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Depression

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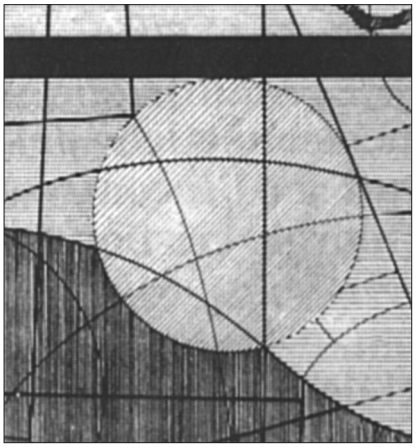

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Contents

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quando l'antico è futuro"
edited by Anna Maria Affanni
Beta Gamma

ADDRESS OF HOMAGE TO THE HOLY FATHER

Most Blessed Father,

As Your Holiness has so often observed, to construct the new society without the deepest values that are at its roots is so mistaken that it leads us without doubt to the culture of death. We observe this when the statistics tell us about what today is described as the greatest murderer of our times – depression.

Your Holiness entrusted our Pontifical Council for Health Pastoral Care with being concerned with emerging diseases. Unfortunately, this infirmity of depression is really emerging and we have dedicated today's international conference to studying at a deep level what depression is, what the Word of God tells us about depression, and in practical terms what we suggest for the cure of this illness.

We know that Your Holiness is the principle of unity and resoluteness of the Church. All her salvific actions come together in you and through your Petrine ministry you give them the resoluteness and clarity that they need so that in them can be effectively heard the creative voice of the Lord, through his cross and resurrection. We humbly ask Your Holiness to give utterance to this ecclesial voice, and request that you guide, and make of our reflections, pathways directed towards showing contemporary men the most adequate way by which to defeat this distancing from the Lord, which in the final analysis means depression.

May I be allowed, Holy Father, to introduce to you those who are the speakers at our conference as well as its highly qualified audience, who today have the privilege of greeting you and listening reverently to your words. Thank you, Holy Father, for your paternal welcome!

His Eminence Cardinal JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Pastoral Care, the Holy See

ADDRESS OF THE HOLY FATHER JOHN PAUL II

Depressive Illness can be *a Way to Discover Other Aspects of Oneself* and New Forms of Encounter with God

Dear Brothers in the Episcopate and in the Priestwood,

Dear Friends,

1. I am pleased to meet you on the occasion of the International Conference organized by the Pontifical Council for Health Pastoral Care on the theme of "Depression". I think Cardinal Javier Lozano Barragán for his kind words on behalf of those present.

I greet the distinguished specialists, who came to offer the fruit of their research in order to further knowledge of this pathology, so as to improve treatment and provide the right type of assistance to those concerned and to their families.

Likewise, my appreciation goes to those who are dedicated to the service of persons with depression, helping them to retain their trust in life. My thoughts naturally extend to families who are accompanying their loved one with affection and sensitivity.

Disturbing increase in depression reaveals human frailty

2. Your work, dear participants in the Congress, has revealed the different, complex aspects of depression: they range from chronic sickness, more or less permanent, to a fleeting state linked to difficult events – conjugal and family conflicts, serious work problems, states of lonelines... – that involve a crack, or even fracture in social, professional or family relationships. This disease is often accompanied by an existential and spiritual crisis that leads to an inability to perceive the meaning of life.

The spread of depressive states has become disturbing. They reveal human, psychological and spiritual frailties which, at least in part, are induced by society. It is important to become aware of the effect on people of messages conveyed by the *media* which exalt consumerism, the immediate satisfaction of desire and the race for ever greater material well-being. It is necessary to propose new ways so that each person may build his own personality by cultivating spiritual life, the foundation of a mature existence. The enthusiastic participation in the World Youth Days shows that the young generations are seeking Someone who can illuminate their daily journey, giving them good reasons for living and helping them to face their difficulties.

Help the depressed person to discover God's love

3. You have stressed that *depression is always a spiritual trial.* The role of those who care for depressed persons and who do not have a specifically therapeutic task consists above all in helping them to rediscover their self-esteem, confidence in their own abilities, interest in the future, the desire to live. It is therefore important to stretch out a hand to the sick, to make them perceive the tenderness of God, to integrate them into a community of faith and life in which they can feel accepted, understood, supported, respected; in a word they can love and be loved. For them as for everyone else, contemplating Christ means letting oneself be "looked at" by him, an experience that opens one to hope and convinces one to choose life (cf. Dt 30:19).

In the spiritual process, *reading and meditation on the Psalms,* in which the sacred author expresses his joys amd anxieties in prayer, can be of great help. *The recitating of the Rosary* makes it possible to find in Mary a loving Mother who teaches us how to live in Christ. *Participation in the Eucharist* is a source of inner peace, because of the effectiveness of the Word and of the Bread of Life,

and because of the integration into the ecclesial community that it achieves. Aware of the effort it costs a depressed person to do something which to other appears simple and spontaneous, one must endeavour to help him with patience and sensitivity, remembering the observation of St Theresa of the Child Jesus: "Little ones take little steps".

In his infinite love, God is always close to those who are suffering. Depressive illness can be *a way to discover other aspects of oneself* and new forms of encounter with God. Christ listens to the cry of those whose boat is rocked by the storm (cf. Mk 4:35-41). He is present beside them to help them in the crossing and guide them to the harbour of rediscovered peace.

Healthy reference points are necessary, especially for youth

4. The phenomenon of depression reminds the Church and all society how important it is to provide people, and especially youth, with examples and experiences that can help them to grow on the human, psychological, moral and spiritual levels. In fact, the absence of reference points can only contribute to making persons more fragile, inducing them to believe that all forms of behaviour are the same. In this perspective, the role of the family, of school, of youth movements and of parish associations is very important because of the effect that these realities have on the person's formation.

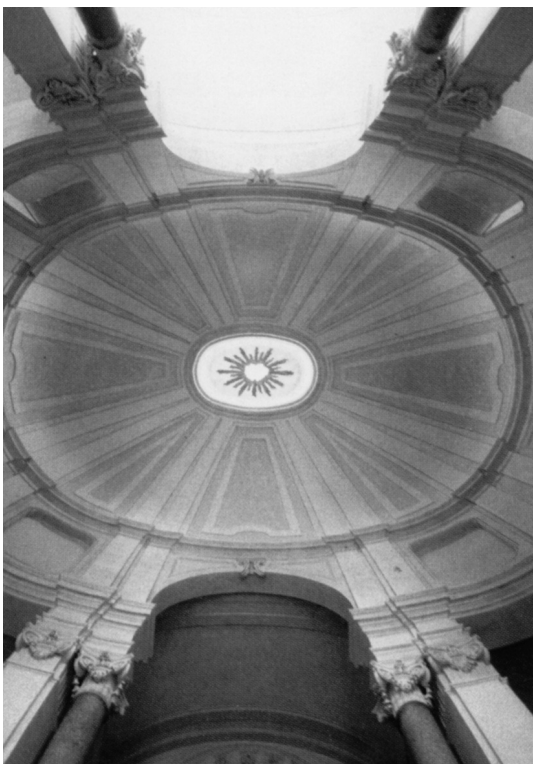
Indeed, the public institutions have a significant role in guaranteeing a dignified standard of living, especially to abandoned, sick and elderly people. Equally necessary are policies for youth aimed at offering the young generations motives for hope to protect them from emptiness or from dangerous fillers.

Disturbing increase in depression reaveals human frailty

5. Dear friends, in encouraging you to a renewed commitment in such an important task beside your brothers and sisters who are suffering from depresion, I entrust you to the intercession of Mary Most Holy, *Salus Infirmorum* (Health of the Sick). May every individual and every family feel her motherly solicitude in times of difficulty.

To you all, to your collaborators and to your loved ones, I cordially impart my Apostolic Blessing.

Depression



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JAVIER LOZANO BARRAGÁN

Inauguration of the Proceedings: Aspects of Post-modern Thought and Depression

In reflecting upon the history of Western thought my attention is directed towards the cycles that present themselves: they begin with the presentation of vital questions that can be summarised as belonging to three major poles – God, man, the world. Various thinkers try to provide relevant answers, these answers grow to the point of reaching brilliant solutions when it seems that mankind has attained his high point, and then one has the impression that specifically at that moment, which is not necessarily the culminating point in terms of time of that epoch (because this can take place at the same time as strong moments), thought decays and becomes weakened in an almost total way.

In ancient Greece, after the great masters of thought such as Socrates, Plato and Aristotle, there occurred the decadence of the currents of scepticism, epicureanism and stoicism. During the Middle Ages, after the great thinkers who culminated in the Scholastics, Aberlard, St. Anselm, Duns Scotus, St. Albert the Great, St. Thomas Aquinas, St. Bonaventure, and others, there came nominalism, led by Occam. Modern thought and its great thinkers – the rationalism of Descartes, the empiricism of Hobbes, Locke and Hume, the idealism of Kant, Fichte, Schelling and Hegel – was followed by the boredom of the Enlightenment, by deism, pietism, the Aufklärung and the Encyclopaedia, which despite their lack of originality could after a certain fashion be considered essays that provided a universal answer to the fundamental questions of God, man and the world. This decline in thought deteriorated during the twentieth century and the beginning of the twenty-first century because of the influence of thinkers such as Nietzsche, Heidegger, Wittgenstein, Lyotard and Vattimo, before falling, like ancient Greece, into scepticism, epicureanism and stoicism.

Such thought, at least in most of the West, is bringing about a cultural change that can be an important frame of reference for us in addressing the subject of our international conference on depression. As a start to our proceedings, and as a small introduction to depression, I would like to mention in a very summarising form what seems to me to be most significant about this thought, which, indeed, sets the contours of the so-called culture of post-modernity.

I will begin with a summarising reference to the basic lines of the positions of the thinkers who seem to me to be at the base of post-modernity. They are Nietzsche, Heidegger, Wittgenstein, Lyotard and Vattimo.[1]

For *Nietzsche*, God is dead and the only norm of morality is now the superman with his will to power. There are no universal and certain values, and there is no possibility of knowing them.[2]

For *Heidegger*, a superior Being exists, but he is ineffable. Instead this Being expresses himself through language and not through thought because thought is already an interpretation of language. In addition, because there are so many interpretations of language they are not true. The only possibility is obscure mystical knowledge. Technical knowledge has objectified the world and falsified it.[3]

For *Wittgenstein*, truth is in language when what it says of facts is scientifically verifiable by the same logicality as language. Values, because they are not facts, are not reliable. Because logicality itself is also a value and thus not a fact, then it, too, cannot be demonstrated. In addition, attention must be paid to the differences between languages, the 'game of language': technical language, game language, political language, poetic language, affective language and so forth. In every game language has a different meaning. There is no common denominator to these language games that one can know. The aim of philosophy is solely to classify the different games that exist. Its function is therapeutic, that is to say to reduce to current and daily language what is expressed in other systems of language. God means that we observe the fact that many things do not depend on us but we depend on them. God is the whole of the world that is independent of our will.[4]

When commenting on previous authors, *Jean-Francois Lyotard* says that the 'meta-tales', that is to say the universal summarising examples of the thought of modernity such as the Enlightenment, Marxism, Christianity, Capitalism etc., which provide an all embracing synthesis, are ineffective and incomprehensible. For this thinker, they have no validity at all. Knowledge can only be expressed through the game of language and amounts to research into instability, to which he gives the name of 'Parology'. Only 'mini-tales' are possible, to which assent is given to achieve temporary agreement between interlocutors both in the international field and in the political, affective, sexual, family or cultural fields. There thus exists a plurality that cannot be reduced to unity, which, indeed, does not have universality. This is an anarchic invention of language. Metaphysical universality is a sham. It is not possible to achieve a synthesis from the heterogeneity of the linguistic game. Post-modern

thought dehumanises man in order to go back to humanising him within a context of instability.[5]

Gianni Vattimo is a philosopher from Turin. He interprets Nietzsche and Heidegger taking nihilism as a basis. In the view of Vattimo being has no objectivity and thus is not universal. Only the here and now exists; history does not exist, it has reached it goal, there is nothing new. Knowledge cannot reach being and cannot attain truth. One reaches truth only halfway and thus there is only half-truth. The instrument by which one reaches this is aesthetic, poetic and rhetorical feeling; from *homo sapiens* one moves to *homo sentimentalis*. This is analogous to when someone sees a painting and interprets it according to his own different feelings – the painting thus becomes subject to a myriad of interpretations. Truth is like that: each person sees it according to his own aesthetic and poetic feelings and expresses it with different linguistic systems.

Television, for example, provides us with a set of images, but it is not possible to have a single and universal basis that unites that set. Reality is an intersecting of various images, its self-contamination without a central axis. Society is emancipation from reality, from differences, and is an explosion of multiplicity. Thus the universal being, stable foundations, and metaphysics have reached their end. God exists, but only to the extent that He is perceived as God by books, by Holy Scripture, and by tradition. But He is not a God of immutable dogmas – he is a poetic and aesthetic God, formed by each person. In particular He is not the God of the Catholic Church. Thus Christianity becomes secularised and enters into decline. Man follows the pathway of his centre towards an unknown destination – 'X'. He does not need the extreme certainty that was given to him by an ancient magical rite – God. The world is an event involving the game of linguistic interpretations within different concrete frameworks. This new thought, which is called 'weak thought', is the only one possible and is in opposition to the aspired to 'strong thought', which continues to be a myth, a fable left behind by post-modernity.[6]

An attempt to break down post-modern thought by following the ideas of these thinkers could perhaps lead to the following points:

1. Lack of Trust in Man and his Thought

After the fall of the great syntheses of modern thought, thought has become weak thought. Reference is made to the tragedies caused by the ideologies of modernity that brought about millions of deaths and acts of barbarity. Strong thought belongs to the primitive epochs of mankind, to barbaric ages, which have now been left behind us.

2. The Rule of Aesthetic Rationality

Irrationalism: *homo sapiens* has now become *homo sentimentalis*. In modernity, reason was made divine and there was a return to strong thought, which was the cause of all the atrocities that were committed, for example at Auschwitz. Now only the relativism of thoughts in conflict with each other, imprisoned in language, is accepted.

3. Relativism

This takes the place of any claim that there is a rationally ordered world. Scientific rationality is replaced by aesthetic rationality. Scientific rationality was based upon the principles of mathematics and logic, on the principle of identity and contradiction, on the reiteration and verifiability of events. These principles have no validity, and another basis must be looked for, which is aesthetics. Aesthetic rationality is based upon the intensity of feelings, of emotions, of the admiration, the contemplation and the authenticity of experience, on the sensitive and affective dimension of human love, personal decisions and instinctual reactions. For post-modernity, truth is not adaptation to reality but interpretation of reality in a temporality of being. There is nothing else but instrumental reason of a plural nature, which is unbelieving, a matter of play, ironic, destructive, inclined to superficial tendencies of curiosity in a phenomenology of signs and appearances. Truth is replaced by the interplay of images, the ontology of semantics, the determination of indetermination, the transcendence of immanence, and the concepts of metaphor. Instead of the principle of causality there is the principle of the relationship between phenomena. That there is only one religion is absurd, and in the place of God there is a divine generality. Thus one reaches theoretical nihilism, a form of ethical relativism, and a lack of a set of moral rules.

4. Nihilism

This is the philosophy of nothing. Beings, things, values and principles are denied and are reduced to nothing. This is a 'making official' of the destructive tendencies that exist in society. Nihilism is especially connected with Nietzsche who discerned two types of nihilism – good nihilism and bad nihilism. For this thinker, good nihilism is the destruction of all the values of the past in order to construct new values – those of the superman; bad nihilism is calmly waiting for ancient values to come to an end and not substituting them with those of the superman. One cannot know truth; one can only know changing points of view. The will cannot do anything good. Because God is dead there is no normative point of reference. History cannot have an intrinsic self-completion. Everything is fleeting and provisional, and thus one cannot accept any serious undertaking. 'Ontophobia' is proclaimed, and this is a desertification of everything. Objective truth is replaced by 'points of view'. Life has no value because it is not unrepeatable, it is transmuted through reincarnation, and thus one can trade with it through cloning, surplus embryos, eugenics, euthanasia, and all the rest.

5. Lack of Trust in the Future

Everything is perishable, fragmentation and chaos; there is no

eternal and immutable element. The present is a point of intersection of the past and the future, and it is the only one that matters. There is a crisis of temporality and an all present historicism; the past is a kind of museum photograph, fragments of sacred images and images. History and the past are market objects that are consumed and exchanged. It is not possible to formulate any project in relation to the future.

6. The Return to Mystery and Pseudo-religiosity

There is no God without gods; many saviours and religions have taken the place of the single God the saviour. Religions without God and without a Church are envisaged. Reference is made to mystery but in a purely superficial perspective, involving obscurity and nebulosity.

In particular everything is reflected in the 'New Age' movement, whose 'creed' is summed up by Jean Vernette in what he calls 'the ten commandments of the New Age'. These commandments are: 1. You will impatiently await the age of Aquarius. 2. You will believe in the Great Change. 3. Your consciousness will carefully reawaken. 4. You will look after your body in an active way. 5. You will follow your teachers respectfully. 6. You will believe completely in the irrational. 7. You will faithfully venerate the goddess Gaia (the earth). 8. You will rigorously reject existing religions. 9. You will speak about the spirit with all naturalness. 10. You will laugh at death with serenity.

This religion prefers man to make himself God rather than for God to make Himself man. God is not a person but the highest vibration of the cosmos or the highest expression of transcendental consciousness. Truth is believing: 'it is true because you believe it' or 'it is true so that you feel good'. Every individual has an interior illumination. Guilt or sin do not exist, there is no redemption, no atonement, no grace; evil does not exist, and thus nobody is responsible for evil. One should not fear death because there is reincarnation, not resurrection. Religion is projecting one's own hopes; it is made to measure religion. This is the 'weak thought' of a secularised and individualistic society. It totally rejects Christianity.

7. The Principle of Diversity

There is no unity; only fragmentation. Society is transformed into groups of symbols, associations, and movements. The solidity of a political party, of the individual, of the nation, come to be replaced.

8. Tolerance

Through rapid communication contemporary society acquires the characteristic of being pluricultural and pluriracial. This is a society without balance.

9. The World

The starting point is a totalising ecologism which means sustainable growth and development, usually known as 'green peace', and which is to be seen as a reaction against the perverse effects of technological rule. The central tenet is that man depends on nature rather than that nature depends on man.

The world has neither meaning nor value; it has no purpose. Its sacred character is taken away. It is no longer the creation of God but is a universe or universes, infinite worlds subject to the sciences that are called upon to discover them and to dominate them, and, in the case of possible prosperity, to exploit them. The world is very uncertain, weak, and has an unpredictable future. It is merely a depository of things and objects; it has no divine order placed in the laws of nature. The sciences do not aim at human construction but at progress as such; they are directed towards their practical goals: for example increasing well-being, eating better, dressing better, etc., without any ethical evaluation or assessment. Technology and scientific knowledge are motivated by their economic interests and by commercial contracts; free giving is totally suppressed. The horizons of their hope are confined to what is provisional and to what is immediately accessible.

10. Man

Social life is confined to what is economic and political. Man feels lost and without any possibility of integration. He has neither meaning nor purpose; he is a 'tourist', a 'wanderer', a 'moral stranger'. The function of the meaning of everything was at the outset provided by religion. Religion is now relegated to the private world and has neither a economic nor a political role. Man places himself where once God was to be found.

There is nihilism in the philosophical field, relativism in the gnosiological and moral field, and pragmatism in daily life. Man is no longer the centre of nature, who, under the rule of God, governs all things – he is merely a small part of nature like the plants and the animals.

Reference is made to the four ages of man; during the modern age subjectivity was professed as the source of truth and freedom as supreme dominion – this was the age of the 'third man'. Now we have gone on to the culture of the 'fourth man'. The 'first man' was the man of Greek philosophical culture, the 'second man' was the man of Christian medieval culture, the 'third man' was the scientific man of modernity. Today we are faced with the 'fourth man', the man of consumption and the audiovisual. Now neither philosophy nor religion nor science are rejected – they are seen as linguistic games within a pyrotechnical kaleidoscope of knowledge that is no longer monologic but pluralistic and dissipated. 'God is dead. However, one can still believe in God. At base the two things are the same'.[7] One reaches syncretism or total indifference. Thus post-modern man comes to be alone, poor, and insecure; in losing God he loses his identity; he is 'like a wanderer who crosses a desert and knows only the paths marked by his own tracks, which are removed by the wind as he walks along'.[8]

The first man and the second man were a balanced synthesis of

the history of meta-history. This synthesis was destroyed by the third man who replaced religion and philosophy with the sciences. As regards the history of mankind, it is stated that history no longer exists, and that the past in a valid sense does not exist either. There is no past and no future; one lives only today in pleasure and for pleasure, and for this reason it is good to be strong and unbeatable.

Suffering, especially in its terminal stage, is neither pleasant nor good nor useful to anyone at all, and for this reason it has no meaning and must be eliminated by any means possible: (suicide, euthanasia, etc.). Supermen, whom Engelhardt calls 'cosmopolitans' and who are said to be experts in biogenetics, are invited to carry out this elimination by helping the terminal patient 'to die with dignity'.

The fourth man is a man without quality. He has gone from the technology of needs to the technology of desires. He only feels desires that have to be met and satisfied; he no longer feels needs. He can achieve this in particular through the most appropriate technology – the audio-visual media. Philosophical knowledge was specific to the first man, religious knowledge was specific to the second man, scientific knowledge was specific to the third man, and expressive knowledge is specific to the fourth man. There is a confusion between faces and masks, between history and legend. The media create this confusion and in such a way that in the end even legend no longer exists. This is the new knowledge, the knowledge of art or aesthetic knowledge. Radical man is thus constituted. Radical man professes a total, possessive and anarchical individualism; he expresses himself in a series of negations; he is against the family, he is anti-militarist, anti-clerical, anti-party, and against the state. He attributes an absolute value to his spontaneity, with its socio-political consequences of sexual liberation, homosexuality, feminism, abortion, divorce, the fight against lunatic asylums, against prisons, against concordats, in favour of the abolition of religious teaching, etc. He is the man of radical anti-culture.

For this man, the person and the individual are not the same thing. The person is only a set of activities or properties, such as mental operations, self-awareness, the sensorial, and the capacity to communicate and to engage in symbolic representation. Where such activities do not exist, there is not a person but an individual. Thus, for example, when a man who is not conscious is killed, there is no guilt because an individual and not a person is being killed. Thus it is explained that the destruction of embryos, therapeutic cloning, eugenesia, euthanasia, etc. are all licit.

The only evil is repression. Nobody must inhibit anyone else. The phrase 'we are all perfect' is used to counter the saying 'we are all sinners'. Each person is his own yardstick of good. Thus each person can use other people and everything that exists as objects to meet his own desires. Thus one is completely free. One has rights but no duties. Public power is legitimised solely through the principle of utility. Happiness is the same as well-being and pleasure, which is not a matter of meeting needs but of satisfying desires, of consuming objects, things, and experiences. Consumerism is the new god; nothing can exist without this god.

The only limit to radical man is the contract. The law does not bind him because this is directed towards the common good which he denies. A contract is accepted only as reciprocity and only when it is advantageous. Contracts that are not advantageous are not renewed. And when the party that is disadvantaged rebels, power of any kind is used by the strong to suppress the weak. Thus the production, the indiscriminate commercialisation, of any kind of weapon is justified, and the greatest satisfaction is reached. One goes from the defence of the rights of man to the defence of the man of rights.[9]

The environment in which this man lives is the evolved world of high technology, a world in which the rich countries of the world wish to dictate the rules to everyone else. This man dwells within computerised economic globalisation in order to live at the expense of the world of the excluded, the poor countries who no longer matter except as potential for exploitation/investment, both of raw materials or cheap manual labour. Investments are made in anonymous fashion by companies in which the sole motivation is the best economic gain possible in line with the variation of markets, without any attention being paid to the economic disorders produced in poor countries because of the flight of capital abroad.

As a result, we have 'science without a conscience' as the expression of *homo potens*, the lord of life and death, who nonetheless continues to fear death, which he wants to mask by even using corpses at luxurious funerals that are fixed in a smile. Despite all this experience one can see that homo potens at a deep level has become, even though this is something that is not acknowledged, *homo pavidus*.

We should not be surprised at the fact that in a world that wants to organise itself in this way depression turns out to be the greatest murderer that exists.

As without doubt we will hear during this international conference, in the culture of post-modernity, there will be those who explain depression as a conflict caused by old sexual taboos examined by psychoanalysis; or by biological problems caused by cerebral serotonin or nor adrenalin; or by what are termed cerebral cognitive conflicts, akin to the bugs or

viruses in computers; or by reactions that are termed systemic because they can be treated with reference to the 'system', within family therapy; other people refer to Gestalt theories and argue that depression is due to a kind of psychic pattern caused by endogenous and exogenous factors which in the instinct for self-conservation reject unpleasant events.

There can be no doubt that there are forms of depression caused by physiological disturbances and that they must therefore be treated by the drugs and medicines which cure them. There are also psychological, affective or every other kinds of disturbance. But in essentials, in my opinion, the whole of this post-modern mentality, which in this paper we have tried to summarise and systemise, in varyingly explicit ways penetrates the cultural contents of contemporary society and provides us with a 'parology' of instability. We are referring here to the decline of thought, which is rightly called 'weak thought', and which as such can only generate the horrendous culture of death. This culture provokes an uncontrollable fear and is openly expressed in a whole series of forms of depression.

St. Thomas Aquinas and Depression

I would like to finish this introduction by contrasting the absurd thought of the radical anti-culture with some aspects of 'strong' medieval thought as expressed by one of its most important thinkers – St. Thomas Aquinas. In his own way, with the term 'sloth', he drew near to what we now call 'depression'. As in a painting by Caravaggio, with the light and darkness of St. Thomas and post-modernity, we will provide a framework for the study that we are shortly to engage in.

Turning to the thought of St. Gregory, St. John Damascene, St. Isidore of Seville and St. John Cassian, St. Thomas Aquinas provides us with a concise summary of aspects that were considered of importance in ecclesiastical thought and which in my opinion can in our age be thought about to advantage when discussing depression and its cure.

St. Thomas says that sloth is a kind of sadness that has a corporeal connotation which increases with the heat of the day and the season. Some people complain that with it the wished for spiritual fruits do not materialise. It must be borne and overcome. It so depresses the spirit that a depressed person pays attention to nothing and his sadness is thus aggravated.[10] It involves tedium in action. It is a torpor of the mind that allows nothing good to be begun. '*Torpor mentis bona negligentis inchoare*'. It is an evil in itself and in its effects. It is an evil in itself because it sees as evil that which is good. It is evil in its effects because it diverts man from doing good. Its wrongdoing is concentrated around his very desires. It is a sadness that is experienced because of something that is good. It increases with deficient corporeal interaction. Sloth despises the goods that God gives us. It can be defeated by thinking about and experiencing spiritual goods.[11]

According to St. Gregory there are six daughters of sloth: malice, rancour, pusillanimity, desperation, torpor in relation to precepts, and the movement of the mind towards what is illicit.[12] St. Isidore says that sloth is an inclination towards improper rest,[13] and that from it comes idleness, sleepiness, unsuitable mental processes, disquiet of the body, instability, verbosity and curiosity.

It is a kind of sadness under whose weight people are encouraged to engage in certain actions. It weighs upon the spirit and encourages the person to do what most engenders sadness and to avoid what can generate happiness. In order to avoid sloth a man must flee from what causes him sadness or detach himself from those that cause him sadness. Another way of doing this is to do what he likes doing. A flight from purpose is caused by hopelessness; flight from the goods that lead him to his purpose is caused by pusillanimity; the non-fulfilment of precepts is engendered by rancour; a detestation of spiritual goods is brought about by malice; the abandonment of what is spiritual for material appetites is caused by the movement of the mind towards what is illicit. Thus bitterness is generated as an effect of rancour.[14]

Sloth is in opposition to joy. It involves becoming sad about the divine good that is enjoyed through charity. St. John Cassian says that sloth is frequently encountered in those who live alone and is the most contagious and frequent enemy of people who live in the desert.[15]

Sloth is sadness of spiritual good understood as a divine good. And it comes to be a mortal sin when it obtains the complete consent of reason as a flight from, aversion towards, and detestation of, divine good. When it does not arrive at full consciousness but remains in the senses then it is only a venial sin. It is not a drawing away from a spiritual good but from divine good itself. Although amongst the saints there are certain aspects of sloth, they did not fully acknowledge this.[16]

Conclusion

It appears that we thus come to link St. Thomas Aquinas with post-modernity: in the final analysis sloth is sadness in relation to the divine good that is enjoyed through charity. This divine good is nothing else but the divine life itself. To become sad about it is to understand it as an evil, as something that is inconvenient, to deny it. To deny life is death. The whole of the thought of post-modernity leads to death within the so-called radical anti-culture of the fourth man. Thus sloth meets post-modern *homo pavidus*, depressed man. The only remedy is affirmation of life in the face of the anti-culture of death. The only incontestable affirmation of life is the resurrection. Only the resurrection of Christ and our resurrection in him, beyond any brilliant religious invention but as a fact that took place and takes place, distances depression from any palliative and reaches its ultimate roots and destroys them completely. This is because it destroys death itself.

Thus all these summarising ideas about post-modernity and St. Thomas Aquinas serve as a small introduction to our international conference on depression.

We will begin our reflections with the masterful paper by His Eminence Cardinal José Saraiva Martins who will discuss biblical anthropology and Christian faith in relation to depression. After his reflections we will follow the three stages of the conference indicated in detail in the programme. First of all, we will analyse what depression is, then we will try to understand it in the light of the Word of God, and lastly we will draw some practical conclusions on how to address depression.

At the outset I would like to thank most cordially all the great experts who will favour us by accompanying us during this reflection, placing at our disposal their knowledge, their learning and their skills. There can be no doubt that they provide an irreplaceable support for the carrying out of the mission that the Holy Father entrusted to the Pontifical Council for Health Pastoral Care. Once again many thanks to them and many thanks to all of you for your highly-qualified presence

His Eminence Cardinal
JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Pastoral Care, the Holy See

Notes

[1] Cf. I. SANNA, *L'antropologia cristiana tra modernità e postmodernità* (Brescia, 2001), pp. 160-161.

[2] Cf. F. NIETZCHE, *Ecce homo, Wie man wird was man ist*; Italian edition: *Come si diventa ciò che si è,* (Milan, 1965), pp. 80-117.

[3] Cf. M. HEIDEGGER, *Aus der Erfahrung des Denkens* (Pfullingen, 1953), p. 76; *Essere e Tempo* (Milan, 1976), pp. 168-178.

[4] Cf. L. WITTGENSTEIN, *Tractatus logico-philosophicus* (Turin, 1964), prop. 6,52, 521, 41, 42, 4311; *Ricerche filosofiche* (Turin, 1967) I, 124, 130-132. *Tractatus Logico-philosophicus e Quaderni,* 1914-1916, prop. 8,7,16., prop. 8,7,16.

[5] J-F LYOTARD, *Il postmoderno spiegato ai bambini* (Milan 1987), p. 28; *La condizione postmoderna (*Milan, 1981), pp. 6, 20-24, 69-76, 98-122; *Postmoderno e filosofia,* p. 410.

[6] For the works by Vattimo see: G. FORNERO, *Postmoderno e filosofia*, pp. 411-420; 'Il Postmoderno e le sue filosofie', in *Le Filosofie del novecento* (G. Fronero-Tassinari, Milan, 2002), pp. 1204-1214. Cf. G. VATTIMO, *La fine della Modernità, Nichilismo ed ermeneutica nella cultura postmoderna* (Milan, 1985), pp. 9-30, 189; *Credere di credere. È possibile essere cristiano nonostante la Chiesa?* (Milan, 1996), pp. 25-26; *Dopo la cristianità. Per un Cristianesimo non religioso* (Milan, 2002), pp. 57-58; *Filosofia al presente,* 26; *La società trasparente* (Milan, 1989), pp. 11-17.

[7] G. MORRA, *Il quarto uomo* (Rome, 19929, pp. 11-23.

[8] I. SANNA, *L'Antropologia cristiana tra modernità e postmodernità* (Brescia, 2001), p. 337.

[9] For this summary of post-modernity see: ISAÍAS DIES DEL RÌO, 'Postmodernidad y nueva religiosidad', *RelCult* XXXIX (1993) pp. 59-63. M.P. GALLAGHER, *Parlare di Dio all'uomo postmoderno. Linee di discussione* (Pouppard, Rome, 1994), pp. 5, 7; *Fede e cultura* (Cinisello Balsamo, Milan, 1999), pp. 103-108; 124-125; G. BRUNI, *Dire Dio agli uomini d'oggi* (Pouppard, Rome, 1994), pp. 26-27; G. FORIERO, *Postmoderno e Filosofia* (Turin 1994), p. 411; N. ABAGNANO AND G. FORNERO, *Ecologia* (Turin, 1994), p. 335; I. SANNA, *op. cit.*. 220-236; C. TAYLOR, *Il disagio della modernità (*Rome/Bari, 1994), pp. 12-14; G. MUCCI, *La diffusione dell'Indidividualismo (*CivCatill, 1997), pp. 468-477; R. CESARANI, *Raccontare il postmoderno* (Turin, 1997), pp. 140-145; D. HARVEY, *La crisi della Modernità* (Milan, 1993), p. 63; GATTO TROCI, *Nomadi spirituali* (Milan, 1998), p. 17; CH. SINISCALCHI, *Il dio della California* (Rome, 1998), pp. 33-34; G. FILORAMO, *Il risveglio della gnosi ovvero diventare dio (*Rome/-Bari, 1990); J. VERNETTE, *La nuova era* (Rome, 1998), pp. 111-123; F. VOLIPI, 'Nichilismo o nichilismo', *Dfil.*, pp. 756-758; A. SANTUCCI 'Nichilismo', *EncFil*, III, pp. 890-891; V. POSENTI, *Terza Navigazione, Nichilismo e Metafisica (*Rome, 1998), pp. 352-353; G. ARDISONE, *Il postmoderno* (Milan, 1998), pp. 28-32; Z. BAUMAN, *Postmodern Ethics*, (Oxford/Cambridge, 1993), p. 240; DOTOLO, *Secolarismo e Nichilismo nella Fides et ratio* (Cinisello Balsamo 1999), p. 270); S. LATORA, *La ripresa del primato dell'Etica* (Cinisello Balsamo, 1994), pp. 125-126; M. MCKEEVER, 'Postmodern with a difference', *StMore*, 37 (1999) pp. 185-214; R. FRATALLONE, *L'etica teologica e le istanze della postmodernità* (Cinisello Balsamo, 1994), pp. 76-77; G. CHIURASI, *Il postmoderno* (Turin, 1999), pp. 18-22; S. CREMASCHI, *Ecologismo*, ENCFSU, p. 243.

[10] ST JOHN DAMASCENE, *De Fide ortodoxa* I.II, c.14. MG 94, 932B.

[11] ST. THOMAS AQUINAS, *Summa Theologiae,* Seconda Secundae, q.35, a. 1 Marietti, 1952.

[12] ST. GREGORY, *XXXI Moral* C. 45 al 17 in Vet 31 n,88 ML 76, 621 B.

[13] ST. ISIDORE, *De Summo Bono,* Al. Senten. I.II, c. 37 ML 83, 638 C.

[14] ST. THOMAS AQUINAS, *Summa Theologiae,* Seconda Secundae, q,35, a. 4. Marietti, 1952.

[15] ST. JOHN CASSIAN, *Lib. X de Insitutis Cenobiorum,* ML 49,363 A.

[16] ST. THOMAS AQUINAS, *Summa Theologiae,* Seconda Secundae, q.35, a. 2-3. Marietti, 1952.

PROLUSION

JOSÉ SARAIVA MARTINS

Depression: the Clinical Phenomenon, Biblical Anthropology, and Christian Faith

Introduction

Depression has become the illness of our century, almost a symbol of modern times. Perhaps it is not very meaningful to refer to statistics, but according to some calculations depression afflicts 12% of the population.

Because it is so widespread, depression has also been defined as being the 'common cold' of psychiatry. It afflicts men and women, young people and the elderly, the inhabitants of industrialised countries and of developing countries (cf. Nuber, 1991, 6).

A group of researchers has gone beyond this by asking whether we are not all depressed (cf. Woodruff, 1975); and have posed a disquieting question: 'how normal is it to be depressed?' (Zung, 1972). The answer is clear: depression has never been a normal state, even though, as is increasingly demonstrated, in this field there is a notable confusion at the level of concepts, with the absence of a clear distinction between, for example, sadness and mourning (reactions that are completely natural to a situation of loss) and depression as an illness. Indeed, the word 'depression' can have different meanings: it can define a feeling, a clinical state, or the style of a person's character (cf. Friedman, 1974, 282).

This paper does not want to engage in a clinical study of the nature and treatment of depression, but seeks, rather, to be a Christian reflection on a mental phenomenon that also has a religious and spiritual dimension. Specifically from this point of view, after briefly examining the phenomenon of depression, questions will be raised about how depression is seen in biblical anthropology and the possible response of the Christian faith.

1. The Phenomenon of Depression

a. Its definition and classification

By depression is meant a set of symptoms that bring about a sad and 'downcast' mood, a lack of interest and of impulse, motory and psychic inhibitions, with mental contents that are typically depressive, accompanied by specific somatic disturbances (cf. Lindzey, Thompson and Spring, 1991, 685-712.).

In ending his analysis of the different classifications of depression, R. E. Kendall finds that the most frequent criterion is the distinction between depression of an endogenous/psychotic kind and depression of a reactive/neurotic kind. The distinguishing point is to be identified in the ability of the patient to face up to reality (cf. Kendell, 1976, 25; Kendell – Courlay, 1970, 257 etc). Symptoms such as hallucinations, and perhaps also some somatic symptoms (disturbance of sleep, weight loss), can be associated with the psychotic type. Feelings of guilt, anxiety and agitated forms of behaviour can be associated with the neurotic form.

Another proposal, which is of a psychodynamic orientation, is the one formulated by Arieti and Bemporad. These authors are convinced that in most cases of depression it is possible to identify whether one is dealing with psychotic depression or neurotic depression, but they propose to designate these two forms 'severe' depression or 'mild' depression by employing the subjective criteria of the patient, that is to say whether he or she does or does not accept his or her own depression. If the patient accepts his or her depression as a way of living, and thus lives it out as syntonic, then it is severe depression, i.e. psychotic depression. If, on the other hand, his or her depression is not accepted as a way of living and the person looks for help, the depression is seen as dystonic, that is to say it is mild (i.e. neurotic) depression.

b. Depression, sadness and unhappiness

Depression cannot be reduced to a single factor. It is the result of the coinciding of different factors. Biological, historical, environmental and psychological factors play a certain role in its beginning and its evolution (cf. Fennell, 1998, 169).

Many people never reach a state of clinical depression. Such depression, with the feeling of paralysis

that it involves, is different from normal sadness. People with clinical depression, in general, demonstrate physical and psychic alterations; people who are not depressed manifest certain mental signs of sadness.

In addition, people often confuse depression with unhappiness. Often one can hear the phrase 'I feel depressed', even though the person concerned only wants to say that he or she is not happy. Until one has really experienced depression one cannot realise the enormous difference that exists between being depressed and being unhappy. When we are unhappy, despite the scale of the tragedy that has afflicted us, we remain in contact with reality. When other people offer us consolation and love we can still feel gratitude for their warmth and support. But when we are depressed we feel like people who are excluded from the rest of the world. The comfort and love offered by other people do not penetrate our barrier and we feel neither consoled nor loved. To experience real depression means to feel entrapped in pitch or suffocated by some dense, heavy material or buried alive in a dark tunnel. The depressed person is interested in nothing and nobody, and does not feel any hope (Kenneth, 2002, 28).

2. Biblical Anthropology

a. Forms of depression in the Bible

It would be anachronistic to look for a 'clinical' terminology in the Bible, but, on the other hand, given that we are dealing here with universal human experiences, traces of such experiences also exist in the biblical texts. We ask ourselves, in particular, in what form depression is presented in the Old Testament and what remedies are offered for it in the sacred texts.

In the 1990s a rather lively polemic developed between different psychologists. This polemic was generated by an essay published by C.J. Frost, a lecturer at Midway College in the United States of America, which called into question the clinical concept of depression based upon the model of homeostasis, and instead proposed the concept of melancholy as an alternative by which to understand and assess the feeling provoked by an experiential incongruence. Frost argued that the concept is widely present in the literature on religion in general, and in the Hassidic works (biblical texts), as analysed by Elie Wiesel (Frost, 1992, 71).

In short, the author argued that many people labelled as depressed do not suffer from depression (in a clinical sense, that is to say from an abnormal, negative state) but from melancholy (a positive state, which is actively chosen). The point of departure of the author is Hassidic literature, where melancholy means a special configuration of the person's perception: the vision of incongruity. There are certain events in life where the only appropriate human response is melancholy. This does not mean to say that the theories about depression are necessarily false, or that the very concept of depression should be eliminated. The author suggests that a sub-group of experiences could exist, experiences hitherto classified as being depressive, but which could be better assessed and addressed as melancholy.

Beginning with the realm of symptoms, we can read anew certain biblical texts, and in particular a number of psalms, as an expression of the depressive state. Amongst the most visible symptoms that we find in these psalms, we may list the following: sadness, a lack of interest, a reduced capacity for work, disturbances of sleep, weight loss, feelings of guilt, suicidal thoughts (including the desire to die or never to have been born), and the desire to cry. Some examples can be taken from the psalms, where, indeed, some of these symptoms can be recognised.

Psalm 55 (vv. 5-6): fear, darkness (and more extensively vv. 2-15; 17-24):

> My heart is in anguish within me,
> The terrors of death have fallen upon me.
> Fear and trembling come upon me,
> And horror overwhelms me.

Psalm 88 (vv. 1-6): fear, a life transformed into a hell, a man without help:

> O Lord, my God, I call for
> Help by day;
> I cry out in the night before thee.
> Let my prayer come before thee.
> Incline they ear to my cry!
>
> For my soul is full of troubles,
> And my life draws near to Sheol.
> I am reckoned amongst those who go
> down to the Pit;
> I am a man who has no strength...

Psalm102 (vv. 1-12): seems to express certain physiological symptoms of depression:

> Hear my prayer, O Lord;
> Let my cry come to thee!
> Do not hide thy face from me
> In the day of my distress!
> Incline thy ear to me;
> Answer me speedily in the day
> When I call!
>
> For my days pass away like smoke,
> And my bones burn like a furnace.
> My heart is smitten like grass, and withered.
> I forget to eat my bread.
> Because of my loud groaning
> My bones cleave to my flesh

One of the corporeal symptoms of neurotic depression can be *agitated behaviour*. This phenomenon was already documented in the ancient world, including the biblical world. 1 Kings 21:27-28 describes the reaction of Ahab to the prophecy of Elijah who had pronounced the divine sentence: 'And when Ahab heard those words, he rent his clothes, and put sackcloth on his flesh, and fasted and lay in sackcloth, and went about dejectedly'. Tearing one's clothes, putting on sackcloth, fasting etc., are all forms of behaviour that are associated with mourning. However, the reference to going about dejectedly would indicate a state of depression.

We should also take into consideration *Psalm 35:14*: 'as though I grieved for my friend or my brother; I went about as one who laments his mother, bowed down and in mourning', and *Psalm 38:6*: 'I am utterly bowed down and prostrate; all the day I go about mourning'. These two examples place together

walking (going about) with being bowed and prostrate, which are signs of depression. And there is also *Psalm 42:10b*: 'Why go I mourning because of the oppression of the enemy?' (cf. *Psalm 43:2:* 'For thy art the God in whom I take refuge…Why go I mourning because of the oppression of the enemy?').

Another example of agitated behaviour as a symptom of depression is to be found in Job 30:28: 'I go about blackened, but not by the sun; I stand up in the assembly, and cry for help. I am a brother of jackals, and a companion of ostriches. My skin turns black and falls from me, and my bones burn with heat. My lyre is turned to mourning, and my pipe to the voice of those who weep'. These verses appear in the context of laments, to which is associated, some verses later on, the expression: my lyre is turned to mourning (cf. Barre, 2001, 180-181).

b. The Biblical answers to depression

If biblical anthropology knew about the phenomenon of depression, one can ask what answer the holy texts gave to this disturbance. They found the answer in certain fundamental beliefs that were also remedies: the belief that man is always loved and appreciated by God, who is always near to man; that the world, in general terms, is not hostile to man, but good because it expresses the greatness of God; that the world has meaning because its Creator is present within it; and that it is normal to express one's emotions.

Such beliefs are emphasised in particular in certain psalms.

a) *The appreciation and unconditional love of God.* Biblical faith offers an indisputable point of reference as to its value, for example in *Psalm 9-10* (vv. 33-35) we find:

Arise, O Lord; O God lift up thy hand;
Forget not the afflicted.
Why does the wicked renounce God,
And say in his heart, 'Thou wilt not call to account'?

Thou dost see; yes, thou dost note
Trouble and vexation,
That thou mayest take in into thy hands;
The hapless commits himself to thee;
Thou hast been the helper of the fatherless.

b) *The belief that the world, in general terms, is not hostile but good, and expresses the greatness of God*. We can refer here to *Psalm 8* where the psalmist contemplates the greatness of the creation:

O Lord, our God
How majestic is thy name in all the earth!
Thou whose glory above the heavens is chanted…
When I look at thy heavens, the work
Of thy fingers,
The moon and the stars which thou hast established;
What is man that thou art mindful of him,
And the son of man that thou dost care for him?

c) *The belief that the world has meaning because God himself is present within it*. We can refer here to *Psalm 23* which expresses its strong belief in the presence of God, even in the dark, or to *Psalm 139* (vv. 13-14), which sings of the wonder of the wisdom of God:

For thou didst form my inward parts,
Thou didst knit me together in my mother's womb.
I praise thee, for thou art fearful and wonderful!
Wonderful are thy works!
Thou knowest me right well.

d) *The belief that it is normal to express one's own inner feelings*. Some psalms strongly express feelings of disappointment, anger and pain. For example, there is *Psalm 6*, which appears to be a description of the most recognisable symptoms of depression, such as laments, insomnia, physical weakness etc. (vv 2-8):

Be gracious to me, O Lord, for I am languishing;
O Lord, heal me, for my bones are troubled.
My soul also is sorely troubled.
But thou, O Lord, how long?…

I am weary with my moaning;
Every night I flood my bed with tears;
I drench my couch with my weeping.
My eye waste away because of grief,
It grows weak because of all my foes!

All these remedies proposed by biblical anthropology are also valid today. The therapeutic value of the above-mentioned beliefs is still intact. Christian faith, however, adds further perspectives regarding the events of life and thus on depression as well.

3. Depression and the Christian Faith

A relevant number of studies demonstrate the positive impact of the spiritual and religious resources of a person on his or her mental health, and thus on depression as well (Larson and Larson, 2003, 44). Amongst the beneficial effects to be encountered, it has been ascertained that the spiritual resources of the depressed patient have accelerated the healing process. This function of spirituality refers, however, only to the mental and cognitive processes, and

does not have any effect on the biological symptoms of depression, such as weight loss, sleeplessness, reduced concentration etc. (cf. Larson and Larson, 2003, 44). In order to orientate ourselves in the field of the relationship between spirituality and mental health, we should bear in mind certain distinctions.

a. Depression and desolation

One of the contributions of Christian spirituality is the distinction made between depression and desolation: this latter can have spiritual causes. An analysis of desolation is one of the treasures of the book 'Spiritual Exercises' by St. Ignatius of Loyola. In n. 317 he offers us this definition of desolation: 'Fourth rule, Regarding spiritual desolation. By desolation I mean… the darkness of the soul, inner disturbance, the stimulus to low and earthly things; dismay at every kind of agitation and temptation, such as they lead to distrust, without hope and without love; as a result of which the soul is completely lazy, lukewarm, saddened and as though it were separated from its Creator and Lord'.

This definition brings out the similarities and the differences between desolation and depression.

a) Both states have in common the fact that the grief refers to a past experience; present-day experiences are presented as being emotionally unsatisfying, boring and unpleasing; the faculties of the will are weakened and those of the intellect function in an inappropriate way; and the whole of the dynamic of life and of interest in the outside world are empty.

b) There are, however, differences that help us to distinguish between the two states of mind.

– In spiritual desolation, the grieving refers more to the *relationships with the person of God*; the principal problem is worry about the disappearance of the effects of consolation; the spiritual faculties work in a distorted way; and the person does not see the fundamental cause of the temptation to which he or she thinks he or she has, to varying degrees, consented.

– In depression, on the other hand, grieving is more centred round the self-image that the person has formed for himself or herself or thinks that others have of him or her; the person does not manage to identify the real problem and no explanation convinces him or her; his or her spiritual faculties are inhibited; and the causes of all this are hidden in the processes of the unconscious (cf. Aufauvre, 2003, 47-56).

In order to discern the transcendental origin of this experience the following criteria are useful:

1) The person continues to tend in a sincere way towards perfection;

2) Despite all the difficulties at the level of meditation, the person makes progress in his or her moral life: he or she is humble, benevolent and attentive towards other people. From a psychological point of view, one could add that it is clear that his or her will is intact, indeed, is inclined towards an increasing co-operation.

3) In his or her memory there predominate memories of previous graces received, i.e., in his or her soul there prevails nostalgia for God.

4) Although meditation and prayer bear no fruit, his or her interior activities, contemplation and self-analysis remain intact; his or her soul lives in the presence of God (cf. Marcozzi, 1963, 132-135).

b) The preventive function of the spiritual life

A regular spiritual life can prevent neurosis, including reactive depression. This is explained by taking into account the dynamics of neuroses.

Neuroses or abnormal existential reactions are the result of an anomalous working out of emotional stimulations; they are, that is to say, 'inadequate forms of reaction that have become chronic'. Neurotic symptoms can be rooted in reactions that may be considered normal in specific circumstances, but which become pathological because of their intensity and fixation. The core of every neurosis is anxiety, and the neurotic symptoms are essentially forms of the manifestation of this anxiety or of the defence against it.

Experimental research on the preventive function of spirituality in depression has demonstrated that spirituality acts as a moderator between negative and stressful experiences and a depressive reaction (cf. Young *et al.* 2000, 49-58). In other words, an authentic and constant spiritual life also has the collateral effect of corroborating the personal structure, that is to say the interior milieu.

a) A spiritual life provides first and foremost *greater self-awareness*. There are few cultural or artistic activities that direct so much attention towards themselves as religion. Christianity is a constant call to conversion, to purification, and to change. Prayer and confession, for example, are always, by their very nature, activities centred round the person. The first positive effect of a constant spiritual life is thus greater self-awareness. It should be said that psychotherapy also aims, albeit at another level, to achieve growing self-awareness on the part of the person as a path and means of healing. This return to the core of the person in spiritual practice takes place at three points: the first consists in the purification of the mind of everything that St. Ignatius called 'disordered inclinations'; the second is a positive orientation towards higher values (which today is often called self-transcendence); and the third is real interior freedom. Mystic literature calls these three moments the 'three ways': purification, illumination, and union with God.

b) Spiritual life places the believer in a continual situation of divine empathy. In order to organise his pastoral consultancy, S.M. Natale begins from the theological fact that the Incarnation is in fact a 'therapeutic process' of God, that is to say that an ontological acceptance of man by God (cf. Natale, 1977, 21). The point of encounter between theology and psychology is the following: the assumption that man is in basic terms 'acceptable'. Theology calls this state 'justification'. If the person becomes aware of it and accepts it, it is said that he or she is in a 'state of grace'.

c) Faith in God the Creator is the factor that assures meaning to life because it says that each person is created for a personal task in his or her life; that he or she is willed and loved by God. All of this offers the

believers a climate of deep mental security. But religion also performs a specific role at another level. Despite all our attempts, certain irrational phenomena – which are without meaning – remain: wars, destruction, suffering, and death itself. Well, only religion can offer man an acceptable answer to these examples of irrationality.

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

We have examined some psychotherapeutic processes that seek to reinforce the mechanisms of self-defence of the human psyche. The common denominator of all these processes is the fact that they increase the resistance of the interior milieu of man. The same processes, we have seen, are also present in spiritual life, which is not made up of specific practices but of a continuous, stable and personal interior experience.

Conclusion

We have been engaged in a journey within the phenomenon of depression and began with certain data of the professional world of psychology and psychiatry. We then passed through the biblical world, finding therein clues that attest to a knowledge about depression and related responses to it within biblical anthropology. Lastly, we came to the world of Christian spirituality, which in a surprising fashion contains many psychotherapeutic principles that can prevent the imposition of depression and provide relief to it.

This journey has opened up to us new horizons for the study of depression. Suffering man has always occupied a privileged position in biblical anthropology and in the Christian message. God does not forget about the sick person. Indeed, he or she is at the centre of His compassionate love. In the Bible God reveals His identity by saying to Moses: 'I am the God of Abraham, of Isaac and of Jacob'. We could translate these words in the following way: 'I am the God of the sick, of the poor, and of the depressed'. In fact, Jesus specifically announced the beginning of his messianic mission with the words: 'I have come for the sick…', and this included everyone, depressed people as well. Spiritual life transforms this promise into concrete contents that offer the believer spiritual support in facing up to every illness, and thus to depression as well.

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I Section

The Present State of Depression in the Contemporary World

SALVADOR CERVERA-ENGUIX

1. Depression between Malaise and Illness

The Clinical Definition of Depression

Moods must be considered carefully because they reveal and touch upon the principal core of personal inner being. In particular, a mood that expresses sadness is one of the most frequent forms of psychological malaise. However, if a person feels sad or depressed this is not sufficient to say that that person is suffering from depression. This term, in fact, has a number of meanings. It can refer to a sign, a symptom, a syndrome, an emotional state, a reaction, an illness or a well defined clinical phenomenon.

In the scientific world two approaches have been created to establish when a fluctuation in mood is depression and when it is not.

The employment of a *broad criterion* for depression. This includes a series of symptoms that range from not very stable feelings of sadness – provoked by specific events that do not have special repercussions on the life of the individual involved – to profound states of sadness and inhibition that render the person unable to act. It is argued that here the difference is only quantitative, as though there was a continuum between the various manifestations of the condition.

The employment of an *adapted and well defined criterion* for depression, which is clearly differentiated from normal episodes of unhappiness, malaise or anxiety.[1] This affection is described on the basis of the diagnostic principles of every illness (aetiology, development, prognosis) and diagnostic groups have been established that respect well defined criteria. Emphasis is placed not only on the quantitative change in the situation but also on the qualitative differences between the symptoms, and in particular on the characteristics and the consequences of sadness.

The Boundaries between Normal Sadness and Pathological Sadness

It is important to distinguish depressive disturbances from normal feelings of unhappiness, dismay or discouragement, which themselves are habitual and suitable reactions to personal difficult events and situations. *Mourning* for the loss of a person who was loved is a characteristic example of a situation that can be experienced with 'normality' on the one hand, or generate a pathological affection on the other.

The various ways in which a person reacts emotionally to an adverse event can be categorised into three groups: 1. a normal emotional response; 2. a disproportionate emotional response; and 3. a depressive state (which is not always reactive) in line with diagnostic characteristics.

In a *normal emotional response* we are faced with transitory feelings of sadness and frustration that are common in daily life. This sadness, which we call normal, may be characterised as having by three specific features: a) it is suitable to the stimulus that has caused it; b) it has a short duration; and c) it does not affect in any special way the somatic sphere, professional performance or relational activities of the individual involved.

A *disproportionate emotional response* is a response with intense and persistent emotional manifestations that in themselves interfere with the capacity of the individual involved to control the stress that is at the origins of this emotional response.

A *depressive state* in its various forms is a pathological state in which joy in living, the ability to act, and the hope of recovering well-being are all lost. It has a typical set of symptoms that marks a well defined clinical syndrome, that tend to emerge simultaneously, and that are not always associated with stress.

The Principal Characteristics of Depressive States

The term 'depression', considered as a pathology, is a concept that refers to at least two different realities: a) depression as a *symptom* – a sad mood which may accompany most mental illnesses but

which is also present in other medical situations; and b) depression as a *syndrome or clinical phenomenon* – a set of connected symptoms that clearly indicate a clinical state.

In both cases, as has already been pointed out in this paper, we have a pathological state in which joy of living, the ability to act, and the hope of recovering well being are all lost. This is accompanied by the following clinical features.[2]

Mood and affective tone

Sadness with preoccupation, worry or a feeling of loneliness. Low reaction to facts, whether they are pleasurable or not; a lack of motivation; a lost of interest in things and/or pleasures; a feeling of emptiness; apathy; anxiety; tension; irritability; and anger. Difficulties in acting with reference to the future. A lack of a feeling of hope.

Thought

A decline in concentration; indecision or vacillation; a loss of self-confidence or self-esteem; a belief in one's own uselessness; a feeling of guilt without there being any apparent reason for such a feeling; powerlessness; pessimism; desperation; and a desire for death and suicidal ideas.

Psycho-motorial activity

A slowing down of the body movements; a lack of facial movements; an inability to engage in interpersonal communication; a lack of communication or agitation; worry; impatience; and uncontrollable hyperactivity.

Somatic manifestations

Changes in the life functions: insomnia and/or hypersomnia; an increase or reduction in appetite and weight; a decrease in sexual desire.

Changes in vitality: tiredness; fatigue; a decrease in energy; and a lack of vigour.

Vegetative systems: gastrointestinal and cardiovascular disturbances and other types of disturbance connected with the working of the body (e.g. dizziness).

This set of clinical manifestations show that we have a specific pathological state which is clearly different from normal sadness and which has forms and intensities that are well described.

The Clinical Diagnosis of Depressive States

Clinical practice shows that this constellation of characteristic symptoms is not present in its totality in every patient – in each case varyingly complete categories of symptoms are present. One need only recall here what has been pointed out in this paper about depression as an illness, syndrome, symptom, etc, without, however, forgetting about the interrelationship with anxiety or personality disorders, or the links between obsession and depression.

Although in recent decades great advances have been made, most of the physio-pathological mechanisms of depression are still unknown. Our (causal) etiological knowledge of this illness is limited to physical forms of depression and the existence of the many factors, of different kinds (whether biological, personal or environmental), that contribute to the appearance of a depressive condition. The diversity of the models of interpretation of the different schools creates a further difficulty.[3]

For this reason, when a *diagnosis* has to be made one has to use a preeminently clinical criterion based upon the following terms:

1. Knowledge of the psychopathology involved through the case history and observation of the patient with a differentiation of the objective and subjective aspects of the set of symptoms involved.
2. A phenomenological description of the symptoms that define the clinical picture of the patient.
3. The intensity of the symptoms (light, moderate, grave, psychotic).
4. The duration of the set of symptoms.
5. The quantitative and qualitative aspects of the sadness.
6. The presence or otherwise of somatic symptoms.

The Principal Clinical Forms of Depression

There now follows a brief description of the principal disturbances of mood that have been clinically established and diagnosed. Each of them has differentiated diagnostic criteria, aetiopathological peculiarities, and in many cases well defined forms of treatment and diagnosis.

At the present time in the scientific field there are two systems for the classification of mental illness (CIE and DSM IV-TR) which are used at an international level and employed by internationally recognised medical organisations – the World Health Organisation and the American Psychiatric Association.[5] Although there are certain differences between them, they offer a similar system of classification and certain similar diagnostic criteria. The terminology of both these classifications, which are recognised at an international level, are employed in this paper.

Depressive reaction
Adaptation disturbance with depressed mood

This condition was previously termed 'reactive depression'. Its symptoms[6] appear in relation to a specific provoking event that creates in the individual an ungoverned emotional reaction and which continues after the event that has brought it about. Usually this event is a painful fact, but may also involve news or suggestions that something bad is about to happen or could happen. As a result of the disturbance, thoughts about this actual or future event cannot be avoided, they are always present, and they do not allow any other idea to make headway. They thus impede joy and happiness, paralyse activity, and also attack the vegetative processes of the individual afflicted.[7]

Depressive episode
Major depression

To establish a diagnosis of major depression the symptoms have to last for at least two weeks. In this kind of disturbance the depressive mood varies very little from day to day. In addition, there is a loss of a capacity to be interested in and to enjoy things, and there is a decrease in vitality which leads to a reduction in activity and a disproportionate tiredness. There are also supplementary symptoms – a loss of self-confidence and self-esteem, a feeling of self-rebuke or an

excessive feeling of guilt, complaints about, or the reality of, a decrease in the ability to think or to concentrate, indecision or vacillation, sleep disturbance, change in appetite, and also thoughts about death, suicidal acts, or even suicide itself.

In this diagnostic profile three levels of gravity are employed (light, moderate and grave) to describe the broad spectrum of clinical situations that exist within medical practice. Although the boundaries between the different levels of depression are not always easy to determine, their clinical assessment is based upon objective criteria: the level of social and work activity, and the intensity of the symptoms that are present, are established through direct observation or they are measured with well defined scales such as the Hamilton rating scale for depression.[8]

A patient with a *light depressive episode* usually manifests the symptoms characteristic of the syndrome, even though such symptoms do not reach an intense level. And the patient also displays a *certain* difficulty in carrying out his or her activities although he or she will probably not abandon them entirely.

A patient with a *moderate depressive episode* usually encounters great difficulties in going on performing his or her social, working or domestic activities. And it is probable that many of the specific symptoms that are experienced will be of an *intense* level.

During a *grave depressive episode* the patient is *not able to* continue his or her working, social or domestic activity because the set of symptoms are intense, and this is especially true as regards loss of self-esteem and a feeling of, or belief in, his or her uselessness or guilt. At times, the patient has intense anxiety or agitation, but the opposite can also take place, namely a grave inhibition of physical movements. The risk of *suicide* is high in particularly grave cases of depression of this nature.

Dysthymia

In order to establish a diagnosis of *dysthymia* the presence is required of a depressed mood which lasts for at least two years in a continual way, or in a constant-recurrent form, because transitory periods of normal sadness rarely last for more than a few weeks. While the individual is depressed at least three of a set of eleven characteristics are present:[9] 1. A decrease in vitality or activity; 2. insomnia or hypersomnia; 3. A loss of self-confidence or a feeling of incapacity; 4. difficulties in concentrating; 5. a frequent desire to cry; 6. a loss of interest in, or capacity to enjoy, sexual activity or other pleasurable activities; 7. a sense of hopelessness; 8. pessimism in relation to the

future or constant memories of the past; and 9. a decrease in the desire to converse.

The clinical manifestations of dysthymic disturbances, although they are of lesser intensity, are not very different from those of major depression, and this to such an extent that in some cases when the symptoms of dysthymic disturbance intensify to the point of reaching the basic level of major depression we find ourselves faced with the well known *doubtful depression*.

Recurrent depressive disturbances
Bipolar disturbances
Manic-depressive illness

This has a cyclical series of manic and depressive moments with different forms of sequence and intensity – the so-called *type I, type II, and cyclothymia*.[10]

In the set of symptoms of fracture characteristic of depression, in the case of bipolar forms of depression it is usual for apathy to prevail over sadness, for am inhibition of body movements to prevail over anxiety, and for hypersomnia to prevail over insomnia. There is also a lower level of anorexia and loss of weight, a great emotional lability and a greater probability of the development of psychotic symptoms in grave cases.

Depression due to a medical illness or created by substances
Physical depression

Depression in patients afflicted by medical illness, and depression created by substances, have two diagnostic problems.[11] One of these, which is of a qualitative character, lies in the difficulties encountered in determining which are the specific symptoms of depression and which are those of the medical illness, given that some symptoms are not evident (for example sleep disturbance, loss of appetite, fatigue etc.). The problem of a quantitative character is rooted in the difficulties encountered in diagnosing whether the sadness is a normal consequence of the medical illness or whether it is a symptom of an additional depressive state. The clinical picture has to be analysed and compared with the emotional reaction of the patient, and with a weighing of each factor, namely the *medical illness* and the possible *depression*.

This relationship between depressive states and medical illnesses exists in very different clinical situations. In practical terms, there is no pathological illness that is not associated with some kind of depressive response.[12] Amongst the clinical phenomena that are most associated with depression, there are those of a neurological, endocrinal, cardiovascular, rheumatological, infectious and oncological character.[13]

We should also take into consideration the depressive states created by substances. There are many substances that can bring about a depressive state. Those that are

usually involved are certain cardiovascular pharmacies (betablockers, reserpine) and hormonal pharmacies (oral contraceptives and corticoids). Psychoactive pharmacies such as the neuroleptics and benzodiacepine, and the anticholinergics, also have this effect. Drugs that have a depressive impact include alcohol, abstinence from cocaine, opiates and amphetamines.

Melancholy
Major melancholic depression
The grave depressive state
with somatic symptoms

Because of its clinical transcendence, and its specific connotation of being an emotional disturbance, melancholy is a sub-type of depression that is very important. Its causes are attributed to internal factors (*endogeneous depression*) which predispose the individual to this illness. The characteristics that differentiate it from other forms of depression have been pointed out:[14] 1. a constitutional-hereditary nature; 2. a family history of emotional disturbance; 3. a suitable pre-morbid personality; 4. a specific clinical constellation; 5. a biographical fracture which the patient experiences as a categorical break in his or her life; 6. a tendency to recur; 7. the presence of biological anomalies; and 8. a response to biological treatment.

These specific characteristics, and the fact that they can also be encountered in certain clinical forms of major depression and bipolar disturbance, confirm that we are faced with an independent and special category with a higher load of biological components which are of both a genetic origin and derived from the biography of the patient. However, neither the CIE 10 nor the DSM-IV-TR give these components the relevance which in my opinion they deserve.

Psychotic depression
Delirious depression

The definition and classification of these forms of depression remain rather unclear.[15] Psychotic and endogeneous depression have been seen as the same phenomenon by some experts.[16] However, patients with 'endogeneous' symptoms, that is to say patients who have scarce reactivity to their environment, daily variations in mood, terminal insomnia, appetite disturbances and disturbances of sexual desire, do not necessarily have 'psychotic' symptoms, namely delirious ideas and hallucinations.

From a clinical point of view, this depression is characterised by the presence of delirious ideas that

are congruent with the depressive mood of the patient, for example ideas involving hypochondria or nihilistic approaches to life, and by hallucinations in general, although these are less frequent. Together with these symptoms, grave disturbances of body movement are present because of the interrupted, variable and intense presence (without changes during the day) of depressive symptoms.

Factors that Cause the Phenomenon of Depression

What factors are at work in bringing about a response involving depression? Depression is the result of a highly interactive dialogue between biology, personal and psychological factors, and the environment. These three factors, in their turn, are made up of more specific factors, which also combine with each other in a dynamic form. What is the specific influence of each of these factors?

Biological factors

The various methodological modalities employed in genetic studies, those that concentrate on family ties,[17] twins,[18] and adoption,[19] suggest that there is a genetic basis to depression, and although the concrete mode of transmission has still to be clarified, there are various associations between specific genes (for example chromosomes 4, 5, 6, 11, 12, 16, 18q, and 21).

Employing a series of biochemical and neuroendocrinal strategies, alterations in the following *neurotransmitters* have also been found: noradrenalin,[20] serotonin,[21] dopamine,[22] acetylcoline,[23] and gamma aminobutric acid or GABA[24] and glutamate[25] However, it appears clear that these cerebral monoamins do not have a direct effect on the regulation of mood.[26] Recent research on major depression has centred its discoveries on the *intracellular signal pathways*. *Endocrinal and immunological alterations* have also been encountered,[27] which should be seen not as causal agents but as biological markers (indicators) of a state involving depressive illness. Despite this, the pathophysiology of depressive disturbances remains unknown, although everything that we know suggests that a complex interaction is at work, with the superimposing of multiple systems including the neurotransmitters, the endocrinal and immune systems, and the cellular signal pathways.

Personal factors

The *personality characteristics* that involve a predisposition to depressive illness have also been the subject of study and controversy. At least five explanatory hypotheses on the inter-relationship between these personality characteristics and depressive illness have been advanced.[28, 29]

Predisposition: personality characteristics could mean a predisposition to depressive episodes. Reference should be made to Tellenbach's description of '*typus melancholicus*',[30] which is specific to the endogeneous bipolar patient.

The sub-clinical state: certain personality traits (for example cy-

clothymia) could be manifestations of this illness.[31, 32]

Pathoplastia: personality characteristics influence the clinical picture during the duration of the illness or in response to treatment.

Complications: personality characteristics are said to change as a result of depression.

The presence of other illnesses: this involves the co-existence of a personality disturbance with an episode of depressive illness,[33] although in general it is not specified whether such a disturbance predisposes someone to illness or is in fact the result of it.

We can say that each of these describes a part of the cases of the inter-relationship between illness and personality, which depends both upon the type of illness and the biography of the individual concerned.

A series of *factors of vulnerability* exists: neuroticism or a high vulnerability to situations of stress, emotional instability, hypersensitivity or personal dependence, difficulties in interpersonal relationships, a greater tendency to introversion or insecurity, and pessimism, are the personality traits that are most encountered.[34-37] These traits are said to involve a predisposition to this illness, especially when they are associated with negative social factors. Whatever the case, they can amount to a non-specific vulnerability of the personality shared in distinct conditions of mental illness since they have also been observed in other psychiatric phenomena.[38, 39]

There is also a series of *protection factors* that strengthen the subject, such as systems of religious beliefs and values, a level of psychological maturity that allows a balanced response from an emotional and rational point of view, a facility in grasping and taking on board the meaning of one's own experiences and those of other people, stable feelings of support and belonging specific to personal relationships, or the exercise of freedom in carrying out projects that provide stability and involve other people.[40]

Environmental factors

A greater probability of depressive disturbances has been described when adverse external factors exist, such as: a history of traumatic events, recent stressing events, the premature death of a family relative, an inadequate upbringing provided by parents, poverty, malnutrition, medical illnesses, a family or personal history of negative emotional episodes, and insufficient social support.[41] All these environmental factors, which form a part of the biography of the individual, have an effect on him or her by creating a vulnerability to stress. In the same way it has been demonstrated that the appearance of depressive episodes occurs when there is an increase in stressing events.[42]

Stress is an entire state that arises from the perception of an event as being threatening, a situation of conflict, as something that requires a difficult decision, or an experience of frustration. Stressing environmental factors can be acute and specific, chronic, or take place at the same time. Dystymia seems to be associated with high levels of chronic stress[43] and a greater number of daily difficulties,[44] with a significantly higher frequency than is the case with patients afflicted by recurrent major depression. But it is also said to be associated with acute levels of stress that are similar or lower[45] that those in the case of major depression.

A Model for the Interpretation of Depression

A minor problem: overload

The difference between *normal sadness* and *pathological sadness* is marked above all else by the level of affection. We are dealing here with a question of degree and duration. In depression, sadness is pathological not only because it is disproportionate in intensity and length but also because of its different quality and because it interferes in a special way with the life of the individual who is afflicted. Despite this, at times the depressive pathology becomes diluted in the compromised terrain of normal sadness.[46] Reactive forms of depression border with the outposts of normality, and at times it is difficult to be precise about whether the emotional response is suitable or not suitable.

In analysing the disproportionate emotional response, such as that which takes place in *adaptation disturbance with depressed mood*, we are face to face with a pathological response at the level of function but not of form. The pathological is rooted in a greater inner sensitivity towards events. It is like when one receives an affectionate pat on the back and what would provoke a normal or happy reaction becomes transformed into pain and generates sadness.

The personality of each subject shapes the expression of this sadness: silent and patient, passive and painful, or full of impatience and rebellion, a bad mood, irritated, or fanatically obstinate. And it creates very different pathways by which to overcome the problem: mere resignation, a search for consolation in other things, a form of resentment that diminishes the phenomenon, diversion or bewilderment, constant professional activity, or religious practice and the upholding of religious commitment.

The way in which this transformation is achieved is characteristic of each personality and its respective world of values. At times, the subject abandons himself or herself to his or her own reality, at others he or she displays a proud obstinacy, and more often manifests a real pleasure in adopting an approach of suffering.

A qualitative leap: distortion

In the case of *major depression*, a *recurrent depressive episode*, or *dystymia*, the clinical symptoms acquire a notable gravity. The central symptom, namely pathological sadness, does not involve solely a decrease in mood (of varying levels of intensity) but is also accompanied by the mental and somatic characteristics that have already been described in this paper.

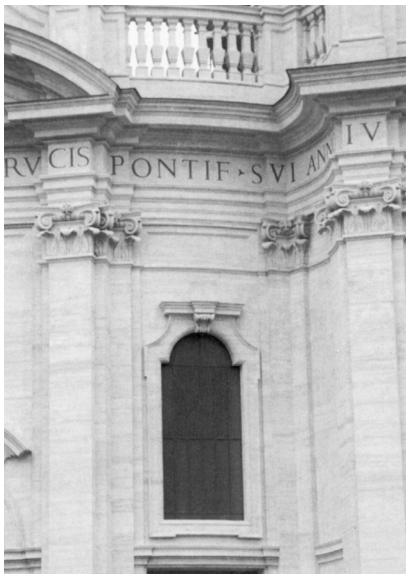
Major depression can be associated both with stressing and important life events and with the circumstances of daily life.[47] On the other hand, the level of the impact of stressing events seems to be connected with the actual capacity of the individual to tackle such factors

of stress.[48] This capacity depends both on the personal resources possessed by this individual and on the social support that he or she receives.

Dystymia is usually associated with a chronic level of stress and with a greater number of daily difficulties. The central psychopathological symptom is a depressive mood which is described as a disproportionate form of reacting or living out certain personal situations. It has been characterised with reference to specific aspects, including high reactivity to the influences of the environment:[49] 1. the absence of vegetative and biological symptoms; 2. numerous precipitating factors; 3. an absence of a recurrent model; 4. an imprecise response to biological treatment; 5. high levels of neuroticism or chronic personality problems; 6. an absence of a familiar burden of depression; 7. and a reactivity to the influences of the environment. This reactivity explains the variations in the picture both at the level of intensity and clinical fluctuations. Irritability-hostility and sensitivity to interpersonal relationships are also frequent symptoms of this condition.

The interpretation of physical depressions caused by medical illness or substances, deserves special mention. In analysing the characteristics of the clinical picture and the way in which the patient reacts to medical illness, three modalities of behaviour arise. Two of them follow the typical depressive mechanism. In one, an acute reaction to the somatic illness (normal effect) is present. In the other, a chronic reactive picture of depression that follows an illness or a therapeutic process of long duration (disturbance of adaptation with depressed mood) is at work.

In the third case the physical illness – or the substance that has been ingested – is the direct cause of the psychiatric affection through the workings of a biological mechanism. Here we are specifically dealing with a disturbance *of mood caused by physical illness or caused by substances*. This phenomenon shows with particular clarity that depressive states have an important biological component. They cannot be interpreted solely with mere approaches adopted voluntarily – they manifest objective and profound alterations in the human body. The same symptoms appear because of the ingestion of a substance, because of the continual or brutal attack of the psychic malaise, or because of the spontaneous development of a congenital deficiency.



A fall into the abyss: interior fracture

Lastly, everything that concerns *melancholic major depression*, *delirious depression* and *bipolar disturbance* contains a very distinct meaning that presupposes, in my opinion, not only a quantitative increase of the depressive situation but a real qualitative leap. This clinical fact expresses an interior fracture, with some symptoms that are clearly different to those of other depressive disturbances.

The essential characteristic of a melancholic episode is loss of interest or pleasure in all or nearly all activity, or a lack of reactivity to stimuli that are usually pleasurable. Four fundamental characteristics of melancholy have been advanced:[50] 1. a distinct model of signs and symptoms; 2. the importance of genetic and biological factors; 3. association with biological anomalies, especially of the adrenal-hypophysis-hypothalamus axis; and 4. a selective response to biological treatment.

In addition, a series of characteristic symptoms is present. The quality of specific sadness is notoriously different from other moods, such as, for example, that experienced after the death of a loved one or that specific to a non-melancholic depressive episode.

This is a sadness that seems to spring from the very guts of a person and has repercussions on the radical core of that person's self-perception: an absolute absence of meaning (perception) of one's own value and thus of the meaning of one's life, which must, however, be lived. And this marked experience, which is at times totally enveloping, can be compatible with an intellectual belief about its falseness or with a security full of the love of God because it is not in itself an experience that develops at an intellectual level or a religious level – it evolves at the emotional-physical level and within the realm of self-perception. We are dealing with an emotional pain that can overload the capacity of the individual to react, similar to the case of physical pain that leads to fainting.

Sadness has provoked a fracture in the mechanisms of expression and perception of the self. The intellectual awareness of this fracture and the feeling of a total lack of meaning and value, of uselessness, means that a cycle of mutual nourishment is formed between sadness, pain and self-view that – like the whining of a microphone – has a follow-up that can bring the person to the edge of collapse.

In such a condition, depression is usually worse in the morning, with early waking, and is accompanied by a psycho-motorial slowing down or agitation. A significant anorexia is present, or weight loss, and a feeling of excessive and inappropriate guilt.

Over the last forty years we have come to realise that these forms of major intensity of depression involve a complex interaction of neurobiological aspects: genetic aspects, endocrinal aspects, immunological aspects, the neurotransmission systems, and the cerebral networks or circuits. This strengthens the thesis that an important biological component, of both a genetic and a biographical character, is present.

Conclusion

The factors that play a role in the genesis of depressive illness form a part of an *interactive system* that modulates the response to the sufferings that generate sadness. This interactive system includes an evaluation, a *personal internal discernment*, that gives meaning to what is perceived and establishes a variety of expressions that acquire very different clinical meanings. In *normal affection*, although there is an affection, this does not break the harmonic meaning of the person and for this reason a response suitable to the individual and to what surrounds him or her is produced. In *adaptation disturbance* the affection is disproportionate. In *major depression* and in *dystymia* the affection of the structures is not only intense but also distorting. In the case of *melancholy*, *bipolar disturbance* and *psychotic depression* the response is fragmentary, with a broad break compared with the other forms of depression because it involves an internal fracture which implies a quantitative and qualitative leap.

For example, a metal coffin subjected to pressure by a lateral force first bends but maintains its flexibility and returns to its previous form. If that force is increased, one comes to its 'yield point', a precise point in every case, and the coffin remains permanently deformed. A quantitative increase has brought about a qualitative change. If the force continues to grow one reaches the 'breaking point', another precise point, and the metal breaks. Here we have another qualitative change brought about by a quantitative change. We are referring here to 'metal fatigue' where metal is subjected to small but constant pressure and suddenly breaks without any warning in response to a not particularly sizeable pressure.

The same thing happens with human beings. A tendon or a muscle works and then recovers its forms. At a certain level of pressure there is an *overload*. With more pressure they become *distorted*, and finally they *break*. The corresponding pain is not only greater, it is also *different*, and constitutes a symptom of internal qualitative changes with distortions of form and of function.

This examples can illustrate some of the relationships and differences between the different types and levels of depression. Here as well, because the central factor that generates depression is anxiety, we encounter first the capacity of emotional response, then the capacity to react in a balanced way (flexibility or fracture) and lastly the capacity to act (to live). The human mind is a unity of spirit and of body. And since it is also a body, even the strongest of minds, in the face of an continual or brutal attack of pain, can reach its breaking point. It first experiences a simple overload, it then passes from being flexible to being deformed, it becomes distorted, and finally it breaks.

Four points summarise what has been put forward in this paper.

Normal sadness is an emotional response made up of the feelings of daily life of varying levels of intensity, but which rarely last. They appear with situations of stress, frustration and loss. This must be seen as a normal depressive experience.

Depression as a pathological state is a phenomenon in which the desire to live is lost, like the capacity to act and the hope of recovering well being. It is accompanied by somatic and psychic manifestations and produces different levels of incapacity in the person.

The process of the management of the pathological depressive experience is highly dynamic over time, with vulnerabilities that derive from a combination of biology and personal and social-environmental factors, and which get worse or decrease during the personal biography of the individual and the experiences of him and her and of the surrounding circumstances.

Given that it is a strictly personal experience, the experience of depressive illness, like normal sadness, must be seen as being unique for every person, and thus its personal significance must be understood at an existential level.

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B. SARACENO

2. Depression: facts and perspectives

Depression and its burden

Cases of depression have been recognized as a health problem from the dawn of medicine. The torments of King Saul, referred to in the Book of Samuel, would today be clearly recognized as a typical case of depression. It was probably Hypocrates, in the fourth century BC, who first made a clinical description of depression as melancholia, in line with the theory of the four humours then prevailing.

Nowadays, depression is a common mental disorder affecting about 150 million people worldwide, of all genders, ages, and backgrounds. This represents 1%-10% (depending on the methodology of the study) of the general population: Women (especially young mothers), persons with a personal or family history of depression, those suffering from different chronic diseases (hypertension, diabetes, rheumatism, etc), those who are poor, socially isolated, or are experiencing severe life stressors are at particularly high risk for depression.

The risks of depression increase with age and tend to be associated also with the occurrence of other mental health problems (particularly alcoholism) and of different chronic physical health problems (e.g. hypertension, diabetes, stroke, Parkinson's disease, tuberculosis and HIV/AIDS). This condition is called co-morbidity and its appropriate management represents one of the major challenges of current public health.

Diagnostic criteria for depression include symptoms such as sad or low mood, loss of interest or pleasure, disturbed sleep, poor concentration, guilt or low self-worth, disturbed appetite, poor energy, decreased interest in and enjoyment of sex, physical agitation or slowing, and thoughts or acts of suicide. People with major depression experience 5 or more of these symptoms nearly every day for 2 weeks or more.

At its worst, depression can lead to suicide, a tragic fatality associated with the loss of nearly 1 million lives per year. Untreated depression may remit after a number of weeks or months, but depression is a recurrent or chronic problem for more than 50% of those affected.

It is also associated with substantial losses in daily functioning and productivity, and greatly contributes to reduce the quality of life. It is currently the leading cause of disability and the fourth major cause of the global burden of disease (GBD). If we look at specific groups, it is the leading cause of disease burden for

women between 15 and 44 in both developed and developing countries, and is the second leading cause of disease burden for men in this age group. It is predicted that depressive illness will be the leading cause of disease burden worldwide by the year 2020, representing 7.1% of the total burden of disease.

Depression and primary health care

Approximately 5%-15% (once again, depending on the methodological factors) of patients seen in primary health care, for whatever reasons, are depressed. However, only approximately 50% of depressed patients are recognized in primary health care settings, and fewer than 25% receive effective treatments such as antidepressant medications or appropriate psychotherapy (in some countries fewer than 5%).

There are several effective interventions for depressive illness, both pharmacological and psychosocial. In spite of the possibility of these being delivered even by non-physicians, there is a wide gap between their availability and widespread implementation.

Antidepressant medications and brief, structured forms of psychotherapy are effective in 60-80% of patients with depression; both antidepressant medications and psychotherapy can be delivered in primary health care settings by primary health care personnel.

Unfortunately, antidepressants are often not used at sufficient doses or for a sufficient period of time. Many depressed patients unduly receive sedative medications that are not effective for depression and can cause dangerous side effects or drug dependence, whereas antidepressant medications are not addictive.

In the best case scenarios (i.e. in countries with well developed health systems), it has been estimated that not more than 35% of

persons suffering from depressive illness receive treatment. In other countries such as Sub-Saharan Africa and China, treatment rates for depression are as low as 5%.

If depression is not so difficult to be diagnosed, if more than one modality of effective treatment exists, why is it that so many people with depression are not treated appropriately? Why so large a treatment gap?

The treatment gap in depression

A series of factors and elements conspire to this state of affairs. First, a lack of awareness in both the population and in primary health care staff on the early signs of depression and of the means available to combat them. Second, the stigma and discrimination still attached in many places to mental disorders in general – including depressive states – which limits (a) the degree to

which patients present for treatment, (b) the degree to which doctors and health workers have been trained adequately as well as their willingness to intervene, and (c) the willingness of decision-makers to fund depression-related programmes. Third, the poor or limited application of cost-effective mental health interventions due to: inadequate undergraduate curriculum of health schools, lack of national care guidelines, scarcity of skilled policy makers and health professionals, restricted availability of essential psychotropic drugs (including modern antidepressants) particularly at lower levels of the health system. Fourth, a lack of facilities and care management for systematically following up those who have had a recognized episode of depression.

In brief, barriers to effective care of people with depression include the social stigma associated with mental disorders including depression, the lack of resources and the lack of trained providers.

Ovecoming the problem

Traditionally, the initiatives taken by different agencies (universities, professional organizations, departments of mental health, etc) to overcome this situation have classically concentrated on either (i) the production and dissemination of resources for improving depression care, target most frequently at mental health care professionals, as well as workshops to strengthen their capacity to identify and treat depression or (ii) events to increase awareness about depression and to reduce the stigma associated with depression. More recently, programmes on quality improvement programmes for depression have been tested in a few places and have shown positive results.

However, in view of the magnitude of the problem, and the nature of the existing effective interventions, a need is felt to adopt other approaches, basically centred on the primary health care strategy. Primary care based programmes for depression have been shown to improve the quality of care, satisfaction with care, health outcomes, functioning, economic productivity, and household wealth at a reasonable cost.

In this respect, the following activities should be put into action:

The improvement of the capacity of countries to create policies supportive of improving care for depression and to provide effective management of depression in primary care, in the framework of the Primary Health Care strategy.

Educational activities aimed at patients, family members, providers, and policy makers on depression and its treatment.

Training of primary health care personnel in the early diagnosis and management of depression.

Recent innovation

In relation to the latter point, a few recent and innovative initiatives deserve our attention and further reflection.

Recently, a training programme on the detection and treatment of depression was tested by the PAHO/WHO. In it, nurses working in primary health care clinics were randomized into two groups, one of which was exposed to the training programme and the other one was not (control group).

The content of the training included diagnostic issues, treatment options and side effects of treatment. The nurses who underwent the training programme showed a statistically significant improvement in knowledge and detection of depression; in addition, they increased their notification and referral of patients with depression to physicians. No change was noted in the control group.

Also, an experimental programme exploring the potential of hairdressers to identify depression among their clients and refer them to health services is right now going on. This is far from the traditional medical approach but fits very well within the primary health care strategy, on the use of community resources to overcome health problems. We hope to be able to report on the follow-up of this project soon.

The role of spiritual leaders

And here comes another innovative idea; the integration of spiritual leaders into the process that

aims at reducing the gap between treated and untreated depression.

The very nature of the pastoral action brings spiritual leaders into contact with people who are suffering in different ways an we have reasons to believe that for many of them depression is an important component of their suffering. Without denying the spiritual dimension of the suffering, there could be room for the consideration of depression as another dimension of that suffering. In such cases, the referral of the person to a health care facility would be much appropriate; this could be facilitated by previous contacts between spiritual and health leaders.

Conclusion

People with depression are hundreds of millions (the problem), cost-effective treatments exist (technology), facilities and personnel to care for people with depression also exist (infrastructure). There is no reason why someone suffering from depression – irrespective of age, sex, social class or place of residence – should not receive appropriate treatment. There is no reason why we should not mobilize current technology and infrastructure to benefit those people.

It has been estimated that the global burden of disease attributable to depression could be reduced by more than 50% if all individuals with depressive illness were treated with methods currently available. Improving treatment rates will reduce disability and health care costs and will also improve economic and social productivity.

The challenge is ahead of us to find intelligent solutions with the elements available and to identify new ones. There is no justification for remaining inactive or, worse, repeating the errors and mistakes of the past.

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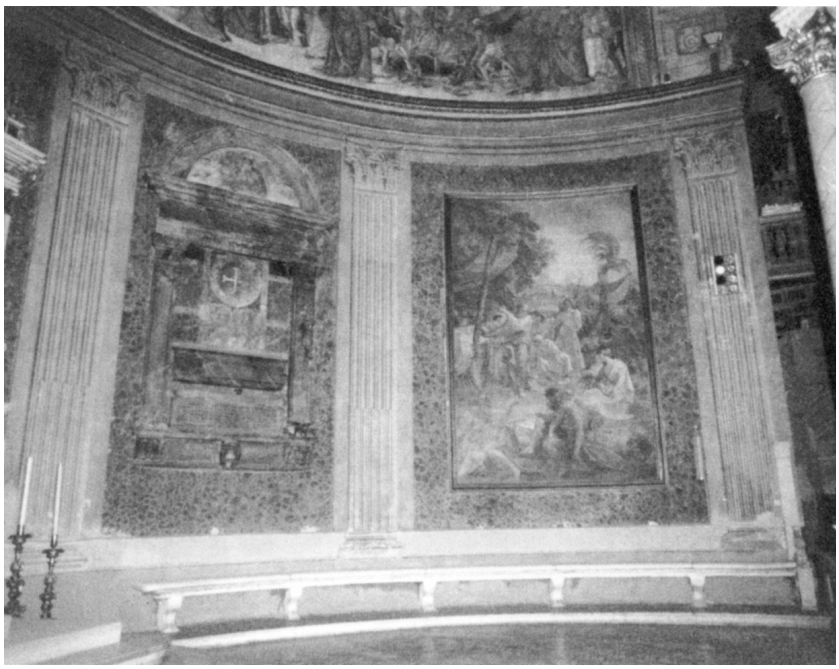


TONY ANATRELLA

3. A Depressed Society?

Introduction

Can society be depressed? This is the question that we ask ourselves when we read the provocative title given to my paper. Can society become depressed in the same way that a person does, who doubts himself, withdraws from society, and is sad and melancholic? We can advance a reply: it is people who get depressed, not society, which, indeed, is the image of the individuals who go to make it up. Thus society is less depressed than people who suffer imbalances when they are not able to face up to reality.

However, in social psychiatry we know that society produces social pathologies that have repercussions on people according to the individual situations involved. Individualism, unemployment, divorce, insecurity, the absence of a real upbringing, the lack of a transmission of knowledge, culture, morality and religious life, and the neglect of objective norms because of ethical relativism, can only weaken and make fragile a person's personality because of a lack of attachment and of stability in his or her existence. In this way society can amplify depressive disorders.

In this paper I will examine the following points:

a. Depressive loneliness between illness and existential problems.
b. A world without limits.
c. A feeling of powerlessness.
d. Anxiety about living.

1. Depressive Loneliness: between Illness and Existential Problems

The development of depressive states in the contemporary world has become worrying. But before defining their role one should make clear what we mean when we refer to 'depression'.

From a medical point of view, in order to establish a diagnosis of depression for an individual such depression must have had a length and an intensity as to involve verifiable symptoms: moral pain, self-doubt, rejection of life, a decrease in mental functions, the formulation of sad thoughts, disgust for food, sleep disturbance, mental tiredness, relational isolation, pessimism, constant worry, weeping, and an inability to engage in work and to discharge one's family responsibilities. In such conditions, it is important for the person to allow himself or herself to be treated. The use of anti-depressives or other forms of treatment involving psychotherapy, when this is especially indicated, are instruments that allow the recovery of health. However, one cannot attribute recovery to the mere taking of a drug or medicine. In many cases, as is borne out by the experience of people who have suffered from depression and by the literature in this field, there is also an inner disturbance which leads the individual involved to withdraw from the deleterious climate in which he finds himself.

Three types of depression may be identified.

Endogenous depression is linked, or so it is thought, despite the fact that proof is still lacking, to the biological balance of the brain, which can bring about the appearance of melancholic states. Anxiety neuroses and bipolar mood disturbances, which were defined as manic-depressive psychoses, are often to be found in a family for more than one generation. But the role played by biological factors, identification, and personal resistance to the frustrations and echoes of life and the environment, has still to be determined. This question remains largely open because hitherto we have not been able to demonstrate that at the origins of mood disorders there is a specific genetic error. No doubt we are dealing here with a subtle connection and thus the question remains a complicated one. In some cases we can observe that there are people who react more than others in order to free themselves from the handicap of depression. This tendency shows that a person is not systematically reduced to his or her determining factors.

Depression can arise from a reaction and develop following events such as moving home, the loss of a job, a failure, divorce, a marriage crisis that requires one of the partners to change, mourning, the move to another stage of life, and so forth. Often one is dealing here with a painful episode in a person's existence, but which is transitory and can be overcome. People tend to want to 'medicalise' the various problems of existence in order to recognise that each person can live out painful events, and events that are difficult to address, without being in a state of depression.

Lastly, there is another form of depression, which is of a more subtle character, and which is often the expression of an existential crisis that appears at times during adolescence, during the middle age crisis, or at the onset of old age. Life seems no longer to have a purpose and appears to be without meaning, and this causes a feeling of confusion and powerlessness in the person concerned. The individual thinks that he is lost and he does not know how to accept his own existence. He is sad and experiences no joy in living. This kind of existential depression seems to

spread – as is the case in other moments of history – through the difficulties encountered in giving a meaning to life.

Melancholy and depressive states at a medical level, and as we understand them today, have always existed and indicate the presence of disturbances of the biology of the brain and the psyche. An existential crisis that provokes malaise is also intrinsic to the human condition and comes from a multiplicity of questions to which a person has to find answers with the support of society and the Church in particular.

2. A World without Limits

Nowadays, the individual often finds himself alone in a society that makes him believe that everything can be decided on the basis of the experience, the subjective needs and the concerns of the moment. Thus the child is the master of his own upbringing in opposition to what is transmitted to him; every adult becomes the arbiter of the right to life and to death and decides about abortion, suicide or euthanasia in a way that is outside the parameters of natural law, that is to say beyond universal values and the common good of mankind. Faced with the difficult and even dramatic situations of existence, answers involving death are often proffered. We find ourselves at a time of the inversion of the values of life, in a paradoxical climate in which we rightly fight against the death penalty but at the same time uphold the right to kill unborn children and to kill the sick and the disabled in the name of the right 'to die with dignity'. This upholding of death has collateral effects in society and makes the value of life become lost in the minds of its members and especially its younger members.

Our intellectual universe leads us to understand that everything is possible, that we are in a world without limits, and that it is up to each one of us to make decisions in line with our own feelings. The result of this is the exaltation of individualism, but there is also the risk that individuals suffocate their own feelings in the face of such a power of omnipotence.

The socio-cultural context fosters malaise and existential depression, a subject that I analysed in one of my books that I published in France in 1993 entitled *Non à la société dépressive* (Flammarion), in which I demonstrate that the human environment no longer contributes anything and each person becomes their own point of reference. In this way society gives value to individualism, that is to say to the individual who gives himself a personal project (in a positive sense) and who establishes his own points of reference (which generates numerous problems).But given that the person does not find himself at ease in this individualistic model, he or she runs the risk of undervaluing himself or herself and of manifesting a feeling of confusion. Individual freedom, seduction in social relations, the desire to give a good image of oneself, identification with youth and the rejection of the smallest signs of ageing, have mow become our points of reference. All these obligations are more compelling than social norms and moral rules, which are the real basis of forms of behaviour and allow each person to create his or her own lifestyle through social interaction.

12. Consumer society also deviates the meaning of happiness by making people believe that it involves consumption, the possession of goods, and the fulfilment of all desires. It contributes to confusing happiness and prosperity, which are not the same thing. Policies, advertising campaigns and television programmes promise happiness through immediate satisfaction. Happiness is not only a right, it is also an obligation. We have to be happy, dynamic and have success – these are the criteria of selection in professional life. Those people who do not manage to achieve this state are placed at the margins of social life. They then blame themselves, they undervalue themselves, and think that they are not up to what is expected of them. Society also tends to substitute mental blame and the idea of sin with self-contempt.

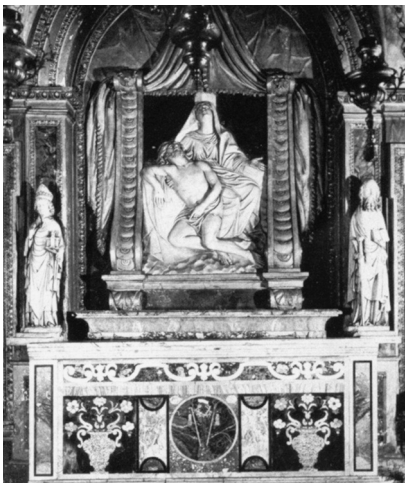
In order to create a euphoric environment, society even comes to invent new festivities which we may term commercial because they are without meaning and tradition. They do not celebrate anything in the history of society and they do not contribute to social ties because people meet in cities to celebrate themselves on the pretext of an artificial event (white night, music day, science day, wealth day, or even the sinister Halloween which cultivates the most imaginary fears and involves regressions, etc.) During these periods the special days of the calendar year are neglected, of both a religious and civic nature, as though we had to forget our history and the contribution that Christianity has made to our societies. In this way society has a depressive relationship with what has established it and constructed it and it becomes ashamed about its own origins.

In a world without limits that disrupts the existent signs but which refuses to inspire itself to organise life, anxiety and depressive states can only emerge. Cinema and television products, novels, and also most of the video games for children and adolescents, are for the most part illustrated with degenerative, deforming, criminal and catastrophic images. The individual imagination is impregnated with such models which have no positive results for the individual and the social fabric. It is no longer

a matter of having hope, of working to build a better world, of knowing how to forgive and achieve renewal, but of directing oneself towards a future of nightmares. The Western world is no longer led by the utopian philosophies of the enlightened who promised progress and the happiness of man liberated from nature and from God. Separated from these ideas, which, indeed, have become marooned, man encounters once again his own existential worries because he does not know the meaning of his own destiny. The contemporary approach is that of fear, which, indeed, has outlined to us a universe in which we should distrust everything. This fact fosters violence, calumny, and to subjection of everyone to everybody else's judgement. Contemporary culture knows only how to reflect on the meaning of anxiety, guilt, suffering, and the evil inherent in the human condition. This malaise of civilisation leads people to commiserate on their own lives and the lives of others with a judgement on existence. We must always look for a guilty person, judge him, condemn him, and then turn him into a scapegoat. Christ, however, freed us from this predominant vision of guilt and guiltiness.

The future has always been uncertain for man but it has now become disquieting, and there is the sensation that man can no longer control the consequences of human action for the earth and that this will have harmful effects on future generations. Within such a total historical immaturity we have lost the sense of conserving life for the generations to come. In this way, we work and build solely for the present-day generation, with the aim of taking advantage of everything. Until a few years ago, for example, schools and universities were built with the intention that they would last over time and would communicate the importance of the transmission of things. The constructions of today's world, within a decade, fall into ruins and demonstrate the low view that people have of education and the young generations.

Society has become narcissistic and is a source of existential depression because people, who see themselves as the centre and the reference point of life, easily undervalue themselves. In a society that at the same time becomes less supportive and is permissive and lax, depressive personalities rebuke themselves for not having the freedom to be different. Depression becomes a mistake when it is not a human weakness in a person who until a short time ago could be supported in a more structured en-



vironment and with much more socialised relationships.

The declaration of the death of God and the rejection of transcendental values have left man alone with himself. This is certainly nothing new. The environmental culture which aims at the 'individual' in order to make him believe that he is left entirely to himself seeks to eliminate the entire transcendental and spiritual dimension of life in the name of the secular. Ideas are principally addressed to immediate self-interest and at times fall into a dramatic approach to the simple acts of life such as the upbringing of children and adolescents, in relation to whom, in fact, adults are lost. The mass media foster individualism when they apply pressure to the juridical power and want to make a problem of society an individual and specific case, as we have seen recently in France with euthanasia applied to a young patient, an act for which the mother declared herself responsible. Society also loses the meaning of the universal values that build up the person and which enable us to live together. It is as though we were in a world without laws where each person tries to justify his or her own narcissistic behaviour by asking the legislature to pass laws that can legitimise subjective needs and special interests.

Personalities also live in confusion and disorder. They are lost, have no confidence in themselves, and encounter difficulty in accepting themselves. They express a need for recognition that can no longer take place starting with common values but only through a constant desire to affirm themselves, by any means, in relation to other people. Such a situation generates mental doubts about facing life – doubt about oneself arises and there is a feeling that one is deprived of internal resources. In a society that suggests that more than one life should be realised at the same time, for many people it becomes difficult to become established and involved within such a disintegrated vision of existence.

3. A Feeling of Powerlessness

Contemporary personalities are locked into subjectivism and run the risk of living in an idealistic and disenchanted universe with a feeling of powerlessness in relation to the difficult realities of life. People may come to believe that they are experiencing unprecedented sufferings and difficulties in historical terms, but in fact these have always been present in the human condition. This is because it is more interesting to respond to the question about the direction to take and give meaning to one's own existence than pity one's life or try to flee from it.

In the present day mentality we encounter a logic of powerlessness in thinking about the world in which we live and the vision that we have of ourselves. Contemporary man has the tendency to live as though he were the victim of his life, of society and of his own upbringing, and he at times condemns himself for not shouldering his own responsibilities. He thinks that he is sick and he turns to medicine which should be able to solve all his existential problems because its purpose is to treat and heal illnesses. Ethics of malaise increase

the opportunities for the social system to try to compensate for what people are unable to achieve in their inner lives. The most characteristic example of this is the invasion of psychological emergency units that were created to deal with accidents or dramatic events when people need support – for example when they have to rapidly repair their homes after a flood. This phenomenon demonstrates the invasion of society, which thereby tries to take on responsibility for the subjective life of individuals and to entrust that life to social assistance.

The rise in suicide levels (in young people and the elderly), the increase in violent crime, the degradation and destruction of the environment in its various forms, of goods and of objects, in order to give oneself the impression that one exists through an 'eroticisation' of violence, and the cynical and asocial approach employed by the mass media in addressing young people, all exalt the primary and compulsive character of behaviour, They demonstrate that what is legal and seeks to ensure the social fabric is not always known about.

Lastly, the absence of ties afflicts with an extraordinary breadth the marital and family universe. Divorce, which has been constantly increasing, makes emotional life increasingly fragile and fosters an alteration in that life so that the family is no longer a place of trust and safety for adults and for children. In such conditions, many young people are not encouraged to commit themselves to the unification of their own lives of impulses and drives because their relationships with other people are not always gratifying. Adults do not know how to address their own affective difficulties, the problems of communication between the marriage partners, and the stages in the life of the couple, and thus they break their relationship at the smallest conflict. Thus we have entered a society of fracture and the absence of ties. There only has to be a conflict or a lack of understanding in the couple for the marriage partners to believe that they no longer love each other and to decide to separate. Divorce, which has been made increasingly easy by the law, which at the outset wanted to limit it or to reduce it, has in reality become a point of reference. In creating social reality the law has led in recent years to a constant increase in this phenomenon, which, indeed, undermines people and society. This fracture acts as a model for young people who see adults solve their problems through separation. Young people come to doubt themselves and the relevance of commitment within marriage when they aspire to it. Society itself does not emphasise commitment and stability in relations when it declares that it wants to legitimise *de facto* unions, which do not have the same value of the couple that is formed through, and committed to, marriage between a man and a woman. Society creates depressive conditions in order to destabilise people who no longer have confidence in themselves, and we may indeed ask ourselves whether they know why they live, work and love.

4. A Psychic Implosion

Given that society does not lay enough stress on the values of life, it creates uncertainty and fear in people who turn in on themselves in the hope of finding in their own mental lives what society does not provide them with. This turning in on oneself is without doubt a reflection of deprivation which is the consequence of the individualistic philosophy derived from liberalism. In this way the person is returned to his subjectivity and not finding what he is searching for he runs the risk of losing his own identity because he divides his research into single aspects of himself. In fact, we live in a disintegrated society that has the most contradictory reference points and fosters, on the one hand, the development of broken down personalities who encounter great difficulty in unifying themselves psychologically and morally.

In the absence of cultural, moral and religious resources, contemporary personalities become internally emptied. Children and adolescents are highly sensitive, excitable, and manifest serious difficulties at the level of concentration. They often remain at a level of sensory psychology and suffer in going on to a rational psychology. Most people, both young people and adults, develop a psychology based on the imagination and a psychology that is also weak. This psychology is more important for their narcissistic perceptions than for the discovery of reality. The smallest problematic event wounds them and disturbs them, and they thus demonstrate a lack of resistance when faced with the frustrations of life. These personalities at times organise themselves around a false 'self' and express difficulties in belonging, in taking possession of their selves. They live in appearances and outside their own inner lives.

Contemporary ways of living do not help people to deal with the mental conflict that exists between the needs of the internal life and the needs of reality. The process of internalisation is poor and the internal life is neglected when the person, closed up in his or her own narcissism and in his own self-sufficiency, does not manage to integrate the riches of culture, religion and morality. He or she denies these resources in believing that he or she does not need them. Only appearances, the image that he or she wants to give of himself or herself through various physical modifications and with the intention of being recognised by other people, really matter. The contemporary enthusiasm of young people about appearing in television programmes enables us to understand that they want to become stars, and it also expresses their wish to be appreciated at the same time as being in a situation of personal insecurity. They want to be seen and to be remembered at a physical level.

The body has become the identity support of people, who, because they do not manage to be accepted, invent an imaginary body for themselves. The portrayal of this body in the contemporary world is broken down and the mode of dressing with spacious and asymmetrical clothes is a symptom of a body that knows no limits. It is also an expression of the flight from the real body, which is transformed through tattoos, piercing, scarring and self-mutilation, as though

these people wanted to silence their worries and find new limits. In this way people manifest their fears about accepting their own real bodies because they do not manage to work out all their internal tensions caused by their lives of impulses and drives. They try to flee by acting on their bodies, whilst their inner lives continue to experience a confusion at the level of identity. They have more a tribal view of their bodies than a personal one; they do not manage to take on board their own specific character: their idea of their own bodies is depressive.

The body is reduced to skin because contemporary fashion involves first and foremost its destabilisation in order to show its surfaces in an entirely naked state. But this phenomenon goes beyond this specific reality: under the false pretext of spontaneity and freedom from oneself, the exhibition of nudity has become dominant. Thus it is that an increasingly large number of media figures appear naked in newspapers. This is because, in fact, they have nothing to say. It is true that when one no longer knows what to say, how to speak or how to formulate ideas, one shows the world one's body. Commercial society exalts this vision of a psychotic body. The images of the mass media, through advertising and television, come to predominate over ideas, and as the years go by they produce scenarios that incite people to become physically and sexually impulsive. This 'eroticisation' of social portrayals creates a climate of sexual arousal and of movement towards action with the body which changes ideas about one's relationships with other people. The desire to impose oneself and to take possession of others is a characteristic of gaining power in order to take advantage of an individual rather than taking part in a relational process in order to know him, understand him, appreciate him, and make projects. In this way sexuality is detached from the meaning of love and becomes an activity involving play that is principally narcissistic but is also depressive, as is borne out by the requests for consultation by young people and adults who want to free themselves from a sexuality of the imagination created for solitary pleasure and which does not allow a real encounter with a loved person. They discover that they have been deceived by the social models to which they adhered. In such a context, and paradoxically, sexual aggression and acts of violence incite people to act in an impulsive way. There is thus a move from the social portrayals of the body and sexuality to what is built up at a practical level, where people are searching for forms of behaviour that are healthier and more authentic.

The forms of behaviour that I have described above strive to liquidate, suppress and avoid everything that takes place in the interior life of a person, rather than working it out through various activities – reflecting on oneself, reading, religious and moral searching, and so forth.

5. Anxiety about living

In existential crises anxiety is often the first form of suffering that manifests itself. Anxiety about living, about knowing about what one does in one's own commitments and activities. 'What is the point of all these efforts?' 'What is the purpose of everything that I do every day?' 'What is the point of my existence?' The vertigo of anxiety invades and inhibits most of the functions of the life of the psyche. In commiserating himself on his life, the individual pities himself, undoubtedly because he feels that he has lost the meaning of his own existence.

Anxiety about living is a special feature of human psychology which clinical literature on mental life has known how to put in its proper perspective. The psychoanalyst Mélenie Klein was the first scholar to try to identify the roots of this anxiety in the birth of the psyche of children. Clinical experience and theoretical formulation have confirmed the validity of her research. Dr. Klein was able to demonstrate that from an early age a child is animated by aggressive drives to impose himself on life, to obtain food to meet his own needs and to obtain human presence in order to gain support. The first aspects of his personality rapidly manifest themselves when he works through his own sensations, despite the positive approaches of his parents. The child goes through depressive periods, not in a medical sense but in the sense that he has to renounce certain things in a bad spirit in order to reach new things, such as his mother's breast. In the same way the child experiences moments when he thinks that he is persecuted because he thinks that he is undergoing attacks from people that he loves because of the wrong that he thinks he causes because of his aggressive drives. We find this form of behaviour in adolescents or in adults who are treated by psychotherapy or psychoanalysis and who unconsciously feel a strong sense of guilt and suffering because of their inability to repair the harm they think they are guilty of because of their interior aggression. They often want to change their position and project their own torment externally by accusing the medical doctor who is treating them of causing them harm. They express complaints that lead them back to primitive frustrations that are still active. They feel persecuted and attacked. Anxiety involving a sense of persecution has become a dominant phenomenon in order to escape a feeling of personal guilt, which is of course imaginary. Feelings of love disappear and other people become a bad object – they can no longer be loved. The other person thus has to be accused and rebuked and aggressive drives towards him or her appear to be justified. This is a way of reinforcing anxiety about being persecuted and of fleeing from guilt and desperation. It is interesting to observe this first movement in the life of the psyche, which is designed to work out aggressive drives and guilt. In the best of cases these are reorganised into love for other people and the working out of the person's drives. But they can also continue in a situation of permanent conflict in those who cultivate constant hostile approaches in relation to their parents and life. Such people engage in a process involving their own education, society and the Church.

Like boredom in relation to life, anxiety is not extraneous to the pri-

mordial anxiety experienced by the ego of the subject in relation to the threat of destruction that comes from its aggressive drives. Such drives are so strong that they are a danger perceived by the child himself. One need only observe how small children or children at nursery school if they are not controlled by adults allow themselves to be moved by their own violence against themselves and others. If a milk-fed child had the possibility to use the nuclear bomb to obtain his bottle right away he would not hesitate to use it. But, luckily enough, children develop defensive activities to protect themselves and direct such aggression outwards, believing that the threat comes from the outside. This allows them to locate parental figures and reality in a better way. The love of their senses protects them, reassures them, and supports them, telling them that life is possible and giving them the instruments by which to discern its pathway and its journey.

Conclusion

Whatever form it takes, depression always has psychological and spiritual consequences. Its spiritual consequences will be examined in another paper that I will give. Before that, we can advance the principle that the life of the psyche of a depressed person is marked by an anxiety about annihilation, that is to say of being deprived of one's own instruments of survival, not being able to exist for others or for an ideal. Here we encounter not only the experience which is undergone at the beginning of life but a reality that is inherent in the human condition and which is expressed in living badly, in melancholy and in depression. The ancients already observed and reflected on this phenomenon. Some of the first Christian monks lived out this trial in their ascetic way of life. It was known by the term of 'sloth', which means the suffering of being in this world and whose consequence is a lack of interest in life. But sloth was linked to the spiritual life and was felt in the sphere of the wish for God and a creative relationship with Him. Depression, on the other hand, is a way of being deprived of oneself and of being put out of action. However, in the modern world there is a connection between sloth and depression. The feeling of powerlessness and a loss of meanings has often been described as one of the component parts of depression. Although depression is an illness that has to be treated, understanding it cannot be reduced to a mere individual affection, above all because this malady and this suffering are widely experienced. It does not only involve medicine; it also involves social conditions because the points of reference of people are confused and the needs of the spiritual life are not respected by listening to the word of God. This is because depression cannot be interpreted as the trial of being oneself given that contemporary personalities should do without transcendent values and invent their lives on their own, relying only on their own subject forms of self-interest. Depression, and in particular existential depression, demonstrates a deeper reality which began with mankind and which is manifested through rejection of, and lack of adherence to, life. Sadness cannot be solely the central emotional phenomenon of depression in which the individual is sad because of something: he is sad in himself because of an interior uncertainty and a lack of self-fulfilment. Recourse to drugs in the members of the young generation conceals this reality when they try to fill their internal void through cannabis, searching for new stimuli through cocaine, and the achievement of a greater performance through ecstasy. They are fighting against an existential depression that comes, on the one hand, from a rejection of accepting and entering life. Today's man, like yesterday's man, is involved in the same question: how to learn to love life so as to find realisation in his humanity and discover the meaning of existence.

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MARIANO GALVE MORENO

4. Depression and Religious Crisis

'One cannot understand how one can move forward without faith'

1. Introduction

1.1. Three Preliminary Premises

1.1. In our Western culture, although it is defined as being one of 'prosperity', symptoms that we could define as 'depressive' are becoming increasingly widespread. Today depression is an illness that is in fashion. It could be diagnosed in anyone who has existential problems.

1.2. And nobody doubts that the old shape of our lives is disappearing and that the world and religion are undergoing a deep crisis, without anybody being able to know or define this crisis in its totality and at the level of its relationships.

1.3. What is not equally evident is that the existence of a strong link, of a deep and secret character, between depression and a spiritual crisis, is certainly not something that in fashion. This is because we are used solely to the evidence of the external, denying what is vital for every man, that is to say that the internal has its own breath and provides oxygen to the whole of the being, which in this internal place is the cement upon which every stable tie with other people is based and perhaps, for some people, the cornerstone that allows us to feel dwelt in by the Other, and that only thanks to them - God and other people – is our spirit nourished, breaths, and becomes mobile, burning and friendly.

At the present time these healthy and health-inducing ties where they are not denied are certainly lacking, and thus our culture and individuals manifest the easy tendency of the 'minimum effort', which fosters an increase in depression. The so-called 'chronic illnesses' are such because we have not descended to that central privileged point of our inner selves. And because we do not have the strength that dwells there we are obliged to repeat ourselves unceasingly, like a child whose parents do not want to listen to him and who makes a martyr of everyone with his persistence.

1.2. The Crisis of our Spirituality

We must admit that we are reaching a point when external goods – prosperity and material possessions – are taking the place of spiritual goods as an ideal. This trend is creating a notable dissociation and a denial of the role that our spiritual needs play in life. Although material well being is increasing, our need to love – that supreme and unique religious norm which is the highest defence against depression – is neglected and can even succumb.

For this reason, we grasp for external satisfactions, whereas the difficult struggle for inner wealth and peace of conscience are left to chance, thereby giving rise, in my opinion, to the roots of the contemporary religious crisis. Our struggles – between love and hatred, between anger and patience, between compulsion and the ascetic, receive very little help from our care and our conscious efforts. It is certainly the case that our great need to encourage and nourish love and suppress and modify hatred are looking for new paths in life, but as an individual internal question this receives little direct support.

In depression, the *spirit* falls silent and life is absent when we do not place trust in them, when we despise them, oppress them, or shut them up like children in a dark room. When this occurs, suffering, injury, trials and pain arise.

In the depressed person life, does not seem to be life, history and the movement of life seem to be suspended, hope does not know what to hope, and being does not exist – it becomes limited to being a possibility of which the person is not aware. The depressed person does not fear death, and does not wait for it; death is the depressed person himself or herself. In this experience nothing manages to calm or to reconcile. Nothing assures the depressed person that he or she is going through a process of a recapitulation of his or her life which has two aspects – life and death, which, indeed, are two inseparable neighbours and sisters.

However, under this thick frozen covering life goes on without anyone realising the fact, not even the depressed person himself or herself. Only here does life continue to exist like an activated spy who resists like a survivor during a war. And in this deep covering of our inner selves is born that mysterious ability to be born again, to lose oneself in another person, and to locate oneself again elsewhere.

In this sense, *complaints and symptoms* are the result of a negotiation between the call to life and the fear of living. The curative glance is happy to identify the two forces present, but firmly chooses one of the two – that of the timid and vacillating desire that tries to make itself heard and to find a road between the thin surfaces of anxiety and the ditches of guilt.

2. The Roots of Depression: Significant Losses and Attacks on Everything that is Good

Religion and existential psychology coincide in pointing to two great causes that are at the origin of depressive suffering – one is the

loss of significant objects and the other is the bad structuring of the destructive impulse.

2.1. Both around us and in our inner world many losses exist

The loss can come from childhood, when a father or a mother die or abandon their family. The loss could be more recent, for example when a father or a mother who is loved or hated left this life without a word of reconciliation. Perhaps the loved person has not died but has gone away and loves another person.

How can the depressed person demonstrate the guilt that he or she feels at having failed, his or her anger at being abandoned, his or her desolation at being left on his or her own, abandoned, without any reward or reconciliation?

There is also pain caused by the loss of childhood or fear of growing up, or by the loss of youth, beauty and virility. In the background there is the fear of becoming dependent on other people and causing them worry and problems.

Pain such as this creates desperation. The depressed person is full of a heavy and grey indifference; towards people who were previously important for him or her as well. Love has drawn away, leaving that depressed person with a perception of its absence.

2.2. Depression as 'separateness'

'I am very troubled when I hear someone happily say 'I do not believe in God'. I have the impression that in following fashion and the most obtuse permissiveness we are losing the most valuable thing that we possess, and that, unfortunately, in this same movement the virus of depression is taking control of us'.

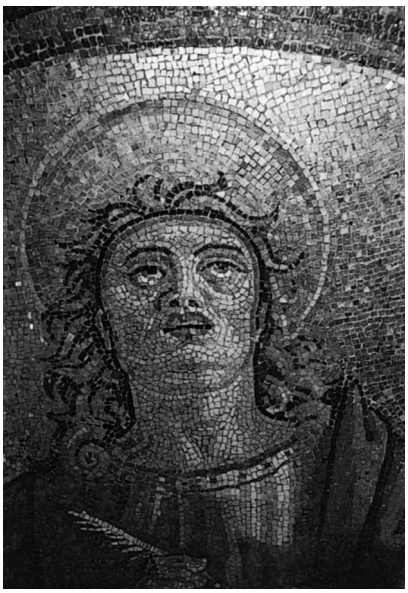
From a religious point of view, the key word to understand depression is 'separateness'. The radical evil, which is a source of all depressive experiences, comes from the fact that we wrongly believe that we are separated from God, from ourselves and from other people.

The feeling that we have damned and destroyed our relationship with God and what it symbolises – its tie with the paradigm of goodness – decreases the trust of the depressed person in the sincerity of his or her subsequent relationships and makes him or her doubt his or her own capacity to love and to be good.

Doubts about the Supreme Good can also arise. Under the pressure of depressive worry, faith and trust in good objects are usually shaken.

Significant changes in mood occur with a greater probability in those who have not established their connection with God in a secure way and are not able to feel gratitude towards Him.

To the significant loss of God is added the grave destruction of the rhythm of time. The depressed person loses his or her selective memory and is unable to see himself or herself and read himself or herself



in his or her own past; he or she does not accept the present, is full of suffering and loneliness, and above all does not have a future because in the very movement of the loss of God he or she has also lost transcendence.

The loss of the future, on which is based the 'meaning of life', disturbs the time that is experienced. Thus, for example, the attempt to cancel Christian roots from the European Constitution falsifies our past and for this reason colours it with a depressive tinge.

To employ an expression of Simone Veil, such contempt for time is something that belongs to criminals, prostitutes, and slaves. It is, therefore, a badge of disgrace.

For this reason, when depressed people dig into their pasts they discover that these losses are more painful and greater than is the case with people who are not depressed, even though one is dealing with small betrayals, disloyalties, acts of cruelty, condemnations, threats, rebukes, acts of cowardice, jealousies and acts of ingratitude that take place in every community that is not led by love and by persons.

2.3. The deep effects of separateness: it attacks the unconscious

Each form of depression and its symptoms are internal and make faith in love difficult. All these dangers tend to distance us from inner goodness because of fear of the disappointment, being abandoned and insecurity that threaten us.

The feeling of injury caused by separateness (from God, from other people and also from ourselves), the great anxiety that this causes and the resulting uncertainty about the goodness of the representatives of good, have the effect of increasing our voracity, our compulsion, and our destructive impulses.

Voracity first of all. The lack of a connection with the sources of God and its representatives provokes an interior emptiness that the numerous things of this world cannot fill.

Man, however, tries to fill this void and embarks on the unstoppable mechanism of *compulsion*. The compulsion of being, or the compulsion of greed and its equivalent, ambition, which is bound up with rivalry and competition in human relationships.

Lastly, the emergence of *destructive impulses*. Because of this emptiness and dissatisfaction, internal anger sets in motion the mechanism of hatred. The consequence of this is impoverishment because such anger impedes integration and synthesis.

3. Treatment. Escaping Depression

The experiences that are 'deep rudders' – love, creation and religious experiences – confer the role of structuring the individual. They are the basis of every faith, every birth, and every rebirth.

3.1. Admitting the bitter taste of truth

The greater the crisis within us and our world, the more abundant the request for revelations of varying levels of truth and truthfulness. It is also certain that in the main only false answers are obtained to authentic questions.

The first duty of the *depressed person* who really wants to be treated, that is to say who wants to change his or her anxious fear, is to let himself or herself drop without a complaint, without reserve and without grimaces, like a tired child who is dropping from sleep and falls asleep in the first place that can be found.

It should not be thought that this means making suffering chronic. We are dealing here solely with a second chance that a depressed person can give himself or herself in order to walk towards his or her own deep vitality. In order to achieve this what is needed that, in an impulse of faith of a rare quality, pain is received, accepted, absorbed and ingested, and this requires the giving of a meaning to feelings and a great capacity to deepen experiences.

The monks of the West, the wise men of the East, the fathers of the desert, and the luminaries of Islam all dedicated their lives to entering the paths that lead to the inner life. And they well knew that to reach the core of this inner space – wherein dwell the times and the places supported by grace – it is necessary to enter mystery through that depressive hole, admitting this suffering, this fall and this silence, as though it were a connection between life and death.

3.2. Beginning with our inner selves and broadening and strengthening the weak heartbeat of life

Seriousness and doing things well have no meaning if desire is not vital, the heart lively and the lungs 'scarlet'. These deep areas of our inner selves need to be nourished, protected and cared for with concern and attention. A warm contact with other people is the principal nourishment of the heart.

Both in the Gospel and in daily life there are beings who embody truth. They are at one and the same time authentic, truthful, testers and tested. Without employing speech, they bring out the naked reality of those people who draw near to them. Such a process of revelation arises from their own approach of desire and truth in relation to which we feel the yearning and the value of daring to be, ultimately, ourselves; of suppressing our existential ankylosis, of contemplating without pleasure our timidity and our afraid apprehensions.

3.3. Giving time to the pathway of treatment

Transgression feeds guilt and this nourishes forgiveness and reparation (Winnicott). In the same way, this last leads to the acceptance of ourselves, to care and concern, to goodness, to being concerned about other people, to good sense, which in turn generates love for God (the Gospel). Thus transgression of the law is the pathway towards the feast of the father (the prodigal son: 'there is more rejoicing in heaven for a sinner who repents…').

4. Psychological and Spiritual Therapies: Reparation and Reconciliation

'Only what we have assimilated, expressed and incorporated into our inner selves through confession and forgiveness can we understand and has full meaning. Allowing ourselves to forgive in the presence of another person is an alchemy that animates, reanimates and vivifies'.

Religion and analytical therapy agree on the following principle as well: when a presence becomes an absence, this object can be recreated, brought into play, and replaced by our inner space thanks to reparation and reconciliation. When this takes place, another presence is born which is even more present than the previous one, given that it is internal, and this means that life continues on its pathway despite lack and death. The so-called 'working out of mourning' shares the fact that in addition to lack it implies certain forms of working out something, which are themselves examples of fullness taken from emptiness, achievements that transcend loss, glances that despise death, and images of resurrection.

4.1. Reconciliation as acceptance, better relationships with ourselves and with other people and a clearer perception of external and internal reality

The situation of accepting ourselves certainly gives rise to great spiritual pain and guilt, but it also creates feelings of consolation and hope that in their turn make personal unity less difficult. This hope is based upon a growing unconscious knowledge that the idea and the experience of God and other people are not as bad as they were felt to be during the dissociated aspects of depression.

For this reason, depression is a *repairer of one's own being*. The depressed person has learnt that the only point of support that is worthwhile is a warm and stable inner being in contrast to the feverish search for multiple and shallow contacts which once characterised his or her existence. Healing has given him or her over to his or her inner self. For the individual who has died and risen again this is the foundation of another way of taking on himself or herself. In escaping from the depressive void the person turns towards his or her inner self because he or she has experienced the precariousness and the lack of meaning of the external.

But reconciliation also acts as a

repairer of *other* beings. The ability to accept loneliness allows the reconciled person to understand and to console the pain of others, given that he or she has a personal knowledge of reparation and resurrection. When he or she takes on the suffering of his or her neighbour and shares it, that suffering is transformed into concern, compassion and responsibility.

Reconciliation is also creative. It loves the world so it is valued and does not fear it so much as not to transform it. It captures within itself that tenderness and that violence that engender animated existences and living words.

When reconciliation can be brought to such depths, the pernicious effects of depression decrease and there is a great trust in constructive and repairing forces. The result is greater tolerance of one's own limits and better relationships with other people, as well as a clearer perception of internal and external reality.

Thus, with respect to compulsion 'William James observes that more depressed people are cured through religious conversion that by all the medicine of the world. It is believed that this continues to be true despite the great advances achieved by modern psychiatry'.

Reconciliation when marked by these characteristics gives us above all else a healthy relationship with God, with our Father, and with our Redeemer, Jesus Christ, a 'yes' to grace and to the task of loving each other.

4.2. Reconciled acceptance promotes satisfaction

Whereas the state of non-reconciliation is a source of great unhappiness, the act of reconciling is seen as a sub-stratum of the mental states of satisfaction and peace, and lastly of wisdom. In fact, this is also the basis of the human resources and the elasticity that can be observed in those who recover their spiritual peace even after going through great adversity and moral pain. This approach, which includes gratitude towards the pleasures of the past and the pleasure of what the present can give, is expressed in serenity.

4.3. Gratitude as an antidote to depression

The more one experiences gratification in the act of engaging in a relationship with God and with his analogues, the more pleasure and gratitude are felt at the deepest level, and this plays an important role in every sublimation and in the capacity to repair.

Gratitude is closely bound up with generosity. Inner wealth derives from having assimilated good so that the individual becomes able to share his or her own gifts with others. In this way it is possible to internalise a more propitious external world and as result a feeling of enrichment is created.

After the depressive chill, because reconciliation is born from death, the spirit experiences free giving, the received and the given. This freely received and given life teaches something about the mystery of lineage and paternity.

Through the feeling of gratitude the believer opens up to his or her own history and to history, which are both histories of salvation.

The opposite pole is the sick memory, which is concerned and at times completely possessed by resentment, by rancour, and by a lack of satisfaction. The grateful person does not take pleasure in constantly touching old wounds. His or her feeling of gratitude shed light constantly and helps other people to free themselves from complaints and accusations.

5. A New Life: Renewed and Resuscitated Experience

*'The psycho-hygienic importance of therapy is incommensurable against the fear installed by Jesus. Even if consider the question simply from the point of view of the history of comparative religions, we can clearly see that Jesus is the only founder of a religion to have eliminated the element of the depressive mood from religion' (*Bernhard Hassler).

To face depressive death and be reborn is the history of every authentic depression baptised or otherwise with the name of depression by medicine. To be depressed and then recover means assimilating that life is more free and that desire is capable of being reborn and being resuscitated.

5.1. In depression recovering 'health' involves recovering the meaning of life

Desire is a way of 'being present' of 'giving meaning' in contact with oneself, with the universe, and with the absolute.

Desire enormously mobilises the meaning of life. It is known that neurosis and depression assault individuals who have become petrified in a single approach to existence. For this reason, a return to the recovery of the meaning of one's own life is the crucial and primary point of therapy, given that it is the fundamental instance of every intention directed towards deepening the self.

Escaping from depression means being able to say once again that this 'meaning' acts in the space of the inner self – to learn once again to live, to allow those balsams and those forms of treatment to work within us, which console and take away guilt, and have been present one after the other in our histories.

Finding again – outside ourselves or inside ourselves – a place in which there is meaning, must take place at the same time as the discovery of meaning, its use, the pleasures and the consolations that it provides, and the freedom of which they are the humble instruments.

In this way, a piece of bread and a glass of wine that are received and incorporated as symbols and 'meaning' represent all the good things of this world, and for Christians they represent to the full the good loving nature of God. Profoundly incorporated, a tiny particle of bread can ensure that the infinite of our inner being, the infinite of the world, and the infinite of God enter into play.

6.1. In depression regaining 'health' means recovering basic trust

It is necessary to have nothing to lose, to hope for nothing from one's own strength, not to uphold the compulsion to be, and not to

believe in survival, in order to trust in resurrection. Radical hope amidst desperation and trust in full dismay is mystery: the mystery of life, which is stronger than death.

Such basic trust, which emerges from the depths of being, after a purifying journey through depressive death, is a foundation of reality, the truth of being and the truthfulness of one's relationships with the world and one's own history.

6.3. In depression regaining 'health' involves recovering authorisation to love and to be loved

I possess 'life' if I allow my desire to operate in my body, in my history and in my world; I love if I accept, if I hope for, the same free and trusting movement by another person from his or her desire. This trusting and loving approach can be called 'authorisation'.

One dies if one is not loved and one lives again if one is loved. For this reason, this authorising look, this loving relationship, is the first of the 'actions' of the person who has taken on the task of restoring life, a history, an original sovereignty.

A mother, for example, is the first granter of this 'authorisation', this love that authorises. The first offering of her breast, as an answer to the first hunger experienced by her child, teaches the newly-born child that need announces joy, that internal emptiness is matched by external abundance, and that it is sweet to ask and to receive. But this approval of initial need is extended during a life revivified by every experience that involves an answered request.

For believers, the supreme giver of authorisation is God, who is total love and total readiness to help.

As regards non-believers, I would like to recall that young *depressed* psychiatrist who tried to commit suicide. After recovering he asked a friend what he had to do in order not to fall into the same kind of suffering. His friend said to him: 'I have a trick for those people who do not believe in God. To feel alive and real you must allow yourself to be touched each day by something or by someone'. We should allow other people to nourish our hearts, we should exchange great and emotional signs of life: we should allow them to interfere with us, that is to say animate us with a glance, a spoken word, a gesture, and if possible a caress.

I would like to finish my paper with an appeal to implement every ounce of authorising goodness that exists in God, in the world, in communities, in people, and in the things which give a 'meaning' to our lives.

The move towards the depressive tendency in our society is strong. For this reason, I believe that the disciplines that are dedicated to looking after minds and bodies must form an alliance with the health-giving reconciling resources of religion in order to provide, without any delay, necessary support for inner honesty and well being, which form a part of inner emotional reality and are a source for loving communication with the outside world, wherein, of course, dwell our brothers and sisters.

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5. The Suicide Crisis

Introduction

Suicide is a crisis – for the individual, for the family and for the community. Suicide is a unique kind of death, and the most malignant manifestation of depression. If ever a condition begged for an integrated understanding that takes into account social, theological, biological, clinical, and subjective factors, this one does. Suicide and suicidal behaviour are the end result of very complex interaction. It is very rare for suicide to be based on a simple and logical decision. Suicide is the culmination of a long process in which people in various ways try to reduce their profound emotional pain.

Many of those who commit suicide visit a non-mental health clinician or someone else in the helping professions – including the Church – during the last month of their lives.

Since a suicide crisis is so complex there are also many ways to intervene and to prevent suicide. And another very important aspect – when the disaster has struck – is to care for the bereaved and especially for suffering children who are left. On the one hand, advances in medical technology bring more complex (medical, legal, moral, and ethical) controversies regarding life and death. On the other hand, depression and suicide have been with mankind as long as there have been written records.

We all tend to interpret things on the basis of our own experiences, of our own perceptions. But we must also, within the confines of respect for the privacy of individuals, deal as openly as possible with the members of the community when we are dealing with depression and suicide. My presentation is based on my own daily work as a Swedish physician in a university city in northern Europe, where suicide is treated as a medical and psychiatric emergency. But it is an incontrovertible fact that suicide is a world-wide major health problem with many different aspects to it.

Definitions

Previously we have heard statistics describing the depression epidemic. There has been a hope that this crisis has been declining. However, it has in fact increased despite the availability of better knowledge and treatment options. We have also heard that approximately one million people will die from suicide annually. In the last 45 years suicide rates have *increased* 60% world-wide. One suicide is committed every 40 seconds around the world. In the U.S. a youth commits suicide every two hours. Suicide claims more adolescents than any disease or natural cause. Suicide is among the three leading causes of death among those aged 15-44. And still, there are far more suicidal attempts and gestures than actual completed suicides. It is important to keep in mind that there are approximately 10-20 times more attempted suicides than completed ones.

However, statistics about suicide are difficult to collate, and may be inaccurate because of the sensitivity of the issue. In some countries suicide still is an absolute taboo. Lost in the reporting are also misclassifications of the cause of death, accidents of undetermined cause, and so-called chronic or silent suicides (such as substance abuse, or poor adherence to medical regimens). It is also a paradox that while depressions are well-defined medical entities, and as such also official diagnoses and easier to evaluate statistically, suicides are not always treated as separate medical entities and therefore much harder to collate reliable statistics about. Despite this, official statistics should not, as a rule, be believed to be misrepresentations. However, a word of caution is needed in relation to the interpretation of rates in countries with small populations, where a few more – or a few less – suicides can greatly modify rates.

Progression of suicidal behaviour

There are a few technical definitions that may be of help:

Suicidal thoughts – having thoughts about killing oneself.

Suicidal gestures – self-directed, potentially harmful behaviours which do not result in physical injury.

Attempted suicide – self-inflicted harm in which a person's intent was to kill him or herself but was unsuccessful in doing so.

Completed suicide – a suicide attempt that results in death.

But it must be emphasised that there are also a significant number of so called *silent suicides*, mainly among the elderly, where self-starvation and medical non-compliance leads to death. These silent suicides are never found in the statistics.

Another type that is very seldom recognized is suicidal gestures in children, who for instance may intentionally take an overdose of whatever pills they find in their parents drawers, often to get attention for their problem.

Risk factors

Risk factors include previous suicide attempts, a close family member who has committed suicide, past psychiatric hospitalisation, recent losses (such as deaths, divorce, job or other position, honour), social isolation, migration, drug or alcohol abuse, exposure to violence; often in combination with male gender. Other risk factors are different types of childhood trauma, such as neglect, physical or sexual abuse. The single most important risk factor for a completed suicide is previous attempts.

Often psychiatric disorders are components on the way towards suicide, mainly depressive disor-

ders (50-90%) and/or alcoholism, in some cases schizophrenia (5%). Depression is thus regarded as one main risk factor for suicidal behaviour. But depression is seldom sufficient in itself. Most suicide victims have received no treatment for depression and lack of resources does not explain this in all cases. The antidepressant treatment of depression before death has been found in too many cases to be absent or inadequate. Feelings of hopelessness, helplessness, worthlessness and loneliness may be overwhelming. Anticipated or recent stressful events can finally trigger suicidal behaviour (such as changing job or schools, career changes).

It can never be said too often that all of us have the responsibility to be alerted by these warning signs.

Stages in Suicide Planning

In the *resolution phase* the individual is struggling with the moral and ethical issues surrounding suicide, asking themselves if or not suicide is a sin, and what effect it will have on loved ones and friends. Often those around them notice this as a period of extreme anxiety and agitation. Next, the second stage, or the *initiation phase*, the individual formulates actual plans. Finally, a stage of *postponement* ensues, often observed as a time when the individual, paradoxically, can relax, and bide his time.

Protective factors

Work, family, parenthood and a stable social net-work, in general, protect against suicide. Participation in religious activities may or may not be protective. Historically, suicide rates among Catholic populations have been lower than among Protestants and Jews. It may be that a religion's degree of orthodoxy and integration is a more accurate measure of risk in this category than simple institutional religious affiliation. It is, for instance, well known that Catholics who have migrated to another country, have a higher risk of suicidal behaviour than those left in the 'old' country.

Prevention and Intervention

Suicidality can be treated both on the individual level and in society. Previously mentioned protective factors should always be taken in account. Prevention includes education within the community about the problem of suicidal behaviour. Not only medical health care but all organisations in the community can, and should, be involved in this work. Access to common means of suicide should be restricted (such as poison control, controlled prescription of drugs, gun safety).

An attempted or completed suicide can have a powerful effect on the surrounding community. There are indeed conflicting reports on the incidence of a contagious effect creating more suicides. Adequate steps have to be taken when there has been a suicide in the community. There should be clear plans and guidelines, involving staff members and administration with protocols and clear lines of communication. Such inventories should be made in advance so as to find professional medical, social and psychiatric help. These guidelines are necessities in schools, working places and in dioceses and parishes.

Barriers to Treatment and Intervention

The attitudes towards suicidal behaviour vary between different regions. In some countries or cultures suicide is an absolute taboo. Despite this, suicidal behaviour also exists there. And, on the individual level, for the untrained person, suicide may generate such a high anxiety that the problem is dealt with by thoughts of denial.

Physician-Assisted Suicide

The current debate is centred on physician-assisted suicide rather than on euthanasia or on 'proper' suicide. Some have argued that physician-assisted suicide is a human alternative to active euthanasia. Others believe that the distinction between physician assisted suicide and euthanasia is capricious. The intention in both cases is to bring about a patient's death. It is well-known that in most cases a depression is involved and hidden here.

Despite the abhorrence that many physicians and medical ethical experts express towards physician assisted suicide, poll after poll shows that many 'ordinary citizens' would favour physician assisted suicide in certain circumstances. Even if many profession-

al associations of the medical community have opposed physician assisted suicide I must strongly urge that this should continue to be brought up on the agenda.

Other forms of suicidal behaviour

Self-mutilation can be regarded as another contemporary type of suicidal or self-destructive behaviour. People harm themselves in many ways, including burning or scratching, pulling out hair, hitting their bodies against something, drinking heavily or taking excessive amounts of drugs. Here we are confronted with activities with a high physical risk, but for the individual not necessarily with a suicidal intent. But it is always an indication of an underlying problem and is often kept secret. And it is a challenge for the medical profession.

The media are filled with reports of killings where 'suicide' is also included as a means to intentionally cause harm to other people for a political cause, sometimes under the guise of religion. We hear about so called '*suicide bombers'* or '*suicide blasts'*. This type of self-sacrificing suicide has nothing to do with depression in the medical sense. Nevertheless it has great impact on our attitude towards suicide, life and death.

Physician-assisted suicide and these latter forms of suicidal behaviour are thus not necessarily associated with depression in the medical context but are important aspects of present-day threats to human life.

The Swedish experience

Sweden is a small country of only 8.9 million people. Today, our standard of living is among the highest. Approximately 8 per cent of Sweden's gross national product amounts to health and medical services. Our people are among those who live longest. Almost 18 per cent of Sweden's population are over 65 years old and 4.7 per cent over 80 years old. The average life expectancy is 76.1 years for men and 81.4 years for women.

The Swedish health and medical services are organised into a uniform, nation-wide program that gives each person access and the right to the best available care.

In Sweden, health care is regarded as the responsibility of the public sector and this stems from traditions dating back to the 16th century. Only 8 per cent of physicians work in private practice. The Ministry of Health and Social Affairs draws up general plans for services. The government's National Board of Health and Welfare is the main agency for Swedish health care. It supervises public and private medical care and plans national services.

There are about 27,400 physicians in Sweden. General practitioners at health centres provide medical treatment, advisory services and preventive care. The school health services regularly check the health of school children.

In Sweden suicide is responsible for about 1,500 deaths each year. By way of comparison, approximately 600 persons are killed in traffic accidents yearly. Swedish women are likely to experience episodes of major depression twice as much as men. However, for suicide male gender dominates. The rates among adolescents have increased markedly, and in the 15-44 age group suicide is the main cause of death. Depression is the most common experience in elderly suicide victims, while alcoholism is the most common diagnosis in the younger. Several professions have been noted as having suicide rates higher than would be expected. Surprisingly, female physicians are one example. But in general, higher rates of suicide are more frequent in occupations of lower prestige and salary.

Our national program for suicidal prevention is based on a national strategy developed by the Centre for Research and Prevention of Suicide and Mental Ill-Health (N.A.S.P.) in collaboration with the W.H.O. in Geneva, and has resulted in six regional networks. Educational efforts are particularly aimed at psychiatrists, psychotherapists, psychologists and social workers, but also at general practitioners. There are also guidelines available for suicide prevention in schools. A great deal of emphasis has been put on education especially at the primary care level and by removing barriers to treatment and increasing access to help. This can be exemplified by a successful project from the province of Gotland, but such efforts have to be ongoing.

Even if much of the function is interdisciplinary and has an integrated approach, it is the case so far that organisations like the Churches in Sweden have not been involved more than on a voluntarily and individual basis. However, this has resulted in several crisis telephone hotlines aimed at different groups – children, students, adults for examples, but much more needs to be done.

Concluding remarks, future perspectives

Suicide is a medical issue. But it is also a social, moral, economic and a political issue as well. It is important to remember that at least 10% of people who complete suicide do not have any known psychiatric diagnosis.

General remarks on prevention of suicide in society

People do not choose to be depressed. There are biological, biochemical, environmental and social factors that can lead to depression. Most suicidal persons do not want death. They just want their emotional pain to stop.

Open debate and honest exchange of viewpoints are needed. We must deal with the suicide crises as a public health crises. Health care policies must provide adequate insurance, home care, and hospice services to all appropriate patients. National and international efforts (W.H.O.) to prevent suicide must be encouraged. Prevention centres, crisis listening posts and telephone hot lines likewise. Not only patients, physicians and staff, but also organisa-

tions outside the health care systems need to be involved and educated about depression, pain management, palliative care and quality of life. Basic professional education and training programs need to treat death, dying, and palliative care and give the attention these important aspects deserve. Young children especially must be taught how to cope with difficulties.

Community organisations including the Church should be involved in the prevention of suicide with own established guidelines. Any parishioner who expresses suicidal ideas or a threat to end their life should be promptly referred to a doctor or a psychiatric service.

Helping victims become survivors

Victims, who are they – the committer, the person who tried to commit suicide but survived, or the family and friends around? No survivors walk the same path toward recovery. Survivors have different methods of coping, but must be encouraged to move forward on life's journey, and where applicable, also continuing as participating members of the Catholic Church or other congregations of faith.

Almost without exception a completed suicide leaves people with a complex process of grieving. We must reach out to the victims and their families and communicate sincere commitment for their spiritual and emotional well being. There is no doubt that individuals close to the suicide victim may have years of distress, because of the unanswered questions about the death and the assumptions of guilt for the persons action's. In a non-judgmental way we must relieve the tremendous burden of guilt and failure. And sadly, often a previously stable social network around the family too often disintegrates after a suicide, creating also secondary losses. Counselling and support are essential cornerstones.

Efforts must therefore be focused not only on medical depressions, but on other factors as well to prevent suicide – since even when effective treatment of depression is available it has failed to make a significant impact on suicide rates.

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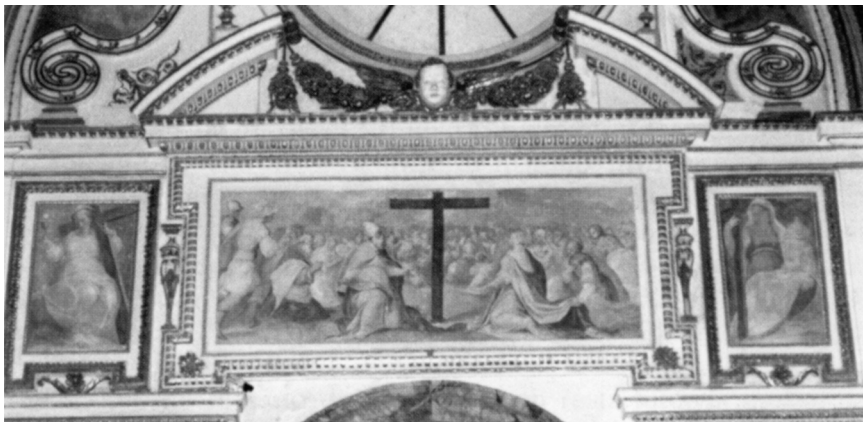
The Clinical Science of Suicide Prevention (Volume 932 of the Annals of the New York Academy of Sciences). Eds. Hendin & Mann (ISBN 1-57331-330-0).

Theme Issue: Depression, Ed. Glass. The Journal of the American Medical Association Vol. 289, No. 23, 2003.

Resources on the Internet

http://www.who.int/mental_health/
WHO, prevention of suicidal behaviours
http://www.psychiatry.ox.ac.uk/csr
Centre for Suicide Research, University of Oxford, Britain
http://www.siec.ca
Suicide & Education Centre, Canada
http://www.mentalhealth.org/suicideprevention/strategy.asp
National Strategy for Suicide Prevention, U.S.A.
http://www.suzidprophylaxe.de
Deutsche Gesellschaft für Suicideprävention, Germany
http://www.ki.se/suicide/english/index.html
National Centre for Suicide Research and Prevention of Mental Ill-Health, Sweden
http://www.survivorsofsuicide.com
Information to survivors and friends
http://1000deaths.com/1000deaths.html
Information to survivors and friends
http://www.survivingsuicide.com
Information to survivors and friends
http://www.befrienders.org/suicide.html
International organisation, voluntary efforts focused on prevention, with emphasis on the younger generation



ADOLFO PETIZIOL

6. The Biological Model and the Psychological Model of Depression

'Go into a garden of plants, of grasses and of flowers, however smiling it may be, in the best season of the year, and wherever you look, you cannot but fix your gaze on affliction; that whole family of plants is in a state of suffering; suffering rules. There, that rose is offended by the sun, which gave it life; there, that lily is sucked by a bee in its most sensitive, vital parts; here a branch is broken by the wind and by its own weight; and the gardener is wisely cutting the sensitive parts of plants, with his nails or with a blade'.

What appears at a superficial glance as a full expression of vitality, in the multitude of colours, sounds and scents of a garden, when more closely examined by Leopardi (in his *Zibaldone* of 1826) is in fact intrinsically linked to a condition of suffering.

Evolutionary life, in fact, is a set of relations, of forms of co-evolution, of infinite networks of macroscopic and microscopic interactions, interactions between living beings, and between biological species and ecosystems.

In this context is to be located depression, which is a weakening of the neuro-psychic tone that involves the affections and the psychosomatic condition of man.

When one refers to the affections, one is referring to feelings, emotions and moods.

Feelings are affective charges that are experienced by the self, and their typical polarities move between the sphere of pleasure and the sphere of pain. However, in seeking to understand the origins, the relationships and the meaning of the affective experience, which accompanies the history of each and every man, and in order to understand its influence in determining and conditioning moods, feelings and emotions in terms of their most significant aspects, it is of interest and help to refer to certain realities from an evolutionary point of view.

In this approach we can say that affective ties are the evolutionary result of what has been biogenetically separated with the dissociation of motility from primitive instinct.

The control of motility, that is to say of behaviour, with cultural evolution of a neo-cortical nature becomes no longer instinctive but instead moves under the control of the conscious part (the self) of man.

The affective ties, from this point of view, dissociated and differentiated from the instincts during the course of evolution, and permeated by culture and civilisation, conserve their influence on the evolution and development of culture, maintaining those original adaptive values that are the guarantors of the original ecological evolving equilibrium which works for the full realisation of man in every culture.

We are dealing here with genetically codified functions that work for the realisation of a progressive cultural and environmental integration of an affective kind.

Indeed, during the course of evolution a biochemical system, which is plastic in its relationship to different cultures, is selected and evolves, and this means that man is organised for conditions of attachment of an affective character in relation to situations and other people.

This biochemical system responds with the synthesis of endogenous substances (which are responsible for situations of dependency and abstinence of an affective character) to all those variable environmental and cultural conditions that are indispensable for the survival of the individual and for the continuation and evolution of the species through the conservation of the primitive ecological equilibrium.

Through such mechanisms man becomes biologically predisposed to experience the most significant affective ties of his existence.

To return to the subject of depression, however, it should be said that this is a universal emotion and state of mind that belongs to the daily lives of individuals. In clinical practice, although depression is a well-defined element from a phenomenological and psychopathological point of view, there is not always a clear and net distinction between the respective physiological and pathological spheres of this state. For this reason, the elements that represent the affective and emotional modulation of the symphony of life can be confused with the symptoms of fracture of the ideo-affective harmony, that is to say the pathognomonyms of mental disturbance. In addition, the stigma of a psychiatric definition of clinical depression helps to make the interpretational aspect of the feelings connected with it, and the correct assessment of what should be done, more complex and ambiguous in character.

Given that the universality of these emotions in the normal course of life in reaction to stressing events and experiences of loss can expand to the point of reaching real and authentic clinical situations that can lead to medical observation, it is absolutely necessary to possess clinical instruments and instruments of deep knowledge in relation to the definition and delineation of the emotional and affective problems of the general population in order to engage in suitable and adequate clinical and therapeutic choices.

Clinical depression is an unhealthy sadness that be expressed in different levels of severity from light disturbance to the overall destruction of the individual. Over recent decades a large number of scientific works have been produced which have increased our understanding of the causes and pathogenesis of depression. A variety of psychological, interpersonal and biological factors are involved which clinics have associated with an equally various abundance of innovative forms of treatment.

But the habitual vice of psychiatry of separating the sources of knowledge in relation to the subject of depression rather than integrating them still leads today to the biological and psychological models of interpretation of depression being in opposition to one another.

According to the first model, as an object of study on the part of the neurosciences depression is a phenotype that is complex and heterogeneous in its biological expression and its aetiology. Genetic studies have helped to clarify certain aspects of this heterogeneous character of depression but we are still far from establishing the relevant molecular foundations of this condition, although a certain level of genetic variability in the genes of the serotonin system seems to contribute to the risk of an outbreak of depression or some of its clinical aspects. Greater risk of a depressive episode increases with the number of genes that are shared with a family member who has suffered from depression, but in genetic terms, and given the level of risk that has been found, a certain overlapping with bipolar disturbances and schizophrenia is also to be encountered. These biological data lead us to reflect on the meaning of genetic risk observed in families and on its relative specificity. It is probable that genetic studies must abandon the phenotype category definition of depression and begin to employ psychopathological dimensions in order to delineate sub-groups that are present in functional psychoses.

Progress in the field of the biotechnologies has called into question the simplistic and erroneous belief that a single system of neurotransmission can be altered by depression and that a specific treatment is possible. Molecular biology and genetics have suggested other possible chemical alterations of the brain, in addition to the simple participation of the system of monoaminergic neuro-modulation, which, indeed, has been the classic hypothesis in this field.

Although anti-depressives have been used at a clinical level for over fifty years, no agreement has as yet been reached on the precise mechanisms of their action at a molecular level.

The therapeutic protocols of the treatment of depression have undergone notable development over the last two decades, with the establishment of pharmaceutical treatment as the form of action that is most correct at a clinical level.

The present-day availability of a relevant number of active molecules in the set of symptoms in the case of depression co-exists with a refinement of the noxographical and diagnostic approaches to the disturbances of the spectrum of depression which are individually attributed to the prevalent dysfunction of a neurotransmitter system.

In searching for a common denominator in the great variety of active principles that we now have available, one could observe that each of them, independently of the category to which they belong, is able to increase the cerebral availability of the biological amines, that is to say nor adrenalin, serotonin and dopamine.

The first differentiation to be made is that between the old and new generation molecules. The action on the receptors of the tricycle anti-depressives (TRC) and of the monoaminoxidasis inhibitors (IMAO) has turned out to be not very selective. Over the last decades, thanks to new methods of investigation (binding techniques, assessment of the activities of the AMP cycle), empirical attention has been drawn, for example, to numerous interactions at the level of the receptors in the case of the TCA tricycle anti-depressives: alpha1 and alpha2 receptor adrenergics, beta 1 adrenergics, 5HT2 and 5HT1A serotoninergics, muscarinic receptors, D2 dopaminergics and H1 and H2 hystaminergics.

The blocking mechanism on a large number of receptor systems, however, is the reason for the frequent side effects associated with the use of TCA tricycle anti-depressives.

This plurality of actions at the level of the impact of drugs on receptors, although supported in the clinical field by a large number of successes at the level of treatment, and although in addition it guarantees anti-inhibiting or sedative antidepressive effects, all too often also constitutes the weak side of this approach to treatment.

Nor adrenalin and serotonin are certainly involved in the mechanisms of depression. The scientific evidence suggests that double action anti-depressives that affect two monoaminergic systems can be very effective and have a shorter period to take effect than pharmacies that act on a single monoaminergic system.

In addition, there is evidence to support the view that there is a relationship between depression and the therapeutic effects of the classic anti-depressives based upon the action of different biological systems. For example, the peptide system that involves the CRH (corticotropin release hormone), the cortisol and the functional state of the respective receptors, or the systems that transmit the intracellular signal with the cAMP on the transcription factors such as the CREB and the neurotopins, or the immunity system and the citosins, or glutamatergic transmission, or the neuropeptide system of the P substance, or neuroactive steroids and neuroglia.

I have emphasised these technical examples in order to bring out how the biological aspect is in correlation with the set of symptoms and treatment. These are new and varied biochemical hypotheses about depression and the possibilities of following new therapeutic pathways. In reality, it is not possible to state that we really know about the exact causes or the precise processes that bring about depression or lead to the improvements that are currently attributed to the pharmacological treatments now available. For that matter, we await great help from the biotechnologies in improving our understanding of the relationship between the nervous system, the endocrinal system and the immunity system, with their

respective intracellular cascades, and the final outcomes of genetic expression and proteic functions in conditions of depression. This advance in understanding will allow more effective pharmacies that are more selective and rapid in their effects, and in the future, with the help of psychogenomics, it will also permit the creation of different made to measure drugs for different patients.

Indeed, geneticists have predicted that the advances achieved by their discipline will revolutionise our understanding of human illnesses, unhealthy forms of behaviour, and their forms of treatment.

For example, pharmacogenomics is a powerful instrument that can be employed to identify genes correlated with anti-depressives or correlated with other effective therapeutic manipulations.

Hundreds of fragments of cDNA as genes correlated with anti-depressives (ADRGs) have been already identified. Some of these 'candidate genes' can codify shared functional molecules induced by treatment for chronic depression with anti-depressives. The establishment of the role of different molecules in the neural plasticity induced by a pharmacy means that we are near to transforming the direction of research into the biological bases of anti-depressives. Such detailed knowledge, indeed, will have profound effects on the diagnosis, prevention and treatment of depression. One may expect that the new biological approaches that go beyond the 'monoaminergic hypothesis' will in the future shift the paradigms of research in relation to anti-depressives.

Such references to the future and references to technology in the assessment of biological models is in opposition to the humanism of psychological models, a humanism that at times flows over into pure philosophy. And just as many of the biological and biochemical interpretations of the last decades belong to the history of psychiatry, so the model of 'orality' or introjected aggression of Abraham, or of the loss of objects of Freud, or of the depressive position of Klein belong to classic psychodynamic literature. The cognitive triad of Beck or the theory of attachment of Bowlby belong to history, even though these last interpretations have allowed the construction of a bridge between the bank of psychology and that of biology through evolutionistic biology, as, indeed, was observed at the beginning of this paper.

According to this approach, human beings at every stage of their development are 'compromises' in their constant adaptation to changes in their environment. Employing a neo-Darwinian perspective, evolutionistic psychiatry suggests that whereas natural selection does not delineate the illness in itself, it does delineate its human traits and thus a person's vulnerability to illness.

The concept of 'vulnerability' is without doubt one of the strong organisers of contemporary psychological and psychiatric knowledge, both because of the summarising vision that it proposes as regards the multifactoriality of the genesis of psychic disturbance and mental illness, and because of its marked clinical and pragmatic inclinations. In this sense, the concept of vulnerability should be understood in the heuristic meaning of the term rather than in the descriptive-naturalistic sense (of a 'predisposition to'). The individual is vulnerable because he or she is subjected to biological and psychosocial variables that interact with personological factors, which are biologically predisposed and modified by the impact of the environment on genetic self-expression.

In line with this hypothesis, depression is a human emotion that can be a positive response of survival and which, for this reason, is not always pathological. Depression is said to bring about a reduced relative or absolute availability of vital energy at a given moment when the quantity of environmental requests becomes exaggerated in terms of the capacities of the individual concerned. The perception of a reduction in energy leads at a physiological level to a re-adaptation of expectations in relation to the environment, with a consequent reduction of the pressure that comes from that environment.

The variability of the different factors involved in the genesis of clinical depression can, therefore, be of influence in terms of greater vulnerability (the bio-psychological factor in mutual interaction) and of the requests of the environment (the psycho-social factor in mutual interaction). It is from this point of view of interaction that the social origin of depression, which was born as a sole hypothesis in the early 1970s, acquires value. This hypothesis emphasises the importance of taking into account the context and the meaning of the causal and proximate factors, and the factors that can be traced back to the person's entire life history. The individual and social historical element provides elements of knowledge of a comparative and developmental perspective by emphasising a biological and psychological individual human nature and a shared nature of a social kind that brings in

the complete variety of the cultural settings. This is a serious bio-psycho-social perspective.

In particular, therefore, the approach of social psychiatry seeks today to understand dynamics within an overall context within which a given psychopathological phenomenon arises and takes on relevance with all its biological and/or psychological determinants. The individual impact of a mental pathology can be measured on the basis of the choice of sentry symptoms that condition to varying degrees the psychic functioning of the individual. But to measure a human, emotional, behavioural, and cognitive phenomenon without taking into consideration the collective determinant amounts to rendering abstract a concrete element of the sick person's difficulties in living. It means justifying the withdrawal of the depressed person from the sphere of social interaction in the name of obtaining the minimal individual damage possible.

In addition, the collective impact of a correct psychosocial approach to the defence of mental health, although it is not measurable, is of such a character, when it takes place, to render the assessment of the outcome incontestable.

In this sense it is of fundamental importance to perform the role of promotion of a complementary perspective in the psychiatric disciplines through attention focused on the world of the attitudes, values and beliefs that underlie the being of the individual in his or her own world of relations with the environment. This is a humanistic and dynamic approach to measurable phenomena applied to the object of study, 'man' in his entirety.

This does not mean a wish to withdraw own actions from judgements as to their efficacy: quite the contrary. The development of the integration of culture, society, mental health, mental disturbance and mental illness must be carried out (by social psychiatry) in the clinical field in order to produce a synthesis between culture and psychobiology, with the promotion of a real and authentic ecological approach to man and his health.

And specifically in the clinical field, attention to the social must flank biological psychiatry in the assessment of the dynamics of the collective experience both as regards the biological manifestations of mental illness and its forms of treatment. It is not enough to confine ourselves to considering the mere biochemical mechanism of a pharmacy and its action at the level of symptoms, with a measurement of its effects as well, neglecting thereby the impact on the individual of the collective judgement on being afflicted by a mental disturbance or taking a psychotropic drug.

A fundamental victory at the level of an overall vision of the experience of the sick person has been represented by the introduction, in almost all the experimental clinical work carried out in recent years, of parameters for the assessment of quality of life. This is certainly a subjective element, but in the age of the need to objectify everything, to provide a measurement of the satisfaction with one's life of an individual and to make it an outcome indicator seems nonetheless to be a major success…while awaiting, that is, the advances achieved by the future of the neurosciences.

Prof. ADOLFO PETIZIOL
President of the European Society of Social Psychiatry

DONNA J. MARKHAM

7. Stress, Burnout, Mission and the Media

Introduction

My reflections this afternoon are based upon my experience as a clinician with over 30 years experience and, in particular, upon my work of the past ten years as President of the Southdown Institute in Ontario, Canada. The Southdown Institute is a multidisciplinary residential psychiatric facility that treats severely ill priests and religious from across the world. (Thus, my presentation reflects the past 10 years – not my past few weeks at my new assignment at Georgetown University!)

Imagine, for a moment, the following situation: It is late on a Friday afternoon. I am in my office at the Southdown Institute. Earlier during the day, a very experienced clinician came in to see me about his growing sense of hopelessness around the widening scandals in the church. A dedicated, wonderful layman, he said, "I wonder if the walls here are big enough to contain all the tears..." A priest patient had tried to asphyxiate himself earlier that day, (fortunately, unsuccessfully). A female borderline patient had once again found a way to mutilate herself. A steady procession of very stressed and deeply saddened religious superiors and bishops had been in and out of my office all day. Just as I was looking forward to a day off, the phone rang and it was a reporter from the *National Post* (a Canadian newspaper) wanting an interview. A typical day in the life of a health care administrator. Is it any surprise that I began to experience difficulty getting to sleep at night?!

My situation is not all that dissimilar from many persons in leadership who are faced with overwhelming demands on their time and emotions. And, as if the usual demands of leadership today were not enough, add to the picture the reality of living in a postmodern global environment in which we feel far less secure than we did ten years ago, We are all too aware of our fragility and vulnerability as human beings. Terrorism, war, and a range of environmental catastrophes have taken their silent toll on us. Then, for us in North America, this includes being shaken by a church in a serious crisis of credibility. We are all, to some extent, contending with sufficient stress to make it difficult, even for the hardiest among us, to maintain a sense of equilibrium.

This is simply to say that it should not seem unrealistic or aberrant for us to feel defensive, anxious, perhaps irritated, when an "outsider" like a representative of the media, suddenly steps into our chaotic worlds and seeks to "do a story". At times such as this, we can feel quite vulnerable, exploited, caught off-guard. In such a state, it becomes difficult to consider media professionals as colleagues and potential assets in trying to present a truthful and responsible picture to the public. We have all, at one time or another, experienced journalistic distortion and the sensationalizing of events; we may have found ourselves at times victimized by unscrupulous reporters. Clearly, there are persons in any profession who do their colleagues a disservice because of their poor adherence to the ethical principles inherent in their disciplines. This is sadly true in our own ministries as priests and religious, it is true for those in healthcare services, and it is true in professions such as journalism and reporting. It is beyond our ability to control any professional person who deliberately chooses to sensationalize, exploit or distort the truth. The media portrayal of a culture narcissistically focused and engaged in self-serving exploitation of others clearly has heightened our sense of social angst. That being said, we cannot blame the media for our global reality anymore than we can place blame any one group for the pervasive conflicts inherent in our trying to live our lives meaningfully in this postmodern context. It would be dangerous for us to categorize an entire profession based upon the unscrupulous behaviours of a minority. (For example, to say that all media personnel are determined to exploit or promote hedonism is analogous to saying that all clergy are sexually acting out). Both statements are perilous; both are founded on bias and ignorance.)

My focus this afternoon will be on what we can do by means of internal preparation to contend with the noxious effects of stress, especially as related to engaging the media in highly sensitive situations – whatever they may be – that deeply affect our lives as Catholic leaders. I will address some considerations pertaining to the management of stress, in general. Then, I will focus on two components that I believe can assist us in lowering our own stress levels when we are engaging with the media: that is, 1), substantive "inner work" that is grounded in community and prayer; and 2), the development of an effective media strategy that restores some sense of being in control in the midst of very stressful situations. I realize this is quite an ambitious undertaking in a short amount of time, and beg your indulgence for not being able to develop the topic as fully as the material warrants.

Stress, 'Burnout' and Effective Performance in the Workplace

Stress is a physiological response to persistent pain, feelings of heightened danger, or fears of being harmed. Clearly, reading the newspapers, listening to television and radio, by which we are barraged by a steady stream of global catastrophes, increases stress. The euphemistic non-clinical term, "burnout" is frequently used colloquially to describe the experience of someone who has had prolonged exposure to a highly stressful situation and who experiences a combination of emotional and physical responses. Among a myriad of descriptors used to delineate this transient situation are: anxiety, depression, irritability, anger, diminished self-esteem, self-reproach, difficulties in concentration, problems in decision-making, and mild impairment in otherwise good judgment.

Some researchers have questioned whether a heightened orientation to others' needs places caregivers at greater risk for "burnout" or depression. In other words, might we ourselves be more susceptible to stress because of our roles in ministry and in the helping professions? Interestingly, and albeit, fortunately for us, this hypothesis was not supported. (Bersoff and Glass, 1982; Thomas and Keznioff, 1984).[1] Concern for others is *not* a necessary factor contributing to depression.

Historically, significant bodies of research on stress have identified certain factors that seem to help persons contend with, contain, or overcome stress in the workplace. It was generally thought that if people had a sufficient degree of autonomy, felt in control of certain aspects in their environment, had developed effective negotiating strategies, and had opportunities for professional development and good communication, stress would be significantly lowered and productivity heightened. The meta-analysis of research during this period in the 1980's further identified several other major factors that enhanced a person's capacity to resist the deleterious effects of stress and maintain physical and emotional balance as he or she faced disturbing events. These additional factors included: physical health, adequate self-esteem, social support, and a sense of control over one's life.[2]

Of particular interest is a fascinating recent longitudinal study conducted by Cary Cherniss and published in a book entitled *Beyond Burnout*,[3] in which she studied professional caregivers over the course of a ten year period. Cherniss' research revealed curious findings that suggested that these earlier factors were not enough to prevent stress and burnout. In tracking research subjects over the course of a decade, it was discovered that there were some notable exceptions to the earlier hypotheses suggesting that as long as people had a sufficient degree of autonomy, felt relatively in control in their environment, had adequate negotiating strategies, opportunities for professional development and good collegial communication, stress would be significantly lowered and productivity heightened. Cherniss' research revealed that even after these factors were attended to, many of the research subjects were still experiencing heightened stress. Some had dealt with their stress by settling into safe niches – no longer engaged in creative projects, but rather choosing to lapse into familiar routines in an effort to assuage stress and bind the subjective anxiety they felt. This occurrence most certainly did not serve to enhance the mission of their various service organizations. Employees manifested little enthusiasm or passion for the work they were doing. Many had become quite complacent and had, despite all predictions, drifted into feeling pervasively stressed, if not bored. What accounted for these findings? If all the requisites were apparently in place to offset this happening, why did these service providers feel so stressed? Cherniss discovered that the key factor missing in these individuals' experience was a *strong sense of moral purpose* in the work they were undertaking.

Furthermore, in the study, a statistically significant sub-group within the total population of research subjects was identified that did *not* become victims of stress. The individuals in this sub-group worked in settings in which all the conditions typically associated with the development of extremely high levels of acute stress and "burnout" were present. They often worked seven days a week, year in and year out, had little autonomy, and were routinely expected to carry out very menial tasks. (The sub-group actually comprised a group of women religious.)

What factors differentiated this group from the others? Stress was mitigated in the face of a compelling sense of "moral purpose." We might call this a *strong sense of mission*. If persons felt that they were simply part of a service delivery system, they were at far greater risk of becoming victims of burnout and debilitating stress – regardless of all the efforts made to ensure a healthy workplace environment. Making application to our ministry, therefore, it would seem that a significant antidote to the noxious effects of stress is our overt awareness of our participation in the healing mission of Jesus.

In order to remain viable agents in the living out of the Gospel, all of us who serve in our institutions must continually assess whether our way of addressing the mission is adequate to responding to critical needs of our times. People who have become settled and satisfied, passive and comfortable, or paralyzed by anxiety are incapable of making the radical adaptations required in a continually changing global environment. They endanger the future life of their institutions, the well-being of those whom they serve, and ultimately inflict damage on themselves.

For health care administrators and direct-line service providers, there is clearly an increased risk for the injection of debilitating stress, leading to diminished performance and disillusionment. This risk becomes intensified when there is little experience of belonging to a community of colleagues who share in the mission, who have a strong sense of moral purpose. The sense of corporate mission, a connection between

one's spirituality and the daily work undertaken, and a passionate commitment to the healing ministry of Jesus help to mitigate the noxious effects of stress. Let me share with you an example of how a group of us narrowly escaped slipping into the negative space of shared depression, burnout and excessive stress and anxiety.

One day during the height of the sex abuse crisis, a group of colleagues and I were talking about what we needed to do in order not to become angry, resentful, rude or defensive when we were confronted by a myriad of reporters and journalists who were under deadlines to get stories written. Even more seriously, we began to discuss what we needed to do so that we would not internalize the anguish and the anxiety that was surrounding us. One psychologist mused that perhaps what we needed was for the 110 of us on staff to take a day apart from the patients and pray together. After checking with the other members of the staff, that is precisely what we did – obtained clinical coverage, and spent a day in prayer for our patients, for the church, for one another. We recognized the toll that was being taken on all of us; we were able to name our feelings; we knew what we needed to in order to feel re-inspirited. We were corporately refusing to slip into becoming merely a good health care delivery system. We were becoming a *community* of caregivers ever more deeply immersed in a healing mission together. No one of us was alone.

As I felt the support of my colleagues and had taken the time for personal prayer and prayer with them, I found my stress level significantly decreased when reporters appeared at the doorstep. I felt I was part of a community of men and women who were passionate in their commitment to help others experience the healing power of God. My anxiety abated; my thinking became clearer; my sense of reclaiming appropriate control increased. I no longer felt the burden of events rested solely on me, not did I hold such fear of making a mistake. We were in this together and it was sacred work. When we do not feel supported or have lost sight of the meaning of what we are doing, we are in increased danger of slipping into patterns of withdrawal and psychic safety. When this occurs, we do not participate in the mission to the extent to which we once aspired. Like the research subjects, we are likely to find ourselves becoming overly irritable, stressed, defensive and anxious. In this state, the media become just one more irritant in an already overly demanding day.

I share this incident with you not because I was responsible for taking the initiative to minister to the group of caregivers – it was a colleague, whose intuitive sense of the precariousness of our corporate *persona* protected us. I share it with you because I believe in some providential way that my colleague guided us toward taking action that freed us and, thankfully, freed me to respond in greater freedom and courage in the midst of an extraordinarily difficult set of circumstances. Unaware at the time of Cherniss' research, we actually had substantiated her findings. *Community*, *personal and communal prayer*, *deliberate reflection on the meaningfulness and sacredness of the work* in which we are engaged – this is the preparatory inner work needed to inoculate ourselves against the deleterious effects of stress. As Viktor Frankl so eloquently wrote, "Suffering ceases to be suffering in some way at the moment it finds a meaning, such as the meaning of sacrifice."[4]

Working with the Media

Another component that can assist us in lessening the likelihood of responding defensively or feeling victimized is to obtain proper training in managing the media. This is part of reclaiming a sense of control. It allows us to address some of the factors identified by researchers as beneficial in lowering anxiety. Along with the collegial reflective inner work necessary, I believe we can help ourselves to reframe the crises which precipitate media involvement.

It is understandable that we feel intimidated when faced with reporters. We may feel fearful of making an irretrievable error that will become immediately public; we may experience ourselves being defensive or incompetent; we can feel out of control; leading us to greater passivity in our responses than would normally be our style. In short, the situation serves to highlight our vulnerabilities resulting in stress levels that are personally quite destructive if we have not done our personal inner work and if we have not anticipated the potentially stressful situation. Furthermore, the heightened public visibility of a negative situation or distorted portrayal of a contentious situation by the medial can lead toward a social contagion of stress, a culture of tinder-box tension, and an exacerbation of distrust. In light of this, a serious question we must ask ourselves is: How might we assist our communities to grow stronger in confidence in the compassionate care of God? Or, in other words, how will we counter postmodern deconstruction with *Gospel-focused reconstruction*?

Thus, in addition to the immersion in prayer and communal grounding in the compassion of God, we must also take into consideration some very practical concerns. A colleague from the media[5] strongly urged us to engage in a disciplined preparation for dealing with reporters and journalists. He suggests that we pre-emptively develop a plan for the media management of crises in anticipation of the likelihood of something happening that will draw media attention. Such a plan

should be clear in delineating who will handle the situation publicly. It should include developing a media relations and crisis communications policy and procedures. Certainly, many groups have such a policy, but anxiety still abounds. Planning without training is not sufficient. Training and practice are strong antidotes to anxiety and must be included in any media management plan. Taking part in workshops designed to assist leaders in managing the media, identifying and practicing delivery techniques, and learning about common traps one can fall into help leaders feel more in control of the situation and less apt to get caught in a quagmire of debilitating anxiety.

When we can engage reporters in asking us the questions we want to be asked; when we have become at ease avoiding common pitfalls of personal opinion, over-spontaneity, or foretelling the future; when we have avoided addressing a topic we are not expert in, to name a few, we are well on our way to regaining a sense of personal control and authority in relation to the media. We are well on the way to mitigating anxiety and the concomitant experience of stress.

To summarise, Frank Emmerson, a consultant who trains leaders in working with reporters and journalists, suggests a seven-point crisis communication strategy that should be developed by every leader who is faced with the likelihood of engaging with the media. Using such a strategy is a means of binding anxiety and the debilitating effects of undo stress inherent in these situations.

Plan: develop media relations and crisis communications policies and procedures

Collaborate with experts in the media field to solicit guidance and support

Train: ensure all staff are aware of these policies and their roles

Prepare: identify potential issues and prepare crisis communications briefs

Anticipate: monitor emerging "hot" issues

Respond: deal with immediate issues

Evaluate: review the adequacy and effectiveness of policies and procedures and revise as needed.

When such a strategy is in place, we are less likely to feel incompetent, out of control, and terror-stricken when faced with a potential media event. I would hasten to reiterate, however, that strategy alone is not sufficient. We must attend to the reflective, collegial inner work that keeps us clear-eyed and steady in our commitment to the healing mission of the Jesus. As my colleague so poignantly said, "The walls of this place are not big enough to contain the tears." But when we have the support and prayer of one another through whatever crisis befalls us, the communion of human hearts in the compassion of God can sustain more than we can ever imagine.

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Notes

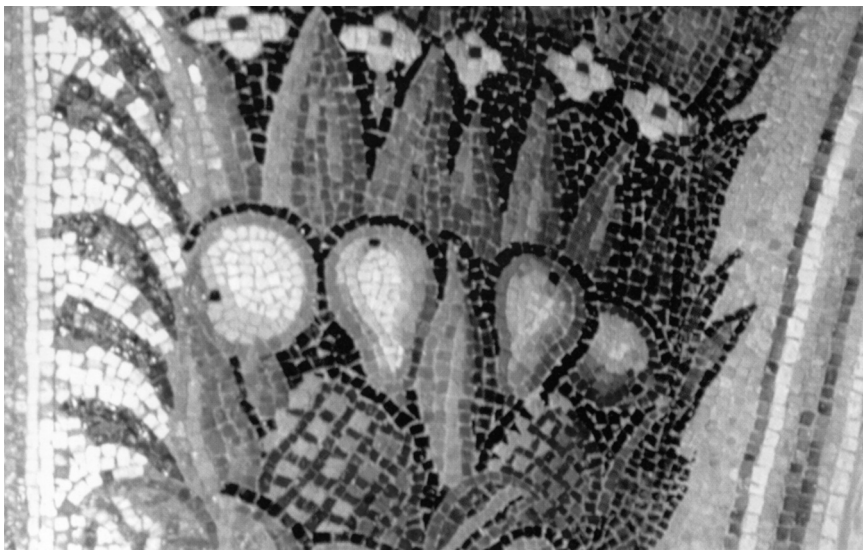
[1] In WILSON, J. & RAPHAEL, B. (1993). *International Handbook of Traumatic Stress Syndromes.* New York: Plenum Press.

[2] HOWARTH, I. & DUSSUYER, I. (1988) Helping people cope with the long-term effects of stress. In S.Fisher & J. Reason (eds.), *Handbook of life stress, cognition and health.* New York. Wiley.

[3] CHERNISS, CARY. (1995) *Beyond Burnout: Helping teachers, nurses, therapists, and lawyers recover from stress and disillusionment.* New York: Routledge.

[4] FRANKL, VIKTOR E. (1997 edition) *Man's search for meaning.* New York: Mass Market Paperback.

[5] FRANK EMMERSON, author of *Tough Questions under Fire: Media Interview Skills for Leaders.* Emmerson Communications, 2002. Frank prepared us to work with the media as we contended with the clergy crisis.



AQUILINO POLAINO LORENTE

8. Is Depression Solely a Matter of Medical Intervention?

Introduction

Science is not reality and although it helps us to know reality it also helps in other circumstances to mask reality and even to alter its nature. Contemporary science uses 'models', pre-fabricated analogies of reality, so that in replacing phenomena and events with its analogues they become more easily observable, quantifiable and utilisable than reality.

Science addresses reality from a point of view, from a perspective that necessarily must be limited and reductive, and this imposes a necessary abandonment of the remaining dimensions of reality which, by definition or by design, are excluded from its approach.

Hence Frankl concludes as follows: 'science is a necessary elimination of the omnidimensional structure of reality: science has to mask and to exclude; it must pretend and act 'as though…''. Specifically for this reason, the part (the discoveries of science) must not be taken for the whole (the reality to which the part that has not been studied belongs).

Natures puts up a certain resistance to being known by man. The illness of depression is a fundamentally natural phenomenon, although it is open to culture which without doubt also exercises an influence upon it.

Like many other illnesses, it, too, is influenced by a vast range of psychological factors that shape its clinical development and psychological manifestations together with those that shape its intensity of expression, its frequency, and its duration.

Despite this resistance to being known about, in recent decades advances have been made in our knowledge about, and the treatment of, depression. This has come about principally as a result of the advance and clearly innovative contribution of anti-depressive pharmacies and certain forms of psychotherapy.

But without any doubt today we are still far from having therapies that are effective in all cases. Both because of the complexity of these disturbances and because of the residual ignorance that at the present time is to be found in the present state of our understanding of them, we must acknowledge the fact that in some situations there is a certain level of failure in the treatment of a small number of patients afflicted by depression, which authorities in the field estimate at ranging between 15% and 20%.

There thus arises the concept of resistant forms of depression, that is to say forms of depression that do not respond and that are refractory to the various pharmacological/psychotherapeutic strategies that are presently employed to treat them.

The phenomenon of depression seems at times to behave like an obstinate fact that conceals the truth about it not only from the gaze of those who are curious or of outsiders but also of very expert specialists in psychiatry.

In such cases a different strategy has to be employed: the *studiositas* approach to the phenomenon of depression, that is to say study and research. Only when a medical doctor dedicates himself entirely and generously to the study of the illness can the morbose fact – hitherto resistant – reveal its inner self and consign the truth about itself.

Perhaps for this reason the treatment of depression will be effective – will be real treatment – only if the experts dedicate themselves to its study without holding back any effort and by addressing it from *a new and much more open perspective* that, at the same time, is not without strong passion.

Science always proceeds by successive approximations, going from what is simple to what is complex. Science is not complete knowledge; it is not final and hermetic knowledge that cannot be improved upon.

Science presents us with the truths – truths that are always circumscribed and temporary – that it has obtained by deducing them from reality by that cumulative process of which it is itself constituted. Hence one can state that there is at the present time no scientific question that is closed or whose causal factors are completely known.

It is more the case that man – and especially the scientist – gets tired in studying these factors without ever reaching an identification of the ultimate explanatory reason. In this framework one must recognise that *science offers us almost always penultimate explanations*. This is because almost always the phenomenon that is studied – and depression is a good example of this – is also open to the beyond, is near or distant to what transcends it, and at the same time as making us advance offers us a rather circumscribed and reduced explanation that is never completely definitive.

A psychiatrist is a person who has to treat a patient with depression who does not respond to pharmacies or to psychotherapy. In his therapeutic work the specialist very often proceeds by the *trial and error and correction of the error system* when he prescribes this or that anti-depressive pharmacy or certain combinations of anti-depressive drugs, and he tries to do the

same in relation to the psychotherapeutic strategies that he employs.

This mode of proceeding would be more productive if it was more effectively based, that is to say if the medical doctor was more informed about, and nearer to, the contribution made by basic science. Whatever the case, one cannot say that this practice is deplorable because, as Aristotle said, 'to know what we must do, we must do what we would like to know'.

Hence ethical limits must always be respected and the 'will to treat' by the standard programmes that are now available to us must be met in the treatment of depression. Such a way of proceeding in taking decisions about therapy also has a relevant scientific validity.

Contemporary psychiatry is immersed – and no other choice is possible – *in the knowledge society*, a society characterised not only by knowing more but also by a better exchange of the knowledge that we already possess.

The therapeutic potential of present-day forms of psychiatric treatment is not mere knowledge derived from already acquired knowledge. The therapeutic strategies that we should use should not be surrounded by the halo of mere inertial clinical practice.

We need to turn to innovative processes that reach the basis of other alternative procedures which, although they are at the present time still concealed, can be revealed at any time and become or be raised to the status of forms of new emerging knowledge that are of direct and immediate relevance to core questions such as those forms of depression that so engulf a sick person in lacerating pain.

But beyond this prudent way of dedicating himself to a patient within the context of clinical practice, the specialist senses, perceives and knows that his own patient not only must collaborate with his medical doctor but must also personally become involved in order to counter the lack of mental health that he is suffering from.

We specialists feel that we are called upon during the actual moment of the suffering of our patients with depression. But we are aware that if the sick person and the social environment do not collaborate the problem will not be solved and will take a much longer time to be effectively dealt with.

For this reason, with the patient emphasis must also be placed on the fact that 'the illness you have acquired without you playing any part cannot be treated without you playing a part'. Something similar should be done with his family relatives and with his social environment, although in this context the action of the specialist is much more limited because of the simple reason that his role does not always coincide with that of a family therapist and even less with that of an expert in political science.

In definitive terms one is dealing with alleviating the pain of patients suffering from depression and the pain of their family relatives so that once the illness has been overcome they can be integrated again into society, develop their potential to the benefit of other people, and achieve their goals.

What does depression, in its outbreak, development and complete cure involve? Only the action of the medical doctor? Only the wish to be treated of the patient? Both? Are there not at times many other factors that influence the outbreak and manifestation of depression, factors that in some way involve the medical doctor and the patient? Does not something similar occur with respect to other numerous factors on which a cure ultimately depends?

As things appear, the treatment of depression is not merely a matter of the role of the medical doctor. Depression cannot be treated by his action alone, but at the same time without such action, without such a rigorous intervention, it cannot be treated either. We have to put together the two wills, that of the patient and that of the medical doctor, as though they were one much stronger will with a common goal – the complete overcoming of this lacerating illness – and when this is not possible the shared aim should be the achievement of relief and the partial recovery of the patient.

In the lines that now follow I will attempt to survey the factors that escape the action of the medical doctor and can have a positive or negative impact on people in the illness of depression.

Biological Factors that Bear upon Depression

At the present time there is unanimous agreement amongst the researchers of the scientific community that there are numerous biological factors that are probably at work in the different kinds of depression that have been diagnosed.

It is very possible that in the near future we will be able to specify these factors with greater rigour and precision so that once they have been identified they can be used as effective predictors. Thus the psychopharmacies that should be specifically prescribed for each kind of depression will be determined and a rapid therapeutic response will be obtained from patients.

There can be no doubt that biological factors are tout court the emblematic element and the key to the etiological study of the illness of depression, as, indeed, has been demonstrated in numerous scientific publications (Polaino-Lorente, 1978a and 1986).

And yet despite such knowledge – in which so much hope is placed – no expert in the field can conceal the fact that the psycho-pathological profile of patients with depression does not at the present time complete a description that is fully satisfying in the tackling of these problems. It is more that the opposite occurs. Indeed, the vast scientific literature that is now available to us lays much emphasis on the relevance that psycho-social factors have in the genesis, establishment and persistence of depression.

This means that with regard to the possible categories of depression that in the future may be established for the identification of patients suffering from depression we should consider as being of inescapable importance the greater or lesser weight that these psycho-social factors exert in the emergence or otherwise of resistant forms of depression (for a survey see Polaino-Lorente, 1985a and 1985b; 1995).

Given that one is dealing here with answering the question posed in the title of this paper, a rich list of data will now be offered, data that we now have available on the most important psycho-social factors

that exercise an influence in cases of depression. One understands, firstly, that many of these factors can be modified by the sick person himself, by his family relatives or by society as a whole, and secondly that these factors are not a matter for the medical doctor given that they escape the ethical range of his profession and it is not his responsibility to act upon them.

But one should not, therefore, conclude that there is unanimous agreement amongst researchers on the importance that should today be attributed to these factors.

Psycho-social Factors that Bear upon Depression

Numerous factors are referred to by the various schools and the different theories of psychopathology when they have considered depressive behaviour.

Amongst those that stand out, to judge from the scientific literature to which they have given rise, we should mention the following: early emotional deprivation caused by the loss of a parent or the separation of the parents; low self-esteem (Polaino-Lorente, 2003a and 2003b); stressing life events; the absence of social support and a suitable family climate; the style of communication between the marriage partners and the diminution or abolition of communication on the part of parents with their children; an increase in emotional dependence and conflict between the marriage partners; social vulnerability and adaptive difficulties; the framework of an altered personality (Polaino-Lorente, 2003c); feelings of insecurity and guilt etc. (Polaino-Lorente, 1984).

Debate and polemic have followed one another and they appear to continue in relation to this proliferation of factors – some of which have still not been verified sufficiently through requisite empirical investigations. Notwithstanding the absence of strength in many of these theories, it should be pointed out that despite themselves they have contributed to our more complex and realistic knowledge of the illness of depression, as well as to more effective developments in the sphere of psychotherapy, a subject that will be addressed later in this paper.

The fact that women are more vulnerable to depression than men has given rise to many hypotheses, of a hormonal, genetic, educational, cultural (etc.) character, but at the present time it is not yet possible to completely verify these theories or to reject them.

There can be no doubt that some forms of depression appear to be connected with personality disorders (Polaino-Lorente, 2003c and 1983a). However, at the present time we do not know if these presumed disorders are caused by structural personality factors or, in opposite fashion, if such alterations are the consequence of stressing life events: the absence of necessary love during childhood, the educational and upbringing models to which a person is exposed, emotional deprivation or the way in which a person expresses his emotions.

Whatever the case, there is a difference between the way in which depression is manifested in men and in women, as well as in the level of incidence of depression amongst the sexes. Styles of communication are given great emphasis by the researchers belonging to the Bristol group (cf. Keitner, Miller, Epstein and Bishop, 1990). It appears that patients with depression have a style of communication with their marriage partners that is very different from the one they adopt with people who are outside their families.

The style of communication of *a depressed man* is characterised by tension and hostility, elements which become normal when the depression disappears. In *depressed women* the most characteristic indicator of their style of communication is manifestations of anxiety and hostility, elements which continue even after the depression has gone away.

In both marriage partners the way of responding to these *depressive styles* changes: women who are not depressed usually respond with anxiety, whereas husbands that are not depressed become much more independent of their wives.

Paradoxically, this style of communication varies in both categories when their relationships with each other and their relationships with other people are observed. This demonstrates that the family climate, when one of the marriage partners is afflicted by depression, is a factor that increases the probability of bad marital adaptation and the emergence of *conflicts between the marriage partners*, two situations which, because of their proximity, stability and intensity, could be seen as factors that increase the risk of falling victim to depression.

During the depressive episode husbands become more dependent on their wives, although they become more independent when their wives are depressed. In opposite fashion, *depressed women patients* usually adopt a passive, aggressive or regressive approach to their husbands, which encourages their husbands to avoid them, flee from the situation, and not pay them due attention.

Depressed men, instead, adopt a more dependent position in relation to their healthy marriage partner, who usually respond by protecting them and displaying a maternal approach. In synthesis, *the style of communication* within the couple in which one member suffers from depression is marked by emotional tensions, negative attitudes and dysphoric disturbances which then come out in very concrete and irrelevant problems and distort the family climate in an excessive way to the point of generating an unbreathable atmosphere of *emotional alienation*.

Within the context of the family the depressed person is protected, but at the same time he is excluded from the family organisation, an exclusion that is perceived by the sick person as frustration and loss of status. This provokes aggressive forms of behaviour in him towards the other members of the family which thus perpetuates the conflicts that are already present (Gastò, Vallejo and Menchón, 1993; Polaino-Lorente, 1983b).

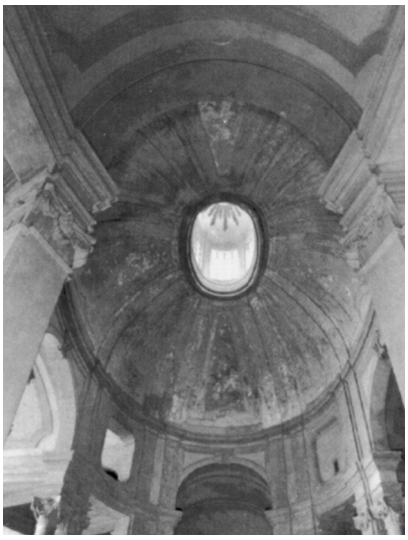
Although many of these observations are rigorous they should nonetheless be integrated better with clinical data because otherwise they cannot be generalised and their predictive effectiveness becomes rather limited as regards the therapeutic strategies that should be employed in the case of depression.

Whatever the case, these results partially match those obtained by the New Haven group during the 1970s (Weissmans and Paykel, 1974). The results *in North American cases where the husband or the wife are depressed* is incontestable – a diminution of communication, an increase in conjugal dependency and conflict, and tendency to control the other person with reference to the manifestations of their symptoms.

In this research there are also significant differences between men who are depressed and women who are depressed. In the case of women, the level of repercussions on social relationships is more global and holistic than is the case with men; the retrieval of these relationships once depression has been overcome is slower in the case of women than in the case of men; and social adaptation after the illness has been defeated is less satisfactory in the case of women than in the case of men.

Previous manifestations of depression could have a certain value at the level of explanation because of the greater incidence of depression in women and the fact they suffer more relapses than men do (Polaino-Lorente, 1983a). There is nothing surprising in the fact that a more prolonged exposure to previous factors impoverishes or ruins a woman's social competence and abilities, and that with an alteration in her personal relationships she takes refuge in the family environment, a process that in such conditions can in absolute terms help to achieve an overcoming of her depressive disturbance.

It is also not strange that there is a greater incidence of infantile depression amongst the *children of depressed mothers* than amongst the children of depressed fathers (Polaino-Lorente, 1987a), leaving aside the fact that this greater incidence may be caused by other factors that are not tested in this and other research, such as, for example, the interaction and the affection between children and their mother and between children and their father.



From the point of view of *social vulnerability, the early loss of one or two parents* may be seen as a powerful factor in engendering a risk of depression (Polaino-Lorente, 1987a and 1987b). In a group of 458 women who were diagnosed as being afflicted by chronic or acute depression, 22% had lost their mothers and 17% had lost their fathers before the age of eleven. In the control group of women who were not depressed these levels were only 6% and 12%.

According to the data that we have available this isolated factor does not seem to have sufficient weight to give rise to depression – another factor has to be added to it. When it is associated with another generating factor in women who had lost their mothers before the age of eleven, the risk of depression rose by 46%.

Together with the death of one of the parents one should also consider *the separation* of one of them one or two years before the age of seventeen; *the loss of a sibling* between the ages of one and seventeen; and *the death of one of the spouses* at any age.

These *risk factors* are correlated with other *factors of vulnerability* to depression such as low levels of intimacy with the husband and the absence of female friends with whom to talk in a confidential way.

The above factors usually contribute indirectly to delineating certain unsatisfactory conjugal relationships. First of all because they foster the formation of an altered personality, and secondly because they generate feelings of insecurity and guilt (Polaino-Lorente, 1991a and 1991b) in young women who try to overcome such feelings by marrying very early in order to alleviate their need for protection, which, for that matter, is not something that augurs well for future happy relationships.

The above data, however, should not be seen as factors that specifically provoke depression. In fact, on their own they are usually insufficient to explain the pathogenesis of depression.

Their explanatory importance is greater and more plausible in those *atypical depressive disturbances* that are not connected with biological factors in patients where in some way *personality disturbances* are present, that is to say disturbances specific to depression, which usually respond the worst to pharmacological treatment.

But we should not forget that in much of the research that is now available to us certain positive characteristics in people are not assessed which could be seen as factors that *neutralise the risk of depression* and as a result play the role of factors that increase resistance to suffering from depression.

Whatever the case, Andrei and Brown (1987) believe that *the risk of suffering chronic depression is associated in women* with three possible variables: the absence of social support, low self-esteem and early emotional deprivation caused by the loss or separation of their parents. This group found in a previous work that the rehabilitation of

chronically depressed patients was frequently preceded by the presence of neutralising events.

For Hirschfeld *et al.* (1986) the only predictive variable of chronic depression found in ninety patients with greater depression was *neurosis*, with early loss of a parent, stressing life events and the absence of social support being irrelevant.

For their part, Matussek and Wiegand (1985) found in a sample of ninety five people with endogenous depression and fifty seven people with neurotic depression that what most influenced neurosis in women was *the infidelity of their parents or their divorce or their separation* (Gastò, Vallejo and Menchon, 1993; Polaino-Lorente, 1981).

As regards the higher or lower *relevance of social support* to depression, there are many questions that still have not been answered. On the one hand, it is necessary to assess the quality of social support taking into account its broad versatility in different human groups.

On the other hand, a deficit of *social skills* – which necessarily involves a greater absence of social support – is present in many people before the depressive framework appears. This deficit is usually correlated in a significant way with *low self-esteem*, which at times could be interpreted as an effect of depression during a long period in which it appears in a sub-clinical form (Polaino-Lorente, 1988 and 2003a; Polaino-Lorente and Buceta, 1982; Polaino-Lorente and Garcia Villamisar, 1982, 1984 and 1985).

In testing this hypothesis one should conclude specifically the opposite – that the absence of social support is not a cause of depression but its consequence. It could also happen that greater or lesser social support is completely independent of the appearance of the depressive framework and that instead it operates as a variable modulator of its expression in terms of symptoms – less social support meaning a greater expression of symptoms.

Finally, the analysis, the identification and the isolation of each of the psycho-social factors that were cited above in order to achieve a rigorous assessment of the role that they play in generating depression and making it chronic is not realisable in practical terms. Indeed, all these factors are cited together with a certain frequency in people suffering from depression and interact with each other with mutual effects (acting together, neutralising each other, multiplying each other, diminishing each other).

Hence it is clear that future research is required in which in a rigorous way – if this is possible – one establishes the relative and/or absolute weight of each of these factors, considered independently, as well as the interplay of the forms of synergy and antagonism that can take place between them when they are examined together or affect a specific patient.

Until this has been established one must conclude that low social support increases vulnerability to depression only in those patients that have been exposed to unavoidable and stressing events over a prolonged period of time (Catalán, 1990).

Psycho-social Factors and the Response of Depression to Pharmacies and Psychotherapy

The relevance achieved over the last decade by psycho-social factors in relation to the analysis of affective disturbances owes much to cognitive theories (cf. Polaino-Lorente, 1983b, 1987a and 1987b, 1995, and 2003a and 2003b). But in their turn cognitive-behavioural theories would probably never have come to be used in the clinical treatment of depression if a change in the paradigm of basic research has not taken place with the subsequent introduction of the concept of 'learned helplessness' (on this point see Vázquez and Polaino-Lorente, 1981, 1982; Polaino-Lorente and Vázquez 1982a and 1982b; Polaino-Lorente, 1986, 1991a, 2000, and 2003a),

Thus, for example, for Ezquiaga Tarras and García Lopez (1986) neither life events nor *stressing factors* seem to have had an influence upon, or to have prognosticated, the response to therapy in a group of seventy-seven patients diagnosed as severely depressed according to the criteria of DSM-III. The authors conclude that the chronic stressing factors studied by them and which continue to influence the patient during the course of treatment do not seem to do so in a significant way when it comes to their response to therapy.

Something analogous happens with the *life events* which they also studied, and this despite the greater emphasis on their etiological role in depression attributed to them by other authors. In this publication these authors explicitly refer to life events that are independent of the psychic pathology and which occurred prior to the onset of the symptoms of depression, as well as to others that were not controllable. In this sample none of the factors referred to above seem to have influenced the response of the patient to therapy.

Thase and Howland (1994) studied the possible relationship between psycho-social factors and depression. These authors found that the forms of depression studied were associated with the following characteristics: *the presence in patients of neurotic personality traits, a high level of dysfunctional attitudes, and the persistence of stressing life events*.

In their view one can establish a differential predictive profile of the patients to predict whether they will respond or otherwise to the use of psychopharmacies and whether their response to the action of psychotherapy will be poor – in this research reference is principally made to cognitive-behavioural therapy and to interpersonal therapy.

The most telling aspects amongst the patients that did not respond to cognitive therapy were the following: the chronic level of the illness, a high level of dysfunctional attitudes, not being married, and the presence of other illnesses which at the same time led to other diagnoses. According to the results of this research, only 25% to 50% of depressed patients responded to cognitive therapy, as long as this was employed at the beginning of their treatment.

In opposite fashion, amongst patients *that did not respond to pharmacological treatment* the characteristics that were more frequently encountered were the following:

grave alterations and neurotic aspects of the personality, a high level of dysfunctional attitudes, and inadequate social support. These data argue in favour of the presence of two very different profiles in patients that did not respond to one or other of these therapies.

Phillips and Nieremberg (1994) acknowledge that in depressed patients where there is a *borderline personality disturbance* an association of pharmacological treatment and psycho-social treatment is to be recommended because with the employment of only one of them it is very difficult to obtain a satisfactory result at the level of therapy.

In research carried out by the author of this paper and his collaborators (Polaino-Lorente, Maldonado Buitrago and Barcelo Iranzo, 1991a and 1991b, 1992 and 1993), in which three groups of eight patients each were treated with cognitive therapy, psycho-pharmacy therapy and mixed therapy, greater effectiveness was found in the case of pharmacological strategies than in cognitive therapy when each of these was used separately, and this was especially the case in terms of the length and the economic cost of these actions.

Indeed, although in the group of patients subjected to *mixed therapy* there was a significant response to therapy, nonetheless there was a higher number of patients who responded (50%) in the sub-group in which only psycho-pharmacy therapy – without any support from cognitive therapy – was employed.

In this research a comparison was made with the results obtained with pharmacological treatment used by other authors, involving the employment of the '5-HT cocktail' (phenelcine, 1-trypophane and lithium; Barker *et al.*, 1987) in patients with chronic depression who did not respond to tricyclical antidepressives.

On the other hand, some of the *psychological effects that are presumably modified by cognitive therapy* (the cognitive symptoms of depression, self-esteem and control locus) are also modified and certainly in a very effective way by psycho-pharmacological treatment.

According to our results, both *self-esteem* and the *cognitive self-assessment of the set of symptoms of depression* (using the Beck questionnaire) improve in patients treated with pharmacies. These two characteristics, however, never manage to reach the levels obtained in non-depressed people in the control group with which they are compared, at least during a period when the treatment is continued for six months. This leads the authors to suppose that at times the *cognitive variables* can have a greater explanatory value in relation to what is presented by the clinical development of patients with depression.

In an analogous way, patients treated exclusively with pharmacies had modified their *control locus* (a decrease in external competence), even in a significant way, by the end of the study.

To summarise, exclusively pharmacological treatment manages to provoke and install a certain level of internal competence in the *control locus* of these patients, which also emerges as a improvement in their style of competence and the assertiveness experienced by them.

At this point pharmacological treatment managed to bring out a *new cognitive restructuring of the patient* which, for that matter, remained stable during the continuation of the therapy with certain levels of internal competence (the Rotter scale), which in practice were not different from the results obtained in the healthy people of the control group.

Certain Psycho-social Predictors of Response to Therapy for Depression

At the present time we have available psycho-social predictors of depressive disturbances that are reliable and have been rigorously established. However, I will now list some of those that in the presently available scientific literature seem to be the most relevant, to the point of being a point of reference that at times can be of a certain utility in directing medical doctors in their work.

1. In depressed women and before the illness makes its appearance an impoverishment of their personal relationships was found, as well as a dilution in their work capacities and an increase in their affective dependence.

2. In patients that suffer from an acute depressive episode one can establish a predictor as to their recovery on the basis of the general effective working of their families. The greater the effective working of their families the more rapid their recovery (Keitner *et al.*, 1990).

3. Depressive illness in elderly patients is higher the lower the level of the social support they receive.

4. In depressed women social support correlates with the response to pharmacological treatment. The lower the level of social support the more likely is it that they will be resistant to the administration of pharmacies (Gasto, 1993).

5. The speed of the response to therapy correlates in both sexes with the social support they receive. The higher the level of social support, the more rapid the response.

6. The presence of negative psycho-social factors seems to prognosticate a worse development and evolution of depression in women than in men.

7. Having available a greater or small repertoire of assertive forms of behaviour is not to be seen as a rigorous predictor of future depressions but probably has a greater predictive importance in relation to the development of the illness, the appearance of relapses and the future retrieval of personal relationships.

8. Cognitive disturbances and depressive attributions can have a relative predictive value in relation to vulnerability to relapses and the development of a chronic character to depression.

9. When cognitive distortions appear only during the course of the illness they usually respond better to biological forms of treatment. In opposite fashion, if the cognitive style and the attributive distortions are chronic and independent of mood disturbances the use of cognitive therapy is advisable, together or otherwise with pharmacological treatment.

10. The early loss or separation of parents (before the age of eleven) should not be seen as a pre-

dictor of depression if it is not associated with other factors of vulnerability caused by stressing life events (Andrews and Brown, 1987).

11. A high rating in the level of neurotisisation measured by any scale can be considered as a predictive variable of chronic depression (Hirschfeld *et al.*, 1986).

12. The infidelity of the person's parents, their divorce or their separation can be considered as risk factors leading to a neurotisasation of depressed women that can hinder the response to treatment with antidepressives (Matussek and Wiegand, 1985).

13. Unavoidable stressing life events triple the incidence of depression, whereas low social support doubles the incidence of depression (Gastó *et al.*, 1993).

Depression in Elderly People and Cognitive Theories

Cognitive and behaviour theories are especially recommended in the case of elderly people suffering from depression, although obviously enough their effectiveness is a little less than in the case of adult and young patients. Such measures, in opposition to what in principle one might suppose, have shown themselves to be effective. And at the present time they are much more precise and effective because today our societies marginalise elderly people so intensely.

Many of these procedures can in addition be used as programmes in institutions (hospices etc.) where elderly people reside and lack the required stimuli. It is curious here that Abraham, at the age of almost ninety, expressed his surprise at the good response of a depressed elderly person to the psychotherapeutic treatment he had received.

Community psychology and social psychotherapy, today as yesterday, have found in *cultural therapy* a splendid ally in the modification and/or prevention of depressive behaviour in elderly people.

While I write these lines it is calculated that in the capital of Madrid alone there live more than three hundred thousand people above the age of sixty-five, who, of course, do not receive necessary forms of care and are even deprived of affection and of the cultural stimuli to which as persons they have a right.

This fact seems to confirm the social diagnosis made by Lasch (1979) who typified our contemporary culture as a *culture of narcissism* – a culture in which every person relies on himself alone and is horrified by old age and radically marginalises the elderly.

The use of cognitive therapy (henceforth CT) has its origins in the year 1960 when the psychoanalyst Beck discovered the ineffectiveness of psychoanalytical therapies, and especially those which revolved around sexual conflicts. Beck (1976) then stated that depressed and elderly patients suffered depression more because of their thoughts and ideas than their sexual conflicts.

In concrete terms some of these thought and ideas mean that the subject assesses himself negatively and wrongly perceives reality in a negative way, having a negative view of what will happen in the future. This author then introduces certain strategies that in an active and structural way could be useful in the *modification of the negative ideas and thoughts of depressed patients*.

This therapeutic approximation gives great importance to the mental portrayals made by patients, mental portrays which, as relevant internal stimuli and automatic thoughts, mould and shape the depressive style of behaviour. These automatic thoughts are usually vague and not always well formulated, they do not arise from a reflective consideration of reality, and they are very difficult for the patient to stop, who, indeed, strongly believes in them despite their unreality and their lack of connection with logic (Polaino-Lorente, 2000b and 2000c).

Cognitive theories postulate that these thoughts, as *cognitive styles*, are an important etiological factor in the production of dysphoric feelings, disordered forms of behaviour, and psychiatric symptoms.

As a result, in patients with depression there is an *excess of negative cognitions* that tend to persist and whose intensity evolves in parallel with the intensity of the set of symptoms of depression. Hence the depressed person perceives himself in a negative way, also perceives the world negatively and has a negative view of the future.

These cognitions are organised in the form of *cognitive schemata* that bring with them *assumptions, premises, inferences, attributions and ways of thinking about reality that are typically depressive, and which at the same time also generate perceptions, expectations and forms of behaviour of a depressive character in the patient.*

What one is dealing with in this strategy is, in the final analysis, *the construction of a new cognitive style*, a new way of thinking, which is able to act in an opposite way to the typical cognitive profile of depression. This takes place by a cognitive route to modify (or restructure) the depressive way of thinking and through this to bear upon depressive feelings.

Over the last quarter of a century cognitive therapies have demonstrated their effectiveness in the treatment of depression. These results are congruent with much of the clinical information available to us, such as the fact that there are forms of depression provoked by psychological factors that act as trigger mechanisms, precipitators, generators or perpetuators of depressive symptoms (Akistal *et al.*, 1978; Blaney, 1977). The fact is that other depressive frameworks are strongly connected with the flow of stimuli that come from a person's environment and their negative or positive impact on him,

as a result of which it is supposed that their change can lead to a modification of the depression (Paykel *et al.* 1975; Polaino-Lorente, 1984a; Shipley, 1973 etc.). And when a depressed person perceives that he can exercise a certain control over his environment, his depressive symptoms improve (Lewinsohn, 1984).

I myself have addressed this subject on many occasions (Polaino-Lorente, 1984a, 1984b, 1985, 1987, 1997, 2000 and 2003c), and I thus direct the reader to these publications for further information on this matter.

I will now summarise the *specific characteristics of cognitive therapy* (CT):

1. Cognitive therapy is a structured form of therapy that is rigorously planned for the treatment of factors of a specifically cognitive character involved in forms of depressive behaviour, whether these are of a moderate or severe type.

2. CT involves a set of integrated strategies by which the patient and the therapist work together in an active way.

3. CT has the following objectives: 1) to identify and modify the cognitive alterations of the patient; 2) to bring out in an explicit way the cognitive pattern underlying the depressive behaviour; 3) to increase the repertoire of adaptation of the patient to solve his problems; 4) to examine, together with the patient, the evidence to support and not to support his distorted automatic thinking.

4. CT employs strategies and situations that are projected *ad hoc* in the identification of the cognitive disorders of the patient. To this end behavioural tasks are assigned to the person suffering from depression so that he can experience and record the situations and problems that he considers to be especially insuperable. Through empirical proof and oral analysis the beliefs and the modes of attribution in which his depressive cognitive patterns are situated are clarified.

5. CT trains the patient through the employment of these strategies *so that the patient himself can obtain the relevant information* and so that by helping himself through its use he can increase the interpretation/attribution of the stimulating situations that hitherto have been functionally depressed.

6. CT helps the patient *to learn and accept his altered construction of reality*. This is the first step that must be taken in the treatment of his depressive symptoms. While the therapist trains the patient in this activity he can introduce strategies for action that he considers relevant in line with the needs of the patient and his circumstances.

7. The therapist must, in agreement with his patient, select the sphere around which his work must be centred. In cognitive therapy applied to depression certain mo-

ments and cognitive manifestations are of primary importance. I will summarise below – by way of providing an orientation – some of the preferential aspects on which the therapist should concentrate and as far as possible act with the strategies for action that he considers most relevant.

a. Premises and/or assumptions that are deduced in a persistent and repetitive way.

b. The most frequent themes and stereotyped conclusions engaged in and reached by the patient, whatever the situations of stimulus that surround him.

c. Feelings of disapproval, negative self-esteem and/or dependency provoked both by his cognitions and by his family ecological environment. Unreal premises that support these negative assumptions.

d. Illumination of the way in which the patient examines, attributes and processes the stimulatory information of his environment to deduce these erroneous conclusions.

e. a re-examination with the help of the patient of the cognitive process that generates these erroneous conclusions so that the patient can learn other cognitive strategies to counter such conclusions.

f. The reformulation and reattribution of the patient's perceptions and cognitions in order to establish more real and suitable behaviour.

g. The observation and registration of the extreme contingencies that bring out this negative cognitive set which they reactivate or support. The proposed modification of these contingencies.

h. The training of the patient in the assessment and reformulation of the strategies and hypotheses suggested by his therapist so that he can test or reject their validity and effectiveness in relation to the modification of his behaviour.

i. These strategies must be structured in a clear way by following the objectives and the sequence of the steps or stages to be followed. Flexibility in planning is very advisable and must be done in relation to the development experienced by the sick person.

j. The therapist must not base his strategies on authoritarianism or suggestion. Every area of the programme must be based on facts that can be verified by the patient and by the therapist. Through the analysis of these data the patient can assess the results that are achieved and thereby modify his system of attribution.

k. The therapist must try to limit his action without discussing or seeking to invalidate the arguments, the interpretations or the feelings of the patient. His mission is confined to observing, quantifying, recording and assessing the depressive behaviour of his patient. Later on it is upon this assessment that the explanatory hypotheses are based, and on the basis of such hypotheses that the strategies to be used are planned.

In Beck's view (1976) the employment of cognitive therapy in the treatment of depression *is recommended* in the following situa-

tions: the failure of the response to therapy on the part of the patient after the appropriate use of two anti-depressive pharmacies; a partial or unsatisfactory response to adequate doses of anti-depressives after a partial or total lack of success following the isolated use of other traditional forms of psychotherapy; the existence of a diagnosis of minor affective disorder or reactive depression; the presence of depressive feelings in reaction to environmental events; the presence of a correlation between these feelings and negative cognitions; the absence of hallucinations and forms of delirium with a capacity to concentrate and the memory still intact; an inability to tolerate the medication employed both because of its undesirable side effects or because it is believed that there is an excessive risk for the patient.

To the indications made by Beck I would add others: the age of the patient, given that young people respond better than elderly people and adults to these strategies; the patient's cultural level (the higher this level the more easily one obtains a good response to therapy); verbal fluidity and intellectual capacity and the motivation and the expectations that the patient has in relation to these measures.

The personality of the therapist is also a factor that contributes in an important way to the outcome of the treatment, and thus this should always be assessed when this is possible.

Situations where the combined use of CT and psycho-pharmacies is advisable are as follows: major depressive episodes that decrease after the use of anti-depressives and in which there is a decrease in vegetative symptoms; recurrent forms of depression in which medication is effective; patients with depression in which family relatives have responded well to the anti-depressive treatment; patients with depression whose response to medication is partial or incomplete; patients in whom compliance with curative treatment is very poor and whose compliance improves after CT; patients with intermittent depression caused by maladjusted behaviour and functions.

A combination of both procedures was studied more than a quarter of a century ago by three different teams (New Haven-Boston, Baltimore and Philadelphia) under the direction of the Psychopharmacology Research Branch of the National Institute of Mental Health.

The results obtained by these three teams matched in indicating that psychotherapies act specifically *on non-specifically depressive areas of behaviour* (personal relationships, adaptation to the environment, addressing stress etc.) but when they are associated with them the effectiveness of therapy in depression can be reduced.

At the same time it also emerged that *pharmacies have a positive effect* on psychotherapy and make the patient more accessible to these approaches.

On the other hand, *psychotherapy can help to optimise the compliance of a patient with pharmacological treatment*. Although it appears that both methods act selectively on these very different behavioural areas and sets of symptoms (independent effects), each of them interact with each other and reinforces their effectiveness (interaction effects).This brings out how depression is not exclusively a matter for the medical doctor, although its treatment depends largely on him it does not depend exclusively on him.

However, not everything can be remedied through the use of psychopharmacies. Other areas of the personality of the patient should also be addressed, such as some of his abilities and skills which, without being directly involved or influenced by the depression, can help to alleviate it or to improve it.

Another question that has to be addressed in greater depth in the future is that of the consequences produced by depression in the social and personal relationships of the patient. I am referring here, obviously enough, to the dual tie that exists between psycho-social factors and depression. Hitherto greater emphasis has been placed on the etiological role played by psycho-social factors in the field of depression. *The role played by depression in the deterioration of the psycho-social dimension of the chronically depressed person has either been ignored or underestimated*, and the same may be said about the fact that if such consequences improve then the depression is lightened.

Thus, for example, we do not know what the consequences are of depression in the life of a patient for his personal relationships, his family life, his conjugal existence, his professional and vocational adaptation, the dynamics of his personality, the upbringing of his children and so forth. These is even more serious because depression can also generate effects because of its chronic level in the family relatives and in the people closest to the patient through their relationships with him (Polaino-Lorente, 1984; for a survey see Gastó, Vellejo and Menchon, 1993, pp. 71-5).

But the family can also do much, indeed a great deal, for the patient with depression, but this will be discussed in the last section of this paper.

What Can the Depressed Patient do to Alleviate his Illness?

It is not always easy to answer this question and certain distinctions must be made. It should be said that the most rigorous answer to this question has two faces: the patient can and cannot improve or alleviate his illness.

The patient with depression in general can do very little in a narrow sense to alleviate his illness with a certain efficacy. In this sense one should say that the patient must seek the help of an expert and be sent as soon as possible to a specialist.

But in another sense the patient can do a great deal to alleviate his illness. We have available a long historical tradition of patients who have written their 'pathographies' and the remedies that they used to bear the illness of depression in a more effective way. Such is the case for example with Richard Burton (1577-1640) who in his work *The Anatomy of Melancholie* (1621) declares that he used to modify 'his pessimistic judgements and even to express a joy in living' when he was in conversation with people whose company was pleasant.

Many other suggestions can be found in the work *De Arte Medica*

by Alejandro de Tralles (525-605), in works by Andrés Piquer (1711-1772), and in the *Tratado de la Mania* by Philippe Pinel (1745-1826). Some of these suggestions are now obsolete, but some of them are not (cf. Chinchila, 1846).

Today as yesterday it would be very advantageous to dedicate more attention to these questions, given that it is helpful to train and help the patient with depression so that he can help himself.

Whatever the case, it is *helpful to remind the patient* that he should comply with the indications and the rules that are given to him by the specialist, whom he should consult as regards everything connected with his illness. It is not at all advisable for him to treat himself with pharmacies; the more time he spends in bed the more difficult it will be for him to escape his depression; physical exercise or some kind of sport are very useful in addressing the illness he suffers from; he should not stay at home watching television but must go out and walk down streets and begin to take up again those small things that before his illness made him feel happy; not talking to other people is not a good travel companion for this illness: he must retrieve – although this has its price – the relationships and social relationships of his friendships; he must try to have a full day, even if this amounts to various kinds of small activities; etc.

At the present time *spiritual resources* are almost completely neglected but they can be effective instruments in improving the patient's quality of life and the illness from which he suffers. In reality, a great deal of research has still to be carried out in this area because as clinical experience teaches us Catholics – specifically because of their system of beliefs (hope, suffering has a meaning, the existence of a life beyond this one, the communion of saints, etc.) – find it easier to create an important barrier of resistance to suicidal ideas, worry about their illness, etc. Their beliefs increase their tolerance to frustration and reinforce their spirit of strength in bearing the sufferings that afflict them.

This and other advice, although necessary, is not sufficient. The family must warned and directed towards what should be done or otherwise with its sick member.

Depression and Pastoral Care

But before concluding this paper by referring to the role that the family must play in depression I would like to make a few brief reflections about pastoral care for a depressed person.

Depression afflicts equally believers and non-believers and thus one cannot attribute depression – as was thought a few decades ago – to problems connected with a lack of consistency between one's faith and one's behaviour, even though, without doubt, this can be one of the many factors that at times influence its appearance in the bio-psycho-social context in which the illness occurs.

It can happen that in a very broad framework of multifactorial and pluricausal aetiology that people should be warned that the fight against this illness is something that concerns everyone and especially those who are most directly involved in the field of pastoral care.

As a result there must be an end to the pseudo-spiritualist and erroneously psychotherapeutic label that caused so much suffering to these patients in the past, and a recognition once and for all that a person has the right to be ill with depression, that it is something connected with the human condition itself, and that the person must be understood in his suffering.

Spirituality and care for souls, together with psychopharmacology and psychotherapy, are today some of the principal ingredients in the treatment of the depressive illness. These principal factors are also relevant to prevention, an area in which educators must be involved. It is not the case that because there are more priests there should be less psychiatrists, not least because some priests suffer from depression. As a result, with more depressed priests there should be more psychiatrists to look after them. One is not dealing here with the false alternative 'priests or psychiatrists' but of their union – 'pastors and psychiatrists'.

During my long professional experience as a psychiatrist which has lasted almost four decades I have been able to observe that pastoral action – and more specifically the sacrament of penitence – can help to improve this suffering, especially in people who after many years of silence have not dealt with their feelings of guilt caused, for example, by having had an abortion.

Biographical and vocational crises are an area in which the presence of depression is especially frequent. In this case the work of the psychiatrist and the psychotherapist must be adapted to, and converge with, that of the priest or the person who welcomes and accompanies the spiritual journey of the patient. In these circumstances an excellent welcoming of the sick person – which should not be judgmental but understanding – and one that leads him to ask for forgiveness and to forgive himself and to reaffirm himself in his personal values is usually highly effective at the level of therapy and in achieving his restoration to health.

Praise for the Family in the Context of Depressive Illness

Depression is one of the most important burdens – according to the epidemiological data we have available it is the most frequent psychiatric illness today – that the family has to bear, whichever family member is suffering from it. At the present time, the psychopathological effect that depression generates in the children of depressed fathers are unknown, as are the damaging effects of it on the marriage partner when the other partner is afflicted by it.

The emergence of the illness of depression in the family context without doubt involves damaging effects for the members of the family but the impact of this illness is not confined to these effects alone.

Beyond these, *the family can also do a great deal to improve the depressive illness of one of its members*. One should not forget that the family is the place where the person is treated as a person. This should be borne out by all the family members who through their care and their stimulating approach do

their utmost to ensure that their sick family relative is treated as a person.

For this reason, *depression is also an excellent scenario in which the family members can realise themselves as persons*. By 'realisation' is meant here a process by which a person can give importance to that most difficult and complex goal – a successful life, a fulfilled biography. In the particular case of the family one of whose members suffers from depression, the values that each of the family members implements through care for the patient matches the values to which the sick person is exposed, and in which, indeed, he can grow.

The self-realisation of the healthy family members and the sick person can and must coincide. If the family members exercise patience and tact in stimulating the patient, in addition to helping him in his illness, this will probably help them to grow and develop; if the family members ask more of themselves in order to speak in a particular way about their successes, then the same will happen to the patient. In this way, the self-realisation of the family members who look after the sick person becomes a justifying, evaluative and legitimising criterion for the self-realisation of the patient.

After a certain fashion a self-realisation is not possible – whatever the context in which this is studied – that does not sooner or later involve the self-realisation of these same values in a specific context, situation or environment. This means that *self-realisation* – even though it does not stop being a personal process – ends up by being *something that is transpersonal*, something that transcends the person who is realised.

The presence of illness in the family context invites us to escape from anonymity and to mark ourselves out in a participatory and solidarity-inspired way so that the personal realisation of the family members is constructed through the personal self-realisation of the patient to whom these family members dedicate themselves.

For this reason, freedom is a *conditio sine qua non* for those who receive or give themselves to another person in the family context. The other person in the family is much more than an object perceived by objective knowledge. The other person is a person who must develop and fully achieve his freedom to fulfil himself. I collaborate with his freedom and I help him to be that which he has freely chosen. Because of this solidarity-inspired help, this participation in the process of self-realisation of the sick person, the family members are a part of *participated and participating self-completion* when they become aware of the value of their freedom. As Jaspers writes: 'we become aware of our freedom when we see that others place their hope in us'.

As a result, the family member who looks after a patient with depression will feel himself called upon to improve himself personally because through his personal completion he can contribute to the happiness of others. And who can deny himself a small effort to make happier specifically that person who is suffering?

The ideal to which we call the family *paideia* is certainly very demanding and ambitious. But we do not assume that such was not previously the case because, as Garcia Morente points out(1975) as regards the educator, 'the profession that I would have chosen is very demanding and exclusive if it makes a man complete. Not only does it call on the public part of one's personality but also the private and inner parts… For a teacher to give his whole life to his profession he will reserve nothing to himself, he will give everything and after a certain fashion he will sacrifice himself entirely to the altar of his duties'. These words can be applied and are specifically required in relation to those pastors who devote themselves to care for these sick people.

This last statement can be subscribed to in the most radical form as regards any family member who, in agreement with what has been said above, gives himself entirely to this gigantic, emblematic and necessary task of taking care of those who, being nearer to us and being one of us, no longer need our attention.

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PAUL POUPARD

9. The Depressive Ideas of the Contemporary World

1. *For me it is a great joy to share with you certain opinions* of the Pontifical Council for Culture on 'the depressive ideas of the contemporary world'. My point of view will certainly not be that of the medical doctor, of the psychoanalyst, or of the sociologist, but that of the Christian humanist who perceives in the dominant culture numerous points of fracture in which man finds himself in a limit-situation and becomes particularly vulnerable, to the point of falling into the various symptoms of depression, in which, from Prometheus to Sisyphus, postmodernity seems to sink into Narcissus.

I cordially greet Your Eminence, and your collaborators of the Pontifical Council for Health Pastoral Care. The subject of 'depression' deserves the greatest attention from the Church, and it is my hope and wish that the proceedings of this eighteenth international conference will be able to make a contribution to this.

2. *Medical doctors define depression* as 'a pathological mood disorder' that is expressed, among other things, in a spreading sadness, dark thoughts, a folding in on oneself, and obsession with death. Depression is experienced as failure, an experience of emptiness that devastates an entire life and makes it slide into an abyss. The depressed person thinks that he can go on no longer, that he is an abyss, at the mercy of a tide that dismantles, crushes and drowns him. Then fear arrives, which can become terror. In his eyes is to be found the shaken light of one who believes that he has seen the void. *Ennui* takes hold of that person. His will abandons him. Indifference paralyses him. Nothing has meaning: a tenacious nausea invades him, to the point of hopelessness and a desire to die.

This inner drama, which afflicts far too many people (men and women, young people and adults, rich and poor, artists and the great of this world, as well as sportsmen and humble artisans), undoubtedly finds in contemporary culture aggravating factors that are translated into the figures and statistics that we know and which so dismay us. Everything takes place as though the dominant culture provokes in our contemporaries – and here I employ an image borrowed from geology – a crack in the deepest part of their being, then a fissure, and finally a crevice between the plates of identity, which instead should come together for the development of the multiple potentialities that are available to us. Prised apart, these 'plates' allow depression to slide in, the bearer of regression in relation to oneself and aggression towards others, with disdain for an ideal of life and its value that structures personality.

Ten years ago our friend Tony Anatrella, in an edifying essay, said no to the depressive society: 'threatened by implosion, in which the individual, in the absence of any project or dimension outside him, is led back to his subjectivity alone…A '*tête à tête*' destroyer in an interiority in crisis and a life of drives that is installed at its first stages; a regression whose effect is also to dissolve social ties in contempt of the roots of our civilisation'.[1]

3. *The human person*, in fact, is rich in a great variety of dimensions, and it is from their flowering that culture is born – the source of civilisation in its various elements. 'The word 'culture' in its general sense', emphasised Vatican Council II in its pastoral Constitution on the Church in the contemporary world, 'indicates everything whereby man develops and perfects his many bodily and spiritual qualities; he strives by his knowledge and his labour, to bring the world itself under his control. He renders social life more human both in the family and the civic community, through improvement of customs and institutions. Throughout the course of time he expresses, communicates and conserves in his works, great spiritual experiences and desires, that they might be of advantage to the progress of many, even of the whole human family' (*Gaudium et spes*, 53).

The only culture is that by man, through man and for man. The document of the Pontifical Council for Culture, 'A Pastoral Approach to Culture', observes that 'culture is so natural to man that human nature can only be revealed through culture.'[2] We need, therefore, to discern what in the dominant culture perverts man and damages his development, 'his intelligence and his emotions, his quest for meaning, his customs and ethics, and his openness to transcendence.' The counter-values that break apart the harmony of a culture, the domain in which men and peoples cultivate their relationship with nature and their fellows, with themselves and with God, are the product of depressive ideas that bear within them in embryonic form the destruction of the humanity of man and disfigure it – to the point of making it incapable of recognising itself in what it experiences.

4. *Human life is fulfilled in the different modalities of human ac-*

tivity. For man, to exist does not mean to exist '*simpliciter*': he is everywhere and at the same time *homo faber* and *homo amicus*, *homo politicus* and *homo sapiens*, and – of this we are convinced – *homo religiosus*. In the view of philosophers, unity is acquired both according to form and according to purpose. We may observe that a human person is perfectly 'unified' to the extent to which he is fully bound to his purpose, and not only through the subject himself that acts. The personal unity of a being – that by which he recognises himself – in conformity with what he tries to construct and what makes of him a unique original being different from other beings, is built through his own capacity to achieve the goal to which he has committed himself in a life project. It is, therefore, the requirements of work, of friendship, of social life and of intelligence, together with aspiration to transcendence, that will allow man, inserted into a culture – on the condition, certainly, of being reunited – to unify his own life in a harmonious development of the potentialities that animate him. If the unity of the person is that of the spirit, it is clear that this spirit in man is incarnated and is fulfilled solely in an existential and not abstract dimension.

In contrary fashion, the root of the loss of personal unity is to be located in the *dominant ideas* of contemporary culture which tend to despise work, to pervert the ties between men, both in friendship and social life, to close down the development of intelligence in an 'impasse', and to deviate man from his pathway to God. I would like to call these ideas 'depressive' because they are the cause of an *explosion* in our cultures which runs the risk of placing the men and women of our time in what the philosopher Jaspers calls 'limit-situations', which are deeply destabilising and factors that lead to the explosion of the personality. They are like walls that rise up in front of us under the influence of these *depressive ideas*. In order to knock them down we need strength, perseverance and lucidity, with the help of the grace of God. But it is also the duty of the Church to propose an alternative to these ideas in an authentic pastoral approach to culture inspired by Christian humanism, which is in its turn nourished by the Gospel.

5. *Man is* 'at a primary level' *homo faber*. The dimension of work, the production of fine and good works – *kala kagata*, as the ancient Greeks said – and of everything that is useful to the daily life of individuals and peoples, is fundamental to the life of man and is a constituent feature of his nature. As we well know, it is through work that man enters into contact with the universe, that he 'dialogues' with matter so as to recognise it and transform it, respecting its intrinsic order. Although the works produced through labour do not orientate man in a narrow sense, we can see that all the limit situations experienced in the order of *doing* have greater repercussions at a psychological level. It is the fact that work is the most conscious activity of man that makes it an extremely strong conditioning, if not indeed the dominating, force of our daily lives. As Pope Paul VI emphasised in his encyclical *Populorum progressio*: 'God gave man intelligence, sensitivity and the power of thought - tools with which to finish and perfect the work He began. Every worker is, to some extent, a creator - be he artist, craftsman, executive, labourer or farmer… Further, when work is done in common - when hope, hardship, ambition and joy are shared – it brings together and firmly unites the wills, minds and hearts of men. In its accomplishment, men find themselves to be brothers.'[3] Failures in this field will have as a consequence important repercussions on a person's psychological equilibrium. We need, therefore, to unmask the depressive ideas of dominant culture in this field, those ideas that lead to impasse and pervert the human dimension of the artistic and work activity of man.

In the field of the arts strictly speaking it is evident that the idea of art without ideal value, the promotion of works that have meaning solely for a public whose morbid imagination they feed on by proposing to it the exposition of the darkest areas of the psychology of disorientated men and women, offer favourable terrain for depression. In his 'Letter to Artists' of Easter 1999, which I had the joy to present to the international press, the Holy Father John Paul II, quoting his compatriot Cyprian Norwid, stated: 'beauty is to enthuse us for work, and work is to raise us up'. There can be no doubt that a symphony by Beethoven, 'la Pietà' by Michelangelo and 'le Madonne' by Boticelli introduce us, through beauty, into a world of meaning. In contrary fashion, contemporary works, which express a corrupt ugliness, make us think, in their provocation, that there is no meaning in anything and that the abyss is the beginning and the end

of all things. These deviances of contemporary art in part find their origins in Nietzsche's idea of the *superman*, the depressive idea *par excellence*, because this idea introduces us to a feeling of absolute creative identity that is totally illusory. There is, in fact, nothing more destabilising than an insurmountable illusion, a source of closure, and the temptation of the *superman* opens up an abyss that sooner or later provokes the vertigo of the person who has the ingenuousness to believe that he is a god in the exalted state of discovering that he is a creator.

6. *The activity of doing or making* also has the purpose of improving man's life conditions. The development of industry, which is the consequence of advances in technology, the globalisation of trade and international finance, the standardisation of products generated by the singular capacity of the mass media to spread single models throughout the world that often have no other value than that of being profitable, are also consequences of a *depressive* idea of society. This industrialised world promoted by the economic ambitions of certain 'powers' to the detriment of the most noble ideas of development – 'the new name of peace', to employ a phrase of Paul VI in his encyclical *Populorum progressio* quoted below – and distributive justice (which requires the distribution of wealth), is the consequence of *depressive ideas* that are widely spread in modern society. Pope John Paul II says the same thing when he condemns 'structures of sin': that is to say the development – willed by some people – of gigantic structures that generate gigantic 'profits' to the total detriment of human dignity, and which have no other result than the destruction of the human person, opening up authentic springs of depression. This is the whole subject of the encyclical *Laborem exercens*, which has already been referred to in this paper, in which the Pope addresses 'work, the key to the social question' and offers a strong analysis of the *depressive ideas of the contemporary world* in the sphere of human work, which has been perverted in its profound essence by the 'various trends of *materialistic and economistic* thought' (n. 7).

In recent years a new challenge has arisen. When the artisan produces his work he works with material from which he learns a certain realism: he discovers the future that is inherent in 'things', the order of nature of which he is neither the author nor the master, and this contact makes him noble by committing him, at the same time, to the road of humility. Today we observe with deep sadness that a by no means derisory number of scientists want to intervene in life, and in opposition to the fundamental order written into nature, at all levels of its various manifestations. The declared aim is to 'produce' human beings through the technique of cloning. Do we not encounter here an absolute superego that expresses itself through the scientist in the form of *metatemptation*, and which in the long term can only sink humanity itself into a terrible depression: life would become no longer the fruit of shared love and responsible freedom? What would the freedom to conceive – which is often the sole real wealth of the poorest – become in the face of the 'work' of scientists who seek to 'manufacture' a superior race? Would it then be necessary to legislate, limit and as a result attack such freedom? More than towards an impasse, it is towards the edge of a frightening precipice that deviated science runs the risk of dragging mankind.

7. *Man is homo amicus*. Able to enter a relationship with his fellow man, he discovers in another a person who is able to share with him 'the joys and the hopes, the sadness and the worries' of daily life. Friendship is realised is a mutual personal giving based upon respect, trust, and loyalty. Friendship allows the exchange of 'secrets' whose sharing expresses communion between two beings and seals the harmony of their wills. The death of friendship (and the betrayal of a secret is such a betrayal), the inability to make friends (which leads to a closure into loneliness), the deviancies of looks that do not see the other person any longer as an object of desire, all the illnesses of non-love that develop in the dominant culture, can only involve dramatic consequences for the equilibrium of individuals whose *depression* they foster by depriving them of that friendship that orientates them in relation to their special meaning. Here, as well, we can refer to the encyclicals of the Holy Father. I am thinking in particular of *Veritatis splendor*, but also of *Evangelium vitae* and *Fides et ratio*, which offer deep analyses of depressive ideas in the various realms of morality, the vision of human beings and life, the orientation of intelligence towards the true and of the will towards good.

Culture, that context in which we develop as human persons, inevitably influences our way of perceiving other people. The sophistication of an education that has developed down the centuries in the whole of a society irrigated by Greco-Latin humanity and inspired by the Gospel has produced notable fruits in the regulation of ways of thinking in society. Education in virtue, the presentation of models of courage and loyalty – I am thinking here of the Greek ideal proposed by Homer to young generations through the mythical figures of Ulysses and Antigone – and awareness of the good to be pursued and the evil to be rejected in a decisive fashion, allow men and women to live in the right harmony and to have lasting ties of love and friendship.

In contrary fashion, the philosophy of Sartre of 'hell is other people', the Freudian psychoanalytical vision that reduces man to his drives, the orchestration of advertising campaigns that exalt the female body with an artificially altered deceptive aestheticism, the strong invitation to sexuality – which is often not confessed – even at an early age when the personality of a young person is not yet formed, are all examples of the *depressive ideas of the contemporary world*. The damage caused by the popular '*feuilletons*' that are sluiced through the television channels at low cost, to the point of reaching the most remote parts of the world, are certainly the product of *depressive ideas* whose aim is to make money to the total detriment of values that allow man to develop as the *image and likeness* of his Creator and Father. The audio and visual barrage that is so obstinately pursued is translated into an exacerbated exaltation of the senses. The declared aim is to excite forms of concupiscence by pushing the limits that society tolerates to the extremes, but which at the same time it ceases to push further and further back, while the intolerable of yesterday becomes the banal of today. The effects are dramatic, you know them, and I do not want to tarry in dwelling upon them.

However, I would like to bring out the destructive effects of this invasive culture of the mass media on the family, the fundamental unit of society. We can observe that the *culture of the contemporary world* is the bearer of ideas about the family that lead to its fracture, that is to say to its destruction, which is not without its effects on society itself. The dual purpose of marriage, the mutual love of the spouses and the procreation that comes from this love, is gravely called into question by the development of the ideology of 'everything is allowed' and by a search 'at any cost' of *personal development*. According to widespread *ideas*, women find their own development only in autonomy (which in reality is illusory) that will give her a job outside her home, and not in the beauty of a motherhood that has flowered in her family and in the deeply committed upbringing of the 'flesh of her flesh'. We can observe that the *idea* that only a condom can effectively defend a person against AIDS is not only a shameful shortcut that deceives people about the very nature of human sexuality but also impedes the posing of the fundamental question about the full development of man: what kind of relationship does it create amongst people? A deep reflection on this subject would certainly encounter one of the most destabilising *depressive ideas* of dominant culture. As regards *the depressive ideas of the contemporary world* that endanger marriage and the family, I take the liberty of referring you to another important document of the Holy Father, the apostolic exhortation *Familiaris consortio*, the fruit of the Synod of Bishops of 1980.

8. *Homo politicus is also the subject of the depressive ideas* that are widespread in modern culture. This is not the place to address the broad subject of man and politics, but everybody knows the situations of injustice and lack of rights that generate the Machiavellian *ideas* that govern the political systems of numerous nations. Some of the *depressive ideas* in the contemporary world have their origins in the way in which people are treated in modern society. It is significant that Pope John Paul II has felt the need to write various 'Letters' addressed to groups of people that experience – because of very widespread *depressive ideas* – situations of injustice and lack of respect for their dignity. Thus his 'Letter to Families' of 2 February 1994, 'Letter to Children' of 13 December 1994, 'Letter to women' of 29 June 1995, 'Letter to Artists' of 4 April 1999, and 'Letter to Elderly People' of 1 October 1999. We should not forget in this list his 'Letter to Priests' of Good Friday of 2003: priests, like all consecrated people, are continually faced with challenges posed by depressive ideas and the Christian communities of our individualised societies must work to help them and engage in self-protection.

9. *Man is also homo scientificus*. The explosion of scientific knowledge, the loss of a wisdom that unites knowledge and orders it to man, the centre and culminating point of the universe, the temptations that I have brought out of the superman of Nietzsche which, through the advances of technology in the field of the life sciences, open up grave horizons of uncertainty for mankind, are further situations that generate *depressive ideas*. At the same time the drama of the separation between faith and reason generates, in its deeply injurious consequences, numerous *depressive ideas* that are especially tenacious. 'As a result of the crisis of rationalism, what has appeared finally is *nihilism*. As a philosophy of nothingness, it has a certain attraction for people of our time. Its adherents claim that the search is an end in itself, without any hope or possibility of ever attaining the goal of truth. In the nihilist interpretation, life is no more than an occasion for sensations and experiences in which the ephemeral has pride of place' (*Fides et ratio*, n. 46).

Vatican Council II reaffirmed the legitimate autonomy of the sciences in the field of research that belongs to them, and refused any right to dictate from the outside how research should be carried out. The only limit is the dignity of man. In fact, the advances in science have contributed to a spectacular advance in technology and have conferred upon man a power whose use involves the posing of grave questions. How, in fact, can we not observe that advance in many areas of our knowledge is far from always being accompanied by equal progress in moral values? Science has a limit because it comes from the dignity of man, that man who is the subject and the end of all his knowledge. Science loses its own dignity of human knowledge when its advances take place at the price of the violation of human dignity. To invert the relationship of knowing *about* man and of knowing *for* man would mean to return to the dark and inhuman experience of Auschwitz, where medical doctors carried out experiments on prisoners who were considered in the Nazi logic as inferior beings and not as persons. In the face of the temptation of recent developments in biogenetic research and experiments involving the cloning of human embryos that are seen as mere objects, we need to emphasise once again that progress which reduces man to an object can never been seen as real progress.

The culture of truth is without doubt the anti-depressive of intelligence that to be itself must rediscover its own fundamental orientation towards truth. This is what is outlined by the Holy Father in his masterful encyclical *Fides et ratio*, in which he offers a reflection on the very roots of the *depressive*

ideas that pervert and obscure reason: 'It should also be borne in mind that the role of philosophy itself', observes John Paul II, 'has changed in modern culture. From universal wisdom and learning, it has been gradually reduced to one of the many fields of human knowing; indeed in some ways it has been consigned to a wholly marginal role. Other forms of rationality have acquired an ever higher profile, making philosophical learning appear all the more peripheral. These forms of rationality are directed not towards the contemplation of truth and the search for the ultimate goal and meaning of life; but instead, as "instrumental reason", they are directed – actually or potentially – towards the promotion of utilitarian ends, towards enjoyment or power (n. 47). And referring to his first encyclical letter, *Redemptor hominis* of 4 March 1979, this philosopher-Pope brought out the consequences of such a deviance of reason in the field of work: 'The man of today seems ever to be under threat from what he produces, that is to say from the result of the work of his hands and, even more so, of the work of his intellect and the tendencies of his will. All too soon, and often in an unforeseeable way, what this manifold activity of man yields is not only subject to 'alienation', in the sense that it is simply taken away from the person who produces it, but rather it turns against man himself, at least in part, through the indirect consequences of its effects returning on himself. It is or can be directed against him. This seems to make up the main chapter of the drama of present-day human existence in its broadest and universal dimension. Man therefore lives increasingly in fear. He is afraid of what he produces – not all of it, of course, or even most of it, but part of it and precisely that part that contains a special share of his genius and initiative – can radically turn against himself' (*Fides et ratio*, n. 47).

From Michel Foucault to Claude Lévi-Strauss, post-modern anthropology has dug a depressive abyss that is without precedent. The former proposes to direct man towards an 'anthropological sleep' which, thanks to structuralist euthanasia, could become a real and authentic 'death of man'.[4] And the latter concludes his mythological trilogy not, as Wagner did, with the twilight of the gods, but with the 'twilight of men', with the word 'nothing'.[5]

10. *You know that the study of non-belief and of religious indifference* is one of the principal tasks entrusted by the Holy Father to the Pontifical Council for Culture. It is specifically on this subject that the proceedings of the next plenary session of our Dicastery, to be held in March 2004, will dwell. Today we can observe that there is no longer a precise geography of non-belief, such as the Berlin Wall of sad memory. But if the three hundred replies received to out preparatory inquiry demonstrate a militant atheism that is losing vigour and does not have great influence, they also emphasise that above all in cultures with a Christian tradition there has been developing an attitude of contempt, hostility and derision towards religion, and above all to Christianity, which the powerful modern mass media have been disseminating in a shameless way. Today we are faced with a dilution of religious feeling in a culture that is falsely ascetic. In his apostolic exhortation *Ecclesia in Europa* the Holy Father warns the European continent about the temptation of 'the dimming of hope' in an age that appears to be a 'time of bewilderment' (n. 7). Amongst the depressive ideas that present themselves today as a challenge to Christian hope, how can we not ask ourselves about that strange faculty that has appeared today in the full light of day of a total amnesia in relation to the Christian roots that have given and continue to give life to a culture of a wonderful fertility, and the dramatic aphasia of intellectuals and political leaders who seek to act on behalf of humanism, but who instead gravely mutilate man in completely forgetting about his origins and his ends? An addition of scepticism cannot organise an existence. The culture that rejects the absolute has come to absolutise the relative, and a society of unbelievers cannot but believe. Thus it was that the last century tragically idolised race, class, ethnic group and science, and with lethal consequences. The dominant culture exacerbates the drive of desires, the search for pleasures, the pursuit of having, of knowing and of power. But deprived of his anchorage in God, man, who was created in His image and likeness, does not know how to rediscover his own face in what is a shattered looking glass. Each piece reflects only a part of that image. The fragments are taken for a whole, whose coherence has, in fact, dissolved into fragments. Whether one is dealing with the economy, politics, the family, social life or the mass media, the incomplete image that each of the pieces reflects is reduced, it is though it were wounded, and this involves a growing absence of trust on the part of human beings in relation to their own humanity. The person becomes fragile, the social tissue unravels, and the nation breaks up. We see peoples waste away while they flow over with prosperity but no longer have an essence. The excessive bestowing of value on sexual pleasure deprives them of the irreplaceable joy of fatherhood and motherhood. This mortal disassociation to which Pope Paul VI in vain tried to draw people's attention (which was distracted by the dominant culture) over thirty-five years ago in his encyclical *Humanae vitae*, is without doubt the most dramatic depressive peril of the hegemonic culture of rich countries: 'love' without children and children without love. Today, many children feel that they are dying because of the fact that they are orphans. They desperately need to be loved. And they are immersed in an ocean of images whose destructive abundance dismantles them, in that other mortally depressive disassociation between the hypertrophy of the means we have available and the atrophy of the ends we pursue.

11. *Homo religious*. Dear friends, the *depressive ideas* of the culture of the contemporary world are infinite in number, and they take many forms that endanger the humanity of man. In the face of the existential void to which these

ideas lead, and to address all the influences that exist without falling victim to them, Viktor Frankl, a neurologist in Vienna and a professor at Harvard, Stanford, Pittsburgh and Dallas, who died in 1997 at the age of ninety-two, upheld, in his too often forgotten book *Le dieu inconscient*, 'the power of dissent of the spirit'. He began with the principle that 'the fundamental need of man is not sexual reward or self-appreciation but fullness of meaning'.[6] In this lapidary statement, which turns upside down the *depressive philosophy of the Freudian school*, he opened up the question of 'the will to meaning'. The neuroses that torment the research of certain psychologists and psychiatrists and thus easily open up a path to depression are primarily the expression of a being that is frustrated and thus inclined to the vertigo of the existential void. Modern man, prey to the depressive ideas of the contemporary world, is touched to his depths in relation to his reasons for living. And it is here, the heart of his desires, and to the point of his malaises and existential frustrations, that we must reach. To this end we are offered the pathway of the Gospel, the creator of culture because the bearer of the Truth of man, and of the Truth about man, revealed by that God who took on the face of man in Jesus Christ, Son of the Virgin Mary, to share with us the love of the Father.

The antidote to the depressive ideas of our time is faith in he who told us: 'I am the way, the truth, and the life'. The Gospel makes us share in the secret of the joy given to us by Christ that allows us to live out the days of the week with a heart dressed in festive clothes.

Joy is that gift of God of which the Church is the bearer for our depressive cultures. 'I love those priests', Julien Green confided to his diary, 'who come from the New Testament with the Good News in their eyes'. 'Joy', writes Paul Claudel, 'is the first and last word of the Gospel'.[7]

His Eminence Cardinal
PAUL POUPARD,
Prefect of the Pontifical Council for Culture, the Holy See.

Notes

[1] Flammarion, 1993.

[2] Pontifical Council for Culture, *Towards a Pastoral Approach to Culture* (Pentecost, 1999), n. 2.

[3] PAUL VI, *Populorum progressio* (Easter 1967), n. 27; cf. John Paul II, *Laborem Exercens* (14 September 1981), nn. 4-10.

[4] MICHEL FOUCAULT, *Les mots et les choses* (Gallimard, 1966).

[5] CLAUDE LÉVI-STRAUSS, *L'homme nu* (Plon, 1971).

[6] VIKTOR FRANKL, *Le dieu inconscient* (Coll. Religion et sciences de l'homme, Edition du Centurion, 1975), pp. 92-93.

[7] Cf. PAUL POUPARD, *Le christianisme à l'aube du III*ème *millénaire*, III, *L'avenir est à l'espérance* (Plon-Mame, 1999), p. 248.

FIORENZA DERIU, DANIEL CABEZAS, ROSA MEROLA

10. The Results of a Mental Health Survey: a Focus on Depression

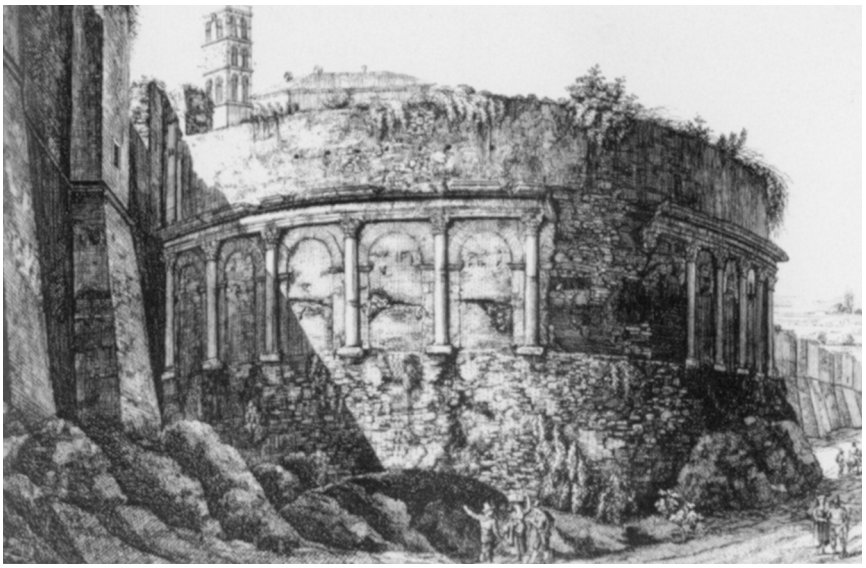
The papers that have preceded my paper during this interesting first day of this conference have clearly brought out how in mental health in a really special way two inseparable elements are conjoined – existential malaise and biological malaise. Within the concept of existential malaise it is possible to identify three further spaces of meaning connected respectively with the psychological, spiritual and social dimensions of the human person. From the literature that we have available on the subject, and not least the information supplied by the World Health Organisation, it emerges that the manifestation of the depressive state is to be traced back both to the biological and behavioural factors of the individual and to his or her life conditions: poverty or wealth, deprivation, both from an educational and employment point of view, a lack of prospects, loneliness and social isolation, and tensions in the family or at the workplace. Depression is a common illness that can afflict us all; it is an illness that does not respect in a special way gender differences – even though it is more common among young women – or age differences. From a sociological point of view, we could say that social malaise intertwines in various ways with individual malaise, overlaying it and at times bringing it about. The study of depressive psychopathology, therefore, if carried out from an exclusively micro-perspective, or with reference solely to the psychological dimension of the individual, can be reductive.

Thus, in the definition of the research project, and in particular in the creation of the instruments by which to gather information, a mixed approach was chosen that took into account the above-mentioned dimensions, but from a macro-perspective, in order to identify a series of constituent elements of our society that after a certain fashion 'act the individual', to employ Durkheim's notion,[1] although at the same time acknowledging that the person and his or her will have the ability to react and direct in relation to his or her existence.

The hypothesis of the work: beginning with a holistic concept of man and accepting the theoretical postulate that defines mental illness and in particular depression as an illness in which elements of a biological, psychological, spiritual and social character play their part, the aim of the project was to verify whether certain psycho-social factors that can favour its manifestation, such as a widespread exposure during the course of one's lifetime to the risk of experiencing critical events that set in motion processes of deprivation, exclusion and social marginalisation; the inadequateness of systems of social protection; and the critical character of contemporary family contexts, are also the expression of the crisis of cultural and religious values of contemporary societies.

The objectives of the survey carried out by the Pontifical Council can be summarised as follows: the definition of certain latent structures of the social/cultural and family context in which mental illnesses manifest themselves; the identification in the local Churches of pastoral programmes on the subject; the identification of Catholic structures for the provision of assistance to, the accompanying, and the treatment of, patients and their family relatives, with a description of the various models of intervention; and a comparison between the perception of the phenomenon by bishops and the actual experience in the field of the directors of the Catholic centres that had been identified.

The methodology: this survey was carried out with a methodology that was different to the one employed in the surveys of the



past of this Pontifical Council, which were concerned with the subjects of the health of women, AIDS, and Catholic hospitals. Indeed, given the sensitive character of the subject it was thought advisable to refer to two different sources of information: the one hundred and twenty-seven bishops who are responsible for pastoral care in health in one hundred and twenty-one countries throughout the world, on the one hand; and the directors of Catholic centres or structures that provide assistance to patients with problems of mental health, on the other. Thus two different instruments of information gathering were created, that is to say two questionnaires, within which, however, we envisaged the insertion of a battery of shared questions in order to allow a comparison between the perception of the phenomenon by the bishops and the experience in the field of the directors of the centres that had been contacted. This research is still underway, and for this reason the results are provisional and necessarily partial given the large number of aspects that were addressed during the course of the survey. In this paper, therefore, an attempt is made to present only those data that can offer, in this context, certain points of reflection on depressive psychopathology.

However, from a first examination of the survey at its present stage it is clear – and this is something that we expected – that this subject is encountering major difficulty in making headway in the field of pastoral care in health: the percentage of replies, so far a little more than 20%, is very much lower than was the case with the surveys carried out in the past by this Pontifical Council. Mental illness continues to be the Cinderella of socio-health care questions and pastoral work and endeavour. However, a space remains to ask whether, perhaps, specifically where the human mind gets 'lost', it is not even more necessary – if not indispensable – to provide the support of the spirit, the warmth of a comfort that goes beyond responsibility and treatment, in order to open the suffering person to a space of trust and hope.

An important aspect of this survey was that an opportunity was provided to draw up a map of the Catholic structures working in this specific area of assistance and pastoral care in health (thirty one so far), a map that was enriched by a great deal of information about the kinds of structures involved; about the number and types of professional figures working in them; about the services offered by them and their waiting lists; about their sources of finance; about the socio-demographical characteristics of those who use them; about the prevalent pathologies or mental disturbances; about the modalities of approach to the patient and innovative therapeutic pathways; about the activities envisaged at the level of primary, secondary and tertiary levels; about the links with the formal and informal institutional realities of the local area; and about courses of pastoral training and the study and investigation of ethical questions connected with the care and treatment of a person with mental health problems.

First Results

First of all it is interesting to begin with the analysis of the results that emerged from the answers to the battery of questions shared by the two groups of respondents – the bishops and the directors of centres. In the first part of this battery of questions those addressed were asked to express their views on certain aspects of contemporary society in their own countries that they believed could influence the origins and spread of mental illnesses, with special reference to depressive disturbances. These aspects were grouped beforehand into three macro-areas relating to the system of cultural and religious values, the situations at risk and systems of social protection.

A joint analysis of the answers about 'situations at risk' and the 'systems of social protection' of the various countries allowed a definition of certain latent structures with a social profile within which depressive psychopathology arises and is nourished. It would appear that certain social factors lead people to enter a state of crisis. In particular, from the information contained in this table we can see the importance of difficulties in obtaining employment and its precarious character, together with the weakening in the networks of intra-family help and difficulties in the management of emotional life. These are followed in order of importance by poverty, lack of education, and processes of social exclusion.

Table 1 – Questionnaires answered by the Bishops (B) and the Directors of Centres (D). On the basis of your experience, to what extent do you believe that the following aspects of contemporary society in your country can have an influence on the emergence and spread of mental illnesses) (analysis of multiple replies).

SITUATIONS AT RISK	Number (B-D)	Percentage of replies (B-D)	Percentage of cases (B-D)
Precariousness of means of subsistence, poverty	21-24	12.5-11.2	80.8-88.9
Lack of education/training	18-22	10.7-10.3	69.2-81.5
Precariousness of employment	21-22	12.5-10.3	80.8-81.5
Difficulties in obtaining employment	20-22	11.9-10.3	76.9-81.5
Weakening of help networks and ties of solidarity	18-23	10.7-10.7	69.2-85.2
Alienation of human rights	9-14	5.4-6.5	34.6-51.9
Processes of exclusion, social marginalisation	14-23	8.3-10.7	53.8-85.2
Wars	6-9	3.6-4.2	23.1-33.3
Terrorism	5-8	3.0-3.7	19.2-29.6
Bad education as regards the management of feelings in relational life	18-19	10.7-8.9	69.2-70.4
Processes of detachment from reality/recourse to virtual reality	6-8	3.6-3.7	23.1-29.6
Conditioning influences of the environmental context	12-20	7.1-9.3	46.2-74.1
Totals	**168-214**	**100.0-100.0**	**646.2-792.6**

These data bring out two important contexts in which each individual is involved to the full – the world of work and the world of relationships. To express the point in terms of the thinking of Bourdieu,[2] this is the area in which each person employs his or her economic capital and his or her social capital: in this area the person can get lost and never find himself or herself again. Difficulties in finding employment involve difficulties in obtaining one's own independence, in being able to make projects for the future, and it can also mean not being able to maintain one's family and not being able to offer one's children that one wanted them to have. These difficulties also grow greater when the relational dimension becomes weaker: the crisis of the family help networks is a given fact that affects not only most European countries, as the recent Eurostat statistics bring out, but also the poorest countries of the world in which the processes of post-colonial assimilation and inculturation have lacerated the foundations of the native cultures, causing thereby a disappearance of the traditional forms of solidarity and support which sustained groups or individuals in difficulty in the villages and small towns of the rural regions. The human experience seems to be precipitating towards an increasingly accentuated individualistic dimension that is translated into bad education as regards the expression of one's own feelings in relational life: the incapacity to look at, and open oneself up to, other people with trust; difficulties in overcoming the loneliness of a society that is, indeed, not very welcoming and not very attentive to the needs of the person.

So do mental illness, and in particular depression, have something to do with the systems of social protection? From a first analysis of this group of answers depression seems to have much to do with governments that support a culture that proposes models of behaviour marked by success, wealth and self-affirmation, but which does not manage to guarantee a sufficient fairness as regards health care, economic and social policy.

Table 2 – Questionnaires answered by the Bishops (B) and the Directors of Centres (D). On the basis of your experience, to what extent do you believe that the following aspects of contemporary society in your country can have an influence on the emergence and spread of mental illnesses) (analysis of multiple replies).

SITUATIONS AT RISK	Number (B-D)	Percentage of replies (B-D)	Percentage of cases (B-D)
The low level of fairness of economic policies	14-20	21.2-22.5	70.0-80.0
The low level of fairness of health care policies	17-17	25.8-19.1	85.0-68.0
The low level of fairness of social policies	14-20	21.2-22.5	70.0-80.0
Contradictions between objectives and the implementation of policies by the governing classes	13-18	19.7-20.2	65.0-72.0
Corruption	8-14	12.1-15.7	40.0-56.0
Totals	**66-89**	**100.0-100.0**	**330.0-356.0**

As can be observed from this table, both the bishops and the directors of centres agreed that there is a basic weakness in the systems of social protection and that a low level of attention is paid to guaranteeing measures that express social fairness. The policies that are most affected by this problem seem to be primarily health care policies, followed by socio-economic policies. This weakness of the systems of social protection, which become translated into a gap between the objectives proposed by the dominant culture and the means that are available to achieve them, can set in motion processes that in many cases becomes expressed in depressive psychopathology. The American sociologist Merton,[3] sixty years ago, identified five forms of social behaviour that correspond differently to the ability of an individual to adapt to the cultural values proposed by the cultural context of reference and to the means allowed to that end. Each one of us is propelled by the social context in which we live to attain those goals, but it is equally true that not all of us have the same means to get there. It is the poorest people, the less educated people, those who are unemployed, those who do not have a family at their shoulders or one that they have themselves established, who are also the most disadvantaged. A system that is not committed to protecting these people by supporting them and accompanying them on a pathway of psycho-social inclusion exposes the individual to an 'abandonment' that is translated into deviant forms of behaviour, to employ the sociological meaning of this phrase, such as life on the streets, being tramps, alcoholism, and drug-addiction. Depression, therefore, is a psychosocial malaise that has its roots in a society that excludes rather than includes, that rejects rather than welcomes, and that abandons rather than protects. We need policies that assume responsibility for the problems of citizens by guaranteeing them fairness at a social, economic and health care level.

If the reactive manifestation to things going wrong can be traced back in a sociological sense to the concept of Merton of 'abandonment', in psychopathological terms such a manifestation becomes conflict, the disorganisation of behaviour, emotional and motivational destabilisation, a disturbance/symptom of the malaise of the contemporary human condition. As can be seen from this table, the answers of both the bishops and the directors of centres identify the states of worry and frustration as being amongst the

most widespread disturbances; these are followed by disappointment and low self-esteem. In summarising form, this amounts to a personalogical failure, the collapse of the system of expectations, a failure to meet the need to give full meaning to one's own existence.

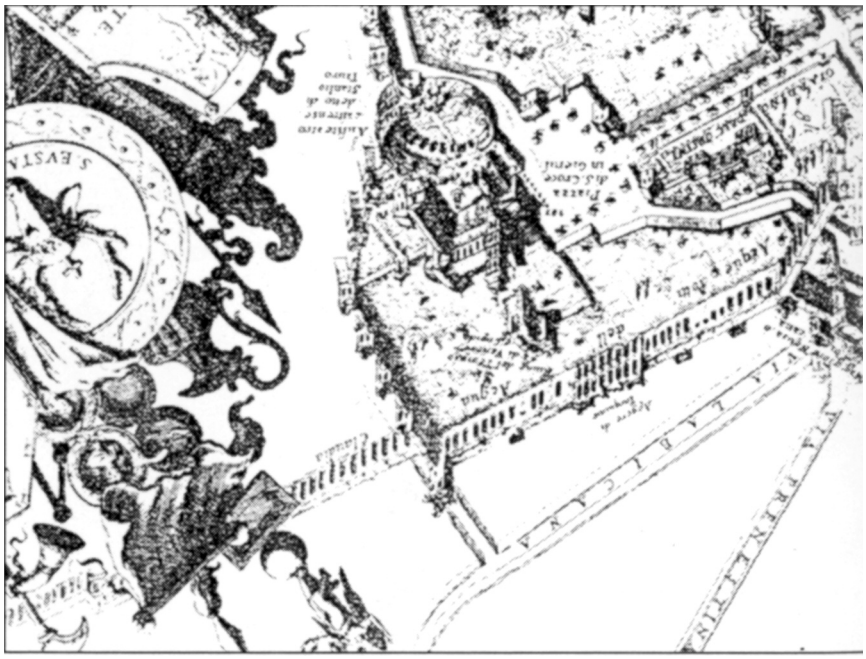
Table 3 – Questionnaires answered by the Bishops (B) and the Directors of Centres (D). On the basis of your experience, to what extent do you believe that the following aspects of contemporary society in your country can have an influence on the emergence and spread of mental illnesses) (analysis of multiple replies).

	Number (B-D)	Percentage of replies (B-D)	Percentage of cases (B-D)
Anxiety	21-26	9.3-9.2	77.8-92.9
Frustration	21-26	9.3-9.2	77.8-92.9
Boredom	14-18	6.2-6.4	51.9-64.3
Disappointment	19-23	8.4-8.2	70.4-82.1
Low self-esteem	19-25	8.4-8.9	70.4-89.3
Feeling of inadequacy	18-20	8.0-7.1	66.7-71.4
Non-acceptance of the limits of the human dimension	11-16	4.9-5.7	40.7-57.1
Aggression	17-14	7.5-5.0	63.0-50.0
Alcohol addiction	22-23	9.7-8.2	81.5-82.1
Drug addiction	18-20	8.0-7.1	66.7-71.4
Dipendence on ideal images	10-24	4.4-8.5	37.0-85.7
Forced dependence on other people	12-14	5.3-5.0	44.4-50.0
Dependence on absolute value models	7-12	3.1-4.3	25.9-42.9
Difficulties in expressing one's own feelings	17-21	7.5-7.4	63.0-75.0
Totals	**168-282**	**100.0-100.0**	**646.2-1007.1**

The individualistic model that dominates in contemporary society places the subject in his or her relationship to the other person exclusively within a dynamic of competitive comparison. Life is a race to affirm oneself over another person. The failure to achieve this objective brings to the fore a widespread sense of inadequacy, another factor indicated by those who filled in the questionnaire, which takes the practical form of different modalities of pathogenic behaviour that oscillate between passivity and aggression. These are approaches in which a person's striving for equilibrium can at times result in recourse to alcohol or the use of drugs. This reading of the data, which is applied to countries that belong to regions of development and opulence, may appear distant from the reality of those people who live in conditions of deprivation. However, such is not the case. Worry and existential frustration are manifested even more in those people who, lacking the suitable means and funds, desperately strive to 'survive' the abject poverty of daily life. When reference is made to 'empowerment' in the projects for co-operation designed to achieve growth and development the following is meant: restoring trust in a person's own means, strengthening the processes of self-esteem, and supporting entire populations that are abandoned to themselves in overcoming a feeling of inadequacy so that they take their own destinies into their own hands.

Emphasis should be laid on the data on how aggression is an element of grave disturbance that characterises the depressive state. It can at times express itself in violent forms of behaviour within the family context as a compensation for the frustrations and disappointments accumulated in outside contexts. Aggression feeds on itself by provoking in the subject contradictory feelings that range from a feeling of guilt to that of revenge. The family is often the principal victim of this reality both because of the difficulties it encounters it carrying out the difficult task of helping and looking after the depressed person, given the lack of suitable services with which to tackle the problem, and because families are abandoned to themselves by governments with 'weak' policies and rather unstructured policies in the field of mental health.

But the family does not form a part of this analysis by this route alone. The present critical state of family contexts is one of the aspects that would seem to have most influence in a significant way on the pathogenesis of depressive states according to both the perception of bishops and the experience of the directors of centres. In the next table the factors that are indicated are in large measure data that refer to the increasingly widespread breakdown of families, together with the progressive weakening of the value of the institution of mar-



riage, which in turn is accompanied by a significant increase in the number of separations and divorces, and the lack of communication within the nuclear family. People do not spend much time together, there is no dialogue, there is no exchange of views, and there is no authentic experience of sharing. We seem to have before us a widespread inability to experience a communion of intentions, the sharing of a common life project.

This is a mirror of the dominant individualistic culture. It also brings out the lack of mature parental figures that are able to be a point of reference for their own children, who are able to propose models in which they can recognise themselves. Loneliness insinuates itself into the family unit to the point of becoming devastating. Feeling alone when one is amongst one's nearest and dearest amplifies the feeling of anxiety and worry. And unfortunately these states of mind increasingly connote the human condition of the new generations.

At the end of this first vision of the psychosocial and family context in which mental illness, and in particular depression, emerge, we can but try to understand if and to what extent the weakening and/or disappearance of certain transversal cultural and religious values of a secular and ecclesial citizenry have an influence on the emergence and spread of depressive psychopathology. In the next table it is possible to identify the aspects on which both the bishops and the directors of centres agreed and which prevalently relate to the crisis of values of reference, the exaggeration of desires, and a culture that is strongly orientated towards hedonism.

Table 4 – Questionnaires answered by the Bishops (B) and the Directors of Centres (D). On the basis of your experience, to what extent do you believe that the following aspects of contemporary society in your country can have an influence on the emergence and spread of mental illnesses) (analysis of multiple replies).

	Number (B-D)	Percentage of replies (B-D)	Percentage of cases (B-D)
Imbalance between male and female roles	14-18	5.2-5.9	53.8-66.7
Lack of parental figures as reference points	22-25	8.2-8.3	84.6-92.6
Separations and divorces – breakdown of family units	23-23	8.6-7.6	88.5-85.2
Loss of the value of marriage as an institution	19-23	7.1-7.6	73.1-85.2
Lack of communication – dialogue	23-25	8.6-8.3	88.5-92.6
Lack of time to be together	20-21	7.5-6.9	76.9-77.8
"Immaturity" of the parents	19-24	7.1-7.9	73.1-88.9
Conflict and disharmony between the parents	22-24	8.2-7.9	84.6-88.9
Delegation of responsibility to third parties	12-17	4.5-5.6	46.2-63.0
Delegation of responsibility to institutions	13-13	4.9-4.3	50.0-48.1
The weakening of shared life projects	17-18	6.3-5.9	65.4-66.7
Inadequate preparation for married life	20-22	7.5-7.3	76.9-81.5
Conflict between parents and their children	21-25	7.8-8.3	80.8-92.6
Aggressive or violent behaviour within the family unit	23-25	8.6-8.3	88.5-92.6
Totals	**268-303**	**100.0-100.0**	**1030.8-1122.2**

It is clear that these aspects are more emphasised by the Church respondents whereas the lay respondents give less stress to, although they do not underestimate, the same critical factors. These first data provoke sociological reflection: every person acts within a given cultural system. The contemporary system of cultural norms would appear to be directed towards the exaggeration of individualistic models in which appearance and the external dominate the space of the realisation of the human person. A dominant culture that leads towards the external to the detriment of the internal, where appearing and having prevail over belonging and being. A culture in which desire is a right: everything is contained in desire; in desire the very object of desire disappears. And when the desire cannot be realised or is not attainable, incurable lacerations are provoked, which are followed by frustration and annihilation - the precursors of depressive psychopathology.

It is within this framework that the contribution of pastoral care in health is to be located. To this end, the survey wanted to express the opinions of bishops responsible for pastoral care in health in the various countries involved in the survey on the state of pastoral action in relation to this sensitive subject.

First and foremost, those who answered the questionnaire were asked about the existence of a pastoral programme in the various local Churches dedicated to the subject of mental health. As is clear from the next table, over 60% of bishops declared that no pastoral

Table 5 – Questionnaires answered by the Bishops (B) and the Directors of Centres (D). On the basis of your experience, to what extent do you believe that the following aspects of contemporary society in your country can have an influence on the emergence and spread of mental illnesses) (analysis of multiple replies).

CULTURAL AND RELIGIOUS VALUES	Number (B-D)	Percentage of replies (B-D)	Percentage of cases (B-D)
Crisis of values of reference (life, family, education)	23-22	17.6-15.9	88.5-91.7
Selfishness	13-19	9.9-13.8	50.0-79.2
Hedonism	20-18	15.3-13.0	76.9-75.0
Technological culture/technologism	9-9	6.9-6.5	34.6-37.5
Search for the impossible	8-7	6.1-5.1	30.8-29.2
Exaggerated desires	17-20	13.0-14.5	65.4-83.3
Cultural conflict	8-8	6.1-5.8	30.8-33.3
Magic rituals	12-13	9.2-9.4	46.2-54.2
Denial of transcendence	8-13	6.1-9.4	30.8-54.2
Ethical and religious relativism	13-9	9.9-6.5	50.0-37.5
Totals	**131-138**	**100.0-100.0**	**503.8-575.0**

programme in this field yet existed, which confirms that there is still a long and difficult pathway to travel as regards making the action of the Church on behalf of those who suffer from these pathologies more incisive.

Table 6: The existence of a pastoral programme of the local Church dedicated specifically to the subject of mental health/disturbance (distribution of absolute and percentage values)

	Absolute values	Percentage values
Yes	8	30,8
No	16	61,5
No answer	2	7,7
Total	**26**	**100,0**

It seems that just as is the case with civil society, so also with the Church community it is necessary to work in favour of greater sensitisation in relation to these subjects, as regards which precise pastoral guidelines have not yet been developed. In this sense, this international conference, which is dedicated specifically to depression, a transversal psychopathology affecting the developed and developing worlds, is an important moment for reflection on the relaunching of pastoral commitment in this very difficult area which is often neglected – I would dare to say forgotten – by the civil world.

However, in our survey we attempted to investigate the contemporary state of affairs to the full in order to identify, within pastoral programmes that are now underway, guidelines for action and implementation that could be suggestions for the work of other Churches in this field.

From an analysis of the objectives of the pastoral programmes now underway it was possible to identify five principal lines of action:

- Pastoral action that places sick people and their family relatives at the centre of things as recipients and agents of *evangelisation*.

- An intense *action of sensitisation* of the local political decision makers, and of civil and ecclesial society, on the importance of defending the rights of people with mental health problems, in order to promote new attention and consideration of the questions and issues that bear upon the suffering of the human mind.

- Pastoral action in the field of *prevention*, both through support for people at risk and through an intense activity of providing information to the community about both the physical and social effects of the abuse of such substances as drug

and alcohol, whose use can be correlated to the presence of mental illnesses and/or depressive disturbances.

- Pastoral action directed towards the *rehabilitation* of people with mental illness so that they can return to their family, working, and relational lives.

- And lastly, a *training action* directed towards preparing pastoral workers in the field of mental health who will not only be able to accompany people with these problems but also to identify innovative pastoral strategies suited to tackling this phenomenon in an effective way.

However, this planning does not seem to be accompanied by an adequate availability of human and material resources that are sufficient to meet all the commitments that the above mentioned objectives would require. In the majority of cases the bishops in their answers expressed themselves by referring to the presence of 'competent Christians who do their best' or to 'groups of young people, small Christian communities, teams of professionals with good will' – all this is voluntary help. They also refer to chaplains, and male and female religious. In general, there was a complaint about a lack of stable and qualified personnel with specific professional and pastoral responsibilities. From the answers given by the bishops one can see a difficult attempt to do what is possible in the circumstances, in conditions which are mostly difficult, in which it is necessary above all else to challenge the stigma and the prejudice connected with a phenomenon that scares people, which arouses fear and distance.

The bodies through which pastoral care in health is expressed in this field are units of pastoral workers involved in providing services in the field of mental health, hospital chaplainries active on this front, and at a higher level psychiatric committees for pastoral encouragement in specialist clinics and departments for spiritual assistance for people with mental illnesses.

An attempt was then made to explore the forms of co-ordination of such pastoral programme in the local area and the level of satisfaction in relation to such forms of collaboration. From the answers given by the bishops, the diocese would appear to be the reality in the local area that acts as a catalyst for such forms of pastoral action – it is followed by connections with the parishes and the health care structures. However, the level of satisfaction that was registered is not very encouraging and this demonstrates the difficulties that these programmes have to deal with every day. Attention should, however, be paid to the encouraging fact about collaboration with the prison institutions. We are led to ask ourselves whether it is not the case that perhaps specifically where man seems to have lost everything, reason and freedom, it is pastoral action that opens up to man a space of trust and hope to which the conscience more than reason can entrust itself. And man

opens to 'salvation', to the search for himself, other people and God, whatever his Faith may be.

There is not enough time in this paper to go beyond this analysis and discuss the results of this work. However, I believe that there is enough here to grasp the extent to which work in the field of mental health is for all health care workers – both lay and religious – a challenge and a mission at one and the same time. A challenge against the prejudice and fear that surround these pathologies, and which makes not only those who suffer from mental illness but also their family relatives more alone. A mission because the relationship with people with problems of mental suffering requires more than any other relationship the courage to recognise in the other person the image of Christ who calls us to an act of love, and the image of the Good Samaritan becomes once again its symbolic effigy. To end this paper, I would like to briefly recall the story of an encounter that was narrated by Mother Teresa of Calcutta in a speech that she gave in 1979 in a Carmelite church in Dublin and in which she seemed to me to summarise perfectly the 'hunger' for love of our time, of which without doubt depression is one of the many possible expressions. It is the story of a boy met on the street on a pavement in the middle of the night because he had been turned out of his home by his mother. When the sisters returned the boy had taken an overdose and had to be taken to hospital. Mother Teresa remembered: 'I could not but think that perhaps his mother was one of those people who worked for our hungry people of India. And here was her son who was hungry, hungry for her, hungry for love, hungry for her care, and she refused him it. Bring love into your homes. If you really love God you will begin to love your children, your husband, your wife. Where are the old people? Why are they not with you? And where is the handicapped child? Why is he not with you? That child, that old person, young fathers, young mothers, is a gift of God'.[4]

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Notes

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3. R.K. Merton, *Social Theory and Social Structure* (Glencoe, Ill., The Free Press), Italian edition: *Teoria e Struttura Sociale* (Bologna, Il Mulino, 1992).
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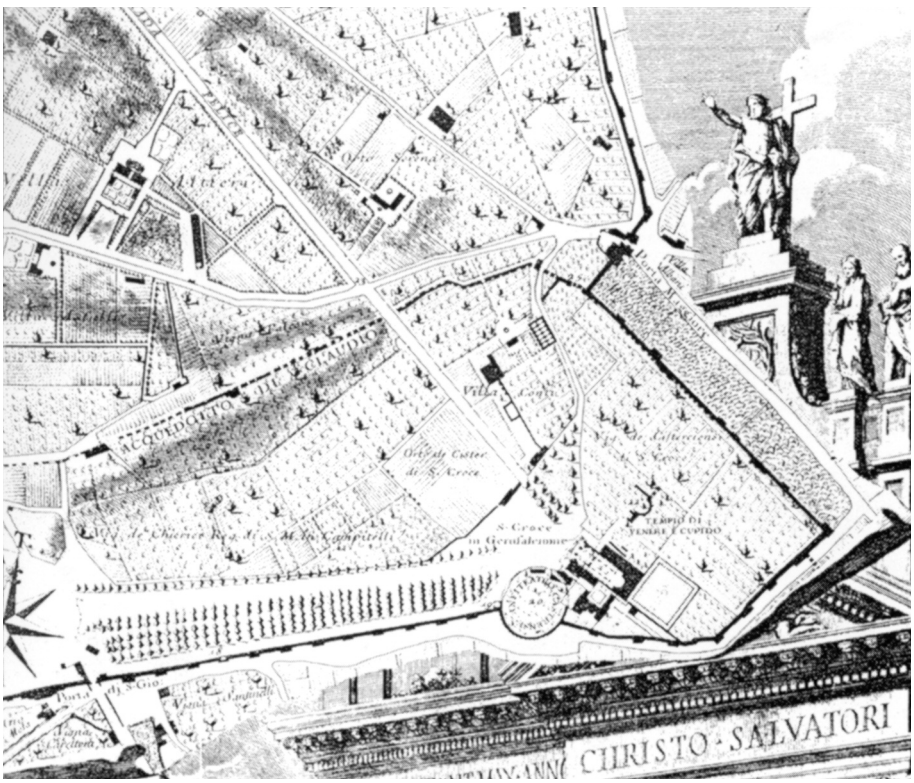

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II Section

The Light of Faith in the World of Depression

MASSIMO ALIVERTI

1. The History of Depression

It seems that the Greek physician Hippocrates (lived between the 5th-4th century B.C.) one day paid a visit to the home of the philosopher Democrites, whose friends believed that he was displaying signs of mental imbalance. Democrites 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 maintain 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 Epheseus 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 Epheseus, 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).

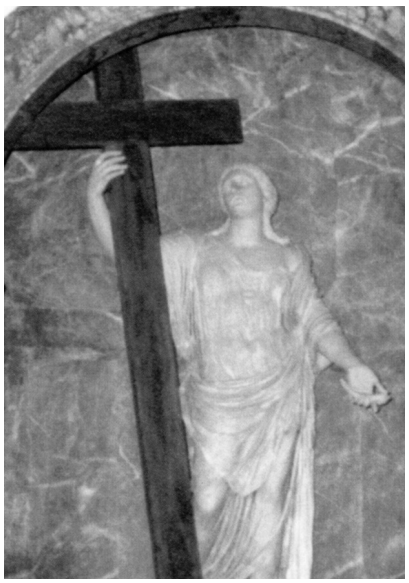
In medieval Europe these were long in fashion in the treatment of mental illness, rather like those broadly based potions that were proclaimed to have prodigious health-bestowing virtues that were derived from the rarity or high value of their ingredients. Remedies or therapeutic practices were often 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.

Joahnnes Weyer (1515-1588), who came from Brabante, 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 a 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 Malady*, 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 'lipemania' 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 Baillarger (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, strophantus 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 'evolutive 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 twentieth 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 the 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 'serotoninergic') 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 extent 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 irreconcilable, 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.

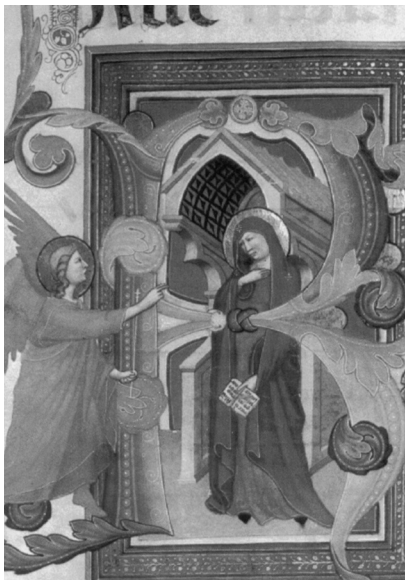
From a psychological point of view, a person who has fallen into depression needs human company that helps him to overcome loneliness and isolation; he needs to engage in satisfying activity that is successful and to discover those fissures in his own personality that have allowed the depressive state 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 contemplation 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 to 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 dissociating 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 depressive 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 exhausting. 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.

His Eminence Cardinal
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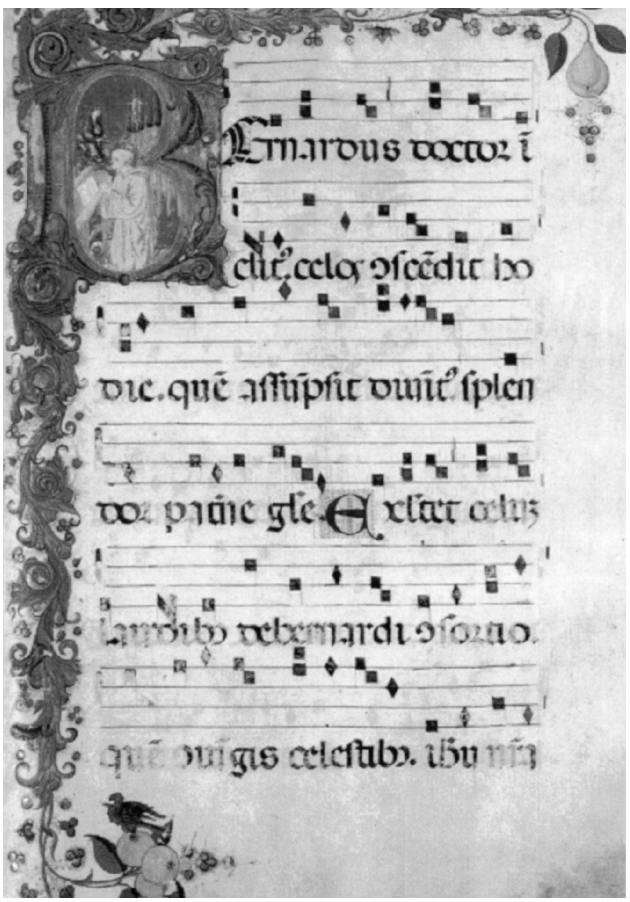

CARLO CASALONE

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 petrifaction 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 arbitration 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 illness 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.[1] 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.[2]

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.[3] 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'.[4] 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 dot not seek to judge the hidden secrets of the heart', said St. Augustine when speaking about suicide.[5] 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 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.[6] We are, therefore, in a situation in 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 misunderstandings. A feeling of guilt is a feeling of unworthiness and unease that emerges after an act or an approach which is seen as mistaken.[7] 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 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 rejection 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 or 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.[8] 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 present 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.[9] 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'.[10] 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.[11] 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,[12] 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.[13] In cases of depression, the motivations involved can cover a very broad spectrum.[14] 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)[13] and ceased to list people who had committed suicide amongst those excluded from a Church burial and a funeral mass.[14]

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 mans 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.[15] 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 Qoelet, 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 nearness, 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

[1] 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.

[2] 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.

[3] Cf. BORGNA E., *Noi siamo un colloquio. Gli orizzonti della conoscenza e della cura in psichiatria* (Feltrinelli, Milan, 1999), pp. 75-97).

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

[5] ST. AUGUSTINE, *The City of God*, Book 1, chaps. XX-VI.

[6] Cf. GABBARD G.O., *Psichiatria psicodinamica* (Cortina, Milan, 2002), pp. 217-218.

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

[8] Cf. MINKOWSKI E., *Le temps vécu* (PUF, Paris, 1995) (1st. edn. 1933).

[9] Cf. MINKOWSKI E., *op. cit.*, p. 294.

[10] BORGNA E., *op. cit.*, p. 67.

[11] Cf. THOMAS AQUINAS, *La Somma Teologica*, II-II, q. 64, a. 5.

[12] Cf. ARISTOTLE, *Etica Nicomachea*, V, 15, 1138 a 5-14.

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

[14] Cf. GABBARD G. O., *op. cit.*, pp. 220-223.

[15] Cf. Can. 1240 § 1,3.

[16] Cf. Cann. 1184-1185.

[17] 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; TETTAMANZI 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).

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4. Pastoral Care: The Rejection of Suffering and the Search for Personal Wellbeing

Introduction

Suffering is a reality that human beings cannot avoid. From birth until death we meet suffering in its different expressions: loneliness, physical pain, moral defects, broken relationships, sadness, tiredness, guilty feelings, starvation, depression, oppression, alienation, anomie, anger, and varied forms of weakness.

Our Holy Father, Pope John Paul II, offers us a key insight from which to begin this consideration when he says: "…what we express by the word "suffering" seems to be particularly *essential to the nature of man.* It is as deep as man himself, precisely because it manifests in its own way that depth which is proper to man, and in its own way surpasses it. Suffering seems to belong to man's transcendence: it is one of those points in which man is in a certain sense "destined" to go beyond himself, and he is called to this in a mysterious way."[1]

It is also clear that suffering and pain are frequently associated with the evil that is present in the world. On one hand, it can be considered a consequence of evil. On the other, we can say that suffering is itself an evil, a limitation, negation of a determined good. Suffering is evidence of our own limitations, our finitude, and regarding it from only this perspective prompts us to reject it.

The contemporary dominant culture, deeply marked as it is by hedonism, and tainted by the *culture of death*[2] has taken a clear position before the mystery of suffering and pain. The world flees from suffering, seeking a desperate escape, adopting an attitude which seeks to evade pain by all means. However, the problem runs deeper than the mere avoidance of suffering. It concerns an immature and evasive position regarding life. On a cultural level, this position could be expressed by the maxim: "Seek pleasure and comfort always and everywhere in all the ways you can".

Without faith, it is easy to identify pain as evil. Regarding pain as only an evil leads inevitably to desperation. That is a major reason why many people with an essentially secularist understanding of life invest tremendous efforts to escape from this reality.

Despite our formidable technological and scientific advances, humanity cannot rid itself of pain and death. Aware of these fundamental concerns regarding the person, Vatican II posed the question: "What is this sense of sorrow, of evil, of death, which continues to exist despite so much progress?[3]

Avoiding these questions will not make them disappear. We need to answer them. We can say that by engaging the problem of pain and suffering we respond to an imperative of our heart and open the doors to faith. In the depths of the human heart is an insistent need for answers on this matter, and one important imperative of faith is to respond to the call of the Lord to live and proclaim the answer that Jesus himself gives to the question of pain and suffering.

The Lord Jesus has not come to free us from suffering but to lead us through it to the discovery of its inner meaning. In his earthly life he lived the experience of suffering intensely. Nothing human is foreign to Christ, with the exception of sin.[4] In Jesus the Lord, all our questions about pain and suffering find their source of meaning and come to resolution. In the suffering Christ we discover that pain loses its overwhelming load of negativity, and suffering becomes an occasion for growth in love and hope. The meaning of suffering has been uncovered, disclosed by the Cross and it points to a plentiful joy because of the Resurrection. By the light of the cross, we can discover the fundamentals of a sort of pedagogy of God. Jesus, our model and teacher, wants to shape and form us by this dialectic of "joy and pain" that is the pathway to life in its fullness.

When we speak of a pedagogy of "pain-joy" or "joy-pain" we are asserting that in the Christian life there is a dynamic process where both realities intertwine like the threads of a fabric. However, it is not a matter of successive moments of pain followed by joy, but the same dynamism where for the most part joy and pain occur in the same moment. Looking carefully at the life of the Lord and his Blessed Mother we can discover that "Christian joy" subsists even in pain, just as hope rises in the midst of the most dramatic situations.

In this way, the cross is transformed from its original status as an instrument of torture and death, to a new significance as the sign and instrument of salvation, reconciliation, redemption, and hope. The Lord Jesus continually invites us to deepen our understanding of the mystery of human suffering and to allow it to become a process of spiritual

growth and a source of redemption. That is what Saint Paul expresses in Colossians by saying: "In my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the Church".[5]

In 1981, shortly after the assassination attempt which nearly took his life, Pope John Paul wrote a powerful Apostolic letter entitled "Salvifici Doloris". While enjoying the status of authoritative papal teaching, this document also gives us a moving and experientially grounded testimony of the Holy Father's own experience and reflection on the mystery of suffering. In the very first paragraph of this document we read:

"Declaring the power of salvific suffering, the Apostle Paul says: "In my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the Church". These words seem to emerge at the end of the long road that winds through the suffering which forms part of the history of man and which is illuminated by the Word of God. These words have as it were the value of a final discovery, which is accompanied by joy. For this reason Saint Paul writes: "Now I rejoice in my sufferings for your sake". The joy comes from the discovery of the meaning of suffering, and this discovery, even if it is most personally shared in by Paul of Tarsus who wrote these words, is at the same time valid for others. The Apostle shares his own discovery and rejoices in it because of all those whom it can help – just as it helped him – to understand *the salvific meaning of suffering*."[6]

Connecting our human experience of suffering with the suffering of Jesus offers a totally new interpretation of its mystery. Such a perspective challenges to their core the assumptions and presumptions of a consumerist culture of pleasure and instant gratification closed in upon itself. This vision invites us to enter more deeply into the notion of a 'Divine pedagogy' associated with the mystery of suffering.

Original Sin

The perennial question concerning evil and its consequences is dramatically urgent at this point in human history. Why suffering? Why spiritual, psychological, physical pain? Why so many ruptures and disharmonies? When we contemplate the evil in the world and compare it with the goodness of creation we are impelled to seek answers, explanations. Through the contemplation of nature and by Revelation the human being can attain some understanding about the human vocation for *communion and participation*[7], and also, about the presence of evil.

Created by God, we experience our being as a participation in God's own being and love. It is clear that the dynamism present at the core of our interiority, is an impulse in the direction of happiness tending towards the discovery of truth and meaning.[8] In consequence, our actions tend to strive towards horizons of infinity and plenitude. We feel a call in our inmost depths to respond in freedom to the Lord.[9]

We know that God, in an effusion of divine love, creates the human being and invites him to be in relationship with him. God also invites us to be in communion with ourselves and with other people.

Due to the rebellion of our first parents, sin entered the world and is transmitted with its consequences from generation to generation. This rupture, which in the language of theology is described as "original sin," has marred creation and given rise to the evil we see in the world. Human reflection across cultures, time, and even variant systems of religious belief concur that there exists a "fundamental" rupture close to our origins, and ascribe to this rupture the genesis of the evil we face.[10]

Though created in love, from the beginning human beings rejected the love of God, and thereby rejected life in communion with Him. Humanity opted to build a kingdom without God. Instead of paying adoration to the true God, it paid adoration to idols created by human hands, things of the world, and became self-adoring. That is the fundamental wound which humanity, in isolation from God, inflicts upon itself. The world has thus been opened to evil, death, violence, illness, hate and fear. Our happiness and inner harmony, and also the brotherly relationship between humans has been profoundly disturbed. Wounded and broken by sin at the core of his humanity, man severed his union with God, thereby becoming subject to the experience of various kinds of slavery and weakness.[11]

Now, as in the past, sin shows itself as rupture. Moreover, it is a dynamism of rupture, a sort of anti-love. This dynamism "will be a permanent obstacle for the growth in love and communion of human beings. This reality will manifest itself not only in the hearts of people but from the different structures created for the human person. The sin of our first parents has left indelible and destructive imprints"[12] in our anthropology at all levels of our existence, – spiritual, psychological and physical.

Despite this tragic moment of "the fall," God's promise nourished the hope of his children. Humanity witnessed the fulfilment of God's wonderful promise in the Incarnation of the Eternal Word.

In the Post-Synodal Apostolic Exhortation *Reconciliation and Penance,* published on 2 December, 1984 Pope John Paul develops a most insightful approach to the mystery of sin and evil and their consequences. His exegesis of the parable of the Prodigal Son gives us a clear understanding of how our rupture with God has caused us to suffer the consequences of ruptures within ourselves, with others and even with our environment. He has powerfully exposed the deepest desire of our hearts: to be reconciled with the Father, with ourselves, with our brothers and sisters and with nature. Jesus is presented in this Exhortation as the Reconciler.[13]

Sin and its Attendant Consequences

Because of original sin, the fruit of a free but mistaken choice, evil is introduced tragically into human life and into the world. Even more, that first unfortunate choice has defined a pattern for further similar choices leading to the same poisoned fruit.

Every time a human person exercises his freedom he opts for *his vision of things,* and this vision, ratified by concrete choice and action, produces a culture. When freedom is activated in wrongful choice, man acts against God, and in a word, he sins. By doing so, and as a consequence of his option, he is introduced into a suicidal dynamic that brings into the present the tragedy of that original Fall in the garden of Eden. Called to happiness in communion with God, self, with others and with nature, by sinning man refuses this call. The bonds of communion are broken or weakened and the heart becomes divided. Opting to define one's own good without reference to God, the person so choosing moves forward on the road to spiritual death.[14]

The first victim of the choice of sin is the one who chooses to sin. By sinning a person denies the dynamism printed in the heart by God. The sinner plunges into a world of illusions and error. Sin's interior rupture exacerbates the existent disorder already present in his wounded nature. Isolated and interiorly divided, the sinner becomes even more alienated in the awareness of being a creature loved by God and invited to participate in a communion of love, but now in refusal of that very communion that gives life.[15]

The consequences of personal sin are terrible and tragic for the sinner. Cut off from the source of life and profoundly divided within, the sinner is caught in a snare from which he cannot escape without the intervention of divine

love. Sin does not stand alone in him. Even the more intimate and private sin extends its evil to other human beings and structures surrounding the person, thus manifesting in a negative way the unity and interdependence of humankind.

What is said of rupture in the personal realm can also be applied to the culture in which we live. Pope John Paul has called these processes and manifestations a *culture of death*.[16] In this forum we do not have the leisure to consider further development of this theme, except to remark its formative influence on what some have described as a "depressive society". Certainly, in those nations sometimes described as "developed," we can observe that the dominant secular culture in this twenty first century has scant understanding of suffering because of its horizontal preconceptions and the closed paradigms of materialism and individualism. This dominant culture has a profound impact on our understanding and way of life. The necessity of an *evangelisation of culture*[17] is one of the most important tasks before us as Church.

Addressing the theme of social sin, Pope John Paul observes: "...by virtue of human solidarity which is as mysterious and intangible as it is real and concrete, each individual's sin in some way affects others. This is the other aspect of that solidarity which on the religious level is developed in the profound and magnificent mystery of the communion of saints, thanks to which it has been possible to say that "every soul that rises above itself, raises up the world."[18]

Drawing these observations together, there is no doubt about the importance of our striving for holiness as a personal and a social imperative. We already have the grace we need to co-operate with the call to holiness. Our striving leads us to seek to be fully reconciled[19] with the Lord, regaining our inner harmony, health and self-mastery in a deep experience of communion with God, ourselves, others and with nature.

Depression

We turn now to a more immediate consideration of the topic of depression. It would be totally unfair, untrue, and harmful to suggest that all the suffering we experience is a consequence of our own particular sins. However, the particular sins of each of us influence the fabric of the human community of which we are part. We suffer the consequences of evil acts, whether our own or those of others, and this kind of "solidarity in sin" extends to the whole human family.

During this conference we are addressing the specific human experience of depression which in its complex reality affects vast numbers of persons, and is the

cause of incalculable and frequently intense suffering. Faith reflection on this ubiquitous human problem cannot fail to explore its meaning and seek for remedies within the context of a Christian anthropology. This perspective both invites and challenges a rich dialogue with the fields of medicine, psychiatry, psychology, and social science. Fifty years ago Pope Pius XII in a discourse regarding the appropriate orientation of Psychology and Psychotherapy noted that: "...man is a transcendent unity in tendency toward God" – *(L'homme comme unité transcendante en tendance vers Dieu)"*.[20] This affirmation proposes a truth about the human person that needs to be regarded as the corner stone of all else that we say concerning human health.

According to the American National Institute for Mental Health, "a depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression."

Throughout this address I refer to "depression" with this descriptive definition in mind and drawing upon biblical data that confirms our understanding of depression as a complex bio-psycho-spiritual experience.[21] Some data and observation from the world of science will be instructive as to the extent of the disorder and its relationship with the spiritual and religious dimension of the person.

According to a recent "Psychological Bulletin" published by the American Psychological Association: "Depression and depressive symptoms are among the most common of all mental disorders and health complaints. Throughout the world, as many as 330 million people may suffer from depression at any given time, with prevalence estimates ranging from 2%-3% for men and 5%-12% for women (American Psychiatric Association, 2000). Approximately 20 million visits to physicians in 1993-1994 involved reports of depressive symptoms (Pincus et al., 1998)."[22] If these numbers represent an accurate description of the extent of the phenomenon, they challenge us to look deeply at our readiness to respond to this specific kind of suffering of so many brothers and sisters in our *particular churches*.

In an informative research article published in *The Canadian Journal of Psychiatry,* March 2002, entitled "Canadian Psychiatric Inpatient Religious Commitment: An Association with Mental Health," we find the following research results: "A total of 59% (of the research sample) believed in a God who rewards and punishes, 27% had a high frequency of worship attendance, 35% prayed once or more daily. More frequency of worship attenders had less severe depressive symptoms, shorter current length of stay, higher satisfaction with life, and lower rates of current and life time alcohol abuse, when compared with those with less frequent or no worship attendance. In contrast, private spirituality was associated with lower depressive symptoms and current alcohol use only, and prayer frequency had no significance associations".[23] The information captures our attention.

In research reported in the "Handbook of Religion and Health" concerning the role of health and religious professionals in interaction with patients in hospitals in the United States, evidence is given regarding the positive influence of religion in the healing process. Speaking of health professionals it is said: "After... reviewing the research on religion and health, we explored the implications of this research for doctors (medical physicians, psychiatrists, and psychologists) and for other health professionals (such as nurses, social workers, counsellors, and physical and occupational therapists). We focused on how the research findings apply to the everyday work of caring for patients... Medical education is increasingly training physicians to address the religious and spiritual needs, or at least to consider the religious backgrounds of patients when making decisions about health care".[24]

Regarding religious professionals, we read in the same research: "The research that demonstrates a link between religious or spiritual factors and health, particularly mental health, has significant implications for clergy. This is especially true for chaplains because of the increasing pressure placed on them by hospital administrators to demonstrate the impact of their work on health outcomes. The research has shown us that the vast majority of patients, both medical and psychiatric, have religious and spiritual needs that likely impact their ability to cope with illness and affect the speed at which they recover. Chaplains are uniquely positioned to meet spiritual needs of patients, and they are the only professional in the health care setting that is trained to do this".[25]

The infiltration of secular humanism into many aspects of academic life has significantly impeded the presentation of a religious or Christian perspective of the human person. Especially in many medical and nursing schools, there is an absence of a solid theologically grounded understanding of suffering and of hope. It is also true that a general understanding of the bio-psycho-spiritual unity of the person has been greatly diminished. These are cogent and compelling reasons for us to seek new opportunities to make present to the world of science, medical education and practice the rich heritage of Christian anthropology.

While depression has risen to a new prominence in our age, it is not a phenomenon that is peculiar to our times. The early monastic tradition generated some especially interesting approaches to depression. Terms like "sadness" or the trilogy of characteristics of

"acedia-sloth-sadness" associated with depression are very well described and treated in the monastic experience of earlier times in the Church, as for instance in spiritual masters like John Casian.[26] Early monasticism sometimes viewed the experience of depression in association with capital sins and prescribed for its cure the biblical remedies of conversion of mind and heart.[27]

For multiple and complex reasons there is an explosive emergence of depression-related illness in our present time. While clearly a medical and mental health concern, this also points to a cultural crisis that requires attention. Depression is an illness that affects particular people, but we also need to take stock of the cultural references that may contribute to the disorder. The cosmic vision and manner of understanding and interpreting life are significant contributory influences to depression. Secularism, postmodern relativism, hedonism and the different epistemological crises prevalent in many sectors of contemporary society generate a culture that places people at high risk of a loss of meaning in life and a consequent state of hopelessness.

On a cultural level, we find a "functional agnosticism"[28] in the understanding and lifestyle of many men and women of our time. Many people, including those who profess religious adherence, live as though faith has no relevance to the real issues and questions of life. At the level of concrete daily life, they conduct their lives according to the closed horizons of rationalist functionalism. The criteria and values of this "functional agnosticism" are closed to the Gospel. Also, the quest for comfort and sensate gratification as ultimate goals in this culture truncate the human yearning for the infinite. Together, these factors build a real "culture of *acedia*" in which the inner dynamism that seeks transcendence and profound meaning in life are dormant. The result is a certain renunciation of human identity.

In stark contrast to this functional agnosticism is the vision of a Christian anthropology that regards the human person as created by God and called to participate in God's own being and divine love. The dynamism present at the core of our being orients us to seek for ultimate happiness and profound meaning. Living and acting in accord with this dynamism opens our horizons to the infinite and the quest for the fullness of life. When the human spirit is formed in this vision, we become alert to the call in our inmost depths to respond with freedom to the Lord.

Influenced by the "culture of death" many people in the world today either reject or ignore the quest for the infinite. Consequently, there is a diminishing understanding of the meaning of suffering from a Christian perspective and a withering of the ground of hope. An eclipse of coherent belief in the mystery of the Incarnation leads to an impoverished understanding of the goal and potential of human existence. Lacking an adequate self-understanding, and with a weak or absent theology of the cross and its promise of a share in the joy of the Resurrection of the Lord Jesus, many of our contemporaries become prey to the seduction of the culture of death.

With horizons closed to what lies beyond the horizontal plane of existence, the dominant secular culture leaves us with an incapacity to face pain, suffering, or any form of discomfort. In combination, the premises of this culture close out the possibility of a dialogue with the deeper implications of human experience, leaving only a form of superficial psychologized self-understanding that does not have the capacity to propose adequate or lasting remedies for the disorder of depression. Even in these circumstances, the quest for wellbeing continues to emerge as a deep impulse of the human heart. In the timeless words of Saint Augustine of Hippo we discover the depth of psychological and spiritual wisdom of Catholic tradition concerning this quest when he writes in the opening meditation of his confessions: "...you have made us and drawn us to yourself, and our heart is restless until it rests in you."[29] It is only in the discovery of God and the gracious design of providence that the human striving for ultimate happiness and completion can be realized. In affluent societies this reflection regarding the quest for happiness is a fruitful way to invite people to rekindle the search for truth and for God.

Bio-Psycho-Spiritual Illness

Depression is a disorder, an illness. The term "depression" is not properly applied to a light or even an intense state of sadness, if it is situational and transitory. Everybody at one time or another experiences sad or blue moments. The disorder we call depression has characteristic symptoms. For clarity in this presentation I will summarize from the professional descriptions available to me the chief indicators or symptoms by which the illness is recognized.

There seems to be agreement in the scientific literature that in order to consider a person to be suffering from the illness of depression, several of the following symptoms would need to be simultaneously present for a significant period of time (minimally one week):

Persistent sad, anxious, or "empty" mood; feelings of hopelessness, pessimism; disproportional feelings of guilt, worthlessness, helplessness; loss of interest or pleasure in hobbies and activities that were once enjoyed; decreased energy, psychomotor retardation or agitation, fatigue, being "slowed down"; difficulty concentrating, remembering, making decisions; insomnia, early morning awakening, or over-sleeping; appetite and/or weight loss or over-eating and weight gain; panic or anxiety attacks; thoughts of death or suicide, or suicide attempts; restlessness or irritability; persistent physical symptoms that do not respond to treatment such as headaches, digestive disorders, and chronic pain.[30]

Even a cursory view of the noted symptoms reveal what a burdensome load this disorder constitutes for someone suffering

from it, especially if there is no "meaning" for the experience.

Studies reveal that certain types of depression run in families, indicating that inheritance may play a role in contributing to biological vulnerability to the disorder. Families in which members of successive generations suffer from bipolar disorder show that those who have the illness manifest a somewhat different genetic makeup than those who do not become ill. Curiously, the reverse is not true; not every family member who has the genetic vulnerability to bipolar disorder necessarily has the illness. This seems to indicate that other factors such as stress may be the precipitating cause of the onset of the illness. While there is evidence of generational transfer of major depression in families, it can also occur in people who have no family history of the disease. The disorder is often associated with changes in brain structures or brain function. Frequently, the onset of depression is triggered by a combination of genetic, psychological, and environmental factors, in particular intensely stressful events or situations. Subsequent episodes of the illness may be triggered by only mildly stressful experiences, or even none at all. Whatever the cause or precipitating circumstances for the onset of depression, the role of religious experience and firmly held convictions of faith occupy a key position in the restoration of mental balance and healing from the disorder.[31]

Saint Paul offers us an anthropology that is clear in its definition of what he calls *"pneuma"* (spirit) as distinct from – *"psiqué"* (soul), *"kardia"* (heart), and *"nous"* (mind). He also distinguishes "pneuma" from those aspects of the person which he names *"soma"* (body) and *"sarx"* (flesh). The significance of these distinctions is that they give foundation to the theological and philosophical tradition that considers *"pneuma",* the spiritual element of our anthropology, as constitutive of the human reality and different from our psyche and/or reason. For instance, we read in Paul's letter to the Thessalonians: "May the God of peace make you perfect in holiness. May He preserve you whole and entire, *spirit, soul, and body*, irreproachable at the coming of our Lord Jesus Christ".[32] The Augustinian and Thomist traditions also witness to the value and singular presence of the "spirit" or "anima" in the human being as distinct from the body, from reason and from emotions.

Refinements and development of these and similar subtle distinctions in anthropology are beyond the scope of this presentation. I mention them only in support of the proposition that the human person needs to be considered as a "bio-psycho-spiritual" unity. Failure to maintain this perspective is what contributes most to the incompleteness of some contemporary psychological theories. Regarding the human person as a unity of all three elements or dimensions calls for taking each aspect seriously and seeing them in their interconnected relationship and meaning.

For any discourse on illness and healing to be complete, the totality of the elements or aspects that constitute the human person need to be considered. The "bio-psycho-spiritual" dimensions of a human person are different aspects of our anthropology, always united and in total interactivity. In this vein we might take account of the impact of God's grace and the power of the Sacraments as important factors that contribute to achieving and maintaining psychological and bodily health, in addition to their immediate spiritual effects, as we can witness in pastoral experience. There are demonstrable instances in daily pastoral life of authentic healings that come about by someone accepting the Word of the God, by receiving the grace of the sacraments, by prayer, or by performance of the works of mercy. While consideration must also be given to the power of autosuggestion, clearly the influence of grace accomplishes marvellous things.

For a thorough understanding of depression, all of these elements of the human person must be considered. Even with a firm grasp of the "bio-psycho-spiritual" unity of the person, there remains a further risk of separating out one or other of these dimensions. This is what we might call a psycho-spiritual reductionism. One can deny or minimize the physical or biological aspects of depression. No matter what causes an episode of depression, all the three elements of the person are affected and need to be treated. While avoiding a bio-psychological bias in treating depression, it is also important to avoid psycho-spiritual ones. There is a biological and organic aspect of depression and it needs to be included in any adequate approach to understanding or treating the disorder. At times psycho-spiritual problems may have a somatic cause, as in other cases physical disorders may have a psycho-spiritual foundation. The point here is that all three dimensions of the human person relate in a constant interaction and one cannot treat one aspect without having an impact on the others. Clinical experience shows that in treating certain forms of depression appropriate medication may be the most effective first response, followed by psychological, spiritual and communitarian support that allows the patient to regain their health and inner equilibrium.

It is important to note that there are many and varied causative influences that contribute to depressive disorders. At times a person may simply experience the confluence of demands and situational pressures in life as beyond one's capacity to sustain. Especially, when one's circumstances of life lose their significance and

the structures that support meaning are weakened, intense pressure or stress can bring on a depressive response. The process has its own dynamism and whether or not the person is conscious of the lack of adequate support in his personal environment and framework of meaning, the consequence is a situation of disequilibrium.

As someone suffering from depression becomes more aware of their need for support and regains the ability to assess their situation with some objectivity, recovery becomes much more probable. In most cases in which the disorder persists, it seems to be related to the inability to escape from a completely subjective perception of the factors that cause us pain.[33]

Processes and methods of interpreting one's experience are frequently a more relevant consideration than the simple presence of stress factors. It is not uncommon for depression to be triggered by intense personal frustration occasioned by unrealistic expectations of our performance, by false interpretations of reality, by internalizing feelings of inferiority or inadequacy, or by clinging to inappropriate aspirations incapable of fulfilment. Other factors that may play a significant role in contributing to depression, particularly in the values of the current dominant culture are the inordinate stress on the perfection of bodily image, pressures to excel achievable models of physical performance as we see in the world of sport competitions, an inordinate assessment of the value of material wealth, success, fashion or pleasure.

While there are many organic causes and consequences of depression, the rediscovery of an integrated Christian vision of the person and of society holds an immense potential for effective responses to this disorder. The objective and hopeful interpretation of personal life and of social realities that Christian belief brings offers a powerful antidote to the frenetic pressures in a secularized world. To discover meaning in life and its struggles, and to interpret one's personal and social framework with evangelical criteria offer powerful sources for authentic healing. Different therapies need to keep in mind the essential unity of the human person, and the potential for growth and positive change. This process of interior transformation, which in biblical language is called "*metanoia*," points to the capacity in the human person for profound personal change through the action of grace working upon the mind and the heart. This interior conversion or "*metanoia"* leads to a reconfiguration of feelings and the evangelisation of our behaviour.[34]

Pastoral Reflections

Some of the new expressions of the action of the Holy Spirit in the Church today, such as the rise of new ecclesial movements and new communities of Christian life, hold great promise in terms of addressing the real and urgent needs of our day. In many of these movements there is a developed sensitivity for understanding the influence and impact that secular culture and its values bring to bear on life in the contemporary situation. The new ecclesial movements offer promising interpretations, creative solutions and pastoral insights to many contemporary challenges.[35] Various insightful pastors have understood this interesting evidence of the work of the Spirit in our day, providing us with thoughtful and engaging studies.[36]

What we find in some of these movements is a re-discovery of the ancient wisdoms of the Church brought forward with new vigour and in new expressions. The ardour with which these new "ecclesial expressions" interact with the culture creates what at times is a powerful source of deeper comprehension of certain challenges and problems of our day. This is especially true of those movements which have embraced the importance of solidarity, communion, and compassionate understanding of the suffering that results from the absence of meaning.

Some of the successful experiences we have witnessed in the life of certain new communities can be related to the intensely hopeful vision of life that is fostered by their integration of the perspective of faith into daily life. This is much more than a mere cheerfulness or optimism. Nor is it a matter of measuring the greater or lesser incidences of depression amongst adherents of the movements. What they offer is a clear spiritually informed and grounded understanding of life that draws upon the fonts of meaning in the confession of Christian faith. Alert to God's pedagogy in daily problems and struggles, they foster a strong cli-

mate of mutual accompaniment among their members. Some of these movements seek to recreate the life of the first communities who celebrated their faith in Christ – crucified and risen in glory, living profound bonds of solidarity and loving communion.[37]

I would like to mention some means or ways drawn from pastoral experience in the life of the new movements that seem to hold special promise for our focus on the disorder of depression and the quest for wellbeing:

a. Conversion of the mind and heart – the experience of *"metanoia":* "Transform yourselves by the conversion of your mind...". In the permanent contact with cultural aggression some movements have developed clear Catholic positions and criteria for the formation of their members. We note the concern and the contribution of many of the founders of these movements for the analysis of contemporary culture, and the proposal of effective pastoral solutions to various crises and problems.

b. Emphasis on a vibrant spiritual life, growing in an effective and affective relationship with the Lord. Different methodologies or spiritualities are espoused by various movements, but with real ardour.

c. Sacramental Life: promoting an openess to the grace of God as a source of strength in daily life.

d. Appreciation for the beauty and power of the Church's liturgy to evangelize and transform our lives by bringing us into contact with the most sacred realities

e. Sustained encounter with the Word of God which as a "two-edged sword..." penetrates and shapes our thoughts, feelings and actions according to the mind of the Lord.

f. Living life as a celebration. This is expressed in the joy of being in community, by the production of art and music and poetry, and in the consecration of temporal realities to God's purposes.

g. Clearly identifying the role of the community in the Church and heeding the universal call to holiness through different ministries and vocations.

h. Commitment to solidarity with needy people and those who are suffering.

i. Fostering a realistic position before life that is rooted in a mature faith and hope. Integrating faith with the challenges and difficulties of daily life within a broad understanding of life according to the gospel.

j. Deep experiences of reconciliation and of self-acceptance.

k. The integration of personal talents with professional, technological and secular formation for the transformation of culture according to God's plan. Heightened awareness of the importance of work.

l. Faithfulness to the Church, her Magisterium, and her pastors.

m. Creativity in methods of evangelisation.

n. Seeking to have an undivided Catholic heart; loving the Church and thinking with her.

o. Engagement with the apostolic endeavours of the Church.

p. Commitment to life in community, marked by a joyful openness to new members. Friendship fostered as a motivational and ascetical way to conversion.

q. Formation of those members called to Holy Orders that is consistent with the spirituality of the movement; fostering sound homiletic, intellectual, spiritual and pastoral training.

r. Embrace of a well-grounded Mariology that understands and promotes the role of our Blessed Mother in the lives of the members.

s. Cherishing and supporting the family as a "school of virtue" and as the locus for a strong commitment to the Church and in testimony of love to the culture.

t. Coherent witness of life in secular environments. Living life in a positive and hope-filled way while engaging the struggles of the day as a means to evangelize the culture.

u. Knowledge and use of traditional and new methodologies within the Church's life.

v. Openness to spiritual accompaniment or spiritual direction.

Most of the ways and means of life mentioned above are concrete, appealing and attainable for almost any person seeking the experience of Christian community. When embraced, these methods - "always old and always new," hold great promise for the rebuilding of our parishes and communities with a new Gospel-rooted vitality. The importance of the formation of an authentic Christian community is that it provides an environment for personal and communal growth. It also creates a climate in which healing from the wounds and stressful experiences of life, is enhanced through the wisdom of a faith imbued vision of the "mystery of man." Faith, and its communal expression in community does not dissolve the tensions of life, but it offers a pathway to that destination which lies ahead of us and for which we yearn with certain hope. In the rich and profound insight of Monsignor Luigi Giussani about the nature of the Christian community we read: "Alone, we cannot be ourselves. The company, which will be called the Christian community, is essential for man's itinerary. ... The Christian concept of human existence foresees that the human community will never wholly adhere with its freedom to the condition to which Jesus harkens us. Therefore, the life of humanity in this world will always be sorrowful and confused. But the task of those who have discovered Jesus Christ – the task of the Christian community – is precisely to bring about, as much as possible, the solution to human problems on the basis of Jesus' call."[38]

Our parishes and communities need to become more fully conscious of their role as centres of meaning, and as places for healing and belonging. The joy and purpose that comes from an engaged life of faith, the strong bonds of solidarity and communion, and a vibrant awareness of the presence of God are potent features in the life of a Christian community that diminish vulnerability to the ravages of stress and depressive disorders. Special pastoral attention might be given to the formation of counsellors who are well versed in the human sciences and in theology so as to be ready to offer effective help to the growing number of persons who

struggle with depression and the management of high levels of stress in their lives. We need the very best of insights, the most effective therapies that science can offer, but even more, we need the certainty and joy of faith in the mystery of the Incarnation as the event which has transformed history, the truth of which we are called to recognize with love. "The task of the Christian is to fulfil the greatest function in history – to announce that the man, Jesus of Nazareth, is God."[39] To take this mystery seriously means that the struggles and problems of life as expressions of the reality of the world are not foreign to faith or to the intervention of God.

Humility and Hope

Precisely because of God's choice to send His Son to us in concrete human nature, we need to recognise and accept the totality of our human condition with all of its fragility and potential for greatness, with its misery and its dignity, as aspects of the profound mystery of humanity. To live in this truth of our real identity before God, the source and origin of our being, is to be like the Virgin Mary – humble and free in the complete acceptance of her status as a creature, entirely open to God.

The virtue of humility is indispensable in the healing process because it opens the suffering person to the profound meaning of his experience, and elevates the human struggle to its highest dimension as the yearning for the fullness of "salus-health-salvation".[40] We recall that magnificent passage in Matthew's Gospel where Jesus tells us: "Come to me, all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me; for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light."[41]

Every person who is willing to enter into the depths of his humanity through suffering, discovers on the one hand a desire for fullness and infinitude, and on the other – his fragility and contingency. In the experience of our own frailty and vulnerability we discover that whatever physical, psychological or spiritual limitations we encounter, the Lord invites us to respond to his call and to find in him our strength and salvation. The truth of our humanity is revealed to us by suffering in that it brings us to the source of truth, "the Word was the real light that gives light to everyone".[42] Hope is the gift and promise of our encounter with the Incarnate Word. This encounter is the opening to our true life, as so eloquently expressed in the Council document on the Church in the Modern World:

"He Who is "the image of the invisible God", is Himself the perfect man. To the sons of Adam He restores the divine likeness which had been disfigured from the first sin onward. Since human nature as He assumed it was not annulled, by that very fact it has been raised up to a divine dignity in our respect too. For by His incarnation the Son of God has united Himself in some fashion with every man. He worked with human hands, He thought with a human mind, acted by human choice and loved with a human heart. Born of the Virgin Mary, He has truly been made one of us, like us in all things except sin. As an innocent lamb He merited for us life by the free shedding of His own blood. In Him God reconciled us to Himself and among ourselves; from bondage to the devil and sin He delivered us, so that each one of us can say with the Apostle: The Son of God "loved me and gave Himself up for me". By suffering for us He not only provided us with an example for our imitation, He blazed a trail, and if we follow it, life and death are made holy and take on a new meaning".[43]

What we said earlier concerning the mystery of suffering is brought to its fullest meaning when we understand our experience as a participation in the life and suffering of Christ. Without meaning, suffering crushes us and drives us to despair. Set in the light of Christ's suffering love on the Cross, our suffering becomes a means to bring us beyond the limits of our finitude. It remains, nonetheless profoundly mysterious. Pope John Paul captures this exquisitely when he writes:

"…Human suffering evokes *compassion;* it also evokes *respect,* and in its own way *it intimidates.* For in suffering is contained the greatness of a specific mystery. This special respect for every form of human suffering must be set at the beginning of what will be expressed here later by the deepest *need of the heart,* and also by the deep *imperative of faith.* About the theme of suffering these two reasons seem to draw particularly close to each other and to become one: the need of the heart commands us to overcome fear, and the imperative of faith – formulated, for example, in the words of Saint Paul quoted at the beginning – provides the content, in the name of which and by virtue of which we dare to touch what appears in every man so intangible: for man, in his suffering, remains an intangible mystery."[44]

Conclusion

The object of pastoral care in the presence of human suffering is ultimately to nourish that hope that is born of the Gospel. This is the hope that does not disappoint.[45] Walking humbly on the journey of life with our fellow travellers, we are all subject, one way or another, to the burden of suffering and pain. Taught by the mystery of Christ's Cross, we are invited to embrace our human struggle as the pathway to that fullness of life that is our deepest longing. This is what we have called the divine pedagogy of the Cross. The voice of love calling out to us from the One who hangs upon the Cross, invites us to respond, to accompany Him in His anguish, to look with Him beyond the limits of the encroaching darkness to where the brilliant light of eternity shines upon us. This is the call of the Infinite that stirs us to the utter depths of our existence.

Nourished by the divine promises, the Christian, aware of being a pilgrim in this earth, lives in a permanent "tension-toward."

Relying on Christ's promises and not on our own strength we move forward through the dark mystery of suffering enlightened by Christ. Even in the midst of trials and suffering we are offered joy in the sure knowledge that God is with us and that our cries are heard. Yearning with all our strength for the fullness of life and wellbeing, we turn to the Lord of life, saying:

Hope, O my soul, hope. You know neither the day nor the hour. Watch carefully, for everything passes quickly, even though your impatience makes doubtful what is certain, and turns a very short time into a long one. Dream that the more you struggle, the more you prove the love that you bear your God, and the more you will rejoice one day with your beloved, in a happiness and rapture that can never end.[46]

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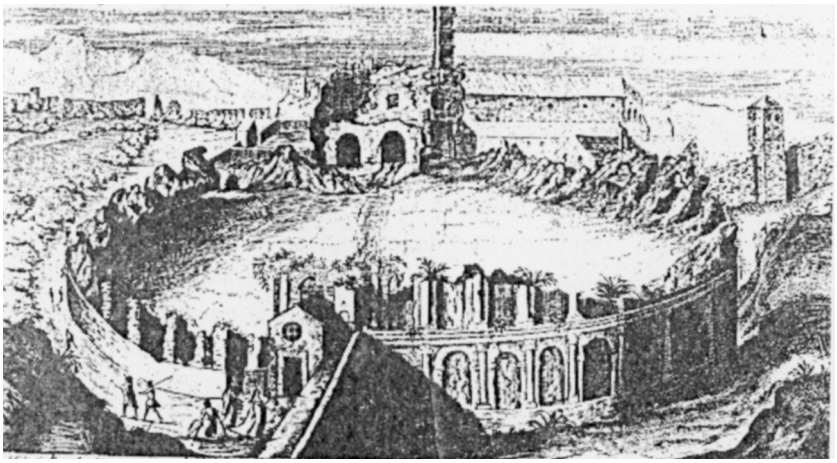
Notes

[1] *Salvifici Doloris,* 2
[2] *Evangelium Vitae,* 12
[3] *Gaudium et Spes,* 10
[4] *Phil* 2, 6-7
[5] *Col* 1, 24
[6] *Salvifici Doloris,* 1
[7] *Puebla Document,* 15
[8] *Confessions* I,1,1, SAINT AUGUSTINE OF HIPPO.
[9] *Crossing the Threshold of Hope,* JOHN PAUL II, translated by Jenny McPhee and Marth McPhee, (Canada: Alfred A. Knopf, Inc., 1994), p. 180.
[10] *Gaudium et Spes,* 20; *Redemptoris Missio,* 14c; *Dominum et Vivificantem,* 29b.
[11] *Puebla Document,* 185-186
[12] *Puebla Document,* 281
[13] *Reconciliatio et Paenitentia,* 7; cf *Rom* 5, 10f; cf Col 1, 20-22
[14] *Reconciliatio et Paenitentia,* 15
[15] *Libertatis Conscientia,* 38, Congregation for Doctrine of Faith.
[16] *Evangelium Vitae,* 12; cf. *Wis.* 1, 13-14; cf. Wis. 2, 23-24
[17] *Centesimus Annus* 50b
[18] *Reconciliatio et Paenitentia,* 16
[19] *Reconciliatio et Paenitentia,* 22
[20] S.S. PIUS XII, Discourse to V International Congress of Psychotherapy and Clinical Psychology, 15-4-1953: AAS 45, (1953), P. 284
[21] *1 Thes.* 5, 23.
[22] *Psychological Bulletin* 2003, Vol 129, N.4, 614-636.
[23] *Canadian Journal of Psychiatry,* vol 47, N.2, March 2002.
[24] *Handbook of Religion and Health.* HAROLD KOENIG, MICHAEL MC CULLOUGH, DAVID B. LARSON. Oxford 2001.
[25] Op. Cit.
[26] *Institutiones.* JOHN CASIAN. Rialp. 1979.
[27] *Rom* 12, 2.
[28] *Nostalgia de Infinito,* LUIS FERNANDO FIGARI. E-book. Ve Multimedios, Lima 2002. P. 28-29.
[29] ST. AUGUSTINE OF HIPPO, *The Confessions.* Book 1, no. 1.
[30] National Institute of Mental Health, Publication No. 02-3561, Printed 2000.
[31] International Center for the Integration of Health & Spirituality. *Research Approaches.* Jan/2003.
[32] *Thes.* 5, 23
[33] *Lazarus,* 1991b, p.112
[34] *Rom* 12, 2. Mc 1, 15. *Redemptoris Missio* 59a. *Redemptor Hominis* 16h, 20e.
[35] JOHN PAUL II, Discourse 29-9-1984; Homily at the Vigil of Pentecost 25-5/1996, 7.
[36] CARDINAL JORGE MEDINA ESTÉVEZ, when Archbishop of Valparaíso. *Apuntes sobre el tema de los movimientos eclesiales.* Valparaíso-Chile. 1994.
[37] *John Paul II and the Ecclesial Movements, Gift of the Spirit.* German Doig Vida y Espiritualidad. Lima 1998. P. 46-58.
[38] LUIGI GIUSSANI, *At the Origin of the Christian Claim*, translated by Viviane Hewitt (Montreal & Kingston: McGill – Queens University Press, 1998), pp. 96, 98.
[39] LUIGI GIUSSANI, *At the Origin of the Christian Claim*, p. 107
[40] CARDINAL LOZANO BARRAGAN. *Teología y Salud.*
[41] *Matthew* 11, 28-30
[42] *John* 1, 9.
[43] *Gaudium et Spes,* 22.
[44] *Salvifici Doloris,* 4.
[45] Cf. *Romans,* 5:5.
[46] ST. TERESA OF AVILA, *Excl.,* 15:3.



5. Inter-religious Dialogue: the Meaning of Depression and Existential Malaise Seen from the Perspective of Religion

ABRAMO ALBERTO PIATTELLI

5.1 The Jewish Vision

According to experts, the causes of depression are not completely clear. A large number of factors work together to bring it about: a genetic predisposition, socio-environmental factors and psychological factors. Situations of hopelessness, worry, marginalisation, alienation, pain, and mourning bring about this condition, which, indeed, is so frequent nowadays.

In this paper I would like to refer to cases of depression that are to be found within the Jewish community and to try to identify its causes and focus on the contribution that Judaism can offer to a solution to this problem in the light of its millennia-old tradition

From an examination of the condition of a depressed person, what most provokes anxiety and interest is to see that in such a person every vital dynamism is suppressed and this is translated into a strong diminution in that person's interests and initiatives; indeed, to the point of reducing the activity of the subject to a state of complete inhibition.

This is a condition, to tell the truth, that is the outcome of a journey that has led the individual to detachment from the society that surrounds him, to his marginalisation from the group in relation to which he should have sought to strengthen his ties and interests.

In a society in which individualism is exalted and relationships between people are limited, every individual runs the risk of being alienated and isolated by society.

In this dramatic context we would do well to remember the words of Holy Scripture: 'it is not good that man is alone'. According to the Creator, it is not good to exist alone.

From a theological point of view, the human community works against the loneliness of man and the loneliness of God. Thus it is that a Midrash states: 'since the first day of the creation the Holy One, may He be blessed, has wanted to enter into communion with the terrestrial world and live amidst the creation together with His creatures'.

A philosopher of our time, L. Fuerbach, in analysing the diological doctrine of Martin Buber, stated among other things that 'the human being, taken individually, is not in himself the essence of man, both as an ethical and a thinking being'. This essence is to be found in the unity of man with his neighbour.

Every Jew who leads an existence according to the dictates of tradition knows how close the relationships are that link him with society as a whole. In the same way, society as a whole cannot ignore the condition of the individual human being but must, rather, see him as an integral part of itself.

National memories unite all Jews and support them in their mission. The same may be said of daily religious practice, which ensures that a bond exists between all the members of the community. For a Jew, the bond with the community is essential. The whole of Jewish practice is constructed in such a way that the individual finds his proper role in that community.

Let us examine, for example, what Rabbi J.D. Soloveitchik defines as the 'community of prayer'. By this he means a community united in shared pain, in shared suffering, and also in shared joy. According to the Jewish tradition, the language of prayer must always be in the plural so that the praying person always associated his own neighbour with the supplications that are expressed. Individual prayers, that is to say those expressed at times of illness, mourning or other critical moments, must also be expressed in the plural. A person afflicted by mourning receives the prayer: 'may the Almighty console you together with those that suffer because of the fate of Zion and Jerusalem', while a sick person receives the prayer: 'I pray that healing be sent to this person and to all sick people'. In this way the whole community takes upon itself the suffering of another person and works for his reconnection with the community.

Each of the practices of Judaism has a socialising value. The celebration of the various religious events works to exalt the meaningful participation of each individual.

For example, the celebration of 'Kippur', the day of atonement when the community passes the whole day in reflection, in fasting, and in prayer, to seek forgiveness both from God and men, is an important opportunity to re-establish ties between all the members of the community, in solidarity and in the reaffirmation of a shared destiny.

Without doubt, the celebration of 'Seder', the paschal supper, when every Jew relives the ancient experience of slavery in Egypt and his liberation, is an important moment both for the individual and for society as whole. This is a process involving the actualisation of past events in which every participant is called to express his own questionings and offer answers about the meaning of this celebration.

The correlation that exists between the individual and society, and the obligations that derive from this correlation, are the foundation of the whole of Judaism.

During our time, in which the most evident symptom of depression lies in the marginalisation of the individual and his non-relevance within society, the Jewish tradition emphasises the value of the participation of the individual in the life of the community, precisely because in this context man is called by his destiny to manifest all his dignity. The concern of the community in relation to the individual who suffers from depression involves freeing this person from worry, paralysis and desperation.

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KAMEL AJLOUNI

5.2 Depression and Treatment in the Light of the Koran and the Sunnah

God has shown in His Glorious Book and the holy prophet Muhammad – peace be on him – has pointed out numerous guidelines which would protect a believer from depression and many psychological disease before their incidence, provide him with immunity against such aliments and lead him through to recovery and deliverance if he fell victim to them.

It is true that medicine has achieved a tremendous advancement in the treatment of bodily diseases, but psychological diseases which have proliferated with the progress of materialist civilization cannot be treated and resisted, nor can man have the immunity and power to counter them with modern medicine, despite its tremendous advancement: psychological diseases also need to be addressed through belief in Great God and His Most Beautiful Names.

This will be clarified in the following paragraphs:

1. Conception of divinity in the Glorious Koran. Its Effect on Psychological Health: God is the Lord of all worlds, Most Gracious, Most Merciful. These are among the attributes and most beautiful names of God which a Muslim believes in and repeats in his prayer and acts of worship and uses as guides throughout his life. These attributes fill a believer's heart with the love of his Lord who looks after him, bestows his blessings on him and extends his mercy to him. If a believer does good, God will be more benevolent towards him, and if he does wrong God will open wide the door for him to enjoy his forgiveness and enables him to repent, correct his behavior and return to his Lord. God-be He exalted – says in this respect:

(قل يا عبادي الذين أسرفوا على أنفسهم من رحمة الله إن الله يغفر الذنوب جميعاً إنه هو الغفور الرحيم)

(Say: "O my Servants who Have transgressed against their souls! Despair not of the Mercy of God: for God forgives All sins: for He is Oft-Forgiving, Most Merciful". (Surat al Zumar39, verse 53)

The main reason why man collapses before life's stresses, strains, demands, fears and risks is that he does not find the shelter and safe haven where he will find his tranquility, rest and serenity. True faith is the place of refuge and haven within which a believer hears the call of his Lord who says:

أم من يجيب المضطر إذا دعاه ويكشف السوء.." النمل /62"

(Or, who listens to the (soul) Distressed when it calls On Him, and who relieves. Its suffering) (Surat al-Naml, 27, verse 62)

God be He exalted also says:

وقال تعالى" قل من يرزقكم من السماء والأرض أم من يملك السمع والإبصار ومن يخرج الحي من الميت ويخرج الميت من الحي ومن يدبر الأمور، فسيقولون الله، فقل أفلا تتقون" يونس/31.

(Say: "Who is it that Sustains you (in life) From the sky and from the earth? Or who is it that Has power over hearing And sight? And who Is it that brings out The living from the dead And the dead from the living? And who is it that Rules and regulates all affairs? They will soon say, "God". Say, "Will ye not then Show piety (to him)?" (Surat Viunus, 10,verse31)

He also says:

قل من ينجيكم من ظلمات البر والبحر تدعونه تضرعاً وخفية لئن أنجانا " من هذه لنكونن من الشاكرين، قل الله ينجيكم منها ومن كل كرب ثم أنتم تشركون/الأنعام 63و64.

(Say: "Who is it That delivereth you From the dark recesses Of land and sea, When ye call upon Him In humility And silent terror: 'If He only delivers us From these (dangers), (We vow) we shall truly Show our gratitude'? "Say: :It is God That delivereth you From these and all (other) Distresses: and yet Ye worship false gods!" (Surat al-An'am 6, verses 3,64)

The dark recesses of land and sea here means their horrors and the hardships, disasters and risks to which man is exposed.

The Glorious Koran has drawn attention to cases where man breaks down when he is deprived of a blessing or when beneficence and mercy are restored to him, and how a believer holds firm to patience when he loses a favor and resorts to thanking God when he enjoys this favor. God be He exalted says:

ولئن أذقنا الإنسان منا رحمة ثم نزعناها منه إنه ليؤوس كفور / ولئن أذقناه " نعماء بعد ضراء مسته ليقولن ذهب السيئات عني إنه لفرح فخور / إلا الذين صبروا وعملوا الصالحات أولئك لهم مغفرة وأجر كبير" هود 9-11

(If We give man a taste Of Mercy from Ourselves, And then withdraw it from him, Behold! He is in despair And (falls into) blasphemy. But if We give him a taste Of (Our) favours after Adversity hath touched him, He is sure to say, "All evil has departed from me: Behold! He falls into exultation And pride. Not so do those who show Patience and constancy, and work. Righteousness; for them Is forgiveness (of sins) And a great reward. (Surat Hud, verses 9-11)

2. There should be no despair, no despondency. The true believer is fortified by his faith against anything that causes despair, hopelessness and frustration before hardships and ordeals. In this respect he is guided by holy Koranic verses and prophet Muhammad's hadiths (sayings). In this context, God-be He exalted – says:

وإن يمسسك الله بضر فلا كاشف له إلا هو وإن يردك بخير فلا راده لفضله" يصيب به من يشاء من عبادة وهو الغفور الرحيم" يونس/107

(If God do touch thee With hurt, there is none Can remove it but He: If He do design some benefit For thee, there is none Can keep back His favour: He causeth it to reach Whomsoever of His servants He pleaseth. And He is The Oft-Forgiving, Most Merciful) (Surat Yunus 10,verse 107)

3. Following the example of prophet Muhammad-peace be on him-who faced the severest calamities and difficulties without being weakened, yielding or losing heart. In fact he turned misfortunes into gifts, and converted adversity into prosperity. Meanwhile his Lord told him not to fret himself to death while he experienced obstinacy, rejection and harm by his own people. Here Almighty God says to Muhammad:

فلعلك باخع نفسك على آثارهم إن لم يؤمنوا بهذا الحديث أسفاً" الكهف 6 –" ومعنى باخع نفسك: مهلكها

(Thou wouldst only, perchance, Fret thyself to death, Following after them, in grief, If they believe not In this Message) (Surat al-Kahf,18, verse 6)

4. Worship, remembrance of God, supplication and sincere reliance on God. This includes surrendering oneself to God, revival of one's heart by remembrance of God, sincere dependence on God, entrusting one's affairs to Him and expectation of reward from Him; emancipation from the burdens of materialism, from clinging to the embellishments of this worldly life; purification from disobedience and sins that overburden the soul and reduce it to a mere captive of its passions and carnal desires, so that if a person lost these transitory pleasures his life would become oppressive and he would be into the bitterness of affliction and dejection. In this context, Almighty God Says:

فاذكروني أذكركم وأشكروا لي ولا تكفرون/ يا أيها الذين آمنو إستعينوا" بالصبر والصلاة إن الله مع الصابرين ولا تقولوا لمن يقتل في سبيل الله أموات، بل أحياء ولكن لا تشعرون/ ولنبلونكم بشيء من الخوف والجوع ونقص من الأموال والأنفس والثمرات وبشر الصابرين/ الذين إذا أصابهم مصيبة قالوا إنا لله وإنا إليه راجعون أولئك عليهم صلوات من ربهم ورحمة .وأولئك هم المهتدون" البقرة 152-157

(Then do ye remember Me; I will remember You. Be grateful to Me, And reject not Faith. Ye who believe! Seek help With patient Perseverance And Prayer: for God is with those Who patiently persevere. And say not of those Who are slain in the way Of God: "They are dead". Nay, they are living, Though ye perceive (it) not. Be sure we shall test you With something of fear And hunger, some loss In goods or lives or the fruits (Of your toil), but give Glad tidings to those Who patiently persevere, Who say, when afflicted With calamity: "To God We belong, and to Him Is our return": They are those on whom (Descend) blessings from God, And Mercy, And they are the ones That receive guidance). (Surat al-Baqarah 2, verses 152-157).

Belief in the Hereafter and its effect on protection against these disease and the treatment thereof:-

To believe in the hereafter widens the believer's horizon and outlook to life so that he may not suffer from the straits of this world. Thus a true believer is not the one who is contented only when he achieves his worldly aims and if he fails to achieve that, he will feel weak, depressed and ruined and think that he has lost everything.

This is what the Holy Quran draws attention to where God says:

إن الإنسان خلق هلوعاً، إذا مسّه الشر جزوعا، وإذا مسّه الخير منوعا، إلا" المصلين/ الذين هم على صلاتهم دائمون/ والذين في أموالهم حق معلوم/ للسائل والمحروم/ والذين يصدقون بيوم الدين/ والذين هم من عذاب ربهم مشفقون"... إلى قولـه تعالى "أولئك في جنات مكرمون" المعارج 19-35.

(Truly man was created very impatient; Fretful when evil Touches him; And niggardly when Good reaches him; Not so those devoted To Prayer: Those who remain steadfast To their prayer; And those in whose wealth Is recognized right For the (needy) who asks And him who is prevented (For some reason from asking); And those who hold To the truth of the Day Of Judgment; And those who fear The displeasure of their Lord, For their Lord's displeasure Is the opposite of Peace And Tranquillity; And those who guard Their chastity, Except with their wives And the (captives) whom Their right hands possess, For (then) they are not To be blamed, But those who trespass Beyond this are transgressors; And those who respect Their trusts and covenants, And those who stand firm In their testimonies; And those who guard (The sacredness) of their worship; Such will be The honoured ones In the Gardens (of Bliss). (Surat al-Ma'arij, 70, verses 19-35)

In Conclusion:

For the Moslem who has depression he/she should:

1. Seek modern medical advice, since it is the law of Islam that we should seek treatment for every illness because God created a medicine to every sickness except death
2. Believe that God and only God will save him and bestows on him peace and tranquility
3. Attachment to God and believing in him is the only prevention and protection from depression.

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BHARATI PATIL

5.3 The Meaning of Depression and Malaise seen from the Perspective of Hinduism

"A healthy mind has a healthy body". The mental health of the individual plays a significant role in the well being of a person. The WHO also defines health as 'physical, mental and social well being.' During the past two decades interest and research in the field of mental health and mental disorders have grown rapidly. A recent study conducted by the WHO has predicted that in terms of disease burden by the year 2020 (that is in the next seventeen years) depressive illness will become the no.2 disease in the world above diabetes, cancer, arthritis etc.

Depressive disease is universal and has been prevalent in society since time immemorial. Its clinical features were described in ancient Indian literature by Sudarka, a renowned playwright of the sec-

ond century B.C. It figured prominently in the sacred writings of India, its mythological literature, including the twin epics, the Ramayana and the Mahabharata. In the Mahabharata, Arjun was afflicted with the illness. He says, "Mind is very restless, forceful and strong, O Krishna, Krishana it is more difficult to control the mind than the wind."

Mind is the cause for both bondage and liberation. The verse is an ethmological pun, manu; human is derived from man 'to think.' Milkon too rhymed that the mind is in its own place; it may make heaven of hell or hell of heaven. Mind, which should have been source of joy '*ananda*', becomes a source of sorrow '*dukha*'. In Atharvveda, mind has been called a sixth sense, which is made active in us by the Supreme Being.

The old civilization of India was a concrete unity of a many sided development in arts, architecture, literature, religion and morals and science as far as it was understood in those days. But the important achievement of Indian thought was philosophy. It was regarded as the goal of all highest practical and theoretical activities and indicted the point of unity amidst apparent diversities.

I am grateful to the organizers of this eighteenth international conference of Catholic health care institution for inviting me to participate in inter-religious dialogue and giving me an opportunity to express my views on "The Meaning of Depression and Malaise seen from the Perspective of Hinduism."

Hinduism is a major religion of India, which has at its heart a kind of ethical mysticism, based on sacred scriptures. At its heart is a love of life in all its forms. It believes that one's actions in this life will generate Karma or consequences in the next life. Reincarnation (on the wheel of life, Samsara) may be at a higher level or not, depending on one's current actions. It accepts the body and soul as a equal partners in life and the use of both in religious life. When Hindus meet they greet God as present in the other person. Many Hindus believe that religious practice involves the awakening of the '*chakras*' or energy centers of the body, in order to let divine energy flow into the body freely. This perception is included in the eastern and western ideas of energy bodies or 'auras', which surround the physical body.

Concept of Mind In Vedas (10,000 to 5000 BC)

Mind has been conceived to be a functional element of ATMAN (soul which is self) in Vedas, which are the earliest written script of human race. In Rigveda and Yajurveda there is mention of prayer through mantras for noble thoughts to come into the mind. It has been mentioned that thoughts determine facial appearance, thoughts influence facial appearance, and thoughts can be purified through mantras and purified thoughts influence instincts. In Veda there is emphasis on the prevention of mental pain (depression).

In Rigveda, the speed of mind, curiosity for methods of mental happiness, prayers for mental happiness and methods of increasing *medha* (intelligence) have been described. It has been further stated in Rigveda that purification of mind prevents diseases in human beings therefore one should have noble thoughts. The power of mind in healing has also been described. This was the first time the three traits of personality – *Sattva,* Rajas and Tamas were described, and also mental illnesses were independently identified, along with physical illnesses, where it prayed that these mental illnesses will not destroy the body.

In Yajurveda the mind has been conceptualized as the inner flame of knowledge. It describes perceiving knowledge as mind, mind is described as *yog* and *Samadhi* (state of mind), all our sensory organs are under control of the mind and they function under the control of the mind.

According to Bhagvad Gita the senses and objects constantly blast the mind. Here it is said that the self is like the lord of the chariot and the body is his chariot. The intellect is the charioteer and the mind the reins. The senses they say are the horses; the objects of the senses are the roads. The senses (horses) are to be controlled by the *buddhi* (the charioteer) through the reins, the mind. The mind restrained or unrestrained by the *buddhi* leads to the region of vivid joy or the cycle of birth and rebirth *(samsara)* respectively.

The mind of man is like a veritable battle field: *'manahkshetra'* in which there is an endless state of war between opposing forces. This constant tussle within the mind is called *"psychomacia"* by the ancient Greeks.

The Ayurvedic Era (1500-1400 BC)

Ayurveda derives its roots from Athervaveda and it is one of the ancient sciences, the science of life. The classic written documents are *Charak Samhita* and *Shushrut Samhita.* These two describe mental disorders, personality types according to *trigunas* – the *satva, raj* and *tam* and *tridoshas* – the three humours in the body *vat, pitta, kapha.* The 14 causative factors are mentioned for mental disorders as follows-

1. *Pragyaparadh* – involving socially unsanctioned behavior and actions arising out of envy, pride, fear, anger, greed, attraction, pride and deluded thinking.

2. *Anuchit bramhacharya* – one

who is out following the rules of brahmacharya, which includes *Indriya Nigrah* i.e, control over demands of instincts. Due to this when the person carries out activities to gratify his instinctual conscience is not able to control his mind, becomes conflict ridden and this leads to mental disorders like depression.

3. *Durbal satva* – people who have weak *satva* characteristics have increased *raj* and *tam* characteristics, which leads to emotions like anger, and uncontrolled emotions, which leads to mental disorders.

4. *Durbal Sharir* – nutritional deficiencies leading to weak physical structure can lead to mental disorders

5. *Sharir dosh vikriti* – according to *Sushrut* and *Charak,* an increase in one of the three humours of the body either *vat, pitta* or *kapha* leads to mental disturbances like insomnia, anger, fear etc.

6. *Manas dosh* – (psychological factors) different detrimental emotions arise out of disorder of *raj* and *tam.*

7. *Agantuk karan* – outside factors affecting the body like bacteria, evil spirits.

8. *Manobhighat kardravya*-trauma to the mind because of substance abuse.

9. *Malinahar vihar* – bad food and bad lifestyle both lead to mental illness.

10. *Manoabhighat* – trauma to the mind because of stress.

11. *Ashasht manah* – conflicts arising in the mind.

12. *Ojokshaya* – loss of confidence leads to weakness of the mind, depression.

13. *Ayukta nidra* – excessive and inappropriate time sleep leads to mental illness.

14. *Chintya man* – inappropriate anxiety.

According to Vedanta, the structure of man can be further divided into five material layers enveloping *Atman. Atman* is the core of personality. It is represented in the diagram by the mystic symbol. The five concentric circles around the symbol represent the five layers of matter. They are called sheaths or *koshas* in Sanskrit. First *Anna-maya kosh,* the gross human body is made up of the *panchmahabhutas* – the five primordial elements i.e. *Akash* (vaccum), *Vayu* (air), *Agni* (fire), *Jal* (water) and *prithvi* (earth). It is directly under control of the next subtler body, the *pranmaya kosh,* the vital energy.

The next three koshas, *Manomaya, Vigyanmaya* and *Anandmaya* pertain to the mental faculties of a person. The *Manomaya kosh* receives all the sensory inputs, interprets them as good or bad and desires good. The feeling of 'me' and 'mine' and the faculty of intelligence and reasoning constitute the fourth or *Vigyanmaya kosh.* The fifth or the *Anandmaya kosh* means full of pleasure, and is the innermost *kosh* in close proximity of the soul.

When one considers the symptoms of depression, religious flavour is evident in the ideas of guilt and sin and their expiation by a suicide act. Even lethargy and laziness are considered as a sign and symbol of devils and demons. In India, Psychiatrists and Psychologists use religion as a psychotherapy. It performs certain function such as answering question about ultimate meaning; it gives emotional support, social cohesion, a sense of belonging and guidelines for life. A steady state of mind and sustenance of peace have been the aims of all philosophies.

Gita states "Let a man raise by himself by his own self, let him not debase himself. For he is himself his friend, himself his foe." One's own mind has a preventive and a curative function. Healthy habits of mind, thoughts, dispositions and feeling can offer equilibrium. It brings out the fact of the enormous resources that are available within for healing. This has been termed "Anjeneya complex" which is explored in psychotherapy.

Since India has been the nursery of saints and sages, scientists and the founders of world's major religions, certain yogic and religious practices help to attain a steady state of mind. Maharshi Patanjali, the father of the modern concept of yoga and a great physician himself, defined yoga as the complete mastery of the mind and emotions. It is a science which shows us the way to unite the body and mind. The only form of yoga which has been studied scientifically is transcendental meditation, a special meditation technique as taught by Maharshi Mahesh Yogi. He claims that after regular periods of meditation for even a few months the individual becomes more resilient to the stresses of life, works with increased efficiency, and is less likely to be dependent on alcohol or drugs.

Vedic therapy emphasize satvic diet, as diet produces a great effect on a man's temperament. Non-vegetarian food makes man lustful, revengeful, and furious; while a vegetarian diet makes him kind, cool and soft. Also Vedas enjoins man to leave lethargy and lead a life of actions.

Certain Hindu rituals like *Bhajans, Kirtans,* chanting mantras called Namapathy by Swami Sivananda of Rishikesh, help in eliminating repressions and resistances and bring into the field of waking consciousness many drives, emotions and complexes that were creating difficulties in the un-

conscious. It helps to achieve a state of deep relaxation. Similarly there are certain Hindu festivals and ceremonies associated not only with gods and goddesses but also with the sun, moon, planets, rivers, oceans, trees and animals. Some of the popular Hindu festivals are *Deepawali, Holi, Dussehra,* and *Ganesh Chaturthi,* which allow people to share their joy and sorrows and helps to elevate mood.

These innumerable festive occasions and religious practices make the Indian tradition rich and colorful. It gives us the powers, tolerence, adaptability, courage, co-operation, patience and humility which help to restore holistic health, harmony and happiness in our life and society today.

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RAYMOND R.M. TAI, HENG-CHING SHIH

5.4. The Perspective of Buddhism

Forward

It is my great honor to be invited to address the problem of depression on behalf of the Buddhists in this important and timely international meeting. According to a World Health Organization (WHO) report, 3% of the world population suffer from depression in the year of 2001. *Depression* has become one of the three most threatening illnesses to public health besides *Cancer* and *AIDS* in the twenty-first century.

Although I come from a country where Buddhists are in an overwhelming majority, I myself am not of the Buddhist faith. When I was asked to address the subject "The Meaning of Depression and Malaise seen from the Perspective of Buddhism," I hesitated to accept this invitation since I know little about depression. However, I was advised to seek help from Buddhists, either religious or lay people, for advice. After I did some preliminary research, I decided to accept the offer to address this issue.

Taking Taiwan and the United States as examples, the problem of depression is very serious. A 2002 survey recently released by the Bureau of Health Promotion, Department of Health of my country showed that in Taiwan almost 9% of the 18.4 million people above the age of 15 have symptoms of depression, that is to say 1.63 million people among the total 23 million population in Taiwan suffer from depression, most often caused by the challenges people have to face in an ever-competitive consumer-oriented society. Women experience depressive disorders twice as much as men. Among the depressed, only 2.3% of them seek medical treatment. This research report also revealed that among those in the white collars group, 32% have the idea of committing suicide, 26% thinking of punching their bosses, and only 8.2% take medicines to relieve their psychological pressure.

According to another recent research report on depression carried out by the National Institute of Health in the USA, more than 16% of Americans, as many as 35 million people, suffer from depression severe enough to need treatment at some time in their lives, resulting in a US$30 billion loss to employers.

Realizing the seriousness of this problem, I sought help from Ven. Prof. Heng-ching *Shih*, a

Buddhist nun who has a Ph.D. from the University of Wisconsin and Professor of Philosophy at National Taiwan University in Taipei. Prof. Shih has written extensively on Buddhist spirituality in modern society, particularly in Taiwan, China, Korea, and Japan. Professor Shih tells us Buddhism has a different approach towards depression, facing the problem with meditation and emphasis on compassion and loving kindness. Even though these methods may neither be quick nor always effective, negative side effects are virtually unheard of. Now, I wish to present Ven. Shih's paper.

Depression is one of the most common emotional disorders, afflicting more and more people in the modern world. Although psychologists and psychiatrists have not yet discovered all they would like to know about depression, they agree that the apparent symptoms of depression include dysphoria, lost of interest, anhedonia, social dysfunction, problems of memory and concentration, low self-esteem, suicidal tendencies, shame and guilt, hopelessness, eating and sleeping problems, etc. (Costello, 1993). All these symptoms are precipitated by biological, psychological factors, i.e., neurological abnormality, illness, bereavement, frustration, unemployment, and so forth.

Instead of discussing the causes, symptoms and treatments of depression from the Western psychological and psychiatric viewpoint, let me turn to Buddhism to find a different analysis and answers. There is a Chinese Saying: "the illness of mind can only be treated with the medicine of mind". Actually, Buddhism is the codification of insight about human psychology developed by Gotama Buddha in the course of his meditation investigations of his own mind. Thus, the primary emphasis of Buddhism is placed on learning about and transforming the mind and body through direct spiritual experience.

1. The four noble truths

As an excellent doctor of the mind, the Buddha's diagnosis of human life through the Four Noble Truths (四聖諦) provides us with insight into the causes and treatments of depression. The Four Noble Truths are: suffering (dukkha 苦), the cause of the accumulation of suffering (集), the cessation of suffering (滅) and the ways to the cessation of suffering (道). This doctrine delineates the symptom, diagnosis, prognosis, and treatment plan to alleviate human suffering. (Rahula, 1959, pp.16-50)

In the First Noble Truth, the Buddha equated all existence with *dukkha* (suffering). In addition to the general meanings of suffering such as "pain", "sorrow", or "misery", *dukkha* also includes deeper ideas such as "imperfection", "impermanence", "emptiness", "insubstantiality".

The conception of *dukkha* may be viewed from three aspects: (1) *dukkha* as ordinary suffering (苦苦), (2) *dukkha* as produced by change (壞苦), and (3) *dukkha* as conditioned state (行苦). *Dukkha* as ordinary suffering refers to all kinds of suffering in life like birth, old age, sickness, death, association with unpleasant persons and conditions, separation from beloved ones and pleasant conditions, not getting what one desires, grief, lamentation, distress – all such forms of physical and mental suffering, which are universally accepted as suffering and pain.

Buddhism teaches that all things are impermanent. Phenomenal things are in existence due to particular causes and conditions. When a happy feeling or a happy condition in life, which is not everlasting, changes, it produces pain, suffering, unhappiness. This vicissitude is *dukkha* as suffering produced by change.

The third form of *dukkha* as a conditioned state is not easy to comprehend because it involves the understanding of what Buddhism considers as "being". According to Buddhist philosophy, what we call a "being" is only a combination of ever-changing physical and mental forces or energies, which may be divided into five groups or aggregates, i.e. those of matter (色), sensations (受), perceptions (想), mental formation (行), and consciousness (識). The Buddha said, "These five aggregates of attachment are *dukkha*." The existence of and the attachment of the five aggregates, which constitute the personality are suffering. In other words, the five aggregates and *dukkha* are not two different things; the five aggregates are themselves *dukkha*.

The second Noble Truth is the cause of the accumulation of suffering: desire, attachment and craving. The Buddha explained in the *Majjhima Nikaya*, "It is craving, which brings renewal of being, in accompanied by delight and lust, that is craving for sensual pleasure, craving for being and craving for non-being." Suffering, from the Buddhist perspective, derives from our difficulty in acknowledging a fundamental aspect of life: that everything is impermanent and transitory. Suffering arises when we resist the flow of life and cling to people, events, and ideas as permanent. The doctrine of impermanence also includes the notion that there is no single self that is the subject of our changing experience.

The Third Noble Truth is that suffering can be completely eradicated, and emancipation, liberation and freedom from suffering can be achieved. This is called the Noble Truth of the Cessation of *dukkha,* which is *nirvana.*

The Fourth Noble Truth pro-

vides a treatment plan, the Eightfold Path (八正道), to alleviate suffering and achieve ideal health. The Eightfold Path is right speech (正語), right action (正業), right livelihood (正命), right effort (正精), right mindfulness (正思), right concentration (正定), right view (正見) and right thought (正念). These eight practices aim at promoting and perfecting the three essentials of Buddhist training and discipline: namely: (1) ethical conduct (*sila* 戒), (2) mental discipline (*samadhi* 定) and (3) wisdom (*prajna* 慧).

2. Suffering

The issue of human suffering has occupied both Buddhism and psychoanalysis since their inception. The anxiety and depressive affect has been the central focus of most psychoanalytic views on psychopathology and suffering. Both anxiety and depression relate to loss, i.e., object loss, loss of love, and physical loss. Depression relates to loss in the present or past, whereas anxiety relates to loss in the future (Christensen, 1999, pp.39-42).

Suffering is a desire or wish for one's experience not to include loss. The degree or strength of a person's suffering is directly related to the degree that the loss subjectively threatens a particular self-state. For example, for most people, death may be the most intense suffering humans endure. For others, extreme suffering may be related to the desire to be loved. People get depressed and anxious, because they want things to be different than they are, hence suffering.

Buddhism emphasizes the nature and the role of suffering and the nature and role of the self. Suffering and self are interrelated and they interact in perpetuating mental pain. From a Buddhist perspective, not understanding or experiencing the self clearly or correctly leads to suffering. Buddhism contributes to the understanding of the self by proposing that three main features define the dialectic self: (1) the self is both process and structure, (2) it is associated with both suffering and liberation, and (3) it is interdependent with others and at the same time separate.

Buddhism stands unique in the history of human thought in denying the substantial existence of a Self (*atman* 我). According to the teaching of the Buddha, the idea of self is an imaginary, false belief, which has no corresponding reality. The attachment to the idea of a permanent self produces harmful thoughts of "me", "mine", selfish desire, craving, hatred, ill-will, pride, and other defilements, which all result in suffering. Although the absence of a permanent, fixed self is considered a foundation of the Buddha's teaching, it is not so much the self that the Buddha encouraged one to relinquish as one's attachment to the view of a permanent, substantial self, because it is the attachment to a false view of self that leads to sufferings.

The definition of suffering derived from psychoanalytic sources is close to the Buddhist view that suffering is wanting things to be different from what they are at the moment. From the Buddhist perspective, all of life is association with suffering. Not only psychopathology but also normal healthy living is associated suffering, however, this does not mean that life is nothing but suffering and pain.

Buddhism believes that the self and all phenomena are unsatisfactory and create suffering. This follows the Buddhist logic that everything is in constant change and decay. Buddhism encourages practitioners to be aware of and experience the desires, thoughts, and feelings connected to a view of a permanent self as being in constant change and with substance. Working with suffering from this perspective, one would become more and more aware of anxiety and depressed affect through the tools of empathy, inquire and enactment. For example, in depression the loss, despair, and loneliness would be explored with the hope that those experiences, being impermanent, could be tolerated. (Christensen, 1999, p.49)

Just like every other phenomenon, suffering itself is also impermanent and without a separate entity. In other words, there is no separate self who is experiencing the suffering. Thus, in a paradoxical turn, Buddhism states that suffering too is conditioned by external causes, has no essence, is inseparable from other phenomena, and thus is empty, non-self (*anatman* 無我) and liberated from any constraints. In this dialectic, the self is both associated with suffering and liberation and joy. As the famous Buddhist Philosopher Nagarjuna explained, "There is not slightest difference between cyclic existence (loss, desire and suffering) and *nirvana* (liberation)". (Christensen, 1999, p.44)

3. Meditation

Now that we have discussed the Buddha's diagnosis of the symptoms and causes of human illness of the mind (depression being one of human mental illnesses), what are the Buddhist methods and techniques to alleviate the illness?

Fundamentally, the Buddha stressed perceiving reality as it is with minimum distortion and interpretation. Technically, the Buddha avoided theoretical and metaphysical constructs that are difficult to measure and/or have questionable usefulness to problems of daily life. The Buddha's whole approach is aimed at the person living more fully in here and now. Thus, Buddhist practices, particularly meditation, lead to a more direct perception of the present, while decreasing the amount the person is lost in memories of the past and anticipations or anxiety for the future. Thus, meditation is one of the best antidotes for the depressed patients.

Meditation refers to a family of techniques which make a conscious attempt to focus attention in a non-analytical way, and an attempt not to dwell on discursive, ruminating thought. Meditation aims at producing a state of perfect mental health, tranquility and equilibrium in body and mind through breath and mind regulation.

The mental development from meditation cleanses the mind of impurities and disturbance, such as lustful desires, hatred, ill-will, indolence, worries, restlessness, skeptical doubts, and cultivates such qualities such as concentration, awareness, intelligence, will, energy, confidence, joy, the analytical faculty, tranquility, leading finally to the attainment of highest wisdom, which sees the nature of things as they really are, and realizes the Ultimate Truth, *Nirvana.*

Within many different branches of Buddhism there is a wide variety of meditation practice. All of them, however, stress both of the following components: "concentration (止*samatha*)", the one-pointedness of mind, and "insight (觀*vipassana*)".

In concentration meditation, we focus on a single object, such as the breath, a mantra, or a *zen koan* (公案), with wholehearted attentiveness. It is the cultivation of self-control of attention through the control of the mind. In Buddhism, the mind is often described as a drunken monkey running wildly within six windows. Five of the windows correspond to sensory impressions from our five senses and the sixth window corresponds to our mental sense of internally generated impressions including thought and memories. For most people the monkey runs from window to window out of control. Through concentration practices, the meditator learns to control the monkey and keep consciousness focused on some meditation object. (Mikulas, 1981, pp.333)

One of the most well-known, popular and practical examples of concentration meditation is called "the mindfulness of in-and-out breathing (*anapanasati*). We breathe in and out all day and night, yet we are hardly mindful of it. In order to mediate, we sit physically still in an upright position to receive the immediate flow of moment-to-moment experience, attending to the breathing process, silently noting the inhalation and exhalation at the nostrils and abdomen. The effort is not to control breathing but to be attentive to it.

At the beginning it is difficult to pay attention to our breathing for even a few consecutive seconds. The more we attempt to pay attention to it, the more we become distracted. Memories, daydreams and anxieties arise. There is an apparently endless flood of thoughts, feelings and fantasies. One of these usually catches our attention and we become oblivious to the present moment.

As soon as we notice that our attention has wandered, we should resume our attention to breath. Like a child who reaches for one toy, becomes bored, and reaches for another, and then another, our mind keeps jumping from one thought, feeling or fantasy to another. Interestingly, by noticing that we have been inattentive we slowly cultivates increased attentiveness and focus. (Rubin, 1999, pp.7-8.)

After a certain period of practice, we may experience for just a split second that our mind is fully concentrated on our breathing, when we will not hear even sounds nearby, when no external would exists. This slight moment is a tremendous experience, full of joy, happiness and tranquility (Rahula, 1959, pp. 67-75).

The exercise of mindfulness of breathing, which is one of the simplest and easiest practices, can be applied to every action of daily life. People do not generally like their present actions. They live in the past or in the future. This is especially true with depressed patients. Though they seem to be doing something now, they live somewhere else in their thought, in their imaginary problems and worries, usually in the memories of the past or in desires and speculations about the future.

The Vietnamese Zen Master Thich Nhat Hanh gives the following instruction of practicing mindfulness: while washing the dishes, you might be thinking about the tea afterwards, and so try get them out of the way quickly as possible in order to drink the tea. But that means that you are incapable of living during the time you are washing the dishes. When you are washing the dishes, washing the dishes must be the most important thing in you life. Just as when you are drinking tea, drinking tea must be the most important thing in your life. (Morvay, 1999, pp. 29-30)

As awareness becomes clearer and more focused through mindfulness meditation, people experience a sense of psychological spaciousness. Wholehearted attention promotes greater receptivity and attunement to internal and interpersonal experience. This fosters a more spacious perspective on one's experience. In other words, meditation fosters what Buddhists term non-attachment, a non-grasping state of mind to which the meditators hold their viewpoints less tightly. It can help reduce self-criticism and tolerate a greater range of feeling without fleeing from them, and relate to oneself and others with greater flexibility and openness. It helps some people, such as many de-

pressives, by keeping them from being overrun by undesired thoughts. Most importantly, it helps them increasingly tolerate the presence of depressive thoughts and moods without being overwhelmed. The depressed patient develops "the capacity to experience having the depression instead experiencing the depression as having him", and thereby overcoming his depression (Christensen, 1999, pp. 38).

The second meditation component is "insight". The insight meditation is to develop the ability to notice objectively whatever arises in one's consciousness without elaborating on it, reacting to it, identifying with it, or getting lost in it. It is called choiceless awareness, bare attention, and detached observation. It involves the cultivation of comprehensive, objective, non-reactive observation of sensations, covert behaviors, and related processes of the mind, and eventually the experiences of self and will (Mikulas, 1981, p. 334.).

In insight meditation, we attend without attachment or aversion to whatever thoughts, feelings, fantasies, or somatic sensations are being experienced. The purpose of such practice, contrary to popular misconception, is not to make anything happen, such as silencing or emptying the chattering mind, but to relate to and examine whatever is happening in our experience (no matter how painful). It is an analytical method based on mindfulness, awareness, vigilance, observation, which sees the true nature of things, lays the groundwork for insight into the basic understanding of self, existence and reality, and eventually leads to the realization of the Ultimate Truth.

4. Morita Therapy

As we have discussed above, Buddhist teachings provide very good antidote for people suffering from depression. "Morita Therapy" is a well-known example of applying Buddhism, especially Zen Buddhism, to psychotherapy. Morita therapy is a therapeutic technique developed by the Japanese psychologist Shoma Morita (1874-1938) in the early part of the twentieth century. Many of the principles of Morita therapy are based on Zen Buddhism. Morita himself was strongly interested in Zen Buddhism and had some experiences in Rinzai Zen Buddhism under Zen Master Shaku Soen, the teacher of D.T. Suzuki. Morita's method was initially developed as a treatment for a type of anxiety neurosis, and in the last decades the applications of Morita therapy have broadened to the treatment of depression and other mental disorders.

Here are the main concepts of Morita psychotherapy.

Desire for life: according to Morita, the basic force of human being is the strong desire for life. The converse of this is the fear of death, both being aspects of the same force. The efforts of human beings to lead a fulfilled life are all manifestations of the desire for life. At the same time a manifestation of desire for life is the tendency to fear curtailments and threats to one's own well-being; Morita calls this tendency "hypochondriacal basic tone". This tendency is common to all human beings, but in introverted and very sensitive persons, this tendency can be the starting point of a process which finally ends in depression and neurosis.

Psychic interaction: if attention is paid to some sensation, the sensation becomes very sharp, and by mutual interaction of sensation and attention, the sensation will become more and more excessive. This is a kind of vicious circle which grows out of being prepossessed with one's own oversensitiveness, for example, sad feelings, hopelessness, fear, distraction, insomnia and so on.

Self-suggestion: self-suggestion helps to fix a problem in the form of a symptom through formation of a conviction that, for example, blushing is abnormal, and endless repetition of this conviction, so that rational reflection is excluded. Thus free-floating attention, a main characteristic of a healthy and productive person, is lost, and attention is always fixed on the same ideas.

Contradiction of thought: sensations and feelings are an integral part of human life; they arise, reach their climax and vanish. The inclination to contrast a present feeling or sensation with the ideal state, and trying hard to realize this ideal state instead of pursing the task at hand, is call contradiction of thought by Morita. Contradiction of thought, aided by self-suggestion, works together in the formation of neurosis and depression.

Arugamama – to be as one is: *arugamama,* literally "as it is", or regarding a person, "to be as one is", is the central conception of Morita therapy and at the same time forms the goal of therapeutic efforts. Instead of making efforts to change a given reality, the patient is taught to accept reality as it is. This means that if he feels depressed, he accepts his feeling of depression. If he feels anxious, he accepts the feelings of anxiety. Rather than direct his attention and energy to his feeling state, he instead directs his efforts toward living his life well (Rhyner, 1988, pp. 7-8).

Key Ideas of Zen Buddhism

1. Zen discipline consists in attaining enlightenment.
2. For Zen Buddhism, enlightenment finds its meaning hidden in our daily concrete particular experiences, such as eating, drinking, or business of all kinds.
3. The meaning thus revealed is not something added from the outside. It is in being itself, in becoming itself, in living itself. This may be called "as-it-is-ness". Reality is its isness.
4. Some may say, "there cannot be any meaning in mere isness." But this is not the view held by Zen, for according to it, isness is the meaning. When I see into it I see it as clearly as I see myself reflected in a mirror.
5. This is what made P'ang Chu-shih, a lay disciple of the eighth century, declares:

How wondrous,
how mysterious!
I carry fuel, I draw water.

The fuel-carrying or the water-drawing, in fact, every move in

daily life, apart from its practical purpose, is full of meaning; hence full of wonder and mystery.

6. Zen does not, therefore, indulge in abstraction or in conceptualization.

7. Enlightenment is emancipation, moral, spiritual, as well as intellectual (Rhyner, 1988, pp. 8-9).

Having understood the principles of Morita and Zen Buddhism, we can now compare them. Morita first claims that the basic force in human being is the desire or craving for existence. According to Buddhism, craving (for sensual pleasure, existence, and non-existence) is one of the main factors that keep beings in the cycle of rebirth or suffering.

In the next stage, we have contradiction of thought, due to a very strong intellectual attitude, which labels a normal phenomenon, e.g., shyness in front of strangers, as abnormal, and causes a strong wish to get rid of this shyness. Increased attention is paid to shyness, which in turn intensifies it (psychic interaction) and finally turns into a depressive tension.

In the case of the Zen monk, his desire for enlightenment gets him involved in endless attempts to solve his *koan*. The *koan* is a challenging statement or question (for example, What was your nature before you were born?) given to the monk by the Zen Master. The monk tries to solve the *koan* with all his intellectual strength, he concentrates his thought again and again on the *koan* but is unable to solve it. He is caught in a vicious circle and soon finds himself deadlocked, which leads to great anxiety and suffering. His strong intellectual attitude makes him believe there is a rational solution to his problem. He focuses again and again on his *koan* and repeats it countless times for himself, which is the same process Morita describes as psychic interaction and self-suggestion.

Another point in common on this level is an egocentric attitude. It is this directing of attention inward, which, together with an intellectual attitude, opens the way to depression and neurosis, according to Morita theory. But Morita does not go as far as the Buddhists, who deny the reality of the self. It is exactly the intellectual attitude and the notion of a self which Zen training, through meditation and the use of the *koan,* wants to break.

Regarding the breaking of the neurotic vicious circle, Morita advises the patient to go directly into his depression, to become with it. This psychic state, in which the patient accepts his sufferings and becomes one with them, Morita calls "the psychic conflict is emancipation". In other words, in the midst of his suffering, which he has tried so much to escape, there lies the answer.

Similarly, Buddhism has a saying: affliction is enlightenment (*Klesa* is *Nirvana*). That is, in the middle of suffering there lies enlightenment; suffering and enlightenment cannot be separated, like the lotus flower growing in mud. Obviously, Morita has phrased his psychological findings along the line of this Buddhist saying.

Now we come to the central point of Morita therapy, both on the level of theory as well as concerning the therapeutic effort: the concept of "as it is". This basic principle means seeing reality as it is, accepting it and acting according to the actual situation. The realization of the state of *arugamama* (as it is) in Morita therapy is equal to a complete cure. But being cured does not mean that a patient will not have depression, fears or anxieties any more. He will experience every kind of emotion as before. What changes through his experience of Morita therapy is his attitude toward his problems. Where before he tried to escape, he is now able to accept fear as fear, anxiety as anxiety, and pain as pain. He faces the same reality but now he can accept it as it is.

Both the patient and the Zen monk try with their might to realize their ideals: the patient wants to be cured by solving his self-made problem; the Zen monk wants to reach enlightenment by solving his *koan.* In pursuing their ideals, both are split in themselves and miss the only manifest reality. By giving up their pursuit and accepting reality as it is, the split between patient and symptom, monk and *koan* ceases to exist and at the same moment the problem situation ceases to exist, there is no more problem to be solved (Rhyner, 1988, pp. 9-13).

In general, the stronger we desire something, the more we want to succeed, and the greater our anxiety about failure. Our worries and fears are reminders of the strength of our positive desires. Our anxieties are indispensable in spite of the discomfort that accompanies them. To try to do away with them would be foolish. Morita therapy is not really a psychotherapeutic method of getting rid of "symptoms." It is more an educational method for outgrowing our self-imposed limitations. Through Morita therapy we learn to accept the naturalness of ourselves.

In conclusion, I will cite the following enlightening quotation from the *Shobogenzo* by the eminent Zen Master Dogen, which best illustrates the close relation between the principle of Zen Buddhism and Morita therapy (Christensen, 1999, p. 37). It says:

To study Buddhism is to study the self.
To study the self is to forget the self.
To forget the self is to be at one with the ten thousand phenomena.
To be at one with the ten thousand phenomena
Is to free one's body and mind and those of others.

It seems to me that Ven. Shih's advice to those who have symptoms of depression is to study the self and forget the self. For many, to forget is more difficult than to remember. I guess it would be nice for people to remember something pleasant and to forget something unpleasant.

Finally, I wish to add that, in order to protect public health, my government has included the illness of depression in our National Health Program. On the non-governmental side, a "Depression Prevention Association" was established in Taiwan on December

9, 2001 to promote the awareness of this problem and to provide advice for prevention and treatment. The Catholic Church in Taiwan together with other religions is also a source of help for the depressed.

Thank You!

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III Section

What Can be Done to Escape Depression?

1. Faith

SERGIO PINTOR

1.1 The Principal Points of Faith on which Special Emphasis should be Placed

The subject under examination, with its practical perspective, leads us to ask ourselves in a serious way about the therapeutic dimension of the Christian faith and the role that this faith can play as regards not only people who suffer from depression but also those who are called to take care of them at the level of prevention and of accompanying and treatment.

In what sense and in what ways can the Christian faith contribute to looking after health and overcoming depression? Which characteristics and qualities of faith should be respected? Which aspects and features of faith should be most emphasised?

In this paper only some fundamental aspects will be referred to in relation to these questions and issues, which are of a very broad character.

1. Some Preliminary Observations

Some preliminary observations, however, seem to be advisable if we want to achieve a correct approach to, and analysis of, this subject.

First of all, we should avoid any improper and any exploitative form of Christian faith through endowing it – when faced with the condition of the depressed person – of prefabricated and almost 'magic' answers which will solve his or her problems, or through making Christian faith into a factor which takes the place of, or is isolated from, other factors and responsibilities at the level of care and treatment.

In reality one is dealing here with believing strongly in the specific virtuous capacities of Christian faith, with respecting its real identity, and with respecting its dynamic of incarnating the realities and practical conditions of human existence.

2. From the Condition of Disappointment/Sadness to the Condition of Hope

Two pages from the gospels, which have an especial paradigmatic value as regards the communication of faith embodied in people's lives, constitute a light-filled background to this analysis. The first is from the Gospel according to St. Luke and will be used to begin this paper (this is the account of the two disciples of Emmaus (cf. Lk 24:13-35); the second is from the Gospel according to St. John and will be used to end this paper and conclude it (the meeting between Jesus and the woman from Samaria: cf. Jn 4:4-30).

In these two pages of 'revelation', and the illumination that they provide, we encounter two possible signposts by which to analyse this subject – one is to do with the characteristics of Christian faith that should be respected and appreciated; the other concerns certain specific points of Christian faith that should be emphasised in order to achieve a therapeutic contribution to prevention and treatment in the case of people who suffer from depression.

From 'Emmaus' to 'Jerusalem'

The journey of the teaching of the faith that St. Luke the Evangelist presents in chapter twenty-four of his gospel (cf. Lk 24:13-35) is very much to the fore: Jesus meets two disciples who are in an existential state of disappointment/sadness, of regression and closure within themselves symbolised by their departure from Jerusalem (the city of hope) to go towards Emmaus. Jesus makes himself the companion of their journey, he enters into dialogue with them, he listens to their questions and hopes and illuminates them with the speaking of the Word; he opens them to prayer and to the wish to escape from the loneliness of their condition; he makes them aware of a change that is underway and of a mission; and he leads them back to the knowledge of being within the framework of a project of hope and commitment.

To summarise, this page from the Gospels offers a perspective on the essential elements that a communication of faith must bear in mind if it wants to contribute in a proper way to prevention and care in the case of depressed people.

3. The Identities and Characteristics of Christian Faith that must be Respected, Experienced and Communicated in order to Contribute to a Practical Commitment to Prevention and Care in Relation to People Who are in a State of Depression

First of all, it is necessary to consider faith in all its authenticity, wholeness and potentiality as a 'theological virtue', that is to say as 'possibilities' and 'energies' that are communicated to us by God as participation in His life through communion with His Son, Jesus Christ, in the Spirit.

In the New Testament, in the 'Letter to the Hebrews', we are offered a summarising but meaningful and profound definition of Christian faith: 'Now faith is the assurance of things hoped for, the conviction of things not seen'.[1] In its essence this statement emphasises the existential dimension of faith in the human experience of the believer: it is an 'assurance', that is to say it is at the origins and the base of every experience – and the very identify – of the person. It is an 'assurance' and an assurance 'of things hoped for', that is to say of the most authentic and profound hopes for joy and fulfilment that are in the heart of the person, and which for the Christian are the certainty of a fulfilment, liberation and full salvation in Jesus Christ. Lastly, faith is 'the conviction of things not seen',

a 'horizon' of meaning and a future promised by God, the bearer and revealer of signs of just how much the loyalty and love of God will achieve.

All these aspects that have just been referred to – 'faith as assurance', a guarantee and horizon of meaning and complete fulfilment – refer at a deep level to the human experience with its questions about the meaning of a person's life and a person's conduct, a person's own identity, and a person's hopes and projects. These are aspects and questions that a state of depression, in particular, can place in a state of crisis, but which in this overall vision of faith can also produce therapeutic and incisive resources for its prevention.

In relation to Christian faith, it seems to be important to emphasise the following aspects in particular:

a) *Christian faith as 'listening', 'welcome', and 'obedience'* (*ob-audire*) on the part of the whole of the person in relation to God, who speaks, reveals Himself, and communicates. This is an aspect that the *Catechism of the Catholic Church*, under the heading of 'Dei Verbum', stresses in particular.[2] 'Obedience' in faith is to entrust oneself and 'to submit freely to the word that has been heard, because its truth is guaranteed by God, who is Truth itself'.[3] A significant model in the biblical tradition is the faith of Abraham, with his approach which involved full and total trust in the promises made by God, obedience to His Word, and knowledge about God in the events of his life.[4]

It cannot escape us that these fundamental attitudes, within an experience and process of education in faith, can be important in a therapeutic process and relationship.

b) *Christian faith as a dialogue/relationship of love*. Christian faith has a character that is strongly marked by responsibility, dialogue and relationships, as an expression of a love given by God and received by the believing person. The person who believes is called to recognise the love of God, to give himself or herself freely and with total trust to Him, and to know how to share in the communion/relationship of God the Father, God the Son, and God the Holy Spirit.

'God is love' (1 Jn 4:8,16): the very Being of God is love. In sending in the fullness of time His only begotten Son and the Spirit of Love, God revealed his innermost secret – He Himself is an eternal exchange of Love: Father, Son and Holy Spirit - and He destined us to be participants on this.'[5]

This awareness and practice of Christian faith is the light and strength that can illuminate and sustain a person in every situation, especially if he or she is in a state of suffering, loneliness, and discouragement, as is the case with the condition of depression.

c) *Faith as conversion/metanoia*. 'Believing in the Gospel' requires on the part of the person a 'conversion' of his or her heart and personal and social action. Without this process of gradual and permanent 'conversion', there is no growth, liberation or salvation. In the biblical vision, the 'conversion/metanoia' required of the person who believes is much more than simple

'repentance' or a simple return to his or her inner self.

'It is not the turning to oneself that saves', writes Cardinal Ratzinger, 'but rather the movement with which we detach ourselves from ourselves to go towards God who calls us… It is for this reason that *'metanoia'* means the same thing as obedience and faith. It is for this reason, also, that *'metanoia'* belongs to the structure made by the Covenant.'[6]

To convert means to adopt a different way of thinking and acting, placing God and His will at the top of one's priorities; and it means freeing oneself from the possible idols that have been created and which make us prisoners (prestige, self-interest, career, prejudices, the search for power and profit, etc.).[7] Christian faith as conversion lies in the discovery of new and surprising possibilities for growth and fulfilment, in the joyful discovery of a good so much awaited, of a constantly new peace, and of the presence of God within us, who never ceases to love us.

We should really ask ourselves what positive consequences a faith of this kind communicated, practiced, and borne witness to by the Christian communities, at a personal and community level, at the level of professional life in health care and in voluntary work, at the level of religious health care institutions and within public institutions, could have in the world of health and the treatment of depression. One thing seems clear: it is not the ideology of a faith that is levelled down and homogenised to, and with, the dominant culture, and which lacks the '*vis profetica*', that can contribute to the liberation and treatment of people.

d) *Christian faith as trust and joy, as welcoming of the Gospel.* Always but above all else when one is faced by, and placed within, the human experience of limitations, of suffering caused by illness, of a state of health in which worry and sadness seem to prevail, one cannot forget that Christian faith amounts to the welcoming of the Gospel, that is to say the 'happy and surprising', liberating and saving, news/event of Jesus Christ.

The Christian message begins with the term '*chaire*', 'be happy', 'be joyful', the word with which the angel begins his announcement of the future birth of Jesus to Mary in the account that is provided to us by St. Luke the Evangelist.[8]

This is a term used again by the same Evangelist when he narrates the birth of Jesus. The angel says to the shepherds: I bring tidings to you all of great joy ('*charam megater*').[9] St. Luke thus emphasises what the essence of Christianity is: 'a gospel, a happy and good message'.[10] For that matter, 'joy' is spoken about two hundred and fifty times in the form of different terms or expressions.[11]

But how should we communicate this joy through our Christian faith today, how should be bear witness to it and allow it to be seen as a force and light of hope, even in situations of suffering, sadness and depression?

In reality, the origin of joy is the harmony of a person with himself or herself (and in this sense one can notice a clear reference to the new idea itself of health!).

The person who manages to accept himself or herself has managed to utter a decisive 'yes' in, and for, his or her life; and only in this way can he or she accept the 'you' of other people and the world. But can the human person by himself or herself, always and in every situation, accept himself or herself, accept his or her own 'I'? Only when the human person is accepted by another 'I' can he or she accept himself or herself. A person can love himself or herself if he or she already feels that he or she is loved. Mere physical birth is not enough for the human person to achieve full being if this is not accompanied by the welcome that without speaking words comes to say 'it is good and important that you are'; that is to say if he or she is not welcomed with love.

Yet, above all in certain situations, a question still arises: ' is it true that it is good that I am?'; 'is the person who told me this and still tells me this actually right?'

We are thus confronted with the question of 'truth' and not only of love (a question of universal importance). And we probably find ourselves at the root of the anxiety and lack of confidence that are present in so many people. Love needs to be conjoined with truth because only 'the truth makes us free',[12] and thus opens us to joy.

Christian faith welcomes this radical question and answers it by joining together love and truth.

God thinks that the human person is so important that He not only created man but also personally suffered for him, giving Himself for love in His Son. The cross, with the fullness of the resurrection, be-

comes the core and heart of the Gospel as 'good news and comes to say to every human person: not only is it good that you are but you should be. Those who, like the Apostle Paul, feel so loved by God that they can say 'who loved me and gave himself for me',[13] really feel loved and loved in every situation.

The cross, as the 'happy message' of the radical and surprising love of God, thus becomes a recognition of the positive nature and inestimable value of our lives; it becomes the base that removes ambiguity from every other joy and makes that joy worthy of being enjoyed in the daily realities of existence; it becomes a 'happy message' that is able to reach the roots of our lives and to support us with its strength even when everything around us becomes dark and we feel tired and oppressed'.[14]

It is not surprising, therefore, that John Paul II, in his apostolic exhortation *Catechesi tradendae*, strongly affirms that 'the most valuable gift that the Church can offer to to-

day's world, which is disorientated and distressed, is that of forming Christians who are aware of the essential nature of, and are humbly happy with, their faith'.[15]

This is certainly not a Church that is merely more organised or superficially festive that will be able to communicate more effectively this joyous and essential character of Christian faith. What is needed is a humble and creative attempt – in various situations and in encounter with people – to speak about the love, the welcome and the tenderness of God with the Word of God, with education in the meaning of Christian celebration, and with the signs of solidarity and communion that remove people from their state of loneliness.

e) *The ecclesial dimension of Christian faith*. Faith is without doubt a personal act and a free response to God who communicates and reveals Himself. But it is not an isolated act. 'Nobody can believe alone, just as nobody can live alone. Nobody ever gave faith to themselves, just as nobody has given existence to themselves'.[16]

Christian faith is always ecclesial faith. The personal 'I believe' is an expression of the 'we believe' of the Church and in the Church; it is the faith of the Church professed personally by every believer, above all at the time of baptism. Faith gives conversion and uproots loneliness.

This profound 'solidarity' of Christian faith – in which we are debtors of faith to each other, and in which we are led to make others share in our faith – deserves to be borne especially in mind by those who work and live in the world of health and health care, the world of care and treatment of the sick and the suffering. If it is true that 'I cannot believe without being supported by the faith of other people',[17] we may ask ourselves what the consequences are of this in the prevention and treatment of depression What should be done, beginning with our Christian communities and religious health care institutions, in order to promote an 'atmosphere' of authentic and community-based faith that works against the depressing and poisoning smog of self-interested, competitive, disrespectful, and cold human relationships, whose negative consequences have a deleterious impact on the weakest and most fragile amongst us?

4. The Emphases that should be Made in Education and Formation in Christian Faith

In the light of the requests for help and care that come from the world of depression, and in the light of some properties of Christian faith that in relationship to this question it appears important to bear in mind, and which have just been referred to, it may now be advisable to emphasise in a more precise and concrete way certain points in Christian faith that should be especially stressed when it comes to the prevention and care that are provided to people in a state of depression.

First of all, we should remember a dual and inseparable loyalty that should be observed – loyalty to God and his liberating and healing message, on the one hand, and loyalty to the depressed human person with his or her specific problems and life circumstances, on the other.[18]

Depression is a clinical situation that requires a multiplicity of therapeutic actions that take into account the different aspects of the person, including his or her spiritual and religious aspects.

The depressed person – in different ways according to the stages of the depression being suffered – is generally characterised by profound inner suffering, attitudes involving apathy, low confidence in himself or herself and in life, feelings of inadequacy and guilt, feelings of failure and of being abandoned by other people, and at times the feeling that he or she has been abandoned by God as well.

These are all aspects of experienced and suffered human existence that a communication of faith is called to throw light on, for the purposes of both prevention and treatment. At the base of these attitudes there is without doubt a certain vision of the world, of ourselves, and of God, that we need to understand in order to open it to the realistic, positive and liberating vision that is specific to Christian faith.

As a result, a communication of faith in these circumstances should in particular emphasise the following aspects, and in a way that overcomes the risk of using simple and abstract prefabricated 'good words'.

a) *Strengthening the importance and the meaning of Christian faith in such a situation*, as a gift and element that offers a truer and more positively realistic vision of life and ourselves, and as an answer to the deepest hopes for fulfilment and joy that are in the heart of each person.

This should be done beginning with the questions that the depressed person feels, his or her doubts and uncertainties, the questions that are provoked in him or her and that are directed through empathetic dialogue. We are dealing here with ensuring that the person sees that Christian faith for the person is 'possible and even advantageous, desirable, and existentially necessary'.[19]

b) *Presenting Christian faith as a full and fulfilling answer* to the question about, and the search for, the meaning of life, which is raised in an acute way above all when the person is experiencing a condition of suffering.

A communication of faith must bring out in particular how the Christian answer finds in Christ 'the deep meaning' of the human person, of his or her origins and his or her existence in every condition, and his or her fulfilment. Vatican Council II, in *Gaudium et Spes*, reminds us how 'only in the mystery of the incarnated Word does the mystery of man take on light. Christ…fully reveals man to himself and makes his supreme calling clear'.[20]

As John Paul II comments in *Salvific Doloris*: 'If these words refer to everything that concerns the mystery of man, then they certainly refer in a very special way to human suffering. Precisely at this point the 'revealing of man to himself and making his supreme calling clear' is particularly indispensable'.[21]

From this point of view, Christian faith is rooted in the deepest existential question of the person, opening the believer to the 'certainty' that by totally entrusting himself or herself to God revealed in Jesus Christ, and welcoming the proposal of life, he or she will obtain what he or she has always looked for. A

communication of faith thus becomes both a vehicle by which 'to know' the real meaning of a person's life and a way by which to educate when to comes to the capacity of the person to entrust himself or herself to 'another', that is to say to Christ, in order to fulfil the real meaning of his or her life. Without this framework of faith, it appears difficult, indeed impossible, to answer the most dramatic problems that accompany human existence.

c) *Helping in the rediscovery or discovery of the real Face of God*, through the proclaiming of God, as Jesus Christ manifested it to us: a Father who with freely-given love takes care of each one of his children and is near and in communion with us always, and even more when we experience weakness and suffering. The face of God, who created us out of love, has for us a project of full life, He accompanies us with His tenderness, and with the gift-presence of His Spirit He never leaves us on our own but supports us on our journey.

d) *The discovery of the real face of God necessarily requires an accentuation of a communication of faith in terms of total and trusting adherence to the person of Christ and his mystery of salvation*, and through him to an astonished and joyous welcoming of the mystery of God: Father, Son, Holy Spirit, as the mystery of love and vital communion.

The apostolic exhortation *Catechesi tradendae* reminds us that 'the ultimate purpose of the catechesis is not only to place someone in contact, but also in communion, with Jesus Christ'.[22] Through a narration of the gospels one makes a person encounter the person of Christ in the inseparable totality of his mystery: in his humanity and his divinity. The communication of faith – not only with words but also with witness – should emphasise certain particular features of the person of Jesus, the features that are nearest to the experience undergone by the depressed person: his care and tenderness towards suffering people, his healing of the sick, his welcome and mercy in relation to sinners, his admiration for the love of God the Father and the joy of the Kingdom of God; and his ability to read the hearts of people, his relationship of trust and total abandonment to the will of the Father, his profound friendship, his love for truth, his courage, his communication of the commandment of love, his taking upon himself of our sufferings out of love and his own death to make us participants in his resurrection and a fully fulfilled life; and the fact of his being Lord, Redeemer, and Saviour, for all of us.

From this point of view, the choice of certain very meaningful pages from the gospels, and the ones that most correspond to the realities experienced by the depressed person, can be useful: for example, the words and actions of Jesus that invite people to have trust in God and transmit that trust; signs of welcome and healing; and the parables that tell us of the love and tenderness of God.

e) *Educating in and promoting, through an adequate communication of faith, awareness of the baptismal identity and extraordinary dignity of the person*. A French theologian tells us: 'as a young priest I was sent during a summer period to be the chaplain of the prison of Fresnes. One morning in the infirmary I met a prisoner who said to me 'I have just finished reading chapter XVII of John." And he quoted the words of Jesus: "that they may all be one; even as thou, Father, art in me, and I in thee, that they may become perfectly one, so that the world may believe that thou hast sent me" (Jn 17:21). "If my understanding of this is correct', the prisoner continued, "we are thus all deified". And he went on: "This is amazing. Why do you not tell us about this?" I have always kept this rebuke within me as an appeal to proclaim the deepest mystery of our human condition, that of our deification!'[23]

To lay stress upon this immense personal dignity – which nobody or any situation can take away; to lay stress on this fact of always being 'important' and whatever the case of being for God, can be a therapeutic and healing contribution for a person, for example for a depressed person, who is induced to have low self-esteem, with all the consequences that follow from this condition.

f) *A communication of faith that educates people in the healing meaning of the celebration of the liturgy and the joyous meaning of Christian festivities*. Depressed people should be helped to become aware that every celebration of the sacraments, and especially the celebration of the Eucharist, becomes the sign and the instrument of the presence of the saving communion of God with them through the action of the resurrected Christ and His Spirit. This celebration can become a therapeutic moment if managed without artificial efforts in its signs and symbols, in the proclaiming and listening to the word of God, in participatory reply with prayer and worship, in an intensely human climate of the expression of celebration.

g) *A communication of faith that educates people in the meaning and the experience of Christian prayer,* as a dialogue of confidence and total filial trust with God, in the name of Jesus and the Holy Spirit, that opens the heart and life to hope.

h) *A communication of faith that educates people to love their own lives, as a gift and as a vocation-task of love,* as the new lives of children who know that they are loved and feel called to love, inseparably, God, themselves, and other people. This 'responsibility' in replying to the gift of life and to one's own vocation cannot be presented with a 'psychological overcharge', which is, indeed, bearable by none and above all by a depressed person, but as a 'possibility' given to our poor and wounded humanity, as well, through the power of faith and the Spirit.

It is important to help depressed people, through a proclaiming of the Gospel, to encounter the person of Jesus who gives to us the 'commandment of love' as the secret to the deepest joy, and which is able to illuminate and sustain even the moment of darkness and suffering of life; to encounter Jesus, the teacher of an authentic and serene human relationship with himself and with the people that he meets, because he lives out a deep and trusting relationship with the Father who loves him and who is always in communion with him.

All this requires of the Christian communities and Christians - who are able to express love and wel-

come (without any conditions) towards the lives of people at the level of facts – a capacity to engage in relationships which are really inspired by the commandment of love.

5. A Page from the Gospels that is Especially Paradigmatic

This paper may be ended with a page from the gospels which is especially paradigmatic, where St. John the Evangelist presents a dense and exemplary summary of a catechesis and which I would now like to re-read within the context of a communication of the faith to people that carefully takes into account the fact that they are in a state of depression.

I am referring here to the meeting of Jesus of Nazareth with the woman from Samaria who has gone to Jacob's well to draw water.[24]

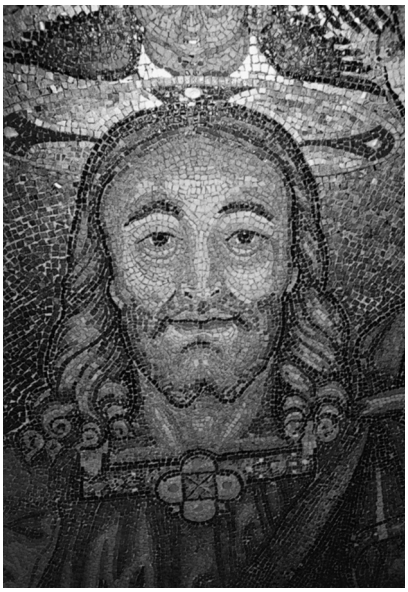
One can immediately observe that this meeting takes place within the framework of a normal and daily experience of human life – that of thirst – and that Jesus himself takes the initiative to begin a dialogue. In the conversation that then takes place Jesus tries to bring out another thirst – which is even more profound and existential – in the experience of the woman – the thirst to live, with the need for another spring that satisfies that thirst.

In reality, the dialogue of Jesus with the woman from Samaria – however much they share the same words and the elementary experience of thirst is expanded – really takes place at two levels.

The woman from Samaria thinks, after a certain fashion, that what is being referred to is an elixir of long life, water that is almost magic and that can satisfy her thirst to live, thereby lating at a level that is purely 'biological' in character. Jesus, however, wants to lead her to discover life in its fullness.

However, during the dialogue an important shift takes place when the woman, beginning with her thirst to live, is involved in the totality of her own person, and from the question about 'something' (water), she shifts to a question that relates to her personally at the level of her whole life. In this way one understands better the sentence spoken by Jesus ("Call your husband"; Jn 4:16). The woman from Samaria is now placed in front of herself and is invited to recognise her deepest truth so that she can more effectively understand her relationship with God. In other words, the woman is led back to her radical poverty, her own 'self'.

It would appear that this is a precise and universally valid task of a communication of faith incarnated in the human experience: it must promote a knowledge of oneself



and an acquisition of awareness of one's own practical condition, with all the poverty and the limitations that characterise this condition.

At this point, proceeding with our re-reading of the account as related by St. John, the question of this 'self' becomes the question of God and the question of an authentic relationship with Him. The question asked by the woman from Samaria about the 'worship of God', which is apparently without reason and seems to constitute a diversion, is in reality inevitable: it opens up the question of the foundation and the very purpose of her own life.

This is the moment when it is possible to offer the real gift of Jesus. The 'gift of God' of which Jesus speaks at the beginning of the dialogue is God Himself, God as a gift of love, that is to say, of the Holy Spirit (Jn 10:24).

The woman can now recognise the essential thirst that she feels in her innermost being and discover the only spring that can satisfy that thirst.[25]

'Jesus hold out to her the prospect of a new relationship with God 'in the spirit and truth' (Jn 4:24), he shows her that he is the awaited Messiah, the only person who is able to give her water that will take away her thirst for ever. The woman then leaves her vase at the well and runs with enthusiasm to call her fellow villagers to 'come and see' (Jn 4:29). She feels that he has found, perhaps unknowingly, what she has always been looking for'.[26]

So what, therefore, is the task of a communication of faith in the case of depressed people?

The passage taken from St. John brings out elements that should certainly form a part of a communication of faith in any human condition. And yet, re-read with greater specific attention being paid to a communication of faith with people who suffer from depression, certain elements of an especial therapeutic and liberating value seem to come to the fore: stimulating dialogue with a person who tends to retreat into himself or herself; gradual accompanying in a move from their own most immediate, and often conditioning, experiences, to an experience of knowledge about themselves and their deepest and most radical needs; their thirst to be, to have trust, to rediscover inner harmony, and to feel that they are within a horizon of growth, fulfilment and full life.

The specific task, therefore, of a communication of faith and accompanying in a more authentic and healing experience of faith, appears to be that of helping and leading the person to perceive and recognise his or her own radical thirst, beginning with his or her very experiences of his or her limitations, so as to open that thirst to encounter with the only spring that can satisfy it - encounter with the mystery of God of tenderness and freely-given love who calls each one of us by name to fulfil ourselves, who loves us as His children and is near to us, indeed, is in communion with us. This is a gradual journey – where attention should always be paid to the pace and the always special conditions of each person – that must help the depressed person to recognise himself

or herself with trust and realism in the truth about himself or herself, to redirect himself or herself in a more authentic relationship with God, to recognise inseparably the 'gift' that is God, the 'gift' that he or she is for other people, and, indeed, that other people are for him or her.

But in order to ensure that this therapeutic dimension of Christian faith is proclaimed and experienced words, are not enough: they take on a healing force only when they are communicated in the 'power of the Spirit' through the witness of the authentic faith of Christians, of a Christian community that makes the faith that it professes desirable by others, and enables the transforming force of that faith in its members' own lives to be seen by other people.[27]

And how much the saints are able to say this more and better than us, with their own lives, and often in an essential and poetic way! St. Teresa of Jesus may be taken as an example:

'Nothing worries you/nothing frightens you.
Everything passes/God does not change.
Patience obtains everything/He who has God
Lacks for nothing/God alone is enough.'[28]

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Notes

[1] Heb 11:1.
[2] Cf. *CCC*, 143-1444; *DV* 2:5; cf. also Rom 10:14-17).
[3] *CCC*, 144.
[4] Cf. *Gen* 1:1-21; Rom 4:18-25.
[5] *CCC*, 221.
[6] J. RATZINGER, *Elementi di teologia fondamentale* (Mocelliana, Brescia, 1986), p. 50.
[7] Cf. CEI, *La verità vi farà liberi* (Libreria Ed. Vaticana, Rome, 1995), p. 82.
[8] Cf. Lk 1:28.
[9] Lk 2:10.
[10] Cf. R. LAURENTIN, *I vangeli dell'infanzia di Cristo* (Ed. Cinisello, 1895).
[11] Quoted in note 4 of *Humanae vitae*, p. 37.
[12] Cf. J 8:32.
[13] Gal 2:20.
[14] Cf. J. RATZINGER, *Elementi di Teologia fondamentale*, pp. 69-79.
[15] *Ct*, 61.
[16] *CCC*, 166.
[17] *Ibidem*.
[18] Cf. *CT*, 55; cf. also *GC* 145-147.
[19] Y. CONGAR, *Situation et taches presentes de teologie*, Cerf, Paris, p. 76.
[20] *GS*, 22.
[21] John Paul II, *Salvifici doloris*, 31.
[22] *CT*, 5; cf. also *DGC*, 80-83; *CCC*, 426.
[23] B. SESBOUÈ, *Riconciliati in Cristo* (Queriniana, Brescia, 1990), p. 110.
[24] Cf. Jn 4:5-30.
[25] Cf. J. RATZINGER, *Elementi di Teologia Fondamentale*, pp. 93-95.
[26] CEI, *La verità vi farà liberi – Catechismo degli adulti* (Lib. Ed. Vaticana, Rome, 1995), p. 18.
[27] Cf. C. KLEBERS, 'Croire pour plaisir', in *Lumen Vitae*, XLIII, 1988, 1, p. 69.
[28] SANTA TERESA DI GESÙ, *Poesie*, 30.

TONY ANATRELLA

1.2 Emphasising (Personal and Community) Education in the Meaning of the Person, Responsibility and Self-esteem in the Light of Christianity

Introduction

A depressed person often feels exhausted, without inner resources, and does not know how to relate to other people and to life. Depression as an illness is a state of deep and painful sadness that has effects on daily life, which becomes difficult and even unbearable because it progressively loses meaning. Lack of interest and at times hopelessness invade the person who, not knowing how to project himself or herself into tomorrow, loses confidence, and assailed by doubts wrongly tends to undervalue himself or herself. Not seeing a way out of the crisis, the sick person enters into a dimension of existence all of his or her own.

Depression in all its forms always leads us back to questions of meaning. It is for this reason that we cannot limit ourselves to the observation of a depressive disturbance without posing the following question: how can we open that person to hope, which will help him or her to develop, to integrate socially, and which brings out the meaning of his or her existence? How can we make the spiritual dimension more present for the individual and for society beginning with which one can build and strengthen his or her inner life? An individual can develop his or her inner life only in relation to, and in interaction with, an objective reality, with a third person, with a dimension that is different from his or her own. Otherwise he or she will have a feeling of emptiness. It is for this reason that from a Christian perspective man can really find himself again only in a relationship with God, who calls him continual-

ly to form an alliance with Him. I would like to show you that Christian hope is an anthropological source that inspires the education of the person and his or her special vocation with reference to the following subjects:

The objective conditions of depression.

Discovering the meaning of the person and of his or her relationship with the community.

Educating in the meaning of the person.

Educating in the meaning of responsibility.

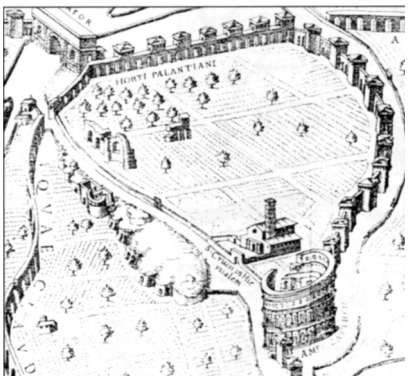
Educating in the meaning of the inner life.

1. The Objective Conditions of Depression

A depressed person is often alone with himself or herself even when he or she is surrounded by his or her family and friends. We are not dealing here with the loneliness inherent in every person, which is the result of our singular selves (individuality), but of isolation, distance, and the abandonment of life. The sick person no longer knows how to esteem himself or herself and to find value in his or her own eyes. He or she no longer knows how to connect his or her own personal history with the history of society.

Such isolation is all the more accentuated the more contemporary society, which has become individualistic in character, values subjectivism and a form of freedom that is not to be based upon objective truths and moral norms. Modern man is alone – without others with whom to compare himself – in the face of events, and he is without a historical consciousness, as though, that is, the universe had been born with him and he was living out unprecedented situations. Society also creates the objective conditions of depression by multiplying laws to meet special cases to the detriment of the common good. In this way it does not support its integrating framework by giving worth to values and the symbolic order: for example, through marriage and the family, which are structuring points of references for people and the social fabric. It has the same tendency to distrust, that is to say to despise, the religious dimension of man. This era of confusion in thoughts and feelings dominates men's spirits.

We are living in forms of society that are losing their memory of the past and of what they have achieved. Pope John Paul II has rightly recalled the historical truth that 'the Christian faith shaped the culture of Europe'[1] at a time when there is an attempt to ignore and to censure this reality in the preamble to the prospective European Constitution. As economically developed countries, in the main, we are engaged in a counter-identification as regards our history and our origins. There thus arises from political approaches a denial as regards the structural dimension of the religious world as a social and institutional reality, shame about our origins, about our past and about Christianity, which does not allow us to think about the future. When an attempt is made to remove the



past and to deny it, it is difficult to build our history. Modern man finds difficulty in entering into contact with the real aspect of humanity because he no longer has reasons for living. In having only subjective interests, he no longer knows how to think about himself in terms of personal and collective destinies.

The narcissism of contemporary social models, which reduces the person to an individual and makes each man his own point of reference and the end of everything, is rather tragic. In these conditions, the person does not become enriched with other reference points that are different to himself or herself and social ties can no longer be congenial or a source of projects. Life stops with oneself and there cannot be a life in front of oneself. Social and cultural life is reduced to consumer society and commercial celebrations. The barometers of consumption become the sole criteria for the assessment of the state of mentalities. Thus people speak about the 'low morale of couples' when there is a decrease in levels of purchase, and of a 'return of confidence' when citizens increase their consumption and celebrate events which are artificially programmed in a play of light and *paillettes*. Purchases and commercial celebrations against depression are not a sign of social health; indeed, they are preparing the ground in the more or less long term for a grave moral crisis. In all this we should perceive the presence of an absence of authentic spiritual life.

Such a condition of the spirit runs the risk of producing consequences for religion and morality, which, indeed, no longer appear as sites of resources. The new malaise of civilisation is that of believing that we do not have moral and spiritual reference points, whereas in fact they exist and it is we ourselves who do not want to turn to them.

Spiritual authors have always known how to distinguish between *depression*, which is an illness of a biological and psychological character, and *despair*, which is an expression of a crisis in a person's spiritual life. But at times the former can provoke the latter, and vice versa. Here we encounter the unity of the human person as presented by Christian thought. The incarnation of the Son of God, who took upon himself the human condition, enabled man to enter the heart of God because God Himself is in the heart of man. Man discovers the truth about himself in the word of God because he is in His likeness. He was created in the image and likeness of God as a human person and called to freedom and responsibility. He was given to himself to be the creator of life in communion with the Father so as to enter into the humanity of Christ. Existential depression manifests, among other things, a spiritual loss where there is an attenuation of the understanding of the presence and call of God. In the present day context, existential crises run the risk of being sec-

ularised and emptied of their spiritual dimension. For this reason, the smallest problem as regards life is consigned to be treated by a medical doctor; this is an approach to the spirit that shifts the spiritual dimension onto health care concerns. However, existential crises are an important moment when the person can examine his or her own existence and ask himself or herself about what he or she is doing with his or her life.

2. Discovering the Meaning of the Person and of His or Her Relationship with the Community

I have just observed that in contemporary approaches in designating what a human being is, the idea of the 'individual' is increasingly used as opposed to the notion of the 'human person'. A whole current of society tends to equate the human being's psychology and his biology with that of the animal world. In doing this an attempt is made to demonstrate with a certain effectiveness that we have shared particularities with the animal kingdom. But in acting in this way the meaning of human nature is diminished because man is shifted from his condition as a person to that of being an individual amongst other individuals. There is a difference at the level of nature between man and the animal world. Such an ideological transfer produces shifts that mean that the dignity of the human being, the meaning of his or her freedom, responsibility and upbringing, is no longer intelligible. If the human being is an individual, he or she cannot be reduced to this order, which, instead, belongs to that of the human person. 'Man is not closed up within the limits of nature; in him there is a mystery that confers upon him a superior value and gives him access to the supernatural level of God'.[2]

The Christian conception of a triune God whose relationship between the persons of the Most Holy Trinity is animated by love, that is to say by what communicates life, by giving, and by exchange. All the visions of God often give rise to different ideas about man. Thus the Christian faith is at the origin of the meaning of the dignity of the human person, his or her inner being, his or her freedom, his or her responsibility, and equality and democracy, with a distinction between temporal power and spiritual power. The personalistic and communitarian thought of John Paul II, which is rooted in the Christian tradition, has strongly emphasised all these truths about human nature, which can be discovered by reason and are illuminated and appear in the word of God.

The Church thus created marriage for love in upholding the equality of men and women, freedom to choose and to commit themselves to each other for the

pleasure of constructing a community of life and of giving life to children. The Church has had to struggle for nearly twenty centuries for this model to be accepted politically by society, which favoured marriages arranged by families as well as forced marriages. The Church has always supported man as a human person so that he could be the subject of his own existence and the community relationships that he develops with other members of society. Religion, and the Christian faith in particular, is a factor that fosters social ties and integration. It allows each person to find himself or herself anew with himself or herself, to become humanised and to socialise. For this reason, we should contest the political approach that wants religion to be reduced to the private sphere. Religion also has a social and institutional dimension; it is, indeed, the creator of civilisation.

In the face of the various forms of depression (endogenous, reactive or existential depression), can we think of a educational approach that limits its effects? I believe that an upbringing and education that transmits cultural, spiritual and moral matters by remaining centred round the meaning of the person, his or her esteem and his or her responsibility, should offer not only a stimulus to him or to her to open up to himself or herself and to other people but also a support and a form of significant treatment in order to address existential difficulties. Often man finds himself faced with a challenge that we encounter in an accentuated way during adolescence and depressive states: that of accepting himself and of adhering to life.

3. Educating in the Meaning of the Person

Man is created in the likeness of God. He shares in the life of God and thus receives his specific dignity as a human person as a gift. In being born every person is given to himself or herself. Life can be seen as burdensome and restrictive to the point of involving both existence and the rejection of life at the same time. In the best of cases, the subject is invited to accept himself or herself and to welcome life. This is the dilemma that is experienced at times during adolescence when a young person asks himself or herself questions, and asks 'what is the point of all this?' He or she does not know how to accept himself or herself, he or she does not know what meaning to give to his or her life, and he or she runs the risk of becoming depressed and de-motivated. All this runs the risk of becoming worse in a context in which adults lose the meaning of upbringing and education and leave children and adolescents without points of reference and alone with themselves, and without a cultural and religious transmission that gives them pleasure in living.

Upbringing and education must teach children very early on to accept themselves. Such an accep-

tance of themselves often takes place through a recognition that they receive from their parents and adults who accompany them during their growth and development. When a child feels accepted and correctly valued, that child can recognise himself or herself. At times this positive approach on the part of the parents is insufficient when the child resists agreeing to life for personal reasons or following an unconscious interference by the parents. It is necessary to know how to identify both situations in order to find a teaching approach that will help the child to progress and advance. At times it is enough to take away a fear, a doubt and the worry-provoking interpretation of a meaningful event.

The more the child is respected the more he or she will acquire a knowledge of his or her own dignity. He or she will discover that he or she belongs to himself or herself and that his or her parents, like the other adults, are near to him or her to help him or her in learning to exercise his or her freedom, a freedom that has been given to him or her to discover the truth about life and the truth about God. Truth makes us free when we try in life to place our own freedom at the service of good. A child will soon discover the weakness of human freedom that can betray his or her openness through a search for 'finite, limited and ephemeral goods'.[3] But patient and trusting love will help the child to regain himself or herself in order to become increasingly free. A religious education and upbringing will help the child to discover that the 'worship of God and a relationship with truth are revealed in Jesus Christ as the deepest foundation of truth'.[4]

Educating in the meaning of freedom is based upon the development of reason and the will in order to discern what it is right to do in relation to moral values and their implementation. Moral values are a path by which to achieve happiness in living. They do not have the purpose of limiting or condemning the subject but, on the contrary, of illuminating his or her conscience in the choices of his or her human conduct. Moral law is at the service of good and truth. It allows a person to be formed in the school of freedom in a trusting relationship with God and with other people. Contemporary thought, which is increasingly centred round a hypothetical affective development leading towards self-fulfilment, in its reflection in a moral and spiritual sense upon existence is not able to provide the cultural means by which to work internally to accede to the problems of existence. It exalts individual freedom 'to such an extent that it becomes an absolute, which would then be the source of values'.[5] It is necessary to follow 'one's own conscience', 'be in agreement with oneself', and assess everything in a moral sense beginning with one's own sincerity. Sincerity is not the criterion of authenticity – a person can be sincerely mistaken without knowing it. John Paul II, in *Veritatis splendor*, reminds us that 'the conscience is no longer considered in its primordial reality as an act of a person's intelligence, the function of which is to apply the universal knowledge of the good in a specific situation and thus to express a judgement about the right conduct to be chosen here and now. Instead, there is a tendency to grant to the individual conscience the prerogative of independently determining the criteria of good and evil and then acting accordingly. Such an outlook is quite congenial to an individualist ethic, wherein each individual is faced with his own truth, different from the truth of others'.[6] Thus the subjective truths inherent in the experience of the subject run the risk of becoming confused with objective truths. In these conditions, the person encounters difficulty in being conscious of objective realities. This is a phenomenon that is observed when a mistake is replaced by an error or by a behavioural accident where there is an apology rather than an attempt to make amends. Such a dislocation explains, on the one hand, the obsessive tendency of Western society to reduce everything to a juridical aspect because, not knowing how to make use of moral meaning, they turn to the legal system in the search for a guilty person. Such societies lose the meaning of transgression and sin, which for a person are always an opportunity to work on his or her own renewal and conversion to rediscover the love of God. In other words, the discovery of freedom must be accompanied by an increasingly refined sense of one's own responsibilities.

4. Educating in the Meaning of Responsibility

The freedom that is given to man is one of the characteristics that defines the human person. In becoming increasingly free in relation to his own desires and the obligations of his existence, man further acquires the meaning of his responsibilities in his relationship with himself and in his relations with other people. To be aware of the meaning of one's own responsibilities, to be capable, that is to say, of responding for one's own actions to existential values, means to refine one's own inner life and develop a sense of community. Indeed, an action carried out by a person always involves consequences for that person, for other people, and for the social fabric, and it will also have positive or negative repercussions for that person.

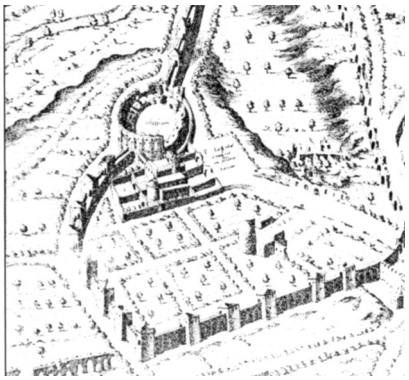
I pointed out in a previous paper that certain people have at times the tendency to live as though they were victims of life when they are faced with the difficulties of existence, which, indeed, they interpret as injustices committed by others and/or by God. In this way, they demonstrate that they are subjected to existence rather than accepting it or taking it on their shoulders. They do not gain a correct vision of their personal and collective responsibilities. They must be able to gain from society and they even require that its rules and regulations should be in conformity with their subjective interests.

Biblical revelation teaches us that life is given to us and that it is entrusted to the freedom of each one of us for the good of people and the community. It invites man to leave pagan thought, that is to say the savage thought of contemporary repression, in order to be freed from the fatalism of victimisation. Christ took upon himself the burden of being the victim of the sin of men, and in his passion and resurrection he revealed to us the faithfulness of God who does not aban-

don those who love Him. Man accedes to the pathway that allows him to share in the life, the action and the passion of God made man. Thanks to the Incarnation of Jesus Christ we enter into the humanity of God with a different view at ourselves and our existence. We move from the conception of a man who is the victim of existence to that of a free man who is responsible for his own consent to life. For a Christian to love God means to love life and to love man. The ways of God pass by man, as John Paul II observes in his encyclical *Redemptor hominis*.

An acceptance of life allows man to become responsible for himself and for other people. But consent to life is often a trial for man. He can withdraw from it, flee from it or shift it onto other concerns; nonetheless the question remains and can express itself in an existential and spiritual malaise that is often to be observed in 'despair', which we find in the laments of Job or the psalmist: 'For my soul is full of troubles and my life draws near to Sheol. I am reckoned amongst those who go down to the pit; I am a man who has no strength, like one forsaken amongst the dead' (Psalm 87:4-5). Such existential suffering has always been known about. The first Christian monks addressed it and thought about it with the notion of 'sloth', that is to say a difficulty in accepting living, in being concerned about oneself, and in accepting being able to control the most contradictory desires that invade the human consciousness. Sloth, as has already been observed, is at the intersection between a spiritual crisis and depression, and involves how to take responsibility for oneself and discover meaning, beginning with which one's personal history can be constructed.

Ancient thought saw the intervention of the gods in all inner torments. Greek thought dramatised them to the extreme; Roman thought was gripped by terror and fear; and the Asian currents of thought tried to achieve a liberation from inner struggle through the elimination of desires. The Christians who followed on from Christ in the spirituality of the incarnation accepted reflection on human desires and like the psalmist and the Fathers of the Church sought to ask themselves about their contents in order to know how to live them out, torn between dismay and anxiety. The Confessions of St. Augustine are a perfect illustration of this when he sought to see his inner self clearly by speaking about himself in the presence of God, the Third One who allows a communication with oneself and the discovery of the meaning of one's existence. In Book IX, St. Augustine establishes the premises for psychoanalysis,



which he would not have been able to invent outside the context of a civilisation based upon meaning and the experienced consequences of the word of God. The Christian faith is thus the creator of inner life in which God is present, as well as being the inspirer of civilisation and culture.

Reflection on human desires, beyond mere psychological interests, cannot be carried out spiritually without having first discovered the meaning of life as revealed to us by Jesus Christ. Otherwise, how could we agree to living, to building an existence, and to developing ourselves without being joined to the spring of life? This reflection has become difficult in a cultural universe whose approach is broadly directed towards contempt for the religious dimension and the systematic denigration of Christianity, when, that is, it does not amount to the disinformation about Christianity pumped out by the mass media.

In secularised societies, which neutralise the spiritual life, the drama of religiously indifferent humanism, and not only atheist humanism, impoverishes the human consciousness. We forget that in the history of ideas the conception of secularity has Christian origins. The Church introduced this concept in order to distinguish temporal power from religious power when political power wanted to interfere in, and control, religious questions. Subsequently, the meaning of secularity was deprived of its original meaning and became an ideology that excluded the religious dimension from the public domain. This ideology contributed to the development of religious indifference and progressively denied the right to religion by emphasising in relation to the 'individual' solely the freedom to believe and the freedom of conscience. This was not enough. Indeed, freedom of conscience is a subjective and personal aspect that is not the same as the right to religion when a restrictive secular ideology rejects its social and institutional dimension in order to reduce it to the realm of private life, and can even come to prohibit the display of religious signs and symbols. Atheistic humanism, upheld by the Communist and Socialist countries, wanted to destroy the Church, which, despite this fact, and because of the courage of generations of Christians, has known how resist in the name of Christ and the freedom and the dignity of the human person in order to maintain the right to religion. The humanism of indifference to religion, which at the present time is pervasive, is even more terrible when it states, in the name of a secularity which seeks to transcend the religious, that it wants to protect individual freedoms and public freedoms from every form of religious influence. Secularity cannot have this role by trying to apply political power to religious power. This is only a juridical framework and a way of reorganising relations between the political world and the religious world. Although the political power is separate from the religious power, this does not mean that society is separate from religion. Men must be able to express themselves in religious terms both at a personal level and at a social level. A large number of members of the European Parliament have an erroneous vision of religion and of Christianity in particular. Some of them are prepared to redefine its relationship

with society and to further limit religious expression in the face of the appearance of religious forms of behaviour that come from outside European culture. The right to religion and the right to express oneself in religious terms through specific symbols are at times called into question. The Christian origins of European values, Christian festivities and signs, can be denied and rejected by members of religious currents that are now present in various European countries. There is the risk that political and judicial decisions are taken that are not favourable to our origins and our symbols in the name of an erroneous idea of equality. We have heard an eminent member of the European Court of Human Rights state that 'the frame work of freedom of conscience is envisaged by law'.[7] Will the political approach, once again, become totalitarian by denying the role played by religion in social ties and in anthropological reflection that enriches human thought?[8] During an epoch in which people are often uprooted and without a history, the approach involving the suppression of religion destroys the meaning of belonging to a spiritual line and a spiritual tradition. The social identity of a person has many aspects, it cannot be traced to a psychological and political identity (however much this last has a meaning), as people would have us believe at the present time. The need to belong to a family, to a country, to a culture and to a religion is a vital necessity. In political terms it is suicide to deny the Christian and cultural origins of society in order to show that one has a welcoming attitude in relation to other religions. We are in a paradoxical situation in which the lack of transmission and belonging is deplored and yet at the same time decisions are taken that have the effect of suffocating them. In such an approach should we not perceive a political wish to further reduce the role of the Church and the Christian faith by confusing them with sects and religions which come from other cultural areas? The policy of religious indifference, which dries up the human consciousness, diminishes in young people the meaning of religion, in which, indeed, they cannot at the outset identify. Young people, indeed, can internalise religious values and a religious approach only if they hear them spoken about in positive terms. At the present time this does not take place. They need time, and at times they need to acquire a critical attitude towards the political and school approach which sweetens religious reality so as to discover in a more authentic form the message of the Gospel and the mission of the Church. This form of secularity is not neutral when it confines religion to a corpus of arbitrary laws that resemble religious persecution. It is even destructive in relation to the religious world, whereas certain policies recognise that religion is able to carry out a real public service, and in its ideological blindness intolerant secularity nourishes an important moral crisis that will in the future become a factor leading to existential crisis. To deny the social dimension of religion means to deprive oneself of the greatest resources of existence directed towards self-fulfilment through finding the happiness of the Beatitudes. And it is in this last point of the encounter with God that man can discover the meaning of life and take on his own responsibilities in order to say 'yes' to life. For this reason, the education of the inner man is a social and pastoral challenge.

6. Educating in the Meaning of the Inner Life

Depression also expresses an interior crisis of the subject who is lost in himself or herself and in the paradoxical anxiety of living. He or she does not know what to do with himself or herself and with his or her existence. He or she is the prisoner of the mirror of his or her own feelings without having any mediation by which to take possession of his or her own existence. It is though he or she were closed up in his or her own subjectivity, in which what is experienced and imagined seems more real than objective reality. Without denying the existence of a specific depressive pathology and the forms of treatment that can be employed to cure it, education and upbringing must give to the subject the means, from childhood onwards, to learn to deal with his or her own inner, psychological, and at the same time spiritual, space, in order to accept himself or herself completely.

The dynamism and the strength of a personality depend upon interior dialogue. This takes place beginning with the psychological function of the ideal that fosters the birth and the development of subjectivity. The function of the ideal is important in learning to identify with people and values that are present as reference points and beginning with which the subject will then develop. He or she can deal with and deepen his or her interior life thanks to them. He or she will become able to make projects, to appreciate himself or herself, and to foresee the future. A person cannot develop his or her own inner life if he or she does not become involved in a work of association between his or her subjectivity and objective realities and truths. In other words, the inner life is constituted solely in relation to other people, rather than in relation to oneself.

In depression, the subject is without any internal dynamic, which we need to know about and, to the extent that this is possible, set in motion again. For this reason, upbringing and education must be directed towards nourishing and stimulating the inner life through dialogue, reading, reflecting about oneself, the contribution of religious culture and searching, and by inviting the person to enrich his or her spiritual life by paying attention to the word and the presence of God.

From a Christian perspective, his relationship with God allows man to recognise his own supernatural destiny.[9] Man is called to live here and now by the love of God, who reveals to man the depth of his own being. God alone can meet the desires of man's spiritual life. He invites man to share in divine life, which goes beyond anything that man can conceive.[10] The inner life of the believer is the space where supernatural life is developed in response to the gospel-based call and the gift of grace. The spiritual life is thus the expression of the presence of God within man. It expresses itself through different forms of spirituality. It is for this reason that the

spiritual life cannot be confused with the life of intelligence, as today poetry, art, aesthetics, philosophy and moral wisdom would have it when reference is made to 'secular spirituality'. More specifically, the Holy Spirit is the teacher of the inner life and gives birth to, and develops, the 'inner man' (Rom 7:22; Eph 3:16). For this reason, the spiritual life is always in a relationship with the religious and Christian dimension which acts as its foundation.

Conclusion

A person who undergoes a depressive experience needs to be surrounded and to be esteemed through daily actions. He or she should be shown that people are interested in him or her, that life continues, so that he or she can take part in it. He or she should not be rebuked for the state that he or she is in; he or she should be loved, and life should be continued as before. This approach prepares the ground for the moment when the subject refuses to go on in his or her depressive weakness, tries to rise up, to find 'the strength to heal', and to find a taste for living again, beginning with food. While waiting for this moment the depressed person will have tried to pick himself or herself up and to live in a different way.

A man who experiences depression has no self-esteem and know longer knows what to do with himself. He needs to feel words that free him and help him to take possession of his own existence. Finding confidence in himself again and in life also takes place through the teaching of Christian hope. A hope that opens us to a future with God and which roots us in the wish to find our happiness with Christ in eternal life supported by the grace of the Holy Spirit.

The Beatitudes outline for us the pathway through the trials that we encounter by which to reach Christ and to begin, right away, to live spiritually what was promised to us. Hope in eternal life illuminates us and it is beginning with the Risen Christ that we must reconsider our lives. It is within himself and in the aspiration of happiness inscribed by God in the heart of every man that the depressed man finds the strength to change his way of living. A man left alone with his own misfortune and his wandering, without another person who encourages him to rise up, to turn his gaze to, and to receive, the word of God who is love, will encounter difficulty in freeing himself spiritually from an image that reduces him to what he does. He will continue to project his present situation into the future, whereas Christ shows us that we need to change our perspectives in order to find love.

Consenting to life is an act of love. We need to reach the love that God has given us despite the trials of existence that Christ shared in to the point of the cross. Is not educating in the meaning of the person, freedom, and responsibility perhaps trying to fulfil the life that has been given to us and to receive what God still wants to offer us? To all those who, like the psalmist, say sadly: 'How long must I bear pain in my soul, and have sorrow in my heart all the day?' (Psalm 13: 2), Christ replies: 'I came that they may have life, and have it abundantly' (Jn 10:10).

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Notes

[1] JOHN PAUL II, address at the Angelus of Sunday 20 July 2003 given at Castel Gandolfo.
[2] G. LA PIRA, *La valeur de la personne humaine* (Paris, Marne, 1962).
[3] JOHN PAUL II, *Veritatis splendor*, n. 86.
[4] *Ibid.*, n. 87.
[5] *Ibid.*, n. 32.
[6] *Ibid.*, n. 32.
[7] JEAN-PAUL COSTA, the Vice President of the CEDH, before the French Commission on Secularity, *Le Figaro*, Saturday and Sunday 18-19 October 2003.
[8] On the other hand, the French Prime Minister wanted to furnish a fairer vision of secularity founded upon mutual and institutional respect between society and the Church: 'In essential terms, modern secularity is not so different from the secularity spoken about before Vatican Council II by Pope Pius XII when he referred to sound secularity. The dialogue that we have developed with the representatives of the Catholic Church, and with the other Christian denominations and other religions, consolidates the solidarity and the cohesion of the country. Far from every idea that would like to reduce the place of religion in social life, the separation of the roles between the state and the religions, and mutual respect, is a principle of freedom'. From the speech made on Saturday 18 October 2003 at the French Embassy to the Holy See, *La Croix*, Monday 20 October 2003, p. 5.
[9] Cf. H. DE LUBAC, 'Surnaturel', *DDB* (1991), 2000.
[10] Cf. H. DE LUBAC, 'Le mystére du surnaturel', *Oeuvres complètes* XII (Paris, Cerf, 2000).

2. Charity

DOMINIQUE MEGGLÉ

2.1. Establishing Social Ties in a Society that is Broken Down and Dominated by Individualism

For more than a decade in industrialised countries we have witnessed an enormous spread in depression, an important epidemic that is unprecedented in the whole of the history of mankind. And yet depression is not a modern invention. In all continents and in all epochs it has always been seen as an existential disturbance in need of treatment, but previously it was sporadic and limited. Now such is not the case. It does not cease to expand.

In the outlying zones of Africa depression is sporadic but in the large and more developed African cities the statistics on depression 'become Western'. What has happened? There is something that has deteriorated in what in the absence of other definitions I would define as 'modernity'. This means that we are not at all in a good state and that the situation is becoming a little worse every day.

Because it does not know its causes, psychiatry does not argue that depression is an illness. However, it treats it as such and often does so with success. Nonetheless, it manages to prevent its return less than one in every two cases. In its evolution psychiatry has tried to base itself on the human sciences. However, the human sciences are themselves demoralising. They reduce man to a series of biological, psychological and sociological inevitabilities. According to these, I as a man am entirely conditioned – there is no hope left. They are not the sciences of the human but the sciences of the sub-human. They have neglected what is specific in man amongst all the primates, what makes him a human being, that is to say everything that belongs to the sphere of his freedom, his responsibility, his values, and what makes him a human person able to live in a community of persons.

For that matter, being sciences, the more they enter into the details of their analysis the more they are incapable of assessing man in his entirety. They are not based upon any philosophical anthropology, something that should urgently be done when one is interested in a problem such as depression, which calls into question our reasons for living – why live? Why die? The depressed person who does not want to live encounters the great questions of the philosophies and religions of all ages. These certainly have much to say about depression but they behave *as though* they were in practical terms useless.

In fact, the explanatory theories on depression have increased at the rate of the increase in depression, the trends of the moment and of the market. Here are some examples of this. The organicists think that depression comes from a biological malaise of a person's mood, whereas for the psychoanalysts it comes from a psychological malaise of a person's mood. According to the cognitivists sadness is not a primary reality but is secondary to a complex of erroneous beliefs. All agree on the fact that everything takes place within the interior of man, who is conceived of as a monad in Leibniz's sense of the term.[1] The systematics, in contrary fashion, state that depression is not the prerogative of an individual but of a whole family. They speak about 'dysfunctional' families in the sense that the inter-personal relationships within a family are so disturbed that they produce depression in each of its members. But the individuals who make up the family are completely disassociated from each other in this outlook in favour of an approach which perceives a system of family inter-relationships – in this outlook the individuals no longer exist.[2]

Despite appearances, although in some cases there is much to them, the biological theories do not have much weight. At the present time they are not well confirmed and work and act more for the commercial promotion of pharmacies than for the progress of knowledge. Not even the psychological theories have much substance. In fact, each one of them is built for a generalisation and begins from only a few studied cases. No verification of them is possible. Not one of them can be confuted. When a theory encounters a depressed person who does not belong to the category envisaged for him or, it becomes complicated and more contorted, to the extent of incorporating the new case into the above-mentioned category. You will never see one of these theoreticians, confronted with a new fact, say that he or she

has made a mistake and that it is necessary to revise certain bases of his or her theory.

This is why for the specialists the only correct scientific behaviour is that of rejecting theories taken from books and concentrating on the real, concrete and unique experience of each depressed person. Each depressed person is unique and the experience of each depressed person is unique. There are as many depressive states as there are depressed patients. And it is the real patient that we must be interested in.

And it is by concentrating on what has generated my dismay and not by categorising me under the aspects of one theory or another that I will be helped to escape the pain of having lost my mother, my job, my health, of having a schizophrenic child or of having contracted AIDS. On this alone should the scientific therapist concentrate his or her attention. This assumes that he or she respectfully enters my universe in order to explore it, trying to pay attention to his or her way of communicating. I must feel that I am understood; there are, indeed, words that wound, kill, injure or heal.

Luckily, during the last half century communication has achieved major advances. Careful and respectful communication, a real interpersonal relationship, involves the first recovery of social ties. It will form the basis of the whole therapeutic work.

Certain things have also been analysed more effectively. It was once said that depression emerges after a loss – the loss of a job, of a loved one, of security or of something else. The idea was true but anonymous, individualistic in character, and was something that was fitted to the statistics. At the present time, this loss is placed within the family cycle. We are children, then we become adults, then we marry, we have children, our children leave us to marry in their turn, after a short time we have grandchildren, and we have to know how to live out retiring, growing old, and dying. This is the story of our times; each time we leave known shores to reach others. Each time we have to lose in order to win.

Each one of us lives out this cycle in a different way. If we reject the loss of the known we grow rigid and a depressive crisis emerges. There is no other way by which to go forward than to put up with the consequences of the deprivations that have been experienced. To resist the course of life means to condemn oneself to depression and not to discover new horizons. Such is reality: if it is accepted, one opens up to life; if one rejects it, something breaks inside us. Here we encounter a practical objective of therapy – the relaunching of the person in the cycle of his or her family life. This is pragmatic and helps to place the human being amongst his fellows,

in the mystery of his personal and communal destiny.

The whole of this approach (communication, life cycles) could not be addressed some thirty years ago. Adequate answers are now possible. They carry the weight of authority.

Despite this, such answers do not solve the question raised at the beginning of this paper, namely: what are the reasons behind this epidemic of depression? And we have observed that the theories involved confuse the question rather than helping to find a solution to it. For this reason, we need to consider the evolution of our society as we have wanted this evolution. The truth is that we live like madmen and that although we complain, we have no intention of behaving otherwise. We should not, therefore, be surprised, if there is an explosion in the incidence of depression.

Here is a short list of 'wonders' that we have managed to achieve in less than half a century.

We have suppressed nearly all the traditions that gave us points of reference but which we adjudged to be too restrictive Thus we replaced them with obligatory 'celebrations' belonging to consumerism, such as Halloween and sports meetings.

Couples have become terribly unstable and while they are being formed their break up is already being prepared. Modern man, who is individualistic, is enough for himself. He boasts of being a monad. He does not admit that changes can modify him. He does not have exchanges, he has experiences that are sufficient for him to consume – at the same level – sex, food or music. Upholding his freedom and the sincerity of his feelings, he has replaced being with having. He consumes and after gaining enjoyment he feels sad.

Pornography spreads in all directions. It shows a form of sexuality to us that is nothing else but a consumer good.

In the evolution of the human person and society, the role of work is no longer perceived. Work has become competitive slavery, experienced in permanent insecurity. We are nothing else but instruments of production who must be in good condition. And we must move increasingly quickly, with our minds filled with too much information, disorientated by too many calls on us that drag us everywhere and in the end make us nervous and upset. We are dealing here with the modern illness of the three 'e's: *Encombrement*, *Eparpillement*, *Enervement*, that is to say: lack of outlets, dispersion, and bad nerves.[3]

For the first time in the history of mankind, religion is no longer of interest, although man had always found in religion a meaning for his own life. In contrary fashion, a new religiosity has spread that seeks to meet the disquiet of our monads, who are turned in on

themselves, with techniques of relaxation that are pretentiously defined as being 'meditations'.

We no longer have confidence in our political representatives, all of whom are seen as technicians, Fascists, or corrupt. They should be there to govern and to point out the path to follow. In the main their messages are confused: the Euro and globalisation are presented at one and the same time as wonderful opportunities and yet as merciless impositions from which we cannot escape. Who should we believe in? What should we believe in? Here I will finish my short list. How can we not become depressed amidst all of this?

And in all this explodes rancour, resentment, hatred and depression.

The modern form of this widespread depression has neither a biological nor a psychological cause. It is a form of depression that springs from something higher. It is a form of depression that comes from the removal of a meaning to existence; it is what Victor Frankl calls: 'noogeneous neurosis or existential depression'.[4] It belongs to the sphere of the mind and shows that a society that replaces being with having in a systematic way produces a whole series of depressed people. It makes them mad. The removal of meaning disturbs the human psyche and human cerebral biology.

In this case the good news takes two forms. On the one hand, we have the experimental proof that in order to function correctly the human being needs values and to be able to give a meaning to his or her life. We can no longer deny the fact. It is in front of our very eyes.

Given that we have done nearly everything that we should not have done, by exclusion we now know what we have to do to escape from the pandemic of depression, or at least we know the path to follow: the placing of man, his freedom, his values, his search for meaning but also his sense of responsibility, once again at the centre and the summit of the whole of social, economic and political life.

All of this may appear pretentious and utopian. I think that it is neither one nor the other, and this for a very simple reason. The fact is that the path that we have taken has turned out to be a one way street. We therefore have to take another and we cannot afford the luxury of not doing so, unless, that is, we want to engage in collective suicide (which is widely encouraged by the widespread presence of failure).We are dealing here with a matter of survival.

The second good news is that because the form of depression whose consequences we experience is located in the sphere of the mind, an action in that sphere could reduce it, retrieving both individuals and society at a stroke. An individual concrete action is possible.

In this case morality would recover all of its importance; indeed, as never before in history. Morality has been despised for decades and it is now more despised than ever before. As if by accident, during this period, depression has spread and continues to expand. Despised by non-believers who substitute it with 'ethics' of variable forms of geometry, morality has also been eliminated from Western Churches in the name of love – we should not be 'moralistic', they said. For this reason, morality is the science of human happiness, the way in which the human being should be committed, and, please forgive the phrase, it is the 'friction' of love. With morality one learns to love. With it the 'human engine' advances. Without it that engine makes only noise.

The need for this great return to morality, promoted in an explicit way, announced as such, without any sense of false modesty, as an emergency measure for the regaining of public health, should not surprise us. St. Benedict in his 'Rule', which was written during another turbulent period of history, felt the need to clarify to his monks that they should neither kill nor steal nor bear false witness: thus there were men who isolated themselves in a closed monastery out of love for the Lord to whom it was necessary to repeat, just to start with, the most elementary of the Ten Commandments! It was this realism that evangelised Europe by creating real social ties, beginning with a concrete change in the behaviour of each and every man.[5]

In conclusion I would like to end this paper with the essential, the Gospel and the *mandatum novum*. Fundamentally, human beings do not love each other, and the channel of depression causes the same pain to us as a war. Our Lord told us: 'love your neighbour as yourself'. Many patients tell me that they cannot love other people because they do not love themselves. They have not understood that Jesus asks us to love other people and that in loving others we begin to love ourselves, which is by far and away the most difficult task of every man since the original sin. It is specifically because we do not love ourselves that we have a formal order to get to work. And it is in giving ourselves to others, as Christ did, that we will begin, gradually, to love ourselves. We will thus free ourselves of a great burden, the worst burden of all - ourselves. Christ asks us to engage in a real and authentic effort, the most important one of our whole lives, with the help of his grace, with the points of reference of natural law and the Holy Church. And it is in this way that he raises up the broke-hearted – '*et erigit omnes depressos*.'[6]

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Notes

[1] Monads are perfectly self-sufficient beings that are unaffected by external influences and do not have relationships with other monads. Monads move and meet each other without modifying each other. 'They cannot be penetrated by any external action, they are different from each other, they are subject to continual change that comes from their substratum, and they all have appetition and perception': A. LALANDE, *Vocabulaire technique et cristique de la philosophie* (PUF, Paris, 1976).

[2] D. MEGGLÉ, *Les Thérapies brèves* (Presses de la Renaisance, Paris, 2002).

[3] P. AMEDEE AND D. MEGGLÉ, *Le Moine et le psychiatre* (Bayard/Centurion, Paris, 1995).

[4] V.E. FRANKL, *The Doctor and the Soul* (Vintage Books, New York, 1986).

[5] La vie et la règle de Saint Benoit (Desclée de Brouwer, Paris, 1965), Règle, ch. IV, *Quels sont les instruments des hommes oeuvres*.

[6] Psalm CXLIV.

DANIEL CABEZAS

2.2 The Reception and Welcoming of People with Depression in the Medical and Hospital Context

As a premise, and before taking about the subject of how to receive and welcome people with depression, I should make a reference to the sick person, to that individual for whom 'the arrival of every disturbance, whether it is benign in its influence or is a direct threat to life, like an acute abdomen or a cancerous illness, naturally provokes reactions that are not only biological in character but also psychological'.[1] Illness interrupts and disorganises a person's usual life rhythms, places his or her relationships with his or her own body and the world in which he or she lives in a state of crisis, and becomes, thereby, a sort of 'disorientation of identity', where, however, 'illness is more than a clinical fact that is medically circumscribable. Illness is always the condition of a man, of a sick person'.[2] In my university or specialisation courses I have not been able to find an outline of a curriculum which includes such elements. I have learnt about such facts in the hospitals in which I have worked: the nursing homes of the 'Hospital Sisters of the Sacred Heart of Jesus', the 'Fatabenefratelli Hospitals of St. John of God', and the 'Camillianum Institute for Pastoral Care in Health' in Rome.

Since remote times, as was observed by the distinguished speakers who have preceded me, illness has been interpreted according to the culture and the evolution of science of that particular historical moment. It is thus understandable that illness has been seen as an event to be considered within the context of man's relationship with the gods, as the outcome of the humours, as merely a physical thing, as a mental thing, as a social product, and on until our times when we still know little about the process that is involved when an individual becomes a sick person. Illness nearly always means the appearance of symptoms and the problem of grouping and classifying them. In recent years the fact of becoming a 'patient' has apparently been interpreted as the ultimate recourse of a person who is not able to help himself or herself and thus who does not have social support.[3]

To speak about the reception and welcoming of people in a health care context is to understand that hospitals, illness and medical action are important threats to the mental equilibrium of the patient, whose response, indeed, is a conscious or unconscious experience of fear. For the person who feels threatened, certainties vacillate and tremble; he or she perceives a danger to his or her physical integrity, and according to the level of the seriousness of the clinical situation, he or she also perhaps fears for his or her life, and thus the spectre of death also arises.[4] The experience of anxiety, at times of panic and often of unease, all of which cannot be referred to something that is precise or a specific aspect of the illness,[5] can be caused by the excessive worry that comes from mistaken, incomplete, or absent information about the illness, its treatment, and its prognosis.

All of this becomes more complex when one is dealing with depression. Nowadays, there is an acceptance of the multifactorial genesis of depressive disturbances, where the personality factors and psychosocial events increase with the physio-pathological aspects and the genetic predisposition of the person in different proportions.[6]

It is obvious that this approach is especially attractive within the context of the medicine practiced by a general hospital, as is demonstrated by the extensive literature on the subject, which enables us to see that there is much that is 'mental' inside the 'physical', and which seeks to overcome the reductive anachronism of spirit/body dualism.

Depression in the medical context is revealed and illuminated in epidemiological terms in the professional practice of the family doctor in primary prevention and is described in terms of the well-known 'iceberg phenomenon' of Watts. In the multifaceted world of depression, 85% of people with depression are 'silent' because they have had spontaneous remission and have not been noticed; of the remaining 15%, 13% suffer from minor depression that does not require help from the health care services, and only 1.8% of these people require medical assistance – 1.5% from the family doctor, 0.2% from a psychiatrist, and 0.1% of them need to be placed within a psychiatric service.[7]

This reality is connected with another, which demonstrates that there is a considerable lapse of time between the onset of the illness and its recognition, with periods of time that range in average from seven months to a year in equivalent cases of depression, and to thirty-four months in cases of concealed depression. This demonstrates the relevance of depressive disturbances which go beyond the specific field of psychiatry and are acquiring an increasing importance in general medical practice. This development is the result of the high prevalence of, and the possibility of carrying out, adequate and suitable diagnoses and treatment of depression at the level of primary medical assistance.[8]

In hospitals, to move to another sphere, depression has features that are of great interest, and not only for psychiatry. Excluding the aspects of depressive disturbances in the psychiatric services and paying attention to patients who are admitted into other services for various reasons (with a diagnosis of presumed depression or another kind of mental disturbance) and to consultation visits, we can state that one of the interesting aspects of research into depressive illness in people who are admitted to institutions for non-psychiatric rea-

sons is the time (delay) that passes between admission and the request for a consultation.

The differences between hospital services with different specialisations that require a psychiatric consultation are notable (I am referring here to a study carried out in the Clinical Hospital of Valladolid in Spain).[9] The proportion of consultations was of a ratio of four to one when compared to surgical medicine, and when depression was suspected most of the cases were diagnosed as brief depressive reactions. This fact leads us to think that hospitalisation may be a possible generating factor, that is to say that admission or other circumstances correlated to hospitalisation (possible hostile or traumatising situations) may provoke a disturbance in the psychological equilibrium of many patients by fostering the generation of situations of isolation, depersonalisation, disinformation, dependency, and the loss of privacy and freedom.

One of the grave consequences that this delay can cause in relation to the request for a psychiatric consultation is the suicide of the patient who has been admitted, and one of the elements correlated with a diagnosis of depression is specifically hospitalisation as a joint cause of depression.[10]

What has been said above are only considerations that have been made in order to draw your attention to the need for a greater understanding of the patient and his or her illness, and to allow a perception of the pathway of the illness, which in turn permits a better direction of the therapeutic measures that should be adopted. At this point it is obvious that we should think about the frequency of the complexities and the difficulties encountered in treating accompanying pathologies in patients who suffer from depression. We are dealing here with physical factors such as systemic illnesses, illnesses of the central nervous system, the side effects of drugs and medicines, cardiovascular diseases, the consequences that can affect a patient who has undergone surgery or major physical traumas, or who is a geriatric patient, and so forth. It is equally true that the factors that are experienced as a reaction to the patient's illness, as a reaction to his or her hospitalisation, and as a reaction to his or her loss, are relevant factors that come together to generate the depressive episode. Given that it can provoke physical and existential factors, we should ask ourselves whether a hospital reduces fears or increases sadness.[11] *We may also in this sense assert that a demonstration of care and concern for patients on the part of health care staff characterises an approach of welcoming, a state of mind towards the sick person, before, that is, constituting a sort of set of technical abilities*.[12]

It is true that phenomena of anxiety are more evident in those who manifest this disturbance before the hospitalisation that is required by the illness, and it is equally true that this is a normal reaction in the face of the first symptoms of the illness that are connected to many thoughts that are full of uncertainty. If the patient can speak and find a person or an environment that is able to receive and contain these anxieties in a suitable and appropriate way, that is able to listen, to invite that person to speak about his or her own fears and to inform him or her in a right way, this can be a way by which the equilibrium that has been lost by the patient because of the illness can be restored. This loss of equilibrium exists where the hospital, the illness, and medical action all represent important threats and generate as a response a conscious or unconscious experience of fear in the patient.

A health care worker who is careful and conscientious in managing these aspects of the illness of the patient can be certain that he or she has had a better approach of welcoming and has re-established the psychophysical equilibrium of the person concerned.

The illness of the patient is often experienced as a 'loss', with a justified or imagined fear of losing something that is important – a physical or social function, health, habitual relationships, a life context, or the patient's self-image. At times the idea emerges that everything is over, there also arises the idea that life is over, and this depresses and dismays the patient. At times his or her response to the illness appears to be exaggerated, and a meaning is adopted in relation to it that is not rooted in reality. In a different fashion, chronic, invalid-making or terminal illnesses constitute the cause of the depression, which thereby becomes clearly identified; at other times, on the other hand, the symptoms of depression are more subtle, and only more careful study allows us to discern a certain form of lack of interest in,[13] and indifference towards, the patient's family, home, work, etc. At other times a strong tendency to weeping, to self-isolation, to say that one is tired and would like to sleep for a while, becomes the most valid reason for shutting oneself away in order to hide or isolate oneself, thereby conserving the ideas that cause fear and which it is difficult to admit to or to share.

Feelings of guilt appear because of events that took place in the past; the patient is not able to do anything, a feeling of inadequacy and incapacity lasts the whole day, time becomes unending; the day of the depressed person never ends, and during hospitalisation this effect is increased by the interminable twenty-four hours, the timetables, the rhythms and activities that are clearly different from normal daily life; the hospital, the doctors, the forms of treatment – everything becomes different and difficult, and thus patients adopt a passive attitude, they surrender, they give up the struggle, they do not find reasons to live or possibilities of doing so, and despair, powerlessness, tiredness and frustration emerge.

The obstacle represented by the illness and hospitalisation of the patient, the non-satisfaction of the person's needs (biological needs, emotional needs, needs connected with relationships and with work etc.) provoke in the patient a sense of impediment that is by no means of small account or importance, and which brings about responses of *frustration*, generating in turn feelings of *anger* and of *aggression*, which are intended to remove the obstacle.[14]

Aggression is not always directed towards the reasons for the frustration that is felt – very frequently it is directed towards the weakest and nearest people around the patient: a family relative, a nurse, and in the case of children towards mothers or brothers etc.

Very often the patient is unable to bear his or her own illness; he or she attacks the health care workers or his or her own family relatives, who become scapegoats for that illness.

This form of behaviour can be interpreted as an irrational way of defending oneself against anxiety and depression. There are moments when the inability to tolerate anxiety and illness provoke other forms of behaviour in people. This involves new ways of relating to their world and

themselves.[15] There are individuals who, as is the case with other frustrating situations, change their characters, show that they are not willing to help and are diffident, become intractable, are never satisfied with the care or treatment that they receive, blame those who are near to them, those who are weakest, refuse care and treatment, and become totally aggressive and unpleasant. At other times such aggression is more subtle in its character: the patient becomes a 'victim' of everything, 'suffers', and 'has to put up with' a great deal; aggression is projected onto other people, and the patient shows that it is other people who are really aggressive; the responsibility for his or her illness is placed on other people's shoulders, indeed often on those of a relative who has 'neglected' him or her or on those of a medical doctor who is 'incompetent'.

Many times this sense of suffering and feeling that one is 'being subjected to things' can be experienced as though external forces were at work (destiny, incompetent health care workers, neglectful family relatives etc.), with the projection outwards of the causes of the patient's 'misfortune' and an attempt in this way to free himself or herself from the burden of too much anxiety. An example of this is the constant changing of the medical doctor, whether a specialist or otherwise, and of the health care structure (it is better if it is more expensive and highly qualified) by the patient who wants in this way to control his or her treatment, who may not accept it, and who does not accept any side effect that is caused by the drugs or medicines that form a part of the treatment.

The aggression of the sick person generates equal (symmetric) and contrary responses on the part of the health care staff, who, in the case of greater calls on their professional skills, respond with an approach of detachment, and this generates a vicious circle that aggravates the disturbance and the problems associated with it.[16]

At other times we health care workers find ourselves faced with psychological mechanisms of an unconscious character by which the patient adopts forms of behaviour characteristic of a previous stage of his or her life (*regression*: the return to forms of thinking and relational modes that belong to a previous stage in the development of the subject, as though he or she was searching for a state of greater protection, with less duties and responsibilities, with an infantile and selfish approach, especially as regards personal cleanliness and the physical functions: the patient sees the health care staff as all-powerful beings, along the lines that children see their parents) in order to escape from the frustration of contemporary reality.[17] The medical doctor becomes an 'all-powerful father' or the nurse is given the role of the 'good mother'. *Regression is an inevitable and universal mechanism that each health care worker must know about and understand in its various aspects so as to be able to manage it*.[18]

Such a powerful mechanism of defence is accompanied by attitudes of various kinds: a reduction in interest (the patient becomes poorer intellectually, he or she shuts himself away, and becomes socially isolated), he or she takes refuge in a past that is full of fantasies, and is selfish; only what is connected with the patient is important, and there are complaints about any kind of frustration that may arise (visits that do not take place, unbearable timetables, work that has been abandoned etc.).The aim of this behaviour is to convince the patient that he or she is at the centre of the social universe.

The patient looks for *dependence* on other people in relation to food, drink, looking after his or her body, and this is accompanied by a hypersensitivity to their reaction. The patient complains that he or she cannot do things independently, there is a return to primal satisfactions, refuge is taken in sleep, special requirements and needs as regards food and diet are developed, the patient becomes full of magical and not logical thoughts, and seeks omnipotence in medicine and the health care staff.

At other times we encounter psychological states in patients who, when faced with serious illness, have the tendency to *deny reality*. They block out emotional tension and exclude any consciousness of what is connected with their own suffering.[19] This is a way of defending themselves from anxiety about death and at times an attitude such as that described can also be useful in relation to the psycho-physical impact of suffering and illness because the anxiety and danger that the stress involves can be tolerated.

Understanding aggressive, regressive and defensive behaviour, which is the outcome of frustration, and to move towards the person with an approach of welcoming in order to accompany that person in the re-establishment of the equilibrium that has gone away, does not mean 'keeping quiet about the truth', it does not mean engaging in misdirection. On the contrary, it should involve a responsible act which helps the patient to become aware of his or her situation and regain equilibrium, the homeostasis that has been lost, with his or her rhythms, his or her strength, his or her personality, his or her mechanisms of defence, and his or her culture.

It is very important to draw near to the patient and to try to understand these things that are not said, that are not well identified. In the mind of the health care worker the approach of psychiatry is unfortunately inherent, and psychiatry employs difficult language, indeed, at times language that is not well structured and sometimes contradictory. For this reason it is better to ask for a consultation.

On the other hand, when the patient is being examined, one can identify the other part of his or her being, that part that thinks and feels fear and loneliness, and a great deal of confusion; the patient who defends himself or herself with the methods that he or she has learnt in the course of a lifetime, which are at times aggressive, at other times regressive, but always defensive with a denial of frustration, but where the patient always needs to find people who help him or her to understand that phenomenon which is a part of life, namely falling ill, being faced by suffering, and as is so often the case, addressing the strongest moment of life – death.

So much money, pain, suffering, and only to think that illness is a physio-pathological phenomenon, that everything can be reduced to a biological cause. How much pain, suffering and resources of every kind could be saved if we approached man in his entirety, and managed this moment, which is so strong, in communion with the awareness that is supplied by culture and history! A history rich in experience that shows us the pathway of civilisation by which to understand and fight against death, with so many people, who, like St. Vincent de Paul, St. Camillo di Lellis and St. John of God, 'have eyes to see needs and suffering…ears to hear

the clamour of the poor…and hands ready to help',[20] and a culture where 'man, among all the creatures, is endowed with a unique dignity'.[21]

It is worthwhile to talk for a moment about adolescents in conditions of malaise who today ask for care and treatment with greater frequency than was previously the case. A corporeal mediation of psychological problems transfers such problems onto the somatic plain. Adolescents have a low tolerance towards health care structures which, indeed, place them in an isolated condition amongst elderly people or very small children. I may refer here to an inquiry carried out by Marie Choquet and Silvie Ledoux in 1994[22], which demonstrates that adolescents who go for a medical examination do so above all else for reasons that are initially of a physical character: accidents, teeth problems, eyesight problems, skin problems, contraception and tiredness. The approach of family relatives is of determining importance in how the individual behaves. The frequency of the requests for a medical examination can be broken down as follows: at least 75% ask for an examination by a general practitioner, at least 65% ask to see a dentist, at least 22% ask to see an eye, nose and throat specialist, at least 21% ask to see a dermatologist, at least 9.5% ask to see a gynaecologist, at least 6.5% ask to see a paediatrician, and at least 4% ask to see a psychiatrist or a psychologist. At the same time, one adolescent in every eight is admitted at least once to hospital and 2% of adolescents are admitted more than once. The frequency of admittance to first-aid or emergency structures is due in half of the cases to accidents, whilst the other reasons for such admittances are linked to various medical/surgical pathologies (40%), to suicide attempts recognised as such (8%), and to the results of physical assaults (3%).[23]

We should not forget that a clinic for adolescents is different, from many points of view (even though points of convergence do exist) to clinics for children or adults.[24] If adolescents in difficulty go where they are expected to go, where because of its special features (the importance of the body, the fear of being different, the need for exchange with people of their own age) suffering encounters difficulty in expressing itself in words (if not, that is, where it is shouted out), then action takes the place of speech, and this helps to disturb or irritate the family, schools, social centres, first aid centres, and hospital wards, because of the adoption of provocative hostile attitudes. At times behind a specific form of behaviour is to be found pain that can only be expressed through action.[25] Faced with such a strong phenomenon, how should adolescents be received? *Certainly not only as clinical case to which should be applied the fruits of one's own knowledge, but, instead, always as a suffering person towards whom we should 'adopt a sincere approach of 'sympathy', which requires love: readiness to help, attention, comprehension, sharing, benevolence, patience, and dialogue*.' 'Scientific and professional examination' is not enough – we need 'personal participation in the concrete situations of the individual patient'.[26] *The family* can only rarely deal on its own with strongly emotional and critical moments. The person who intervenes must understand the reality of the situation as it is expressed, seek to offer tolerable contexts of protection, and reduce the suffering of the patient and that of his dear ones by helping them to express that suffering orally and by finding out its meaning, and by containing the impulsive forays rather than repressing them.[27]

Illness means threat, frustration and loss both for the sick person and for his or her family, and it endangers not only the patient's economic and social stability but also his or her relational and emotional stability. The reaction of the family and the reaction of the sick person influence each other in mutual fashion and imperils the equilibrium that has been achieved,[28] generating, thereby, a modality of expression which differs according to the people that are involved. This is something that obliges us to understand that helping a sick person also means working with and helping the family, with its reactions and forms of internal relationships, with the same mechanisms of anxiety that lead the family to try to protect the family member through different mechanisms of control and by not allowing the sick person a minimum of autonomy in relation to his or her own reality. At other times there are reactions involving *regression*, where a form of behaviour is developed in which the family members *shut themselves away on their own*, isolated from their reality and their context. Illness can be experienced in such a burdensome way that the response of the family group and the sick person is *to deny reality* and the danger that exists; everything becomes superficial; they are faced with a problem that is not easily understood and they are unable to free themselves from it: *rejection, aggression, paralysis and depression*.

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Notes

[1] K.Schneider, quoted by L. SANDRIN, *Capire e aiutare il malato* (Camilliane, 1989).
[2] Pontificio Consiglio della Pastorale Sanitaria, *Carta degli Operatori Sanitari* (Vatican City, 1994).
[3] M. JONES, *La psichiatria sociale nella pratica* (Americalee, 1970).
[4] L. SANDRIN *ET AL. Capire e aiutare il malato* (Camilliane, 1989).
[5] *Ibid.*
[6] J.L. RUBIO SANCHEZ, *Epidemiologia Ospedaliera dei quadri Depressivi. La depressione nei diversi livelli assistenziali* (PTD, Spain, 1997).
[7] A. RODRIGUEZ *ET AL.*, *La depressione nei diversi livelli assistenziali*, PTD, Spain, 1997).
[8] F.J. VAZ LEAL *ET AL.*, 'Disturbi affettivi: depressione', *Medicine*, 6, 2969-2969. Quoted by P. Serrano, *La depressione nei diversi livelli assistenziali* (PTD, Spain, 1997).
[9] J.L. RUBIO SANCHEZ, *Epidemiologia Ospedaliera dei quadri Depressivi, La depressione nei diversi livelli assistenziali* (PTD, Spain, 1997).
[10] *Ibid.*
[11] *Ibid.*
[12] A. BRUSCO, *La Relazione Pastorale d'Aiuto* (Camilliane, 1993).
[13] L. SANDRIN, *et al.*, *Capire e aiutare il malato* (Camilliane, 1989).
[14] *Ibid.*
[15] P.B. SCHNEIDER, *Psicologia medica* (Feltrinelli, Milan, 1978).
[16] L. SANDRIN *et al. Capire e aiutare il malato* (Camilliane, 1989).
[17] L. SANDRIN *et al. Capire e aiutare il malato* (Camilliane, 1989).
[18] P. JEANNET *et al.*, *Psicologia medica* (Masson, 1957).
[19] L. SANDRIN *et al.*, *Capire e aiutare il malato* (Camilliane, 1989).
[20] C. Vendrame, in G. SOMMARUGA, *Cammillo di Lellis, un messaggio di misericordia*.
[21] GIOVANNI PAOLO II, 'Discorso alla XI Conferenza Internazionale', *Dolentium Hominum*, 34, 1997.
[22] Quoted by X. Pommereau, *La tentazione estrema* (Pratiche, Milan, 1999).
[23] *Ibid.*
[24] *Ibid.*
[25] *Ibid.*
[26] Cf. GIOVANNI PAOLO II, 'Al congresso dei medici Cattolici Italiani', quoted in Pontificio Consiglio della Pastorale per gli Operatori Sanitari, *Carta degli Operatori Sanitari* (Vatican City, 1994).
[27] X. POMMEREUAU, *La tentazione estrema* (Pratiche, Milan, 1999).
[28] L. Sandrin *et al.*, *Capire e aiutare il malato* (Camilliane, 1989).

JORGE ENRIQUE JIMÉNEZ CARVAJAL

2.3 The Role of the Family Faced with Depression

There can be no doubt that all the evils of society lurk in the family, just as there can be no doubt that the family is the privileged place from which the salvation of society itself must begin.

1. The family as a natural area in which to grow and develop in a healthy way

God did not want man to be alone. For this reason, He created them 'male and female', and beginning with them, He created the family. It is in the family that everyone, both men and women, can realise themselves as persons. And this is an obligatory pathway.

The family is the natural space for men and women to grow up healthy. In the family people mature, there their identity is strengthened, and there they find their group of reference and of belonging that gives them the possibility to grow and develop in a healthy way.

The family is the place in which men and women take on the basic values that allow them to address existence in their fundamental relations with God, with other people, and with themselves. This balanced growth enables them to mature and to open themselves to life in society.

2. The family: an institution subject to special attacks in contemporary society

It is very probable that there is no institution that suffers greater attacks in present-day society than the family.

What is to be observed in contemporary society works in various ways against the Christian and human meaning of the family, and it is the family that reproduces and repeats on a micro-scale in a permanent way the evil that it receives, thereby creating that terrible reality that makes us recognise that the institution that is in fact called 'to save' society is itself the institution that is attacked by society.

Present-day society, which is marked by an absolute lack of sense of the future and of interest in others, and which is accompanied by a spirit of immediacy, shallowness, selfishness, and necrophilia, and by that ruling 'approach of Cain to life' which makes us assume that nobody is responsible for anybody at all or as regards anybody, is a society of 'every man for himself' which submerges today's young generations in a world of hopelessness and of dismay. Such generations, and every day this is increasingly the case, fall prey to disappointment and to disenchantment, and easily succumb to one of the 'evils' that afflict millions of people in all the continents of the world.

John Paul portrayed the desolate scenario of today's family in his pastoral exhortation *Ecclesia in America*: 'many insidious forces are endangering the solidity of the institution of the family in most countries of America, and these represent so many challenges for Christians. Among them we should mention the increase in divorce, the spread of abortion, infanticide and the contraceptive mentality.'[1]

To the problems pointed out by the Pope we should add others, at least in Latin America, which afflict in a grave way the institution of the family. They are: the very low number of marriages; the high percentage of *de facto* unions, which are insecure and lack stability – with all the consequences that follow from this; the increasing and high level of family breakdown brought about by divorce – which is so easily accepted and legalised in nearly all countries, because one of the marriage partners abandons the family home (nearly always the father), and because of forms of sexual licence generated by a false idea of masculinity. To all this should be added the emphasis on hedonism and eroticism that is created by the asphyxiating propaganda promoted by consumer society.

It should be pointed out that many of these situations are systematically created by the policies of the various institutions of the United Nations, institutions which have an influence on the legislation of all the countries of the world and often condition nature of the economic aid that is provided by the international economic institutions.

It is important to point out that the post-modern mentality, which was graphically described by Cardinal Javier Lozano Barragán at the beginning of this international conference, is causally connected in a very significant way with the fragility of the institution of the family and the growth of many of the problems that have been pointed out in this paper. One may observe how today it is common for young people to be reluctant to take a choice that affects their whole lives, for example a choice in favour of Christian marriage.

3. The family is often the origin of the syndrome of depression

In relation to everything that has been said in the previous sub-section, it is important to recognise that the family, too, is, to a substantial extent, the origin of depression and many forms of mental illness. The great evils that pass through the family – divorce, separation, irregular situations, the phenomenon of teenage mothers and so on – are often the source of depression in many of its forms. Usually, it is children and adolescents who most bear the burden.

In an almost systematic fashion, it is necessary, when depression is diagnosed, to enter into the depths of the family reality, where, indeed, many of the causes of depression are to be located. The fragilities that exist in the family make possible many

of those forms of mental illness that we have been discussing over recent days.

4. The Family: a privileged area to prevent and overcome the syndrome of depression

However, the family is also a privileged area to prevent and overcome the syndrome of depression. Indeed, the best treatment for depression is a well-founded family in which all its members grow and develop as persons. In the family, persons find a place to protect themselves from the so-termed 'depressive society', without engaging in dangerous flights from reality.

The family is called upon to play a very important role in strengthening its members and in projecting itself beyond the home, as the origin of authentic and free persons who are more concerned to serve with joy more than to allow the entrance of this scourge that afflicts individuals because of desperation.

We must identify who in the family manifests signs of depression and why they do. This can be an opportunity for renewal at a family and personal level by fostering constructive dialogue. When, however, these signs remain and imperil daily life there is good reason to increase the paths that can offer a solution through engaging the help of professionals in the fields of psychology and psychiatry. Without treatment, indeed, depression can last for years.

Accompanying and family solidarity are always advisable in helping those who are *at the doors of* depression or who are already in its clutches. It is better to be accompanied in a process that may well be slow but which every day obtains positive results if it includes a plan of practicable and concrete activities that includes physical, intellectual, recreational, religious and social activity.

In the case of melancholy,[2] which in olden times was what such emotional disturbance was known as, or in depression, which is a disturbance of the soul, there is a lack of a meaning to life itself. It is a very great privilege to be born and to live in a family, and if one is dealing with a family in which ethical and moral values are cultivated then this privilege is even greater given the context of a society that is in a state of crisis. It is clear that faith is acquired in the daily routine of family life and is not obtained through a mere apprenticeship of knowledge within the family, which is an 'intimate community of life and love'.[3]

In a condition of negative loneliness, or in melancholy or depression, sadness is not healthy and one cannot achieve a rapid redress of personal balance if one does not have the support of one's own personality and its connected values within the family. In the face of difficulties that seem immense we should not fall on our knees or descend into pity. Instead, we should rise ourselves up with courage. One is dealing here with a spiritual fight against apathy and the deep sadness of the void or shallowness; indeed, we have before us a spiritual fight to overcome such difficulties and overcome hopelessness.

At this time in history, when the family sees itself attacked as the fundamental institution of society, what is required is a 'vast, extensive and systematic work, sustained not only by culture but also by economic and legislative means, which will safeguard the role of the family in its task of being the primary place of "humanisation" for the person and society.'[4]

The role of the family, as thus described, promotes that growth in 'humanity' that invites us to action despite indifference and apathy; to joy, despite sadness and melancholy; to solidarity, despite selfishness; and to Christian hope, despite the depression that abounds in families and which we can help to uproot because, as John Paul II, has emphasised, it is in the family that each person 'can become aware of their dignity and prepare to face their unique and individual destiny'.[5]

5. Pastoral care of the family: a pastoral priority of the Church

Integral pastoral care of the family that strengthens the family unit is the best preventive treatment for the many forms of depression that afflict contemporary men and women. It can also, in many cases, save those who already suffer from this grave syndrome.

In his *Novo Millennio Ineunte*, John Paul II launched an urgent appeal for the crisis that is now being experienced to be dealt with beginning with pastoral care of the family: 'special attention must also be given to the pastoral care of the family, particularly when this fundamental institution is experiencing a radical and widespread crisis'.[6]

It is important to point out that joint pastoral care has a special importance in this kind of pastoral action. In addition to pastoral care in health, indeed, many are the forms of pastoral care that bear upon the family: pastoral care of the family; pastoral care of young people, pastoral care of children and adolescents; pastoral care in education, sexual education as a part of progressive education in love which will allow young people to discover the beauty of love and the human value of sex;[7] pastoral care of adults; and pastoral care of the family in meetings of the couple etc. All this acquires unity in making 'the Church the home and the school of communion'.[8] The family is the fundamental cell because it is the home and school of the Christian values that are shared in the unity of the Church.

The General Conference of the Latin American Episcopate, when it met in 1968 in Medellín (Colombia) argued that in order to decide upon pastoral action that would lead the family to conserve or to acquire those fundamental values that enable it to carry out its mission, it was essential for this institution to be a 'former of people, an educator in faith and a promoter of development'.

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Notes

[1] JOHN PAUL II, *Ecclesia in America,* n. 46.
[2] 'A vague, profound, calm and permanent sadness that makes the person who suffers from it find pleasure or entertainment in any thing': *Dizionario Manuals Illustrado della Lingua Spagnola*.
[1] Cf. *Gaudium et spes*, n. 48.
[4] JOHN PAUL II, *Christifideles Laici*, n. 40.
[5] Cf. JOHN PAUL II, *Centesimus Annus*, n. 39.
[6] JOHN PAUL II, *Novo Millennio Ineunte*, n. 47.
[7] Cf. *Documento de Puebla*, n. 606.
[8] JOHN PAUL II, *Novo Millennio Ineunte*, n. 43.

CARLOS AMIGO VALLEJO

2.4 The Spiritual and Pastoral Care of the Depressed Person and his Family

How can we help a person who is suffering from depression at a spiritual level? What should be said to his family? What pastoral support should be offered to them both? A certain minimum knowledge is indispensable if we want to know if a real illness is involved or if, instead, we are dealing with only a bad passing moment, a fall in spirits. The spiritual and pastoral accompanying of this kind of sick person cannot be hi-jacked and made into a sort of substitute therapy. Pastoral action does not exist to 'cure' a person but rather to help that person to carry his cross. The rest comes later and will be in the hands of God, of expert medical doctors, and of professional psychologists.

These sick people are children of God; they are our brothers and sisters. We should try to understand them, to accept their situation, however much this may hurt us, and help them, if possible, to escape from their illness. When we speak about these sick people we should not forget the environment that surrounds them, above all the environment of their family, which, indeed, requires special understanding, spiritual support and every kind of help.

It should be said, in addition, that depression cannot be portrayed in any way as a punishment meted out by God, as a kind of inner leprosy which ruins life, as the consequence of some kind of strange sin that has been committed. A feeling of guilt is not unusual in depressed people.

However, it is not easy for a depressed person to express this state of feeling. He has lost all will power, in extreme cases he has even lost the will to speak. At the base of a depressive state there seems to be an indefinite and oppressive fear of living, a fear of life. It is said that as long as there is life there is hope. In this case both things are absent – the quality of personal life is very low and hope has disappeared.

Spiritual and pastoral accompanying

As priests, teachers of the catechism, spiritual directors and workers in the field of pastoral care in health it is incumbent upon us to accompany and care for these depressed people in a spiritual way by helping them to live the life of grace, of faith, and of the Spirit that dwells in them, by engaging in the pastoral actions that are most suited to their 'evangelisation'. We must, that is to say, ensure that Christ is the yeast of their lives so that this very deteriorated experience that they are undergoing comes to be totally changed.

Man, in the face of illness and suffering, more than turning his gaze to God, complains about Him; he even attributes to Him his own affliction: why have you treated me in this way? Why have you punished me in this way? In reality, God is not to be rebuked, but this is something that is ignored. God is more than an idea, He is somebody who is very present in life, even though this nearness and intimacy is not realised.

The depressed person should be cared for and treated as a sick person. His illness and pain can be like a wall that separates him from God, who is accused of being the cause of the affliction. This illness provokes massive internal laceration; it does not only afflict the person – it enslaves him. It detaches him from himself and transforms him into an object in the hands of others, on whom he almost completely depends. The sick person thus loses his autonomy; he ceases to be himself. His illness is a new experience and certainly a painful one. And nothing can cure this personal limitation better than health.

However, from limitation one should move to the freedom of being able to consciously live out what has been said in faith (as Job repeats: 'I know that my God lives!') And this experience of the nearness of God is not only a consolation but also a belief that beyond our human limitations there is the strength of our own dignity as children of God. The child is sick but his father and mother are at his side and they love him with all their soul, even though the sick child is not aware of this.

All this may also be applied to the family of the depressed person, which very often is the body that must bear the hardest burden – that of incomprehension. It does not understand the suffering of its sick family member and it does not feel that it is understood by the social environment.

Welcoming he who arrives. He is a brother

More than going to a priest and a spiritual adviser, a depressed person should be brought to them. He is not able to take any decisions at all. We are face to face with a sad person who has fallen into indifference, who is personally tired – his life has become an uphill struggle and freeing himself of it would be a great liberation, a person who spreads pessimism and tiredness, thinks that he is useless and cannot be rehabilitated, is interested in nothing, and walks through this world with anxious hope and an enormous feeling of guilt…

But for us this person is not a mere patient with specific pathological symptoms – he is our brother and as such we must welcome him and care for him.

The company and effectiveness of the grace of divine adoption must always be present in spiritual care for this kind of person. In Christ we were reconciled with the Father (Rm 5:10). God receives us and loves us as we are – redeemed by Christ and served by the presence and the grace of the Holy Spirit.

Thus the first step in pastoral care can only be the step of drawing the depressed person near to reconciliation, that is to say to the sacrament of penitence. He should be brought to this sacrament and an attempt should be made to convince him that forgiveness will bring him the inner peace that he needs.

The most suitable pastoral actions at this point are those that enable him to receive the support of the community, above all through the celebration of the Eucharist. The Risen Lord makes himself present amongst his own, speaks to them and gives them the bread of life to eat, and he listens to their prayers and their requests.

Spiritual and pastoral care must follow the pathway of silent accompanying. The sick person must know that there is somebody at his side: above all God, but also the Church, which prays for him but prays above all else for his family. This community of life and love must now be more alive than ever. Very many times, in relation to the person who suffers, the only thing that can be done is to be near him, like Mary, John and the women at the foot of the Crucified One on Calvary.

From the recovery of self-esteem to the help provided by others

The really bad thing is not being paralysed, blind, deaf or sick, but not wanting to do anything to escape one's situation. The path of Christ must be found, and because he cannot always do this on his own, the sick person must allow himself to be helped by those who are the good nurses of God, who provide us with care, who take care of us, and who cure us.

The support of the family and the social and religious community is of the essence. The best help that can be given to a person on his own is to make him feel that he is accompanied. For that matter, helping the depressed person to enter a space of prayer can be of major help in combating his physical and spiritual abandonment.

Love your neighbour as yourself, says the Lord. And what if a person dislikes himself? If he does not attribute to himself suitable value? This is something that occurs in depression. There is a notable deficit at the level of self-esteem. The depressed person has fallen into the great lie of not recognising the truth about himself. He is now about to retrieve the pathway of truth and of values. But values without certain virtues through which they are lived out and expressed are mere fantasies. We need to reconstruct coherent and loyal behaviour in relation to what is believed in, which leads to there being great moral meaning in behaviour.

This not a matter of trying to achieve an impossible goal but rather of coming out of oneself so as to meet Christ, who is alive and present in every person that he meets on his pathway. From being a lost and fallen man, the depressed person becomes a Good Samaritan who looks for others and meets Christ in them, because, as John Paul II says, 'by his Incarnation, he, the son of God, *in a certain way united himself with each man' (Redemptor hominis,* 8).

It is no use saying: what is the point of what is happening to me? The approach to be adopted should be very different: what can I do for other people? Complaints should not be emphasised: who is responsible for so much suffering? Why is this happening to me? Instead, there should be a positive expression of the wish to help: how can I help other people, with all my defects?

If self-esteem has been lost, an attempt can be made to identify the depressed person with a completely new model – Christ. What is required is not mere imitation of Christ but identification with Christ. At a supernatural level this mysterious identification is realised by grace. It is not me, but Christ who lives in me, observed St. Paul (Gal 2:20).

In identifying himself with Christ in this way, help is strengthened, which is that which is most absent in the life of a depressed person, and he moves from a loss of self-esteem to the esteem of other people. Faith is not a magic cure for the treatment of depression but when it is alive and at work it helps to achieve a recovery.

The family

When one of its members is afflicted by depression, the family suffers and feels disorientated and confused because at an apparent level there are no reasons for the situation in which the depressed person finds himself. Understanding and drawing near need to be manifested with attempts at accompanying and dialogue and the sharing of prayer and spiritual support with the sick person. Words and animation impressed into the depressed person with the hope of freeing him from his depressed state are of little help. This is because for such sick people it is practically impossible take any decision at all. They suffer but they do not know what is happening to them; they make others suffer and everybody feels dismayed, undefended and abandoned.

Voluntary workers and family associations can play an important role here in transmitting their support, their spiritual accompanying and also material collaboration (if this is needed) to the families of such sick people. In pastoral care for the family a special chapter should be devoted to those families who have amongst their members people suffering from depression. It is important to pay attention to them, support them with faith, promote associations of families who are thus afflicted, and offer them help.

On the other hand, the family is the best therapist there is for a depressed person. However, it is by no means unusual for the family to adopt an attitude of closure towards its depressed member, who, indeed, is often seen as a kind of 'hypochondriac'. The support of the family is indispensable. But this is where we encounter the great problem: by no means rarely the reason for the depression the person is suffering is precisely his family, its problems, its wish to command, its non-existence in real terms. Suitable pastoral care for the family is the best preventive treatment there is for depression.

We need to listen, to understand, and to animate. The depressed person should always be appreciated. He should be helped to participate. He should be shown that it is good to be next to him and that in no way is he seen as a comic actor who is pretending to be ill for reasons of convenience or out of desperation.

We must love people as they want to be loved. We should not want the depressed person to change because this would be good for his family but because he himself would feel better with himself. It is not necessary to use many words – he must see that his family is at his side, that it is ready to listen to him, to understand him, and to help him. Affection should be given to the depressed person but what he can offer should also be received and he should be shown gratitude for this.

Coherence should never be sought for in the depressed person. He is sad and unable to define the reasons for this. To ask for coherence from him means to increase his endless torments. Rather than reasoning with him, one needs to love him. When there is doubt about what to do, the best pathway to follow is always that of mercy.

He should be helped to take part in family life, in social life, and in parish life, but not in an oppressive way. It is for others to bear the burden of the situation, without, however, the depressed person knowing about this. One should give one's life to him, but hr should never know about this. The depressed person does not have small worries – everything oppresses him, and with an enormous weight. We should take on these worries of his as though they were our own, not according to our own assessment of them but with the approach of the depressed person himself: 'we should become depressed with the depressed person'.

Spiritual and pastoral care

I will now attempt in very brief and summarising form to offer certain spiritual and pastoral 'recipes' for the 'patient' who is suffering from depression which contain certain 'specific medicines', and this so that families may know how to administer them, as well as a guide to 'treatment' for pastoral workers.

The mercy of God is infinite. If one looks sincerely at God every feeling of guilt disappears. Pain, offered with that of Christ, is a source of salvation for oneself and for other people. The depressed person should allow himself to be accompanied by the Spirit of God and also by a person who acts as a guide and as a support; he should also allow himself to follow a progressive itinerary of encounter with God in prayer, so as to see reality not with his own lines of reasoning but as a person who is contemplated and loved by God; and all this in addition to connecting with the love of Christ and of the Virgin Mary, and feeling their company and their protection. The meaning of life is not obtained by looking at oneself but by looking at God and at other people.

Here are some important points: the depressed person should form new relationships with people so as to find reasons for living; he should help other people; he should take an active part in certain pastoral and charitable projects by accepting small responsibilities, but without any kind of anxiety being involved; he should feel that he needs other people. The community cannot do without him – he is one of its members. The Church is not a society of strong and brilliant personalities. A certain positive resignation should not be excluded – the depressed person should accept his own limits.

The depressed person should be himself so as to encounter his own personality – he should be a man for others. He should be helped to know how to light the 'wonderful lighthouses' of the word of God, which throws light on everything. And he should have an approach of great generosity – life is for other people, it should be led on behalf of others and not be let to rot inside oneself. In a few words – the depressed person should be helped to be reconciled with himself and to accept the Good News as an effective yeast of healing.

As Christians, the only bread that we can give to others is the bread that we ourselves live by – the bread of the word of God and the bread of the sacraments. Pastoral workers, therefore, should not fall into the trap of 'psychologism', of being keen therapists but mediocre pastoral workers.

Your love alleviates pain. Words that can be very beautiful can also be evasive if they are not given, starting from our Christian faith, all the depth that they should express. There is nothing that is so demanding and so calls on our responsibility as love. The love of the person who serves a sick person is an encouragement to engage in permanent training to find all the means possible that are able to lead to an uprooting of the illness and the healing of the sick person.

The love of he who serves becomes caring respect for the situation of the person in need; it is distant from any kind of 'pityism', negative resignation or paternalism. On the contrary, it helps the depressed person to draw near to the goodness of God, who cares for all things, to engage in an objective acceptance of his personal realities and to open himself to the support that others can give him.

Jesus replied to the question of pain by taking it upon himself. For this reason, the preaching of the Gospel and care for the sick are inseparably bound up. We can but remember Christ in the garden of olives. Suffering has only one justification: the hope of being filled with life, the hope of new life. And in speaking about hope let us recall the happy thought of St. John of Avila, who calls Mary 'the nurse of the hospital of the mercy of God' (Nat. V.M.III, 20).

H.Em. Card. CARLOS AMIGO VALLEJO
Archbishop of Seville
Spain

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november

3. Hope

IVAN DIAS

Towards a Pastoral Care of Christian Faith and Trust in Life

In the course of this conference we have considered the various causes and effects of the world-wide phenomenon of depression. It is both meet and just that we now explore the Church's pastoral role to assist depressed people by caring for their Christian faith and leading them to trust in life.

Experts tell us that depression is an illness of the emotions and its classification as a mental illness does not make it any less real or painful. It is a disturbance characterized by varying degrees of fluctuations in mood, viz. sadness, disappointment, loneliness, hopelessness, self-doubt, and guilt. These feelings can be quite intense and last for a long period of time. Daily activities may become more difficult, but the individual may still be able to cope with them. It is at this level, however, that feelings of hopelessness can become so intense that suicide may seem to be the only solution. We are further told that a person going through severe depression may even experience a desire for complete withdrawal from daily routine and/or the outside world. Experts in fact tell us that depressed persons live in a closed world and feel that no one can help them. Even God is shut out of their lives. And it is understandable, for – as the proverb goes – "when you shut God out of your life, you shut yourself in the dungeon of your emotional morass". Furthermore, the return to a balanced mental and emotional state is not an overnight process, and it may be very painful. There may be leftover baggage of hurts suffered, wrong attitudes, incorrect information and so on. This can be a source of depression and may slow down the process of recovery. On the other hand, depression is nothing to be ashamed of, and is not a sign of weakness. It is a common ailment and anyone, even the strongest in character, can be faced with situations which would lead to depression. Even psychologists and psychiatrists, and pastoral agents like bishops, priests, religious and competent laypeople who counsel others, can fall a prey to depression. Depression is treatable, whether by medication, by therapy and counselling, or both. Persistent prayer of close relatives and friends for and with the depressed person will facilitate the process of emotional healing. One does not have to feel guilty about being depressed. The past failures can become a strong foundation on which to rebuild a brighter future.

There is a Chinese proverb which says: instead of cursing the darkness, light a candle. While those who are in a state of depression curse their lot and may cause others to do the same with them, Christian faith and trust in life invites us to help them to light a candle of hope, because hope is a strong antidote against depression and a powerful cure for it. For Christians, this pastoral approach is an important, nay indispensable, accompaniment to other treatments such as medication, therapy, counselling and loving moral support, and can help to bring true solace or relief to persons tied up in a dungeon of depression.

Such pastoral care, I repeat, has a reference to the virtue of hope, which makes people see the silver lining in dark clouds, causes them to expect healings and even miracles, and urges them to strive for victory in the face of tough challenges. Hope, we know, can be a mere human trait of character or a theological virtue. As a human trait it can be seen, for example, in mothers when caring for their babies or nursing their sick, weak or disabled children, or nurturing plans for their future. A hundred and fifty years ago, in the United States of America there was a young lad named Thomas who was hard of hearing and a slow learner, and risked being dismissed from school. Knowing how this would depress him, his mother withdrew him from school and told him: "Son, we shall do things together." The mother's love reached where the academic proficiency of the school teachers did not. The young boy, who later on became completely deaf, started showing remarkable signs of creativity, first in small matters and then in bigger ones. And when he died at the age of 84 on October 18, 1931 he had patented over a thousand inventions and the whole country briefly turned off its lights in

memory of the man who had invented the electric bulb: Thomas Alva Edison. Thus a mother's determination prevented distress from becoming depression, and turned it into a success story. It was the triumph of hope on a human level which binds human persons together.

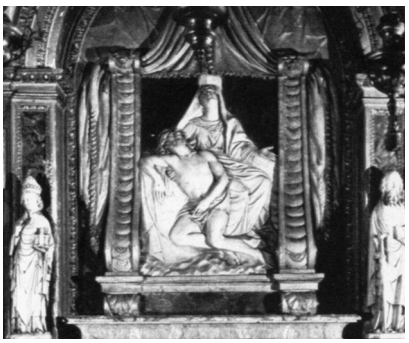
The topic of this talk centres around the theological virtue of Christian faith and trust in life which links human beings with an all-powerful, all-knowing and all-loving God, without of course excluding links with human intermediaries. As the human virtue of hope, so also the theological virtue of hope is deep-seated in the human heart. For this reason, people offer prayers to God, to the Blessed Virgin Mary, the angels and the saints, they make sacrifices and vows to God, they go on pilgrimages to holy shrines, etc. Christian faith and trust in life must be nurtured as part of the normal pastoral ministry of the Church in favor of those suffering from depression. Hence the topic we are discussing would concern more pastoral agents – bishops, priests, religious and lay persons – than depressed people themselves.

Besides personal prayer for and with such persons and close fellowship with them, I would like to indicate some valuable resources and make certain observations which could be useful in the pastoral care of Christian faith and trust in life when dealing with depressed persons.

1. The Holy Bible

The Holy Bible abounds in episodes of people who could have become depressed but which had a happy ending thanks to the strength received from God. Many of the episodes concern cases which happen even today and often lead to depression, viz. the lack of an offspring, or a rebellion against one's leadership, a cold shoulder from subordinates, ill treatment from one's near and dear ones, a sinful life, unhealed memories, false accusations, etc. Here are some flashes into the Old Testament.

There was 75-year-old *Abraham* to whom God had promised that his descendants would be more numerous than the stars in the heavens and the grains of sand on the seashore, but for many years his wife, Sarah, bore him no offspring. So Abraham fathered a son by his maid-servant, Agar: but he was not to be the child of God's promise. Rather than plunging into depression, a perplexed and bewildered Abraham persevered believing in God's promise with "hope against all hope" and Isaac, the son of promise, was born when he was a hundred years old and Sarah was ninety.[1]



There was the case of Abraham's grandson *Joseph*, son of Jacob (Israel), whose brothers sold him to some merchants because they were envious of the affection his father used to shower on him. The merchants took him to Egypt and sold him as a slave, but his master's wife falsely accused him of immoral behavior and he was sent to prison. He would have languished here with depression had Providence not willed that he would win the good graces of the king and be promoted as second-in-command in the realm. When famine struck that land, he was able to give food and shelter to its citizens and also to the neighbouring people, among whom were his own father and the very brothers who had treated him unjustly.[2]

Then there was *Moses* to whom God entrusted his chosen people, numbering some hundreds of thousands, to be led from slavery in Egypt to the Promised Land. Very often during their forty-year wandering in the desert the people forgot God's many wonders in their favor against the Pharaohs of Egypt and rebelled against Moses, criticized his leadership, made difficult demands like asking for food and water in the desert, worshipped idols of their own making, and led Moses almost to despair. Yet Moses was not depressed: rather he resorted to the Lord and faced each of those challenges successfully.[3]

There is *Tobit*, a man who walked in the ways of truth and righteousness, did heroic acts of charity to everyone giving bread to the hungry and clothes to the naked, spending his nights burying the dead notwithstanding his neighbors scoffing at him. At the age of fifty-eight he was blinded by the droppings of a sparrow. He could have asked: "Why me, Lord?" But he didn't. He endured his lot with patience for eight long years until God sent the archangel Raphael to cure him.[4]

There is the story of *Job* who was known for his piety, honesty and patience, and yet he suffered the loss of his material possessions and the death of his sons and daughters. He even lost the sympathy of his wife and close friends. At first, he resisted bravely to such misfortunes saying: "The Lord has given. the Lord has taken away: blessed be His holy name". But after some time his patience ran out and he succumbed to depression and "cursed the day he was born". God challenged him and made him see how futile his protests were. Job repented, overcame his depressed state and was rewarded with many more possessions than those he had lost.[5]

In the *Psalms,* too, there are many verses instilling courage and trust in God,[6] or which express the poignant cries for help raised to God from the heart of a person deeply in distress.[7] These can be used to encourage many a dejected person to have confidence in God who always hears the cries of His children.

In the *New Testament,* too, we have many episodes with a happy ending which could help persons who are subject to depression or tempted to suicide. There were *Mary of Magdalen*,[8] *the Samari-*

tan woman,[9] *Zaccheus,*[10] *the woman caught in adultery*[11] and others who were steeped in vices and low in people's reputation, and yet in Jesus' company they found peace, forgiveness and respectability. In him they found someone who did not condemn, but who understood, forgave and healed.

There is an episode in the Gospels which, taken symbolically, can help us to understand the role of faith and hope in a person's life. It is when Jesus came to his disciples walking on the Lake of Galilee. At Peter's request, Jesus bade him to come towards him walking on the water. Peter joyfully gets out of the boat, and with his eyes fixed on Jesus walks courageously over the water, even though he was surrounded by roaring waves and tempest winds. At one moment, Peter is distracted by the winds and the waves around him; he gets frightened and begins to sink. He cries out for help, and Jesus pulls him up and chides him: "Why did you doubt, man of little faith?"[12] This is exactly what happens to a depressed person: he gets distracted, loses confidence and focuses all attention on himself and starts to sink into depression. It is only when he puts his full trust in Jesus and fixes his eyes only on Him, who is the Master of the winds and the waves, that can he get back on his feet and walk again over the waters of life.

We have a very relevant episode in the lives of the Apostles: among them there was Judas who betrayed Jesus, and Peter who denied Him three times. Both of them had played foul and certainly had a sense of guilt because of the way they had treated him, whom a few hours before at the Last Supper they had acclaimed as their Lord and Master. Judas got depressed because his conscience nagged him for betraying an innocent person and he was driven to suicide, while Peter shed tears of repentance and was confirmed by Jesus as the future leader of His Church: "Feed my lambs, feed my sheep".[13]

On the day of Jesus' Resurrection two disciples were walking home to Emmaus with broken hearts and shattered dreams, depressed about what had happened in Jerusalem during the previous days when Jesus, whom they had hoped to be the long-awaited Messiah, was put to an ignominious death on the cross. The Risen Lord walked by their side and explained the Scriptures at length to them, and said that it was necessary for the Messiah to suffer and to die, in such a way that their hearts began to burn and their eyes were opened to recognize Him when He broke bread with them. They came out of their depressed state of mind and became fervent apostles of the Risen Lord and Savior.[14]

There are also many passages in the Bible which could have a special meaning to those suffering from depression, such as this quotation from St.Paul to the Philippians: "Rejoice in the Lord always, again I say: rejoice... The Lord is near. Have no anxiety about anything; but if there is anything you need, by prayer and supplication let your requests be made known to God with thanksgiving. And that peace of God, which passes all understanding, will keep your hearts and your thoughts in Christ Jesus. Brothers, fill your minds with everything that is true and noble, everything that is good and pure, everything that is lovely and honorable, and everything that is virtuous and worthy of praise... And the God of peace will be with you".[15]

Such quotations and the many episodes with a happy ending from the Bible, or from Church history, from the lives of saints or from contemporary history, can help pastoral agents when assisting persons who are on the brink of depression or drowned in their cup of woes. They can help to raise up their moral courage and to encourage them to lift up their eyes to heaven from where there comes hope, joy and peace. Of course, both in the Old and New Testaments we have also cases of frustration and depression which end badly, as for instance King Saul who had himself killed when he was defeated in battle on the hills of Gilboa,[16] and Judas the Apostle of Jesus when, after betraying the Master, he felt remorse and committed suicide.[17] But these are exceptions rather than the rule in the Bible.

2. The Holy Spirit and the Sacraments

Some years ago the participants at a conference of psychologists and psychiatrists affirmed that they were capable of helping their patients to analyse their problems, to diagnose the causes and to indicate how best they could cope with their problems. But they admitted that they could not do away with the problems. That was indeed a humble, but truthful, admission. Christian faith and hope, however, can go further and can even help people to get rid of their problems, because of the spiritual means at their disposal. I am referring to the supernatural power of the Holy Spirit and the Sacraments in the Catholic Church.

The Holy Spirit has been at work since the beginning of the universe and was poured out at Pentecost to complete Christ's saving mission, "to heal the broken-hearted, to lift up the downtrodden and to release those who are captive".[18] All these qualities are symptoms of depressed persons: they are broken-hearted, feel downtrodden and are captives of their self-centred emotions. However, today, there are millions of persons all over the world – some of whom have passed through the valley of depression – who frequent movements of the Holy Spirit, such as Charismatic Renewal, and experience a deep healing of harrowing memories of the past (which are often the cause of depression), who witness the action of the Holy Spirit "taking out their hearts of stone and putting in a heart of flesh instead", who feel that their cup of woes has been emptied and filled with love, joy and "a peace that passes all understanding", and enjoy a mental equilibrium they have never experienced before. It is the same Spirit who builds up depressed people through the Word of God in the Holy Scriptures, and gives them life through the Sacraments,

whatever be the physical, psychological or moral causes of their depressive state.

The Catholic Church has seven life-giving founts of grace and of healing called the Sacraments. As far as the pastoral care of the depressed is concerned, I would like to emphasize the value of three Sacraments: the Holy Eucharist, the Sacrament of Reconciliation and Anointing of the Sick. We must remember that it is Christ Himself who is at work in each Sacrament, and that the priest who performs a Sacrament does so *"in persona Christi"* (in the person of Christ).

It is an open secret that hidden and unforgiven sins easily lead a person to be depressed. For those burdened with personal sins there is the *Sacrament of Reconciliation* which, if received with a truly contrite heart and a firm resolve to amend one's ways, obtains God's forgiveness which wipes away the sinful past and gives deep inner peace. I remember a lady deeply steeped in depression and full of anger with herself, with her family, friends and everyone else, and was even blaming God for her depressed state. She reluctantly accepted to speak to a priest. After she had poured out her bitterness to him, he suspected that there was a root cause for such behavior and asked her bluntly if she had had an abortion. She was furious at first, but then broke down in tears and narrated her sad story of unfaithfulness in marriage which led to a pregnancy which she had interrupted (and hence she cursed her husband who had abandoned her, her lover who deserted her, the doctor who performed the abortion, and others who were not sensitive to her distress). The priest led her step by step to receive the Sacrament of Reconciliation, and then helped her to accept the child she had rejected, to love it and even to give it a name. At every step the lady became calmer and at the end was all smiles at the thought of meeting her baby one day.

To those suffering from serious ailments the *Sacrament of the Anointing of the Sick*. In my pastoral ministry I have witnessed how this Sacrament gives moral courage and spiritual strength and comfort, and at times even physical healing, to those who are depressed because of their physical or psychological illnesses. I know of three couples who were in deep depression and approached a priest for help. They were no ordinary couples: two of them were homosexuals and one was lesbian. For many years they had been sincerely trying to get rid of their inordinate attachments through professional counselling and through the confessional, but in vain. The priest they now contacted led them first to receive individually the Sacrament of Reconciliation, and then the Anointing of the Sick, because their problem was leading them not to death of the body, but more seriously to that of the soul. You will be glad to learn that all the three cases were cured completely of their unnatural tendencies.

Finally, there is the *Sacrament of the Holy Eucharist*, where the Divine Healer Himself is present who has said: "Come to me, all you who labor and are heavily burdened – we can add, who are deeply depressed – and I will give you rest, I will refresh you, I will make you whole."[19] For those suffering from depression, of whatever cause it may be, these words of Our Lord are welcoming today as ever. Just before receiving Holy Communion at Mass we say: "Say but the word and I shall be healed". It is like healing prayer. In fact, it is on Jesus' word that the doctors' advice and medical prescriptions take healing effect. What happens in Lourdes and in many shrines and charismatic and other prayer groups throughout the world should convince us that any type of depression can be submitted to the healing touch of Him who alone "can say the word" and heal.

This may seem utopian to some. But true Christian faith can move mountains. There are so many examples of persons overcoming depression in their lives because of their faith and trust in life. Let me narrate just one of them. It is the heroic witness of *Dr. Tagachi Nagai*, a medical practitioner working in the department of radiology in Nagasaki when the atom bomb fell on the city on August 9, 1945. That bomb burst 500 metres above the city, created fires of 3.000 degrees centigrade in a few seconds, killed some 74,000 and injured 75,000 persons, and caused immense damage to human life and property, the effects of which are still visible today. Dr. Nagai had been suffering from chronic leukaemia and was given just three years to live; the atom bomb blast only aggravated his health conditions. He lost his dear wife in the explosion. He had enough reasons to be depressed. And yet, it was not so. A few months before he had become a Catholic. His newly acquired faith in the Risen Lord and Saviour, whom he believed to be present in the Holy Eucharist, urged him to rise up over his personal losses. One of the buildings to be destroyed was the cathedral of Nagasaki, which formerly had stood out as a symbol of faith and the pride of the people of that city. Dr. Nagai thought: if one could only find the bell of the cathedral, it would give the people courage to rise up from their depression and to build themselves up again. So he rallied the citizens together and toiled day and night in the rubble of the bombings till he found the bell. When the bell was installed at the top of the neighbouring hill on Christmas night, Dr. Nagai addressed the multitudes gathered there and spoke with such enthusiasm and conviction of the glorious resurrection of Jesus Christ and His victory over sin and death, that he impressed on all those present the need to hope

and to work for a better tomorrow. Although his health was slowly waning away, he used all his talents – as medical practitioner, poet and patriot – to encourage his fellow-citizens till the very end. He enshrined his noble thoughts in a book entitled *The Bells of Nagasaki*, and died at the young age of 41, five years after the fatal atom bomb fell on Nagasaki. The foundations of today's modern rebuilt Nagasaki were laid by Dr.Nagai, thanks to his heroic Christian faith and trust in life.

3. Some pastoral observations

From the experience of those who are engaged in the pastoral care of depressed persons, we know that this ministry demands that pastoral agents be persons of deep faith and hope. May I mention some areas which come up normally in this regard.

1. *Importance of forgiveness.* A person may get into a severe depression because he is full of resentments and hurt feelings, and he finds it difficult, almost impossible, to forgive those who have hurt him. In order to get such a depressed person back to normal he/she must be led to forgive the person(s) who were the origin of such hurt feelings. Depressed persons often close themselves in self-pity and self-justification, they lick their wounds, so to speak. They must be taught and helped to overcome this hurdle. The example of Christ on the cross forgiving those who had unjustly tortured and crucified him can be a forceful invitation to do the same.

Everyone knows the story of Coreen ten Boom, a Dutch lady who lost her parents, many relatives and friends at the hands of the Nazis during World War II, just because she was a Jew. She and her sister were shunted from one concentration camp to another. It was only by God's providence that she was released from the camp at Ravensbruch, a week after her sister died there. As a Christian, she realized that she had to forgive those who had harmed her near and dear ones. She felt a deep peace when she made the act of forgiveness. She then travelled the world over giving this message of love and forgiveness as taught by Our Lord: "If you do not forgive others, then neither will my Father in heaven forgive you". But one day in Germany she met face to face the one who had ill-treated her and her sister so badly in the concentration camp. The guard from Ravensbruck held out his hand begging for pardon and reconciliation. All the bitter memories and the traumas she had passed flashed back to her mind, and she felt paralysed. After a couple of minutes – she tells us in her book *Tramp for the Lord* – the grace of God overwhelmed her and she embraced her former Nazi persecutor. That was the time she really forgave completely, and experienced God's peace which never left her again.

2. *Correct priorities.* A person may have gone into depression because of false or mistaken priorities, when for example one's professional career has taken precedence over one's family's well-being or when worldly pursuits eclipse one's personal pursuit of holiness. Unbalanced priorities can often be the cause of constant friction and depression. They must be set aright before healing can take place.

A few years ago I was visited by a deeply depressed couple, married for ten years: the woman was twice involved in adulterous relationships and the husband, though of a forgiving nature, was under pressure from his family not to take her back: there was a clash of allegiances (to his wife and to his family) and months of sessions with psychiatrists proved to be of no avail. Both husband and wife were terribly confused and had separately filed for a civil divorce. This was the time I met them. I spoke to them separately first, and then together: the lady was led to renew her request for forgiveness and the husband to forgive and to accept the priority of his marriage commitment over his family ties. They received the Sacrament of Reconciliation. Having got rid of their baggage of past unpleasant memories, the next morning they renewed their marriage vows at Holy Mass and have lived happily ever afterwards. Depression was converted to joy without end.

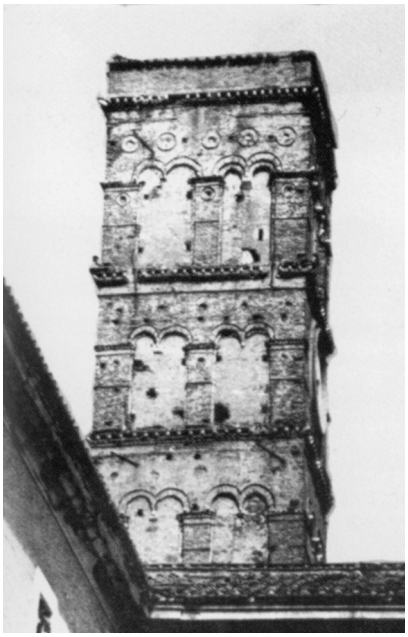
3. *Thought of death.* Some people get depressed with the thought of death: their own or that of their dear ones. Christian faith and hope will help them to look far beyond the barriers of death to the assurance of their bodily resurrection. Jesus gave us a foretaste of His divine power when He rose up Jairus' daughter and a widow's only son from the dead, when he brought Lazarus back to life after he had been buried for three days, and when He himself rose from the dead the third day after his death on the cross. Jesus is a God to whom nothing is impossible, who found his way out of a grave, and who has pledged to raise up our mortal bodies on the last day.

4. *Life is worth living.* Above all, depressed persons must be led to a conviction that life is indeed worth living, because it is a gift of God. No matter how badly they have used or abused it in the past, God is ready to forgive the past and to give them a new lease of life with Him. Hope can give courage and sight to the blind, as was the case of Helen, who was blind and yet developed her other senses and invented Braille writing so that the blind could see through their fingertips.

5. *Good Friday is a prelude to Easter Sunday.* Jesus taught this while walking with His disciples to Emmaus.[20] The pastoral care of the depressed should therefore highlight the value of the cross of Jesus Christ and the Christian meaning of suffering. There can be no Easter Sunday without a preceding Good Friday. Very often, spiritual benefits follow from depression, and seldom the other way around. I know a lady in South Korea, Julia Kim, who made a wonderful journey from depression to wholeness of life. A Buddhist at birth, married with two children, she was always ill

and was often taken to the hospital only to be told to go home because that there was nothing the doctors could do. Her religious beliefs in *karma* (the succession of births) made her bitter, because she was not aware of any wrongdoing in her previous life that could vouch for such ill-health in the present one. She became deeply depressed and twice attempted suicide, but failed. One evening she went to town determined to find a way to end her life. It was her third attempt at suicide. In her blurred vision she saw light coming from a nearby building. It was a church. She entered it, sat down in a pew and started weeping profusely. The priest-in-charge noticed her and asked her what was the matter. When she explained her plight and her complaint that she was suffering for no reason, the priest pointed to a large Crucifix and said: "You know, madam, innocent suffering is useful to God to help others to become good." This simple phrase cleared the horizons of pain and anguish in the lady's mind. She became a Christian and her new-found faith and trust in God led her to dedicate her life to charity: she would visit orphanages and give food and alms to the poor, she opened her house to truck drivers who would stop in that city and offered them a free afternoon meal, and she made such progress in her spiritual life that she began to receive many spiritual charisms and mystical manifestations. Her bitter tears of depression had turned into tears of joy.

6. Dark night of the soul. It will be wise to say a word here of the possibility of a mystical meaning to depression in some cases. I am referring to the "dark night of the soul" experienced by so many mystics: St. John of the Cross. St. Theresa of Avila, St. Bernadette, and others. The recently beatified Mother Teresa of Calcutta, too, lived under a continuous mystical experience she called "the darkness". It was only after her death that this heroic aspect of her life was revealed. Hidden from all eyes, even from those closest to her, was her interior life marked by an experience of a deep, painful and abiding feeling of being separated from God, even rejected by Him, along with an ever-increasing longing for His love. This "painful night" of her soul began around the time she started her work for the poor and continued till the end of her life, and it led Mother Teresa to an ever more profound union with God. It was almost as if Jesus' "I thirst", which she had experienced on the inspirational journey from Calcutta to Darjeeling in 1946, was accompanied all



through her life with the same Jesus' "My God, my God, why have you forsaken Me?" Through this darkness she mystically participated in the thirst of Jesus on the Cross, in His painful and burning longing for love, and shared in the interior desolation of the poor. And yet she went about boldly with her normal activities in favor of the poorest of the poor, meeting popes and kings, and achieving innumerable awards, including the prestigious Nobel Peace Prize in 1979.

7. Christian meditation. There is an important development with regard to spiritual therapy for depression. The world over, people are trying to achieve peace of mind by taking up practices such as yoga, vypassana, zen and transcendental meditation and even resort to superstitious New Age practices propagated by fengshui, vaatsu, reiki, etc. All these are mere palliatives in comparison with what the Church can offer. The Catholic Church has its own well tried practices which would help solve cases of depression, or prevent them. I am speaking of Christian meditation which leads people to a personal union with the Triune God, in contrast with the aforementioned non-Christian practices which speak of a union with an unknown and impersonal being or force. Unfortunately, in today's hectic lifestyle, the meditative and contemplative dimension of our Christian identity are sadly missing. Christians must be taught the art of Christian meditation so as to be able to face the ups and downs of everyday life and meet the challenge "to be in the world but not of it".

This meditation – or what the early Christians called *pure prayer* – is Christocentric. It is centred on the prayer of Christ which is continuously poured forth by the Holy Spirit in the depth of each human being. Deeper than all ideas of God is God himself. Deeper than imagination is the reality of God. Thus, in this way of *pure prayer* we leave all thoughts, words, images behind in order to set our minds on the Kingdom of God before all else, we leave our egotistical self behind to die and rise to our true self in Christ. Meditation does not exclude other types of prayer and indeed deepens one's reverence for the Sacraments and one's reading of Scriptures.[21]

Christian meditation could easily be a part of preventive therapy and be useful also as a curative for depressed cases.

Conclusion

Our Lord Jesus Christ described the role which Christian faith and trust in life can play in a person in the parable of the house built on a rock, in contrast with one built on sand. The house built on a rock – says Jesus – can withstand the rains, floods and winds, while the one built on sand collapses at the least provoca-

tion.[22] As an antidote to depression in some and a cure for it in others, this parable underscores the importance of giving our spiritual lives a strong faith and hope foundation. St. Paul speaks of a "hope that does not disappoint" and echoes Jesus' teaching of a house built on the rock: "Who shall separate us from the love of Christ? Shall tribulation, or distress, or persecution, or famine, or nakedness, or peril, or sword?... No, in all these things we are more than conquerors through him who loved us. For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord".[23] Such a faith and trust in God makes the psalmist sing: "The Lord is my shepherd, there is nothing I shall want... even if I should walk in the valley of darkness, no evil would I fear, because your are there with your rod and your staff."[24]

The image of the rock of hope as an antidote to depression may apply not only to individuals, but also to a whole society, a people, a continent. It is indeed significant that our Holy Father took "hope" as the main theme of his Apostolic Exhortation *Ecclesia in Europa* after the Second Special Assembly for Europe of the Synod of Bishops. Because – the Pope says – "there was a need to proclaim this message of hope to a Europe which seems to have lost sight of it".[25] Europe today is a continent of light and shadows: despite – or, perhaps, because of – the affluence in wealth, the immensity of knowledge and the spectacular inventions and achievements, it is being crushed down "by grave uncertainties at the levels of culture, anthropology, ethics and spirituality",[26] in particular, by godless ideologies and enticing proposals that exalt the anti-God cultures, including the culture of death, by striving to build a city of man apart from God or even in opposition to Him, and by leading people towards self-destruction, depression and despair. Never before in the history of humankind has there been such a proliferation of soothsayers and black magicians, of psychiatrists and quacks, of esoteric theories and healers. The rates of suicides are on the increase in richer countries more than in the developing ones". Europe today, says the Pope, faces "a growing need for hope, a hope that will enable us to give meaning to life and history and to continue our way together"[27] and "despite all appearances, even if its effects are not yet seen, the victory of Christ has already taken place and is final... thanks to the Risen One, present and at work in history".[28] What the Holy Father says of Europe can easily apply to the so-called developed nations all over the world and be a warning to those poorer ones who try to mimic the richer ones following the all-imposing globalizing trends.

Pastoral care for the depressed is a must today: it must enter every home, parish, community, diocese, and society at large. It is not a passive apostolate, just helping people to accept their situation with resignation, but requires an actively positive attitude to help a person to get out of his shackles of negativity and to breathe the freedom of the sons of God. It requires pastoral agents who have a patient listening ear and a compassionate heart, who lovingly persevere in their determination to help a brother or sister to come out of the dungeon of his seclusion. Much will depend on the spiritual and moral strength of the pastoral agent, and his/her capacity to instil hope and confidence in the person being assisted. Only then will the agent be able to discern the causes of the problems assailing the depressed person and help in solving them with the spiritual resources we have mentioned earlier, of course together with other means available, like medication, therapy, counselling, and loving moral support. The stronger the rock of faith and trust in life which the agent will build in the depressed person, the easier will it be to accompany him from "cursing the darkness" to "lighting a candle" of hope, and the more these are lit, the faster will be the recovery of the depressed person.

As a general rule, therefore, pastoral agents dealing with them should have a particular sensitivity to their feelings and be firmly convinced that, no matter how difficult the case may be, they can bring them relief. This optimism is the first requisite of those who are called to help a depressed person.

"Unless the Lord build the house, in vain do the workers toil".[29] It is the same if one has to rebuild the house of confidence in a depressed person, whose foundations have cracked and whose building has collapsed.

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Notes

[1] *Gen* 12:1-21:7.
[2] *Gen* 30:22-49:33.
[3] *Ex* 3:1-14:30.
[4] *Tob* 1:3-14:15.
[5] *Job* 1:1-42:16.
[6] e.g. *Ps* 20, 23, 27, 40, 42, 103, 121, 130,
[7] e.g. *Ps* 6, 10, 13, 22, 28, 31,43, 51, 57, 69, 70, 86, 88, 130, 140, 143.
[8] cf. *Mt* 26:6-13; *Mk* 14:3-9; *Lk* 7:36-50.
[9] *Jn* 4:5-26.
[10] *Lk* 19:2-10.
[11] *Jn* 8:1-11.
[12] *Mt* 14:28-32.
[13] *Mt* 27:3-5; *Jn* 20:15-17.
[14] *Lk* 24:13-35.
[15] *Phil* 4:4-9.
[16] 1 *Sam* 31:1-12.
[17] *Mt* 27:3-5.
[18] *Is* 61:1-2.
[19] *Mt* 11:28.
[20] *Lk* 24:13-35.
[21] Fr. Laurence Freeman, spiritual director of the Worldwide Community of Christian Meditators.
[22] *Mt* 7:24-27.
[23] *Rm* 8:35-39.
[24] *Ps* 23:1,4.
[25] *Ecclesia in Europa.*
[26] *Ibid,* 30.
[27] *Ibid*, 4.
[28] *Ibid*,5.
[29] *Ps* 127:1.

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