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Comments

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Depression and Moral Health: *A Response to the Commentary*

[Mike W. Martin](#)

S. Nassir Ghaemi tells us that whereas "neurologists are sometimes accused of admiring disease rather than treating it," psychiatrists seek to cure disease even when they do not understand it. At the same time, he notes that Freud had both theoretical and practical interests that occasionally point in different directions, and psychiatrists have learned that theoretical understanding of the sources of suffering does not always translate directly into useful clinical practice. For their part, philosophers are often criticized for indulging in armchair speculation that yields neither empirical understanding nor practical efficacy. Writing as a philosopher in "Depression: Illness, Insight, and Identity," I had hoped to engage both scientific and therapeutic interests while linking them to humanistic concerns about values. Ghaemi's emphasis is primarily therapeutic--to help, to heal--but he seems generally sympathetic to my goal of integrating moral and therapeutic perspectives. I benefited from his cautions about the need to pursue that integration with close attention to therapeutic imperatives.

My essay is part of a larger project of interweaving morality and therapy as applied to an array of human problems, or rather of elaborating on an integration that has already evolved in our society, and which now permeates self-help literature, talk shows, sermons, and much psychotherapy (Martin 1999b). This integration resonates with Plato's daring intuition in *Republic* that morality and mental health are fundamentally linked through a concept of moral health. *Moral health* is something more than a metaphor. It refers to active capacities that are essential for both moral life and psychological coping. But Plato went too far when he equated virtue and mental health: "Virtue is as it were the health and comeliness and well-being of the soul, as wickedness is disease, deformity, and weakness" (1945, trans. Cornford). So did humanistic psychologists, such as Erich Fromm, who attempted to derive moral principles from psychological facts (1947). Certainly we must not make moral judgments about dementia, consider episodic wrongdoing simply pathological, or lapse into the patronizing notion that the higher reaches of moral commitment are merely signs of sound health. Nevertheless, I am convinced that Plato glimpsed a larger truth than his critics allow (Kenny 1973).

Certainly we need to dissolve any rigid dichotomy between moral and therapeutic perspectives on depression, while still appreciating that different practical purposes warrant different emphases. Two powerful trends have undermined the moral/therapeutic dichotomy during the twentieth century, and yet have also made it difficult to see **[End Page 295]** where we now stand. On one hand, the therapeutic trend has medicalized moral problems by approaching them in terms of health and therapy. On the other, the unmasking trend

reveals that therapy itself embodies moral values, thereby debunking its pretension to function as a morally neutral replacement for morality. Both trends are at work, for example, in the case of alcoholism.

Alcoholism is a disease, according to the dominant view in the therapeutic community. Citizens and law enforcement agencies, however, continue to regard alcohol abuse as something for which individuals should be held accountable. Furthermore, Alcoholics Anonymous, the most popular form of alcoholism therapy, conjoins an insistence that alcoholism is a disease with moral (and religious) values about accepting personal responsibility. In my view, alcoholism is typically both a sickness and something which involves wrongdoing (Martin 1999a). It is a sickness insofar as it constitutes impaired agency, and it is concerned with wrongdoing insofar as it violates responsibilities to care for one's health and to be accountable for one's drinking behavior. Responsibility does not vanish once alcoholism has ravaged one's capacity directly to control drinking, for even then there remains a duty on the alcoholic's part to seek and to cooperate with available therapeutic help. Nevertheless, the different social constituencies dealing with alcoholics have strikingly different emphases: therapists emphasize nonjudgmental helping, law enforcement personnel accentuate punishment for alcohol-related crimes, insurance companies focus on alcoholism's cost liabilities, and legislators formulate laws that provide incentives for responsible drinking behavior. All of these emphases overlap at various junctures, and as a society, we need a comprehensive perspective that renders them coherent.

To look at another example, analogous differences in emphasis are inevitable and even desirable in thinking about depression, given the varying and sometimes conflicting concerns of sufferers, agents coping with problems, health care providers, theoreticians in psychiatry and the social sciences, groups that pay for medical care, and the depressed person's family and community. But again, like alcoholism, we need a comprehensive vision of the interplay of illness and insight, pathology and personal meaning, and health and moral values in depression. Like alcohol dependency, depression generates questions about responsibility. As a general point, recently noted by Lawrence Becker, both mental and moral health exclude the crippling forms of severe depression; they exclude any of "the basic personality tenors (phobias, distrust, pessimism, depression) that paralyze agency or render agents unable to feel or express empathy, or unable to take a benevolent interest in others" (Becker 1998, 104). What I said about depression impairing autonomy is germane to responsibility issues, but my primary focus was elsewhere--on personal meaning and values.

Ghaemi rightly insists that *severe* pathological depression "almost always interferes with the free, rational exercise of moral agency due to cognitive distortions." Equally important, he insists that severe depression needs treatment, and that its value aspects should not sanction avoiding help--a dangerous practice that results in part from the cognitive and emotional distortions involved in severe depression, and in part from the continuing social stigma of mental illness. All of these points are consistent with what I said in discussing Peter Kramer, but they deserve the emphasis Ghaemi gives to them. Ghaemi is also on target when he says that I failed to distinguish between insights that occur during or after a

state of depression. Severe depression is perhaps rarely a source of insights while it lasts, given the emotional and cognitive inhibition it causes. Mill's insights came after, and in light of his suffering, not during it.

Value judgments enter the discussion in another way. Ghaemi outlines the "depressive realism" approach to understanding depression, an approach that finds some correlation between a state of mild depression and a realistic grasp of the world. I alluded to that literature without emphasizing it. If anything, I discussed psychoanalytic perspectives more extensively, while also taking account of biochemical and cognitive-behavioral approaches. My themes cut across the varied psychological-psychiatric perspectives, and I did not intend to make a "conceptual argument" for associating depression with insight, especially if "insight" connotes accurate perception. **[End Page 296]** Ghaemi cites his own and others' studies suggesting that insight is correlated at most with the milder forms of depression, and that finding is consistent with my views.

I emphasize again, however, that my paper dealt with identity and values more than with "insights" into facts about the world. Empirical studies tend to focus on how depression affects one's knowledge of facts ("reality testing") and to neglect value judgments and their connections with one's changes in identity and wider perspectives on life. Value judgments can be studied empirically, but only as to: (i) how depression shapes individuals' beliefs about values (rather than whether the values themselves are valid); and (ii) the extent to which those value beliefs are adaptive or socially effective, according to a given standard. Hence, empirical studies would help us better understand when depression is beneficial ("adaptive") or harmful only if we begin with value *assumptions* that have not themselves been proven empirically. Moreover, depression-linked changes in a person's values and identity need not be changes for the better, contrary to the impression my essay may have created. Autonomy and authenticity do not always produce more substantive moral behaviors.

Actually, Ghaemi makes a number of extremely interesting observations about depression and values. Whereas I emphasized personal meaning, while taking some note of Mill's contributions to the history of ethics, Ghaemi shifts to social and political results. He discusses the coping and social contributions of depression, even the occasional political and military value of presidents and generals who suffered from something far more severe than normal depression. *Coping* has normative connotations in that it presupposes a framework of what counts as proper social adjustment; for example, seeking to win a war rather than shunning war as pacifists would urge. Ghaemi also makes illuminating comments about the coping value of selective ignorance and inattention. I would add that those comments pertain to many more human conditions than depression. For example, they relate to understanding and morally assessing self-deception (Martin 1986; Lockard and Paulhus 1988; Taylor 1989).

Although Ghaemi finds my discussion of the moral aspects of therapy apt, perhaps more needs to be said. My blending of moral and therapeutic perspectives tends to favor therapies that complement medication with counseling. Although such therapy is still common, it is increasingly at risk because of the relative convenience and lower cost of medication alone

as compared to counseling services. A biopsychosocial--and moral--understanding of human beings should lead us to celebrate pharmaceutical treatments while still continuing to appreciate the value explorations that play a key role in psychotherapy.

Finally, Ghaemi challenges my suggestion that most depression is not a sickness. He says this claim is an empirical assertion subject to scientific investigation, and he doubts whether it will be confirmed. I would note a few complexities in conducting such studies. Empirical investigations need to begin with plausible and agreed-upon definitions of what depression is, something which neither Ghaemi nor I offered. (I only cited the *DSM-IV* definition of Major Depressive Disorder.) When I suggested that most depression is not a sickness, I had in mind that depression (as distinct from sadness or fatigue but overlapping with despair) is a mood of low spirits or dejection centered around a sense of worthlessness or hopelessness, either about life as a whole or about specific engagements with the world. I also noted how Aaron Beck (1967) restricted the term *depression* to abnormal states, and I suspect the everyday work of psychiatrists might prompt similar biases in acknowledging the frequency of "normal" depression. In addition, empirical studies must rely on a plausible definition of psychopathology or mental disorder. Here we should be careful in how we respond to the cultural trend of associating mental health with high self-esteem, confidence, and happiness in ways that automatically render depression suspect. If we use a broad definition of depression combined with the current *DSM-IV* definition of mental disorders, then perhaps my claim is not implausible.

Perhaps we can draw a rough analogy with jealousy, as found in erotic love and a great many other areas of life. Many a lover will testify that intense jealousy is unpleasant, albeit not exactly [End Page 297] in the way depression is (although the two can be found in tandem). Some jealousy is pathological, but much of it is normal and healthy. It is plausible to view jealousy as an adaptive emotional response that evolved to help protect erotic love and other caring relationships by functioning as a warning about threats to them. To be sure, an opposing attitude emerged during the 1960s, according to which all jealousy is a sign of immaturity and even pathology. That difference in value perspectives mirrors, on a smaller scale, disagreements about the extent to which depression should be pathologized in a society that insists on continual cheerfulness at the workplace. I agree that today pathological depression is far more common than pathological jealousy, but I would also guess that normal depression is as commonplace as normal jealousy. In any case, here as elsewhere, value judgments will shape empirical investigations and interpretations.

In concluding, I thank Dr. Ghaemi for his stimulating comments, which have strengthened my sense of the need for integrating moral and therapeutic perspectives. Just as therapy has clear moral implications, morality should become increasingly attuned to psychological understanding and to therapeutic values of healing and personal growth. The primary juncture at which that attunement occurs is moral psychology--psychology of the moral life, and moral aspects of psychology--a field that is only recently emerging from the shadow of debates about abstract ethical theories on right and wrong. Those theories themselves stand to benefit from greater psychological realism and nuanced integration with a compassionate therapeutic vision in responding to human suffering.

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