1999

Depression: Illness, Insight, and Identity

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Abstract: Depression needs to be understood within interdisciplinary scientific, biopsychosocial, therapeutic frameworks, but it also has a moral dimension. The tendency to oppose moral and therapeutic perspectives, as well as to replace moral outlooks with mental-health outlooks, handicaps thinking about depression and many other topics. John Stuart Mill's midlife crisis illustrates how an experience of depression can be both a sickness and a source of moral insight. Furthermore, therapy has a moral dimension, and conversely a humane outlook is interwoven with health-oriented approaches and avoids excessive blaming and guilt. Complicating matters, depression sometimes undermines moral autonomy, and there is a continuum between healthy and unhealthy depression.

Keywords: depression, psychopathology, identity, autonomy, authenticity, psychoanalysis, John Stuart Mill

Depression has overtaken anxiety as our presiding discontent," reports psychiatrist Michael Miller (1997, vii). As a contributing factor in suicide, drug addiction, alcoholism, troubled relationships, damaged careers, and much plain misery, depression is a fundamental source of self-diminishment. Hence we should celebrate the powerful new treatments for it, both pharmaceutical and psychotherapeutic. Yet, most depression is not a sickness, and critics worry that we have gone too far in medicalizing it. A knee-jerk resort to "mood brightening" drugs threatens its evolution-rooted functions of stimulating insights and fostering positive change. Some link this worry to wider concerns about the ongoing "therapeutic trend" that they understand as replacing moral perspectives with health-oriented approaches to every aspect of life, including addiction, bigotry, crime, divorce, education, family abuse, gambling, hyperactivity, and so on through the alphabet (Illich 1976; Conrad and Schneider 1992; Peele 1995).

Is depression a therapeutic matter--a clinical syndrome of mood disorder, cognitive dysfunction, low self-esteem, and especially chemical imbalance? Or is it a moral matter--a potentially creative encounter with troubled relationships, activities, values, and self-respect? It can be either, and one approach is to apply a *morality-therapy dichotomy*: Each instance of depression is either pathological, in which case a therapeutic perspective applies, or healthy, in which case a moral perspective is applicable. I will argue that this approach is too simple. It fails to take account of the many instances of depression that simultaneously raise moral and health issues.

Each of the following sections critiques the morality-therapy dichotomy from a different perspective. Section 1 shows how the same instance of depression can be a sickness and insight-provoking. Section 2 attends to how, in general, morality and therapy intertwine, such that therapy has a moral dimension and morality can be understood within a

therapeutic vision. Section 3 emphasizes **[End Page 271]** how depression sometimes undermines moral autonomy, and it highlights the continuum between healthy and unhealthy states of depression. An overarching theme is that the therapeutic trend is best interpreted as a *reconciliation project* integrating moral and therapeutic perspectives, rather than a *replacement project* abandoning moral perspectives in favor of therapeutic perspectives.

1. Mill's Moral Malady

In 1826, at age twenty, John Stuart Mill suffered a "mental crisis" that has intrigued psychologists and philosophers alike. Following a remarkable education, in which he read Greek and Latin before age ten and mastered logic and economics before age fourteen, Mill fell into a profound depression. At the time he was working very hard, taking on increased responsibilities at his job in the Examiner's Office of the East India Company and editing a five-volume work by Jeremy Bentham. Sheer exhaustion cannot by itself explain the depression, however, if only because Mill always managed a Herculean workload. Mill presents the depression as a crisis in his intellectual and moral development. Moral ideas permeate his account of the cause, content, cure, and consequences of the depression.

First, Mill had been raised to believe in the utilitarian ethic espoused by his father James Mill and their frequent household guest Jeremy Bentham. One day he asked himself, "'Suppose that all your objects in life were realized; that all the changes in institutions and opinions which you are looking forward to, could be completely effected at this very instant: would this be a great joy and happiness to you?' And an irrepressible self-consciousness distinctly answered, 'No!' At this my heart sank within me. The end had ceased to charm, and how could there ever again be any interest in the means?" (Mill 1989, 112). His self-questioning precipitated a severe depression lasting most of a year and causing six months of "irremediable wretchedness" before gradually easing. The occasion for the self-questioning is noteworthy as well. He was undergoing what he initially describes as commonplace doldrums but immediately redescribes in graver terms: "I was in a dull state of nerves, such as everybody is occasionally liable to; unsusceptible to enjoyment or pleasurable excitement; one of those moods when what is pleasure at other times, becomes insipid or indifferent; the state, I should think, in which converts to Methodism usually are, when smitten by their first 'conviction of sin'" (1989, 112). This suggests that when he posed his fateful question, he was already in a mild depression characterized by unhappiness (anhedonia), self-doubt, incipient despair, and guilt (given the allusion to sin).

Second, the six months of unrelenting suffering included a dramatic loss of meaning and moral commitment in which Mill felt there was "nothing left to live for." His despair was not a *feature-specific depression*, focused on one or a few aspects or components of his life. Or at least he was not aware of being depressed about some particular misfortune, nor suffering from some "project-specific despair" about an activity or relationship (Garrett 1994, 74). (To be sure, mistaken self-explanations and unconscious objects of depression are both possible and common.) Instead, he experienced a *nonspecific depression*, a general hopelessness in which all his activities and relationships seemed futile and worthless, even

though he managed to carry on in a dispirited manner. This wholesale loss of meaning was itself a moral loss, in addition to the weakening of particular moral commitments, given that morality includes a concern for self-respect and meaningful life--meaningful in terms of both objective values and a subjective sense of worthwhileness.

Third, Mill felt the need for a type of help that was moral in nature. He sought a friend or loved one, someone in whom he could confide his suffering in order to receive understanding, advice, and compassionate support. Sadly, no one was available, least of all his father whom he was certain could only find his depression mystifying. What did help, eventually, was literature dealing with moral values and relationships. The first glimmer of hope came when he found himself crying as he read a memoir about a family's grief in response to the death of the father. The tears confirmed that he was still capable of feeling, and later the poetry of Wordsworth helped sustain the recovery. **[End Page 272]**

Fourth, Mill's depression led to significant changes in his moral outlook. He came to regard the ethical theories espoused by his father and Bentham as seriously incomplete. Personal happiness must be pursued indirectly by finding enjoyment in other things, rather than directly as he had been taught. Furthermore, moral commitment must be rooted in something deeper than artificial conditioning, especially within a life of philosophical analysis that constantly challenges and erodes contingent mental associations. A sound education would establish more natural ties between pleasures and commitments to intrinsic goods, including the general well-being of humanity. This insight later shaped his famous doctrine of higher pleasures, that is, enjoyments derived from activities and relationships cherished as inherently valuable, rather than solely for how they promote our own happiness (Anderson 1991). In sharp contrast with Bentham, who valued pushpin (a trivial pastime) as much as poetry, given equal quantities, Mill would make discriminating taste and moral emotions central to his vision of good lives.

Because Mill's depression was pivotal in transforming his ethics and his personal character, philosophers and intellectual historians have strongly opposed attempts to reduce it to an illness. For example, Allan D. Nelson insists that Mill's difficulty "was essentially a crisis of the understanding" and that any further psychological factors involved are "substantially irrelevant to a proper understanding of the nature of that crisis, its cause and its resolution" (1985, 360). Exhaustion, overwork, family tensions, unconscious mechanisms, and biochemical imbalances may have been catalysts for the depression, but they do not illuminate what was essentially a creative process. Nelson draws a sharp distinction between the "mood" Mill underwent and his intellectual "crisis": "while the 'mood' and whatever generated it may have helped to trigger the thoughts, there is no evidence to suggest that the thought which ensued was in any way determined or distorted by the 'mood' or any subrational elements underlying it" (361). The depression was one thing, the intellectual changes were another, and there was little connection between them.

In "Melancholic Epistemology," an important essay to which I will return, George Graham (1990) also suggests that Mill's depression was not an illness. He opposes Nelson's view, however, that the depression is irrelevant to understanding Mill's transformation. On the contrary, the depression was a direct stimulus, causally and cognitively, for the intellectual

changes that took place. By "drawing valuable insights from depression and using such insights to build a better life," Mill illustrates how depression can be justified, rational, and prudent, as well as morally creative. Graham worries that the medical model of depression as a neurochemical disruption eclipses the valuable functions performed by justified depressions. Thus, in the absence of his depression, Mill "had no reason to miss [i.e., overlook the importance of] aesthetic experience" in a good life, and he might not have come to appreciate "the practical possibility of rebuilding a person's own character, which heretofore Mill had denied" (1990, 417).

The problem with Nelson's and Graham's views is that clearly Mill did suffer from a pathological state, and the transformation he underwent involved a movement toward health based on insight. Certainly Mill met the criteria for a Major Depressive Disorder as set forth in the American Psychiatric Association's *DSM*, the *Diagnostic and Statistical Manual of Mental Disorders* (APA 1994). According to those criteria, Major Depressive Disorder occurs when five or more of the following symptoms are present nearly every day over at least two weeks: (1) a depressed mood (e.g., feeling sad or empty), (2) markedly reduced interest and pleasure in most activities, (3) loss or increase in appetite or weight, (4) insomnia or excessive sleep, (5) psychomotor agitation or retardation, (6) fatigue, (7) feelings of worthlessness or inappropriate guilt, (8) inability to concentrate, (9) recurrent thoughts of death or suicide (APA 1994, 327). As a stiff-upper-lip Victorian, Mill did not dwell on his symptoms in writing his autobiography, but there is ample evidence that he met many of these criteria. (1): He underwent six months of what Coleridge described as "[a] grief without a pang, void, dark and drear." (2): The "cloud" of dejection was carried "into **[End Page 273]** all companies, into all occupations." (6): He could only carry on "mechanically." (7): He disparaged his life and even his own depression as "in no way honorable." Furthermore, there are hints that additional criteria may have been met. (4): Sleep failed to refresh and brought only "a renewed consciousness" of having nothing to live for. (8): Able to function only mechanically, he could later "remember next to nothing" of the speeches he delivered during the depression. (9): "I frequently asked myself, if I could, or if I was bound to go on living," and I did not think I could possibly bear it beyond a year."

The *DSM* distinguishes between mild, moderate, and severe forms, and it would seem that Mill's depression fell toward the severe end of the spectrum. Moreover, even if there were doubts that he suffered a Major Depressive Disorder, the *DSM* identifies additional categories of illness that might apply and that are relevant to the issues discussed here. Thus, the *DSM* distinguishes depression as a single episode and as a chronic or recurrent problem, and Mill indicates the depression recurred, with some relapses that "lasted many months," although never again as severely. There are a half-dozen forms of Bipolar Disorder ("manic-depression") in which tendencies to depression are mixed with states of abnormally elevated, expansive, excited states. And Dysthymic Disorder has symptoms that are less severe but more chronic, specifically, two or more of the following symptoms during most hours or most days over a two year period: poor or excessive appetite, insomnia or sleeping too much, fatigue, low self-esteem, poor concentration, feelings of hopelessness.

Of course, the *DSM* definitions can be contested. The specific lists of criteria and numbers often seem arbitrary: Why nine criteria, five of nine features, two weeks, or two years? Some critics argue that the *DSM* creates a semblance of scientific rigor when in fact it represents an ever-shifting rough consensus based on committee votes, political compromises among the experts, and relativistic judgments about what is socially acceptable (Kutchins and Kirk 1997). Moreover, the authoritative tone creates the impression that psychiatrists understand the hundreds of disorders they classify, when, in fact by their own admission, they usually do not understand the etiology of what they label *disorders* on the basis on observed behavior emotions.

In my view, critics of the *DSM* tend to overstate their case. Obviously the definitions do reflect cultural and political beliefs, and there are complex conceptual and moral issues surrounding most of the definitions (Sadler, Wiggins, and Schwartz 1994). Nevertheless, the *DSM* represents the best collaborative effort to improve reliability of diagnosis in light of ongoing psychiatric and psychological research (Akiskal and Cassano 1997). We need not dwell on these methodological difficulties, however, because even common sense tells us that Mill suffered from a very unhealthy state.

How could Graham think otherwise? I suggest his thinking is dominated by the morality-therapy dichotomy. Thus, he sharply contrasts "depression as deep vision or insight and depression as sickness or illness" (Graham 1990, 401), as if we must choose between mutually exclusive options. In addition, he seems to infer that there was no pathology because pathology implies harm to oneself, whereas Mill reacted to the depression in a positive way, such that the final outcome was valuable, or "adaptive" as psychologists say. But that is like arguing that a heart attack is not pathological if it motivates a person to adopt a healthier way of living. Fortunately, much sickness, including life-threatening depression, has positive results, beyond its mere cessation (e.g., Styron 1990). Indeed, the creative potential of even severe disease to provoke insights is a familiar theme in fiction, biography, and clinical studies (Kleinman 1988; Goodwin and Jamison 1990). In any case, we need to distinguish between (a) thoroughgoing harm to oneself, and (b) elements of harm mixed with wider benefits. Although Mill benefited overall from his depression, the depression contained pathological elements of extreme suffering, self-deprecation, impaired agency, and dangerous despair that may have carried risks of suicide.

Psychologists have been far less willing than **[End Page 274]** philosophers to accept at face value Mill's analysis of his mental crisis. Here I cannot canvass the myriad psychological approaches--by one estimate there are over four hundred types of psychotherapy currently being practiced (Erwin 1997, ix), nearly all of which have been applied to depression. I will sketch a psychoanalytic perspective, according to which unconscious defense mechanisms blinded Mill to the cause, cure, and nature of his condition. Psychoanalysis has undergone a sharp decline in recent decades, and its former dominance in explaining depression has given way to popular cognitive-behavioral and chemical-neurological explanations that I take account of later. Nevertheless, psychoanalytic explanations remain useful as an illustration. They have been explicitly applied to Mill, and many therapists continue to believe they capture truths about the *causes* of family-related depressions, even though they lack the effectiveness of drug and cognitive-behavior therapies as *cures* of depression. Most

important for my purposes, their very limitations serve to reveal the general difficulties with the morality-therapy dichotomy.

Expanding Karl Abraham's suggestion, Freud interpreted depression as aggression turned against oneself, motivated by unconscious conflicts and ambivalence. In "Mourning and Melancholia" Freud interpreted the self-devaluation characteristic of depression (melancholia) as rooted in "reproaches against a loved object which have been shifted on to the patient's own ego" (Freud 1917, 169). When the loved one dies or when we fear the loss of their love, the unexpressed hostility is redirected inward, targeting an introjected and idealized version of the "love object." Later, after introducing the idea of a superego, Freud reconceptualized this process as the unconscious part of the superego channeling aggression toward the ego as punishment for the id's socially unacceptable aggressive impulses (Freud 1961). Either way, hostility is repressed because we find it unacceptable to hate people we also love.

Working within this psychoanalytic framework, A. W. Levi insisted the "real explanation" of Mill's crisis had nothing to do with dissatisfactions over Bentham's utilitarian theory. "The real cause was . . . repressed death wishes against his father, the vague and unarticulated guilt feeling which he had in consequence, and the latent, though still present dread that never now should he be free of his father's domination" (Levi 1945, 98; cf. Machann 1973; Glassman 1985). Mill revered his father as the parent who oversaw every detail of his upbringing and education, who played the additional roles usually reserved for teachers, heroes, and mothers. Yet, by Mill's own admission, and confirmed by observations from peers like Bentham, James Mill was a severe disciplinarian who made excessive demands accompanied by implicit threats of punishment for any failure. Levi makes a plausible case for young Mill experiencing intense ambivalence toward his tyrannical father, mingling (conscious) love and respect and affection with (unconscious) fear and resentment. The conflicted love-hate relationship led to the emotional blockage, or rather shutdown, constituting the depression.

Levi draws attention to another important detail. The passage that precipitated Mill's recovery was a scene in Jean-Francois Marmontel's memoir describing the impact of a father's death on a son. The passage resonated with Mill's filial ambivalence, evoking (conscious) sadness at the possibility of losing his father while releasing (unconscious) hatred and pleasure at the thought of his father's death. Hence, it was not mere happenstance that one passage within a literary life of constant reading initiated the recovery. Instead, the passage was well suited to tap the powerful forces at work all along.

Levi might have extended the psychoanalytic account further. In his later work, especially *Civilization and Its Discontents*, Freud located the cause of much depression and anxiety in unrealistic moral standards characterizing the Victorian era: "[W]e are very often obliged, for therapeutic purposes, to oppose the super-ego, and we endeavour to lower its demands. Exactly the same objections can be made against the ethical demands of the cultural super-ego [i.e., social conventions]" (Freud 1961, 90). Freud explicitly criticized Christian ideals, such as loving everyone as oneself, but he would have similarly objected to Mill's secularized **[End Page 275]** ideal of impartially promoting the good of all. Such impractical

ideals are psychologically unrealistic and radically underestimate the tenaciousness of aggression and conflict that cause much unhappiness through guilt, shame, and depression. Mill's objections to Bentham are minor compared to Freud's sweeping objections to both of them!

Mill's philosophical and Levi's psychoanalytic explanations differ greatly, but must they be opposed? Must the "real" or "essential" nature of the crisis reside in either moral insight or mental pathology, as the morality-therapy dichotomy suggests? There is a third possibility: Dissolve the dichotomy by identifying how depression can have both moral and health dimensions.

Like most experiences, Mill's depression undoubtedly had multiple causes, whether the causes operated in mutually reinforcing ways to constitute one jointly sufficient determinant, or whether they "overdetermined" his depression as several individually sufficient causes. Mill's excessively intellectual account and Levi's reductionistic account both contain insights, even without considering additional influences rooted in biochemical, genetic, temperamental, cognitive, and behavioral factors. Indeed, there is an obvious bridge between the two accounts. Mill's emotional rebellion against his father's power and his intellectual rebellion against his father's philosophy would naturally go together, given James Mill's thoroughgoing dominance.

Interestingly, Mill himself opened the door to an integrated model. Although he portrayed his depression as an intellectual crisis, he unobtrusively scattered medical terms throughout the portrayal. For example, he requested a "physician who could heal" his "mental malady," and he referred to Wordsworth's poems as "medicine for my state of mind" (1989, 113, 116, 121). Far from being mere literary embellishments, these phrases are truncated indications of an illness that he found embarrassingly "egotistical" and "in no way honorable" (119). We should take seriously his remark that "the words of Macbeth to the physician often occurred to my thoughts:" "Canst thou not minister to a mind diseased . . . .?" We should also note that he alluded to these words without actually quoting them, as if doing so might make all too explicit the nature of his suffering (1989, 113).

Mill was sick and he knew it. He interpreted his depression as simultaneously a medical and moral concern, even though he highlighted the latter when he wrote his autobiography. The depression was a mental and moral sickness, a pathology of mind and character, of caring and commitment. In my view, much depression has moral and health dimensions, contrary to the morality-therapy dichotomy.

2. Therapeutic Morality

How would Mill fare were he to seek help in today's health care system and within our increasingly therapeutic culture? There is no point in speculating. Contemporary therapies are enormously diverse, and their outcomes depend on the interpersonal dynamics between particular patients and therapists (Fancher 1995). Moreover, Mill was a rare genius who might react to any therapist in a singular manner. And some might object that his distinctively philosophical interests render his case too singular to serve as a paradigm for

contemporary reflections on depression-generated insights. Let us, then, broaden the discussion by shifting from John Mill to John Moorehead.

John Moorehead was in his forties and working as the provost at a Jesuit college when he suddenly began to experience severe mood irregularities: sadness, anxiety, irritability, listlessness, and general loss of capacity for enjoyment. Normally a person of abundant energy, he found himself unable to perform the simplest task without enormous effort. There were additional bodily symptoms, such as loss of appetite and disruption of sleep patterns. And cognitive problems included intense self-blame and the inability to concentrate. Although he could cope with these difficulties, he sought psychiatric help at the promptings of his sister and because he was alarmed by persistent thoughts of suicide. That is how he became the patient of Peter C. Whybrow, a distinguished psychiatrist who has chaired psychiatric departments at leading research institutions. **[End Page 276]**

In preliminary discussions with Whybrow, Moorehead offered his own explanation of the depression, framed in terms of his religious tradition. In his eyes, the problem centered around laziness, spiritual pride, and moral weakness, the affliction that in the Middle Ages the Christian Church called acedia and regarded as an occasion for spiritual self-scrutiny (Jackson 1985). (Had he been Protestant instead of Catholic, he might have cited Kierkegaard's ruminations about the sick soul [Khan 1994]). Whybrow immediately dismissed Moorehead's self-diagnosis as a medieval excrescence illustrating the "pervasive cultural confusion that still haunts us today--whether depression is a medical illness or some sinful sickness, an outcome of laziness and moral turpitude" (1997, 97). "John Moorehead, struggling to explain his changing mental state within the terms of his own experience, had missed the mark; he was suffering not from sloth but the medical illness of severe depression" (1997, 95). To understand his illness, we need to look at synapses, not sin, for his condition was "a disturbance in the dynamic regulation of the neurotransmitter messenger systems that sustains communication among the neuronal centers of the limbic alliance" (1997, 145). The immediate source of the biological disturbance was stress that disrupted serotonin levels, and the cure was to be found in pharmacology rather than spiritual transformation.

As with Mill, we are again confronted with one-sided interpretations: Moorehead's spiritual loftiness versus Whybrow's biochemical realism. Both neglect the possibility that much depression is simultaneously a moral and biological phenomenon. Moorehead neglects earthy moral matters about his personal relationships and community tensions, glossing over them with the blanket label "acedia." For his part, Whybrow is more subtle in avoiding crass biological reductionism: "Stress, genetic predisposition, learning, and social networks weave a dynamic tapestry in determining vulnerability to mood disorder" (1997, 189). Nevertheless, he introduces a sharp contrast between Moorehead's religious-moral explanation, which he rejects wholesale, and the primarily biological explanation in terms of multi-caused stress that disrupts serotonin levels.

In fact, Whybrow's clinically nuanced account of the sources of stress--which interact with temperament, genetics, and learning--can be recast as a distinctively moral explanation of Moorehead's depression. The stress and ensuing depression were linked to disrupted

relationships of trust, collegiality, and mutual support. During the year prior to the depression, Moorehead was involved in a major upheaval at his college. The conflict centered on whether Jesuit colleges like his should recruit distinguished non-Jesuit professors in order to raise the quality of the colleges and thus solve the problem of declining enrollments. Moorehead led the movement for change, but the personal cost was enormous. He lost the friendship of the college's chief administrative officer, who had been a mentor during his career and was something of a father figure to him (echoes of Mill?). He accepted the trustees' offer to become the provost but quickly became isolated from his colleagues, including those who backed him during the conflict. Morally alienated, self-doubting, and cut off from his usual support systems, he was in a crisis that had not only biological implications but a moral (and in his eyes spiritual) dimension as well.

With this example in mind, let us return to the morality-therapy dichotomy. To begin with psychiatrists and psychologists, must they set themselves against moral ideas in thinking about depression? Even therapists who aspire to be value-neutral need to take into account their patients' beliefs about the values embedded in their relationships and activities. Moorehead needed help in understanding how his depression was linked to broken personal and community ties that he had cherished. Evidently the medication helped him improve to the point where he could make this discovery for himself. Regardless of Whybrow's own value perspective, he needed to appreciate that Moorehead might not be altogether unreasonable in viewing himself as sharing some responsibility for the unhappy events at his college. The cure to Moorehead's depression required responsible adjustments in moral relationships as well as in serotonin levels.

Doesn't introducing this moral language invite blaming, which would be therapeutically self-defeating? **[End Page 277]** Pathologically depressed persons are already unreasonably hard on themselves; indeed, their excessive self-blame is one of their primary symptoms. Negative moral judgments only add to their irrational self-depreciation. In general, therapy is a special context of support aimed at healing, and appropriate "professional distance" requires suspending negative moral judgments. Thus, whatever moral responsibility Moorehead shared for his strained personal relationships, his self-blame was exaggerated. Indeed, it was morally objectionable in its own right, in that it failed to show appropriate self-respect, and for a therapist or an observer to engage in blaming would be cruel.

Nevertheless, a great many therapists understand the ultimate goal of therapy to be empowering the client to accept responsibility in dealing with their problems. At appropriate times during therapy they may deliberately use the term "responsibility," as well as additional moral (or morally resonant) language such as "caring" about oneself, mustering "courage," "forgiving" oneself, and participation in "community." In doing so, they understand responsibility as forward-looking obligations to deal appropriately with difficulties, not backward-looking blame for shortcomings. Whybrow is no exception. As a skilled therapist, he underscores the need for patients to accept personal responsibility for their recovery, although he does not say this is a specifically moral responsibility (Whybrow 1997, 234). And he admits that restoring understanding and trust with colleagues

was the culmination of Moorehead's therapy, although again he casts these factors in terms of health rather than morality (1997, 193).

Therapy is indeed a special context, but we need to take seriously how extensively therapeutic attitudes now permeate our culture, far beyond the psychologist's office. The public has eagerly embraced an ever-increasing role for mental health approaches to an enormous array of major social problems. The reasons for this acceptance include frustrations with purely moral approaches that have either not worked or, as Freud contended, made things worse; the perceived growing expertise and authority of health professionals; and the advantages in being able to excuse personal addictions, failings, and even cruelties as being sicknesses. But the reasons also include a compelling sense that many problems--including depression--have both psychological and moral dimensions that frequently blend together (Weiner 1993). As I see it, we should neither replace moral with therapeutic concepts nor renounce therapeutic attitudes and return to purely moral attitudes. Instead, we should begin the constructive task of integrating moral and therapeutic perspectives, or rather of bringing to light the integration that has already taken place implicitly.

A humane ethics will be therapeutically oriented toward growth and helping rather than guilt and blame. If all moral perspectives have to acknowledge some role for guilt and blame, a humane perspective will limit that role and be wary of its tendency toward excess in the forms of cruelty toward oneself and self-righteousness toward others. A humane ethics is also psychologically realistic. Only thus can it guide conduct (in tune with Kant's dictim "ought implies can") and avoid causing harm by making impossible demands (Flanagan 1991). Without abandoning morality, a therapeutic vision of morality takes seriously Freud's warnings about "the pathology of moral aspiration" (Rieff 1979, 319).

Indeed, given the centrality of moral values in meaningful lives, the attempt to abandon them inevitably results in smuggling them back in uncritically. To cite a glaring example, James Gilligan opens an essay entitled "Beyond Morality" by declaring that "Morality is dead" and should be replaced by a psychoanalytic theory "which sees morality as a force antagonistic to life and to love, a force causing illness and death--neurosis and psychosis, homicide and [depression-linked] suicide' (1976, 144-45). In fact, it quickly becomes clear that Gilligan has narrowly and pejoratively redefined morality, reducing it to objectionable outlooks centered on excessive guilt, shame, and irrational compulsions that cause anxiety and depression. In the guise of scientific neutrality, he then casually and uncritically sketches what ethicists call a virtue-oriented morality accenting love, honesty, and self-respect. Not only does he conceal the moral content of these virtues, **[End Page 278]** but he naively assumes they can magically remove the conflicts that he accuses guilt moralities and shame moralities of generating, conflicts that any moral outlook must confront.

A therapeutic vision of morality also accents self-respect as the virtue warranting and delimiting appropriate self-esteem. "Self-esteem" is a psychological concept and "self-respect" is a moral one (Massey 1983). Self-esteem is simply a favorable attitude toward oneself, shown for example by self-confidence and positive emotions toward one's life. It comes in many degrees and can be appropriate but also excessive, as exhibited in

narcissistic, histrionic, or arrogant individuals. Self-respect, by contrast, is the virtue of valuing oneself in morally appropriate ways, as manifested in conduct, attitude, and emotion. It cannot be excessive, since it is already what Aristotle called a "mean"--a reasonable middle ground between excess and deficiency.

Self-respect implies responsibilities to care for oneself, and it also implies appropriate self-esteem. No aspect of depression, in healthy or unhealthy forms, is more poignant than self-denigration. The downgrading may begin with dismay over a particular event, but it quickly expands to the entire self: I am worthless; my life means nothing; there is no hope for things improving. Self-esteem enters into the virtue of self-respect, of valuing ourselves in appropriate and desirable ways. That virtue is fundamental, as Kant (1963) emphasized, in meeting all responsibilities, including the minimal responsibility to carry on with our lives.

Turning to philosophers, should ethicists feel threatened by therapeutic approaches to depression? Certainly there is a legitimate concern that reducing depression to neurochemical imbalances will eclipse the relevance of values in understanding it. More than most forms of suffering that might stimulate insights, depression is singularly important because it centers on self-worth, which in turn is central to identity and meaning. Typically, depression is an experience of diminished self-respect, self-esteem, self-confidence, hope, and commitment, all of which are vital ingredients of meaningful life. As such, depression forces us to fight to regain what it threatens, lest we suffer irrevocable loss.

Thus, after acknowledging that depression, like all emotions, can take pathological forms, the philosopher Robert C. Solomon argues that it can also be an eminently healthy "window to the soul" (1977, 294). It can be, "our most courageous attempt to open ourselves up to the most gnawing doubts about ourselves and our lives" (1977, 295), courageous because it requires responding to the threat of radical self-diminishment. Solomon implies that depression, unlike sadness or grief, constitutes an emotional signal that we have doubts about the values and structures in our lives:

In depression, we (literally) "press ourselves down," force on ourselves the burdens of universal doubt, the Cartesian method on a visceral level. Our depression is our way of wrenching ourselves from the established values of our world, the tasks in which we have been unquestioningly immersed, the opinions we have uncritically nursed, the relationships we have accepted without challenge and often without meaning. A depression is a self-imposed purge. It is the beginning of self-realization, unless it is simply ignored, or drugged away, or allows itself to give in to the demands for its own avoidance--the most extreme of which is suicide (1977, 295).

Solomon captures an enormously important truth, but he overstates it and comes close to romanticizing melancholia, as did the nineteenth-century Romantics with whom he acknowledges a strong affinity. Some depression is simply the pained awareness of the difficult, defeating, tragic aspects of life. As such, it is less a stimulus for self-insight than something to be lived through, frequently with the help of friends or professional therapists. And many instances of depression have little connection with moral insight. Persons who become depressed because their stock investments fall short of expectations may be

provoked to reflect on their materialistic preoccupations, but more likely they will be stimulated to seek other ways to earn more. Depression can be healthy without being a window to the soul, and it can also be such a window when it is pathological, as with Mill and Moorehead. **[End Page 279]**

George Graham introduces a distinction that, recast, helps us avoid romanticizing depression while appreciating its potential as a source of insight. The first distinction is between depressions that are mere biochemical eruptions and those that are "intentional," in the phenomenological sense of having an object--of being about something. Intentional depressions can be justified or unjustified, according to whether the beliefs, emotions, and desires they embody are appropriate or not. The same cannot be said of nonintentional depressions: "Suppose, for example, David's depression is produced by kidney toxins, independent of his beliefs. There is no more point asking if David's depression is appropriate than asking this of a flu or virus" (Graham 1990, 406). Graham says the distinction parallels psychiatrists' distinction between depressions that are reactions to the environment (reactive, exogenous) and those that are caused by physiology alone (biochemical, endogenous).

Graham conflates objects of moods with their causes. In a sense, all depressions have objects; they are "intentional" in that they are about something, if only about ourselves and our lives as a whole--even when they are caused neurochemically. Although frequently psychiatrists also conflate causes with objects, the primary point of their exogenous-endogenous distinction is to distinguish two different etiologies or causes: biological versus environmental (regardless of their phenomenological objects) (Coyne 1986, 16).

I would redraw Graham's distinction along different lines, using a distinction I drew earlier. Some depressions are feature-specific in that they are focused on specific aspects of our lives (relationships, activities, events, etc.), while other depressions are nonspecific in that they have no particular focus. Both kinds of depression can be intentional in targeting one's life as a whole, but feature-specific depressions have an additional intentionality in being about particular aspects of our lives. Again, both kinds of depression can be justified or not, but feature-specific depressions pose both feature-focused and global questions about justification.

Using this distinction, we can agree with Graham that the beliefs, emotions, and desires embedded in either type of depression can be justified or unjustified. They are justified when the beliefs (e.g., that some bad event has occurred) are true or well-supported, when the emotions (e.g., misery, hopelessness) are appropriate to the situation, when the desires (e.g., to withdraw from social interactions) express good judgment, and, I would add, when the patterns of reasoning involved are warranted. Both feature-specific and nonspecific depressions can be unjustified, as revealed by critical scrutiny of the depression and its context. Depression can be valuable or harmful, rational or irrational, healthy or sick, a window to the soul or a prison (Rowe 1996).

Graham draws a second distinction between (1) reasons for the state of depression, and (2) reasons for the reactions to and under the influence of the depression. "Saying that

depression is justified may mean that depression (the state of mind or emotional condition) itself is justified. . . . It can also mean that the person is warranted in how he reacts once depressed, that is, he is reasonable or prudent in the manner in which he allows depression to affect his life" (Graham 1990, 407). For example, a person whose spouse dies may be fully justified in becoming depressed, but he or she might be unjustified in reacting to the depression by committing suicide. According to Graham, the difference between healthy and pathological depression turns primarily on reactions to depressions, on whether we allow the depression to harm us or instead to produce insights (1990, 415).

In reply, we might question whether the depression itself is neatly separable from our reactions to it. The reactions Graham refers to might be symptoms of pathological depression that an individual has difficulty controlling without outside help, rather than voluntary choices in which someone "allows depression to affect his life" (1990, 407). Graham fails to take account of how depression can impair voluntary agency, an issue to which I return in the next section.

Solomon and Graham worry that therapeutic approaches to depression undermine explorations of values, as if prescribing Prozac to Mill would have impeded the history of ethics. But a humane morality implies therapy for severe suffering, and **[End Page 280]** therapy is rooted in moral values of caring and respect. Moreover, therapeutic responses to depression are far more diverse than a knee-jerk prescription of drugs. Even where drugs are applied they are usually combined with psychotherapy. Insight-oriented therapies, including psychoanalysis, existential, and cognitive therapies, are compatible with Graham and Solomon's insight-oriented concerns, at least in principle.

In principle--but in practice? Let us recast the concerns expressed by Solomon and Graham in terms of cautions rather than dichotomies. The cautions apply to many current therapeutic approaches to depression, not only to psychopharmacology. Most therapy is narrowly targeted on removing symptoms, especially when it is funded by insurance programs that pay for quick cures rather than extended insight-based transformations through psychotherapy. Perceiving the disruptive symptoms of depression as the problem, the solution is to remove the symptoms, whether by drugs, behavioral modification, cognitive retraining for greater optimism, or whatever. Call this the "quick-fix aim": Unhealthy depressions are cured by efficient removal of symptoms, by largely shunting aside value inquiries.

There is a related quick-fix aim regarding healthy depressions. Both in everyday life and in many therapeutic contexts, there is an excessive tendency to regard depressed ways of thinking and acting as unhealthy. In this connection, Graham accuses Aaron Beck, a pioneer of cognitive therapies, as claiming that all depression is unjustified and unhealthy because it is characterized by illogical thinking patterns such as overgeneralization ("I never succeed at anything"), magnification ("I will never find another job"), and personalization ("It's all my fault"). But Graham fails to note that Beck is well aware that there are many normal moods of feeling blue, unhappy, empty, or lonely--what Graham would call healthy and reasonable depression (Beck 1967, 7). Let us then recast Graham's criticism: When Beck restricts the everyday word *depression* to abnormal states, he invites confusion, especially

by a general public eager to be rid of unpleasant states. Anything but optimistic thinking implicitly becomes suspect. Even in the hands of a careful researcher like Martin Seligman (1991), once research is cast in the form of popular writings that are read quickly by a public already predisposed against depression, it encourages an equation of mental health with optimistic styles of reasoning.

This result reinforces worries about overuse of prescription drugs. For, if the primary problems are narrowly targeted therapies aimed solely at removing symptoms, and the trend is steadily toward pathologizing everyday depressions, then drugs remain the preferred solution: quick, inexpensive, and equally available for cosmetic purposes.

3. Autonomy and Authenticity

The expression "cosmetic psychopharmacology" was coined by Peter Kramer in *Listening to Prozac* in reference to using medicines for nonpathological conditions. Despite his somewhat exuberant celebration of Prozac, Kramer raises important issues about the continuum between unhealthy and "normal" forms of depression, and also about personal identity and autonomy. As a psychiatrist who deals daily with depressed individuals, Kramer challenges philosophers' generalizations about the insight-provoking virtues of depression.

Solomon and Graham viewed depression as a signal of other problems to which individuals ideally respond autonomously, in authentically reshaping their identities, but Kramer grapples with how depression itself is a problem that interferes with autonomy and authenticity. Had he discussed Mill, he might have highlighted the dramatic impairment of agency during the worst six months of the depression. He might also have noted how Mill's recovery had less to do with exercising autonomy than with a spontaneous remission due to a fortunate restoration of his emotional capacities. Again, had he discussed Moorehead, he would have us attend to how the depression distorted, rather than sharpened, his capacities for insight and self-understanding. But let us consider one of Kramer's own examples, the first patient he treated with Prozac.

"Tess" was referred to Kramer by a psychologist **[End Page 281]** who had been conducting extended psychotherapy with her. The psychologist helped Tess confront many painful aspects of her life, including sexual abuse in childhood, a father who died when she was twelve, a mother who thereafter suffered from unremitting depression, finding herself the surrogate parent for nine siblings, suffering through an unhappy marriage, and surviving several abusive relationships. The therapy did not succeed in stemming her deepening unhappiness, weariness, low self-esteem, and suicidal wishes. Kramer first prescribed imipramine, a long-proven antidepressant, but it brought only mild relief. He then decided to try Prozac, which had only recently been approved by the Food and Drug Administration. Within two weeks the drug transformed Tess, not merely healing the depression but dramatically altering her personality, making her "better than well." She became more relaxed, energetic, and self-confident in ways that improved her work and her relationships with men. Eventually Kramer weaned her from Prozac, but after eight months without medication she requested it again because she was experiencing lessened energy and a

somewhat lowered mood. Kramer again prescribed the drug, this time to a person who was not seriously depressed but who instead insisted she was not "herself" without the drug.

We can distinguish four issues concerning autonomy and identity raised by the case: autonomy-impairment, self-identity, health-illness continuum, and lack of privileged access.

I. Autonomy-Impairment

Severe depression can adversely affect autonomy. Solomon and Graham leave the impression that depression is simply an unpleasant state to which we are free to respond by exercising our usual autonomy. Yet, depression can erode autonomy, in varying degrees, certainly insofar as it becomes an unhealthy state. The difficulty is not that as a mood it is not fully subject to our direct control; rather, depression impairs autonomy by lessening capacities for energy, enthusiasm, concentration, hope, optimism, self-esteem, and self-respect--all of which contribute to autonomy in shaping one's life. It is naive, even dangerous, to call for the severely depressed person to just "snap out of it!" In addition, depression can disrupt normal assessment of risks, either because of misjudging degrees of risk or by lowering capacities to care about particular risks in the manner of healthy persons (Elliott 1999, 95).

"Pharmacological Calvinists" (Kramer 1997, 274), and here we might include Graham and Solomon, object to the widespread use of antidepressants. They warn of the danger that pill-popping to avoid serious emotional experiences could reduce openness and tolerance to difficult emotions and unpleasant realities. Kramer acknowledges this danger and agrees with objections to repeatedly using short-acting pills to manipulate emotions (257). But this emotional self-crippling was not what he observed in his patients. Instead, they were empowered by antidepressant drugs to undergo a wider range of emotional experiences and difficulties. The drugs strengthened autonomy by restoring capacities to explore, to have courage, and to live with hope and confidence.

II. Self-Identity

Autonomy plays a role in personal decisions about the identity one affirms. Kramer observes that drugs can substantially alter personality and be "so profound that there are almost two different persons. . . . Whose autonomy are we out to preserve?" (1997, 268). Given our traditions of valuing individuality, presumably individuals have rights to make their decisions about whether to use legally prescribed drugs. After all, much is at stake for them, not only in shaping and maintaining their commitments but also in responding to social pressures that favor particular personality types, particular kinds of "selves."

The "selves" at issue are not givens but instead value-laden constructions--selves esteemed or devalued, both for specific features and overall. The construction of those selves is never achieved once and for all. It is an ongoing struggle within the framework of one's past, social present, and projected future. Questions about authenticity arise when people passively accept the mandates of their societies, but none of us can or should live in complete independence of those mandates. Our society tends to favor outgoing, friendly,

[End Page 282] nondepressed personalities, and Prozac highlights this cultural preference (Kramer 1997, 270). Are we inauthentic because we aspire to have socially affirmed identities? Surely not. Such a view would condemn psychotherapy and many other forms of self-shaping. It would mistakenly stipulate that choices under pressure--and in social contexts there are always pressures--cannot express autonomous moral judgments about desirable and undesirable dispositions and moods.

Authenticity and autonomy are linked. Charles Taylor defines authenticity this way: "Being true to myself means being true to my own originality, and that is something only I can articulate and discover. In articulating it, I am also defining myself. I am realizing a potentiality that is properly my own" (1992, 29). Is this potentiality a given, to be discovered, or something I create? According to an essentialist view, there is some one true self for each of us, typically a higher self defined in terms of a favored value perspective (such as a particular religious viewpoint). By contrast, a process view allows that we can shape ourselves in many different directions and that we are authentic insofar as we choose honestly and autonomously. I endorse a process view. True, some persons have sufficiently focused talents and opportunities that their authenticity seems to aim straightforwardly in one direction, at least at many junctures in their lives. Thus, it may seem obvious that Moorehead's authentic identity, in his circumstances, consisted in restoring him to his place in the Jesuit community from which his depression had isolated him. Yet even he had other options, and his postdepression choice to return to the community was very much an autonomous decision, one that therapy empowered him to make.

III. Health-Illness Continuum

Health and illness are connected along a continuum, rather than separated by a sharp line. This provides yet another reason for abandoning the morality-therapy dichotomy. Moreover, unless we grant the medical community wholesale authority, each of us participates in distinguishing health and illness with regard to ourselves, especially in the large middle ground of "unhealthiness" that falls short of full-blown illness, disease, or sickness. Insofar as the notion of "health" is normative, and especially morally normative when mental health is at stake, individuals have a right to assess when depression is unhealthy. That is not to say that health is wholly subjective.

Jerome Wakefield suggests that mental disorders are harmful dysfunctions. "Dysfunction" is a descriptive term referring to impairment of a natural (evolutionary-designed) function, and "harmful" is a value term whose standards are specified by sociocultural standards (1992, 374). The relevant function at issue with depression is the exercise of effective agency, which can be impaired in varying degrees. When the impairment becomes severe, the psychiatrists' *DSM* defines it as a sickness, based on sociocultural standards for normal or accepted behavior. But neither psychiatrists nor sociocultural standards are the final word. Insofar as values are at stake, there is some legitimate domain within which individuals can reasonably make their own assessments, according to their own values, of sickness and unhealthiness (a broader notion than sickness).

Is there some room for cosmetic psychopharmacology in which individuals shape their moods, analogously to how they use cosmetic surgery to shape their bodies? In both types of self-shaping, individual decisions are made in response to social pressures that may themselves be morally objectionable. The social bias against mildly dysthymic individuals can be tyrannical, subtly coercing individuals to use medication they would prefer not to use (Weisberger 1995). But short of waiting for a utopian world, there is always the urgency of social engagement that requires some self-shaping of moods.

David A. Karp perhaps underestimates that urgency, in his otherwise insightful sociological analysis. In *Speaking of Sadness*, Karp argues that rampant depression is a manifestation of the breakdown of community and that "we need to rediscover community as the very best medicine for many of our ills, including the sadness of depression" (1996, 187). He critiques psychiatrists, whose *DSM* manifests a "demonstrated arbitrariness" revealing "that much of what we **[End Page 283]** call mental illness is nothing more than a political designation sold as science" (1996, 54). Depression can be "a normal response to pathological social structures" and we should change those disintegrating community structures rather than "cure" normal emotional responses to them (1996, 80).

In illuminating the social dimensions of depression, Karp reveals how "depression arises out of an enormously complicated, constantly shifting, elusive concatenation of social circumstance, individual temperament, and biochemistry" (1996, 79). Some confirmation for his views can be found in a cross-cultural study that locates a very low incidence of depression in Taiwan and a very high incidence in both Beirut and Paris (Weissman et al. 1996). Yet, in bemoaning the breakdown of community that contributes to depression, he leaves us with little hope for immediate cure, apart from a concluding sympathetic nod in the direction of spirituality. Depression can be "normal," in the sense of an understandable and expected response to harmful social structures and yet have pathological aspects that disrupt our ability to carry on with our lives. We cannot wait until the vaster problems of community are resolved before dealing with the suffering generated by those problems.

IV. Non-Privileged Access

Finally, returning to the earlier topic of autonomously generated insights, Kramer challenges any general assumption that depression (whether healthy or unhealthy) offers privileged access to insights into personal identity and the human condition. Admittedly, studies have shown that depressed persons tend to be more accurate in their assessments of their own abilities and of problems confronted (Alloy and Abramson 1979; Golin, Terrell, and Johnson 1977). But perhaps depressed individuals are blocked from deeper truths about the joys to be found in commitments and relationships undermined by the depression (Garrett 1994). Why should we assume the self-deprecating and pessimistic depressed self is always more genuine than the chemically brightened self?

Kramer does not settle the question, and at this point his discussion could benefit from invoking Graham's distinction between justified and unjustified depression. In particular, he might observe that when the onset, reactions to, and expressions of depression are justified, then hasty resort to drugs would undermine valuable engagements with the world as it

really is. Instead, Kramer ends his book on a note of uncertainty, ambiguity, and ambivalence that clashes with his overall optimism about Prozac. That concluding note rings true. Depression can be a creative source of insight and self-transformation, or it can constitute a problem that undermines insight and impedes autonomy. My discussion adds to these complexities by accentuating how depression can be simultaneously pathological and insight-provoking, how therapeutic and moral values are interwoven, and how the continuity between health and sickness enmeshes all of us in a therapeutic morality.

To conclude, perhaps it is not surprising that depression has become our "presiding discontent," given our postmodernist preoccupations with identity, recognition, and self-worth in light of the erosion of community and the explosion of change. As such, depression is receiving attention within many disciplines, although it has yet to receive the integrated interdisciplinary scrutiny it deserves. That scrutiny is needed to balance and temper some sociologists' narrow preoccupation with social causes, some psychiatrists' biological reductionism, some psychologists' narrow focus on symptoms, and some philosophers' excessive celebration of depression as insight-provoking. Most important, the newly emerging biopsychosocial explanations of depression do not automatically oppose and replace moral perspectives. A century ago, the physician-psychologist-philosopher William James urged that religious experiences, including "religious melancholy," have both neurological and value dimensions (James 1902). In a similar spirit, I have urged that therapeutic perspectives both complement and merge with moral perspectives, rather than replacing them.

Acknowledgment

In making final revisions of this essay, I benefited greatly from the insights of three reviewers for this journal.

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