Is depression a sin? A philosophical examination of Christian voluntarism

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Abstract

Among the more notable Christian understandings of depression is the idea that depression is a sin or the result of sin. While this idea is dismissed by many Christians and non-Christians, it is difficult to pinpoint what exactly is wrong with it. This paper seeks to address this problem, focusing on a common premise of the ‘depression is a sin’ claim: that it is within a person’s power to recover, such that remaining depressed is a choice. This claim is held not only by Christians who believe depression to be a sin, but also by other religious and non-religious voluntarists, who believe depression to be under the control of the will. I will object to this idea by pointing to accounts that indicate that one widespread feature of depression is an experience of diminished free will, and will argue that this means that asserting the possibility of making choices that are relevant to recovery in the context of all depression is misplaced. I will then turn from the question of whether ‘depression is a choice’ claims are true, to whether they are helpful, and will argue that they can be helpful, but only in non-extreme forms of depression. Finally, I will reflect on the pastoral and clinical implications of the discussion.

Introduction

Some Christian literature aimed at depression sufferers connects depression to sin by claiming that depression is a sin or the result of sin. This is because people experiencing depression are seen to lack some of the spiritual fruits that are regarded as evidence of genuine Christian faith:

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

 (Jessy Grondin, cited Camp, 2009; see Galatians 5:22; John 15)

These attitudes held by some Christians are voluntaristic because they emphasise the role of libertarian free will and choice in the attitudes and behaviours of people with depression, such that depression is seen to be a sin, or the result of sin, because depression sufferers are able to do (and be) otherwise. Accordingly, people with depression are advised in this literature to make changes to their lifestyles (usually involving such things as taking more exercise, seeing friends, altruistic activities, and meditation and prayer) and, crucially, making these changes is regarded as being within their power, and they are deemed guilty, responsible or sinful if they fail to do them.

To evaluate voluntaristic accounts of depression, I will look at some recent work on the phenomenology of depression that supports the idea that depression sometimes involves a diminished experience of free will. I will then argue that we have good reason to suppose that there is a correspondence between a phenomenology of diminished free will and an ontology of diminished free will – i.e., that people who experience diminished free will actually have diminished free will. In other words, according to my argument, the feeling of being unable to get out of bed (for example) corresponds to a real diminished ability to get out of bed, and the feeling of being unable to get out of bed (and being unable to do a number of other things, such as take exercise or see friends) is a common feature of depression. If I am correct, then this would mean that a major premise of (Christian and non-Christian forms of) voluntarism - that depression is a choice (by virtue of not making the relevant choices to recover) - is, at least in the more severe cases of depression (in which a diminishment of free will is experienced most keenly) erroneous. The voluntarist claim that depression is a choice (and the result of sin) can therefore not be maintained. I will defend this claim against generic voluntarist, and specifically Christian voluntarist, objections.

I will then turn from a consideration of the truthfulness of (Christian and non-Christian) voluntarism, to its helpfulness. Much criticism of voluntarism (and, in particular, of the idea that depression is a sin) is motivated by a perception that voluntarism is uncompassionate and damaging. However, at least some voluntarism is motivated by the belief that voluntarism is the most helpful, and therefore the kindest, approach to dealing with depression. I will point to examples that indicate that there are cases in which voluntarism is conducive to recovery, but will argue that this is by no means universal – and that it is likely to be when depression is at its most severe, and free will most diminished, that voluntarism is liable to be damaging rather than helpful. Finally, I will consider the pastoral and clinical implications of this discussion.

Before embarking on the examination and evaluation of voluntarism, a couple of notes may be helpful about the implications this paper has, and the implications it doesn’t have, for related debates about both choice and sin. First, while the accounts I focus on express the idea that depression is the responsibility of the sufferer in theistic and harmartiological (sin-related) terms, voluntarist accounts of depression also occur in secular thought. Unqualified belief in our capacity for agency and therefore our moral responsibility is also not just the preserve of non-academic thought, as is highlighted by Sartre’s contention that even “the red hot pincers of the torturer do not exempt us from being free” (Sartre, 1989, p.505). Much of my critique of Christian voluntarism applies to non-religious as well as to Christian forms of voluntarism about depression, and is also relevant to Jewish and Muslim discussions. It is less relevant to Buddhist and Hindu ways of relating ‘sin’ and ‘depression’ which involve the idea of *karma*, because these do not necessarily emphasise the role of choice and free will at the time of depression: in contrast to many western religious accounts, which emphasise the role of present choice and potential conversion of lifestyle, the perceived sin is usually thought to have taken place in the past, in this or a previous life, and may not be something over which the person has contemporary control.

Second, in the literature I will look at, depression is seen as a personal sin, as a punishment for personal sin, or as the natural outworking of personal sin, whether behavioural or attitudinal. Inherent in these accounts is the idea that sin is something for which the individual is responsible, and that the depression sufferer is therefore guilty. I am aware that there are other accounts of sin which posit a more complex relationship between sin and the will and which do not suffer from the same philosophical or pastoral problems. One is that sin is a byword for human brokenness that does not imply guilt, moral responsibility, or the power to do otherwise, but simply points to the Christian belief that depression is not part of the fullness of life that God desires for God’s creatures. A second is that sin should be understood primarily in a corporate rather than individual sense, and that depression is often caused by oppressive and dysteleological social structures. On this account, understanding depression in terms of sin does not impute blame to the person with depression. Rather, it forms a corrective to some extreme biomedical understandings that pathologise and medicalise the person while ignoring the context out of which the depression has arisen. Because my principal concern in this paper is with the view of sin and depression put forward in non-academic Christian literature aimed at people who experience depression, and because these other accounts of sin do not feature heavily in these (and are not what people generally understand by ‘depression is a sin’), I will set these aside in this paper.

‘Depression is a sin’ in Christian literature

Accounts which describe depression as sin or as caused by sin written by Christians and aimed at depression sufferers are not difficult to find, whether online, or in often-bestselling books written by mental health professionals and Christian ministers. One example is *Seek God Ministries,* a website written by a US internet minister and missionary based in the Philippines, which outlines different causes and cures of depression. Among the causes are ‘no hope in God, separation from God, no relationship with God’, ‘sin’, ‘being unthankful’ and ‘a spirit of depression; from sin, rebellion, disobedience, or seeking help from people instead of God’ (Ballard, n.d.). Likewise, in a Christian blog written by a US minister and prison chaplain, ‘spiritual failure’ is identified as one of several causes of depression, an identification attributed to psychologists (Sanders, n.d.). The idea that depression and other forms of mental illness are caused by sin is so well known it is simply dubbed the ‘Traditional Christian etiology model’ in some sociology of religion literature (Mathews, 2008).

Common to the claim that depression is a sin or the result of sin is the idea that depression is freely chosen. For example, in their bestselling book, *Happiness is a Choice: The Symptoms, Causes and Cures of Depression,* psychiatrists Frank Minirth (M.D.) and Paul Meier (M.D.) write that happiness and, conversely, depression, are choices (1994, p. 58) or, perhaps more accurately, a series of choices, and that ‘by applying the contents of this book, depression is 100 percent curable…. Indeed, *happiness is a choice’* (Minirth and Meier, 1994, p. 197). The role of free will in depression is sometimes emphasised more implicitly, as in the psychology professor E. Rae Harcum (Ph.D.)’s 2010 book, *God’s Prescription for Mental Health and Religion: Smile if You Truly Believe Your Religion.* This bookutilises what is described as ‘rigorous psychological research’, as well as quotations from the Bible, to claim that the ‘highway’ to mental health is God’s prescription of selfless devotion to others. The converse conclusion, that depressed people are selfish, in a morally reprehensible way (and, implicitly, by virtue of the book’s prescriptive character, have free will with respect to their behaviour), becomes evident in the Preface:

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

Christian voluntarism is found not only in literature written by Christian psychiatrists and psychologists, but also in personal testimonies and other materials aimed at treatment of depression within a worship or Bible study context. As an example of the latter:

I can tell you assuredly that my “chemical imbalance” was a cause [sic] of my own wilful choice to be depressed, and my own fault…. You might say, “Stopping depression isn’t that easy!” but it is. Just like salvation, getting out of bed, or anything else, it’s a choice. Now it’s your choice too!’

(Trenholm, n.d.)

In addition to claiming that depression is freely chosen, the following non-essential claims about depression are typical of voluntarist accounts:

First, depression never, or only rarely, has a physiological basis. For instance, one UK website explains that ‘the notion of "Mental illness" is a myth. There is usually nothing wrong with your body or your brain, you are suffering the consequences of sin in your life. You do indeed feel sick, but you would get better if you repent and change your lifestyle. (1 Timothy 6:10)’. (Smithers, n.d.). Similarly, Minirth and Meier concede that in some cases depression has a physiological basis, and that this kind of depression is less likely to alter in response to the lifestyle and attitude changes the authors advocate. At the same time, they claim the physiologically-based cases of depression are far fewer than generally believed, and that most people claiming physiological bases are using these as ‘excuses’ to ‘avoid facing up to their own behavioural and emotional irresponsibilities as the cause of their depression’ (Minirth and Meier, 1994, p. 48, see also p.124).

Trenholm (cited above) indicates that she thinks the chemical and neurological aspects of depression are, for the most part, correlates rather than causes:

Many will argue that depression is caused by a chemical imbalance in the brain. “Specialists” in this area are still divided. When did the chemical imbalance occur, and why? Was it prior to the depression? Or was it due to the depression [sic]….There may be a few actual cases where a physiological problem is an issue, but if the truth were known, how many of them would actually cause the depression and not vice versa?

 (Trenholm, n.d.)

Where physiological causes of depression are recognised and discussed by voluntarists, these are often interpreted in terms of things that could involve choice. For example, one account describes the ‘physical causes’ of depression as follows:

There is a big correlation of depression and wealth. Depression is mainly a disease of the rich and idle, the "idle rich". You may not consider you self wealthy but if you live in America the odds are that you are more wealthy than most of the people in the world. And if you own a TV you are probably more idle than most of the people in the world. Too much free time, too much junk food, little exercise, and no purpose in life can combine to produce depression, depression American style.

 (Ballard, n.d.)

A second typical voluntarist claim is that situations that precipitate depression are never, or only rarely, outside a person’s control. As an example of the latter:

These precipitating stresses can vary from finding out your child has leukemia to finding out your mate is having an affair. They can include any situation that you, as an individual, perceive as acutely stressful. We bring most of these stresses upon ourselves, through either direct or unconscious irresponsibility. But it would be very naïve and unwise to assume, as some Christians do, that *all* stresses are brought on because of personal sins and irresponsibility.

If a patient comes seeking advice and consolation because her child is dying of leukemia, we will genuinely grieve with her. We will help her to see that this is in no way the result of sin in her life, but that disease and death are as much a part of human life as are birth and falling in love. People erroneously assume that the death of their child must be a punishment for some sin that they – the parents – have committed. To *assume* so is naïve and self-centered. It is self-centered in the sense that we “self”-conscious humans tend to naively think that all of life’s events somehow revolve around us, as though we were the center of the universe.

On the other hand, in some cases when a battered wife comes seeking advice and consolation because her husband beats her up twice a week, we have to wonder if there is a possibility that she has a passive-aggressive personality and may have subconsciously provoking [sic] his own behavior. (Of course, this does not diminish the husband’s responsibility.) In this type of cycle, the husband usually feels very guilty following his behavior and spoils his wife for several weeks. In the meantime, she is getting from people around her the sympathy which she craves, and she is satisfying her unconscious needs to be a masochist.

(Minirth and Meier, 1994, p. 96)

Situations in which we would usually emphasise the non-culpability of the victim, such as domestic abuse, are laid partly at the victim’s feet. The tendency of parents to blame themselves for their children’s sufferings is also criticised as ‘self-centered’. Much of the Christian voluntarist literature also discusses homosexuality as a choice to conduct what is regarded as a sinful lifestyle that is thought to lead to depression, again emphasising the role of responsibility in creating situations that precipitate depression (e.g. Wilkins, n.d.; Minirth and Meier, 1994; Adams, 1986).

A third typical voluntarist claim is that depression-related states, such as loneliness and anxiety, are also within the person’s control. So, for example:

Loneliness, like depression, is a choice. The only people who suffer from loneliness are those who choose not to make the effort it takes (including the occasional rejections) to build a few close friendships… People who are lonely are in fact rejecting intimacy with others, and projecting their rejection onto those around them

(Minirth and Meier, 1994, p. 55)

Worrying is a choice, since the apostle Paul commands us to “be anxious for nothing”.

(Minirth and Meier, 1994, p. 174)

The Bible is quite clear on the ORIGIN of depression… Proverbs 12:25 – Anxiety in the heart of man causes depression, But a good word makes it glad. (NKJV) How quickly you recover from this state of mind and heart is all up to you, because that’s a choice only you can make. That’s right… it’s a choice [….]Depression is a choice to listen to the lies the devil tempts you with.

(Christianity Oasis, n.d.)

Evaluating voluntarism

How are we to evaluate voluntarism? In terms of strengths, its thesis could be said to be empowering, and to foster a sense of hope among depression sufferers that recovery is possible. This is not insignificant, since there is evidence to suggest that a belief in the possibility of recovery is to some extent self-fulfilling. Voluntarist accounts are also often accompanied by advice on lifestyle changes that may help some people to overcome depression, such as taking more exercise, seeing friends, performing altruistic acts, prayer and meditation, and dealing with guilt, and in this sense it is not dissimilar to CBT. At the same time, voluntarism goes far beyond CBT in making strong claims about the role of choice in depression, and the responsibility of the depressed person who is not recovering from their depression. With respect to these claims, its thesis is simplistic, since it takes some thoughts, behaviours and habits that are choices for some people, and asserts that they are choices for all people. Not everyone is able to get a job, particularly in a context where there are fewer jobs available than people to do them – and of course such contexts do exist, in the States and worldwide. This is quite a straightforward example, but it highlights the fact that not everyone has the opportunity to choose the things the authors (rightly or wrongly) claim are conditions for or aspects of choosing happiness.

While absence of available jobs is an external obstacle (a lack of opportunities) to choosing to get a job, there are also internal obstacles (a lack of abilities) that may prevent people from having the choice to choose happiness rather than depression. In a major 2009 – 2012 project on *Emotional Experience in Depression,* Matthew Ratcliffe and Achim Stephan led a phenomenological study on depression designed to complement and contribute to psychiatric and other scientific classifications of, and treatments for, depression. Among other conclusions, this led to a persuasive argument by Ratcliffe that one common feature of depression is a diminished sense of agency on account of a diminished experience of free will (Ratcliffe, 2013). In other words, while there are no external obstacles to the depressed person’s getting out of bed (for example), it is nevertheless experienced by them as an impossibility. Consider, for example, the following:

I can remember lying frozen in bed, crying because I was too frightened to take a shower, and at the same time knowing that showers are not scary. I kept running through the individual steps in my mind: you turn and put your feet on the floor; you stand; you walk from here to the bathroom; you open the bathroom door; you walk to the edge of the tub; you turn on the water; you step under the water; you rub yourself with soap; you rinse; you step out; you dry yourself; you walk back to the bed. Twelve steps, which sounded to me then as onerous as a tour through the stations of the cross. But I knew, logically, that showers were easy, that for years I had taken a shower *every day* and that I had done it so quickly and so matter-of-factly that it had not even warranted comment. I knew that those twelve steps were really quite manageable. I knew that I could even get someone else to help me with some of them. I would have a few seconds of relief contemplating that thought. Someone else could open the bathroom door. I knew I could probably manage two or three steps, so with all the force in my body I would sit up; I would turn and put my feet on the floor; and then I would feel so incapacitated and so frightened that I would roll over and lie facedown, my feet still on the floor. I would sometimes start to cry again, weeping not only because of what I could not do, but because the fact that I could not do it seemed so idiotic to me. All over the world people were taking showers. Why, oh why, could I not be one of them? And then I would reflect that those people also had families and jobs and bank accounts and passports and dinner plans and problems, real problems, cancer and hunger and the death of their children and isolating loneliness and failure; and I had so few problems by comparison, except that I couldn’t turn over again, until a few hours later, when my father or a friend would come in and help to hoist my feet back up into the bed. By then, the idea of a shower would have come to seem foolish and unrealistic, and I would be relieved to have been able to get my feet back up, and I would lie in the safety of the bed and feel ridiculous.

(Solomon, 2001, p. 52 – 53; see also p. 61, and examples in Ratcliffe, 2013)

These and other accounts demonstrate the experience of diminished free will, of a sense of the impossibility of doing seemingly possible things, in at least some cases of depression. The relevant question then becomes, does a diminished experience of free will correspond diminished free will itself, such that a person who experiences an absence of free will does, in fact, lack free will? In other words, does the phenomenology of free will correspond to an ontology of free will? If so, then the choices that voluntarists postulate with respect to depression would not apply to at least some people who have depression, precisely because of the nature of some depression.

I think an affirmative answer should be given to this question: we should take a diminished experience of free will as evidence of diminished free will. One reason for thinking this is that one of the strongest arguments we have for free will is based on the phenomenology of free will (we believe we are free because we experience ourselves as free), and so if we believe that humans have free will at all, we ought to be consistent and regard a diminished experience of free will as indicative of an actual diminished ability to act freely in the world. Therefore, some depressed people may not be able to exercise the choice not to be depressed (or to get out of bed, have a shower, take exercise, go out and meet friends, devote themselves to the service of others, or the other things advocated by Christian and other voluntarists), precisely because they are depressed, and a common (though not necessarily universal) feature of depression is diminished free will. This casts serious doubt on the claims of the voluntarists, who have argued that depression is a sin using the premise that all or virtually all depressed people have the free will to leave behind their depressed state.

One possible way to object to my conclusion that some people suffering from depression have diminished free will is to question the idea that the phenomenology of free will corresponds to the ontology of free will. One could deny this premise by claiming that, for instance, a man might experience his will as free in freely desiring to walk out of a room, but if the door turns out to be locked, then, it could be argued, the phenomenology does not correspond to an ontology of free will after all. However, this argument confuses freedom of action and free will. A prisoner might have free *will* in the sense that she might freely will to leave, but would be prevented by external obstacles, which would curtail her freedom of action. Provided one accepts the free will/freedom of action distinction, there seems to be no reason not to suppose that there is a correspondence between the phenomenology of free will and the ontology of free will (and between a phenomenology of diminished free will and the actual diminishment of the person’s free will).

A second objection to my argument is that a phenomenology of free will doesn’t correspond to an ontology of free will, because free will is an illusion, and so we experience ourselves as free without actually being free. It is not within the scope of this paper to argue against determinism. What is important for the current debate is that, if this were true, it would still be the case that people who experience a diminished sense of free will would actually have an absence of free will, and so referring to their mental state and related actions as a ‘choice’ would be erroneous, and writing self-help books to advise them pointless. In other words, determinism would not help the voluntarist position.

A third objection to my argument is that there is an asymmetry between the experience of free will and the diminished experience of free will. According to this objection, we can posit a correspondence between the experience of free will and free will itself (such that we can use the experience of free will as a basis for arguing for the existence of free will), but we can’t posit any such correspondence in relation to the experience of diminished free will, and diminished free will itself. While it is possible that the two are not symmetrical, this way of construing the relation is highly counter-intuitive, and in fact the reverse symmetry (in which free will is an illusion and non-free will is not – as represented by the objection above) is in fact more defensible. This is because it is difficult to see how a diminished experience of free will could not correspond to diminished free will, given the role of perception in making choices (we need to perceive ourselves as having the ability to choose between x or y, in order to be able to be said genuinely to be choosing between x and y). The voluntarist would have to provide an account of free will such that (non-compatibilist) free will occurred in this kind of situation, and it is difficult to see what such an account would look like.

A fourth objection is open to the voluntarist. She could maintain the relationship between wrong choices and depression in the light of my argument by arguing that someone committed a sin at T1 and is experiencing depression (including diminished free will) as a result, at T2. While this view would be coherent, it isn’t in fact one that voluntarists would wish to appeal to, since they are keen to stress the role of repentance and positive action in overcoming depression, such that free will is posited at the time of depression.[[1]](#endnote-1)

A fifth objection to my argument is an exclusively Christian one, though analogous arguments could be made by people in other religious traditions. Christian voluntarists could appeal to the idea that only one choice needs to be made - the choice to believe in Christ – since, it could be claimed, the power to overcome depression via the other lifestyle choices follows on from this belief. If a person makes this choice, they are virtually guaranteed to overcome depression. If they choose not to believe in Christ, or if they claim to believe in Christ but do not in fact have genuine faith, then they will be unable to make the lifestyle changes, or else the lifestyle changes will not be successful or effective in overcoming depression.

That some Christian voluntarists make this kind of argument is shown in Minirth and Meier’s discussion of faith and depression. They argue that only people who have a personal relationship with Christ will be able to have the power within themselves consistently to live in such a way as to avoid depression. This is based on the idea that Christians are never tempted to sin without being given a way and the power to avoid sin (implicitly, the sin *is* depression in this context). So, for example, Minirth and Meier explain that psychiatrists cringe when Christians say they can’t do things, such as that he or she can’t find a job: ‘Any good psychiatrist knows that “I can’t” and “I’ve tried” are merely lame excuses’ (1994, p. 134). Therefore, they have Christian patients substitute ‘won’t’ for ‘can’t’. However, ‘Whenever a non-Christian patient uses the word *can’t,* we let him get away with it, because we believe him… those who choose not to accept Christ as Savior do not have the power to stay out of depression. A year or so later they get back into the same rut’ (Minirth and Meier, 1994, p. 135; see also Ballard, n.d.). They also add that belief in Christ is itself a choice (Minirth and Meier, 1994, p. 136). On this view, belief in Christ is seen as the primary choice that needs to be made in order for other choices (such as taking more exercise and seeing friends) to be made at all, or to be made consistently over time, or to be successful or effective in the recovery from depression.

It is not clear from Minirth and Meier’s discussion whether belief in Christ is effective by virtue of a divine intervention which takes place as a reward for or result of faith, or by a purely psychological mechanism based on (for instance) helpful practices such as prayer, or confidence that recovery is possible and/or that fullness of life is promised for Christians. However, typically in these accounts, belief in Christ is a necessary condition for overcoming depression, and is either a sufficient or almost-sufficient one, since (if sufficient) the depressed Christian will recover, and (if almost-sufficient, as in Minirth and Meier) she will recover, provided she is not among the very small number of depression sufferers whose depression has a physiological basis.

How are we to evaluate these claims? The idea that belief in Christ is a necessary condition for recovering from depression is evidently false, since some non-Christians recover permanently from depression too. The second claim, that belief in Christ is a sufficient or an almost-sufficient condition for overcoming depression, is less easy to falsify. This is because pointing to individual Christians who have experienced permanent depression is open to the counter-response by Christian voluntarists that either these people were not real Christians (which would allow them to maintain both the sufficiency and the almost-sufficiency claims), or else that they were among the minority of people who had physiologically-based depression (which would allow them to maintain the almost-sufficiency claim). However, there is no conclusive evidence to show that Christians recover from depression more frequently or more permanently than people of other faiths, and so no reason to think that belief in Christ is sufficient or almost-sufficient for permanent recovery from depression.[[2]](#endnote-2) In addition, the Christian voluntarist appeal to belief in Christ as a way of strengthening voluntarism also fails because not everyone has the opportunity to believe in Christ in the way Christian voluntarists claim is necessary for recovery. Some people will never have heard of Christ in a theologically meaningful way. Christian voluntarists usually regard belief in the incarnation, substitutionary atonement, and Jesus’ historical resurrection, as a necessary part of the beliefs required for salvation and, concomitantly, for recovery from depression (e.g. Minirth and Meier, 1994, p. 135 – 136). Some people, though, will have heard the word ‘Christ’, perhaps used as an expletive, without ever hearing of any of these additional doctrines. Therefore, even if it were the case that belief in Christ were a necessary and sufficient condition for overcoming depression (and the above argument shows why this is unlikely to be the case), the voluntarist case would not be salvaged by appeal to belief in Christ, because not everyone has the opportunity to believe in Christ in the way regarded as required by the Christian voluntarists.

So far, I have argued that we have good reason to suppose that a diminished experience of free will corresponds to actual diminished free will, and have pre-empted several voluntarist objections to this position. I have argued for my position on the basis that a significant argument for the existence of free will is the experience of free will, and that we ought to be consistent and regard a diminished experience of free will as indicative of diminished free will. In addition to this (and as I have hinted in response to the third voluntarist objection, above), another good reason to suppose that a diminished experience of free will corresponds to diminished free will (whether or not we accept the experience of free will as a good basis for believing in the existence of free will) exists. This is that it is difficult to see how, on a non-compatibilist account of free will, someone who experiences herself as unfree could be said to be genuinely free. If I perceive x as the only possible course of action, surely there are internal constraints both to choosing y instead, and, if I do x, to the mental processes involved being considered a genuine choice.

Is voluntarism helpful?

I have argued against voluntarist accounts of depression by arguing that one common feature of depression is a diminished experience of free will, which corresponds to actual diminished agency in the cases of those who experience it. The discussion to date has focused on the truthfulness of Christian voluntarist accounts, but an underlying motivation for both voluntarist and non-voluntarist sides of the debate concerns what kind of attitude to depression is most helpful. While non-voluntarists frequently regard telling someone that their depression is a choice or a sin as cruel and insensitive, voluntarists often regard such claims as ‘tough love’ that are ultimately more conducive to recovery. The latter position is expressed by Jay Adams when he writes:

The Medical Model destroys hope. Discouragement and despair permeate the concept of “mental illness”. So to inform a Christian client in an early interview, “Your problem seems basically to be the result of sin”, does not discourage him, but rather gives him hope. Christians know that sin and its effects can be dealt with because God has said so in the Scriptures and Christ died to overcome sin. So when sin in mentioned, there is real hope.

(Adams, 1986, p. 139)

What are we to make of the claim that voluntarism is in fact helpful to people suffering from depression? On the face of it, it might seem to make sense to suppose that the voluntarist approach to depression is helpful: if we suppose that a phenomenology of diminished free will *causes* an ontology of diminished free will (rather than *vice versa* – and both are plausible sets of causal relations) then displacing the experience of diminished free will by challenging the person’s belief in their diminished free will might understandably be believed to be therapeutic.

However, while the attempt to change someone’s experience (in this case, of the impossibility of doing something such as getting out of bed) by changing their underlying belief (by telling them that they can get out of bed) is in many ways laudable, and might work in cases where the experience is less powerful, stronger experiences are unlikely to be pliable in this way. Telling someone with extreme acrophobia that standing on a cliff top is not in fact a dangerous activity is unlikely to cure them of their fear of heights, perhaps because first-hand perceptions are always more convincing than second-hand accounts.

Nevertheless, in spite of this, there is some evidence to suggest that the advice given by Christian voluntarists is sometimes helpful. This is indicated by the following positive Amazon reviews of Minirth and Meier’s book *Happiness is a Choice:*

When I was told to purchase this book, I thought 'Happiness is a Choice' ... yeah right, like I CHOOSE to be depressed, I don't think soooo! I didn't think the book would be worth while at all. In fact, I thought it might try to brainwash or something. But that is not how it works. It gives you insight into depression. It gave me so much to think about. It gave me CONTROL over my depression for the first time. It didn't happen overnight, in fact it didn't happen until about a month after I finished reading the book. But the concepts put forth in this book were so profound, that I was able to say NO to depression for the first time, and after many many years of therapy and medication.

(A Customer (a), 2002)

I read this book about 18 years ago after my pastor recommended it to me. I was in my early 20's and had been experiencing recurring depresssions since my middle teens. I had been suicidal numerous time (e.g., sitting on edge of cliff more than once). I read this book along with my wife and for the first time in my life realized that I was making choices that brought my depression and that I could make other choices that would lead to happiness. I began making those choices and I haven't suffered from a prolonged severe depression since that time. I have now found out that my entire family for 4 generations suffers from depression. This book helped break this in me and I will share it with other members of my family. I recommend it to anyone suffering from depression and or living with anybody who is.

(A Customer (b), 2002)

The above accounts indicate that voluntarism is helpful in some cases. However, positive responses to voluntarism are by no means universal. There are numerous autobiographical internet articles, blogs and comments on blogs describing the negative effects on the writers of being told that their depression is the result of their sin or spiritual failure. To give one of many possible examples, one person who suffered from depression recounts his experiences of going to two conservative Protestant churches in Edinburgh as follows:

After moving house and changing church to a Baptist church the new minister’s preaching was very much of the “you must try harder” variety which made me feel really guilty as I was already running at full capacity just trying to function as a human being. He only had one sermon regardless of the text which was “look at what God has done for you, so how much are you going to do in return”….

Sad to say, if I had stayed away from that church I would have got better quicker.

After withdrawing from church my condition did improve a lot and I made a good recovery followed by a few years of very good health when I was not attending any church. Then another bout of depression set in with quite serious self harm. By this stage I had started going back to church and had chosen the nearest church to my house. This was a pentecostal church. Goodness knows why I was going there. I suppose I went because they were very welcoming, but they had a very clear expectation that the normal Christian life was one of very fast transformation within six months or so of attending. Anything else was a sign of something being wrong with your spiritual life or the result of hidden sin. It was a guaranteed recipe for disaster with regards to my mental health.

(Hudson, 2011)

Another person relates the following story of how someone with bipolar depression was negatively affected by being told their illness resulted from sin and lack of faith:

A few months ago an acquaintance told me about her mother-in-law, Cynthia[…], who had been found to have bipolar disorder in her late 50's. Always having been a competent person, Cynthia had a great deal of trouble coming to terms with this. She refused to accept the diagnosis or to take the medications prescribed by her doctor. She was hospitalized several times. Failing to cope, her life and her family's life was in turmoil.

The evangelical faith she followed did not encourage her in her battle. The general opinion she had grown up with was that 'emotional problems' were an indication of not being right with God - the result of sin.

In her mind, and in the minds of many others in her church, her illness was not a medical issue. They believed, as one author wrote, "If a person has the peace of God which passeth all understanding' (Philippians 4:7) in his life he cannot have emotional conflict. Ultimately symptoms are spiritual problems." Cynthia's friend from church told her that taking medications demonstrated a lack of faith. The friend advised her to throw away her pills. Not long after, Cynthia was found wandering the streets of another city, confused and in a daze. She had to be committed to hospital against her will. To this day, she is still in denial, feeling guilt and shame.

 (Bergen, 2007)

These accounts bear witness to the real and extensive damage that can be caused by Christian voluntarism. This conclusion is strengthened by accounts that speak of people finding release from ‘depression is a sin’ views to be therapeutic. For instance, Parker Palmer relates the case of a woman with depression who asks him why he thinks some people with depression die (by killing themselves) while others become better. At the time, Palmer racked his brain for a good answer but eventually confessed, ‘I have no idea. I really have no idea’. In the days that followed, Palmer was haunted by the regret that he hadn’t been able to come up with anything more helpful. However, when the woman contacted him again she said that, of all the things in their conversation, it was ‘I have no idea’ that stayed with her the most:

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

 (Palmer, 2000, 59)

From the brief exploration of responses by people exposed to Christian voluntarist accounts, it seems we have something of an impasse: some find voluntarism hopeful and empowering, precisely because it provides the belief that it is possible to overcome depression. Others find it damaging and debilitating in the way it emphasises personal responsibility. Exhaustively discerning the causes of these different responses to voluntarism is not within the scope of this paper, but we might speculate that much depends on the extent to which the person feels they are able effectively to put into practice advice to overcome depression. In cases where getting out of bed, seeing friends, being thankful, and so on, are experienced as possible (even if difficult), a belief that they are possible, and acting accordingly, is highly likely to be conducive to overcoming depression, and an emphasis on personal responsibility a prudent antidote to excessive self-pity. In such cases, because of the phenomenology-ontology of free will correspondence, it seems feasible to suppose a person’s belief in their ability to overcome depression is not only more helpful, but also more likely to be true (and that encouraging a person to believe they are able to do x may increase their feeling of being able to do x which may increase their ability to do x). In other, perhaps more severe, cases of depression, where free will is experienced as more significantly diminished, an emphasis on free will and choice is likely to be simply frustrating and alienating if this is not in fact what the person is experiencing: it would be like telling someone that their leg does not really hurt, when they experience it as painful. By virtue of emphasising personal responsibility even in the face of their impotence to do otherwise, anxiety and guilt is likely to be increased, and so the depression worsened.

 What are the pastoral and clinical implications of this conclusion? At the heart of the more benign forms of voluntarism is a concern not to worsen the sense of impotence experienced by depression sufferers by telling them they have no agency, or enabling depression inappropriately to be used as an excuse for destructive behaviour. However, a middle ground between denying and negating agency, and telling people they have chosen to be depressed and that it is a sin, is certainly possible. This is to emphasise to depressed people courses of action which have often helped people with depression in the past (exercise, positive thinking, certain kinds of prayer, altruism, certain kinds of faith, friendship) without accompanying this advice with judgements that such actions are possible and all times for every person, or that the person is responsible or sinful if they do not put the advice into practice. This paper indicates that this would be both a more truthful, and a more helpful, general response to depression than that currently put forward by Christian (and other forms of) voluntarists.

Conclusion

 In this paper, I have pointed to the existence and common features of Christian voluntarist accounts of depression. I have responded to these by highlighting a salient characteristic of at least some cases of depression – a diminished experience of free will – arguing that we have good reason to suppose that a diminished experience of free will corresponds to diminished free will. This is for two reasons. First, a common argument for free will is the experience of free will, and so we should be consistent and regard a diminished experience of free will as indicative of diminished free will. Second, it is difficult to imagine what free will would look like or consist in in the context of a person who experiences herself as unfree or as having significantly diminished free will (on a non-compatibilist account of free will). Having argued against the truthfulness of voluntarist accounts, I have turned to the question of its helpfulness, arguing that it may in fact be helpful in the less extreme cases of depression, but is likely to be alienating and damaging in extreme cases. I have suggested that a ‘best of both worlds’ approach might incorporate some of the encouragement and lifestyle advice of voluntarist accounts, without the associations with choice, responsibility and sin. I hope that this discussion is helpful to psychiatrists and other mental health care professionals in their treatment of patients with religious beliefs about depression, some of whom may hold (or may have experienced) voluntarist accounts. I also hope it is helpful to Christians (whether mental health professionals, ministers, or members of congregations), in their interaction with people with depression. In addition, it is hoped that it will contribute to the growing literature on mental illness and free will (e.g. Meynen, 2012; Callender, 2010).

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1. This is in contrast to some Buddhist and Hindu beliefs about depression being the result of bad karma, which my argument would not be a satisfactory response to. [↑](#endnote-ref-1)
2. There is significant body of evidence to suggest that religion is generally good for mental health (Dein, 2010). However, the data on this is complicated by a number of factors, including: (i) that positive correlations between religiosity and mental health tend to be emphasised in the studies at the expense of negative correlations (Dein, 2006); (ii) that the studies are too US-focused to be globally applicable (see Dein, 2006).

The relevant question here (whether Christianity is better for mental health both than non-religion, and than other forms of religion) is further complicated by the facts that (i) the studies often focus on Christianity and Judaism, with other religious groups being simply described as ‘other’ (see Kennedy, 1998; Dein 2006). Judaism makes for an unfair comparison with Christianity because American Jews have an unusually high level of depression, arguably arising from the experience of Holocaust (Kennedy, 1998); (ii) religio-cultural tendencies (such as some religions and subsets of religions being more vocal about their feelings than others [e.g. idealising ‘suffering in silence’ in Irish Catholicism) are difficult to factor in to research (Kennedy, 1998, p. 132). [↑](#endnote-ref-2)