

## II Section

# The Light of Faith in the World of Depression

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## 1. The History of Depression

It seems that the Greek physician Hippocrates (lived between the 5<sup>th</sup>-4<sup>th</sup> century B.C.) one day paid a visit to the home of the philosopher Democritus, whose friends believed that he was displaying signs of mental imbalance. Democritus was engaged in carrying out dissections on animals and studying their entrails. On this occasion, the Greek philosopher, almost as though he wanted to justify his behaviour, is said to have informed Hippocrates that he, too, had a certain interest in the nature and causes of madness. He is said to have added that given that he wanted to write on the subject he had cut up the animals not out of contempt for the gods but to explore the location and the nature of bile – to the excessive quantities of which the cause of madness was commonly attributed.

At the time of Hippocrates both black and yellow bile were held to be closely connected with anomalies in behaviour and that it was possible to distinguish angry or melancholic temperaments according to the prevalence of one of these two fluids. For that matter, yellow bile and black bile were then considered to be, together with blood and phlegm, the fundamental humours of the human organism, and it was believed that when there was perfect balance and harmony between them they were able to main-

tain the physical and mental health of the individual.

In particular, black bile (called in ancient Greek *melagkolia*) was described as a dense, cold, dark and fluid that was also an irritant. It was thought that it was located in the spleen and could also be produced by evaporating the watery component of the other humours. It was also believed that black bile, whenever it prevailed over the other fluids of the body, could flow out of its natural place within the body, become inflamed and corrupted, and finally obscure the mind. Melancholy, which, it was believed, was produced because of an excess of, and alteration in, a corporeal humour, was thought to have primarily mental symptoms, such as sadness, fear, loss of appetite, sleep disturbance, hallucinations, and delirium.

For Hippocrates, treatment for melancholy involved restoring the excess humour to its harmonious balance with the other three humours. To achieve this, he advised a regime of hygiene and diet, which were united and not separate, above all in the case of patients who were not very co-operative. This regime involved taking medicines (such as bear's foot and mandrake), which, because of their purgative and emetic properties, were thought to be able to eliminate the excess of black bile. Such herbs were usually

gathered by the *rizotomoi* with special precautions and rituals because of the symbolic connotations that were uniformly attributed to them.

However, during the post-Hippocratic period other plant substances were also used in the treatment of melancholy. Thus, for example, Crisippos of Cnid recommended cauliflower; Philistion and Plistonicos advised basil; and Philagrios prescribed a potion based on ginger, pepper, epithem and honey.

Aristotle (384-322 BC) was a disciple of Plato (427-347 BC), who himself saw certain types of madness as a gift from the gods. Aristotle himself associated melancholy with mental brilliance and argued that an excess of black bile could help artists, philosophers and even politicians to excel in their fields. In addition, for Aristotle the heart, which he saw as the chief centre of life and the location of the *sensorium commune*, sent the very hot vapours produced within it to the brain, which then proceeded to cool them and to condense them. In this way the activity of the heart could in its turn be cooled and calmed.

In Alexandria, during the Hellenic age, Herophilos and Herasistratos, both experts in anatomy, provided a new view of the brain, which, they said, constituted the location of the mental functions. Herasistratos, in particular, also

studied melancholy and diagnosed it successfully in Prince Antioch - who was in love with the second wife of his father - as an 'amorous' form. In this case the cure lay in attaining the object of his love, as indeed occurred when his father agreed to follow the advice of the physician.

In Rome, during the first century BC, Asclepiades of Bitinia, in opposition to moral doctrine and as a follower of the theory of solids, prescribed that people suffering from melancholy should have various kinds of baths, suitable diets, and well-lit environments. He also advised that a reassuring and encouraging approach should be adopted in relation to such patients. During



the same epoch the compiler of encyclopaedias, Aulus Cornelius Celsus, in his *De Medicina* described a number of cures to be used for the insomnia suffered by people with melancholy: placing an oil of ginger and iris on the patient's head, mandrake fruits under the sick person's ears, the consumption of a poppy or henbane extract, and the placing of scarifying cups on the neck of the patient.

Seneca, the philosopher who lived between the first century before Christ and the second century after Christ, provided an accurate description of melancholy and supplied those who were suffering from it with suggestions in the forms of exhortations and consolations.

During the first century AD, Rufus of Ephesus also studied melancholy, which he described and subdivided into various types all of which were characterised by the specific location and action of black bile. He also described the delirious forms of melancholy. As regards forms of treatment, he prescribed rules of hygiene and diet, bleeding, and a purgative that was made up of dodder, epithem and aloe.

Soranus of Ephesus, who lived between the first and second centuries AD, was another student of melancholy, and following the doctrine of solids he attributed it a constriction of the fibres that were said to make up the human body. He described the principal symptoms of this malady: silent sadness and unmotivated weeping, anxiety, prostration, gastric disturbances, and animosity towards the sufferer's relatives. As regards treatment he advised above all else cataplasms to be applied to the stomach or back at the level of the shoulder blades. In addition, he did not neglect prescriptions of a psychological-behavioural character and recommended the relatives of the patient to make him or her watch happy comedies and engage in pastimes that would occupy the mind. He also urged them to express admiration and interest in what he or she managed to do.

Areteus of Cappadocia, who lived during the second century AD, studied and described melancholy on more than one occasion and for its treatment prescribed purgatives and cholagogues which contained, among other substances, such elements as bitumen, sulphur and alum. Areteus also thought that there was a possibility of a constitutional predisposition to melancholy and that the state of melancholy was a pathological extension of a normal psychological condition. He also stated that this illness could be completely cured or could reappear again after a number of years.

Claudius Galenus (130-200 AD), a tenacious upholder of the doctrine of humours, attributed melancholy to an excess of black bile and distinguished three types of melancholy. The first was due to the presence of black bile in the main in the brain; the second was caused by the spread of this humour through the

blood to the whole of the organism, including the brain; and the third was provoked by the blockage of the same humour in the hypochondriac region with the resultant production of toxic exhalations that could rise to the brain and influence its workings. He described the symptoms of sadness and anxiety, as well as the delirious thoughts of people suffering from melancholy (one patient, for example, thought he was made out of shells and he was afraid that passers-by would break them; another was afraid that Atlas, tired of bearing the world on his shoulders, would drop it and kill everybody). Galenus advised patients to engage in a regime of hygiene and diet and thus, for example, they had to avoid food that resembled the black and bitterness of black bile. However, he also prescribed medicines such as, for example, a mixture of plantain, mandrake, lime flowers, opium and rucola.

The authors who lived in the epoch immediately after that of Galenus (such as Oribasius of Pergamen, Alexander of Tralles, and Paul of Egina) did not move from the general Hippocratic-Galenic approach in their interpretation and treatment of melancholic disturbances. The Fathers of the Church, although they generally accepted the Galenic system, often displayed a tendency to see depressive symptoms not as an example of illness (that is to say as melancholy and thus caused by physical factors and medically treatable) but as sin (that is to say as sloth and thus to be attributed to diabolical temptations and treated with religious practices). Thus St. Cassian, for example, described a condition in monks that was encouraged by a solitary existence and which was characterised by sadness and worry and made them lazy and unable to perform their duties. In such cases, the most suitable treatment, he thought, could be an act of penitence or a corrective punishment. However, to prevent the sin of sloth he advised banishing laziness through work, and above all kinds of work that required a certain level of physical activity. For that matter, the person suffering from melancholy, who often gave the impression of hating his or her own life and of harbour-

ing a lack of trust in divine mercy, expressed an approach that was certainly deplorable for every good Christian. The depressed person, absorbed by his or fears and his or her forms of delirium, at times seemed to have lost the powers of reason, the divine gift that differentiated man from animals. This situation could easily be interpreted as a sign of divine disapproval and such disapproval was closely connected with the condition of the sinner.

Arab physicians at the time of the highest splendour of that civilisation (the last centuries of the first millennium and the first centuries of the second millennium AD) also studied depression. Generally, they were influenced by the doctrines of Hippocrates and Galenus. Najab ud din Unhammad (who lived between the ninth and tenth centuries) described in particular a form of depression characterised by taciturn and agitated behaviour accompanied by insomnia and antipathy towards one's fellow men. He also described a second form of depression which was marked by sadness and anxiety. In both cases, he prescribed regimes based on hygiene and diet, baths, and at times bleeding as well. Avicenna (who lived between the tenth and eleventh centuries AD) opposed the view that the symptoms of depression derived from the influence of devils and believed that it was an illness that could be treated with medicines (for example he prescribed Aaron's beard for such patients). And the Arab historian Usama ibn Munqidh, who lived in the thirteenth century, tells of a dispute between a Frankish medical doctor and an Arab medical doctor over the case of a woman afflicted by 'consumption'. The former gave an interpretation that was purely physical and proffered prescriptions relating to diet, whereas the latter gave an interpretation based on the action of devils and thus proposed rituals involving exorcism.

Constantine the African, who lived during the eleventh century in North Africa and Italy, was the author of the tract *De melanconia*, one of the first medical texts to be entirely dedicated to the subject of depression, and in which the Greco-Roman tradition became fused with

the contribution made by Arab authors. The set of symptoms of the illness were accurately described, as well as its different clinical forms and its various causes. The book then described the treatment for depression, which was in the main connected with hygiene and diet (the climatic and environmental context, food, the balance between the retention and the expulsion of organic material, physical activity, the sleep rhythm in relation to waking hours, and the sphere of emotions and passions). The pharmacological forms of treatment are then also considered, and these are in general based on purgatives or diaphoretics which were used to achieve the rapid expulsion of the greatest possible quantities of black bile, which was held to be responsible for the state of illness. The plant remedies proposed included: bear's foot, cassia, colocynth, rhubarb, thyme, saffron, almonds and pistachios.

St. Ildegard, the abbess of the convent of Bingen in Germany who lived during the twelfth century, believed that melancholy was closely connected with original sin and directly engendered by the devil. Against this condition she advised remedies which were seen as expression of divine benevolence and taken from the three kingdoms of nature (for example, a potion in which blood, mallow, olive oil and vinegar were combined).

In medieval Europe these were long in fashion in the treatment of mental illness, rather like those broadly based potions that were proclaimed to have prodigious health-bestowing virtues that were derived from the rarity or high value of their ingredients. Remedies or therapeutic practices were often employed which enjoyed a high reputation because they connected with famous physicians of the past or to the patron saints of a particular illness. At times medicines and potions were prescribed on the basis of magical beliefs or supposed astrological influences.

During the Renaissance, the condition of depression began to be seen in a different light from what had been prevalent during the medieval period. In particular, the philosopher Marsilio Ficino (1433-1499), as had been previously been

the case, for that matter, with Aristotle, defined the melancholic temperament and the manifestations of melancholy as a characteristic of the man of genius involved in the arts, the sciences, and politics. In the view of Ficino and the neo-Platonic circle connected with him, the person suffering from melancholy was associated from birth with the planet Saturn, a planet that was seen as ambivalent and capable of ensuring both brilliance and creativity on the one hand, and inertia and inaction on the other. For some time astrology had argued that the various astral spheres influenced the lives of those who were born under their sign. Thus people born under Jupiter were bloodthirsty; those born under Mars were angry; and those born under Saturn were melancholic. Until the Renaissance, however, artists and writers were associated with Mercury, the planet of swift motion, as well as being the god who protected trade, commerce, and the sciences. People born under this sign were thought to be industrious and dedicated to study. But during the Renaissance the Saturnine temperament gradually replaced the mercurial temperament as the prerogative of the creative and innovative genius. At the same time, artists began to bring out or to emphasise the melancholic aspects of their character, which, indeed, was a kind of guarantee of their brilliance. In a kind of textbook on hygiene to be used by writers (*De vita triplici*, 1489), Ficino was full of advice as to how to overcome the malign influences of Saturn: sufferers had to follow rules relating to hygiene and diet, cultivate music, and thank the planet Jupiter so as to add 'joviality' to the basic melancholy of the artist. The French physician Jean Fernel (1486-1557), in his classification of mental illnesses, distinguished three kinds of melancholy: a sad form, a form marked by lycanthropy, and a form with excitement (mania). He also placed within melancholy, which he attributed to damage to brain, those forms of persecution mania where there no fever or agitation was present.

Joannes Weyer (1515-1588), who came from Brabant, saw melancholy as the chief affliction of people who were accused of witch-

craft. For this physician, many of the experiences described by so-called witches were probably the fruit of their disturbed imaginations rather than the result of the real action of the devil. It was thus to be recommended that they should be examined by a medical doctor rather than by a priest.

André Du Laurens, who lived between the middle of the sixteenth century and the first decade of the seventeenth century, wrote *Discours des maladies mélancoliques* (1599) and prescribed rules relating to hygiene and diet to his patients. In particular, he counselled the inhalation of various perfume essences and looking at bright colours. In addition, he recommended pleasant occupations and



company, and did not neglect the use of medicines, which were usually based on plants.

In 1586 Timothy Bright (1551-1617) published his *A Treatise of Melancholie*, in which he made a distinction between the physical form of melancholy to be attributed to black bile and the mental form to be attributed to spiritual worries and preoccupations. For the first, he mostly advised treatment based upon diet and medicines, and for the second he proposed religious and psychological practices.

In 1621 Robert Burton (1577-1640) published his famous treatise *Anatomy of Melancholie*, in which, when referring to the previous literature on the subject, he described the symptoms, categories

and treatment of melancholy. In his book he emphasised, in particular, the possible suicidal behaviour of people suffering from melancholy and descriptions were given of many delirious ideas rooted in depression (for example believing that one is as fragile as glass, as heavy as lead, as light as a feather, as inflammable as straw, etc.) The plant-based substances proposed by Burton included dandelion, ash, willow, tamarisk, poppies and Aaron's beard. There were also magical prescriptions, such as wearing a ring made from the rear right hoof of a donkey.

In order to illustrate the interest of authors and the educated public of the age in the broad variety of symptoms connected with depression, reference may be made to the following works:

*Maladie d'amour ou mélancolie erotique* (1612), by the Frenchman Jacques Ferrand; *Dignotio et cura affectuum melancholicorum* (1622), by the Spaniard Alphonso de Santa Cruz; and *Dissertatio medica de nostalgia* (1688), by the Swiss author Johannes Hofer.

Between the seventeenth and eighteenth centuries certain interpretations arose relating to the symptoms of depression that departed from the traditional attribution of it to the action of black bile. Thomas Willis (1621-1675), working under the influence of the theories of iatrochemistry, attributed the genesis of melancholy to an excess of salinity in the blood that was held to be capable of altering the conformation itself of the brain. Thomas Sydenham (1624-1689) emphasised the importance of the weakness of blood in hypochondria, a weakness that had to be strengthened with corroborative medicines, which were primarily iron based. Hermann Boerhaave (1668-1738), in the wake of the theories of iatrochemistry, attributed the cause of depression to an increase in the oily components of blood with an accompanying reduction in the blood flow to the brain and a weakening of the secretions of the nerves. Frederic Hoffmann (1660-1742) attributed melancholy to a spasm of the dura mater which caused difficulties for the circulation of blood in the brain. George Cheyne (1671-1743), in his book *The English Mal-*

*ady*, dwelt upon the environmental causes of depressive hypochondria (in particular, he referred to the damp and heavy climate of the British Isles and the rhythm of life in the major cities).

However, towards the end of the seventeenth century black bile still held a certain relevance in the interpretation of the symptoms of depression. Thus, for example, Anne-Charles Lorry (1726-1783) distinguished 'humour melancholy' (marked by disturbances in digestion caused by an excess of black bile and to be treated by purgatives) from 'nervous melancholy' (characterised by convulsions due to tension in the fibres making up the human body and to be treated with anti-spasm tonics). Pierre-Jean-Georges Cabanis (1757-1808) argued in favour of the existence of a 'melancholic temperament', which he held to be centred round the hepatic system, which itself was seen as a favourable terrain for the formation of a depressive illness.

Philippe Pinel (1745-1826) saw melancholy as an exclusive idea (monomania) involving a false judgement of the sick person about his or her own body which wrongly led him or her to think that he or she was in danger. Jean-Etienne-Dominique Esquirolle (1772-1840) coined the term 'lipomania' for depression, and this he defined as 'monomania characterised by partial delirium and a sad and oppressive depression'. This author thus distanced the illness from every reference to black bile.

The alienists of the first decades of the nineteenth century were under the influence of 'romantic psychiatry' and attributed all forms of mental illness to an imbalance in the soul. They also resorted to so-called 'moral treatment' in trying to cure depression, which involved an attempt to combat and remove the delirious core identified within the patient through the employment of a pedagogic approach. Thus, for example, recourse was made to the 'pitying fraud' (in this practice the therapist won the trust of the patient by pretending at the outset to share his or her beliefs so as to correct them later on), and if this treatment was not engaged in then patients were procured pleasurable sensations, at times alternated with un-

pleasant sensations, so that the first were increased in their intensity by the second, or an attempt was made to provoke sudden emotions in patients by surprising them with aural or visual stimuli.

However, during the first half of the nineteenth century people still prescribed, in their treatment of melancholy and hypochondria – and this despite the change in interpretations as to their pathological origins – certain pharmacies that belonged to what had become a long tradition such as purgatives, fluidifying medicines, and digestives. Physical therapies were also used with a notable frequency, practices such as the immersion of patients in water, the use of showers, or placing patients in revolving chairs.

Towards the middle of the nineteenth century, in a development line with the progressive shift of psychiatry from the field of philosophical speculation to the field of scientific research (above all in the neuroanatomical and neurophysiological spheres), doctors began to understand depressive illness as an organic disturbance of the brain. Thus, for example, Théodore Hermann Meynert (1833-1892) postulated that melancholy derived from a deficit of cerebral energy usually connected with ischemia. Other authors of the same period, basing themselves on autopsy reports on patients afflicted by depression, referred to differing causes that involved an altered functioning of the brain such as anaemia, hyperemia or edema.

Jean-Pierre Falret (1794-1870) noted in his patients a frequent move from depression to mania, and used the term ‘circular madness’ to describe an illness characterised by a succession of two opposing polarities in mood. In studying depressive behaviour he also carried out research into suicide. Similar observations on swings between depression and mania also appear in the work of Jules Bailarger (1809-1890), who described what he called ‘double madness’, and are referred to by Karl Ludwig Kalbaum (1828-1892), who referred in his writings to ‘*Vesania typica circularis*’.

In the second part of the nineteenth century no particular

progress was achieved in the treatment of depression compared to what had been attained during the previous period. Side by side with medicines that were already known (such as arsenic, strychnine, strophanthus etc.), new pharmacies were also used, such as anaesthetics, or the first hypnotics, which were produced at the end of the century by the pharmaceutical industry. Certain therapies that had meanwhile appeared in medicine, such as animal magnetism, hypnotism and electric therapy, were also used. Many alienists, however, still looked after depressives or hypochondriacs with a wait and see approach. They often confined themselves to preventive or accompanying methods by prescribing pleasure trips or stays in spas to their richer patients.

In his classification of mental illnesses, Emil Kraepelin (1856-1926) associated mania and depression in the ‘manic-depressive psychosis’, which he thought could be divided into three kinds of sets of symptoms (bipolar, unipolar and mixed). Apart from the case of ‘evolutionary melancholy’, his prognosis for such afflictions was not favourable. Subsequently, Ernst Kretschmer (1888-1964) used the term ‘cycloid personality’ to describe the various affective temperaments that had a predisposition to manic-depressive psychosis. The psychological traits of the “tipus melancholicus” were described some decades later by Tellembach.

Sigmund Freud (1856-1939) produced a psycho-dynamic interpretation of depression. In *Mourning and Melancholy* (1917) he emphasised how these two conditions were linked by the loss of an object with a strong emotional resonance with the introjection of unresolved negative feelings. Melanie Klein (1882-1960), for her part, thought that the depressive experience was fundamental in the development of children.

Psychotherapy (from psychoanalysis to behavioural therapy) presented itself during the first half of the twentieth century as a form of innovative treatment in the cure of depression, not least given the meagre results obtained by contemporary biological psychiatry.

Towards the middle of the twen-

tieth century two treatments began to be used which were shown to be especially effective in the case of depression: electro-shock treatment and psychopharmacies. The first was introduced into psychiatry in 1938 by Ugo Cerletti (1877-1963) and then quickly spread to the main Western nations. As regards the second, towards the end of the 1950s ‘anti-depressive tricycles’ and the so-called ‘anti-MAOs’ (inhibitors of the amino-oxidases inhibitors) made their appearance. There then followed the discovery of ‘benzodiazepines’ for use in anxious depression, the use of lithium in the prevention of manic-depressive psychosis, and in more recent years the second generation (‘atypical’ and ‘serotonergic’) anti-depressives. During the last decades of the twentieth century various biochemical theories on the origins of depression emerged and these brought out the determining role of the neurotransmitters.

Thus it is that melancholy, in the space of a few thousand years, has passed from being attributed to the influence of injurious black bile, to the role of the sinister planet Saturn, and on to the still in part obscure laws of neuroscience

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JORGE A. MEDINA ESTÉVEZ

## 2. Depression and Christian Hope

My paper has been preceded by numerous other contributions that have illustrated the psychological phenomenon of depression from various points of view. Aware of the limits to my knowledge as regards the subject of depression, I would like, nonetheless, to express certain concepts in relation to this question by basing myself not on scientific cognitions but on human experiences and the experiences of a priest that are certainly painful and have impressed upon me memories that cannot be cancelled out.

It is difficult to try to set out statistics on depression in the past, both because we do not have data derived from careful observation and because it is not always easy to identify the specific states of mind of historical figures as being what we today call depression.

### 1. Depression as Seen by a Pastor of Souls

I believe that unanimous agreement exists on the fact that the phenomenon of depression is complex and that it is the outcome of various causal elements, some of which are connected with the deep structure of the psychology of a person. Often there exist hereditary factors. In addition, specific powerful trajectories of the educational and upbringing process can exercise a considerable influence. The personal history of those who suffer from depression provides, to varying degrees, elements that explain this phenomenon, and which, as in the case of other factors, can point out a route by which to diagnose the problem, assess its depth, and discern in which direction, and how, the treatment should be directed.

Depression is a state that has a certain similarity to hopelessness, with the loss of hope, with a feeling of permanent frustration, with the

perception that one's own existence is a failure and is a 'tunnel with no end'. At times the characteristic of depression is that this state of hopelessness is seen as a paralysing reality in which the subject experiences a sensation of impotence in exercising his own capacities, and as a result feels that his life is useless. It is not strange, therefore, that depressive states, in their deepest expressions, can lead to a psychological discouragement that sees the only way out as being the end of one's existence, that is to say taking one's own life.

Given that a human being is a psychophysical reality, we should bear in mind that both the diagnosis and the treatment of depression depend upon physiological, psychological and spiritual elements that are interdependent.

In addition, there are factors that can lead to a predisposition to depression, although this phenomenon does not always necessarily emerge. One of such factors is perfectionism, that is to say a disproportionate ambition to obtain perfect results. At an apparent level, such a kind of ambition could be interpreted as being responsibility. However, in reality it denotes a lack of realism, a lack of readiness to admit one's own limitations. The person who allows himself to be transported by extreme perfectionism can fall into a hypercritical approach towards himself and be threatened by a feeling of frustration which roots itself to the extent to which self-criticism becomes exacerbated and destroys that healthy appreciation that everyone should possess in relation to their own possibilities.

Another important factor can be the structure of a subject who has paranoid characteristics. This is a very serious factor that cannot be easily reversed. A person who has a paranoid tendency is to a certain ex-

tent impermeable to experience. Where perfectionism exhibits an exacerbated self-criticism, the person suffering from paranoia has a greatly weakened sense of discernment in relation to his own limitations and responsibilities. Naturally, he blames others for his own failures, and this approach leads him to see other people as constituting a universe of adversaries and enemies. Hence, as a result, his isolation, which takes a dual direction. On the one hand, the subject becomes discouraged because around him he sees only negative signs, and, on the other hand, he provokes refusal on the part of the people who surround him who, indeed, are unable to accept the accusations that they wrongly receive every day from the subject himself.

We need to ask whether depression can be produced when in an absolute sense elements or psychological predispositions do not exist that can foster depression. We may say that a healthy personality, that is to say a personality that is in a profound sense well structured and balanced, does not constitute favourable terrain for depression. It can happen, however, that external circumstances that are extremely unfavourable may provoke a psychological disruption that leads to depression or accompanies it. Amongst such circumstances we may list the following: great failures at the level of a person's emotional life, financial disasters, the appearance of an incurable and long-lasting illness, conflicts between duties that appear to be in opposition with each other and irconcilable, an inevitable loss of status, and a sense of lost honour which cannot be regained through the usual channels. I would like to express, but only as a hypothesis, that the most adverse and persistent circumstances do not manage to produce depression when the per-

son who experiences such circumstances has a well structured and spiritually well constructed personality. I would say that in such conditions depression, if it is produced, is less deep and has greater possibilities of being overcome.

What has been said hitherto in this paper leads me to think that the psychological limits of a person who suffers from depression must be taken into consideration very seriously when the malady has to be diagnosed, its immediate and remote causes discerned, and treatment for it has to be drawn up.

Behind the various kinds of depression, and I say 'different' in the sense of the psychological substratum which is its basis and the external circumstances that act as a detonator or catalyst, there are certain varying shared elements.

One of these is loneliness. A depressed person totally loses the capacity to communicate because he believes that he will not be understood or because he requires a kind of understanding that goes beyond that which commonly exists in human beings in the same conditions. If the feeling of solitude is succumbed to, the isolation of the depressed person becomes more acute and a lack of confidence in the possibility of finding understanding and help increases. In this way, depression creates conditions that are highly unfavourable to its being overcome.

Another element is a certain paralysis of activity. The depressed person experiences an exacerbation of his own sense of self-criticism and tends to colour his own possibilities of action with negativity. Even when he receives stimuli that should give him courage he tends to underestimate them and not to see them as objectives or as generous expressions of benevolence. The person who suffers from a state of depression perceives so many difficulties and so many negative factors that he does not where to begin or how to re-begin. This negative horizon works as an insuperable brake and throws the patient into a paralysis of abstraction in which ruminating on his condition has an important and even preponderant place in his captiousness.

From a psychological point of view, a person who has fallen into

depression needs human company that helps him to overcome loneliness and isolation; he needs to engage in satisfying activity that is successful and to discover those fissures in his own personality that have allowed the depressive state to filter through. All this is much easier to describe than to achieve specifically because the person who suffers from depression is in a situation of negativity or at least of distrust in relation to those who surround him and he tends to avoid that which could require of him a change in his passive and ruinous activity. The person who adopts the profoundly human role of extending a helping hand to another person who manifests symptoms of depression must equip himself with great constancy in order to win the trust of the patient and to ensure that the patient becomes detached from the psychological low state of 'I can't', which, indeed, constitutes the shell that impedes him from receiving help and from beginning the work of recovery.

In what I have just read out I have allowed myself to express a simple and certainly superficial and partial judgement of what constitutes depression that is based on my daily, human and priestly experience. I have not made particular reference to the drama of suicide to which the most serious cases of depression lead. If I do refer to this tragic reality it is because its incidence seems to have increased in a significant way in certain sectors of Western societies and because its spectre often accompanies those who suffer from depression. For this reason, one is not dealing here with an unreal hypothesis or with a hypothesis bearing a low probability. Perhaps we can say that this is a risk that should be borne in mind from the moment when the syndrome of depression appears with a degree of gravity.

Depression, therefore, is a reality that belongs directly to the field of competence of psychology but one cannot and one must not neglect its relationship with faith, morality, and spirituality. For this reason, although the support of a psychiatrist is important and often necessary, a priest, in his capacity as a confessor or a spiritual director, in the same way as a member of the laity who is

qualified in the ways of the spirit, can provide a relevant and complementary support in the process of recovery from depression.

## 2. The Spiritual Aspect of Recovery from Depression

It is clear that if the depressed person is a believer, indeed a Catholic with a clear knowledge of faith and doctrine about almighty, provident and merciful God, and about man in his quality as a creature who bears the mark of sin but



who has received the gift of grace, which is effective in 'bringing out sons of Abraham from these stones' (8Mt 3:9), very solid elements exist by which to achieve the overcoming the world of shadows, of insecurity, of frustration and of mental paralysis into which he has descended.

The certainties of faith for the depressed person are points of support that are solid and valid and in which he can find security and relief. To understand that depression is extraneous to the paths of God, that it is a purifying trial, that it is not an inescapable determinism, and that, whatever the case, the grace of God is always present and operative so that even in this concrete case the truth of the word of Holy Scripture which lays down that 'everything helps to assure the good of those who love God' (Rm 8:28) is relevant – to understand all this is already a very great advance on the

journey to overcoming pain. In pastoral care for those who suffer from depression a primary place is occupied by everything that can strengthen the faith of the depressed person, and by 'faith' is meant certainty as regards the goodness and the wisdom of God, the destiny of happiness that God wants for all men, the merciful love with which God attends to the salvation of men - to the point of giving His Son (cf. Jn 3:16), the paternal and tender welcome with which God receives those sons of His that have drawn away from Him (cf. Lk 15:11-24), the knowledge that God has of our limitations and our weaknesses (cf. Ps 103, 104), and thus of the merciful goodness of His judgements regarding our failures and our falls.

Given that a depressed person suffers a feeling of loneliness and of not being understood - which may not correspond to objective realities but which constitutes a subjective perception - a return to the certainty of faith that it is in God 'that we live, and move, and have our being' (Acts 17:28), amounts to a recovery of a 'spiritual atmosphere' that is propitious in achieving an overcoming of that negative sensation of the person who may think that his existence is without meaning. To believe with certainty that God is near to me, that He 'penetrates me', and that he is closer to me than I am, is a key experience by which to return to seeing life with optimism, without, however, ceasing thereby to perceive one's difficulties and obstacles with realism.

Knowing and believing that God knows our defects and our limits better than us and that His judgement about our erroneous actions is perfectly lucid when it comes to the factors that attenuate our blameworthiness, is a spiritual approach that helps to free us from a hypercritical judgement - which is often simplified - as to our responsibilities and our faults. The facts that have just been listed constitute the characteristics of the Gospel of Jesus, expressed in words or phrases although they underlie many approaches that are equally or more expressive than declarations of concepts.

If the patient recovers a feeling of trust in God, the loving Father, as well as in his own possibilities, a

great step forward in his recovery will have been achieved.

### 3. The State of Depression and the Christian Virtues

Given that the 'spiritual structure' of the Christian lies in the carrying out of good acts that we call 'virtues', and given that the virtues are interconnected, it will not be superfluous to remember that the state of depression requires in particular the exercise of certain virtues and at the same time an opportunity for their growth and development.

First of all, there is the virtue of faith in God and in His attributes. Only in the light of faith in God is it possible to look with serenity on the paradox of the good God, He who loves the good of men and the Almighty One, on the one hand, and on the other, the existence of evil, above all moral evil, but also physical evil, especially when this afflicts innocent creatures. Only in a spirit of faith can we share the statement made by St. Paul that 'everything helps to assure the good of those who love God' (Rm 8:28) and the projection of this in the teaching of St. Augustine to the effect that 'God would not allow evil if were not sufficiently powerful to derive a good from evil itself'. The apex of this paradox is without doubt the drama of Calvary, where the most ferocious of injustices, the most abject forms of cowardice, and the dirtiest forms of political opportunism made up the external framework of the most positive and generous act of love of God for mankind, namely the redemption and salvation of humanity through a murder, which was the external form of the sacrifice of reconciliation.

To the virtue of hope I will devote a number of reflections later on, at the end of this paper.

The charity that is born from the love that God has for us and which precedes any act of love of ours locates man in the perspective of the benevolence of God, His initiative both in the order of the creation and in the order of salvation, of the free-giving of His love which has no limits but those of being defeated by forms of ingratitude expressed by men towards it. The contempla-

tion of this incomparable love can do nothing else but provoke an answer of love, and we know that this answer is already a gift of the love of God that infuses charity into the soul together with the gift of justification and grace. To know how to love and go through the long list of gifts that we have received from God is, as St. Ignatius of Loyola says at the end of his 'Spiritual Exercises', a good pathway 'to obtain love'. From this point of view, depression must be seen as a form of participation in the passion and the cross of Christ and as a painful reality that allows us 'to pay off the debt which the afflictions of Christ leave still to be paid, for the sake of his body, the Church' (Col 1:24).

In a concrete situation of depression the 'cardinal' and 'moral' virtues also enter the picture.

The exercise of prudence chiefly follows two directions. The first is the decision to ask for advice and to accept it within the framework of consulting specialists and an exact following of the forms of treatment that are prescribed. The second belongs to the framework of calibrating activity so that too much is not asked of oneself, on the one hand, and not succumbing to the temptation of inactivity, on the other.

Justice finds expression in seeing medical care and treatment as a tribute due to one's health, as an obligation that derives from the gift of existence received from God, and in seeing that looking after oneself or not is not something to be decided by the arbitrary will of man.

Strength plays a role of extreme importance because a depressed person experiences discouragement, pessimism, and a feeling of a lack of motivation to go on living and to address the challenges of his life. For the patient, life appears hard and marked by a level of difficulty that his own condition tends to overestimate. Great strength is required to address discouragement, to be constant as regards treatment, and not to neglect daily activities despite a lack of will power and a feeling of uselessness.

Temperance or moderation are exercised in observing due proportion as regards inactivity. A depressed person tends to be inactive and such inactivity deepens his state of dissatisfaction and frustra-

tion. It may happen, however, that making an effort is counterproductive. Here temperance proceeds gradually with prudence, justice and strength.

Hope requires special discussion. The principal object of this theological virtue is God Himself, because He is the full and definitive blessing of the human person. Because of hope, man looks to eternal blessing as something that fills his aspirations and that can be reached thanks to the help of man. Theological hope, therefore, refers to the ultimate purpose of man, to that for which man was created and to which he must direct all his decisions in a mediated and non-mediated way. Generally, depression does not call into question the ultimate destiny of the person who suffers from it. Indeed, the depressed person experiences a radical malaise in relation to his own life in this world and sees death as liberation from the pessimism that invades him. It is not that he despairs of his eternal salvation. Rather, that he does not see how he can integrate his state of dissatisfaction and psychological paralysis with his duty to go on living and thereby deserve eternal blessing. The depressed person is unable to understand how the pathway towards eternal life may have to be followed through a trial that shakes to the roots the meaning of temporal life, and this to the point of seeing his own annihilation as a good. Paradoxically, the person who is in a state of depression sees death as a good, to the point of taking recourse to suicide, but without understanding the incongruity between his rebellion in the face of existence and his desire to possess God as a supreme blessing. It should be pointed out that depression has ingredients that call into question faith and charity and that it also has others that obstruct the exercise of Christian hope, in the sense of disassociating final blessing from a pathway that appears to be inconsistent with the desire for happiness that lies in the heart of every man. It is as though there was a fracture between the existential situation that he perceives and the anxiety for happiness that corresponds to the promises made by God. For this reason, it is possible to think that

the relationship between Christian hope and depression is to be principally located not so much in relation to God as the blessed object and ultimate finality of man but in relation to forms of aid that come from God and without which the depressed person cannot reach his ultimate goal, that is to say in a relationship with the grace that makes possible acting supernaturally. What burdens and tries the depressed person is powerlessness as regards overcoming a state of inner disassociation, of dissatisfaction and of paralysis, as a simultaneous weakening of trust in the fact that God is near to him, that He supports him and that His grace has the power to enable the depressed person to overcome the shadows that obscure the horizon of his existence to the point of making him perceive life as something that does not have meaning. Were a psychological phenomenon such as depression to have a purely theological key, it could be defined as a kind of radical Pelagianism which lacks trust in God, who saves and can, and wants, to save always.

The person who undergoes the severe experience of depression needs, from the spiritual point of view, to retrieve a deep trust in God the Saviour, whose grace has the power to overcome the most lacerating trials to which is subjected the complex reality of our psychosomatic being. Believing in the power of grace is the necessary pre-condition to rejecting the temptation of hopelessness; it means feeling the nearness of God, even amidst dark mists and disorientation; it means being convinced that our afflictions, and especially those that are most profound, are at one with the salvation that is achieved through the annihilation of Christ (cf. Ph 2:6-9), in which each and every Christian, in belonging to him, must share in a personal and diversified way. Hence silent and trusting prayer supported by the passion of Christ and his glorious resurrection is a pathway to acquiring that inner peace and that trust in God and oneself that make up the antidote to desperation.

The Christian life is organised around the celebration of the sacraments. Three of the sacraments have a special relationship with de-

pressive states, and they are: the Most Holy Eucharist, Penitence, and the Anointing of the Sick.

Participation in the Eucharistic Sacrifice has a special meaning for the person who suffers from depression. In this participation we encounter the moment of prayer in the garden when the acute concern of Jesus was translated into a copious sweating of blood (Lk 22:44), and in particular when he was on the cross and pronounced the words: 'My God, my God, why hast thou forsaken me' (Mt 27:46; Mk 15:34). However, given that the paschal mystery is revealed by the resurrection of Christ, and that the Christ received in the Eucharist is the Risen One in his state of glory, Holy Communion has a fruit of vitality and joy for every believer, but is this in particular for the believer who suffers and shares in an existential way in the annihilation of Jesus.

The Sacrament of Penitence has a singular relevance for the person who suffers from depression if at the origins of his state there are grave and reiterated moral disorders. The forgiveness of sins can have an especially positive influence on the disturbances that are the consequence of such behaviour.

The Anointing of the Sick is a sacrament that can be of great help to those who suffer from depression. Not only somatic illnesses or illness of old age require the help of this sacrament – psychological disturbances that can lead to imperilling a person's life or seriously threaten its harmony can also receive benefit from this sacrament, which helps a person to carry his cross, supports the spirit of the person who suffers the laceration of his own inner equilibrium, and can also help to restore health.

It is completely natural for the Christian suffering from depression to turn his gaze to the Most Holy Virgin. She had many moments of spiritual pain: the prophecy of the sword of pain that would go through her soul (cf. Lk 2:35); the flight to, and exile in, Egypt (cf. Mt 2:13-15); the loss of the Son of God in the temple (cf. Lk 2:41-50); and her painful presence at the foot of the Cross (cf. Jn 19: 25-27). We do not know the inner state of Mary during these moments of painful

suffering and nothing allows us to think that her spirit suffered a state of psychological depression. On the contrary, we may suppose, given that she was preserved from sin and its consequences, that her soul was always in a healthy equilibrium and in profound harmony. But her experience of pain gave her a special capacity to feel pity for those members of her son subjected to affliction and to obtain consolation on their behalf, joy and strength amidst trials, and especially in the field of depression.

#### 4. Conclusion

The Western world, which is characterised today by secularisation, by a public refusal to acknowledge that its Christian roots are an essential part of its identity, by moral relativism thanks to which the most aberrant forms of behaviour acquire citizenship and recognition in civil legislation, and by a

level of prosperity that is extended to vast sectors of society to the disadvantage of the existences of a notable number of people who live in a state of poverty, if not, indeed, in abject poverty, is the world that appears to be the most afflicted by the scourge of depression. This phenomenon is not limited to specific social strata but is present at a very high level in people who suffer a permanent tension because of needs that they are not able to satisfy. This makes them sink into dissatisfaction in an environment that is rejected and cannot be experienced with realism, strength, and trust in God.

We are deeply convinced that a gaze of faith at one's own existence, helped by recourse to prayer and the support of various people, can, from different points of view, be a valid support by which to avoid isolation, abstraction, inaction, and low self-esteem. All of this is able to form a very positive constellation by which to overcome a psychological state that is painful and ex-

hausting. I think that the supernatural aspect and a strengthening of hope in God, who supports, helps and saves, are key elements in the retrieval of a positive vision of oneself and the world, the only vision that corresponds to Christian optimism, which believes firmly in God, the merciful Father, in His son Jesus Christ, the Good Shepherd and Saviour of mankind, and in the Holy Spirit, who is the author of the Christian news and joy in the work of God, and in our vocation to perfect blessedness. The injunction of St. Paul: 'Joy to you in the Lord at all times; once again I wish you joy' (Phil 4:4), is an always valid programme and a characteristic of every disciple of Christ.

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CARLO CASALONE

### 3. Moral Theology, Depression, Subjective Moral Reference Points and Objective Moral Reference Points

Melancholy, sadness, loss, guilt, desperation, the contraction of the time and space that are experienced, and death, are all experiences specific to the phenomenon that receives the name 'depression' and upon which psychiatry, philosophy and theology reflect. Moral theology, with the instruments that are specific to it, also asks itself about the problems and questions that are raised by depression. The way in which this phenomenon is listened to and known has in itself an ethical relevance. This will be the first point addressed in this paper. I will then move on to examine briefly the relationship between the voluntary and the involuntary. The relationship between these two dimensions has a special relevance in the genesis of the feeling of guilt, which is itself an important element in the psychodynamics of depression. We will thus see how it can be differentiated at a conceptual level from the meaning of sin and of forgiveness. These are valuable distinctions if we do not want to nourish a petrification of a person's memory in relation to the past and a closure to the future and to hope. A brief observation about the illicitness of suicide will end the analysis.

#### **Ethics and a Multidisciplinary Approach**

The first point is already implicit in the way in which this conference is proceeding and it is of a methodological character. An ethical value is already present in the choices regarding knowledge because one is dealing here with ar-

bitration between different forms of rationality. The phenomenon of illness is, indeed, supra-determined in the sense that different factors converge and interact in illness, and these are factors that are studied by differentiated disciplines with their own operational instruments and interpretive models: behaviour cannot be explained with reference to a single cause, whether it is physical, mental or social in character. This should be borne in mind, albeit in the knowledge that it is neither possible nor correct to study a phenomenon when one has at one and the same time the conceptual instruments of different disciplines: we need to break down the nucleus of pertinent meanings through the use of different methodologies. In this undertaking emphasis should be laid on the role of the human sciences. Their contribution involves induction from anthropological prior understandings even before the production of isolated data and theoretical systems. Indeed, they not only provide specific forms of knowledge, they also shape the sensibilities according to which man is perceived and studied.

Psychiatry is in an intermediate position between the objectifying medical model and the interpretive model, and in which the subjectivity of the person who provides treatment takes part in the subjectivity of the person who is being treated by mobilising his or her own set of intentions in a hermeneutic circularity. In basic terms, one is dealing here with the self-implicative component: understanding always involves self-comprehension. Recognition of the supra-determination of the ill-

ness is a reference to the relativity of psychiatry: we are faced with this problem whenever we forget that the knowledge and operative paradigm of psychiatry is only one possible others.

The social sciences refer to values in order to give a reason to behaviour. But the move from values that are observed (and because they are observable such values that can be placed in the same realm as the facts or states of things of the natural sciences) to values that are judged to be effectively valid (in a surreptitious or unknowing way) is a form of naturalistic fallacy.<sup>1</sup> Ethical theology, therefore, should examine the meanings emphasised by the human sciences by comparing their worth with the Christian interpretation of life. This brings into play partial meanings, but to appreciate them it is necessary to refer to the overall purpose of living, with which they necessarily interact in a consonant or dissonant way.<sup>2</sup>

As regards the identification of depression, we turn in this undertaking to psychiatry, although we are aware of the large number of orientations that we can encounter within this discipline. Psychopathology with a phenomenological orientation places depressive phenomena within two fundamental categories.<sup>3</sup> On the one hand, there is reactive sadness or neurotic depression, which is also called psychic or motivated depression; on the other hand, there is endoreactive sadness, which emerges when the cause for the alteration in mood has disappeared but the depression still remains. In this second area we encounter depression as a real and authentic ill-

ness or clinical melancholy, which is also termed 'psychotic' and described as life sadness.

A third kind of sadness can be defined as existential and does not refer to a situation that is specifically pathological. In dynamic psychiatry a distinction is made between simple and melancholic depression, which also involves a disturbance of the ego that endangers identity. Three kinds are described: the 'depressive position', which is always experienced; neurotic depression, which is an alteration in mood, and psychotic melancholy, which can involve disturbances of the personality.

As can be seen, these approaches do not create a 'sick person' as a hypostasised entity who is different from a 'sick person', but fosters a qualitative idea of the illness as an imbalance in the forces or components that are present in all human beings. Those people who provide treatment are no exception to this and are seen more as being similar to their patients than different from them. One can see how, from an ethical point of view, such an approach is not irrelevant.

### The Voluntary and the Involuntary

Moral life involves an exercise of responsible freedom in managing and giving form to what belongs to our interior life, which is made up of feelings and affections, impulses and phantoms. However, this power is not absolute. And it is here that the distinction between the voluntary and the involuntary comes into play. What is experienced in depression and the forms of behaviour that derive from depression – as for that matter is the case in every other mental illness – are influenced by unconscious forms of determinism. One cannot escape such conditioning factors but this does not mean that we exclude free initiative from the subject in giving them an orientation and a configuration. The voluntary has its roots in the involuntary. We are indeed controlled by the forces of the unconscious, but this is not a total control. Freedom under the movement of grace shapes interior reactions and the psychic world,

even if the component attributable to freedom is always very difficult, if not impossible, to assess from outside: 'one can never conclude from the presence of a neurotic motivation that there is a certain absence of a spiritual-ethical motivation'.<sup>4</sup> That is to say, psychic causality can be present but this does not necessarily exclude every other motivation. 'We judge the conscience from the outside. But we do not seek to judge the hidden secrets of the heart', said St. Augustine when speaking about suicide.<sup>5</sup> In more classic terms, we could speak about relationships between the mental life and holiness, to which we all, even when we are ill, are called. This, however, does not remove the fact that an absence of freedom is a deep wound and should be seen as an objective evil or disorder.

The point is well brought out by the title itself of this paper, which

the confusion of disorder and sin can be particularly devastating, when, that is to say, the disorder, the involuntary, is seen as the result of will. And this can take place specifically in the logic of the illness where it is a strategy of the desire for omnipotence seeking to recover a little of the omnipotence that has been lost.

### Feelings of Guilt

For moral theology, the relationship that exists between a feeling of guilt and a feeling of sin is of especial interest, above all in order to promote a better understanding of what fosters access to the experience of forgiveness. When one speaks about sin, indeed, the distinction between sin and a feeling of guilt is not always clear. This is a confusion that generates a large number of painful and useless mis-



refers to the need to link, contemporaneously, objective moral reference points and subjective moral reference points. An ethical distinction in relation to these two dimensions is always important. But this is especially the case in depression, a condition that involves feelings of guilt being at the centre of its own psychodynamic. This sense of guilt springs from a narcissistic wound that leads to a fall in self-esteem, however one may wish to interpret the elements that are in conflict: the components of the personality (the ego, the super-ego, the ideal ego) or tensions between ideals and reality.<sup>6</sup> We are, therefore, in a situation in which

understandings. A feeling of guilt is a feeling of unworthiness and unease that emerges after an act or an approach which is seen as mistaken.<sup>7</sup> At times reference is also made to remorse. This word brings out the two components of the experience. Remorse refers, on the one hand, to aggression directed towards oneself because of the disappointment that the action has involved; and, on the other hand, to a wounded emotional life, which does not like seeing one's self-image ruined by the wrong that has been done (whether it is real or imaginary).

The central characteristic of a feeling of guilt is that one is deal-

ing with an experience that takes place, at a fundamental level, in relation to the different aspects of the personality that each one of us has within ourselves, that is to say the ideal elements and our perception of our own present situation. When the prohibitions of the superego are broken, or a person is not up to the ideal image of himself or herself to which he or she is attached, a feeling of guilt emerges. In itself this experience is a useful alarm bell: it helps us to become aware that there is something that is inadequate in our exterior behaviour or our interior attitudes. However, this feeling of guilt can be excessive or indiscriminate when there is no proportion between the 'wrong' that has been done and the feeling of disturbance that has arisen as a result.

Punitive forms of behaviour can then manifest themselves. The court inside us asks for atonement and reparation, and thus we place ourselves in situations that harm us or prevent us from obtaining success, thereby condemning ourselves to failure. Or even, when the feeling of guilt fluctuates without a known reason within our interior, we engage in a bad action in order to have a point to which to attach that feeling. Committing a wrong in order to find a plausible reason for a feeling of guilt that would otherwise be inexplicable offers some release because it gives some reasonableness to the situation as well as bestowing the illusion of knowing, of knowing ourselves, and of controlling ourselves. An analogous variant is an ability to tolerate success. I am referring here to those cases in which one does not manage to be happy with simplicity in response to a gift or to be pleased with a reward of some kind received at work. In these cases, the result is that the whole of our personality is, as a result of that interior court, in a state, as it were, of arrest, and becomes paralysed. And it is here that neurotic guilt emerges, runs off the rails into pathology, and requires technical help in order to be clarified and managed.

In order to escape from these unpleasant feelings of inadequacy, which at times are also well rooted in reality, we adopt defensive

stances with the intention of reassuring ourselves and treating the narcissistic wound. There is a rigid search for an impossible perfection that involves difficulty in accepting reality as it is and committing oneself to transform it into a practical reality of actual situations. Attitudes arise which are intolerant towards ambivalence and limits, a defensive closing up within the person, and a flight from the present in the search for perfect realities that exist only in the imagination or for a past made up of regrets. These are all signs of an insufficient acceptance of the truth about oneself and other people.



But there is also a positive way of living out a feeling of guilt. A sense of guilt then becomes a stimulus to assess one's actions and attitudes in a realistic way and to open oneself up to improvement. This is a useful feeling which points to the presence of something wrong. One should then assess whether this is really something wrong and what its dimensions are. And one should also consider whether the subsequent development will lead to a repairing/absolving, an opening of oneself up to a future improvement, or whether the patient is stuck on self-condemnation and self-devaluation. This second possibility can lead to depressive sadness. It is rather frequent during our epoch, both because of the excess of ideals that the world of the mass media proposes to us (which are

often false but not for this reason less incisive) and because of the pitiless character of the requirements that the superego and the ideal ego make of us.

### **A Feeling of Sin and Access to Forgiveness**

Whereas a feeling of guilt is something that unfolds amongst the different components of the personality, a feeling of sin is, instead, a large relational reality. It is measured in terms of a wrong done to another person, in an active sense or by omission: it is a rejec-

tion of the promotion of life and freedom which involves caging oneself and others up inside one's own hopes or using him or her for one's own purposes. For this reason, sin, rightly understood, leads a person out of the narcissistic logic of a selfish and self-referential game of mirrors – it shifts attention away from oneself to one's neighbour. To acknowledge that one is a sinner involves, in this sense, opening up to the Other, who makes himself present in the interior evidence of the subject.

One thus understands why in our narcissistic society there has been a decrease in the practice of confession. Or why it becomes exhibitionist confession, which is at the service of a misunderstood grandeur (in wrong) of the ego. A correct practice of reconciliation, which involves the confession of

one's own sin, also means, from the point of view of identity, recognition that the agent and the wrong that he or she has been able or is able to do are not the same thing. It means to de-identify oneself with one's sin: the dignity of the person transcends the wrong that he or she commits. Between the subject and his or her actions, whether they are right or wrong, there is a connection, but the subject and the actions are not equivalent.

An acknowledgement of the fact that one is a sinner does not mean thinking of oneself but recognising that to that call, to that need of the other person, one responded wrongly or one failed to respond. For this reason, one becomes aware of sin thanks to a revelation, a word that comes from the other. In Holy Scripture this takes place through listening to the word of God, that is to say through interpersonal communication with the Other *par excellence*. As can be seen, between a feeling of guilt and feeling of sin there is a progress towards the truth of things and liberation – forgiveness becomes possible.

Asking for forgiveness is different from apologising. In the first case, we are dealing with an action that one tried to avoid but which nonetheless took place. Forgiveness, however, involves as its first characteristic recognising that we are ourselves responsible (when it is asked for), or other people (when there is agreement about it) are responsible, for the action. This moment of recognition as regards responsibility is a sensitive one. It means taking seriously the ability of man to be alienated, to reject life and love, to do wrong and do himself wrong. Sin is not condescension and false indulgence. To forgive another person means to recognise that he or she is responsible for that wrong that he or she has committed. Forgiveness, therefore, includes a moment of accusation. In order to be respectful it requires a bilateral and consensual procedure. I can not, that is to say, forgive a person who does not understand that he or she is responsible for his or her own action or who does not acknowledge that that action is wrong. A

unilateral initiative of forgiveness amounts at the level of meaning to a demonstration of a readiness to engage in reconciliation; it can make evident a propensity of the spirit of he or she who expresses it. But if it does not envisage a moment of listening and communication with the other person, it can be violent and generate resentment and aggression.

Forgiveness is not, therefore, made up of amnesia. The wrong that has been done has consequences and forgiveness is often not able to eliminate them. Instead, forgiveness is made up of an offer of a future to the relationship, which is held to be stronger than what, with its weight, tends to interrupt that relationship. Forgiveness is an offer of a future to a person who has no excuses and this despite the wrong that he or she has done. Forgiveness, therefore, involves a distinction between the sin and the sinner. It judges the sin as such but absolves the sinner.

To summarise, forgiveness is a free gift of a future to a person who recognises – and shoulders the responsibility for – his or her own mistakes. We find this in the Lord in its pure state: God believes in man, He still trusts man and specifically trusts man when man has lost trust in himself. If forgiveness is accepted, it breaks the narcissistic wish for continual reference (which is disappointing to varying degrees) to one's own ego. In this way, the strength and the wish to commit oneself to the gift of the future, freed from fear and self-contempt, can be rediscovered.

This argument is especially relevant for our subject because within depression there is a distortion of the time that is experienced.<sup>8</sup> It is certainly the case that we should distinguish between sadness, which we could call normal and which is caused by an external event involving loss, and pathological or endogenous depression. In the first case, the dimension of the past tends to become stressed and to cause an imbalance in the ordinary flow of the time that is experienced. Memories of previous events emerge with greater relevance and nourish nostalgia. But despite this, the pre-

sent remains open to the future as a horizon of meaning so that a person's memory remains able to generate creative activity, if not, indeed, to give depth to reflection on existence and to touch upon the infinite, and thus it is that one speaks about existential sadness.

In the case of clinical sadness, on the other hand, the passing of the time that is experienced slows down to the point of closing down the horizon of the future. A person's memory becomes fixed on the past. The patient perceives that he or she is not keeping pace with the flow of time: a kind of lag becomes established as a result of which he or she feels that he or she is perennially late, much like the patient to whom Minkowski refers who believed that the watch in his hospital was a few hours behind compared to the watch in the next-door house.<sup>9</sup> The past is obliterated and the past engulfs the present, 'freezing the future and feeding guilt, the experience of guilt, which spreads with the disappearance of the future: of hope and forgiveness (which cannot exist without hope'.<sup>10</sup> The future tends to take the form of waiting for an imminent punishment, as a misfortune that is required by the need for atonement. This difficulty that is experienced in enrolling in the future is expressed in language: the past is the place of regret about what was lost or lament about what was not done, and the future is a spokesman of threats about a forthcoming atonement.

In this situation, the temptation arises to embrace death, which is, indeed, the greatest temptation of these dark moments of suffering.

### Suicide and Depression

In the tradition of moral theology the arguments that support the illicitness of suicide were codified by St. Thomas Aquinas.<sup>11</sup> They are basically three in number. First of all, suicide contradicts the natural inclination towards self-preservation and due love for oneself. The second argument comes from Aristotle,<sup>12</sup> and sees suicide as *iniuria communitati*, that is to say as an act of injustice committed against the society to which a man belongs:

given that his life has meaning and value for other people, a man who commits suicide fails to perform his duty to them and causes them harm. The last argument, going back to Plato, states that life is a gift of God, who is therefore its owner: man cannot see himself as its master by exercising a right that is not his. This would mean not acknowledging the sovereignty of God. These arguments have, in substance, been repeated during the course of the successive development of thought on the matter, and were authoritatively taken up in *Evangelium vitae* (n. 66).

It is certainly the case that the advance in knowledge about psychodynamics has brought out motivational aspects to suicidal behaviour that could not be appreciated in previous epochs. Although one cannot completely solve the element of mystery that is to be found in suicidal behaviour, it has been possible to penetrate more deeply into the meanings that this action can express. We thus learn that often the person who commits suicide does not always seek death as such but more a path by which to solve the existential problems that he or she perceives as being urgent.<sup>13</sup> In cases of depression, the motivations involved can cover a very broad spectrum.<sup>14</sup> They can be determined by aggressive impulses – at times directed towards oneself because of an overly demanding superego or to escape an internal persecutor (a ‘secret executioner’) in the game of object relations. But in other cases such aggression can be directed outwards as a punishment for people who, as the real targets of that suicide, will experience the self-elimination of the subject as a defeat. At other times, instead, aggression plays a rather unimportant role and it amounts in large measure to a wish to be reunified with a lost object of love on whom the person who commits suicide feels dependent and whom he or she seeks to reach by choosing death.

It was perhaps because of a greater sensitivity to the presence of conditions and influences in this sphere that the new Code of Canon Law (1983) mitigated the severity of its predecessor (1917)<sup>13</sup> and

ceased to list people who had committed suicide amongst those excluded from a Church burial and a funeral mass.<sup>14</sup>

The human sciences, therefore, throw light on the sphere of the intention and the effective freedom of the agent – two qualifying aspects of the *actus humanus*. This is of determining importance for the



very definition of suicide, which takes into account not only the empirical description of the act with which a person chooses, or exposes himself or herself to, death, but also bears in mind the interior approach that is expressed in that act: to dispose of one's life as though it were an individual possession, currently rejected and despised, is a closure to every further prospect of meaning.

This clarification allows to specify how all those cases in which exposure to death, even certain death, takes place on behalf of a value that is higher than physical life cannot be defined as acts of suicide. The most explicit example of this is the death of Father Kolbe, which points to a disposing of himself by man in the exercise of a free responsibility towards the Creator, who is the foundation of that freedom (and not its antagonist). We will not consider here those actions that leave room for greater uncertainty in terms of interpretation, to which work on case studies has been amply dedicated.

All this, however, does not remove the illicitness of suicidal behaviour, as some theologians today argue when entering into dialogue with the utilitarian approach to life, which is today so prevalent

in our society, and demonstrating its intrinsically contradictory nature. The core of such an argument is to do with the very notion of life. Life is not a reality in relation to which man is in an external and neutral position, beginning with which he chooses whether it is convenient for him to go on living on the basis of a calculation that compares costs and benefits so that he can maximise his well-being and minimise his sufferings. In actual fact, at the outset we are already inserted into life, from which we gradually emerge as conscious beings. The river of life in which man finds himself immersed is made up not only of his corporeality but also of cultural and relational mediations. Man finds himself immediately rooted in a life endowed with meaning, which precedes him and which is an event and a promise to which he should give his consensus in a process of openness to transcendence.<sup>15</sup> This means that each one of us is not an isolated individual who comes prior to his or her relationships with other people, who is committed to producing meaning on his or her own, with his or her own actions, and without reference to the relationships in which he or she encounters, and acts with, other people. For this reason, to see inter-subjective relationships as a subsequent addition in which each person arbitrarily decides whether it is convenient to become involved or not, does not in the least seem to be respectful of the condition of man and the real development of his existential parabola.

The choice of suicide is a declaration of the senselessness of life, but in the light of what has been said above, this is contradictory: it seeks to go beyond the contradictions experienced in life but it would like to obtain this result by eliminating the very assumption that would allow them to be overcome. In fact, only by continuing to live would it be possible to solve the contradiction, namely by opening oneself up to a new future. In addition, in suicide a false autonomy is affirmed, an autonomy based upon the misapprehension that meaning can be produced on one's own, through one's own action, whereas in fact it can be

grasped only on the basis of the trust that each person places in the reasons in favour of good that life presents him or her with. Here also emerges that intimate correlation between the ethical aspect and the religious aspect of every human existence, and this is because acting is possible only on the basis of trust in a good that from the outset cannot be totally possessed, neither intellectually nor in terms of its practical expressions.

In the tradition of the Bible this trust is placed in the specific promise made by God. In the contradictory situations of trial and of failure as well, man reaffirms his faith in this promise of salvation, knowing that it cannot be produced by his own action. We can turn to the figures of Elijah (1 Kings 19:4) or of Jonah (Jonah 4:3-8), or even to the less immediate figure of the wise man Qohelet, to find examples in this sphere. In all these cases the importance emerges of prayer, as an example of dialogue with the Lord of life, and as a place for the regeneration of the reasons for one's own trust and hope. Here the man of faith engages in an experience of near-

ness, first of foremost of nearness to God, and identifies the paths by which to make himself a neighbour at both an interpersonal and structural level. This is a task which, although its outcome is not taken for granted (as is demonstrated by the interlocutory conclusion of the tale of the recalcitrant Jonah), presents itself in all its urgency, in line with what has often been emphasised - in our culture as well.

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### Notes

<sup>1</sup> Cf. MOLINARO A., 'Scienze umane, filosofia, etica', in GOFFI T. and PIANA G. (eds.), *Corso di Morale I. Vita nuova in Cristo. Morale fondamentale e generale* (Queriniana, Brescia, 1983), pp. 59-68.

<sup>2</sup> Cf. BASTIANEL S., 'Dottrina sociale della chiesa come teologia morale', in BERNAL RESTREPO S. (ed.), *Teologia e dottrina sociale. Il dialogo ecclesiale in un mondo che cambia* (Piemme, Casale Monferrato, 1991), pp. 54-55.

<sup>3</sup> Cf. BORGNA E., *Noi siamo un colloquio. Gli orizzonti della conoscenza e della cura in*

*psichiatria* (Feltrinelli, Milan, 1999), pp. 75-97).

<sup>4</sup> BEIRNAERT L., 'La sanctification dépend-elle du psychisme?', in *Expérience chrétienne et psychologie* (Epi, Paris, 1964), pp. 133-142, 138.

<sup>5</sup> ST. AUGUSTINE, *The City of God*, Book I, chaps. XX-VI.

<sup>6</sup> Cf. GABBARD G.O., *Psichiatria psicotod-namica* (Cortina, Milan, 2002), pp. 217-218.

<sup>7</sup> Cf. SOVERNIGO G., *Senso di colpa* (Elle Di Ci, Castelnuovo don Bosco (AT) 1980); GOLDBERG J., *La culpabilité. Axiome de la psychanalyse* (PUF, Paris, 1985); VIORST J., *Necessary losses* (Ballantine Books, New York, 1986); SPEZIALE-BACCAGLIA R., *Colpa* (Astrolabio, Rome, 1997).

<sup>8</sup> Cf. MINKOWSKI E., *Le temps vécu* (PUF, Paris, 1995) (1st. edn. 1933).

<sup>9</sup> Cf. MINKOWSKI E., *op. cit.*, p. 294.

<sup>10</sup> BORGNA E., *op. cit.*, p. 67.

<sup>11</sup> Cf. THOMAS AQUINAS, *La Somma Teologica*, II-II, q. 64, a. 5.

<sup>12</sup> Cf. ARISTOTLE, *Etica Nicomachea*, v, 15, 1138 a 5-14.

<sup>13</sup> PELLIZZARO G., 'Suicidio', in COMPAGNONI F., PIANA G., and PRIVITERA S. (eds.), *Nuovo Dizionario di Teologia Morale* (Paoline, Cinisello Balsamo (MI), 1990), pp. 1338-1347, quotation p. 1341.

<sup>14</sup> Cf. GABBARD G. O., *op. cit.*, pp. 220-223.

<sup>15</sup> Cf. Can. 1240 § 1.3.

<sup>16</sup> Cf. Cann. 1184-1185.

<sup>17</sup> Cf. ANGELINI G., 'La questione radicale: quale idea di "vita"?', in AA. VV., *La bioetica. Questione civile e problemi teorici sottesi* (Glossa, Milan, 1998), pp. 177-206; REICHLIN M., 'Il suicidio e la morale cristiana', *Rassegna di Teologia* 39 (1998), pp. 863-888; TET- TAMANZI D., *Nuova Bioetica Cristiana* (Piemme, Casale Monferrato (AL)), pp. 107-114; CHIODI M., *Tra cielo e terra. Il senso della vita a partire dal dibattito bioetica* (Queriniana, Brescia 2002).

