postmodern “culture of death,” a “radical anti-culture” resulting from sinful choices that ignore the quest for the infinite and reject the meaning of suffering, indeed of life itself. In hampering the internalization of the “coherent” Christian truth of the incarnation – the mystery of life and death – the “immature,” “evasive” position of postmodernism diminishes the human capacity to face pain (DH 6, 14, 33, 35, 37, 69, 92-93, 96, 98, 100). Depression is its natural result. The only cure is conversion.

Prescriptive Conversion

The objective and hopeful interpretation of personal life and of social realities that Christian belief brings offers a powerful antidote to the frenetic pressures of the secularized world. To discover meaning in life and its struggles, and to interpret one’s personal and social framework with evangelical criteria offer powerful sources for authentic healing.

- Bishop James Wingle, Dolentium Hominum

In the accommodation of current psychiatric models, the Pontifical Council for Health Pastoral Care recognizes depression to be a clinical situation that requires a multiplicity of therapeutic actions, including psychotherapy and psychiatric medication. Indeed, psychiatric help-seeking is posited not just as a virtue and an important first step in recovery, but as a moral imperative for any person in possession of free will (DH 40, 141). Medical intervention is accepted as an effective first response, but again, that approach on its own is seen as incomplete and superficial. Regardless of the root cause, because depression is a condition that affects the entire person, including the spiritual dimension,
pastoral care and religious participation are essential for the successful treatment of depression (DH 64, 86-87, 100-101, 131, 142, 145, 147, 151).

The positive psychotherapeutic effects of pastoral care and religious participation are reiterated throughout the conference (DH 18-20, 38, 40-42, 64, 78, 86-87, 99, 101-102, 120-126, 135, 143). At the same time, Vatican officials are quick to disassociate Catholic spiritual direction and religious activity from other alternative or substitute therapies. Alternative religious therapies are posited as “mere palliatives in comparison with what the Church can offer” (DH 150). Moreover, the effectiveness of belief for preventing or relieving the symptoms of depression is not the primary purpose of religion, but is rather its by-product. Spirituality does not exist to “cure” the depressed person, but to help the person bear that suffering (DH 142).

An “authentic and constant” spiritual life is the foundation of a mature existence, a healthy, integrated personality, an inter-subjective ethic and a meaning-centered worldview, all qualities that help to mediate life experience and depressive reactions. As a rule those with a strong, communal faith life are more emotionally stable and less susceptible to depression (DH 39, 99). For those who do succumb to depression, whatever its cause, the holistic, integrated, spiritual nature of the human person means that depression always involves an existential aspect. Therefore, from the Church’s perspective, the healing of depression is more than a matter of anti-depressants or personal development; is a matter of restoring or reframing one’s perception to that of the Catholic
humanist construction of reality, which consists in the sacredness, mysteriousness and meaningfulness of human life.

Scattered throughout the PCHPC conference proceedings is an extensive list of interrelated spiritual "antidotes" to depression, divisible between those treatments directed toward the individual sufferer and those aimed at the culture at large (DH 41, 72, 88, 102, 145, 150). That is, spiritual prescriptions focus as much on the treatment of individual symptoms as on the elimination of the purported social causes. Individual sufferers are exhorted to pray and to meditate on the Word of God. Spiritual reading is supposed to comfort the depressed person through association with Christ’s passion and other reminders that God is close to the suffering. The rosary and special prayers for the intercession of appropriate patron saints is a traditional Catholic practice in response to situations of suffering. Sacramental participation, especially Eucharistic celebration, is recommended for the therapeutic effects of social integration, the restoration of inner peace and moral courage, a reorientation toward a center of meaning, and even physical healing, all through the power of grace (DH 7, 41, 103, 124, 143, 148, 150).

The general goal of these prescriptions is to overcome what has been posed as the fundamental problem of depression, namely the distorted outlook on life that comes from the retreat into the loneliness of extreme subjectivity. In order to escape depression and restore an objective (i.e. Catholic humanist) view of reality, the perspective and ethic of the sufferer must be converted: redirected outward toward other persons and toward God. There are two basic ways in
which this may be accomplished. The first is literal social reintegration. Thus, beyond the recommendation of Mass attendance, depressed Catholics are exhorted to take part in activities that promote social integration and warm contact with others who have “good,” Christian values. Activities like volunteer service and participation in parish ministries offer healing through dialogue, relationships and the experience of empathy. By engaging in these behaviors sufferers are supposed to recover a sense of joy, thankfulness, and generosity, as well as a sense of meaning, responsibility, and purpose. It is a process of reification through performance. Practicing compassion provokes compassion; practicing generosity provokes thankfulness. “Religion, and the Christian faith in particular, is a factor that fosters social ties and integration. It allows each person to find himself or herself anew with himself or herself, to become humanized and to socialize” (DH 128). To be human is to be communal. To have a mission is therapeutic.

The second way in which a depressed person may be cured of his or her distorted perspective of reality and hyper-subjectivity is through a spiritual and ethical conversion (DH 19, 40-41, 64, 88, 92-93, 102-103, 121-122, 125, 129, 143, 147-150). The Vatican conference on depression identifies metanoia as a positive, if not the best response to the feeling of guilt, either real or imagined, that is characteristic of depression. Metanoia is a gradual and permanent process of purification and conversion through prayer, self-examination and confession that leads by grace to profound personal growth, inner transformation and ultimately “real interior freedom” (DH 19). More than simple repentance or
return to the inner self, it involves self-truth-telling for a "reconfiguration of feelings and the evangelization of our behavior" with the goal of self-detachment and movement toward God (DH 102). In this sense metanoia is tantamount to obedience and faith (DH 122).

The examination of conscience, the Sacrament of Confession and regular spiritual direction are all standard practices of metanoia in the Catholic tradition. By practicing these techniques of self-knowledge and self-improvement the depressed person may attain a clearer perception of reality, realizing that God is merciful, people are good and that things are not as bad as they seem (DH 142). The practice of metanoia is also a means of recognizing the reality of sin. As we have already discussed, the meaning of sin is important to the understanding and treatment of depression among Catholics. The Vatican conference reiterates the role of narcissistic individualism in the emergence or experience of modern depression, citing Christopher Lasch’s Culture of Narcissism (1979) to show how depression arises from a culturally-situated lack of affection, social support and "cultural stimuli" (DH 61). As a counterpoint to the narcissism of contemporary society, a sense of sin is considered a positive orientation when it stems from a consciousness of others and of the Other of God (DH 93, 129). But again, this idea of sin as real, objective and rational is not to be conflated with the subjective feeling of guilt. Through the practices of self-examination and sacramental confession a depressed person may discern whether that sense of guilt is justified or not. If the origin of one's depression is "grave and reiterated moral disorder," then the sacramental forgiveness of sins can be especially helpful for
this disturbance (DH 88). If the guilt is found to be unjustified, the reception of absolution helps to differentiate sin from guilt, which in turn offers hope, joy and peace by ending the cycle of narcissistic self-reference. Therapeutically metanoia promises both self-acceptance and reconciliation with others. But the full significance of the Christian conversion ethic goes far beyond the psychotherapeutic side-effects; without it there is no growth, no fulfillment, no liberation and no salvation (Stroumsa 1990).

Depression is not just an occasion for the conversion of the individual self. For depression to be quelled at its root, the whole society must be evangelized and converted (DH 61, 98, 103, 151). From the Church’s point of view, the cultivation of an inter-subjective ethic through the restoration of a proper sense of sin and the reinstatement of the “correct” practice of confession is needed to combat the narcissism of modern society that underlies depression. The restoration of moral conscience through practices of confession and forgiveness fosters the recognition of one’s own agency and of one’s responsibility in relation to others (DH 93, 129). Through discussion, confession and forgiveness, depression can become an opportunity for constructive dialogue leading to the healing of inter-personal relationships, the renewal of the family, indeed the conversion of the entirety of Euro-American society (DH 140).

The sweeping prescription of a sort of social metanoia stems from the Vatican’s vision of depression as a social contagion spread through secularization:

Although depression is an illness that has to be treated, understanding it cannot be reduced to a mere individual affection, above all because this malady and this suffering are widely experienced. It does not only involve
medicine; it also involves social conditions because the points of reference of people are confused and the needs of the spiritual life are not respected by listening to the word of God (DH 37).

It is the contention of the Pontifical Council for Health Pastoral Care that faith in and obedience to the Catholic Church, the bearer of Christian faith and joy, is the best antidote to the “counter-values” of Euro-American society (DH 67). To counteract depression, “we need to reconstruct coherent and loyal behavior in relation to what is believed in, which leads to there being great moral meaning in behavior” (DH 143). The depressive ideas of postmodernity disrupt cultural harmony, destroy and disfigure humanity, and undermine the fundamental units of society, most prominently the traditional family. Postmodern philosophy also undermines the power of the Church. Therefore it is the “duty of the Church to propose an alternative to [the depressive ideas of modern culture] in an authentic pastoral approach to culture inspired by Christian humanism, which is in its turn nourished by the Gospel” and, coincidentally, promises a restoration of pastoral power (DH 68).

Depression as a site for the restoration of Catholic pastoral power relies on the operation of biopolitical and ethical techniques of subject-formation. In Foucault’s formulation, the locus classicus of biopolitics is the management of children and family. Exemplified in encyclicals like Humanae Vitae (1968), apostolic exhortations like Familiaris Consortio (1981) and Ecclesia in America (1999), John Paul II’s “theology of the body,” and Catholic political rhetoric about the “culture of death,” the exercise of Catholic biopower is largely a matter of moral pedagogy by which Catholic subjects inculcate and embody Catholic beliefs about the meaning and value human “life.” Of the various sites within the
discursive field of the Catholic politics of life, the PCHPC proposes the "traditional" family and moral education as the ideal sites for the re-evangelization and coincident remediation of the "depressed society."

The Church considers the intact, traditional family the fundamental unit of society and the source of the salvation of society itself. It is the privileged site of individual personal development, the transmission of cultural values, social solidarity, in short all that makes a person human and, coincidentally, all those resources necessary for the prevention and cure of depression (DH 65, 140-141). The family is posited as "the best therapist for a depressed person" (143). But "under attack" from contemporary society, the traditional family is in a state of crisis, and one effect of this, it is contended, is depression and other forms of mental illness (DH 57-58, 127, 140). The PCHPC explains how the postmodern lack of a sense of the absolute and disinterest in the future or in others yields irresponsible and weak individuals. Among the results of this moral weakening are separation, divorce, teen pregnancy and other so-called "irregular situations," abortion, infanticide, contraception, low marriage rates and birthrates — all indicators of the instability of families and the erosion of the institution of marriage. All of these behaviors and situations, it is suggested, place family members, especially children, at risk of depression. Abortion, contraception and other examples of illicit sexuality or sexual sin, especially that of women, are strongly implicated in the onset of the condition (DH 32-33, 35, 58-61, 64, 148).

To prevent depression, the stability, form and continuation of the traditional family must be preserved. Intervention in the form of psychological
counseling may help to strengthen the family unit and save those suffering from depression, but pastoral care is necessary, especially in the areas of health, family counseling, and sexual education. Thus, as a solution to depression, the Church reaffirms the values of marriage, procreation, sexual morality, and “the beauty of motherhood” against the rise of individualism and the pursuit of personal development. The importance and naturalness of maintaining established gender roles in particular must be reiterated through the Catholic theology of the body as an extrapolation of natural law (DH 70-71, 140). Thus we see how depression serves as a vehicle for the continued problematization of sexuality by the Catholic Church.

The second front of Catholic biopolitics surrounding the issue of depression is that of the general moral education of children. Youth are imagined to be the group at greatest risk of becoming de-motivated and depressed by the current cultural climate. Isolated and left without the strong “points of reference” of religion and social morality, they experience life as both joyless and meaningless, turning to fillers like drugs and casual sex to fill the void (DH 8, 37, 127-128). The family, schools, churches, parish associations, and public institutions alike are responsible for educating youth in the moral and spiritual meaning of Christian life (DH 103, 123, 130). Ideally a child’s upbringing and education should transmit cultural, spiritual and moral values that center on the meaning of the person as free, dignified and responsible. Only this type of personal formation will make a child open to accepting himself or herself and others, strengthen his or her personality and nourish the inner life so as to
assemble a cache of interior support for dealing with existential difficulties (*DH* 128-129).

Ethical practices such as open dialogue, spiritual reading, self-reflection, and participation in religious culture enrich a child’s spiritual life with attention to God. Not a secular morality, but a specifically Christian religious worldview is necessary for a child to find the source of true happiness, hope and a sense of mission essential for preventing, treating or limiting the effects of depression. A stable and rich spiritual life, it is argued, cannot be confused with a life of intelligence, poetry, aesthetics, philosophy or moral wisdom. Rather, “the spiritual life is always in relationship with the religious and Christian dimension which acts as its foundation” (*DH* 132). Only Christianity promises answers to our deepest hopes for fulfillment and joy through its offer of a “truer and more positively realistic vision of life and ourselves” (*DH* 123).

To effect of the evangelization of culture for the prevention and cure of modern depression the PCHPC proposes three specific measures aimed at the formation of Catholic subjects. These are 1) the promotion of new religious movements, 2) the expansion of religious media, and 3) the public and political affirmation of Christian symbols and values. Youth movements like World Youth Day and new ecclesial movements like the Charismatic Catholic Renewal are said to offer solidarity, communion, clear moral direction and compassionate understanding of existential suffering (7, 102-103, 147). Renewed alertness to “God’s pedagogy” and the rediscovery of mysticism are resources for dealing with daily problems and struggles (*DH* 148). Those who participate in such
movements tend to enjoy a “mental equilibrium” that wards off the depressive effects of postmodern culture (DH 147). For those who experience depression, new ecclesial movements offer powerful ritual forms for the deep healing of terrible memories of sin and trauma that often instigate the condition.

The popular mass media is identified as an insidious element in the transmission of the depressive ideas and corrupt, distorted morals of secular society that weaken individual personality and traditional social structures. In light of the destabilization of traditional sources of moral education like the traditional family and the religious community, impressionable, alienated youth in particular are vulnerable to imbibing the media’s broad and rapid perpetuation of depressing individualist morality, false images of reality, and distorted ideas about the worth and meaning of human life, not to mention “misinformation” about Christianity (DH 7, 13, 33-35, 51, 69-70, 92, 130, 140). To counteract the influence and effects of mainstream media, the Vatican advocates the development and expansion of Catholic communications media at the national and international levels (DH 51-54). In the context of the conference on depression, it is emphasized that Catholic media serves to provide youth in particular with examples, “reference points,” and experiences that encourage growth on the human, psychological, moral, and spiritual levels. Expanded media exposure is also needed to make Christian morality more attractive.

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5 The issue of Catholic media as a modern vehicle for the unification and formation of Catholic subjectivity is a topic of discussion that reaches far beyond the debate about depression. Though it is not cited explicitly by any of the conference participants, the decrees of the Vatican II document on the moral function of Catholic media in the modern world, Inter Mirifica (1963), resonate clearly. In 1967 the Vatican established an annual World Communications Day to draw attention to the importance and impact of Catholic media. For Vatican discussion of media since the PCHPC conference on depression, see Zenit 14 Nov. 2003, 23 Nov. 2003, 6 Feb. 2006, 19 Aug. 2006, 29 Sept. 2006, 11 Oct. 2006, 1 Nov. 2006, 27 November 2006; Septien 2003.
Especially in the wake of the Church sex scandal, Catholic media and Catholic religious appearing in popular media must learn to redirect attention away from the “denigrating” representation of the Church hierarchy in the mass media (DH 53-54, 130). In order to reframe discourse so as to emphasize the positive aspects of Christianity, acknowledgement of institutional failings must be separated from a presentation of the Christian faith as “advantageous, desirable, and existentially necessary” (DH 123).

Young people, it is argued, can only internalize religious values if they encounter them in an authentic, positive and public way. For this to happen Christian moral education cannot be limited to the institutions and mass communication platforms of the Catholic Church. In order for Christianity to be the primary source of moral reference points, religious symbols and values must be reinserted into general public life (DH 8, 89, 99, 130, 135). Like parishes and local religious communities, political institutions must work to establish programs and policies that protect youth from depression by generating hope, joy and a strong sense of solidarity, purpose and moral direction. The “infiltration” of secular humanism in academia and other public institutions has “impeded the presentation of a religious or Christian perspective of the human person” (DH 99). Thus the Church must seek new opportunities to insert a “solid, theologically grounded” understanding of suffering and of hope, especially in those institutions dedicated to the human sciences (Ibid). Most importantly, for faith to be an effective antidote to the depressive values of the modern West, religion cannot be “leveled-down” or “homogenized to, and with, the dominant
culture" (DH 122). Authentic religion is not individualist, but communitarian; thus the Church must systematically discourage individual spirituality and contest any political approach that tries to reduce religion to the private sphere (DH 99, 134-135).

Here we come to the explicitly political significance of the statistics cited to show the high rates of depression in Europe and those nations and cultures that have assimilated European values (DH 89, 133, 151). From the perspective of the institutional Church, where religion is no longer the primary source of moral reference points, indeed of reality itself, depression, social malaise and religious crisis appear to share a common root, namely the “rejection” or “forgetting” of the Christian foundation of Western civilization (DH 33, 71, 89, 131). For this reason, although depression is described as a universal problem, the Vatican conference on depression is addressed especially to the modern West. Reference is made to Pope John Paul II’s apostolic exhortation, Ecclesia in Europa (2003), to substantiate the significance of Europe’s Christian history with respect to depression. In it the Pope laments the loss of Christian ideals and proposes a re-evangelization of Europe that would proclaim a hope which has been lost, crushed by “grave uncertainties at the level of culture, anthropology, ethics and spirituality,” by godless ideology, anti-God culture, and a “culture of death” that lead to self-destruction, depression, and despair (No. 3, quoted in DH 151). From this, conference participants interpret the emergence of depressive ideas to be the result of “total amnesia in relation to the Christian roots that have given and continue to give life to a culture of a wonderful fertility, and the dramatic
aphasia of intellectuals and political leaders who seek to act on behalf of
humanism, but who instead gravely mutilate man in completely forgetting about
his origins and his ends” (DH 71).

Coterminous with the negotiations of the EU constitution, the Vatican
conference on depression became a timely platform from which Church leaders
could voice their condemnation of the exclusion of any mention of Christianity in
that document. The EU and European Parliament are indicted for their role in the
systematic erosion of European historical consciousness by ignoring and
censuring the reality of the Christian influence on European culture. These
political institutions are accused of advancing an erroneous vision of religion,
Christianity in particular, by attempting to limit religious expression in the face of
faith traditions originating outside Europe (DH 131). Such a “totalitarian” denial
of the role of Christian religion in the solidification of social ties and the
enrichment of human thought “falsifies our past and for this reason colors it with
a depressive tinge” (DH 39, 131). “Christian faith,” it is reiterated throughout the
conference, “is at the origin of the meaning of the dignity of the human person,
his or her inner being, his or her freedom, his or her responsibility, and equality
and democracy, with a distinction between temporal power and spiritual power”
(DH 128). It is the source of truth about human nature and the human person in
general, and the personal and collective identity of Europeans in particular.
Without Christianity, Church officials contend, the whole of Euro-American
society slips into depression.
In this chapter we have presented an overview of the current picture of depression from the perspective of the Catholic hierarchy. The next chapter will situate this vision within a genealogy of depression in the Catholic tradition. In it we witness the historical embeddedness of depression as a site for the exercise of ecclesial biopower through strategic accommodation and the prescription of *metanoia*. While the problematization of depression as a matter of state politics is a recent emergence, we shall see that Catholic discourse on depression has consistently been a matter of pastoral power.
III. A Genealogy of Depression in the Catholic Worldview

Like her patron, St. Catherine of Sienna, and so many other female saints, religious fervor was the mark of her Catholic adolescence. Worship was charismatic and the world was clear and beautiful, painted in the comforting palate of black and white. In prayer Christ broke and reshaped her heart. She sensed angels watching her every move; demons threatened to tempt. She wept. A lot. Then sinfully inconsolably. How could it be that amid such confident, fitful devotion, she began helplessly to descend? So began the cycles: in irony and denial.

Sometime during her high school years, there arrived mysteriously in the mail a plastic medal and holy card bearing the icon of St. Dymphna, patron saint of mental disorder and anguish. The saint’s surprise intercession by post would be a source of shame and relief. ‘How did they know? Who has noticed? How did I end up on the mailing list for depressed Catholics?’ Furtively she added the icons to her religious accoutrement. The medal joined the Sacred Heart and the Miraculous Medal on silver chain, warmed against the skin of her chest, clinking rhythmically as she walked. For many years the stoic princess-saint reflected her torment, beaming compassion from the corkboard over her desk. She doesn’t wear the necklace anymore. It is in a drawer, along with the holy card.

‘St. Dymphna, pray for me.’

The legend of St. Dymphna, 7th century virgin and martyr, is a standard recourse of inspiration and comfort for Catholics afflicted with mental and emotional distress and illness. Born to a pagan king of Ireland, the beautiful princess Dymphna was a secret convert to Christianity. After the death of the queen when Dymphna was fourteen years old, her father, Damon, searched for a new wife who would be as beautiful and noble as the first. Unable to find a suitable replacement, the king turned his attention to Dymphna and decided she should replace her mother as his wife. Refusing to enter the incestuous union, Dymphna fled with her confessor, St. Gerebran, to the Belgian village of Gheel. When the king learned of her whereabouts he went to Gheel and offered her
another chance to accept the marriage proposal. When she refused again, the king had the priest executed and beheaded his daughter himself.

The relics of St. Dymphna still rest in Gheel and she became known as the patron saint of the insane and of mental health professionals. To this day pilgrims visit the church there and healing miracles have been reported throughout the history of the shrine. The town became the site of a colony for lunatics. Later an asylum was erected there. With the psychiatric deinstitutionalization movement of the 1960s the asylum was closed and the town became once again a sort of colony for those with mild mental disorders. Patients live with families and participate in town life, yet they are never quitened treated as normal citizens. Despite integrating measures, the stigma of mental illness remains (Roosens 1979). Today Catholics pray for St. Dymphna's intercession for the healing of mental illness and neurological disorder, including depression, as well as demonic possession, incest and rape. A couple dozen other saints are also believed to intercede on behalf of those suffering depression, but the famous image and patronage of St. Dymphna summarizes particularly well the enduring associations assigned to depression in the Catholic worldview.

In the last chapter we presented an overview of the current picture of depression from the perspective of the Catholic hierarchy. This chapter situates that vision within a genealogy of the Catholic Christian problematization of depression as a spiritual, mental and physiological disorder. The various trends in institutional and popular Catholic thinking leading up to contemporary
categories of depression and mental disorder cannot be set in a neat unified, linear pattern. Nor can Catholic thought be reduced to Vatican proclamations. Rather, it is negotiated and developed at various levels of the hierarchy operating in diverse fields of knowledge. Catholic philosophers do not always agree with Catholic scientists. Religious reformers sometimes oppose the official position of the hierarchy. As with any paradigm shift, a certain amount of conflict, compromise and persuasion is a consistent aspect of the evolution of Catholic thought vis-à-vis any new information about the world and its human inhabitants, regardless whether new epistemic insights are proposed by religious or secular sources (Kuhn 1970).

Nor can the story of depression in Catholicism be told simply as a dialectical process in which the development of science confronts religious paradigms. It cannot be reduced to a problem of faith versus reason. For centuries the development, distribution, and control of scientific knowledge rested largely in the hands of religious. Furthermore, the Church itself has never thought of faith and reason to be opposed. Catholic humanistic philosophy and theology based in natural law operate over time through the principle of accommodation; the story of depression is told as an ever-evolving process of the revelation and incorporation of new knowledge that does not change the Church’s understanding of the human condition, but rather serves to expand and support it. Again this is not to say that dissention and struggle are not essential aspects of this process. The Church’s acceptance of new knowledge always involves the slow and deliberate evaluation of such knowledge against the
standard of Christian doctrine. We will see especially with respect to materialist scientific psychiatry that the Church in its panoptic epistemic vigilance continues to seek out congenial spaces in which to rearticulate the holistic, transcendental vision of the human being in dialogue and confrontation with conflicting paradigms.

The 2003 Vatican conference on depression includes one talk specifically addressing the history of depression (DH 80-84). Typical of contemporary historical accounts of the condition, it begins and ends with non-religious proto- and present medical models, starting with the humoral theories of Hippocrates and Galen, and culminating in Kraepelinian symptomological categorization and “the still in part obscure laws of neuroscience” (DH 84). The influence of Christianity appears periodically as one among several minor, magical or moralizing blips along the supposed linear trajectory of scientific progress. Within the other conference presentations, in contrast, the history of depression in the context of Christianity is presented as essential and persistently relevant. Regardless of the exact extent of Christianity’s influence on the understanding of depression, it can be argued that depression has served as an important foil for the articulation of a Christian moral system.

The genealogy presented here will be a non-linear, thematic discussion of the interface of physiological, mental and spiritual explanations of the disordered dynamics of the inner life said to constitute the particular abnormality of depression. But the purpose of the present narrative will be to highlight certain themes in the history of depression that are specific to the Catholic worldview.

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Once again, it must be reiterated that this is not to be a story of faith versus reason, but one of accommodation. It is the genealogy of a discourse that incorporates depression as a device for extrapolating a certain humanistic philosophy and moral theology. The discussion centers not so much on the evolution of definitions of depression, as on the meaning and mystery of good suffering and the place of depression in the ethical mechanisms of self-knowledge and self-discipline that combine in the constitution of the Catholic subject.

Slothful Humor, Sinful Sadness

*It would seem that sorrow is incompatible with virtue...Immoderate sorrow is a disease of the mind: but moderate sorrow is the mark of a well-conditioned mind...*

- Thomas Aquinas, *Summa Theologica* 59:3

*Rejoice in the Lord always. I shall say it again: rejoice! ...The Lord is near. Have no anxiety at all...*

- Philippians, 4: 4,6

Just as modern depression is located in a middle ground between science and philosophy, medicine and morality, depressive mood in the Christian tradition historically has been a matter of contention and complicity among organic, supernatural and moral models. Catholic accounts of the history of depression like that of the Pontifical Council for Health Pastoral Care begin not with Hippocrates or Freud, but with Biblical anthropology. The Bible, the ultimate document of the truth of God and humanity, is believed to hold evidence of the universality of depressive states, the normality of expressing inner anguish, and
the continued validity of the instructive and therapeutic value of the Word of God. Descriptions and examples of the spiritual, mental and corporeal symptoms of depression appear frequently throughout Psalms and are embodied in other figures of the Old Testament: Job’s misery, King Saul’s suicide (1 Samuel 15), and the trials of Ahab (1 Kings), to name a few. In the New Testament we find the example of St. Paul, whose religious fervor and intensity was interspersed with what some have interpreted as bouts of depression. St. Paul describes the oppressive and painful gloom in II Corinthians 12:7 as “a thorn in my flesh, a messenger of Satan, to torment me.”

Myriad Biblical accounts of depressive states are taken to illustrate God’s special concern for and closeness to those in pain. The hardships endured by prophets like Elijah and Jonah are just two occasions among many in which God reaffirms His promise of unconditional love and salvation in times of trial. But embedded here is a moral meaning applied to the experience of despair. The primary instructive value of Biblical appearances and significant absences of depression is to teach the mystery and morality of suffering through examples of good suffering on the one hand, and with injunctions to Christian joy on the other. Moses, Tobit, Abraham and his grandson Joseph all embodied the strength and obedience characteristic of “good” suffering; despite terrible hardship they did not succumb to depression. Though tragedy after tragedy caused Job to despair his life, in the end he repented and acknowledged the supreme goodness of God. At the Vatican conference on depression, multiple presenters point to the New Testament story of the Prodigal Son as illustrative of the same principle: though

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7 See for instance Psalms 35, 38, 42, 43, 55, 88, 102.
sin separated him from God and others, through repentance he was re-
welcomed and redeemed (DH 40, 98). This fundamental principle of metanoia is 
reiterated in the story of Peter and the Apostles after the death of Christ. In a 
state of dejection, their re-encounter with the risen Christ on the road to Emmaus 
changed them, and they were refilled with a sense of hope and of mission. 
Above all the life and passion of Christ, in his tenderness toward sinners and 
courageous and humble abandonment to the will of God, is the paradigm of 
compassion and good suffering.

The antinomy between the depressive position and Christian belief is 
derived from the injunctions to joy that fill the Gospel. From the angel’s greeting 
to the Virgin Mary to Paul’s reminders to the early churches, “rejoice” is the 
resounding theme of the New Testament (DH 103, 121, 124). If joy in freedom 
and obedience is the fundamental message of the Good News of Christ, then 
there is no justification for Christians to fall into oppressive, subjective despair. 
Christian joy is diametrically opposed to states of depression (DH 20). So from 
the Christian perspective depressive sadness is not simply one of the natural 
responses to life’s trials. In its association with evil as part of the eternal mystery 
of suffering and joy, life and death, depression can also be a form or result of sin, 
both original and personal. The Virgin Mary is held up as a model of good 
suffering, but Church officials preemptively note that by virtue of her immaculate 
conception, the Mother of God would have been incapable of depression (DH 
89).
In contrast, if personal transgression is left unacknowledged and unforgiven then the natural response of sadness and guilt over one’s sin can fester and multiply, eventually transforming normal regret into disordered depression, which in its turn can lead to much graver sin. The Biblical paradigm of this degenerative process is Judas Iscariot, who, having betrayed Jesus, is driven by a guilty conscience to take his own life, the ultimate offense against God. Allusions to the association between evil and spiritual weakness on the one hand, and certain mental and physical signs and symptoms of depression on the other, have been derived from the Old Testament as well. Perhaps the best-known example is “the plague that destroys at midday” mentioned in the ninety-first Psalm:

    You will not fear the terror of night,
    nor the arrow that flies by day,
    nor the pestilence that stalks in the darkness,
    nor the plague that destroys at midday.

- Psalm 91:5-6

In the fourth century CE this brief and singular Biblical reference to the “noonday demon,” as it became called, would be isolated to support the moral doctrine that distinguishes the cardinal sin of acedia or sloth. This deadly sin in turn would be associated with the maladies of melancholia and tristitia, two antecedent formulations of what is now discussed as depressive disorder. Indeed the moral status of depression in its ontology, etiology and remediation is an enduring theme in the Christian encounter with the condition. Depression is caught up in a discourse of free will and graduated moral responsibility such that questions about the limiting effect on individual will and the level of culpability
associated with depressive states are of special concern to Christians when evaluating and experiencing the condition. As we shall see, whether one’s depression is thought to be the result or the instigator of sin, or both, evil has always been assumed to underlie inordinate or inappropriate despair.

But this is not to suggest that depression in the Christian worldview is solely a matter of culpability and the suffering associated with sin, original, personal or social. Much in the way depression is caught between biology and philosophy today, explanations of depressive states identified in the Bible and throughout the Christian tradition incorporate organic and super-organic theories, not infrequently in combination, to produce an understanding of depression as both a mental and physical disorder and a spiritual state that can vary in duration from passing to chronic, and in intensity from mild to severe. Indeed the seeds of contemporary nosologies of affective disorder can be found scattered across the Christian tradition in conversation with nascent medical explanations. Contemporary scholars typically tell the story of depression as the latest chapter in the history of a condition known as melancholia. From Hippocrates to Freud, melancholia or melancholy was the term applied most frequently to passing or chronic states of oppressive sadness and paralyzing fear. It was not until the 18th century that the term depression entered diagnostic descriptions and only in the twentieth century did depression fully replace melancholia as an official, unified category of mental disorder.

Far from today’s neat clinical description of depression, across the history of the condition the label of melancholia became attached to a wide variety of
states and behaviors - at times condemned and feared, at other times romanticized - with varying etiologies that crisscrossed the organic and the transcendent. In current psychiatric terms it may be said that melancholia captured manic-depression or bipolar disorder and various personality disorders along with clinical depression. Today many authors tend to make a clean, unproblematic connection between melancholia and depression, suggesting that the diversity of descriptions, explanations, valuations and treatment prescriptions attributed to the former is simply a matter of epistemic evolution or cultural idiom. Certainly culture is an important factor, but Jennifer Radden cautions against modernist accounts that gloss over the differences and read melancholia through contemporary psychiatric nosology (2000b, xi). Not only does this perspective neglect the diversity of distinct and incompatible senses encompassed by melancholia, but the facile collapsing of the two borders on categorical error. That being said, the tendency to connect historic melancholia with today’s understanding of depression is hardly unfounded. Accounts of melancholia over the last two thousand years contain a persistence of descriptions of a subjective experience and observable syndrome with the same sort of complex, cloudy etiology and contentious moral implications that surround modern concepts of depression. Clearly the history of melancholia has significantly informed our thinking about depression today.

Christians are directed to the Bible for ancient examples of depressive states. But as a distinct illness or disorder characterized principally by prolonged fear and depressive mood, melancholia was first identified by ancient Greek
philosophers and physicians as early as the fifth century BCE. The term melancholia comes from the Greek: melas (black) and khole (bile).\(^8\) Hippocrates’ early humoral theory proposed melancholy as a type of madness caused by an excess of black bile produced in the spleen. It was believed that once it reached a certain concentration the bile would erupt from its natural origin to corrupt and inflame the rest of the body and eventually the mind. Cure for this specific humoral imbalance could be effected through a regimen of hygiene and diet, including herbal medications like bear’s foot and mandrake, known for their purgative as well as symbolic effectiveness. The doctrine of humoral medicine systemized by Galen in the second century CE and refined by Avicenna in the eleventh century would consistently dominate both medical and non-medical views of melancholia, serving as the standard for the identification and treatment of the condition for nearly two millennia. Over the centuries Christian observers frequently combined humoral theory with theological explanations of melancholia.

Other pre-Christian organicist models looked to brain anatomy as the seat of mental functions. Besides a growing regimen of herbal remedies, people suffering from melancholy were prescribed certain kinds of baths, bleedings and scarification, and light therapy according to the doctrine of solids. In addition psychological-behavioral prescriptions gained popularity as patients were advised to partake in enjoyable, diverting activities, and physicians were advised to treat sufferers with reassurance, encouragement and consolation. Though popular thought sometimes ascribed melancholia to the capricious curse of evil

\(^8\) Humoral definitions of human constitution were not unique to the West (See for instance Radden 2000). Given our concentration on depression in the Christian tradition, non-Western theories fall outside the scope of the present inquiry.
spirits or the gods’ punishment for wickedness, early Greek experts tended to reject supernatural explanations. They believed that “mental aberrations either constituted a disease or were symptoms of a disease, and, like other diseases and symptoms, should be explained in naturalistic terms” (Jackson 1986, 29). If depression was associated with psycho-spiritual states, then it was only as a psychological reflection of a fundamentally physiological disturbance. Regardless whether the origin was physiological or divine, however, the stigmatization of depression by the Greeks would carry into Christian thought regarding the condition.

Moving beyond the strict organicist explanations, Plato proposed a theory of melancholia as a soul-threatening state that arises from an excess of irrational passions (or emotions) and appetites that reside in the soul, originate in sensory impressions and memory, and are often accompanied by pleasure (Wenzel 1967). Occupying a liminal position between body and spirit, the passions were given meaning both in physiological and ethical terms, thus placing them within the purview of physicians, philosophers, and religious authorities alike. Aristotle’s diagnosis of melancholia further integrated medical notions of the time with Plato’s idea of passion-driven, divine melancholy madness. His theory proposed a unified self in which disturbances of the body affect the soul, and vice versa. While still incorporating humoral theory, Aristotle conceived of melancholy as more than a pathology of mind and body; it is a temperament that forms part of one’s nature or personality. Certain of types of melancholic madness were identified as a divine, precarious gift of creative brilliance bestowed upon artists
by the god Saturn. With this definition depression and suicide first took on an
enviable, romantic connotation (Wittkower and Wittkower 1963). A blessing and
a curse, depression predisposed one to genius as well as to slothfulness, self-
harm or even suicide. Still, “thereafter ideas about melancholia often included
something of this theme of specialness,” as well as references to prophecy as an
accomplishment or a delusion of the melancholic (Jackson 1986, 33). Although
melancholia was regarded primarily as a physical disorder into the Middle Ages,
in the fifteen century philosopher Marsilio Ficino systematized the astrological
significance of the Aristotelian concept of melancholic genius. Melancholia thus
became one of the main categories in the classical doctrine of temperaments.

The holistic perspective of the human person found in the philosophical
anthropology of Aristotle and Plato became a fundamental assumption of
Christian humanist philosophy, which still frames the hierarchy’s discussion of
depression today. The tripartite typology of depression repeated in the Pontifical
Council conference finds support in the philosophical anthropology of St. Paul,
St. Augustine, and St. Thomas Aquinas, which separates human reality into three
inalienable, independent, yet interrelated dimensions: the spiritual, the mental
and the corporeal (DH 14, 87, 101, 130). In turn this perspective plays into moral
explanations of the onset and expressions of depression, particularly with regard
to the illicitness suicide (DH 93). St. Augustine implicates man’s sinful volition in

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9 Born Under Saturn: The Character and Conduct of Artists (Wittkower and Wittkower 1963) offers a full historical account of melancholic artists and of artists’ fascination with and romantic representation of melancholy. See also Kay Redfield Jamison’s Touched with Fire: Manic-Depressive Illness and the Artistic Temperament (1993) for an enumeration of the historical figures whose brilliance are now suspected of being attributable to affective disorder. The traditional linkage between melancholia and creativity is also the subject of empirical examination (Yarhouse and Turcic 2003).
his stark declaration that reason is what separates man from beasts. From this it could be extrapolated that the loss of reason associated with depressive states and other forms of madness is a mark of God’s disfavor, a punishment inflicted upon a sinful soul, a sign of one’s inability to fight off the temptations of the devil. Not only did melancholic despair suggest the commission of sin, it also implied that the sufferer was not suffused with the Christian joy that comes with the certain knowledge of God’s divine love and mercy. As such it represented “a turning away from all that was holy” (Solomon 2001, 292). This was the dawn of Christian demonological theories of madness that would compete with other models up to the emergence of medical psychiatry in the 18th century (Shorter 1997). In the thirteenth century Thomas Aquinas took up the theory of passions to posit physical changes as essential accompaniments to affective states, though not necessarily the cause thereof. One result of this formulation was the location of moral responsibility for and in depression at the level of the individual sufferer. Thus melancholia would be stigmatized not just as a form of madness, but also as a sign of immorality. As Andrew Solomon plainly asserts, “the rise of Christianity was highly disadvantageous for depressives” (2001, 292).

The sinfulness of depressive moods became doctrinally systematized by the early Church Fathers, specifically St. John Cassian (360-433) and St. Gregory the Great (540-604). Acedia, from the Greek meaning “not caring,” was the theological term for the “noonday demon” warned against in the ninety-first Psalm. Today it is translated as the cardinal sin of sloth. Initially acedia referred to a mental and physical state of sadness, apathy and indolence that was a
particular occupational hazard for hermitic ascetics, beginning with the Egyptian Desert Fathers of whom Cassian was one. It was believed that the ascetic, in his striving for inner peace, might experience a stirring of passions, perhaps at the insinuation of a demon. This interference of disturbing, even sinful thoughts would tempt him to yearn for his former life and even to leave his prayerful practice in despair of ever reaching spiritual advancement.

In Cassian’s account acedia is described as a condition “Akin to dejection …especially trying to solitaries and a dangerous and frequent foe to dwellers in the desert; and especially disturbing to a monk about the sixth hour…. It produces dislike of the place, disgust of the cell, and disdain and contempt of the brethren…. It also makes the man lazy and sluggish about all manner of work…” (quoted in Jackson 1986, 67). The restless monk would frequently complain of spiritual dryness or fruitlessness and seek solace in sleep. As a general condition, Lyman describes acedia as, “A withdrawal of one’s self, one’s thoughts, one’s talents, and one’s endeavors from society, or from service to God” (1978, 8). If left unchecked, this retreat into subjectivity and the physical manifestations that accompany it would constitute a mortal sin. But ironically, as unpleasant and undesirable as melancholic acedia was for the medieval monk, or for any Christian for that matter, “it became essential as a means toward paradoxical knowledge of divine truth and constituted the major touchstone for faith” (Kristeva 1989, 8). As we shall see, many Christian mystics understood and experienced melancholia as a liminal state through which one must
inevitably (though not always successfully) pass on the path toward enlightenment and divine union.

As St. John Cassian and St. Gregory the Great began to reformulate the list of cardinal sins, acedia became separated into an active component, sloth, which referred to idleness in one’s movement, charitable activities, and devotional life, and tristitia, which referred to inner states of despair and self-abasing contrition. “Ultimately,” concludes Jackson, “a focus on outward manifestations was more likely to have been associated with moralizing against, while a focus on the unusual mental states of the distressed person was more likely to have been associated with empathetic concern” (1986, 75). Though theologians in the twelfth and thirteenth centuries tended to emphasize the problem of tristitia, focusing on inner states of sorrow and spiritual aridity, “influenced by the increased activity of confessors and preachers, the common man’s image of acedia came to center on spiritual idleness or neglect in the performance of spiritual duties” (Jackson 1986, 71), that is, the sin of sloth. Furthermore, Cassian and various ascetic authors made a distinction between a positive form of tristitia, which can lead to penance and salvation, and negative tristitia, which leads one to death (Jackson 1986, 68; Lyman 1978, 8-11). The negative form of tristitia became assumed under the cardinal sin of sloth, and thus incurred strict moral injunctions against it. Medieval literature treated sloth, and melancholia by association, as a particularly innocuous deadly sin because it was believed to set in motion all the other cardinal sins (Lyman 1978, 12). “By his withdrawal and peevishness, [the melancholic] has a powerful and
unpleasant effect on the world. His sin is in his infliction of the effects of his sadness on the world” (Ibid).

In positing melancholic mood and behavior as a manifestation of God’s disfavor, the Christianity of the Middle Ages succeeded in initiating the moral stigmatization still attached to depression today (Solomon 2001, 285), especially among Christians (Csordas 2002). In recent Church discourse, the 2003 Vatican conference speaks of modern society as a “culture of acedia,” explicitly connecting modern existential depression with the cardinal sin of sloth. This reference is one means of situating depression within the system of Catholic moral theology (DH 14, 37, 99-100, 130). The malaise of the contemporary West is traced to a widespread dormancy of transcendent dynamics and meaning that is in direct opposition to Christian anthropology. Experientially both acedia and depression are conditions that involve subjective feelings of powerlessness and a loss of meaning. In terms of moral theology, just as in the medieval interpretation, contemporary Catholic observers understand depression as evil in itself and in its effects (DH 14). Remembering that the level of sin corresponds to the level of consciousness, if the melancholic position is consciously consented to, it can become a mortal sin that opens the way to other mortal sins. When sin is conceived as essentially inter-subjective – a conscious transgression not just against the supreme Other but against one’s fellows – depression appears as a sort of social pathogen of sin and discord. But Lyman reminds us that this evaluation of depression as social contagion is not limited to the Christian worldview; it was eventually carried over into atheistic psychoanalysis as well.
Although psychoanalysis would propose therapeutic solutions based on an alternative, psychological etiology, scientific psychiatry has been "no less harsh on melancholia than the medieval theologians, pointing to its pathological and abnormal status, its containment of so many unhealthy emotions, its negative effect on interpersonal relations, and its peculiar role in causing troubles for all concerned" (Lyman 1978, 12).

From the point of view of formal Catholic moral theology, the question of the extent of the sinfulness of sadness and madness is directly correlated with the extent to which free will is inhibited. In St. Thomas Aquinas' (ca. 1225-1274) Summa Theologica, the foundational text of Catholic Christian moral doctrine, we find both a philosophical and phenomenological description of depression as well as an exposition of the association between the morality of sorrow and its status as disorder when excessive or extended. In response to the question of whether sorrow can be compatible with moral virtue, Aquinas' answer is, simply, no. Aquinas explains that virtues are the effects of reason and wisdom. That is, virtue is a matter of prudence, temperance, justice and fortitude, all of which are in opposition to emotions or passions like sorrow and despair. Citing Augustine, the wise person is said to possess three good passions and three corresponding bad ones: desire rather than covetousness, joy instead of mirth, and caution as opposed to fear. Sorrow has no place in the list of virtues; it is rather the product of evil, which is the final cause of all pain and suffering. Though not necessarily a sin in itself, sorrow is both a hindrance to good works and the result of sinfulness. At the same time, sorrow, in proper measure, is described as a
normal and good condition of the mind. Even Christ, who was perfect in virtue, experienced sorrow. As a fundamental human emotion it can be compatible with virtue, such as when the sorrow occurs in mourning of loss or in witnessing of an absence of virtue (Summa 59:3).

Aquinas later states that immoderate sorrow is not only in opposition to virtue but is a disease of the mind. But depression, he points out, is not the same as normal sorrow. Sorrow is the most harmful of the soul’s passions to the body; it consumes the soul and can hinder action so as to depress the soul. But sorrow also has the potential to uplift the soul when it turns attention toward God with the hope of forgiveness. In and of itself sorrow is a hindrance, and if intense, can prevent moral formation altogether. But while sorrow and moderate pain are destructive pleasures, they may actually increase the power of moral learning in so far as they take away excess pleasure (Summa 39:1). In contrast, depression only weighs down and paralyzes, making one unable to attend freely to things of the world and depriving one of the use of reason and of life. The depressed soul seems to close in on itself, a familiar formulation of the condition still in use today (DH 40, 67, 131, 139). Depression can be either a result of or a cause of sorrow, and sorrow, in turn, may be a sign that one has fallen prey to melancholy or madness (Summa 37:1-4). Though melancholia and madness both inhibit the faculties of free will, Aquinas does not necessarily equate the two. Still, Aquinas’ explicit statements on madness (Summa 58:3; 68:1), all made with regard to the validity of sacramental participation, are cited at the 2003 Vatican conference to clarify from the point of view of moral theology that mentally ill
persons, including those who are depressed, do not possess a full capacity of reason and thus, while still capable of sin, may be exonerated from at least some culpability.

Melancholia in Medieval Mysticism and Religious Reformation

And upon those who are inclined to melancholy this acts with such effect that they become greatly to be pitied since they are suffering so sadly; for this trial reaches such a point in certain persons, when they have this evil humour, that they believe it to be clear that the devil is ever present with them and that they have no power to prevent this, although some of these persons can prevent his attack by dint of great effort and labor.

- St. John of the Cross, *Dark Night of the Soul*

At the 2003 Vatican conference on depression great effort was made to distinguish the disorder of mental or physiological depression from a normal, even positive form of spiritual depression, the kind experienced and described by Christian saints and mystics from St. Augustine to Mother Theresa. The idea of depression as a purifying spiritual trial derives originally from the medieval separation of a positive form of tristitia from the sin of sloth. Redemptive, mystical melancholia would appear as such well-known formulations as St. Ignatius Loyola’s “spiritual desolation” and the “dark night of the soul” of St. John of the Cross. At the same time the idea of melancholia as a potentially serious disorder of the mind, a true illness with organic factors and definite physiological effects, also emerged as a category in the developing Catholic typology of depression. To enduring acceptance of the humoral explanation was added new emphasis on the compassionate treatment of melancholics as sick persons as well as the importance of approaching each case individually. This humane, medicalizing perspective appeared in conjunction with supernatural etiological
explanations of demonic possession and underlying sinfulness, and spiritual treatments that emphasized conversion and self-discipline. These same parameters of the essential multi-valence of depression are reiterated in the 2003 Vatican conference on depression (DH 14, 16, 37, 64, 69, 72, 86, 90-95, 97-99, 124, 127, 131, 146-147, 149). Though there remains ambivalence about the boundary between spiritual illness and physical illness, culpability and inculpability, the PCHPC today maintains the need for a compassionate, patient attitude toward the sick person (DH 65, 123, 139, 151).

One of the earliest examples of a compassionate, albeit ambivalent, spiritual interpretation of melancholia can be found in the experience and writings of the medieval mystic, Hildegard of Bingen (1098-1179). This twelfth century German Benedictine nun, known as an artist and religious visionary, produced writings on illness and healing that reflected knowledge of popular and monastic medical practices of the day. Based on her own experience as a sufferer and healer she expounded on the theological place of illness, treating conditions like melancholia as more of a trial from God than a punishment for sin. For this reason her approach differed from the "monastic medicine" typical of her time. Still original sin remained the ultimate explanation of suffering. Hildegard’s understanding of melancholia begins with humoral doctrine, proposing that the humors interact with cosmic forces to determine both health and moral behavior. "Thus mental disorders such as melancholy reflect instability in the person’s systems of humors, but ultimately that instability is attributable to original sin," a fundamental part of the human condition that find its roots in the fall of Adam and
Eve (Radden 2000, 80). In Hildegard’s account depressive mood appears fundamentally as a character trait, not a mental disorder. But given the belief that melancholic disorders are caused by imbalances of bile that can result in madness, melancholy remains associated with disorder and illness.

While innovative, the medical insights of Hildegard of Bingen remained a rather insignificant, officially unacknowledged contribution to beliefs about melancholia and mental illness. Propounded by the Catholic hierarchy, theological, especially demonological explanations continued as the popular norm. In the time of the Inquisition the prevailing attitude that equated sin, mental disorder, witchcraft and demonic influence was reflected in Pope Innocent VIII’s instruction on the identification and punishment of witches, *Malleus Maleficarum* (1485). The perceived rise in witchcraft activity in that era was attributed to the wickedness of man. Its origin was not astrological or natural, but the willful cooperation with the temptations of the devil, that is material sin. The manual of the Inquisition employed medical metaphors such as “prescribed remedies” for treating the bewitched and spellbound, along with the legal terms for sentencing witches (*MM* 2:2). All those found to be acting irrationally, experiencing delusion, or appearing possessed were tried by Inquisitors and sentenced to torture and death. Among the better-known Catholic critics of this practice, Regino, Abbot of Prüm (d. 915), Gregory VII (ca. 1020-1085), and the Jesuit Friedrich von Spee (1591-1635), protested against the trying of witches as an institution opposed to humanity, science, and the Catholic Church (*CE* 1910, s.v. "Mental Pathology").
As the power of the Catholic Church waned in the 15th and 16th centuries, acedia became more closely associated with humoral melancholia (Wolpert 1999), thereby solidifying the connection between the moral and the physiological understandings of the condition. The Protestant and Catholic Reformations of the 16th century inspired Christians of both faiths to reflect on the nature of melancholia as an affliction of body and spirit. Among those inspired by the atmosphere of religious fervor was the physician Johann Weyer. His medical book, *De Praestigilis Daemonum* (On Deceiving Demons) (1563), is considered by some to be the first textbook of psychiatry in its articulation of the theological, psychological and medical points of view of witchcraft. The book attests to the widespread, intense social concern with witchcraft and demonology. Weyer is also credited with making the connection between mental abnormality and witchcraft, though the precise etiology remains unclear. In the clearest formulation melancholia was posited as more than a mood state. It was considered a disorder with delusional features, the source of which was the influence of supernatural powers. As in Hildegard's treatment melancholia was still identified with the humors, and Weyer shared her uncommon argument for the humane treatment of melancholics. Though the devil may be to blame, the sufferers themselves should not be blamed or punished for the disorder of their imaginations.

Another 16th century proto-psychiatrist, Timothie Bright, made a similar link between religion and medicine in the etiology and experience of melancholic mood. He differentiated between natural melancholy based in humoral
imbalance and treatable with naturalistic remedies, and the dark mood deriving from the believer’s burden of conscience, for which he recommended spiritual consolations. Pointing to a dialectical interaction between the body and the mind, he sought to demonstrate how an afflicted body negatively impacts the health of the mind, and vice versa, in a sort of etiological feedback loop. Between the two types of melancholy, the suffering related to the sense of sin is relatively greater. Bright’s successor, Protestant theologian and philosopher Robert Burton (1577-1640), is still widely cited for his exhaustive autobiographical and historical tome on melancholia, *The Anatomy of Melancholy*, first published in 1621. The study drew from other treatments of melancholy of the time, most notably André du Laurens’ (1560?-1609) popular *Discourse de la Melancholie*. An essential reference for contemporary writings on depression, Burton even received mention in the 2003 Vatican conference on depression with respect to the therapeutic value of social interaction (*DH 63*).

Among 16th century Catholics, the best-known analyses of melancholia come from Spanish religious reformers: a Carmelite friar later canonized St. John of the Cross (1542-1591), a Carmelite nun canonized Sr. Teresa of Avila (1515-1582), and St. Ignatius Loyola (1491-1556), the founder of the Jesuit Order. All wrote of their experiences of spiritual aridity and subsequent conversion complete with mystical states and visions. Like Hildegard of Bingen four centuries before, St. John and St. Teresa found themselves at odds with the institutional Church and the Inquisition, ultimately influencing the Catholic Reformation. In her treatment of melancholia St. Teresa seems to have
anticipated the sociology of stigma. Though she acknowledged the standard theological explanation of melancholy as demonic influence or possession, the saint insisted that to burden the sufferer with such supernatural and moralistic logic would ultimately have a negative impact on the recovery of sufferers (Radden 2000, 107). This cautionary logic would be repeated in 2003 at the Vatican (DH 91). Rather than simply ascribing the condition to the devil or discarding the sufferer as a sinner, one must instead listen to a melancholic as to a sick person. Teresa’s concern for proper treatment relates to her ongoing medical interest in distinguishing among different types and intensities of melancholic states among the cloistered Sisters. Compassionate reticence was reserved for extreme cases of depression or madness; for the mild melancholic who still retained some rationality, she prescribed strict discipline and punishment to force the nun to control herself. Overall she maintains that confessors were not sensitive enough to the difference between the suffering and delusion of melancholic sickness and the struggle and pain experienced as part of the spiritual quest. Teresa’s experience and descriptions of the spiritual suffering connected with mystical ascent bears striking resemblance to the ascetic rigors of the Desert Fathers, and even more so to that of her contemporary and friend, St. John of the Cross.

In the spiritual writings of St. John of the Cross (1542-1591), the concept of the “dark night of the soul” is introduced as a painful, precarious, yet necessary step on the purifying path toward mystical union. For St. John, the process of disciplining the soul is divided between the purification of the
sensuous part of the soul followed by the purification of the spiritual part. Sensuous purification involves the mortification and negation of all carnal appetites and pleasures and the extinguishment of all sinful desire. So long as the seeker retains the sweet consolation that God approves of his or her prayer life, the contemplative perseveres. It is when he or she enters the state of deep contemplation that the sense of consolation and accomplishment recedes. From this, prayer becomes arid and melancholic mood often arises. Especially during the early stages of purification, “this torment cannot be borne for long, but serves to prepare the soul for the greater purification to come in mystical infusion and contemplation. This purgation draws the soul on to the final stage of mystical illumination…” (Meissner 1999, 285).

Once the senses are purged of sin, spiritual purification may begin. This involves what the saint describes as the putting to death of human nature, for it is the mundane life, based in the body and imprisoning the soul, which accounts for the distance between man and God (Mark 2000, 159). The nearer the soul comes to death or passive nothingness, the more closely it approximates God (Nieto 1979, 59). “At some point, human nature is destroyed to such an extent that the soul is capable of actually possessing God in the perfect love that is spiritual life to the soul” (Meissner 1999, 284). Of the two modes of purification demanded for mystical union, spiritual purification is thought to be by far the more tortuous, for the closer a soul comes to mystical union with God, “the more it feels the pain arising from its lowliness as opposed to [God’s] exaltedness” (Mark 2000, 158). Meissner has interpreted this in psychoanalytic terms,
suggesting that “the pain induced in this state is involved in the discipline
required to purge the soul of the last residues of narcissistic self-involvement and
egoism and any remnants of sensual attachment” (1999, 285).

The principal benefit of the dark night is self-knowledge, “the knowledge of
oneself and of one’s misery” (Meissner 1999, 30). Once that realization is
complete the soul of the contemplative becomes humble, submissive and
obedient so that he or she may grow in love of God and neighbor. It is important
to note that melancholic mood and spiritual aridity proceed “not from the night
and purgation of the sensual desires aforementioned, but from sins and
imperfections, or from weaknesses and lukewarmness, or from some bad humor
or indisposition of the body” (DNS, 21). Thus humoral biology is included as a
potential cause of the melancholy that accompanies sensual purgation. If humor
is indeed the cause, it is mostly a matter of physical ruin, which stands to reason
that the melancholy is not related to concern over one’s service to God. The
agony of true spiritual purification also can be augmented by melancholic humor,
causing a failure to produce the desired purgative effect. In the dark night of the
soul anxiety emerges with the realization of the apparent loss of or distancing
from God. Added rigor does not seem to help; it only exacerbates the anxiety
and depression. St. John ascribes these effects of the dark night to the devil,
who delights in tormenting the mystical seeker, “especially those called to greater
perfection, with severe temptations in the form of scrupulosity, urges to
blaspheme and sins against charity” (Arraj 1986, 58). It seems the path to
mystical union is psychically precarious indeed. “Though many enter this night of
sense which heralds the beginning of contemplation, few successfully emerge” (Mark 2000, 161). That is to say, while melancholy appears in saints’ accounts as an unavoidable step on the path toward spiritual perfection, the experience of existential suffering does not guarantee the achievement of mystical union.

A similar process of painful spiritual purification is described in the Spiritual Exercises of St. Ignatius Loyola. In the Fourth Rule of the Spiritual Exercises, titled “Of Spiritual Desolation,” the saint speaks of desolation as all that is contrary to spiritual consolation, “such as darkness of the soul, disturbances in it, movement to things low and earthly, the unquiet of different agitations and temptations, moving to want of confidence, without hope, without love, when one finds oneself all lazy, tepid, sad, and as if separated from his Creator and Lord” (SE 317). In comparing Ignatian descriptions of spiritual desolation with St. John’s dark night, Meissner argues that “the painful aridity, darkness of mind, anxiety, and the feeling of abandonment and separation from God fit the Ignatian formula for spiritual desolation, but the dark night is a path through which the Spirit guides those who are straining toward the heights of mystical experience” (1999, 284). John’s is thus a fruitful sort of spiritual desolation that can draw the soul closer to God through a painful process of purgation, while in Ignatian spiritual desolation, “the anti-spiritual aspect with overtones of separation from God and increasing discouragement seem to predominate” (286). So while the two descriptions do overlap, St. John’s account appears more complex. The torment of the dark night is induced not by a sense of God’s absence, but “by the sense of presence, more promised than fulfilled"
(Ibid). It is this sense of frustrated longing and unfulfilled desire that provokes the dysphoric affect, a formulation that is missing Ignatius’ account (Ibid).

Though the conditions appear phenomenologically analogous, Meissner acknowledges that it is rather difficult to differentiate between Ignatian spiritual desolation and the contemporary diagnosis of clinical depression. The saint’s term, “spiritual desolation,” could in fact be used to describe depression, or if the two are not precisely synonymous, then one could argue that the state of spiritual desolation may be accompanied by depression (1999, 260). It is possible for an individual to suffer from one but not the other, but as in previous formulations the two conditions might also be related dialectically, with each state giving rise to or augmenting the other. Thus Meissner warns that contemporary spiritual directors ought to be on the lookout for clinical depression among those spiritual seekers who complain of this sense of desolation. St. Ignatius himself suffered a “darkness of the soul” in October of 1522. But rather than destroy his faith, it became a key experience leading to his conversion. Meissner argues that depression in such cases is actually constructive and adaptive, as it is indicative of “the pilgrim’s continuing effort to reconcile discharge of intrapsychic impulses he was experiencing with the system of spiritual and moral values he embraced” (93). Even so, Ignatius makes clear that depression can be dangerous to spiritual growth. Spiritual desolation, as it is treated in Ignatian spirituality, “tends to undermine and destroy faith, hope and charity” (260).

Psychoanalysts like W.W. Meissner are not the only ones curious about the relation between clinical depression and the spiritual suffering of Catholic
saints. In his work on spiritual purification in the tradition of St. John of the Cross and St. Teresa of Avila, Marianist priest and popular Catholic spiritual author Fr. Thomas Dubay, has systematically clarified the distinction between the two conditions. By way of a bi-columnar seven-point comparison, he clarifies the “sharp differences between a mental/emotional problem and the purifying nights” (1989, 163). Unlike a mental/emotional problem, characterized by excessive or obsessive introspection, self-concern, and self-analysis, a person experiencing the dark night of the soul devotes little or no time to introspection “once the condition is adequately explained,” presumably by a spiritual director (Ibid).

Continuing with a list of the common identifiers of depression – fatigue, insomnia, inability to concentrate, hopelessness, poor self-image – Dubay argues that within the dark night there is no depression at all. Rather, any awareness of the problem is isolated to the prayer life only and should not affect the rest of one’s life in any (negative) way. Where depressed persons need therapy, often long-term, the dark night must simply run its course. Reflecting a mode of retrospective diagnosis, the two conditions may be ultimately distinguished by their results. As Dubay explains, “Mental/emotional problems do not of themselves promote virtue or increase depth of relationship with God,” where as the dark nights do “of themselves greatly increase love, humility, patience and the like, and they decidedly prepare one for deeper prayer” and for a closer relationship with God (164, original italics).

These distinctions are presented through the same logic at the 2003 Vatican conference. Just as one must not confuse normal, realistic sadness with
the illness of depression, one must also be careful not to conflate existential depression with the sort of spiritual desolation described by Christian mystics (DH 19, 150). There are, however, certain commonalities between the “dark night of the soul” and the depression that comes from existential crisis. These include grief over past events, emotional disturbances, weakening of the faculties of the will and intellect, and a sense of emptiness and meaningless. Neither depression nor spiritual aridity permits the sufferer to recognize the “real” cause of the problem: a real or imagined separation from God. This is not to say that depression necessarily causes the sufferer to question his or her ultimate destiny. Depression is not a matter of despairing one’s eternal salvation, but is malaise toward one’s earthly life and a grieving over one’s self-image. The fundamental narcissism of depression means there are indeed elements in depression that question faith and charity and obstruct Christian hope. Spiritual desolation, in contrast, is of transcendental origin, relating specifically to one’s relationship with God. In depression one disassociates blessing and meaning from the current path of trial and despair. But while depression is a pathology - an “anomalous working out of emotional stimulation” (DH 19) - the feeling of spiritual desolation, while unpleasant, is a normal and positive step on the path to transcendence and union with God through the mystical participation in Christ’s passion.

While their experiences and descriptions are among the best-known and most carefully recorded examples of the dysphoria of spiritual desolation and subsequent mystical enlightenment, Hildegard of Bingen, St. Teresa of Avila, St.
John of the Cross, and St. Ignatius Loyola are only four among a host of saints and Christian holy persons to have endured spiritual depression. Martin Luther (1483-1546) is known to have both experienced and written on the bio-social-psycho-spiritual phenomenon of depression (Erikson 1962). Among the Catholics St. Catherine of Sienna in the 14th century, St. Catherine of Genoa in the late 15th century, St. Alphonsus Liguori in the 18th century, St. Bernadette and St. Theresa of the Child Jesus in the 19th century, and Blessed Mother Teresa of Calcutta in the 20th century, to name a few, all shared in the experience of spiritual desolation. Each is presented as a model of hope and redemptive practice at the Vatican conference; all are recommended as intercessors for those who suffer depression (DH 126, 150).

Existential depression was especially frequent among contemplatives, many of whom recommended the world-renouncing strictures and asceticism of cloistered life as a way of disciplining the soul for the achievement of divine peace and joy. But their methods did not remain restricted to use by religious. Over the succeeding centuries and into our own, a canon of popular interpretations and applications, both religious and non-religious, has accumulated. The historical precedent of these saints’ lives and writings is still incorporated into and combined with the most recent psychological and psychiatric therapies and theories of the specific condition of depression and more general theories of the psychology of the spiritual self. As we will see in the next section, depression has been consistently problematized at the nexus of Catholic theology and scientific psychiatry.
Catholicism and Psychiatry

Disease is one thing; guilt another. When the two are together, the psychiatrist and the moralist work together.

- Bishop Fulton J. Sheen, Life is Worth Living

As a charitable institution the Catholic Church has played a consistent role in the development of psychiatry, from the "great confinement" of the insane ("Asylums," EC 1910; Foucault 1988; Shorter 1997), to the free community-based counseling services provided by Catholic Charities and Catholic Social Services today. Edward Shorter (1997) begins his account of the birth of psychiatry with the traditional asylums of the Middle Ages, among the oldest and most infamous of which was London’s Bethlehem asylum, later called Bedlam, established by the Priory of St. Mary of Bethlehem in the 13th century. For the discussion of the Catholic Church’s relation to modern psychiatry it is useful to think in terms of the epistemic shifts associated with two interrelated turning points in Church history. The first is the Second World War. The decades following the end of the war were a time of chaos, the dawn of the Age of Anxiety in the face of a precarious global political, economic and social environment. As Euro-American societies began to realize the full extent of the gruesome horrors of the war, a crisis of culture ensued, only to be augmented by the nuclear armament of the Cold War. In the midst of this crisis, perhaps in response to it, the 1950s were marked by a flourish of religious conversion to Christianity. It was a golden age of Catholic religious vocations. The cultural crisis was also the impetus for a second event that can serve to mark the changes in Church
discourse vis-à-vis psychiatry: the Second Vatican Council. Convened by Pope John XXIII in 1962 and closed by Pope Pius VI in 1965, the purpose of the council was to clarify the Church’s position toward the modern, post-war world. What came of it were liberalizing proposals for the continued maintenance and transmission of the Catholic faith in an age of growing cultural criticism and nihilistic cynicism. Vatican II was the Catholic Church’s own critique of the conditions of postmodernity.

What significance do these cultural and ecclesial changes have for the Church’s relation to psychiatry? At first glance, there appears to be very little change. The principle of secular accommodation established in the 17th century continued to be upheld with respect to new scientific discoveries, including insights into the biological basis of some forms of neurosis and psychosis. Thomistic philosophy remained the standard of Christian moral theology and holistic, transcendental humanism, the standard by which such discoveries were evaluated. Society-wide moral crisis indicated by world war, sexual revolution, postmodern consumerism, etc., is consistently imagined to be the root of the widespread rise in the incidence of neurosis (Graff 1959; Sheen 1949, 1950, 1953; Van der Veldt and Odenwald 1952; DH 10-15, 32-39, 51, 55, 67-68, 70, 89, 92, 99-100, 127, 140). In short, Catholic officials maintain that psychiatry, while also a science, is always a moral issue.

What changes can be charted are in terms of the categories and terms of Catholic discourse on mental illness, neurosis in particular, in response to new theories and methods of psychiatry. With the rise of medical psychiatry and
psychoanalysis, the Church faces the perpetual challenge of how to defend the philosophical boundaries of Thomistic humanism in the face of new knowledge about the subconscious and neuro-chemical dynamics of mental disorder. This became especially salient as the post-war crisis of culture met with the post-Vatican II crisis of the Catholic Church. In studying the discursive adjustments to scientific knowledge, the Church's relation to psychiatry appears as an expansion and intensification of the operation of ecclesial biopower. Through the ideological construction of health risk in terms of the theoretical correlation between atheistic or anti-religious philosophical and cultural trends on the one hand, and the statistical increase in psychiatric illness on the other, institutional Catholic discourse continually carves out a space for its authority and influence in both science and culture.

Now, religious officials are quick to point out that there is no Catholic psychology, per se (Misiak and Staudt 1954). But Catholic psychologists do attempt to integrate psychology, philosophy and theology for a complete understanding of man. If psychology, philosophy and theology share the common object of man and pursuit of truth in both faith and science, then, it is reasoned, there can be no real conflict among them. In the spirit of accommodation, 20th century Catholic discussions of mental pathology attempt to provide a "scientifically sane" integration of psychiatry and Christianity, but none claims to offer the "last word" on the topic (Van der Veldt and Odenwald 1952). Rather, if a new theory or method proves helpful to those suffering from mental illness, so long as it does not contradict Catholic teachings, then Church officials
are free and encouraged to learn and employ new scientific knowledge in order to provide the best support possible for the well-being of individuals in the flock (Misiak and Staudt 1954; *DH* 32, 101, 131, 151). Thus it should not be surprising that Catholic officials and scholars have referenced, applied and contributed to the insights of medical psychiatry.

As we have seen in the history of depression, descriptions and theories of madness and mental disturbance date back to the early Greek philosophers. In terms of organic causation, humoral theory was the standard of etiological thinking from the time of Hippocrates through the Elizabethan era (Radden 2000). It was not until the 18th century that biological psychiatry as a formal discipline initiated a turn toward the study of abnormal brain physiology. French physician Phillipe Pinel (1745-1826) is widely regarded as the father of modern psychiatry. In contrast to earlier theoretical approaches that focused on etiology - either physiological or super-organic - Pinel’s psychiatry emphasized the intense observation of symptoms in order to group discrete mental disorders into five basic syndromic categories, one of which was melancholia. The onset of melancholic disorder could be attributed to physiological factors like abnormal skull structure, heredity, illness, cranial trauma, skin conditions, or female biological cycles. Melancholia could also arise from psycho-social (discussed as “moral”) factors including drunkenness, domestic problems, religious fanaticism, abnormal modes of living, and the timely trauma of the French Revolution. Pinel’s classification system would have an enormous influence on emerging 19th century psychiatry. The diagnostic categories would be refined by his student,
Jean-Étienne Dominique Esquirol (1772-1840) in France, Wilhelm Griesinger (1817-1968) in Germany, and Emil Kraepelin (1856-1926), who would come to dominate German psychiatry in the late 19th century. Kraepelin’s classification system represented a shift away from the 18th century emphasis on delusional systems toward descriptions that centered on mood and feelings. He was one of the first psychiatrists to use the term “mental depression” to describe the state of melancholia, a state distinguished by the cognitive symptoms of delusions and the level of coherence and content of ideas (Radden 2000, Shorter 1997).

Catholic philosophers and theologians scrutinized experimental psychology and psychiatry as the disciplines emerged at the nexus of philosophy and physiology. Associated with positivism and materialism, “psychology without a soul” initially garnered widespread rejection as an enemy of Thomistic Christian philosophy (Misiak and Staudt 1954). Still there were scholars within the Catholic community and hierarchy who saw potential in the new science. Misiak and Staudt have documented the history of Catholic advocacy and involvement in scientific psychology and psychiatry. In introducing the biographies of well-known Catholics who contributed to the development and application of the psych-disciplines, the authors remind readers that science and religion are not necessarily opposed or antagonistic. Science is after all theory; like religion it is a matter of faith directed toward the pursuit of truth. Though Church dogma remains mostly unconcerned with empiricism and scientific theory, relying rather on faith in the unseen, the Church accepts practices of inference based on
controlled observation as a valid guide to truth. A similar sentiment is expressed at the 2003 Vatican conference on depression (DH 55).

Among the key Catholic pioneers and supporters of scientific psychology and psychiatry were Thomistic philosopher Cardinal Désiré-Joseph Mercier (1851-1926), priest and clinical psychologist Thomas V. Moore (1877-1969), and Sr. Marie Hilda (1876-1951), a teacher and psychologist who led the early child guidance movement. While these figures encouraged Catholics to cooperate with state clinics and mental hygiene programs, ultimately the goal would be the establishment of Catholic psychiatric research and care facilities, and professional associations that could uphold Catholic moral principles in the practice of science. Focusing especially on adjustment problems and the moral development of children, these early 20th century Catholic psych-experts sought to define a mode of cooperation between religious and scientific authorities that would delegate treatment to one or the other based on symptomological observations, etiological explanations and treatment attempts. Bad behavior in children, for instance, is initially assumed to be a result of poor upbringing and latent original sin. Thus treatment by the priest, not the psychologist or psychiatrist, is the most appropriate course of action. If in the course of moral and religious reformation the child’s condition and behavior do not improve, then the priest would be justified in referring the family to clinical treatment.10 As we saw in the example of the 2003 PCHPC conference on depression, the moral

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10 The role of developmental psychology in the formation of child subjectivity was a broad post-war trend not limited to the sphere of Catholic psychology (Rose 1990). It simply appears that this disciplinary trend was resonant with, and thus made a space of Catholic governmentality.
formation of children still receives particular emphasis in Catholic proposals for the prevention and treatment of depression.

While the preferred site and mode of intervention remains largely the same, the parameters of therapeutic subsidiarity found in pre-Vatican II Catholic psychology do not carry over into 21st century Catholic discourse on depression. Formerly it was agreed that unless the condition is clearly of an organic basis or is extremely severe so as to escape the scope of the priest’s psychological expertise, then the most appropriate initial treatment for depression among Catholics is pastoral care. Only after careful observation in pastoral counseling sessions should the person be referred for professional psychiatric help. But as we saw in the PCHPC conference, accommodation has since placed spiritual and clinical treatments of depression in almost the reverse relation.

Psychological or medical care, including psychotherapy and psychopharmacology is approved as an appropriate first-line treatment and, if shown to be effective in the relief of symptoms, should continue to be pursued by the patient. But treatment cannot take place at the medical level only; the bio-psycho-social-spiritual unity of the human person means that treatment is only complete when it addresses the essential transcendental aspect of depression. Pastoral care must not necessarily be the initial response, but it is still considered the ultimate source of prevention and cure (DH 64, 86-87, 100-101, 131, 142, 145, 147, 151).

Despite the historical and residual skepticism of Catholics toward psychiatry, the hierarchy did not hesitate to maintain the most current information
about the discipline, its theories and methods. Almost as soon as it entered mainstream psychiatry, Kraepelin’s system of diagnostic categorization was assumed into the canon of Catholic knowledge. The entry on “Mental Pathology” in the 1910 edition of the Catholic Encyclopedia is based on Kraepelinian categories of the varieties of insanity. Further entries on “Insanity,” “Psychotherapy,” and “Asylums of the Care for the Insane” draw on the writings of Esquirol, Tuke, Heinroth, Dubois, and other major theorists of late 19th century/early 20th century psychiatry, while clarifying the Church’s historical and present take on each topic. Melancholics, for instance, “often cite in explanation long-forgotten sins of youth.” Taking pleasure in neither prayer nor in socialization, “they accuse themselves of impiety and want of affection.” As for the typical course of illness, “The patients accuse themselves of crimes they never committed: they have made everybody unhappy, have desecrated the Host, and have given themselves up to the Devil” (CE 1910, s.v. “Mental Pathology”). This statement is quickly followed by the proviso that while the Church has accepted demonological explanations of mental disorder since the Middle Ages, there have been Catholics throughout history that opposed the execution of witches.

In applying the Kraepelinian system, Catholic officials were admitting that although the exact organic cause of certain mental illnesses (particularly psychoses like schizophrenia and manic-depression) is not known, it is possible that some organic factors are behind these diseases (Van der Veldt and Odenwald 1952). The possibility that mental illness can arise from pathological
changes in brain structure is addressed in both pre-Vatican II and post-Vatican II discussions, but never without a Thomistic exposition on the question of moral responsibility (both theological and legal) with relation to mental soundness (CE 1910, s.v. “Asylums,” “Insanity,” “Mental Pathology”; Van der Veldt and Odenwald 1952; DH 90-95). While it is understood that mental disease diminishes freedom of will, “In nature…there are no rigid, definite boundaries between disease and health, but only gradual transitions.” Thus psychopathology frequently represents a “‘border-land…between health and disease.” Just as there is a spectrum of severity for mental illness, “moral imbecility” is also a matter of moral gradation. For this reason, “the question of freedom of will cannot be answered by a simple yes or no, but requires a strictly individual weighing of all the conditions of the concrete act.” While the mentally ill may be exculpated to some degree in relation to the severity of the disorder at any one time, from the perspective of Catholic moral theology, their sins are never completely inexcusable, for no one with a semblance of free will is ever completely inculpable (CE 1910, s.v. “Mental Pathology”).

For the Church, then, the Kraepelinian system offered a certain philosophical advantage. Namely, its diagnostic emphasis on symptoms over etiology meant that cause is not rigorously problematized in the definition or identification of a given condition. The focus on the phenomenological leaves a space for religious authorities to propose and maintain a spiritual or moral etiology for some conditions, including depression, and to propose appropriate religious interventions. Stated otherwise, if etiology is not posed as a
fundamental issue for identifying or treating mental illness, then there is less potential for conflict between Catholic moral theology, and biological or psychological explanations of the cause of depression or other mental disorders. But Kraepelin’s diagnostic system was not the only approach to mental illness available in the late 19th/early 20th century. The first wave of bio-medical psychiatry would be soon supplanted by the schools of psychoanalysis (Shorter 1997). When it came to the all-important issues of sin and free will, the predominance of Freudian psychoanalysis posed a particular threat to Catholic belief.

From the Catholic perspective the Freudian school was condemnable on three fronts. The first problem is the underlying philosophical materialism of Freudian psychoanalysis. The view of the person as mechanism, the different aspects of which may be parsed apart for the purpose of treatment, comes in direct contradiction of Catholic holistic humanism. Secondly, the Freudian assumption that unconscious, instinctive sexual conflict is the root of neurosis conflicts with Catholic moral theology, which asserts that while mental illness may inhibit the faculties of the will, such a disabling condition can never completely cancel the existence of free will. Going back to Aquinas’ Summa Theologica, humans are not animals driven only by base instinct, but are conscious and conscientious beings that carry responsibility, and with it the potential for sin, despite psychical inhibition. The final objection to Freudianism and its derivatives is their position toward religion. Freud’s evaluation of religion as a form of collective neurosis that humanity would eventually grow out of was
tantamount to apostasy. Jung’s understanding of religion as psychologically and socially functional, regardless of whether or not it was true, was likewise taken as a direct affront to Catholic doctrine.

Catholic discussions of psychology and psychiatry in the early 20th century almost inevitably contained some condemning commentary on the falsity and illicitness of amoral psychoanalysis (Van der Veldt and Odenwald 1952). Among Freud’s most vocal critics was American Bishop and Catholic televangelist Fulton J. Sheen. In his books and television programs produced in the mid-1950s, Sheen railed against psychoanalysis and the “mind cures” of pop-psycho-spirituality, particularly the positive psychology popularized by Norman Vincent Peale (Massa 1999). Between 1947 and 1948 Bishop Sheen became involved in “a nasty public brawl” with the psychiatric profession (92). The debate centered on the bishop’s contention that people were mistakenly replacing confession with psychoanalysis. He argued fervently that because modern neurosis is often due to “some deep, unabsolved sense of guilt,” cure cannot be effected through therapeutic methods like psychoanalysis that deny the existence of sin and the validity of guilt (Sheen 1953, 88). Bishop Sheen in the 1950s and Vatican officials in 2003 agree that only pastoral counseling, confession and conversion can offer the depressed person real peace (Sheen 1950; DH 86-87, 100-101, 131, 142, 145, 147, 151).

11 Peale is famous for combining the therapeutic aspects of Christianity with the science of psychology in the discourse of “peace of mind,” captured in the iconic 1952 psycho-spiritual self-help book, The Power of Positive Thinking. Historians have noted that despite Sheen’s persistent condemnation of such “soft religion,” his own combination of religion and psychology bears a strong similarity to the pop psychology of his time. Though the bishop never compromised his Catholic beliefs, his writings treaded the fine line “between a sentimentalized ‘peace of mind’ religion and a more orthodox Catholic theology” (Kathleen Fields quoted in Massa 1999, 92).
This is not to say that Fulton J. Sheen and other Catholic psychologists or religionists, both then and now, categorically deny the possibility of some unconscious or organic basis for mental illness. As today, mid-century Catholic thought on psychiatry generally reflects an accommodationist, therapeutic understanding of Christianity. Ever the faithful Thomistic philosopher, Bishop Sheen maintained that the “accumulated wisdom of the human race has always acknowledged that there was some kind of relationship between peace of soul and health. Today, medicine and psychiatry are combining to prove that there is some *intrinsic* relationship between holiness and health” (Sheen 1967, 26).

Regarding melancholia or depression, the bishop acknowledges that some forms can occur organically or are related to involuntary bodily factors (such as the depression associated with the female menstrual cycle). As such, Sheen admits, “It may be true that mental factors such as the consciousness of guilt are not determinants of melancholy in the strict psychological sense of the term” (1949, 123). Still, Thomistic humanism would maintain that because conditions of the body affect the soul, the symptoms of depressive illness might be at times sinful.

Despite his status as a Catholic Bishop, Fulton J. Sheen – and any Catholic religious official for that matter – was not in a position to speak unequivocally about the Church’s position toward psychoanalysis and psychiatry. In response to the growing number of independent clerical condemnations of psychoanalysis and psychotherapy as inherently sinful, Pope Pius XII issued two unprecedented statements regarding the Catholic view of psychiatry. As in the 2003 Vatican conference on depression, the pope issued these statements not
as a promulgation of doctrine, but as an elucidation of a Catholic position on a timely issue. The first address, titled “the Moral Limits of Medical Research and Treatment,” was presented at the First International Congress on the Histopathology of the Nervous System in 1952. There Pius XII reaffirmed the Thomistic principle that even though the mental patient is not absolutely in control of his or her body or mind, to a point each individual is still responsible for his or her actions. The pope echoed popular Catholic opinion when he voiced disapproval of some psychologists’ attribution of all emotional and mental disturbances to unconscious sexual conflict and their prescription of amoral curative methods. Still, when “rightly applied” – that is, when the methods affirm the existence of free will – psychoanalysis is not necessarily contrary to Christian morals (Misiak and Staudt 1954).

The pope’s second statement was made in 1953 on the occasion of the Fifth International Congress of Catholic Psychotherapists. There he reminded Catholic psychologists and psychiatrists to view the human person holistically: as a psychic, structural, social and transcendent unit. Fifty years later the Vatican conference on depression makes reference to Pius XII’s statement to reiterate this point (DH 99). With regard to psychiatry or any other branch of medicine, the general rule for Catholics is to evaluate the moral value of each new procedure, research method or medical treatment with regard to the interests of medical science, of the individual patient, and of the community, that is, the common good. Those schools shown to conflict with Catholic religion, humanistic philosophy, or moral theology should be rejected on philosophical grounds, but if
new methods or theories prove to be beneficial to patients and can be adapted to the Catholic moral system, then these may not only be retained, but Catholic pastors and psych-experts have a responsibility to learn them.

Of the various schools of psychoanalysis, the Third Viennese School led by Victor Frankl was found to be particularly congenial to the Catholic position toward psychoanalysis, especially when it comes to states of mental depression (Van der Veldt 1952; DH 7, 19, 38, 53, 55, 65, 71-72, 125, 127, 130). Even a cursory explanation of Frankl’s existential psychiatry reveals an obvious resonance with Thomistic philosophy. Frankl, a student of Freud, incorporated phenomenology and existential philosophy to create the psychoanalytic methods of existential analysis and “logotherapy.” The school of existential psychiatry was grounded in the assumption that humans are defined by self-awareness. As such, they possess the capability for free choice, and from that are bearers of responsibility. Frankl harbored a critique of Freudian psychoanalysis similar to the Catholic position, namely that Freud’s school is based in an anti-humanist philosophy that denies the essential moral and spiritual dimension that defines the human person. Thus Frankl set for himself the mission of rehumanizing psychiatry to recognize human dignity, holism, and self-determination (1986 [1946], xv; 2006 [1946], 133).

In contrast to the Freudian and Adlerian schools of psychoanalysis, Frankl maintains that the most basic and defining drive of humanity is not the pursuit of pleasure or power, but “logos”: the will-to-meaning (1986 [1946], xvi).\(^\text{12}\) In

\(^{12}\) There are two aspects of Frankl’s existential psychiatry with which Catholic observers might take issue. The first is Frankl’s usage of the term “spiritual” to refer to the human dimension in its
viewing man in his wholeness the "medical ministry" of logotherapy focuses on
curing the soul by leading it to find the meaning of life (xviii). The meaning of life
may be found both passively – as through the appreciation of art and beauty –
and actively through work or creativity, through responsible relationships and the
commitment to something greater than oneself, and in one's response to
suffering. Frankl was convinced by his experience as a prisoner at Auschwitz
that even in the most terrible conditions of mental and psychical stress, the
human person retains the inalienable ability to freely choose how to respond to
life. The realization of this fundamental "spiritual freedom" in turn entails the
quality or ethic of responsibility. Though Frankl acknowledges that only very few
individuals (saints) are capable of ever reaching such high moral standards, he
poses the ethic of responsibility through self-transcendence as both the human
ideal and a moral imperative.

Existential analysts, much like religious pastors, were to be "doctors of the
soul" (1986 [1946], xv). But Frankl makes it clear that logotherapy is not meant
to compete with or replace religion. Religious involvement, he asserts, can be
psychologically very helpful to believers; indeed many of the principles of
logotherapy seem to derive from systems of religious belief. The task of
logotherapy is simply to educate patients toward responsibility and self-

totality, without any religious connotation. The Church, in contrast, would insist that while an
orientation toward the transcendent is indeed a fundamental human trait, such spirituality is not to
be individualistic but must be formed under the direction of organized religion. This relates to the
second issue. Namely, Frankl posits his methods as value-neutral and non-directive.
Logotherapy is meant to encourage the patient to find meaning, but does not tell him or her what
that meaning should be or where it should be found. Catholic psychologists, on the other hand,
reject non-directive therapy, insisting that, because neurosis is typically rooted in problems of
moral formation, therapy cannot be value-neutral but should guide the patient toward a particular
moral reformation (Van der Veldt and Odenwald 1952).
actualization by helping them to transcend their subjectivity and reestablish a realistic perspective. That is, the therapist must help the patient see the world beyond himself or herself. Although logotherapy is not advocated explicitly by Church officials for the treatment of mental disorders like depression, the foundational principles of Frankl's existential approach are broadly cited within the hierarchy.

Particularly salient with regard to depression is Frankl's insight on the meaningfulness of suffering. Existential psychiatry posits that in every negative experience there is an opportunity and a challenge – a chance for meaning-making, if the person only chooses (xiv).¹³ Frankl believed this realization is especially useful to those who are prone to despair. Suffering and death, he explains, are normal and universal aspects of human life – what Catholic theology describes as the dialectical mystery of life and death, joy and pain – and the melancholic response is "nothing less than a mode of human existence" (201). This formulation lends strong support to the contemporary Catholic judgment of depression as a rejection of suffering: to reject the opportunity for meaning-making and spiritual growth in depression is tantamount to the rejection of life itself (DH 32, 37, 92-93, 97, 128).

Another point of commonality between existential psychiatry and 20th century Catholic interpretations of depression is the belief that modern neurosis

¹³ As a Catholic parallel to Frankl’s experience of the meaning of suffering and the exercise of responsibility the Church looks to St. Maximilian Kolbe, a Catholic priest who died in Auschwitz by exchanging his life for the life of another prisoner. The 2003 Vatican conference on depression cites Kolbe’s example to reiterate that the saint’s self-selected martyrdom was not the embracing of death but the exercise and ideal embodiment of an ethic of responsibility toward life. Maximilian Kolbe is now the patron saint of the pro-life movement (DH 94).
is the result of a society-wide crisis of meaning and morality. Following Frankl's formulation, the Vatican conference works with a tripartite etiological typology of depressive neurosis: the endogenous type, the exogenous or reactive type (Frankl's psychotic type), an the existential type, which Frankl calls "noögenic" neurosis. According to Frankl, existential depression is fundamentally an anxious condition that arises within the "existential vacuum," the mass nihilistic neurosis that constitutes modern life. Manifested in feelings of insufficiency, burdensome guilt, hopelessness about the future and nihilism toward the present, existential depression results from a crisis of conscience, as Fulton J. Sheen has described, or from a crisis of meaning stemming from the conditions of modern culture (Frankl 2006 [1946], 101). That modern depression, regardless of its precise etiology, always involves some level of existential crisis, is a consistent perspective of Catholic thought. Indeed it was the rallying cry of the PCHPC conference on depression. Because depression is essentially a matter of the spiritual, human dimension, both Frankl and Catholic experts agree that the person most adept at diagnosing existential depression and prescribing treatment is the spiritual expert or logotherapist. Freudian psychoanalysis, it is reiterated, can be of no help to the depressed if it does not transcend the influence of contemporary nihilistic philosophy; instead of a potential cure it remains just another symptom of mass neurosis (Frankl 1986 [1946], DH 45-50, 70, 133).

In Catholic discourse the connection between moral crisis and modern neurosis appears not only with regard to depression; it is reflected in the
Church’s definition of other moral conditions as psychologically harmful and abnormal. Alcoholism, masturbation, homosexuality, frigidity, impotence and more recently divorce and abortion are all conditions that have merited concern among Catholic psychologists and psychiatrists throughout the 20th century (Abata 1976; CE 1910, s.v. “Mental Pathology”; Van der Veldt and Odenwald 1952; DH 32-33, 35, 58-61, 64, 148). This is not to say that only Catholics define these behaviors as both morally problematic and psychologically abnormal or unnatural. Rather, Catholic religious and lay-persons found in certain psychiatric theories and categories support for traditional Catholic moral positions, at least for a time. The American Psychiatric Association included homosexuality, for example, as a category of mental disorder in the Diagnostic and Statistical Manual of Mental Disorders until 1973. From the 1950s to today certain categories of immorality cum mental disorder were posed not just as discrete conditions of abnormality, but were associated with the risk of depression and nervous disorder. Even as the status of these conditions shifted between the moral and the medical, etiologically speaking, depression was and is recognized both as a discrete neurosis and as a symptom of human weakness manifest in moral-mental disorder.

Somewhat ironically, while Catholics categorically rejected the Freudian theory that the sex drive is the root of neurosis, sexual deviancies and marital problems (especially issues traced to the cycles of female biology) were and are frequently identified as morally problematic and mentally unhealthy, and hence subject to pastoral/therapeutic interventions (Sheen 1949; Van der Veldt and
Odenwald 1952). Like the Victorians of Foucault’s *History of Sexuality, Volume One*, the Church’s treatment of mental disorder betrays an obsession with sex, especially in terms of female sexuality, which in turn has direct implications for the exercise of biopower. The gendering of depression and melancholia has been identified as a misogynistic trend with deep historical roots in and beyond the Christian tradition (Kristeva 1989; Radden 2000; Rubin 1994; Schiesari 1992). Today the identification of depressive states with female biology and personality continues to receive reification through medicalization and demographic study. Contemporary Catholic psych-experts draw on medical, social scientific and historical data to support the contention that women are more vulnerable to depression on account of certain gender-specific social vulnerabilities and personality structures, including weaker sexual self-control (*DH* 29, 57-61, 73, 99). It is suggested that certain types of behaviors and communication styles more common to women, specifically hostility and anxiety, are more likely to lead to emotional alienation and conflict in marriage, another factor in the emergence of depression (*DH* 57). Reasserting a mid-century diagnosis (Sheen 1959; Van der Veldt 1952), the PCHPC maintains that women who reject life and flout natural law by not having many or any children, by rejecting motherhood in favor of a career, or worst of all by aborting a child, are particularly susceptible to depression (*DH* 35, 64-65, 70-71, 127-128, 148). In explicit association with abortion, depression becomes assumed into the Catholic discourse of the “culture of death,” of which women in particular are the victims and embodiment (*DH* 6, 14, 33, 35, 37, 69, 92-93, 96, 98, 100).
In studying the Church's accommodation of medical psychiatry, one frequently encounters Catholic discourse on depression as a tangential issue within discussions of other abnormal mental, emotional or moral states. Among these is a unique spiritual-psychiatric condition involving depressive states that lends particularly well to our analysis of consistencies and shifts in Catholic rhetoric with relation to the moral and medical significance of mental illness. Scrupulosity or scruples is an anxious condition characterized by an obsessive concern with sin (real, but most often imagined) and a compulsion to confess. Religious experts argue that scruples — a type of religious culture-bound syndrome\(^\text{14}\) — only can be experienced and understood by those who profess a belief in the doctrine of sin. Fundamentalist Christians, Orthodox Jews and ritualistic Catholics are particularly prone to this disordered spiritual condition. Many of the medieval saints discussed in the previous section are said to have suffered scruples along with melancholic states (CE 1910 s.v. "Mental Pathology"; Casey 1948; Ciarrocchi 1995; Gearon 1925; Santa 1999). Similar to the phenomenological descriptions of depression, the exaggerated and plaguing guilt of scrupulosity is often experienced in symptoms of anxiety and depression, and the sufferer is said to be in a state of delusional hyper-subjectivity.

Catholic psycho-moral analyses typically identify scrupulous persons as psychologically and spiritually immature, their heightened anxiety over sin possibly the result of poor moral instruction that left them unable to distinguish

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\(^{14}\) "Culture-bound syndrome" is a category used by medical anthropologists to describe "modalities of illness and suffering peculiar to specific culture milieus and [constituted] of the specific meanings, tensions, and ambiguities conveyed to persons by symbolic cues and articulated through the work of culture" (Rubin 1994, 10). Ciarrocchi uses a very similar description in his book on scrupulosity (1995, 8-9).
clearly between what counts as sin and what does not (Van der Veldt and Odenwald 1952, 333). Distinct from a “delicate conscience,” which is actually a desirable quality for good Catholics to have, scrupulosity represents a break with reality. But the anxious guilt and hopeless despair of scrupulosity also can derive from real sins committed in the past about which the person still obsesses (Abata 1976). The issue is not so much whether the sin is objectively real or not, but rather the sufferer’s exaggerated response to the perception of personal sin.

Pre-WWII literature acknowledges that scrupulosity can have a biological basis, frequently discussed in terms of “delicate” or “anxious” constitution, physical illness, lack of sleep or even “inordinate study.” In pastoral guides scrupulosity is listed as a neurosis alongside neurasthenia, psychasthenia, and hysteria, conditions that require treatment by a “nerve specialist” (Casey 1948; Gearon 1925; Van der Veldt 1952). Opinions differ as to whether the nerve trouble associated with scrupulosity is a cause or an effect of the condition. In either case, the mental and physical suffering of the scrupulous person is real and necessitates spiritual, psychological and physical treatments to affect a cure.

Whatever the root cause, because the condition inhibits the scrupulous person from forgiving himself or herself, or from finding consolation and absolution in the Sacrament of Confession, scrupulosity is stigmatized as both a psychological disorder and a potentially sinful state. “As a rule, the scrupulous

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15 Coined in the late 19th century by American neurologist George M. Beard, “neurasthenia” refers to a minor psychiatric illness characterized by “weak nerves.” The diagnosis of neurasthenia encompassed depression, as well as anxiety disorders, hysteria and stress-related psychophysiological reactions to the “pressures” of modern civilization. By the mid-20th century neurasthenia had been largely replaced in contemporary Euro-American diagnostic systems by new terms for those separate categories of mental illness, including clinical depression (Kleinman 1986, 14-16; Shorter 1997, 129-130).
suffer from weakness of will" (Gearon 1925, 74). In a state of anxiety and
depression, the scrupulous person suffers great mental anguish that is a burden
to that individual and to others. But despite this evaluation, writers on
scrupulosity argue that it is a true malady. Sufferers deserve not condemnation,
but protection, empathy and compassion. Pre-Vatican II texts on the subject
were never directed at the sufferers themselves – in some cases scrupulous
persons were explicitly discouraged from reading such books (Casey 1948;
Gearon 1925) – but were meant as guides for the pastoral caretaker. The
reason for this has to do with the method by which scruples could be cured,
namely through blind, child-like, unquestioning obedience to one’s confessor.
Given the religious nature of the condition, a person could only overcome
scrupulosity by submitting to the directives of a religious authority, thus the priest
alone was qualified to deal with scruples (Casey 1948; Gearon 1925; Van der
Veldt and Odenwald 1952).

As psychiatric diagnostic manuals were refined and expanded in the
second half of the century, the compulsive nervous condition thought to underlie
some forms of scrupulosity was identified as the new diagnostic category of
Obsessive-Compulsive Disorder. In situating scrupulosity as a particular iteration
of OCD, Catholic observers took care to clarify that religion is not the cause of
scrupulosity, but rather the context or content of the disorder (Ciarrocchi 1995).
The identification of scrupulosity with actual material sin did not wane with the
explicit medicalization of OCD however; post-Vatican II books on the topic still
trace the condition to poor moral decisions, especially sexual sin (Abata 1976,
Ciarrocchi 1995). One significant shift was a change in the intended audience for Catholic books on scruples. Where pre-Vatican II texts were meant as guides for spiritual directors, late 20th century Catholic books on scrupulosity were directed at the sufferers themselves. This shift was in part incited by an ethical concern over the rights of patients regarding disclosure about their condition. Ciarrocchi even notes that pre-Vatican II texts had a certain paternalistic tone (1995, 12). What is more significant is that a disorder thought only to be treatable through blind obedience to a religious authority, perhaps by way of a tighter association with an identifiable psychiatric condition had entered the realm of popular self-help literature. Still, when it comes to practices of metanoia, there is no such thing as Catholic self-help; authoritative spiritual mediation is always required. In the case of scruples the prescription of obedience to a confessor remains the standard recommendation, but instead of obeying the authority of a priest, the scrupulous person is admonished to obey the authority of a book (Abata 1976).

Depression and scrupulosity both occupy a medical-moral middle ground that defies quick or confident categorization by pastors or psychiatrists. As such, those responsible for treating the two conditions are exhorted to approach each case as individual and distinct. Both scruples and depression have been linked to clinical conditions, yet spiritual explanations and antidotes are never discarded as outmoded or irrelevant. Rather, it is maintained that moral or existential crisis is an intrinsic aspect of these conditions, be it etiological or experiential. As with depression, religious interpretations and suggestions for the treatment of scruples are legitimated to the scientific worldview through historical connections.
that show modern theories and methods to have derived from Catholic religious
tradition (Casey 1948; Chiarrocchi 1995, Santa 1999). As the field of psychiatry
passed through the dominance of psychoanalysis into a second wave of bio-
medical theory, Catholic pastors and psychiatrists were challenged more and
more to maintain that authoritative stake in the moral signification and spiritual
treatment of disordered mental states like depression and anxiety. So we arrive
once again at the first of two central questions posed by this study: How does the
Catholic Church today strategically apply the principle of accommodation to
construct a discourse on depression that is both scientifically and theologically
valid, so as to maintain and extend its legitimacy in defining and treating
problems of moral-mental health from the point of view of Christian humanism?

Clerics and psychiatrists alike recognize that it is not possible to pinpoint
the precise extent to which a person's faculties of will and self-control are
inhibited in states of neurosis and psychosis. It is not even a matter of threshold,
but of a spectrum of severity ranging from mild to severe, whereby milder
disorder corresponds with greater moral responsibility. But as the second wave
of medical psychiatry began to emerge in the late 1960s, accelerating
significantly through the 1990s into the 21st century, the mental illness-morbidity
matrix experienced a major realignment. While it was never denied that some
forms of depression have a biological basis, the medicalization of depression
became intensified through neurological and pharmaceutical research. The
DSM-III released in 1980 revealed a clear shift away from the psychodynamic
viewpoint toward a biomedical model. Carrying on the Kraepelinian tradition,
psychiatry maintained a focus on observed symptomatic diagnosis over theoretical etiology. But with breakthroughs in genetic research, brain imagining technology and psychopharmacology, psychiatrists began to propose a clearer distinction between normal and abnormal.

Whereas the Church contended successfully with psychoanalysis on the philosophical plane, in the second half of the 20th century it would prove increasingly difficult to assert a moral view of depression in the face of the growing dominance of neurobiology. To deal with this new scientific psychiatry, Vatican discourse employs several rhetorical and logical methods for maintaining a space of ecclesial authority to speak on the subject. The philosophical thrust of earlier discussions is never abandoned. Rather, to the Thomistic humanism are added arguments formulated in the language of science tailored to accommodate agreeable data and downplay or discredit amoral psychiatric perspectives. Despite the popular turn to biologicist models, Church officials still refer to the foremost classic and contemporary psychodynamic theories of depression for the definition of the nature and source of the condition as well as for certain treatment proposals. Despite the condemnation of classic Freudian psychoanalysis as “depressive science,” accommodation allows that certain aspects of Freudian theory, such as the ego-id-superego components of the unconscious, be incorporated in so far as they lend to the understanding of psychodynamics and do not conflict with Catholic humanism (DH 37, 69, 91-94). A more congenial position is Melanie Klein’s theory of depression as a normal position toward a lost love-object. This theory supports discussions of reactive or
existential depression as an issue of maladjustment to change and stress. It also resonates with assertions of the significance of the Sacrament of Confession as a mode of reparation that makes depressive absence into integrative presence (DH 36, 38, 94). D.W. Winnicott, a mediator between the Freudian and Kleinian schools of psychoanalysis, offers a salient perspective in terms of the interaction between moral behavior and mental health in depression. According to his theory, transgression (sin) feeds guilt, a key aspect of depression, but if the depressed person pursues forgiveness and reparation, then depression can become a positive, redemptive experience (DH 40). Cognitive models of depression like those of Aaron Beck and Hagop Akiskal likewise act as a counterpoint to Freudian psychoanalysis, lending support to Catholic prescriptions of confession and conversion for the healing of depression. Both Beck and Akiskal focus on transforming or reframing the distorted, negative perceptions of reality characteristic of depression in order to effect more "real," "suitable" behavior (DH 27-28, 49, 59-63, 65).

While psychodynamic and cognitive theories may be split open to make room for the soul, the inclusion of biological models of depression is a more precarious proposal. The philosophical threats of materialism and reductionism are posed by psychodynamic and neurological theory alike, but the visibility of brain images and genetic codes makes it difficult for the Church to offer philosophical and theological alternatives to the amoral medical gaze (Foucault 1973). As we saw in the last chapter, while these new theories are not ignored or rejected outright in Catholic discourse, efforts are made to prevent the
medicalization of “problems of existence” (DH 33). Along with the implication of the illegitimacy, or at least incompleteness, of biomedical data, the retention of a tripartite model of depression as endogenous, reactive or existential serves to open a discursive space for the extension of moral and cultural etiologies and associated philosophical and spiritual interventions. Depression as a reactive condition implies both triggering environmental factors and unstable or weakened interior states formed in response to or as a result of those external factors.

This is the integrative perspective of existential psychiatry, humanistic psychology, and social psychiatry, subfields from which Catholic discourse derives substantial scientific support for its moral claims about the moral-social etiology of depression. While the perspectives of Freudian psychoanalysis and strictly biological psychiatry are indicted for their anti-humanism, existential psychiatry and social psychiatry are said to offer a “real,” “authentic ecological approach to man and his health” (DH 32-37 49-50, 56-63, 70, 133). Resonance between these sub-disciplines and Christian humanism is found in a common holistic understanding of the human person as a complex bio-psycho-social-spiritual being, and of depression, in turn, as an irreducibly complex bio-psycho-social-spiritual phenomenon. Existential psychologist Viktor Frankl once noted that, “Western humanity has turned from the priest to the doctor” (1986 [1946], xv). While the Church has been steadily losing ground to the psych-disciplines when dealing with problems and questions of life, these integrative approaches promise to mitigate that antagonism, simultaneously protecting the autonomy and
emphasizing the irreplaceable importance of both the psychiatric and the pastoral understandings of and interventions for depression (*DH 50*).

Besides sharing a holistic view of the human person, social psychiatry and existential psychiatry also support Catholic discourse on depression through the construction of contemporary secular culture as a contagion of depression. Social psychiatry emerged as a formal discipline in the 1920s, though it has its deepest roots in the Enlightenment thought of Benjamin Rush (Rosen 1968). The discipline underwent a renaissance in the 1960s, coincidentally around the time of Vatican II (Shorter 1997). Drawing from the sociological theory of Gustave LeBon, Emil Durkheim and Herbert Spencer, social psychiatry is based on a hypothesis of the social origins of mental illness. The goal of social psychiatry is to calculate the causal influences of various social factors – ethnicity, gender, social class, certain life events, religious affiliation – that affect the vulnerability to conditions such as depression within certain social groups (Brown and Harris 1978). Closely related to ethnopsychiatry and trans-cultural psychiatry (Kleinman 1986), social psychiatry seeks “to understand the dynamics within an overall context within which a given psychopathological phenomenon arises and takes on relevance with all its biological and/or psychological determinants” (*DH 50*).

The enduring prevalence of Frankl’s existential psychiatry in contemporary Catholic discourse on depression has already been mentioned. His voice echoes through Catholic exhortations to psychiatrists to return to a humanistic foundation in philosophical anthropology. Further, his social diagnosis of the
"existential vacuum" as the source of noögenic neuroses like depression is a precise mirror of the Church’s indictment of modern Euro-American culture. Frankl’s prescriptions to find meaning in relationships, work and suffering likewise reflect the antidotal wisdom put forth by Church representatives. Suffering is an inevitable, normal aspect of the mystery of life. But today’s culture encourages people to shirk from suffering, weakening our tolerance for existential pain in the process. Unable to make suffering meaningful, modern individuals fall more easily into depression (DH 96). Among Frankl’s secular theoretical inheritors, Martin E. Seligman, Abraham Maslow, and William S. Sahakian, are assembled to support the argument that depression is a problem of adjustment and stunted personal development.

Though Frankl’s methods were decidedly non-directive, he notes that religion offers people a ready set of meaning – a sense of mission – that strengthens the personality against depression. Today Catholic discourse draws from a large, well-established canon of interdisciplinary, even dissident psychological literature that explicitly combines theology and psychology for therapeutic purposes.\(^\text{16}\) In contrast to secular psychological models, this literature emphasizes the relevance of religion for the understanding and therapy of depression and the positive impact of religious involvement for the preservation of mental health.\(^\text{17}\) Psychological and sociological studies of the

\(^{16}\) The International Journal for the Psychology of Religion, the Journal for Scientific Study of Religion; the Journal of Religion and Health, the Journal of Psychology and Theology, and Counseling and Values are among the many such journals selected for citation at the conference.

\(^{17}\) Within this literature, including some of the texts cited by conference participants, there are also studies of the negative effects of religion on mental health (Koenig, McCullough and Larson 2001, for instance). But aside from the detrimental effect of social labeling – a problem not limited to
positive impact of organized religion and communal spirituality on personal
development and mental health – especially the prevention of suicide and the
relief of the mental anguish of depression, if not also the biological symptoms –
serve as a prominent and powerful means of resisting the conversion of crises of
the spiritual dimension into an exclusively medical concern (DH 17, 20, 44, 64,
73-79, 99).

The base assumption that society affects the individual psyche, positively
but especially negatively, is the driving force behind the Catholic construction of
postmodern culture as a pathogen of depressing immorality and unbelief. To
substantiate the moral epistemology of the “depressed society,” the hierarchy not
only mobilizes existing scientific data and discourse; it also produces its own.
For the 2003 Vatican conference the Pontifical Council for Health Pastoral Care
commissioned a sociological survey “to verify whether certain psycho-social
factors that can favor [the manifestation of depression]…are also the expression
of the crisis of cultural and religious values of contemporary societies” (DH 73).

The respondents to the survey were not sociologists, psychologists or sufferers
themselves, but a set of high-ranking religious authorities asked about their
opinions and experience with depressed persons. Posed in the language of
social science, the survey quantifies the hierarchy’s opinions about the nature of
depression and the moral-social factors that influence its onset. In so doing, it
lends to the impression of scientific validity of proposals for a moral solution to an
existential/health problem. By employing discursive forms that carry the air of

the religious sphere – research on negative aspects of religion is all but excluded from the
Vatican discussion.
empiricism and objectivity, the Church's philosophical and theological perspective of depression assumes the quality of legitimate scientific knowledge.

**Metanoia as Therapy**

Once triggered, she couldn't make it stop. Twenty-one years old and she found herself, having fled from the dinner table, cowering behind her bed, pathetically whimpering, actually hiding from her confounded family. When she was younger her parents would tell her to stop playing the 'martyr role.' This time when they found her their tone reflected concern, but the accusation became direr. 'You can't let yourself be so unhappy,' her mother told her over and over, often amid her own sobs. 'You will fall into the sin of despair. No one will believe you are a Christian if you are so sad all the time.' Her father was less direct. He bought her a book, Dealing with Scruples, published in 1948 by Fr. Dermot Casey. Five years later she finally took it out of the plastic and read: 'If you are a person troubled with scruples, this book is not for you.... What you need is not a book but a good confessor to whom you will confess regularly and whose directions you must obey with absolute and childlike simplicity.'

The final section of this chapter will address the second key question posed by this thesis: What are the implications of institutional Catholic discourse on depression for the operation of ecclesial power through the practice of Catholic subject-formation? The key to this question, we believe, is the dual significance of *metanoia* – repentance and conversion – both as a mode of therapy for depression and as a crucial aspect of Catholic governmentality.

Neither of these effects of *metanoia* should be understood as the purpose of conversion (Faubion 2003, 151; *DH* 142). Yet we argue that through the prescription of Catholic technologies of the self, the Sacrament of Confession foremost among them, depression becomes a discursive and practical space of Catholic pastoral power/knowledge.

Conversion is one of the most important technologies of the self in the West, especially with respect to Christianity but also with respect to the notion of
morality in general (Foucault 2005, 208). Foucault identifies metanoia as one of at least three concepts of conversion originating in the first three centuries CE. Each involves a different process and telos, and thus should not be conflated. Of these three modes of subject-formation, metanoia is the form specific to the Christian tradition. Its central notion is not conversion, per se, but regret and repentance. Building off of Greco-Roman and Platonic precedents, the concept and practice of metanoia was developed formally in the 3rd and 4th centuries by early Christian ascetics, most notably St. Athanasius (296-373) and St. John Cassian (360-433), though St. Augustine of Hippo (354-430) is largely credited as the innovator of Christian practices of self-analysis and of psychotherapy as well (Sheen 1949, 91; Van der Veldt and Odenwald 1952, 147; DH 100, 130). In his Confessions St. Augustine establishes the effectiveness of self-knowledge for the purpose of self-transcendence (Sheen 1949, 91). The words of this most famous convert — “you have made us and drawn us to yourself, and our heart is restless until it rests in you” (Confessions Book 1, No. 1) — are taken to show that “True self-knowledge is always God-regarding” (Sheen 1950, 81; Van der Veldt and Odenwald 1952, 195; DH 100). In contrast to pre-Christian ideas of conversion, metanoia involves a radical and sudden change of thought and behavior representing a break with the old self and the birth of a new one. Self-reflection, confession, obedient submission to the advice of spiritual directors, and ultimately self-renunciation are required to effect this “transition from one type of being to another, from death to life, from mortality to immortality, from
darkness to light, from the reign of the devil to that of God…” (Foucault 1994a, 195; 2005, 211-216).

Several standard modes of the practice of metanoia evolved over the course of Christian history. These include the examination of conscience, spiritual exercises like those of St. Ignatius Loyola, regular spiritual direction, and of course the Sacrament of Confession. Frequently accompanying these formal practices were prescriptions for the exercise of physical, mental and spiritual self-discipline in the everyday. Originally this collection of practices was meant only for ascetics, but in 1215 the Fourth Lateran Council expanded their scope to the general community by making yearly confession an obligation of all Christians (Foucault 1990, 116; 1994a, 195). According to confessional manuals like that of St. Alfonso de' Liguori (1696-1787), Catholics were required to follow meticulous rules of self-examination (19-20, 116). As a defense against the Protestant Reformation, the Council of Trent (1545-1563) further broadened the scope of the sacrament in order to accelerate the rates of confession in Catholic countries. Through the codification and expansion of the Sacrament of Confession, confession became one of the main rituals of truth in Western society (Foucault 1990, 58).

Early in its history metanoia and other practices of self-cultivation were recognized for their curative and therapeutic effects (Foucault 1994b, 97). With respect to the sin of sloth and states of melancholia or depression, certain exercises and rituals were recommended. In the early Church, spiritual weapons prescribed against acedia included insistent prayer, Biblical reading, the
recitation of psalms, weeping, and even the contemplation of death, for this was supposed turn attention to the heavenly reward that awaits the faithful ascetic (Wenzel 1967, 9). Above all other remedies, the Sacrament of Confession was proposed as the best treatment for acedia. Medieval mystics and spiritual writers likewise recommended methods of metanoia as the right practice for dealing with the sin of sloth as well as for navigating the path of spiritual darkness that leads to spiritual perfection and mystical union. We see in both Meissner’s (1999) Dubay’s (1989) accounts that when dealing with a melancholic ascetic in the depths of a “dark night,” confession and spiritual direction, especially in the early stages, are pivotal to the successful resolution of the spiritual crisis. Like the sin of sloth, the “dark night of the soul” refers to one’s relationship with God. But unlike the spiritual aridity of saints, sloth is not a mystical participation in Jesus suffering, but a negative, even self-inflicted response to a sense of God’s absence. In contrast to both sloth and spiritual darkness, modern depression is understood as a disorder of one’s relationship to oneself, that is, a narcissistic disorder (DH 19). Yet despite their theological and psychological differences, what links all three conditions was and is the prescription of spiritual self-work.

Along with Augustine’s Confessions, the Spiritual Exercises of St. Ignatius Loyola is a Christian exemplar of therapeutic self-truth telling that has informed the premises of psychoanalysis and modern behavior therapy (Ciarrocchi 1995, 40; DH 19, 130). Spiritual practice and confession in the tradition of Christian mysticism serve to purify the mind of “disordered inclinations,” effecting a “positive orientation toward higher values” (DH 19). This method of conversion
as self-transcendence promises "real interior freedom" and "deep mental
security," both of which have psychotherapeutic effects for the prevention and
relief of depression (DH 20). In the same vein, Protestant philosopher,
psychologist and theologian, William James (1842-1910), asserted that more
depressed people are cured by religious conversion than by medication, a truth
which, despite advances in bio-medical psychiatry, must still hold today,
according to the Catholic hierarchy (DH 41). Throughout the 20th century
Catholic literature on depression and other mental illness reiterates the
advantages of God-centered self-knowledge for the preservation and
improvement of mental health. Particularly in terms of the moral basis of
depression, confession is said to have a curative, cathartic effect (Abata 1976;
Sheen 1950, 23; Van der Veldt and Odenwald 1952, 202; DH 64, 88, 143, 148-
149). Bishop Fulton J. Sheen explains, "As repression of guilt begets our
unhappiness, so release of it through Confession creates our inner joy" (Sheen
1950, 25). Or as the PCHPC states, "In reality, the origin of joy is the harmony of
a person with himself or herself (and in this sense one can notice a clear
reference to the new idea itself of health!)" (DH 122).

The positive psychological effects of metanoia are personal growth and
the strengthening of interior resources that ease the endurance of hardship (DH
19, 102). As for the therapeutic side-effects for depression, these amount to the
relief of guilt, the diminishment of loneliness, isolation and fear, and the
evaporation of moodiness, all through the dismantling of egotism (Sheen 1950,
80, 85). The re-centering of values and the promised and actual change in moral
behavior that constitute *metanoia* grant certitude, security, and an overall sense of truth, which relieve the existential anxiety said to underlie depression (Sheen 1949, 274-277, 288; Van der Veldt and Odenwald 1952, 203). Regular confession in particular, “prevents our sins, our worries, our fears, our anxieties from seeping into the unconscious and degenerating into melancholy, psychoses, and neuroses” (Sheen 1949, 146). Still today it is the hierarchy’s opinion that “The first step in pastoral care can only be the step of drawing the depressed person to reconciliation, that is to say the sacrament of penitence,” or confession (*DH* 143).

As we have seen, Catholic authorities point to the similarities between the practices and therapeutic effects of *metanoia* and those of psychotherapy (Ciarrocchi 1995, 40; Sheen 1949, 91; Van der Veldt 1952, 147, 205; *DH* 19, 100, 130). At the same time they insist that psychotherapy cannot equal Christian conversion – of the two, *metanoia* is the superior cure (Sheen 1950 79-80; Van der Veldt and Odenwald 1952, 202; *DH* 14, 32, 35, 56, 63, 85, 90, 101, 125, 127-128). Bishop Fulton J. Sheen was iconic of Church’s position toward psychoanalysis, the dominant method of psychiatry in his time. Throughout his writings the bishop took pains to assert the difference between psychoanalysis and Catholic practices of self-knowledge and conversion (1949, 124-150; 1950, 79-80). First and foremost is the belief that confession was divinely instituted. As such it is a source of grace, an essential aspect of cure that psychotherapy can never provide (1949, 126). Today, as we have seen in the example of the PCHPC conference on depression, the relationship between the Catholic
hierarchy and the discipline of psychiatry is not so openly antagonistic. But despite the instances and appearances of complicity, Catholic experts maintain the assertion that psychiatry is acceptable in its practicality, but not in its philosophy. *Metanoia* as the superior therapy is still defended on the grounds of grace and the Catholic humanist belief in the transcendental nature of the human being. Not to mention, the perpetual process of conversion that characterizes Christian life is said to reach the root of the problem of depression, namely moral corruption or uncertainty; psychotherapy is presented as relatively superficial and ineffective in contrast. For therapy to be truly effective, it is argued, it must always be psychagogic or morally directive (Van der Veldt and Odenwald 1952, 205).

*Metanoia* as therapy operates not only through practices of self-knowledge, but also through the discipline of the will and the body. “After one has discovered the basic defect of the character through self-knowledge, the next step is to put that knowledge into practice by self-discipline,” explains Fulton J. Sheen. “Self-knowledge is diagnosis of the disease; self-discipline is the operation by which the malady is cured” (1950, 103). Drawing on the authority of St. Paul, St. John Cassian prescribed manual labor along with the usual solitary prayerful rigors (Wenzel 1967, 9). In the Middle Ages, St. Ignatius’s counterpart, St. Teresa of Avila, recommended not only spiritual exercises on the part of the melancholic, but also firm treatment for mild cases of melancholia in which the sufferer retains some self-control. Unlike the severe cases in which “darkened” reason counts as illness and therefore merits compassion, those with self-control
must be forced to control themselves as a means toward a cure (Radden 2000). Not just the will, but the body must be disciplined as well. Prescriptions of physical exercise and dietary restrictions as accompaniments to various spiritual and mental disciplines have carried into mid-20th century Catholic discourse on neuroses like depression and scruples (Abata 1976; Casey 1948; Gearon 1925).

The related practices of self-knowledge and self-discipline are always to be undertaken under the constant guidance of and faithful obedience to a representative of moral order (Foucault 1994a, 195). For Catholics this means obedience to the Church and to the priest as the representative of Christ on earth. In the Catholic tradition only the priest can bring true comfort and relief, for he alone has the authority to hear confession, advise penance and confer absolution (Casey 1948, 17; Sheen 1949; 131). His advice must be followed with complete, blind, childlike obedience, submission and cooperation (Casey 1948, 8; Gearon 1925, 63). But for the guidance to be effective, spiritually and therapeutically, this obedience must be freely given; the sufferer cannot be forced to obey (Casey 1948, 48; Van der Veldt and Odenwald 1952, 340). As it is stated in the Catechism, for conversion to be authentic, lasting and coincidentally therapeutic one must “entrust oneself [and] submit freely to the word that has been heard, because its truth is guaranteed by God, who is Truth itself” (CCC 144). Only through “total and trusting adherence to the person of Christ and the mystery of his salvation” can a person realize the truth of self and of Christian values (DH 124). This aspect of metanoia is significant for the exercise of pastoral power, for freedom, as we recall, is a prerequisite for any
form of governmentality; power can only be exercised over subjects insofar as they are free (Foucault 2000b, 341-2).

Further justifying the Church’s insistence that spiritual direction is an “indispensable” accompaniment to other treatments is the psychological diagnosis that a depressed person is not in touch with reality. Though the exact threshold is hard to pinpoint, with respect to depression, the difference between normality and abnormality is basically understood a matter of one’s adjustment to reality, that is, a proportionate reaction to the current situation (Casey 1948, 8; Gearon 1925, 21; Van der Veldt and Odenwald 1952, 2; DH 7, 16-17, 39, 41, 62, 69, 71, 73, 87, 89, 92-94, 96, 101-103, 126-127, 131, 142-144). The distorted, hyper-subjectivity said to characterize depression means that the sufferer is incapable of discovering truth or achieving self-transcendence through isolated self-analysis alone. Depression traps a person in an introspective abyss of nihilism, pessimism and baseless self-accusation. But if, through guidance and grace, that drive to introspection can be positively refocused onto self-transformation, then depression becomes a purifying trial.

The healing of depressed subjectivity through guided self-reflection is essentially a process of reframing the experience of suffering as meaningful. Catholic practices of metanoia instigate a conversion of perspective and behavior that is in closer alignment with the Christian vision of reality and morality. By expressing sincere care, creating a welcoming environment, fostering an active prayer life, and encouraging participation in the sacraments, spiritual direction helps to counteract depressive negativism and return the sufferer to an optimistic
Christian reality couched in the mysterious paradox of evil and good, life and death, joy and suffering (DH 144). In this way existential suffering, though "extraneous to the paths of God," may be an occasion for discovering new aspects of oneself and of God (DH 7-8, 41, 86, 145). Like the parable of the Prodigal Son, depression can be a path to joyful reacceptance, rebirth and redemption (DH 38, 40, 98).

Through the practices of metanoia the depressed Catholic subject is brought to encounter the fundamental reality of sin. Depression, suggests Fulton J. Sheen, comes "not from having faults, but from the refusal to face them...The greatest worries come from our failure to face reality" (Sheen 1949, 113). Mid-20th century Catholic psychiatrists and contemporary Vatican observers agree that, "The fear of sin and of its consequences is, when properly taught, a wholesome sentiment" (Van der Veldt and Odenwald 1952, 205; DH 93, 129). A sense of responsibility to others, to God and to oneself is the foundation of a meaningful, inter-subjective moral reality. It is the loss of this sense of sin and responsibility that causes a person to fall into depression. The restoration of moral sensitivity through the examination of conscience and the Sacrament of Confession is thus proposed as the key to the prevention and treatment of depression.

But metanoia operates well beyond the confessional; it extends into general parish pastoral care and the arenas of pedagogy in which self-discipline and morality are taught. Moral education, including sex education, is consistently emphasized as a preventive and curative measure for dealing with depression.
(Van der Veldt and Odenwald 1952, 205-206; Abata 1976 65-74; DH 69, 126-
132, 141). Furthermore, the therapeutic restoration of moral sensibility is not just
a matter of individual subject-formation; the ultimate cure for depression involves
the broad "evangelization of culture" and large-scale "cultural therapy" (DH 61,
98). This idea of cultural evangelization is a key aspect of the Catholic Church’s
response to modernity in general. In the 1950s the chaos of war was blamed for
the malaise of society. At that time there emerged within that social environment
a new model of religion with relation to culture. Described in H. Richard
Niebuhr’s Christ and Culture (1951), this model of Christianity would be less
concerned about religious boundary-maintenance and more concerned with
helping believers fit in to the wider culture. From then on the duty of Christianity
would be, “to lead, shape, and finally convert human culture along the lines laid
out by the institutional church,” instantiating obedience at the individual and the
social level (Massa 1999, 99).

Today depression is a platform for the proposal of the need for a society-
wide conversion to Christian morality. To resuscitate the “depressed society,”
the PCHPC argues for a “great return to morality, promoted in an explicit way”
and led by the Church, especially in Europe and North America (DH 135). We
argue that the Catholic Church’s construction of depression as a medical risk
posed by postmodern culture is a specifically bio-political operation of Foucault’s
concept of power/knowledge, discussed in later writings as governmentality.
Governmentality, as we recall, is a matter of the intersection between techniques
of knowledge and strategies of power operating within and between technologies
of the self and technologies of domination (Foucault 1990, 98; 1994d, 225).

*Metanoia*, the quintessential Christian technology of the self, is therefore always embedded in relations of power. In touting the therapeutic effects of this type of conversion for depression, Catholic officials accommodate, appropriate and reconstruct scientific knowledge of depression as a mental illness with deep social and moral foundations. But depression is just one discursive plane within a much wider counter-cultural discourse of a Church in crisis. In its very problematization by the Catholic hierarchy, depression becomes an object of relations of power (Foucault 1990, 98). By constructing depression as an ascendant health risk posed by postmodern culture, and by recommending Christianity as its cure, the hierarchy seeks to solidify its stake in subject-formation in Euro-American society, thereby reestablishing Catholic ecclesial power. Though these measures are not the final cause of Catholic governmentality, the hierarchy’s problematization of depression is certainly an operation of Catholic power/knowledge.
IV. Concluding Proposals: From History to the Emergent

We have followed Catholic discourse on depression from its pre-Christian roots to contemporary formulations at the top level of the hierarchy. It is a discourse replete with compassion and stigma, a dichotomous discourse comprised of injunctions to joy and meaning, and the recognition of real, meaningful suffering. We have witnessed Catholic rhetorical strategies for preserving the moral meaning of depression against materialist, “anti-humanist” medicalization. It has been argued that depression, as a foil to Catholic humanism, has served the Church as a vehicle for the construction of a society in crisis. In employing selective accommodation to present depression as a health risk spurred by the moral degeneration of postmodern philosophy and culture, the Catholic Church engages in the operation of governmentality. The favored “antidote” of metanoia – of conversion of the modern self and Euro-American society through the recognition and confession of sin, and obedience to the Church – promises a cure for the overlapping crises of individual and social morality, and of Church authority under the conditions of postmodernity.

A genealogy of depression in Catholic discourse has been laid forth, the encompassing thematic of which has been epistemic politics. Should an anthropologist wish to move from a historical account to an analysis of current or emergent manifestations and transformations (Ong and Collier 2005; Rabinow 2003), then the next question would be, how is this discourse transmitted and experienced among Catholics in the everyday? This is a question of how the phenomenology and subjective experience of depression interrelate and become
molded in fields of power/knowledge. The ethnographic impulse toward the question of local understandings is scattered throughout this history of the present in the form of reflective, anonymized personal vignettes. As a conclusion to this thesis, I wish to explore some precedents and possibilities for the ethnographic study of Catholic depression between the levels of local emergence and super-local cultural articulation: a postmodern ethnography of the Church’s struggle with postmodernity as a problem of subject-formation, via the moral and medical construction of abnormal emotion.

The ethnographic project on Catholicism and depression imagined here would be a multi-sited ethnography that studies the refraction of Catholic discourse as it is perpetually rearticulated among and between the various levels of the institutional hierarchy to become stabilized, contested and embodied in the experience of believers (Strathern 2004). Embedded in the world system that is the Catholic Church, it would be a study that moves between local situations and the super-local spaces in which cultural meanings, objects and identities are circulated (Marcus 1998). Among the questions to be posed in such a study are: Is there something common in the way Catholics in a given cultural context experience depression? How is depression employed by sufferers and authorities to define good Catholics from bad ones? What are the new modes of interaction between religious individuals and institutions, and new psychiatric technologies and therapies? How do these knowledges combine in an embodied Catholic experience of depression, at the level of the individual sufferer, in his or her interaction with the faith community, and in organized systems and programs
established to address the problem? What follows are first, a selection of ethnographies that represent methods and perspectives useful for such a study, and second, a discussion of possible ethnographic sites, both discursive and practical, to which our questions may be posed.

**Ethnographic Models**

Ethnographies of religious systems and communities are myriad. Far less common are ethnographies that specifically problematize the intersection of religion and mental health. There are a few exemplars, however. Most prominent among them is Nancy Schepider-Hughes’ *Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland* (1979). Written amid the 1970s flourishing of ethnopsychiatry and psychiatric anthropology, hers is one among several ethnographies that together represent a shift away from social etiology toward a new interpretive emphasis on the subjective and inter-subjective experience, and effects of mental disorder, particularly the experience of and meaning attributed to suffering and the behavior of help-seeking. In *Saints*, Catholic religion is a fundamental factor in the ethnohistory of the Irish communities that were the subject of research. Specifically, Schepider-Hughes draws a connection between the "psychological predispositions" characteristic of "the austere and puritanical cast of Irish Catholicism," and the emergence of the delusional state of schizophrenia (5-6).

A more recent model is Julius Rubin’s study of depression among pietist Christians. His work on the topic begins with a genealogy of religious

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18 See also Brown and Harris 1978; Kleinman 1986; Townsend 1977.
melancholy among early American Puritans not dissimilar to the “dark nights” of Catholic ascetics (1994). That historical research is followed by an ethnography that examines a particular form of spiritual depression within a contemporary evangelical Pietist community known as the Bruderhof (2000). Here Rubin challenges the privileged modernist understanding of mental health, which poses religious experience and expression as mere epiphenomena. Similar to the theoretical analysis of Catholic subjectivity proposed here, Rubin focuses on the effect that the struggle to embody a particular religious ethic has on the emotional states of Pietist religionists.

The issue of religious subject-formation is a crucial aspect of the study of religion and mental health. For this reason Joel Robbins’ *Becoming Sinners: Christianity and Moral Torment in a Papua New Guinea Society* (2004) merits inclusion among the models of ethnography useful for the proposed study. While Robbins does not engage the issue of mental health and illness explicitly, his account of the tension and “torment” involved in assimilating the theology of sin - so important for an understanding of Catholic ideas about the nature of depression and its cure - lends insight into the emotional and mental perils of living an ethic of self-examination and *metanoia*.

The 2003 Vatican conference on depression points to New Religious Movements, especially youth movements and charismatic revivals, as sites for the renewal of religious morality that promises a prevention and cure for modern depression. Thomas Csordas has dedicated two ethnographies to the study of the North American Catholic Charismatic Renewal movement (1994, 1997). With
respect to religious conceptions of and cures for depression, *The Sacred Self: A Cultural Phenomenology of Charismatic Healing* (1994) is particularly salient. Here Csordas focuses specifically on the psychocultural themes of spontaneity, control and intimacy embedded in the beliefs and practices of ritual healing within these Pentecostal communities. Charismatic healing is directed toward the ‘self’; the inner healing of depression involves one’s “deliverance [from evil spirits] that constitutes a specific kind of emotional self process” effected through imagination, memory, language and emotion, and aimed at the reinstatement of a sense of control and social reintegration (viii).

In building from the genealogy of the Catholic treatment of depression, the conflict and cooperation between medical and moral viewpoints is an anticipated, emergent theme. The PCHPC conference already cautions against the medicalization of moral and existential issues. However, this tension between moralization and medicalization is not problematized explicitly in any of the ethnographies mentioned thus far. Treatments of this theme are found not so much in the anthropology of religion, but rather in the anthropology of psychiatry and the allied field of critical psychiatry or post-psychiatry. These studies are framed not in terms of a dichotomy between moral and medical perspectives, but in terms of the interface between differing epistemologies, especially concerning concepts of the self. Researchers engage the “reality” of mental illness, but instead of pitting one knowledge system against another, they seek to understand disorder as real in so far as the experience, the suffering, the impact on person’s life are real. That is, this approach locates epistemic dissonance
between scientific knowledge and patient subjectivity. The concern is not if mental exists, so much as how it exists (See for instance Dumit 2003; Gaines 1982; Hacking 1995, 1998, 1999; Horowitz 2002; Kleinman 1986, 1988; Luhrmann 2000; Pandolfo 1997; Pickering 2006; Townsend 1977; Young 1995). Among the most recent studies of the epistemology and experience of mental illness, two studies merit special mention. Each has made an innovative theoretical contribution to the study of how new knowledge about mental illness affects the way these conditions are valued and experienced. The first is Joseph Dumit’s work on the impact of the popular circulation of scientific rhetoric surrounding the new technology of brain imaging on understandings of the biological basis for mental illness (2003). By demonstrating the persuasive normalizing power of these images to solidify categories of normal and deviant, Dumit extends the argument that mental illness itself is normalized and destigmatized through the process of biologization. Imaging and pharmaceutical innovations effect a process of “objective self”-fashioning that yields a new, positive identity for depressed persons. Now one has an objective mental illness as opposed to being mentally ill. Dumit terms this new form of self-fashioning the “pharmaceutical self,” referring to the way one’s abnormal neurochemistry is posed at once as one’s identity and as a risk factor for symptoms of mental illness. The pharmaceutical self is managed through observation and drug treatment, placing the person in a self-position that is not quite normal, not quite abnormal, but somehow better. Regardless of the drugs’ effectiveness, “the result is an understanding of oneself as if on drugs” (2003, 43).
Ian Hacking is the second contributor of an innovative anthropological approach to the study of mental illness. In his book, *The Social Construction of What?* (1999), Hacking takes mental illness as an example for a reformulation of social constructionism, which he argues has become worn out with overuse. In a chapter titled “Madness: Biological or Constructed,” Hacking revisits an earlier critique of the debate over whether mental illness is “real” – that is, a fundamentally biochemical, neurological or genetic condition – or culturally contextual and socially constructed. For a more useful alternative to this antagonistic dichotomy, Hacking shifts concern away from the question of reality to that of categorization. He describes “interactive kinds” versus “indifferent kinds” of categorization in terms of whether a kind can influence the modification or replacement of a classification. Interactive kinds influence and can be influenced; indifferent kinds can and do not. Mental illness diagnoses like depression, schizophrenia and bipolar disorder may be considered interactive kinds because they do not have a clear or singular biological basis, but more importantly, because the application of these classifications or labels has over time affected the manifestation and experience of the disorders, which in turn affects modifications of the criteria of classification. Analyses that employ this approach could be dynamic and meaning-centered without having to resort to a contrast between biological organicity and social construction, or between psycho-spiritual and neurological explanations. In the case of depression among Catholics, one application of Hacking’s analytics may be the study of how one’s condition responds to the fundamental Christian injunction to joy.
Each of these ethnographic precedents offers a theoretical and methodological model for the study of how knowledge becomes embodied in practice and experience. As is demonstrated in the last two exemplars, the study of depression among Catholics today must take into consideration how emerging scientific knowledge affects the understanding, experience and behaviors surrounding this illness. In the context of religion we have seen that the interaction – both complicit and competitive – among biological, psychological and spiritual perspectives results in differing degrees and locations of moral responsibility. We have already considered the particular formulation and evaluation of this interrelationship as it is constructed at the top level of the hierarchy. Now, drawing on examples of recent ethnography, we may turn to the question, what about the understanding and experience of the individual depressed Catholic subject? What is the depressed Catholic self that colludes at the nexus of these contrasting epistemologies? How is epistemic complicity and conflict embodied in emotional disorder? What are the implications for self-understanding, the course of illness and the relative effectiveness of different therapies? In the next section we identify various locations and assemblages in which depression and Catholicism may be problematized.

Sites, Practical and Discursive

To locate emergent sites for the problematization of Catholicism and depression, we may take a cue from discussions and proposals at the top level of the Catholic hierarchy. Here we explore five possibilities derived from the 2003 Vatican conference on depression: 1) psychological training and screening for
religious formation; 2) Catholic counseling services and help-seeking behaviors; 3) popular spiritual self-help literature; 4) Catholic media, especially the internet; and 5) New Religious Movements.

1) Psychological training and screening in religious formation

When it comes to issues of mental illness at sites of religious formation, both for professed religious and committed laity, the methods and insights of abnormal psychology and psychiatry appear at two levels. First is the level of Catholic pedagogy for pastoral care. We have seen that priests and other religious pastoral caretakers traditionally have found themselves at the front line of mental healthcare for the faithful. While secular psychology and psychiatry have drawn help-seeking out of the arena of the Church, or perhaps because of this, education in psychology and counseling has become an integral part of seminary training and religious formation alongside theology and philosophy. Since the Second Vatican Council Catholic, universities – key sites for the dissemination of Catholic discourse – have begun to offer advanced degrees and certification in pastoral counseling for lay and religious alike. The emergent professionalization of lay Catholic pastoral counseling is an especially apt site for the examination of proposals about the nature and cure of depression with respect to both the hierarchy’s perspective and the latest psychological and psychiatric knowledge and techniques, in conversation with local institutional and cultural perceptions.

Psychology and psychiatry are also applied in the screening of applicants to the religious life and of laypersons seeking Church employment or volunteer
involvement. Lay people are required to undergo psychological screenings before being permitted to volunteer or work in Church offices or organizations. In the United States these regulations are being implemented and standardized in response to the recent sexual abuse scandal in the Church. Increasingly applicants to seminaries or religious communities also must undergo intensive psychological evaluation and personality testing as part of the pre-screening process. These methods are not yet standardized, and so vary by method and intensity in different regions or dioceses. It may be interesting to research how the crisis of the priesthood – specifically the low number of seminary entrants, the controversy over homosexual religious, and the recent exposure of sexual abuse and exploitation among priests and other religious – in the US and Europe has affected the development and implementation of psychological screening in seminaries, religious communities and dioceses, and how the standards and conditions for acceptance or rejection for membership or employment have changed as a result.

2) Catholic counseling services and help-seeking behaviors

A second site for the study of mental illness and Catholicism is the psychological services offered by Church entities and the types of help-seeking behavior in which depressed Catholics engage. The hierarchy has sought to prove that all depression involves existential crisis, thus therapy in a religious mode is essential for restoring meaning and converting life to affect a cure. For this reason Catholics, both lay and religious, are encouraged to turn to Catholic institutions and representatives for help. Besides the priest himself, depressed
Catholics have a variety of Catholic mental health resources upon which they can draw, including Catholic Social Services and Catholic Charities, retreat centers and counseling centers run by religious orders, and diocesan or parish-based counseling services. Also among these sites are psychological counseling and retreat services for priests and religious experiencing stress, burnout and depression, particularly in response to pressures related to recent Church scandals (DH 51).

In terms of discourse analysis, one may problematize the way in which different Catholic counseling services respond or adapt to new insights from psychology and psychiatry, defining and redefining the boundary between the normal and the abnormal, passing and chronic, adaptive and pathological mental conditions. Lay and religious applications and perspectives may be compared. The issue of interpretive concordance or dissonance may also be examined at inter-religious counseling centers where Catholic and Protestant theologies may encounter depression and psychiatry in different ways. In terms of praxis, anthropologists have identified psychiatric help-seeking behavior as an important site of ethnographic study (Brown and Harris 1978, Kleinman 1986; Scheper-Hughes 1979; Townsend 1977). We have seen that from the perspective of the institutional Church, help-seeking is both a virtue and an indication of a less severe form of depression, which in turn is correlated with relatively greater moral responsibility for one's condition. Ethnographically the help-seeking behavior of depressed Catholics would be a site at which to explore the internalization of possible epistemic conflicts between theological and scientific belief. How is
reason regarding depression and mental illness formed and contested within the individual sufferer and how does self-reflection on the condition affect the symptoms and course of illness? Considering the hierarchy’s standing assertion that Catholics are not best served by, and may actually suffer more under the care of secular psychology and psychiatry, these questions become especially salient in cases where conservative Catholics look to secular resources for mental health care.

3) Popular spiritual self-help literature

We have seen in the example of literature surrounding the treatment of scrupulosity that while Catholicism is a religion characterized by mediation, in the late 20th century there has emerged a broadening space for spiritual self-help. Catholic thought appears in this literature in two ways. First there are the Catholic psychologists and psychiatrists, psychologically-oriented theologians, and Catholic religious without any particular psychological training who write books on depression and other mental health issues for popular consumption. Among Catholics today Bishop Fulton J. Sheen still enjoys an immense readership (1949b, 1953, 1967). Sheen’s writing may be compared to those of more recent popular Catholic psycho-spiritual writers, such as Capuchin brother and psychologist Benedict J. Groeschel, and former monk and Catholic psychotherapist Thomas Moore. In his books, Groeschel proposes spiritual, meaning-centered answers to psychological questions (1987, 1995). Thomas Moore’s Care of the Soul (1992), a New York Times Best Seller, teaches the cultivation of depth, meaning and sacredness in everyday life finds readership
well beyond the Catholic milieu. In addressing depression specifically, Moore
does not advertise his Catholicity nor does he employ the explicit theological
terms one finds in Sheen and other Catholic authors. Rather, in a style
reminiscent of Viktor Frankl's value-neutral existential psychology, he draws
eclectically from a variety of spiritual, philosophical and psychological resources.

Among the lesser-known Catholic writings on depression and emotional
distress, Jesuit Mark E. Thibodeaux's God, I Have Issues (2004) comprises a list
of prayer requests corresponding to different categories of emotion, including
depression. Sr. Rachel Callahan and Sr. Rea McDonnell propose points for
reflection and prayer as part of the “good news for those who are depressed”
(1991). Sister Kathyrn James Hermes draws from her own struggles with
emotional and spiritual desolation to present a Catholic approach to surviving
depression (2003). Hermes' book is especially provocative in that it addresses
many of the stereotypes of depression derived from Catholic theology and
philosophy discussed in this thesis. Among the questions to be posed to this
collection of literature are: How is expert authority established - especially in
those texts written from personal experience and in those that do not bear the
Imprimatur? How is the audience imagined? How are psychological and
psychiatric concepts applied and authorized?

Besides spiritual/emotional self-help texts written by Catholics, Catholic
thought may also be found in books on depression written by Protestant
Christians. In addressing depression as a spiritual crisis, many of these texts
make reference to the Catholic spiritual tradition, especially the mysticism of
figures like St. John of the Cross and St. Therese of Lisieux, but also modern Catholic psycho-spiritual writings like Moore’s *Care of the Soul* (Biebel and Koenig 2004; Gregg-Schroeder 1997; Lewis 2002). Two contemporary Catholic spiritual writers who appear frequently in self-help texts on depression are Fr. Henri Nouwen and Thomas Merton (Gregg-Schroeder 1997; Groeschel 1987; Hermes 2003; Lewis 2002). Nouwen’s *The Wounded Healer* (1972) is cited to remind depressed Christians of their moral responsibility to make suffering meaningful. Not only does Nouwen’s work serve as an apt thread for tracing Catholic thought throughout popular literature, one may also trace the refraction of themes from existential philosophy and trends in pop psychology through his writings.

In his confessional reflections on the contemplative life, Trappist monk Thomas Merton reiterates the power of prayer and the importance of self-knowledge and trust in God when facing life crises in an uncertain age (1986). Like Fulton J. Sheen, who wrote in the same era, Merton was and remains an especially prominent figure in Catholic psycho-spirituality. Both authors criticize shallow therapeutic spirituality and secular intellectualism, yet their writings are consumed precisely as such (Massa 1999). This aspect of commodification points to the possibility of an ethnographic exploration of the Catholic consumption of self-help literature and the popular consumption of Catholic self-help literature, as competing forms of help-seeking behavior for the depressed.
4) Catholic communications media

The hierarchy has proposed the development of Catholic media as a major solution to the dual crises of religion and culture under the conditions of postmodernity. Catholic print, radio, television and now internet media transmit Catholic thought among the various levels of the Church community, from the Vatican to the local parish to the individual believer. Catholic media is also meant as a vehicle for the evangelization of the wider culture. Today Catholic television networks are a growing presence in world media. In the United State the Eternal Word Television Network (EWTN) provides television and radio programming, as well as internet-based information forums on topics ranging from Canon Law to bioethics. Through these venues popular religious experts like Fr. Benedict Groeschel, mentioned above, and Fr. John Corapi broadcast lectures on the topic of depression. On the EWTN website (www.etwn.com) a core of specialists field questions from active Catholics seeking clarification and reassurance about the Church’s position on various aspects of depression. Among the most frequent topics are the relative sinfulness of depression and suicide; the Catholic position on psychiatric treatment, especially anti-depressant medication; the difference between clinical depression and spiritual desolation; the connection between depression and abortion; and testimonies, confessions, prayer requests and suggestions from depressed Catholics. Experts draw on Canon Law, the Catholic Encyclopedia and popular figures like Fr. Groeschel and Fulton J. Sheen as they offer answers and a kind of remote therapy to those seeking advice, spiritual intervention, consolation and even diagnosis. For the
ethnographer this is an excellent site at which to draw out assumptions and conflicts captured in the variety of Catholic thought on depression.

Among the non-network, independently run websites offering a Catholic view on depression is *Chastity – In San Francisco?*, operated by humanistic psychologist Raymond Lloyd Richmond (http://chastitysf.guidetopsychology.com/depanx.htm). This site is a poignant example of how lay Catholic psych-experts may combine and contrast the spiritual and the psychiatric in discourse about depression. To explain the complex interaction among brain chemistry and structure, other physiological factors and psychological activity, Richmond uses Aristotle’s distinction between material cause (physiology) and final cause (psychology). “In regard to depression and anxiety,” he explains, “this psychological activity usually centers around feelings of anger and guilt and victimization,” the roots of which is a lack of trust in God’s providence and justice. He contrasts the effectiveness of psychopharmacology and *metanoia*, stating that prescription of medication, while useful in some extreme cases, is for the most part “a secular scientific error that you can ‘feel better’ without having to alter your lifestyle to assume moral responsibility for your life.” The doctor’s prescriptions for cure include both psycho-spiritual self-help remedies and referral to his private practice.

5) New Religions Movements

The Vatican puts great hope in New Religious Movements for the conversion of the world, the reestablishment of Church authority, and, coincidentally, the eradication of depression. Youth movements like World Youth
Day and Life Teen, charismatic revivals like the Catholic Charismatic Renewal, and ecumenical Christian renewal movements like Cursillo and Taizé, all promise to revitalize the faith and incite mass *metanoia*. At these sites of the active redefinition of embodied Catholicity the ethnographer may explore the meaning of depression among the psycho-spiritual themes of spiritual, psychological and moral maturity; the Christian injunction to joy, hope and meaning; and the redemptive necessity of perpetual moral conversion. Indeed, anthropologists have already recognized the fertility of this research field for the study of religion and mental health (Rubin 1994; Csordas 1994, 1997). In particular the frequency and intensity of religious conversion that takes place in the context of these movements provides an apt site for the exploration of the phenomenology and subjective experience of therapeutic *metanoia*.

**Final Reflections**

From the perspective of contemporary psychiatry and of the Catholic Church, depression represents a break from reality. As we have seen, which reality that is exactly is a matter of worldview and social construction (Berger and Luckmann 1967). The systematic exclusion by Vatican officials of the input of depressed persons not just from the 2003 PCHPC survey, but from the conference in general, is a structural reflection of this belief, and the language of science further justifies the invalidation of the perspective of the sufferers themselves. The preceding proposals open potential windows into the experience of depression among Catholics, and with that a space for a critique of the experiential effects of the moralization and medicalization of depression. The
PCHPC cautions that, "confusion of disorder and sin can be particularly devastating when...the disorder, the involuntary, is seen as the result of will" (DH 91). This warning is in reference to the distorted subjectivity of the depressed, but we believe it holds for the outside observer as well. The power of the expert – psychiatric or spiritual – to influence the way in which a sufferer experiences the condition deserves ethnographic problematization.

Would the Church accept such a critique? Considering the symmetries between social psychiatry, ethnopsychiatry and other branches of medical anthropology, it is surprising to find no references to medical anthropological studies of depression within Catholic discourse on depression, at least within the sources encountered in the course of research. This is especially ironic when one considers that the Catholic Church and contemporary medical anthropology share the same basic project of re-humanizing psychiatry (See for instance Brendel 2006; Kleinman 1988; Luhrmann 2000). Why and whether the institutional Church is closed to secular anthropology is not entirely clear. Perhaps contemporary academic anthropology is seen as too closely aligned with anti-humanist postmodern thought. Perhaps the tradition of Christian anthropology alone is considered sufficient and universally valid, with no need for added or updated insights. In any case the process of accommodation is deliberate and slow-moving. There has been collaboration in the past in the form of pastoral anthropology, a sub-discipline mainly concerned with the appropriation of ethnological data for the purpose of evangelizing non-Christian cultures (Shorter 1974). This is not surprising; accommodation is always
strategic, after all. But one wonders whether there might be further points for fruitful collaboration between anthropological and Catholic religious understandings of the effects of knowledge and belief on the subjective experience of depression.

Last year Pope Benedict XVI co-wrote a book in which he offers a critique of postmodern thought not unlike that of the PCHPC conference (Benedict XVI and Pera 2006). The Pope maintains that the cultural critique of universal values has no solid ground; the contention of Kuhn and Derrida that there are no facts, only interpretations, is simply untrue. But then the Pope goes on to offer a response that seems to anticipate the sort of critique that an anthropology of Catholic depression might pose. There is a reality, he explains, and it is comprised of “facts of experience,” what may also be called subjective truth, and “facts of expectations,” or what we might call inter-subjective truth. There is also “Christian fact,” which is a matter of decisions made on the basis of belief in a universal, transcendent Truth (26). Recognizing that each of these might be reinterpreted as just another variation of subjective truth, the Pope, at the same time he rejects relativism, actually employs postmodern rhetoric to defend the position of Christian faith. The Church has been reflexive about past mistakes, he states, but it cannot let itself be taken as just another self-correcting institution among many (48). Pope John Paul II is also noted to have resorted to postmodern rhetoric and argumentation two decades earlier. For the Catholic Church, “The postmodern theological project is to reaffirm God’s truth without abandoning the powers of reason” (Harvey 1989, 41). In that sense, the
Church's accommodation of postmodern thought is a postmodern project unto itself. It seems hopeful, therefore, that the Church may someday make a self-reflective space in which the perspective of depressed Catholics may illuminate the effects of moral theology on the experience of depression. Until then, it may fall to cultural anthropology to respectfully introduce that possibility.
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