Article:
Scrutton, AP (2015) 'Is depression a sin or a disease?': A critique of moralising and medicalising models of mental illness. Journal of Disability and Religion, 19 (4). pp. 285-311. ISSN 2331-2521

https://doi.org/10.1080/23312521.2015.1087933

‘Is depression a sin or a disease?’ A critique of moralising and medicalising models of mental illness

Abstract:

Moralising accounts of depression include the idea that depression is a sin or the result of sin, and/or that it is the result of demonic possession which has occurred because of moral or spiritual failure. Increasingly some Christian communities, understandably concerned about the debilitating effects these views have on people with depression, have adopted secular folk psychiatry’s ‘medicalising’ campaign, emphasising that depression is an illness for which, like (so-called) physical illnesses, experients should not be held responsible. This paper argues that both moralising and medicalising models of depression are intellectually and practically (pastorally and therapeutically) problematic, gesturing towards more promising emphases.

Keywords: church, Christianity, folk psychiatry, passibility, suffering.

Introduction

An article in The Guardian in November 2014 draws attention to a shift in Christian conceptions of (what our society calls) mental illness (Holpuch, 2014). While the idea that depression is a sin (or the result of sin) is still common, increasingly there are campaigns among church communities to encourage becoming more open and accepting of people with mental disorders. This campaign takes a distinctly medicalising form: mental illness is perceived not as a sin, something for which the person is responsible but, on the contrary, as a medical disease or illness, and as something entirely beyond their control. Thus the article in The Guardian focuses on the case of Carlos Whittaker, an Evangelical musician and writer who suffers from anxiety, and who says ‘This has nothing to with whether I believe in Jesus. […] This does not have anything to do with whether or not I am reading my Bible or how hard I am praying. I can pray 24 hours a day, seven days a week, and I’m still going to have to take that little white pill every single day.’ (Whittaker, cited Holpuch, 2014). The article goes on to connect combatting moralising models (and the blame and judgement associated with them) with the adoption of medicalising models: ‘The battle to approach mental healthcare from a more scientific perspective has long been waged by individuals within the community, but now an effort to change this perception is coming from church leaders’ (Holpuch, 2014). This concern and shift is part of a wider debate in folk psychiatry (the general public’s beliefs about mental disorder), which exists both in and outside the church, in which both medicalising and moralising models are prominent (see Haslam, 2005).

Church communities' attitudes to mental illness are of the upmost importance. It is widely recognised that clergy are frequently the first port of call for religious people experiencing the symptoms of mental illness, and that their attitude to mental illness is often regarded as authoritative (Wood et al., 2011; Stanford, 2007). The attitudes of congregations, too, are influential in shaping the person's experience and a factor in their recovery or non-recovery. In addition to the direct effects of the attitudes themselves, attitudes of congregations determine whether a person turns to their church community, a potentially important source of support, or whether they end up being alienated from it.

Focusing on the experiences now frequently termed depression, I will argue that both moralising and medicalising models of (what is usually called) mental illness are intellectually and practically problematic. In so doing, I will argue that, while 'depression as sin' views do need to be debunked, adopting a medicalising model is not the most helpful, or the most intellectually sound, way to do it. In order to do this, I will begin by outlining depression and sin accounts. I will then criticise these, first on intellectual, and then on practical, grounds. I will then move on to emerging medicalising accounts in Christian discourse. I will argue that these are based on various misconceptions about psychiatry (for example, the idea that depression is caused by a 'chemical imbalance', and in relation to essentialising conceptions of mental disorder), and that they are philosophically problematic (in relation to both physicalist and dualistic presuppositions). Regarding the question of whether they are nevertheless helpful, I will argue that there is evidence to suggest that they are not. In particular, as some recent studies highlight, medicalising models often reduce hope or induce prognostic pessimism: a tendency that may have self-fulfilling characteristics. Like moralising models, they also view the problem as occuring 'inside' the person themselves, and can induce apathy in relation to issues surrounding social injustice which are a causal factor in at least some cases of depression.While the focus of this paper is critical (arguing against both moralising and medicalising models), towards the end I will point briefly to some ideas within the Christian tradition that suggest more promising ways of responding to depression both within and outside the church.

A brief note is needed on my decision to discuss 'depression' experiences, since talking about these experiences as depression may imply that I presuppose that depression is a natural kind, or that it is at least the correct or best way to describe the experiences we currently term depression. As I hope is indicated by my discussion of the problems inherent in essentialising and reifying depression, neither of these is true: 'depression' is not the only way this diverse set of experiences could be categorised, and other cultures have made sense

of these experiences in different and equally (and perhaps more) coherent and helpful ways. Nevertheless, I am using the term 'depression' because the paper is about a particular debate that uses this term to describe these experiences, and my aim is to analyse, evaluate, and move beyond the two sides of this debate.

A possible and related objection to my paper is that the proponents of moralising/sin accounts of depression could be referring to depression in the non-clinical sense in which it is now used in everyday conversation, rather than clinical depression; this would mean that moralising and medicalising accounts of depression are in fact referring to different things.[1] However, this does not seem to be borne out by the moralising/sin literature: many of the writers make explicit reference to clinical cases of depression. Furthermore, because 'clinical depression' simply refers to experiences that have become severe enough for medical attention to be sought and diagnosis made, there does not seem to be any qualitative, ontological or other essential difference between clinical and non-clinical depression that would warrant giving the two radically different interpretations. This does not exclude the possibility that some writers might make the distinction and give the two different interpretations – and some of the writers I discuss at least point to a related (and problematic) distinction between depression that is caused by a chemical imbalance and depression that is not – but the clinical/non-clinical distinction itself does not appear in the writers I discuss and is not useful for my analysis.

One fnal caveat. I am a philosopher rather than a theologian, and consequently most of my discussion will focus on issues such as the coherence of beliefs about depression, the fidelity of these beliefs to experience, and whether or not particular beliefs are helpful. As these are widespread criteria for discerning what beliefs to hold, I hope the discussion will also be of interest to theologians, people in pastoral (and clinical) roles, and people who are simply interested in navigating the range of interpretative possibilities on offer in relation to depression. However, I am aware that there are other criteria, such as fidelity to Scripture and tradition, that are also and especially important to people from faith communities. While the Bible is mentioned at times in this paper, fidelity to Scripture and other more theological criteria are not the focus of this paper. Giving these a fuller consideration is a task significant enough to require a separate treatment, and would, I think, be better attempted by a different author.

[1] Thanks to an anonymous peer reviewer for raising this point.

Depression as a sin, or the result of sin

In his discussion of the heuristics of folk psychiatry, Nick Haslam points to 'moralising' and 'medicalising' conceptions of mental disorder. Moralising conceptions involve 'the judgement that the person is morally accountable for their abnormality', and medicalising ones that 'the abnormality has a somatic basis', which reflects an essentialist mode of thinking (Haslam, 2005, 35). In a Christian context, 'moralising' accounts of mental illness relate to a family of ideas: that the person has not been saved, or is experiencing judgment for sin, or that mental illness is itself a sin, or the result of demonic possession where the demonic possession is 'allowed' because of the person's sinfulness.[2] As one person explains a common expression of it:

> When dealing with people in the church ... some see mental illness as a weakness -- a sign you don't have enough faith. They said: 'It's a problem of the heart. You need to straighten things out with God.' They make depression out to be a sin, because you don't have the joy in your life a Christian is supposed to have. (Jessy Grondin, cited Camp, 2009)

Kay Redfield Jamison recounts that, following the publication of her autobiography An Unquiet Mind in which she details her experience of bipolar disorder:

> I received thousands of letters from people. Most of them were supportive but many were exceedingly hostile. A striking number said that I deserved my illness because I was insufficiently Christian and that the devil had gotten hold of me. More prayer, not medication, was the only answer (Jamison, 2006, p. 534).

Such views are often found on the websites of individual Christians, Christian churches or websites offering resources for Christian communities. One website article has the title 'Anxiety and Depression are sinful behavior choices not diseases' and begins 'Anxiety and depression are sinful behaviors which the Bible specifically warns against. Jesus commanded us not to be anxious and to rejoice. Anxiety and depression are disobedient emotional choices in direct rebellion to Jesus Christ. We are to rely upon God for everything in all of life's situations, even if we are tortured for our faith and crucified upside down on a burning cross. The Christian is never to be anxious or depressed' (Rudd, n.d.; see Author, under peer review [a], for other examples).

[2] Not all demonic possession accounts, and certainly not all spirit possession accounts, associate demonic/spirit possession or involvement with sin; those that do not require a separate treatment and are outside the scope of this paper.

This website goes on to define its position in opposition to the moralising model: ‘The myth is that anxiety and depression are caused by biochemical imbalances in the brain which are corrected with drugs and shocks’, which is perpetuated by ‘drug company commercials on TV where disease is falsely portrayed as a disease or medical issue’; ‘Depression and anxiety are sinful behavior choices not diseases. They are treated with repentance and a change of heart, not drugs and shocks’ (Rudd, n.d.). The author of the website draws on recent secular psychiatric, Buddhist meditational, neuroscientific, and philosophical literature, which variously challenge biomedical explanations for mental illness and/or point to the role of the placebo effect in antidepressant medication, in support of his position.

Other Christian websites combine moralising models with medicalising ones, though usually attributing moral causes to some cases of depression and medical ones to others rather than integrating them with respect to single cases. For example, one church’s website begins an article entitled ‘A Look at Depression through the Lens of Scripture’ with the following anecdote and reflection:

> The man sitting before me would not respond to my questions. He sat, motionless, staring at the floor. That he had been under a great deal of stress was a fact known to all who loved him, but that he was this close to the "edge" surprised us all. Soon he would find himself on the psych ward of a local hospital, medicated and undergoing both individual and group counseling. Unfortunately his life would never be the same. He had come to this state of deep (what some would call "clinical") depression because of unbiblical and sinful choices that he had been making in his life. (Southern View Chapel, 1997)

This website then goes on to qualify the moralising picture with a medicalising one: ‘Some may suffer from depression as a result of brain damage or some other type of disease. Others may have been diagnosed with a chemical imbalance, and while we must leave room for this possibility, we do not believe that it is nearly as common as many people think’ (Southern View Chapel, 1997). In most cases, depression ‘stems from a downward cycle in which we begin with a problem, react to it in a sinful way, causing a complication of the problem which i*s met by an additional sinful response, etc’* since ‘In a world of confusion an unbiblical perspective on life has to be one of the major causes of depression’ (Southern View Chapel, 1997, author’s italics). Because of its overwhelming emphasis on the moral, despite the inclusion of a medicalising caveat, this view can, I think, be classified as a moralising approach.

Moralising accounts are not limited to websites, but also include Christian self-help books, some of which are bestsellers, and some of which are written by professional psychologists or psychiatrists. As this indicates, while some moralising accounts are likely to

reflect the attitudes of individuals whose views are not shared or well-regarded, others are written by people with significant influence in their spheres. Psychologist E. Rae Harcum (Ph.D.)'s 2010 book, *God's Prescription for Mental Health and Religion: Smile if You Truly* Believe Your Religion utilizes 'rigorous psychological research' as well as specific quotations from the Bible to argue that the 'highway' to mental health is God's prescription of selfless devotion to others. Conversely, mental illness is indicative of not living life in the way that God has prescribed:

> A respected social worker once said to me about a mutual friend, "If she would just start thinking about others, instead of herself all the time, she would not have so many physical and psychological problems." Indeed, this one brief proposition summarizes the central lesson of this book: God's prescription, the highway to mental health of individuals and of society is the highway - God's way – which includes selfless devotion and service to others. (Harcum, 2010, Preface)

Psychiatrists Frank Minirth (M.D.) and Paul Meier (M.D.) write that happiness and, conversely, depression, are choices (1994, p. 58) and that 'by applying the contents of this book, depression is 100 percent curable…. Indeed, *happiness is a choice'* (Minirth and Meier, 1994, p. 197). In common with Rudd (n.d.), the authors adopt a medical model in a few cases of depression, but they stress that physiologically-based cases of depression are far fewer than people usually think, and that most people claiming physiological bases are using these as 'excuses' to 'avoid facing up to their own behavioral and emotional irresponsibilities as the cause of their depression' (Minirth and Meier, 1994, p. 48, see also p.124).

Marcia Webb, Kathy Stetz and Kristin Hedden's analysis of Christian self-help books for mental illness discusses, among others, *Battlefield of the mind*, which says that 'God is certainly positive, and to flow with him, you must also be positive' and that people should 'purposely choose right thinking' (Meyer, 1995, 51; 34, cited Webb, Stetz and Hedden, 2008, 706). *The power of a praying woman* advises Christians that they should 'refuse to be depressed' (Omartian, 2002, 182, cited Webb, Stetz and Hedden, 2008, 706). Still another, *Lies women believe and the truth that sets them free,* tells Christians that '…sometimes our depression is caused by our own sin' and to 'confess any sins that may be causing emotional weakness or sickness' (DeMoss, 2001, 206; 210, cited Webb, Stetz and Hedden, 2008, 706). Again, these moralising accounts are often put forward in opposition to medicalising ones, even if medicalising ones are not wholly rejected; as DeMoss writes: 'It is easier to pay for a refill of Prozac than to ask God to show us if we have an ungrateful, demanding, or bitter spirit. These means may provide a measure of relief, but they are likely to be inadequate and

short-lived. Nothing less than the "God of all comfort" can meet our deepest needs at such times' (DeMoss, 2001, p. 209, cited Webb, Stetz and Hedden, 2008, 706).

It could be objected to my classification of these Christian accounts as 'moralising' that sin explanations do not constitute moralising explanations, since in at least some cases it is a lack of faith rather than immoral actions that distance the person from God and make them depressed, and since 'morality' is a secular concept that does not map easily onto the theological language of sin. This is a significant matter for some Protestant denominations, since a central Reformation manifesto was that salvation is through grace (meaning, more specifically, faith in grace) rather than by moral works, as Catholics were alleged to believe. However, many of the features in the contemporary depression and sin literature attributed to lack of faith are described as immoral actions (for example, adultery, fornication and homosexuality). In addition, faith, in this context, seems to function much like a moral action. Furthermore, because the proponents of this kind of view are largely 'Pelagian' in having an individualistic and voluntaristic focus (sin/immorality is emphasised as being freely chosen) and owing more to the American Dream (and its international exportation) than to Christian Scripture and theology (see Webb, 2012), the language of 'sin' maps easily onto moralising accounts. It should be noted that this individualistic, voluntaristic idea is by no means the only Christian conception of sin – and that most theologians would reject this in favour of a more complex view of the relationship between sin, will and grace (see Author, forthcoming [a]; McFadyen, 2000).

The idea that mental disorder is a sin or the result of sin understood in this voluntaristic sense is characteristic of some Evangelical Christianity, with its stress on spiritual warfare and biblical emphases (see Hunneysett, 2006, Wesselman and Graziano, 2010), though examples are found elsewhere. For example, one psychiatrist relates the case of a Catholic Hispanic American woman of Cuban extraction who believed that her depression was the result of God's punishment for the 'abandonment' of her mother in Cuba (Ruiz, 1998, 1763). It is also important to note that by no means all Evangelicals will adopt a sin and depression view (see the discussion of Gray 2001, below; Holpuch, 2014).

Evaluation 'depression as sin' accounts: are they credible?

Evaluating the truth of 'depression and sin' accounts is difficult. Depression and sin accounts can have an intuitive plausibility to people that espouse them because depression often involves feelings of guilt (DSM-5 includes'feelings of worthlessness or excessive or

inappropriate guilt [which may be delusional]' as one of nine possible symptoms of depression), so that people with depression are often able to think of a past (real or imagined) sins, which are then posited as the cause of depression (see American Psychiatric Association, 2013, 161). However, arguing from depressed people's perceptions of sin to actual sin is highly problematic: the perceived sins of depressed people do not seem to be worse than anyone else's sins, and a large number of people seem to commit what these Christians would regard as sins without experiencing the symptoms of depression.

A more moderate version of depression and sin theology is that in some cases people are responsible for their mental illness (for example, through bad lifestyle choices such as taking large amounts of cocaine, or not doing exercise). While this has a common sense plausibility to it, it is epistemologically difficult, since we cannot know whether the bad lifestyle choices are in fact the person's fault or whether they stem from prior psychological damage or other factors outside their control (such as habits formed during their upbringing). That is not to say that bad lifestyle choices are never people's faults: it is to say that we cannot know whether they are, so that the question is a chicken-and-egg one. Therefore, the argument in favour of the 'sometimes' position is also epistemologically problematic.

Depression and sin theologies are also often put forward on the basis that they are biblical. However, as Marcia Webb has persuasively argued, this is misplaced (Webb, 2012, 56 - 62). Opposing the idea that psychological distress is sin, Webb explores the examples of Elijah, Naomi, and Jesus in the Garden of Gethsemane (56 – 58). Regarding demonic possession accounts, most of which are found in the Synoptic Gospels, Webb notes that it is far from clear that the people have what we would call mental illness. In fact, their illnesses often seem to be physical: muteness (Luke 11:14), muteness and blindness (Matthew 12:22), muteness, deafness, and having seizures (Mark 9:17 – 27; Luke 9:37 – 43), being crippled or having arthritis (Luke 13:12). Other accounts speak of demonic possession, without indicating its manifestations (e.g. Matthew 15:21 – 28). There are accounts in which the demonically possessed person is psychologicaly disturbed (e.g. the Gerasene demoniac; see also Acts 19:11 – 16), but for the most part, Webb argues, it seems we erroneously tend to read psychological distress or mental illness back into the biblical accounts (Webb, 2012, 59 – 62), perhaps on the basis of the influence of films such as The Exorcist.

This suggests that biblical arguments for the relationship between depression and sin and/or demonic possession are misplaced. In addition to this, attention to the phenomenology of depression reveals that a diminished experience of free will is a common characteristic of depression (Ratcliffe, 2013). This is significant to those accounts that emphasise the

relationship between depression and current or ongoing sin, since free will does not seem to be the sort of thing that can exist if the subject does not experience it as existing, and so the perception in at least some cases of depression that the person cannot control their mental state or lifestyle in the ways voluntarists wish them to is likely to correspond to a real inability to do so (see Author, forthcoming [a]). This, then, suggests that such accounts are psychologically improbable, and therefore philosophically improbable, since the theory does not correspond to lived experience.

Evaluating 'depression as sin' accounts: are they helpful?

To this last argument the proponent of the moralising model might respond that, by emphasising the role of choice, what they are attempting to do is restore the person's free will and to help them overcome their depression, in much the same way that by challenging beliefs and behaviours cognitive behavioural therapy can provoke a change in an underlying mental state. This moves us from discussing the truth of depression as sin views (arguments in favour of which seem to be inconclusive at best) to discussing practical criteria, such as pastoral helpfulness and therapeutic value. Indeed, despite the intuitive unattractiveness of sin and depression accounts for many, a benign concern of at least some 'sin' proponents is that, by emphasising choice, it may empower the person and give them hope. As one of the websites discussed above puts it:

> When we say that most depression is a result of unbiblical and sinful reactions to problems, it sounds unloving and harsh. Actually the opposite is true. When we realize that it is our reactions that are causing the depression, we can then deal with those reactions God's way. This realization gives us hope that, by God's help, a solution is possible (Phil. 4:13). (Southern View Church, 1997)

Does the hope associated with the moralising approach justify its existence? I suggest not, because of other, problematic consequences it has for the people who are exposed to it. As we have already seen, perceptions of guilt are a common characteristic of depression, and having others assert one's guiltiness is likely to exacerbate feelings of depression (and so the depression itself). This is negatively associated with permanent recovery, as Kvaale, Gottdeiner and Haslam (2013) explain: 'Blame figures prominently as a maintaining factor in many psychological problems, exemplified by the role of family 'expressed emotion' – unproductive affective reactions grounded in the view that affected people can control their problems […] – in predicting relapse' (783).

That blame and guilt exacerbate and perpetuate depression is indicated by an incident related by the Quaker writer Parker Palmer. Palmer relates that he met a woman with depression who asked him why he thought some people with depression recover while others do not, and even implement suicide. At the time, Palmer racked his brain for a good answer but could only say, 'I have no idea. I really have no idea'. In the days that followed, Palmer felt regret that he hadn't been able to come up with anything more helpful. However, when the woman contacted him again she said that, of all the things in their conversation, it was 'I have no idea' that she found most helpful:

> My response had given her an alternative to the cruel 'Christian explanations' common in the church to which she belonged – that people who take their lives lack faith or good works or some other redeeming virtue that might move God to rescue them. My not knowing had freed her to stop judging herself for being depressed and to stop believing that God was judging her. As a result, her depression had lifted a bit. (Palmer, 2000, 59)

In addition to the fact that sin views tend to exacerbate depression by exacerbating feelings of guilt, believing someone to be sinful is likely to lead to less friendly, more avoiding behaviours, and so to further the alienation of the person from otherwise potentially supportive social structures such as church communities.

That this kind of alienation takes place as a result of depression as sin theologies is indicated by the words of Norma Swetman, a pastor's wife who suffers from depression, when she says:

> Several church people told my husband that I did not have enough faith or must have a poor relationship with God or that my mental illness was a form of 'demon possession'. Because of attitudes that still prevail, I am cautious about sharing my experiences. I fear people will consider me a lesser child of God – although I know that to God none of us is 'lesser'. (Swetman, 1998, 2, cited in Greider, 2007, 191; see also Stanford, 2007)

This is likely to be counter-productive to recovery, since it is well-recognised that religious support offers people with mental illness individual resources not available via more general social support (Stanford, 2007; Fiala, Bjorck, & Gorsuch, 2002) and that religious support can play a key role in recovery (Fitchett, Burton, & Sivan, 1997; Lindgren & Coursey, 1995; Yangarber-Hick, 2004). Professor of psychiatry Keith Meador says, 'I can't explain how many times have I yearned, though the worst of the patient's depression might be over, what I really wanted to do is write a prescription for a community, a place to belong' (Holpuch, 2014; see also Pargament, 2007). In discouraging people from seeking support from their

faith community, voluntaristic sin views of depression also separate people from a potential major therapeutic source.

One of the claims I am making here is that sin as depression views make others more judgemental and less friendly towards people with depression. A possible objection to this is derived from Alison Gray's study of a conservative Evangelical church in the UK, in which she discovered that, in spite of their beliefs, the congregation was less judgmental and rejecting of people with mental illness than was the wider population (Gray, 2001, 71 – 79).[3] In advance of the study, Gray hypothesises that 'beliefs associating mental illness with sin and demon possession would generally lead to more negative and rejecting views about those with mental health difficulties in an evangelical Christian group', but the results indicate that 'the church group expressed less stigmatizing views than the national figures (Gray, 2001, 75, 76). However, before we conclude from this that depression and sin/demonic possession views lead to less judgemental attitudes after all, it is significant that, while it may initially appear that Gray is setting out to test whether the association between mental illness and sin/demonic possession leads to more negative and rejecting views about people with mental illness (and to the conclusion that it does not), it turns out the church she in fact tests does not see illness as moral weakness or judgement for sin (76, 77), and so the force of her paper is rather that not all Evangelical churches will adopt depression as sin/demonic possession approaches to mental illness.

It seems to me that the paper evinces a lack of clarity about this issue. This is in part borne out of the paper's tendency to treat 'conservative' and 'Evangelical' as both synonymous and homogenous. The church chosen, an Anglican church in Malvern, Worcestershire, was regarded as conservative Evangelical on the basis that it belonged to the Evangelical Alliance and similar organisations (75), and it seems to have been implicitly assumed that all such churches would regard depression as a sin or a sign of demonic possession. Gray places a variety of different beliefs under the heading of conservative/Evangelical, some of which may be distinctive of conservative Evangelicalism (e.g. punishment by God) and others of which are not (e.g. that Jesus literally rose from the dead) without discriminating between which this church did and did not hold, and while seeming to posit a conceptual connection between them:

> Theologically conservative (Evangelical) groups hold a particular world-view, for example, that the

[3] Thanks to a conversation partner who, following the presentation of an earlier draft of this paper, put forward this objection by email, but who wishes to remain anonymous.

> resurrection of Jesus Christ was a literal, physical historic event (www.eauk.org). This is likely to colour their beliefs around mental illness (Foskett, 1996; Ramm, 1973). Mental illness may be viewed as judgment for wrong-doing (Atkinson, 1993) or as caused by demon possession (Loewenthal, 1995; McLatchie, 1984). (Gray, 2001, 75).

Gray's study cannot be taken to indicate that depression as sin theologies do not in fact lead to judgemental and negative attitudes to mental illness, since the church in question (in common with many other Evangelical churches) did not in fact regard depression as a sin.

In addition to this, moralising models, by situating the cause of (all) depression within the individuals who experience it, mean that the social causes of depression remain unrecognised and unaddressed. Groups of people who suffer from higher rates of depression include women, homosexuals, poor people, immigrants, people who live in cities, people who have been abused or tortured, and people who live or have lived in war zones. While moralising models can be put forward for at least some of these (many Evangelicals regard homosexuality as a sin, and women are significantly more likely than men to have their mental illness dismissed by the church and/or be told not to take psychiatric medication, in favour of moralising explanations for them [Stanford, 2007, 445; 448]), the idea that these groups are especially sinful is highly questionable, and it is even harder to account for others in moralising terms.[4] Poverty, discrimination and oppression may or may not be the only causes of depression, but it is difficult to argue that they are not factors at all. In asserting that the depression is caused by the person's (own) sin, moralising models diminish churches' motivation to combat poverty and social injustice.

In summary, then, it seems that moralising perceptions of depression and other forms of mental illness in Christian contexts are not only intellectually problematic, but also (in spite of some benevolent intentions to empower and give hope) pastorally and therapeutically counter-productive, because they exacerbate the depressed person's feelings of blame, lead to judgemental and alienating behaviours on the part of communities who might otherwise be a source of support, and induce apathy in relation to social injustice.

Medicalising models: depression as disease or illness

Some Christians, understandably concerned about the effects of depression and sin views, have countered moralising models by putting forward what Haslam describes as 'medicalising' approaches to mental illness: judging mental illness to be caused by a bodily

[4] The twin doctrines of reincarnation and karma provide a way of attributing sin to people who (for example) happen to be born in war zones (since it can be argued that they sinned in a previous life). However, reincarnation is not a mainstream or conservative Christian belief.

aberration, which is conceptualised as a causal essence (Haslam, 2005, 36; Holpuch, 2014) This reflects a move towards biomedical accounts in anti-stigma campaigns in the context of secular folk psychiatry; as Kvaale, Gottdeiner and Haslam observe, 'laypeople increasingly understand psychological problems in biogenetic terms (Schomerus et al., 2012), and this medicalized understanding is promoted by anti-stigma organizations which describe schizophrenia as an "illness" that "affects the normal functioning of the brain" (SANE Australia, 2012) and depression as "a biological, medical illness" (National Alliance on Mental Illness, 2012)' (Kvaale, Gottdeiner and Haslam, 2013, 783). This resonates with Edward Shorter's observation that 'If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry – treating mental illness as a genetically influenced disorder of the brain chemistry – has been a smashing success' (Shorter, cited Bentall, 2010 p. 3).

In a Christian context, a medicalising account can be found in the famous Evangelist Billy Graham's response to a question about whether depression is a sin or a disease:

> Q:
> Is it a sin to be depressed? The doctor says I have a chemical imbalance in my brain that he can treat with medication, but a friend of mine says I shouldn't do this because I just need to pray and have more faith. Who is right? I can't stand this much longer.
> A:
> Let me ask you a question: If you broke your arm in an accident, do you think your friend would claim it was a sin for you to have a broken arm, and all you needed to do was pray? I doubt it.
> Neither is it a sin for you to seek treatment for a chemical imbalance in your brain. The Bible says that we are "fearfully and wonderfully made" (Psalm 139:14)–and it's true: Our bodies and minds are very complex. Although doctors can't solve all our problems, we should be grateful that God has enabled them to understand more about our bodies and minds, and has given them new ways to overcome many of our problems. Don't feel that you are somehow sinning by seeking treatment for your depression; it would be wrong for you not to seek treatment. (Graham, 2008)

Again, in an article entitled 'Depression: sin or disease?' a Christian blog writer explains that:

> In writing this blog it has been very interesting to hear so many different people's opinions on all the different topics that we discuss. Something that has really surprised me, though, has been some of the remarks made about depression and related diseases. To hear some people talk depression is just another sin, and it is the person who is suffering from it's [sic] fault. They should repent and be happy. Isn't that sort of like saying to a cancer patient stop having cancer?
> I think part of the problem may be that most people do not understand depression, anxiety disorders, and obsessive compulsive disorders. These disorders are not because someone is sad, anxious, or nervous but because of a chemical imbalance in the brain. They do not choose to be sad but are forced to be sad. When you are sick with the flu you get a runny nose. Can you stop your nose from doing that just by will power? No, it is a symptom, a result of the infection in your system. The same thing can be said of depression, et al, the sadness is a result of the imbalance in the brain. When you have a cold you take amoxicillin to fight the infection and when someone suffers from depression, anxiety disorder, or OCD they must take medicine like Prozac to feel normal or better than they did. (Campbell, 2006)

Another writer, this time in an online Christian magazine, explains that:

> Depression is not what the Church sometimes makes it out to be. It's not a character defect, a spiritual disorder or an emotional dysfunction. And chief of all, it's not a choice. Asking someone to 'try' not being depressed is tantamount to asking someone who's been shot to try and stop bleeding. Such an attitude can dangerously appear in the Church as, 'if only you had enough faith.' (Peach, 2014).

The last article, written by someone who suffers from depression, highlights acutely the alienating effects of treating mental illness as a sin, sensibly critiques the tendency of proponents of sin and depression views to read the Bible out of context, and points to the potential for churches to provide supportive rather than blaming communities. It also espouses a medicalising model of mental illness, asserting that 'to deny medical or psychiatric treatment to someone suffering from mental illness is really no different than denying them to someone with a physical illness. The difference between the two is that the former is invisible' and that 'medical science holds that major depressive disorder is real' (Peach, 2014).

Evaluating Christian medicalising models: are they credible?

How are we to evaluate medicalising models? Because they are opposed to a moralising model, an instinctive response is to be sympathetic towards them, and yet in some respects these too are intellectually, and pastorally, problematic. I will begin by looking at three intellectual problems often associated with them and suggested in the accounts given above: essentialisation, and (in different accounts) physicalist, or else dualist, assumptions about mental illness. My focus here will be on folk psychiatry or popular conceptions (such as the accounts given above) rather than those held by psychiatrists, though at points I will make reference to how these relate to psychiatric literature.

In terms of intellectual problems, the idea that (as the author of the website above puts it) mental illnesses are 'real' reflects a position that is perhaps today more popular in folk psychiatry than among at least some professionals (whether practitioners or theoreticians in the field). This is that there is some kind of 'essence' of (what we call) 'mental' and 'physical' illness that means they belong in the category of illness because of something fundamental about what they are, rather than because it is (arguably) a helpful way in our society to group them in this way. In other words, medicalising models in folk psychiatry often include the idea that the concepts of 'illness', 'depression' and 'schizophrenia' are ontological realities, rather than socially constructed and culturally variable categories. As Haslam explains this view, 'Cognitively, medicalizing represents deviance as the outward

expression of a fixed and identity-determining pathological essence. It reflects an ontological assumption that forms of deviance are discrete "natural kinds" (Kripke, 1980)' (Haslam, 2005, 38). This has its roots, historically, in the biomedical model of mental disorder, leading to the biomedical model being called the 'ontological' approach on account of it postulating latent objective categories (McHugh and Slavney, 1998; cited Haslam, 2005, 38). Studies of folk psychiatry indicate that people tend towards essentialising views of mental disorders: when given information consistent with an essentialist view, they tend to draw additional essentialist inferences from it (e.g. that it is a discrete and historically immutable category with clear defining properties) (Haslam and Ernst, 2002).

The problem with an essentialising approach to mental disorder is that attempts to find an essence for 'mental disorder' in general, and for specific diagnoses such as 'depression' in particular, have been unsuccessful (Littlewood, 1997). This does not entail that these categories have no essence, since it may be that we just haven't found one yet, but (given various biological, aetiological and phenomenological attempts to find one) it strongly suggests they don't. In addition, increasingly attention to the experience of mental disorders such as depression points to the diversity of different experiences in different cases, calling into question not only whether depression has an essence (it might be defined instead in family resemblance terms), but whether the category of 'depression' is coherent at all (see Ratcliffe et al., 2014).[5]

Perhaps on account of psychiatrists having had more reason to reflect on these questions than most non-psychiatrists, essentialism is arguably a more prominent feature today in folk psychiatry than in 'professional' psychiatry. As Robert Kendell and Assen Jablensky argue:

> Thoughtful clinicians have long been aware that diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive inferences about outcome and to guide decisions about treatment. Unfortunately, once a diagnostic concept such as schizophrenia or Gulf War syndrome has come into general use, it tends to become reified. That is people too easily assume that it is an entity of some kind that can be invoked to explain the patient's symptoms and whose validity need not be questioned. (Kendell and Jablensky, 2003, 5)

[5] This does not imply that people who experience what we term 'depression' are not experiencing anything, or that they are not experiencing anything significant. Accounts of depression by sufferers provide strong evidence that this is certainly not the case. Rather, it implies that different people who experience what we term 'depression' are in fact experiencing a wide range of different phenomena, about which it is difficult or impossible to find shared characteristics (except for very general ones shared with other phenomena, such as being extremely unpleasant).

In addition to essentialising, and as in the Christian accounts noted above, popular medicalising models tend to adopt either a physicalist view of depression (depression is caused by physiological factors) or else a dualistic framework (in which mental illness is like physical illness, but is not reducible to physical illness). The physicalist view tends to include a host of misconceptions about science. For example, one website includes the advice that people suffering from deep depression should undergo 'a thorough physical examination' to rule out the possibility that the depression does not arise from an 'organic or brain disease' (Southern View Chapel, 1997). In fact, mental illnesses such as depression are not diagnosed through a physical examination such as a blood test or brain scan, but through a verbal account of symptoms by the patient of their symptoms (and, in some cases, by reports from friends and relatives). Neuroimaging has highlighted some differences between the brains of people who are psychiatric patients and those who are not, but it is difficult to separate cause from correlation: in other words, it is not clear whether the differences in the brain were there from birth and caused the depression, or whether they reflect the experience of depression (or related phenomena, such as a trauma that gave rise to the depression, or psychiatric medications). That the brain may be affected in this way seems incredible if we are used to thinking of the physical brain as immutable, but in fact experiences as diverse as education, meditation, pain and exercise can observably affect its physical composition.

An idea frequently appealed to in popular medicalising models is the idea that depression is caused by a chemical imbalance in the brain (expressed in two of the accounts given above [Graham, 2008; Campbell, 2006]), referring to the idea that depression is caused by an imbalance in the neurotransmitter serotonin (see also Laitinen, 2014). In fact, evidence for this theory remains elusive (Moncrieff, 2008; Bentall, 2010, 77). Despite this, as professor of clinical psychology Richard Bentall notes, the chemical-imbalance explanation for mental illness has proved particularly potent in the minds of lay people (Bentall, 2010, 75). As he puts it, in spite of the absence of evidence for it:

> … the chemical imbalance theory of depression has continued to be enthusiastically promoted in drug advertsements (sometimes targeted directly at consumers rather than professionals: 'Celexa helps to restore the brain's chemical balance by increasing the supply of a chemical messenger in the brain called 'serotonin') and by the popular press. Perhaps this is partly because the idea is so easy to understand, but it is also because this type of explanation for mental illness serves the interests of biologically-orientated psychiatrists and drug companies very well. (Bentall, 2010, 77; see Lacome and Leo, 2005; Leo and Lacome, 2007).

While some popular medicalising models opt for physicalist explanations such as the idea that depression is just (or is just caused by) a chemical imbalance in the brain, others opt for a more dualistic model, in which mental illness is like physical illness, but is not ultimately reducible to physical causes. This is perhaps suggested in the third Christian medicalising account quoted above, in which the author writes that 'to deny medical or psychiatric treatment to someone suffering from mental illness is really no different than denying them to someone with a physical illness. The difference between the two is that the former is invisible' (Peach, 2014). Separating the mental and the physical in this way is problematic, a fact that is highlighted in the context of illness when we begin to reflect on the experiences involved in either alleged type of illness. For example, Matthew Ratcliffe, Matthew Broome, Benedict Smith and Hannah Bowden's comparison of the phenomenology and neurobiology of depression on the one hand, and illnesses typically regarded as somatic (such as influenza) on the other, highlights surprising commonalities between them (Ratcliffe et al., 2014). That some depression is characterised, and characterised significantly, by somatic symptoms, and influenza by mental ones, may seem counter-intuitive to us, but that we are surprised can be explained by the underlying pervasiveness of Cartesian dualism, and by the fact that patients' reports of symptoms may be shaped by preconceptions about what depression or other illnesses consist in (see Ratcliffe et al., 2014, 172). Thus, in non-western cultures, depression is often described in far more somatic terms that in the West, a phenomenon that has historically been attributed by westerners to 'insufficient introspective or verbal capacities' of people from non-western societies who 'somaticise' because they are unable 'to perceive and express their feelings in a mature way' (Fuchs, 2014, 184). Reflection on the ways in which some experiences of depression are in fact significantly somatic may lead us to ask whether the issue at stake is not at least equally to do our 'psychologisation' of depression as a reflection of wider, and problematic, western Cartesian assumptions.

Interestingly, the problematic nature of mind/body dualism reflected in the mental/physical illness separation is something psychiatric literature shows signs of recognising. For example, DSM-IV-TR includes the caveat that:

> …the term mental disorder unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. (American Psychiatric Association, 2000,p. xxx)

As this rather brief discussion indicates, medicalising models are intellectually problematic. This, we might think, is excusable in a pastoral context, if they are helpful in countering moralising models and reducing blame and stigma associated with mental illness. But are they in fact as good as they sound?

Evaluating Christian medicalising models: are they helpful?

Medicalising accounts certainly seem to be helpful in terms of reducing blame and feelings of guilt, one of the most problematic elements of moralising accounts. In a quantitative analysis, Erlend Kvaale, William Gottdiener and Nick Haslam found that people who have a medicalising explanation for mental disorders tend to blame affected persons less for their problems than those who adopt other explanations (Kvaale, Gottdeiner, Haslam, 2013; Kvaale, Haslam, Gottdiener, 2013). Some people find not only other's non-blaming attitudes, but also a medical diagnosis itself, to be a relief and a comfort, for what seem to me to be related reasons. For example, Andrew Solomon relates the case of Lolly, who found a medical diagnosis of depression to be therapeutic, at least in part because it separated her 'likeable' self from the feelings and behaviours she felt afflicted by:

> The labelling of the complaint was an essential step towards her recovery from it. What can be named and described can be contained: the word depression separated Lolly's illness from her personality. If all the things she disliked in herself could be grouped together as aspects of a disease, that left her good qualities as the 'real' Lolly, and it was much easier for her to like this real Lolly, and to turn this real Lolly against the problems that afflicted her. To be given the idea of depression is to master a socially powerful linguistic tool that segregates and empowers the better self to which suffering people aspire. (Solomon, 2002, 343)

It could be argued that moralising Christian accounts have the potential to provide a similar separation between the person and their (sin-induced) depression by emphasising the distinction between the sinner (whom God is said to love) and the sin (which God is said to hate), a distinction sometimes used in the context of Evangelical Christian rhetoric about homosexuality. However, because 'sin' (as conceived by the Christians who tend to espouse moralising approaches to depression) is seen as freely chosen (and disease, apparently, is not) and choice is bound up with the will, which is part of who someone is, moralising Christian accounts are less likely to be successful in enabling the person to feel that they are not indistinguishable from their depression. As we have already seen, because of this emphasis on choice, moralising accounts are also likely to instill a sense of guilt for depression.

That medicalising models diminish blame is a significant point in their favour which needs not to be underrated. However, it is not the only important pastoral or therapeutic factor – and there is some evidence to suggest that the medical model fares less well in other respects. In particular, medicalising models seem to do worse than moralising models in that they are more likely to diminish hope in recovery, or induce prognostic pessimism. This is indicated by the results of Kvaale, Gottdiener and Haslam's quantitative studies; as they hypothesise before their study:

> Rekindling hope is a central process in recovery from psychological problems […], and optimism is associated with adaptive coping behaviors […]. By evoking notions of a deep-seated, fixed disease entity, biogenetic explanations for psychological problems may foster prognostic pessimism, the belief that the problems are unlikely to improve […]. This pessimism could hamper recovery. People with psychological problems might fail to engage with treatment or lose confidence in their ability to overcome their difficulties if they see them as immutable […]. One participant in Easter's (2012) study spoke of genetic explanations as an excuse and a green light to continue problematic eating behavior: 'I think genetic explanations would have been an enabler for me. I wouldn't have stopped the behaviour. Because, I would have thought I couldn't. I would have seen that as the reason I couldn't.' (Kvaale, Haslam and Gottdiener, 2013, 793).

The results of Kvaale, Haslam and Gottdiener support this hypothesis: medicalising models do indeed appear to induce prognostic pessimism when compared with other explanations (2013).

That such explanations have hope-diminishing force is indicated by an incident related by Bentall, who questions medicalising models and biomedical explanations of mental disorder. Bentall recounts having entered into a debate about whether schizophrenia is a genetically determined brain disorder. Following the debate, Bentall relates that a woman chased after him in tears, and told him 'My husband has been mentally ill for twenty years. Nothing they have done has ever helped him. You're the first person I have heard who has given me any hope' (Bentall, 2010, xiii; see also Author, under peer review [b]).

By extension, medicalising models may also lead to the belief that antidepressant drugs alone are the best response to depression. If depression and schizophrenia are biomedical, there is less reason to undertake cognitive behavioural therapies or other talking therapies. This is problematic because there is strong evidence that using both psychotropic drugs and talking therapies is more effective than either form of treatment on its own (Loewenthal, 2007, 59). In addition, medicaling models, like moralising models, root the problem in the depressed person herself, and in so doing draw attention away from the societal factors implicated in depression. Like moralising models, this can lead to apathy in

relation to social justice: in the case of medicalising models, to the impression that the best response to depression and other psychological problems is to medicate people, rather than to change the society in which we live.

In addition to this, medicalising models, particularly when disease is essentialised, can be regarded as exclusive to other ways of understanding the experience: the experience of depression (for example) is regarded as a disease, and essentially and only a disease; there is therefore little space for regarding it as disease-like in some respects but not others. Because of this, medical models can exclude other forms of meaning-making, such as that the experience has spiritual value. This is a shame, since an interpretation that gives an otherwise negative phenomenon spiritual meaning may provide a richer and more therapeutic experience than a biomedical diagnosis is able to do on its own (Stanghellini, 2004). Thus, for example, in a study focusing on people who experience (what are known in psychiatry as) auditory hallucinations positively (as desirable) rather than distressing (as negative), Lana Jackson, Mark Hayward and Anne Cooke observe that:

> Most participants felt that their voice-hearing experiences were meaningful and therefore sought alternative understandings (often spiritual) to an illness-based medical view. Those who had received a diagnosis of mental illness tended to view their voices as more than just "a bunch of symptoms that need fixing" (Rachel). This often conflicted with the medical approachey were offered (Jackson et al, 2010, p. 149).

Spiritual views were experienced as transformative since, as one participant put it, it enabled '…understanding what was happening for me, giving it meaning and breaking down the fear that I had around not knowing and thinking that I was a complete freak, really different and ill' (cited in Jackson et al, 2010, p. 492).

Depression presents a rather different case to auditory hallucination, in that the symptoms of depression are inherently distressing and undesirable rather than being able to be positively experienced; however, spiritual autobiographies of depression also point to the ways in which spiritually valuable traits and experiences can be part of, or arise out of, experiences of depression (Grieder, 2007; Author, forthcoming b). This is perfectly compatible with seeing depression both as inherently negative/undesirable and as being illness- or disease-like in some respects, but it does presuppose that the experience is or can be more than just 'a bunch of symptoms that need fixing'. Because the medical model in folk psychiatry (including Christian folk psychiatry) tends to be essentialising, it also tends to present medical explanations as the only valid, or the most valid, interpretations, and so

positive meaning-making interpretations are forced out of the picture.

Therefore, both moralising and medicalising models of mental illness are problematic. By attempting to empower and provide hope, depression and sin views blame people who are depressed or otherwise mentally ill. By attempting to eliminate blame of people who are depressed, medicalising accounts diminish hope; insodoing, they can effectively become self-fulfilling prophecies, rule out positive ways of making sense of the experience, and erroneously point to psychotropic medications as the only effective treatments, to the exclusion of both talking therapies and social change.

If medicalising and moralising accounts of depression don't work, then what?

Fortunately these are not the only ways of responding depression and other forms of mental disorder that the Christian tradition has to draw on. It is not within the scope of this paper to develop any of these, but I will mention a few that seem to me promising, while also suggesting that their suitability as responses needs to be sensitive to different situations and different people: that we cannot adopt a 'one size fits all' attitude with respect to them. First, having been critical of the idea that depression is caused by individual sin, it seems to me that, by contrast, the idea that at least some depression is caused to some degree by 'societal sin' – in other words, by features such as unequal distribution of wealth (and subsequent poverty) and discrimination and oppression (for example, of women, gay people, and racial minorities) and violence – is persuasive. While language about societal sin may seem to recall the language of sin found in moralising accounts, the concepts of sin are much different: societal sin is non-individualistic, non-voluntaristic, and it does not attribute (particular) moral responsibility to the people who are suffering from depression. The Synoptic Gospels, and especially the Gospel of Luke, have bringing about the Kingdom of God by overcoming these at their heart, and it seems that this is an emphasis through which the Church can contribute both to improving the lives of sufferers of mental illness within its own walls, and also to the wider world.

An obvious response here is that not all cases of depression seem to be caused by societal sin, and, in addition, it is highly unlikely that war, injustice and poverty can be so easily overcome – in the meantime, this emphasis seems to offer little to people who are currently suffering from depression. The emphasis on societal sin (and justice) then is one that is necessary to a Christian response to depression, but it is not sufficient. Other responses

are also needed to help people who have depression in the here and now.

From the end of the nineteenth century on, the idea that God suffers with us (or is 'passible') has been increasingly popular, overturning the earlier notion that God is impassible or emotionless (Author, 2013, 866; 2011). Alfred North Whitehead's powerful phrase that God is the 'fellow sufferer who understands' (Whitehead, 1978, 351) sums up theological passibilism, and resonates with some passibilist Christian responses to mental illness. For example, Webb describes passibilism as offering hope for a reappraisal of mental illness, and as countering what she terms 'Stepford' Christianity's view of God with its simplistic expectations that life for Christians will be tidy and easy (Webb, 2012). In place of Stepford Christianity, Webb suggests passibilist theology as the foundation for a new theology of mental illness.

A passibilist theology, it seems to me, with its emphasis on God's solidarity particularly with people in distress, will be helpful to some people with mental illness in countering alienation and the idea of God-abandonment. However, it is unlikely to be helpful for everyone. Some people are likely to have difficulty with the (unresolved though not necessarily unresolvable) metaphysical problems associated with passibilism. To give an example of one such problem, how can God experience the depths of despair of a depressed person, while simultaneously experiencing divine bliss, or happiness at the repentance of a sinner, or joy at the beauty of creation, without the positive emotions mitigating the negative ones - such that God's empathy with the depressed person has the same phenomenal quality of despair as the despair of the depressed person herself (see Simoni, 1997; Author, 2013 [a])? In addition to this, while some people find the idea of a suffering God hugely comforting, others, by contrast, find it increases rather than diminishes their unhappiness. Among the examples of people in this camp we might cite the example of Richard Creel, an impassibilist philosopher of religon who has also written about his experience of long-term depression (Creel, 1986; 2011). Creel argues that it is morally dubious to wish that others share one's suffering, rather than simply that no one should experience severe suffering at all, and that the doctrine of divine passibilism might bring us dangerously close to pitying rather than worshipping God (Creel, 1986). Passibilist theology may be a helpful response to depression for many sufferers, but we cannot adopt a 'one size fits all' approach with it.

Finally, some people, including (importantly) some people who have suffered from depression, have indicated that, while they regard depression as an undesirable thing in itself,

it can nevertheless be an instrument of divine grace by becoming an occasion for transformation or spiritual growth. Thus, for example, Catholic priest and psychologist Henri Nouwen speaks retrospectively of his depression as follows:

> It certainly was a time of purification for me. My heart, ever questioning my goodness, value, and worth, has become anchored in a deeper love and thus less dependent on the praise and blame of those around me. It also has grown into a greater ability to give love without always expecting love in return….What once seemed such a curse has become a blessing. All the agony that threatened to destroy my life now seems like the fertile ground for greater trust, stronger hope, and deeper love. (Nouwen, 2009, 97 – 98)

Even in the face of ongoing or permanent depression, David Karp has spoken of depression in these terms: 'The recognition that the pain of depression is unlikely to disappear has provoked a redefinition of its meaning, a reordering of its place in my life. It has taken me more than two decades to abandon the medical language of cure in favour of a more spiritual vocabulary of transformation' (Karp, 2001, 148). Transformation is described variously in terms of heightened appreciation of beauty, development of compassion and insight, and ability to heal (see Author, forthcoming b). While it seems to me that this model avoids many of the pitfalls of other Christian models of mental disorder, sensitivity to context, timing and differences between people, and the way the possibility of depression leading to transformation is expressed, are all (as perhaps with all pastoral responses to suffering) needed. For example, if put forward in an overly prescriptive or unsympathetic way, it could be both patronising, and (a little like moralising accounts) present yet another burden of expectation for a person with depression to deal with (see Author, 2013 [b]); Palmer, 2000, 66). This issue is, I think, primarily one of pastoral intelligence rather than an inherent problem with the idea that experiences of depression are, in various ways, potentially transformative.

Conclusion

In conclusion, in this paper I have argued that both moralising models, and the medicalising models which seek to combat them, are intellectually unsatisfactory and practically

problematic. I have gestured towards three alternative responses or models: that depression is caused, and can be countered, in part by societal sin (such as poverty and discrimination), and that Christianity has a distinctive role to play in this regard; that God suffers with people with depression, and is thus particularly close, rather than (as on a sin account) particularly removed from them; that depression is potentially transformative: that depression can become an occasion for particular kinds of personal (spiritual and moral) growth. At the same time, I have indicated that a 'one size fits all' response to depression is likely to be problematic, and, perhaps obviously, that people need to be sensitive to individual differences, to context, and to the manner in which responses are made.

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