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Brain Disease or Emotional Distress? Modern Psychology, Ancient Asceticism, and the Hermeneutics of DSM-5

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This article examines descriptions of emotional distress and social alienation from two interdisciplinary perspectives: modern clinical psychology and late antique hagiography. The first case study examines the current method of classification in psychiatry: the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Offering a broad perspective on how the DSM-5 came to be, we look at the strengths but also the pitfalls of this classification system. We argue that societal context is important when identifying a disorder, but it, ironically, only plays a small part when applying the DSM-5 in everyday psychiatric practice. Furthermore, it will be argued that historical contexts may usefully inform modern clinical practice (for instance, because they show how the interpretation of 'abnormal' behaviour is in flux). The second section will examine descriptions of emotions and distress in hagiographic sources from Late Antiquity. It analyses a hagiographic collection, the *Historia Lausiaca* as a taxonomy that both describes and regulates Christian pious life. In Late Antiquity, social developments, such as the growth of and enthusiasm for the ascetic movement, led to the introduction of new concepts for how to deal with and integrate expressions of emotional distress. Ultimately, by occupying the intersection of religion and medicine, this article aims to further psychologists' understanding of how past societies used religious ideas to shape individual behaviour and its interpretation. Additionally, it will inform historians about modern classification methods in psychiatry and how these have influenced the interpretation of behavioural traits.

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Introduction

In this article, we address descriptions of emotional distress and social alienation from two interdisciplinary perspectives. The different methods of perceiving and classifying these emotions (particularly, sadness and grief) in modern psychiatry provide the starting point for this endeavour. First we look at the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013), an important classification tool in contemporary clinical psychology and psychiatry. In the second part of the paper, we analyse descriptions of emotions in the history of religion which represent a diagnostic tool in personal(ised) narratives focusing on the interdependency between description and perception. Combining modern psychological and historical approaches will ultimately shed light on how different cultural and historical discourses have shaped the description and interpretation of sadness and grief, which has lead to these emotions being characterised in ways ranging from medicalised depression to a clear sign of sanctity (a deep connection with God).[1] Thus, the comparison will emphasise the influence of specific cultural contexts and power dynamics in shaping perception and experience (Foucault, 1976); while, at the same time, it will make clear that neither the DSM-5 nor antique narratives accurately reflect the lived experiences of patients and saints.

We are aware that in psychology there are different definitions of emotions; similarly, historical scholarship emphasizes the changing perceptions of emotions due to different historical and cultural contexts (Rosenwein, 2006). Some psychologists, for instance, consider emotions a bodily experience and, when defining feelings, add the notion of cognition. In this respect, emotions can be considered universal, whereas feelings are subject to cultural diversity. In this article, it is not possible to explore different disciplinary approaches to emotions at length; however, we try to be as clear as possible in individual uses of these terms and, in general, use 'emotions' as a low-treshold term in order to facilitate comparison.[2]

We start this article with a short description of a case, based on our own experience of clinical work (details have been changed, to preserve anonymity) and informed also by

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[1] In Late Antiquity, a new, powerful religious and social key concept arose: that of holy people. They were miracle workers: intermediaries between God and humankind, and had power over demons and diseases. For more information, see the highly influential works of Peter Brown on that topic: Brown (1971); Brown (1983); Brown (2001).

[2] This article is the result of an interdisciplinary collaboration and, to facilitate comparison, the examples and case studies presented here are focused on specific topics and genres. While a discussion of emotions would usually, in both psychology and history, include a broader treatment of the methodological state-of-the-field, this can only be reflected on briefly here by providing references to the relevant literature. For an overview, see foundational works by Stearns and Stearns (1985), Rosenwein (2006), and Reddy (2001), who introduced the concept of 'emotives': emotions as speech acts that express and modify emotions at the same time. Frevert (2014) provides an overview of past concepts and debates; see also note. 10 for further literature.

a recent study pointing out that 66% of patients suffering from bipolar disorder report profound religious or spiritual experiences (Ouwehand et al., 2019). The case is as follows:

A 32-year-old man was admitted to a psychiatric hospital in the Netherlands, against his will, on grounds of severe neglect. He refused to eat and neglected basic hygiene. He also turned down the offer to take antipsychotic medication prescribed to him by a psychiatrist who visited him at the request of the general practitioner. His parents were very worried. Two weeks before the admission, they managed to persuade their son to come back home with them. He had been living in the north of France for five years, making a living with his girlfriend by buying and selling antique furniture that they found at markets. They made a lot of money, mainly because of the enormous energy he devoted to the work. He hardly needed any sleep. Two years ago, suddenly, his girlfriend broke up with him. After two months of deep melancholia, his mood apparently improved. Instead of going back to work, he started dressing up as an angel with wings and an aureole, and walked around town everyday talking to people about being on a mission from God to spread the idea of world peace. He no longer paid his rent and eventually went bankrupt. He also lost a lot of weight because he hardly ate, based on the assumption that the Holy Spirit would keep him fed.

The following symptoms, and assessments of these, were noted in the psychiatric department in the Netherlands: being on a mission from God was seen as a form of grandiosity; being fed by the Holy Spirit was assessed as delusional; communing with so many people in the village was seen as increased talkativeness; and, sleeping for approximately two hours per night without feeling fatigued was assessed as symptoms of mania. Two depressive episodes were identified: one following the break-up with his girlfriend and one when he was 20 years old. Applying the DSM-5,[3] a bipolar disorder was classified. Reluctantly, the patient started using medication (lithium) and accepted some of the interventions by the nursing staff which were aimed at better self-care. Some of the symptoms of mania subsequently decreased. He became less talkative, his sleep pattern improved and he started eating again. He remained convinced, however, that God had special plans for him.

Our second case is described in the *Historia Lausiaca* (hereafter *HL*), an early fifth-century compendium of stories of ascetic saints, written ca. 420 CE.[4] It tells, for instance, of a woman who immured herself in a tomb, of a man who treated his body with scorching irons and of many others who voluntarily submitted themselves to rigorous mental and physical training (*askesis*) in order to overcome their bodies'

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[3] Hence the importance of the DSM-5, which is one of the driving forces assisting the clinician in formulating clinical hypotheses.

[4] All further year dates refer to CE in this article.

needs and desires.[5] Its author, Palladius, a monk and later bishop of Helenopolis, had travelled the deserts of Egypt, Libya and Palestine for several years in order to collect the stories of all these 'living holy people' who dwelled in solitary cells or caves, or who had come together to form the first monastic communities (Dietz, 2005; Caner, 2002; Frank, 2000). He—an experienced ascetic himself—had been encouraged by a member of the Eastern Roman court to document these relatively new, fast-spreading religious practices (Minets, 2017; Rapp, 2014). Palladius' comprehensive work helps us to understand the prevailing fascination with asceticism, the thriving monastic movement, and their rapid development in the 4th and 5th centuries (Diem and Rapp, 2020; Vanderputten, 2020: 5–23; Rubenson, 2007).

Christian asceticism can be described as a 'systematic method to achieve self-control', rooted in the New Testament, which comprises spiritual exercises and physical discipline and is designed to allow individuals to reach spiritual perfection; to become 'a pure vessel of divine will' (Elm, 1994: 13–14).[6] The examples supplied by Palladius' desert monks and nuns cover a broad spectrum of such self-imposed practices, which vary in their intensity. They range from food restrictions, to regular fasting, to starvation; from wearing simple clothes, to dressing in rags or going naked; from celibacy to self-castration; from living within an ascetic community, to dwelling in a cave or standing on a pillar; and, from self-inflicted pain to self-mutilation (Freiberger, 2015: 126–129; Rubenson, 2007: 637–668; Ashbrook Harvey, 1999).

Palladius' stories of the ascetics' spectacular feats and failures testify to the profound transformation of late antique religious experience, which would not only change religious life but also have a great impact on late Roman society as a whole (Dunn, 2000). Ashbrook Harvey (2006) and Brown (1988) have argued that seeing the world through the symbols and language of the Bible was a new and different cognitive, physical and emotional experience that profoundly changed ideas about body and soul. Frank calls this process a 'reeducation of emotions', which refers, on the one hand, to the new spiritual experiences and worldviews that were embedded in the language and symbols of the Bible (Frank, 2017). On the other hand, it identifies the transformation of religious experience in general that accompanied Christianity's rise to political and social significance over the course of the 4th century and that would eventually see it become the religion of the Empire. The cultural shifts from classical antiquity to the

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[5] See the examples in Palladius (1918) ca. 420s, Chapters 2, 5, 11. In Chapter 2, the Egyptian monk Dorotheus summarises his understanding of asceticism as follows: 'My body kills me; I will kill it'. Future in-text references to Palladius (1918) are abbreviated to *HL*.

[6] See also Rubenson (2007); Krawiec (2008); Freiberger (2015). An important assessment of asceticism as a historical concept is provided by Diem (2019).

period of the Christian Roman Empire created a new framework for the construction of social and religious norms, and therefore the interpretation of emotions. While in the Roman Republic the works of classical authors such as Cicero, Vergil and Sallust were highly influential for the behaviour and emotions of the Roman upper class, in the time of late antique Christianity there was, in addition to the Bible, a thriving field of hagiographical literature that specifically provided new behavioural scripts which were later incorporated in medieval monastic rules.[7]

While the *HL* provides a window into and a representation of a very different world—one that is rich in astonishing and bizarre episodes of wonder-working holy people who inhabited even the remotest places of the Roman Empire's deserts—the modern equivalent that we have encountered might read more mundanely; a far less fantastical scene. But is the latter really a clear-cut case of the mental health condition 'bipolar disorder'? How do we interpret such behaviour? Arguably, the 21st-century patient's internal world is just as wondrous as that of the 5th-century desert ascetics. Noting the objective similarities between the cases, we seek to ask what influence the DSM-5 and the *HL* respectively have in the interpretation of such emotions. There is some evidence that the DSM-5 and its predecessors have changed the way we look at common phenomena in everyday life. Where, for example, do we draw the line between 'normal' and 'pathological' sadness or a lack of interest in social relationships? Accordingly, we will ask how taxonomies controlled, constrained, and shaped both the lived and the perceived experiences of the people involved. How did they influence the perception of emotions when inviting their audiences—especially concerning hagiographical texts—to participate intellectually, emotionally and spiritually in the narration? A close examination of each context, along with a reflection on the influence of literary genres and authorial strategies, will prove to be important for answering these questions.

Observations on genre and disciplinary boundaries

Above all, hagiographical texts like the *HL* played an important role in explaining to newly converted Christians what it meant to lead a pious life.[8] The miracles and moral examples provided spiritual inspiration, education and conveyed religious guidelines to a broad lay community (Coon, 1997: 1–27, 71–94). They were at the same time edifying and entertaining so as to reach a wide audience (Dilley, 2017; Rapp, 2010;

[7] The scope of this article does not allow further elaboration on the perception of emotions in classical antiquity; on the interplay between emotions and the ethics of the Roman upper class see Kaster (2005); on the early medieval institutionalization of emotions in Christian monastic contexts see Diem (2020).

[8] Notably, there are some signs that the modern DSM-5 has a normative role as well, which was shown by Watters (2010). He explains how, in a sense, Western psychiatry shapes the way the world 'goes mad'.

1998). Moreover, through respectively writing and learning about a saint, author and reader would be joined in ‘spiritual communication’ together, in the sense that they would testify to the saint’s sanctity and miracles while participating in that holiness (Rapp, 1998). Hagiographical texts were not only designed to instigate imitation of the saint and their virtues in everyday life (Palmer, 2018; Brown, 1983) but, by exemplifying specific virtues, they also conveyed and reinforced moral norms and virtuous behaviour. Thus, *HL* can be understood as a collection as well as a taxonomy of Christian virtues and vices. It describes a new religious context in which behaviour that deviated from traditional Roman social norms—such as excessive fasting, self-inflicted pain, social isolation, neglection of bodily hygiene—was part and parcel of a Christian concept of holiness. From Palladius’ vignettes, specific categories of pious behaviour could be extracted that not only described typical forms of ascetic practice but, in turn, also influenced their appraisal. As ascetic practice and monastic life were, at that time, still fairly new developments within the larger Roman society, hagiographical works played a vital role in their dissemination as well as in the shaping of new religiously influenced social norms and the understanding of emotions.

Moving to the 21st century, in modern Western society, these examples of holiness in hagiographical accounts would, in many cases, be classified as symptoms of a psychiatric disorder rather than spiritual experience—though the importance of religious contextualisation has been emphasised in some recent research in the field of psychiatry.[9] There is, therefore, a chance that a contemporary consultant psychiatrist or clinical psychologist would take the religious context into account when forming a diagnosis and would accordingly consult a spiritual leader, such as a pastor (which

[9] Of course, most psychologists and psychiatrists are not ignorant when it comes to the importance of context, and it is almost a given that one should be careful when speculating on what would have happened in a modern-day case on the basis of the examples given in Palladius’ *Historia Lausiaca*. Some work has been done in this field, however. An example that comes to mind is that of the Jinn who are associated with a number of phenomena that can also be viewed as symptoms of psychiatric conditions. Jinn (or *djnoun*) are described in the Qu’ran as beings created by Allah and made out of fire that does not cause smoke (Qu’ran 18:50). They are invisible (unless they choose to reveal themselves), and they can harass humans by shouting, whispering, hitting them or even by taking possession of their bodies. Mental health workers who have specialised in treating patients who believe in these phenomena advise psychiatrists and psychologists to see these patients together with an Imam (Blom, Eker, Basalan, Aouaj, 2010: 154: A973). The Imam can then assess together with the mental health professional whether or not the phenomena are still within ‘a normal religious range’ or whether they should be seen as psychiatric symptoms. In general, though, our experience is that most Imams in the Netherlands would advise parallel treatment by a mental health specialist and would prefer psychiatric treatment for Muslims whose suffering is severe and causes self-harm (for instance by excessive fasting). Our guess is that most Christian pastors would react in the same way to such behaviour. As Blom and his colleagues point out, the advice that a religious representative should be consulted is not, as yet, often followed (Blom, Eker, Basalan, Aouaj, 2010: 154: A973).

is advised in such cases, in order to arrive at a joint diagnosis on whether behaviour can be seen as erratic in both a clinical and a religious sense). Usually, within a clinical context, psychologists would conduct motivational interviewing. In the opening phase of treatment, the psychologist might address the patient in the following manner: 'So I get the fact that you want to serve God, and that you are planning on doing so by—among other things—restricting your food intake'. They might then continue to explain that 'you will not be able to keep this up for very long if you overdo it. Can you give me permission to explain a little bit about the risks involved with fasting? We can agree on your goal to serve God, but let me help you to do so in a safe way'.

Conversely, in medieval studies there is increased scholarly interest in topics situated at the intersection of medicine, health and religion (Secord, 2017; Marx-Wolf and Upson-Saia, 2015). In the past few years, multi-disciplinary collaborations have questioned traditional concepts of disease, health and disability in the Middle Ages and have generated both new lines of research and methodological approaches (Newby et al., 2017: 478–485; Thorpe, 2015: 3123–3127). New approaches for examining these topics have been suggested which also analyse common perconceptions of medieval medicine (Horden, 2011) and challenge traditional perspectives (Leja, 2022; Mayer, 2015; Crislip, 2005). During Late Antiquity in particular, researchers have tended to identify a declining influence of medicine and science, arguing that this would have been brought about by Christian beliefs and the socio-political transformation of the Roman Empire (as represented for instance in the absence of outstanding scientific authors, and the focus on the re-edition and reproduction of earlier medical works rather than the creation of new ones). However, new approaches critique these assumptions and, for instance, emphasise that medical knowledge and medical topics were discussed more broadly, in a variety of genres, especially in patristic and hagiographic sources (Marx, 2018; Nutton, 2013b).

Comparative perspectives

To return to the comparative nature of this article, as will be explored below, the two taxonomies—the modern DSM-5 and a catalogue of late antique Christian holiness—present case studies from different historical spheres and analytical angles.[10]

[10] On the topic of comparative research, specifically on the units of qualitative analysis and on binary or regional comparison, see Palmberger and Gingrich (2013). Important perspectives are also offered in Detienne (2008), and Kramer (2015), who examine historical, cross-cultural comparison.

There are, however, specific challenges to this comparative approach and, in general, to the analysis of past descriptions of health, sickness and emotions. We would like at this point to address these. Let's start with the narratives under scrutiny: the representations of individual behaviour and emotions from the different epochs examined are conveyed through different genres. The genre of hagiography is characterized by highly formulaic language, and similar plot elements and topoi (which a late Roman or early medieval Christian audience would be familiar with and understand) (Rapp, 2010; Ashbrook Harvey, 1984). A modern reader who is unfamiliar with this genre, or the Bible more generally, might find these difficult to access. The DSM-5 can also be formulaic, using professional terminology that does not always accord with everyday life. A case in point is how DSM-5 deals with panic in the context of a panic disorder. This type of panic—which implies fear of dying, fear of losing control and of losing your mind—is not necessarily how a 'layperson' would define panic: 'excessive worry' (though medical terms may find their way into everyday vocabulary, which has been the case with classifications such as PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactivity Disorder) and Autism).

Thus, both the hagiographical literature and the DSM-5 use a specialised language. In hagiography, the depictions of men and women are stereotypical and primarily intended to confirm and enhance their sanctity. The descriptions of experiences and emotional expressions not only originated from authentic real-world experiences, but were also inspired by previous hagiographical works and biblical examples—as Rapp (1998) has shown, quoting the example of Epiphanius of Pavia, reading the Bible could have a transformative effect on the reader. While this does not mean that the hagiographical descriptions do not refer to genuine situations and experiences (Rosenwein, 2006: 1–31; Rosenwein, 2002), it is important to acknowledge that we do not through these texts gain access to 'real' feelings, but to the authors' perceptions of and attitudes towards emotions which are subjected to historical change.[11] Different genres privilege the representation of emotion in different ways; in medieval hagiographical texts, tears, for instance, are interpreted as an expression of sin and penance, while in romance literature weeping would be a sign of lovesickness (Trzeciak and Kramer, 2019; Rosenwein, 2002: 57–77). In addition, Scheer's concept of emotion as a dynamic 'practice' proves to be helpful for examining emotional expressions that are located at the intersection of narrative and practice (Scheer, 2012). They can be considered both a bodily and a cognitive experience, reflecting different cultural and historical contexts.

[11] See the overviews provided in the works of Rosenwein (2006), and specifically on hagiographic literature and 'what can topoi tell us about real feelings' see: pp. 1–31. See also Garrison (2001).

Although many psychologists learn in university that five basic emotions—anger, fear, happiness, sadness and, arguably, disgust—are universal phenomena (Ekman, 2016: 11[1]), the way these are expressed is also, in part, based on cultural context. As DSM-5 deals with emotions such as sadness and fear, and since it was developed by the American Psychiatric Association, it seems only logical that the modern Western perception of emotions to some extent influenced the classification criteria for disorders.

Recent collaborative projects on the history of medical scholarship have contributed to our understanding of existing methodological problems and challenges, such as the misinterpretation of the historical context, anachronistic assumptions and the difficulty in retrospectively diagnosing illnesses in modern terms on the basis of ancient descriptions (Trzeciak and Kramer, 2019; Gäbel, 2018; Newby et al., 2017; Marx-Wolf and Upson-Saia, 2015: 266–272). From a historian's perspective, this encompasses several aspects: first, accessing sources about medicine is, for some historical periods such as the early medieval one, more limited than others due to a lack of transmitted sources or because the intellectual discourse was focused on other genres and topics (such as exegesis and hagiography (Palmer, 2018; Leja, 2016)). Therefore, focusing primarily on available medical handbooks would not necessarily allow us to gain insight into complex debates about medical conditions when overlapping intellectual/religious systems of healthcare were in place (Marx-Wolf, 2017; Leja, 2016). Thus, we here analyse sources that were not initially intended to present medically relevant information, but do nevertheless offer the possibility for learning more about the discourse informing medical conditions and physical and emotional experiences of the time.

Strictly speaking, the *HL* is not a taxonomy. However, on a comparative level we are not looking for prima facie similarities; we will examine this text as taxonomy on a discursive level, as it tells us more about how religion and socio-religious changes factor into the perception and classification of health and emotions. Especially in the transformative period of Late Antiquity, with Christian beliefs permeating social, cultural, intellectual and political discourse, this nascent and growing religious influence generated new understandings of health, body and mind at the intersection of medicine and religion (Ferngren, 2016; Marx-Wolf and Upson-Saia, 2015; Retief and Cilliers, 2001). Moreover, some authors, like those under scrutiny in this article, were not primarily medical experts or doctors but were rather monks describing physical and emotional conditions through the lens of religion; others writing in this specific historical context might not have received a thorough education in rhetoric in comparison to the elaborate works of well-known hagiographers—which might result in more standardised narratives (Rapp, 1998). Therefore, it is vital to include sources

from a religious and theological context in the analysis of medieval approaches and emotional experiences in Late Antiquity.

In this respect, multi-disciplinary collaborations—between, for instance, historians and psychologists—might help to pinpoint possible shortcomings when classifying disease and emotions, introducing new research questions in the process. Historicising diagnoses and mental illness increases awareness of the extent to which they are embedded in complex social, religious and political discourses; it is not therefore justifiable to reduce someone's identity to a medicalised label. The perspective which psychology brings is the cognitive appraisal and evaluation which produces the emotion; the historical perspective contributes understanding of the broad ways in which emotions can be represented and interpreted; an awareness, in other words, of the complexity of representation and fictionality.

We now move to a brief history of how five successive diagnostic and statistical manuals profoundly changed the way we look at many types of behaviour in the 21st century. We then move to a consideration of how familiarity with the DSM-5 might influence the way contemporary historians perceive 'alienating' behaviour in Late Antiquity.

Part 1: The DSM for Historians

The history of psychiatry in the 20th century could be briefly summarised as: first, there was chaos, and then the Diagnostic and Statistical Manual, Third Edition (DSM-III) arrived (American Psychiatric Association, 1980). While this, of course, is a gross oversimplification, there is some truth to it. The arrival of the DSM-III in 1980 provided mental healthcare professionals with reasonably clear-cut criteria for classifying psychiatric disorders.[12] It assisted them in using consistent language regarding the criteria a patient should meet for classification; for instance, medication studies for various mental health conditions. This, in turn, facilitated Randomised Controlled Trials (RCTs) of psychotherapeutic and pharmacotherapeutic interventions. Because RCTs are considered to be the gold standard for evidence-based medicine, this helped to strengthen the position of psychiatry within science and medicine. It also made it possible to compare European studies with those carried out in the United States; and, as the application of the DSM-III and its successors

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[12] From this point on, we will use 'classification' instead of diagnosis when referring to the DSM. Although the 'D' in DSM refers to 'Diagnostic', in our view, a DSM classification is not sufficient to provide a deeper understanding of the problem a patient is facing: it does not provide a diagnosis. We will reflect on this more thoroughly in the remainder of Part 1 of this article.

spread, with those from other parts of the world.[13] The current edition, DSM-5, was published in 2013 (replacing the DSM-IV) and is the basis for treatment protocols, research, and reimbursement by healthcare insurers.[14] It is worth briefly noting that The American Psychiatric Association stopped using Roman numerals when DSM-5 arrived (arabic numerals allow for more frequent updates; for instance, DSM-5.1 could be developed).

The goal of the first two DSM-volumes, and their predecessors, was to provide some form of standardization. DSM-I was published in 1952 and DSM-II followed in 1968. DSM-I was, in part, based on the *War Department Technical Bulletin, Medical 203* that was developed in 1943 under the auspices of psychiatrist William Meninger, who worked for the US Army (Houts, 2000). As Houts—writing about the history of psychiatric nomenclature—points out, *Medical 203* (developed during World War II) was based on psychodynamic theory and also acknowledged that stressful life-events could produce mental disorders. The scope of psychiatry until this point had focused on severe mental health conditions but was widened following WWII. Regarding the assumed cause of mental disorders underpinning *Medical 203*, Houts writes of: '... some aberration in the development of the personality, most likely, but not necessarily, combined with stressful environmental circumstances' (Houts, 2000: 946).

The DSM followed suit by having hypothetical aberration along psychodynamic lines at its core, and was thus 'theory-driven'. DSM-III, however, marked a break from this psychodynamic framework (Houts, 2000). By the 1970s other frameworks—among them a more biological paradigm—were challenging psychodynamic/psychoanalytical thinking regarding the broad spectrum of mental disorders. DSM-III was, therefore, deliberately 'atheoretical': consensus was deemed more important and this was a

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[13] As one of us (KH) has argued previously (Huijbregts, 2013: p. 10), a common remark about psychiatric disorders is that they mainly affect relatively affluent people in the so-called developed regions of the world. The global burden of disease study by the World Health Organization (GBD Disease and Injury Incidence and Prevalence Collaborators, 2018) does not support this. The researchers studied the epidemiology of all sorts of diseases in 195 countries and found that Major Depressive Disorder (MDD) is the third leading cause of Years Lived in Disability (YLD) worldwide. Another issue is whether or not we should refer to MDD in cultures in which this concept is not well established. On this topic, see *Crazy like US* by Watters (2010). Watters promotes the view that Western psychiatry 'shapes' the way people perceive mental illness (for instance, by introducing the DSM).

[14] DSM-5 is mostly applied in the United States, but also in European countries such as the Netherlands. There are alternatives, such as the *International Classification of Diseases* (currently the ICD-11; the eleventh edition is being rolled out) published by the World Health Organization. Healthcare systems in different countries also apply these classification systems in different ways. The point about DSM-5-classifications being the gold standard in psychiatry and the association with reimbursement most strongly applies to the USA (but also to, for instance, the Netherlands). Author K. Huijbregts works as a clinical psychologist in the Netherlands; the reflections on the DSM-5 are, therefore, focused on its use in that context (but the argument also applies to other countries, at least to an extent).

crucial factor in its success. One of the consequences of the method that created the DSM-III and its successors (through consensus meetings) was the decoupling of disorders from theories of underlying pathology (Dehue, 2008: 46–69). Inter-rater reliability (IRR) was prioritised, facilitating RCTs and the development of treatment protocols for specific disorders.

One could say that the DSM-III and its successors are primarily useful taxonomies; hence we refer to DSM classifications instead of diagnoses (diagnosis implies a deeper level of understanding of the underlying pathology). Problems may arise when a taxonomy is (mis)used to explain a phenomenon without more in-depth diagnostic investigation. It can be argued that explaining a symptom by applying a current DSM classification is a form of circular reasoning. A fictitious case of loneliness disorder concocted by the Dutch researcher Dehue (2010) illustrates this point. Assuming momentarily that loneliness disorder were to be included in DSM-5.1, Dehue suggests that a clinician could then say to a patient: 'No wonder you are lonely: you are suffering from loneliness disorder'. But, does that explain *why* the patient is lonely? If classifying the hypothetical loneliness disorder would lead to society giving adequate attention to loneliness, then this could be useful; however, it is less useful when seen as an explanation in itself. The concequence may be reification: treating an abstraction as if it were a physical reality (Hyman, 2010: 155–179).

Research into the physiological variables associated with DSM-classifications is ongoing but as yet not much can be applied in clinical practice (Van Os, 2014). It is not possible, for instance, to visualise the presence of ADHD (Hyperactivity) on a brain scan in an individual patient. Clinicians have to rely on the DSM to classify the disorder; yet many patients (and clinicians) believe that ADHD is caused mainly by biological variables. Many also assume it to be more of a biologically determined disease than, for instance, borderline personality disorder.[15] This, however, is a reification, as both disorders, when classified according to the DSM, mostly refer to a set of criteria; meeting these criteria does not mean that a demonstrable brain abnormality has been established.

Finding the underlying pathology is also a complex task given the 'fuzziness' of current concepts within psychiatry. The criteria for MDD are a case in point. First, observe the DSM-5 criteria for MDD in **Figure 1**:

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[15] Ahn and colleagues have demonstrated that even expert clinicians tend to make strong distinctions between psychologically and biologically determined disorders, even though there is evidence for a continuum. See: Ahn, Proctor and Flanagan (2009: 147–182).

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation

Figure 1: DSM-5 criteria for Major Depressive Disorder (American Psychiatric Association, 2013).

Note that for an MDD classification, only Symptom 1 (depressed mood) or Symptom 2 (marked loss of interest in activities someone finds pleasurable in a normal state) is essential. Also note that four additional symptoms are needed for diagnosis. This means that two patients can have an MDD classification while having only one symptom in common. More specifically, given that some of the symptoms present two options (e.g. weight gain or weight loss), patients can even have an MDD classification with no symptom in common. The example in **Figure 2**, where two patients meet the criteria for MDD, illustrates this:

<u>Patient 1</u>:

1. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, as indicated by either subjective report or observation made by others.
2. Marked weight loss.
3. Insomnia.
4. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
5. Recurrent thoughts of death.

<u>Patient 2</u>:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
2. Marked weight gain.
3. Hypersomnia.
4. Fatigue or loss of energy nearly every day.
5. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

Figure 2: Two fictitious patients meeting the criteria for Major Depressive Disorder, despite having no symptom in common.

The two patients in the example in Figure 2 have no symptom in common, yet they both meet the criteria for MDD.[16] We should note, however, that this example is an oversimplification: DSM-5 explicitly states that disorders are far more complex than the brief summaries describe (such as for MDD in **Figure 1**). A trained clinician should take a patient's developmental history, biological and social factors, neuropsychological and physiological factors, and the clinical process into account before classifying a DSM-5-disorder. The authors of DSM-5 emphasise in the introduction of the manual that it should not be used as a simple checklist and that a trained clinician should search for underlying

[16] This example is fictitious, though it aligns reasonably well with DSM-5.

causes (for instance, physiological or neuropsychological factors) (American Psychiatric Association, 2013). These factors may be different for individual patients. However, as discussed above, this is often not what happens in everyday psychiatric practice. Clinicians have limited time and resources, and sometimes lack training (for instance, due to waiting-lists or issues concerning reimbursement of time invested), which makes using the simple DSM-5 classification criteria as a checklist the most feasible option (healthcare systems in various counties differ in this respect; see footnote 14).

Another important question is whether or not the patients, their families and the medical professionals who encounter the DSM-5 concepts understand that a classification does not automatically mean that an underlying cause has been identified. Many patients assume that a MDD-classification means they have a biologically determined vulnerability (Bosman, Huijbregts and Verhaak, 2016). Although there is correlational evidence for the involvement of biological variables in MDD (for instance, genes, hormones such as cortisol and neurotransmitters such as serotonin (Hyman, 2010)), there is something troubling about the notion that Patient 1 and Patient 2 in our example would have the same brain disorder without sharing symptoms (this is not, however, completely implausible: there is precedent in medicine for the same underlying cause leading to quite different symptoms. The broad category 'cardiovascular disease' for instance, is connected to both strokes and heart attacks, which have mostly non-overlapping acute symptoms but have high blood pressure as a common underlying cause). Still, it would be preferrable to have more overlap within the categories in the DSM, as for instance marked weight loss and marked weight gain (not symptoms of MDD) may require a different therapeutic approach. Also, more overlap would at the least add face validity to the classifications.

The aforementioned confusion about assumed causes that underlie classifications is often manifest in the consultation room. In the author (KH)'s clinical experience, for instance, some patients prefer an ADHD classification to that of a borderline personality disorder. As mentioned, ADHD is often seen as more biological in nature, whereas personality disorders are perceived by many patients to be more psychological. Clinicians also make such attributions, as shown in an intriguing study by Ahn and colleagues (Ahn, Proctor and Flanagan, 2009), which asked clinicians to rate the DSM-IV disorders on how biologically, psychologically or environmentally determined they assumed them to be. The study found evidence of a perceived continuum, from highly biological disorders (e.g., schizophrenia) to highly non-biological disorders (e.g. social phobia). Furthermore, clinicians thought medication to be more effective for the disorders they presumed to be more biologically determined and psychotherapy better suited to the disorders that were thought to be more psychological in nature. This is suprising, because psychotherapy has been found to be effective in alleviating

symptoms that can be associated with schizophrenia, such as delusions or hallucinations (Croes et al., 2014; Gaag van der, Valmaggia and Smit, 2014), and medication proves to be effective for social phobia (Montgomery et al., 2005). Both therapies are, then, to a certain extent effective in treating both disorders. Most clinicians would agree that a biopsychosocial model (Engel, 1977; Engel, 1980) is most likely to address the complexity of psychiatric disorders—though complexity can be problematic in the consultation room, where a 'diagnosis' is often established under time constraints. We have already discussed the biological and psychological determinants of psychiatric disorders; an example of the influence of social or environmental variables can also be given: Dutch citizens of Moroccan descent are, for instance, more likely to develop schizophrenia than Dutch citizens of Western descent (Hogerzeil et al., 2017). Social or environmental factors, such as low socioeconomic status, are often found to be risk factors for the development (or perpetuation) of mental disorders.[17]

Culture also plays a part. There has, for instance, been criticism made in scientific literature that the way modern Western societies deal (or do not deal) with experiences of loss leads to the overpathologising of emotions such as sadness. In DSM-IV, bereavement was the only significant loss experience that ruled out a classification of MDD (at least for a certain amount of time). However, as Horwitz and Wakefield point out in their book *The Loss of Sadness* (2007), many other types of loss may contribute to depression. What, for example, about the loss of a job after 25 years of loyal service, or an acrimonious divorce? Are people allowed to mourn following such experiences, or do we instead pathologise what is in fact justifiable sadness?[18]

Nevertheless, the DSM-5 might be a useful tool for clinicians as long as it is used for its main purpose: facilitation of communication through classification, as a first

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[17] This article shows that the incidence of schizophrenia might be overestimated in a so-called first contact register compared to a long-term psychiatric register. Dutch citizens of Moroccan decent are at higher risk in both registers but it may be that subtle diagnostic biases place them at a higher risk of receiving a schizophrenia classification at first contact with a Dutch mental healthcare professional (this might, in turn, be due to culturally specific presentations of mental health symptoms). Diagnostic bias is not the only possibility, however. Veling (2013) points out that experiences of social adversity and having a disadvantaged outsider status may also explain the excess risk.

[18] Although the debate on the criteria for psychiatric disorders such as MDD is relevant and important, it should, in my view (KH), not obstruct ongoing research that may help people with problems leading them to seek treatment. My personal view regarding the issue of overinclusive criteria is that depression should probably be diagnosed on a continuum instead of applying 'all or nothing' criteria, and that bereavement should not be the only significant loss experience that rules out depression. Such questions about valid criteria point to the importance of social context in understanding what state or trait can be viewed as a psychiatric disorder. This is not only applicable for the realm of mental healthcare. For instance, is obesity (defined as a Body Mass Index of more than 30) a disease? The answer to that question may vary from culture to culture, and indeed from one historical period to another. In the paintings of Rubens, from the 16th and 17th centuries, the characters depicted are sometimes obese, which might have been viewed as a sign of beauty, possibly even of health.

step in a thorough diagnostic process. For this purpose, it might even be advantageous that it is largely atheoretical (clinicians from different psychotherapy schools of thought at least have its language in common). It becomes problematic, however, when disorders in the DSM are interpreted as ‘natural kinds’, which are impervious to time and cultural context. Research by, among others, Horwitz et al. (2007) point out that such contextual factors are sometimes overlooked. One of the risks of this could be the aforementioned overpathologising of emotions, which might alienate people from seeking treatment. One should note that an effort was made to increase the cultural sensitivity of DSM-5 in comparison to DSM-IV, and that the grouping of disorders was based more on neuroscience and less on symptom expression. For instance, a DSM-5 Culture and Study Group was appointed by the American Psychiatric Association and the World Health Organization (Regier, Kuhl and Kupfer, 2013).

When studying late antique ascetics, one should be aware of the influence that the DSM has on the way we judge certain behaviour. Let’s take, for instance, a narrower timeframe: a hypothetical conversation about a colleague who always sits alone during coffee breaks and excels at doing the jobs others find boring: a typical case of Asperger’s, someone might say. However, Asperger’s syndrome, present in DSM-IV, was dropped from DSM-5. In future literature, younger scholars may have difficulty in determining the difference between ‘autistic disorder’ and ‘Asperger’s disorder’ that had been common knowledge a few decades before. When decades become centuries, such confusion only increases; the same behaviour traits may have been interpreted in a completely different way in late antique times. It is, therefore, important to understand that both DSM-5 and idealised ascetism in religious texts are social constructs based on cultural beliefs and power dynamics within the groups that create them, as pointed out by Foucault (1976). Our aim with this article is to better understand these dynamics: our goal is not to criticise the DSM-5, but to explore how someone interpreting the DSM-5 categories as natural kinds—stable over time and across cultures—would be using tunnel vision. So, let’s progress to ascertain what lessons there are, for contemporary psychologists, in Late Antiquity.

Part 2: Late Antique Hagiographical Taxonomies

In the course of the 4th century, a profound social transformation took place within the Roman upper class, with many members gradually starting to convert to Christianity; some even embraced asceticism and a life of poverty and physical hardship that was diametrically opposed to their previous lives (Brown, 2012; Salzman, 2004). These early ascetic movements and the growth of monastic communities were a diverse phenomenon, defined by the endeavours of individuals with different motivations to reach spiritual perfection. As we can see in the *HL*, it encompassed the efforts of small

village hermits and rich heiresses alike; distinguished consuls, actresses, soldiers and bishops. In his account, Palladius tries to provide an overview of the various ways to live as an ascetic, and he not only includes tales of extraordinary, holy deeds and ascetic struggles and failures but also details the ascetics' dietary habits, their living conditions and physical practices (Frank, 2000: 62). Palladius also presents observations on an ascetic's state of health or illness, on their physical and mental condition, and on their medical treatment (Schulze, 2013). Palladius' observations on health in the story of Benjamin (*HL*, c. 12),[19] for example, provide insight into the perception of disease in late antique ascetic communities. Benjamin, an ascetic of old age, was so far advanced in his ascetic practices that he was allegedly able to heal other people by his touch. In the last months of his life, he fell severely sick and suffered from dropsy. The disease caused a swelling of his body so terrible that Palladius and other visitors were unable to look at him. Benjamin, however, accepted his suffering with 'unbounded thankfulness' and was therefore praised as an ascetic role model.

Another story that elucidates the role of sickness in an ascetic context can be found in the *Life of Pachomius*, probably written around the same time as the *HL*.[20] There, we encounter the monk Palamon, whose experiences and self-neglect are similar to the aforementioned introductory case study of the modern patient. Palamon had damaged his health by rigorous fasting and excessive ascetic practices, and suffered, as a consequence, from a severe disease of the spleen (*Life of Pachomius*: c. 5, 16).[21] Palamon's fellow monks took him to see a doctor, who advised him to start eating again. After a few days, however, Palamon, seeing that the intake of food did not immediately ease his pain, returned to his previous ascetic regimen. He believed that a remedy for his pains could not be provided by any earthly means but only by God (*Life of Pachomius*: c. 16; Crislip, 2006).[22]

Contrary to the modern case study, where a disorder would be diagnosed and numerous measures taken to improve the patient's health and to prevent them from harming themselves, reactions to an ascetic's self-endangerment in late antique Christian communities were more diverse. On the one hand, there was an awareness among contemporaries that excessive ascetic practices such as rigorous fasting could lead to injuries, illness or even death, and that these did not enhance but rather diminished the ascetic's powers (Jerome, *Epistula*: letter 130, c. 11).[23] This is particularly reflected in contemporary rules for monastic communities, as they prioritise the welfare of the whole community over the individual's ascetic ambitions. Thus, the rule of, for

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[19] Palladius (1918).

[20] The *Life* has complex and complicated literary traditions and several versions exists in Coptic, Greek, Latin and Arabic; for more information see Rousseau (1985), Goehring (2000) and Dunn (2000: 25–41).

[21] Anonymous (1980). *Life of Pachomius* (cc. 5, 16)

[22] Anonymous (1980) *Life of Pachomius* (c. 16)

[23] Jerome (1918).

instance, Basil of Caesarea, advocates moderation and a 'disciplined care' for the body's health (Crislip, 2006: 191). In hagiographical accounts, on the other hand, extreme forms of asceticism were often idealised or even promoted. The ascetics strove to imitate the suffering of Christ and the martyrs, meaning that sickness—even if it resulted directly from rigorous practices—could be interpreted as a sign of ascetic accomplishment and sanctity (Hunt, 2016; Crislip, 2006). In the story of Palamon, therefore, his fellow monks did not hinder him from resuming his ascetic regimen, despite being concerned for his health.

Thus, we can observe the appearance of new, Christian concepts of sickness and suffering, which found particularly pronounced expressions in the ascetic movements of Late Antiquity (Ferngren, 2016: 13–41). In an ascetic context, sickness had spiritual significance and was part of the ascetics' struggle for perfection and salvation. The manner of enduring diseases demonstrated the ascetics' spiritual competence (Marx-Wolf, 2015). While the care for others, especially the sick—either in hospitals, hospices or as miracle-workers[24]—was an important element of an ascetic's vocation (*HL*, c. 6, 18, 28, 40, 67),[25] they rarely allowed themselves to receive medical treatment (*HL*, c. 35; Ashbrook Harvey, 1984)[26]. However, one should not jump to the conclusion that, in general, Christians were opposed to medicine and preferred to rely on miracle workers rather than on medical treatments but should see these changed attitudes as part of a larger transformation process towards matters of health, body and soul.

Ascetic practices not only concerned disciplining the body but also training the soul. Just as an ascetic should avoid specific foods—such as fatty, indulgent fare—they had to abstain from anything that would harm the soul, such as 'anger, envy, vain-glory, accidie, detraction, and unreasonable suspicion' (*HL*, prologue).[27] Correlating the condition of body and soul, the health or sickness of the ascetic's body could reveal their inner health, although the interpretation of this connection could go in several directions. For example, the sickness of an ascetic could be interpreted as a warning of 'the moral precariousness of the healthy' (Crislip, 2005: 162; Ashbrook Harvey, 1984) or as a punishment by God for moral misconduct (*HL*, c. 26).[28] The latter did not apply in the case of the story of Benjamin, however, whose moral conduct was beyond doubt in Palladius' view: Benjamin's fellow ascetics noted, in praise, that he was still able to heal others, interpreting his physical sickness as evidence of his inner virtues. Sickness could also be understood as a means of ascetic discipline, serving to strengthen the

[24] Care of the sick, disabled, poor, and charity in general became characteristic new features of late antique and medieval Christian societies. See Brown (2015) and Nutton (2013b).

[25] Palladius (1918).

[26] Palladius (1918)

[27] Palladius (1918).

[28] Palladius (1918).

soul and connect with the divine. Palamon did not, therefore, actively seek medical treatment, and Benjamin told everyone: ‘Pray, my children, that the inner man may not contract dropsy; for this body did not help me when it was well, nor has it caused me harm when faring badly’ (*HL*, c. 12).[29] The ascetic’s body was at the intersection of the human and the divine sphere: bodily sickness could promote spiritual well-being and inner growth.

Although we find numerous descriptions of the ascetic’s treatment of their body and soul, their habits and their environment in the *HL*, it is difficult to arrive at precise conclusions about their mental health or emotional state. Regarding the DSM-5 criteria for MDD, we rarely find them expressed in the *HL*—at least, not directly. When, for instance, tears are shed—an obvious physical description of sadness from a modern perspective—it is always related to a spiritual, religious matter and not to a biological or mental condition. Isidore (*HL*, c. 1),[30] for instance, who is said to ‘weep at table often’, did so because he had to eat ‘irrational food’, while another ascetic wept because of the poverty of others, in order to lead sinful Christians to repentance (*HL*, c. 71).[31] Similar observations can be made when looking at the other criteria in DSM-5, such as: insomnia or hypersomnia; diminished interest or pleasure in all, or almost all activities; feelings of worthlessness or guilt, or recurrent thoughts of death. In an ascetic context, these observations would have a spiritual dimension: insomnia (or the deliberate deprivation of sleep, at least) is part of an ascetic’s routine; humbleness and impassivity are important elements of an ascetic’s posture (HL, c. 17, 32, 49);[32] a preoccupation with death should enable personal salvation and to be ‘dead for the world’ was a desirable goal for an ascetic and displayed their spiritual advancement (*HL*, c. 2, 37).[33]

Only rarely do we find stories that allow us to gain insight into an individual’s emotional or psychological condition and the opportunity to attempt a non-religious interpretation. The story of an anonymous nun who was ‘seduced by a minstrel’ (*HL*, c. 69)[34] is, however, one such example. When she started ‘to hate her seducer intensely she was conscience-smitten to the depths of her soul, and reached such a degree of repentance that she completely lost heart and tried to starve herself to death’ (*HL*, c. 69).[35] A 21st-century psychiatrist or clinical psychologist could interpret this as excessive or inappropriate guilt; a symptom of MDD. The excessive fasting would cause

[29] Palladius (1918).
[30] Palladius (1918).
[31] Palladius (1918).
[32] Palladius (1918).
[33] Palladius (1918).
[34] Palladius (1918).
[35] Palladius (1918).

weight loss and could also be viewed as problematic. The psychiatrist or psychologist might consult a religious official but, following hospitalisation, the fasting could be viewed as excessive to such a degree that a MDD classification would be inevitable. While in the modern context the protagonist would receive treatment and assistance, from a late antique ascetic's perspective severe fasting is part of the individual's penitence, and therefore no support is offered, and no attempt made to stop this behaviour.

Another important narrative element in the lives of saints are the descriptions of visions, visionary dreams and hallucinations because they represent an experience with the divine.[36] Besides their role in hagiographical and patristic literature, as well as their function in political contexts (Dutton, 1994), they have also been studied specifically in order to attempt diagnosis from a modern medical perspective. It has been suggested that these visions could result from malnutrition or a lack of vitamins, but more collaborative research into this needs to be done (Schulze, 2013). In this respect, the vision of Elias (*HL*, c. 29)[37] is a particularly fruitful example for further interdisciplinary analysis. Elias, a young Egyptian ascetic, was the patron and overseer of a large female monastic community that he had established on his own estate. Living as the only male person among nuns, at one point he is tempted by desire. He then leaves the monastery and withdraws to the desert in order to seek God's assistance to free him of his desires. In his sleep, he has a vision of three angels who proceed to castrate him:

> Then one of them seized his [Elias'] hands, and another his feet, and a third taking a razor unmanned him, not really but in the vision. So, he seemed to himself to have been cured, so to say, in the trance. They asked him: 'Do you feel any benefit?' He said to them: 'I feel greatly lightened and am persuaded that I am relieved of my passion.' They said to him: 'Go away, then.' And he returned after five days, the monastery mourning for him the while, and went in and remained inside henceforward, in an adjoining cell, from which being near at hand he corrected them continually so far as he could. But he lived forty years more, always assuring the fathers: 'Passion comes no more into my mind.' Such was the gift of grace of that holy man who thus looked after the monastery (*HL*, c. 29).[38]

This vision tells us much about ascetic ideals and the drastic measures that could be taken to ensure self-control. It also allows us to glimpse the common but physiologically inaccurate idea that the removal of the testicles would diminish all sexual power (Caner,

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[36] Keskiaho (2015). For a broader discussion of how people with visions, emotional or mental distress were treated in everyday contexts in the Late Antiquity and the Middle Ages (which would range from medical treatment, sensible herbal remedies as well as curious practices, to social exclusion or even imprisonment) see Nutton (2013a).

[37] Palladius (1918).

[38] Palladius (1918).

1997: 396–415). From a historical perspective, it also addresses some more practical aspects and problems of late antique, specifically female, monasticism such as the dependence of female ascetics on male monks and patrons and the question of how life within such a community could be organised (Elm, 1994: 322–324). While, from the contemporary perspective, the story of Elias' symbolic castration might appear to be a drastic measure, for the monk and the text's audience it may have seemed like a sensible solution to the difficult problem of maintaining chastity in a mixed-sex monastic community; Elias' goal, the absence of any desire, which he obtains through his symbolic castration, not only signifies his own ascetic self-control but also presents to careful outside observers of the monastery an explanation as to how chastity could be maintained (Caner, 1997: 398). In this respect, Elias' story was told for a wider 'emotional community' (Rosenwein, 2002: 1–31), as it connected the ascetic, the monastery and its local context, the author and the audience, to a discussion about social norms and ascetic ideals. In turn, Elias' behaviour, his retreat to the desert, his dream and its description would have been influenced by the anticipation of this discourse, highlighting the fluid interplay between literary and real experience in hagiographical works.

From a modern, Western, psychological perspective, renouncing sexuality because of excessive desire could be seen as problematic. DSM-5, for instance, offers classifications such as Hypoactive Sexual Desire Disorder in males and Sexual Interest/Arousal Disorder in females, though DSM-5 recommends taking cultural phenomena into account when classifying males (but not, interestingly, the classification of females). Because Elias was male, there is a good chance that from today's lens he would not have Hypoactive Sexual Disorder ascribed to him. After all, his religious convictions can clearly be interpreted as a cultural phenomenon. Nevertheless, a striking difference between the DSM-5 and many religious texts appears to be whether a lack of sexual desire is cast as positive (the story of Elias) or negative (DSM-5); the lack of sexual desire and fantasies ascribed to Elias can be interpreted as a disease in the modern, Western context.

Melania the Younger

While Palladius' short stories help us to better understand the perception and interpretation of body and soul, and their spiritual dimension within an ascetic context, the brevity of the entries (designed like that to make them more accessible and representative of ideal Christian beliefs) makes a full assessment of our research question difficult. Therefore, it is worth examining a longer hagiographical account that describes a process of conversion that spans a lifetime.

The example of Melania the Younger, founder of a monastic community at the Mount of Olives in Jerusalem, who is also depicted in Palladius' catalogue, is remarkable both with regard to the profound transformation process she underwent in the name of asceticism, including extreme self-denial and poverty, as well as her role as a leading female ascetic (Clark, 2021: 76–97). Part way through her life, she decided to break with tradition and social expectations and deliberately turned her back on society, gave up a large fortune and her family possessions and pursued a zealous, ascetic lifestyle (Brown, 2012: 291–307; Alciati and Giorda, 2010: 425–444). Melania's decision was not only inspired by an urge to break away from social norms but also by her personal confrontation with death, personal crisis, mortality, and the subsequent hope of salvation. Her example tells us more about how, in late antique Roman society, individuals coped with the fear of death, how these deliberations could find a religious expression and how belief could be used to overcome, compensate or transform these notions and anxieties.

In the early phase of the spread of asceticism from the Eastern to the Western parts of the Roman Empire, from the 350s on, it was the young aristocracy, especially the wives, widows and daughters of the upper class, who were susceptible to the new social and intellectual possibilities that the pursuit of an ascetic life could offer (Cooper, 2013: 131–154; Dunn, 2007: 669–690; Clark, 1981: 240–257). Educated women from senatorial families started to engage in biblical scholarship, learned Greek or Hebrew, and dedicated themselves to reading and discussing theological treatises).[39] Christian intellectuals joined them and, in turn, inspired and advised these women in the pursuit of their ascetic goals. The elegant villas on Rome's Aventine Hill not only hosted literary circles but also became monastic enclaves of virgins supervised by devout rich widows; these early monastic communities were thus characterised by 'household asceticism' (Cooper, 2013: 131–154; Rousseau, 2005: 165–186; Elm, 1994: 89). A vow of chastity and celibacy presented an opportunity to reject conventional female roles and to break out of the 'cycle of marriage, widowhood and re-marriage' (Dunn, 2007: 670). The lives of Helena Augusta, mother of Constantine the Great, and of Melania the Elder, Paula and Marcella are salient examples of how Christian ascetic ideals changed the way Roman noblewomen perceived and shaped their religious and social roles (Hillner, 2022; Coon, 1997: 95–119). It might seem paradoxical from a contemporary lens, but within the clear-cut patriarchal hierarchies of Rome's aristocratic society, pious women found a niche of relative social and economic

[39] See, for instance, Palladius' (1918) descriptions of mainly female Roman aristocrats who became ascetics: *HL*, c. 41: Paula, Eustochium and others; *HL*, c. 46: Melania the Elder; *HL*, c. 54: Melania the Elder; HL, c. 55: Silvania; *HL*, c. 56: Olympias; *HL*, c. 57: Candida and Gelasia; *HL*, c. 61: Melania the Younger; *HL*, c. 62: Pammachius; *HL*, c. 66: Verus.

autonomy, mobility and self-determination by leading lives not only of religious piety but of rigorous asceticism (Cooper, 2013: 131–154; Dunn, 2008; Cloke, 1995: 25–56; Elm, 1994: 25–59).

Although around the year 400, ascetic ideals were well received among a strata of Rome's upper class, they still presented a counter-culture to the traditional way of aristocratic life and its social and familial responsibilities. Conflicts erupted over aristocratic women who desired to devote themselves to ascetic celibacy, which could threaten the economic or social interests of their families (Brown, 2012: 296–298). A renowned example of family pressure and obligations is portrayed in the *Life of Melania the Younger* (hereafter *VM*), an account that is based on her own memories, looking back after 30 years of ascetic life to her youth.[40] It was likely to have been written by Gerontius, a priest from her entourage in Jerusalem, who took on the responsibility for Melania's monasteries after her death (Coon 1997: 10–119; Clark, 1984: 1–24). Melania and her namesake grandmother, Melania the Elder, herself one of the pioneering early female ascetics, belonged to one of the most influential and wealthy families in the Empire (Brown, 2015; *HL* c. 61).[41] At a very young age, Melania decided to take a vow of marriage to Christ. This wish met with her family's resistance who, as illustrious members of the Roman senate, wanted in the conventional way their daughter's marriage to increase their reputation and wealth. When she was 14, Melania was pressured into marrying Valerius Pinianus, also a young heir to a vast fortune (Brown, 2012: 295; Clark, 1984: 85). On their wedding night, she tried to persuade Pinianus to live together like brother and sister, but he reminded her of their duties to continue the family line (*HL*, c. 61; Castelli, 2017: 278; Coon, 1997: 110–111).[42] They then had two children and both died very young.

These deaths and Melania's ensuing illness helped persuade her husband that it was God's will that they should remain childless. Vowing chastity, they settled into an ascetic lifestyle, but it was only after the death of her father that Melania was legally able to fully embrace asceticism and give her enormous fortune away not in inheritance but to charitable causes (Brown, 2012: 291–307). In 410, they arrived in the city of Thagaste in North Africa, where they generously endowed the local church and commissioned the construction of two monasteries (*VM*: c. 22).[43] When the monasteries were finished, Melania governed the women's community as abbess and patron, and devoted herself to zealous biblical studies and rigorous ascetic practices.

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[40] Gerontius (1984).
[41] Palladius (1918).
[42] Palladius (1918).
[43] Gerontius (1984).

According to her hagiographer, Melania tried to excel as an ascetic role model in everything she did: she was continually fasting; eating only every second and later every fifth day, and ingesting only drops of oil and crumbs of dark, sometimes mouldy bread, while savouring the *Life of the Fathers* as if it was a cake dessert (*VM*: cc. 22–24; Dilley, 2017).[44] Day and night, the nuns and visitors would find Melania studying scripture and theological literature. Out of humility, she hardly ever changed her coarse clothes, which were made of hair (*VM*: cc. 4, 31, 40).[45] She tried to live in as much isolation as possible, and started sleeping in a custom-built chest that was so narrow that she could not move or turn (*VM*: c. 32).[46] Only once a year, at Easter, she would leave her cell. When the young nun who was attending to her tried to clean out her sleeping sack, large lice fell out (*VM*: c. 40).[47]

Gerontius' version of the journey of his patroness towards an ascetic, saintly life integrated typical elements of late antique hagiographic literature and, as Coon argues, drew heavily on topoi associated with male priesthood (Coon, 1997: 109, 114). Melania was described as an inspiring ascetic role model, first for her husband Pinianus, whom she, according to her hagiographer, exceeded in spiritual strength (Clark, 2021), and later for the communities she founded. Gerontius also stressed her importance by stating that her advice was sought by church authorities and even by members of the royal court (*VM*: cc. 34, 36, 51).[48] When she later left Thagaste and, after a pilgrimage to the Egyptian desert hermits, finally settled in a monastery at the Mount of Olives in Jerusalem, Gerontius added further elements to her sanctity: Melania devoted herself to the conversion of prostitutes, care for the poor and the fight for orthodoxy. Finally, after embarking on her journey to Constantinople in 436, she performed her first miracles, healed the twisted ankle of Empress Eudocia and successfully fought a demon (*VM*: cc. 58, 59).[49] Melania, who in her rigorous ascetic practices paralleled the feats of the desert fathers described in the *HL*, took on the role of charismatic leadership (Alciati and Giorda, 2010).

In his hagiographical account, Gerontius used all these vignettes to exemplify the transformation that Melania underwent from her comfortable, aristocratic upbringing to an ascetic life full of self-inflicted hardship. Her personal experiences, especially the resistance she met from her family and her husband before she could embrace asceticism fully, are embedded into a hagiographical narrative. Overcoming these

[44] Gerontius (1984).
[45] Gerontius (1984).
[46] Gerontius (1984).
[47] Gerontius (1984).
[48] Gerontius (1984).
[49] Gerontius (1984).

obstacles and defying her family's wishes are key elements that Gerontius used to demonstrate the truthfulness of Melania's vocation and piety.

The dilemma of weighing family duties and affection against spiritual liberation, which sometimes demanded the loosening of family ties and the abandonment of children, was a common topic in the renunciation stories of late antique female ascetics. It was more than a hagiographical trope, as it represented real-world challenges that aspiring ascetics would have faced (Clark, 1995: 33–56). Personal experiences are similarly told in the light of their religious significance, such as the death of Melania's children, but at the same time may point to authentic emotions and a personal crises that the ascetic underwent. When Melania gave birth to her second child, she had spent the previous night in vigil, 'not taking any rest and having spent the whole night kneeling' in preparation for the feast of Saint Lawrence (*VM*: c. 5).[50] During this excessive demonstration of piety and physical endurance, which draws parallels to Christian martyr stories, she prematurely gave birth to her son (Doerfler, 2017: 113). The baby did not survive and Melania's older child also died soon after.[51]

We know very little about how Melania and Pinanius felt about the death of their children. We only have the account of Melania's hagiographer, Gerontius. He tells us that Melania was 'exceedingly troubled and was giving up on life', and that her husband 'lost courage' as a result. Because Pinianus feared that 'he might never see her again alive', he finally agreed to Melania's wish to convert fully to asceticism: 'Because of grace from on high and the young man's promise, she was cheered; she got better and completely regained her health' (*VM*: c. 6).[52]

In this episode, literary strategies, religious interpretation and real experiences are closely intertwined. The death of Melania's children is presented as an important spiritual turning point that eventually reinforced her determination to become an ascetic. A contemporary clinical lens would typically connect her desperation and suicidal thoughts to grief about losing her children, and traumatic experience as the key motivation for choosing an ascetic life. Gerontius, on the contrary, describes Melania's grief and sadness as expressions of her piety in context of her ascetic journey; she was not only grief-stricken about the loss of her children but also her as-yet unfilled vocation as an ascetic. In the narrative, the birth and death of her second child, a son, are connected with martyrdom, as they happened around the feast of Saint Lawrence, and can be interpreted as a sacrifice in the style of the early

[50] Gerontius (1984).

[51] For more information on the mortality rate of infants and children, which was about one-third of all births, with many deaths occurring at birth or in the first years of life, see Doerfler, (2017: 72) and Horn (2017: 300–311).

[52] Gerontius (1984).

Christian martyrs, which would later allow her to embrace asceticism fully and to be 'free from the world' (*VM*: c. 6).[53]

The motif of motherhood is taken up again at several other points in the *Life*. In 431 or 432, after the death of her own mother, Melania built a monastery for virgins at the Mount of Olives in Jerusalem. She directed all affairs of the monastery but declined out of an 'excess of humility' (*VM*: c. 65)[54] to be addressed as its head. Nevertheless, for the community of nuns she was a 'truly tender mother' (*VM*: c. 65).[55] In the ascetic world, familial ties and worldly honours were translated into a spiritual context (Vuolanto, 2015) and the title *mater* or *amma* is often used for the superior of a nunnery (Doerfler, 2017).[56] Melania and Pinianus became brother and sister after vowing continence, while the nuns in Melania's monastery were addressed as sisters, and Melania was called 'mother' by her hagiographer throughout the *Life*. These spiritual bonds would not only be applied to members of such a close community but could also be expanded to the whole family of Christ, to everyone who shared in ascetic devotion. When, in 438, Empress Eudocia undertook a pilgrimage to Palestine, Melania went to greet her. On this occasion, the Empress expressed a wish to meet her 'true spiritual mother', Melania, and even regarded the virgins of the monastery as her sisters (*VM*: c. 58). In her hagiographical account, Melania's motherhood is transformed into a spiritual motherhood, with her own family expanded to encompass fellow ascetics and nuns in a family of Christ (Doerfler, 2017). Her experiences and emotions are described and reinterpreted as at the interplay of the transformation or subversion of former Roman virtues and social norms. This resulted in the creation of new categories of emotions or emotional scripts inspired by Christian religion (Scheer, Gammerl and Hutta, 2017).

Melania's struggles on her ascetic journey were not only played out against the background of her personal experiences but also in the midst of a debate about wealth and salvation taking place within Rome's aristocracy, concerning its new Christian identity. If, according to the Gospel of Luke (18:18–27) and Gospel of Matthew (19:21–26), it was 'easier for a camel to pass through the eye of a needle than for a rich man to get to heaven', how could rich Christians reconcile their wealth with the New Testament's injunctions to poverty? This presented a veritable cognitive and practical problem to Christian aristocrats (Brown, 2016; Brown, 2015: 82–114; Brown, 2012). Christian

[53] Gerontius (1984).

[54] Gerontius (1984).

[55] Gerontius (1984).

[56] Paulinus of Nola (*Epistula*: 29, c. 7, 692–693) on Melania's grandmother, who enhanced her aristocratic status in dedicating her life to Christ and obtained celestial nobility. See also Jerome's similar description of Paula, discussed in Cooper (2013: 198) and Harries (1984: 54–70).

bishops and intellectuals sought to resolve this tension, by offering explanations as to how wealthy aristocrats could nevertheless achieve redemption. For some, like Melania and her husband, wealth was such a great burden that it had to be renounced without compromise. By disposing of her fortune, Melania hoped to gain something more valuable than her vast but transient possessions, namely eternal spiritual wealth and a 'treasure in heaven' (Lk 18:22; Mt 19:21) (Brown, 2015: 291–307; Harries, 1984). Generally, when looking at late antique tales of ascetic conversion, there is a strong resemblance between the biographies of the different holy men and women who tended to be well-educated and shared a similar social background, and an overlap in the decisive events behind their radical decisions. The confrontation with death, the loss of a family member or a beloved child as well as the expectation of Christ's coming and the hope for salvation were catalysts for profound change in the lives of the prosperous and fortunate. Paradoxically, leading rigorous lives of abnegation and poverty helped to overcome experiences of loss or sadness and the fear of death (Brown, 2012: 3–30, 72–90, 208–240; 2016: 1–16, 36–50; Coon, 1997: 1–27, 95–119). By renouncing the world and turning their backs on society, ascetics died a symbolic, worldly death (as described in the *HL*, c. 2, 37),[57] while at the same time they believed they would overcome literal death and were to be saved spiritually, finding life in God's grace and in paradise (Rev: 21–22).

Conclusion

This article began by posing the question of what psychologists can learn from reading about late antique ascetics and what lessons engaging with the DSM-5 might bring to historians. Comparison between the two historical contexts and the various descriptions of sickness, sadness and grief enabled us to identify similarities and differences (with respect to how people with authority make sense of behaviour and emotions that deviate from societal norms) and to get to a closer understanding of how perception and interpretation of these experiences are intertwined. Behaviours described as exceptional and diverging from a specific social standards can be found in both the DSM-5 and in the hagiographical accounts. The conclusions that could be drawn by contemporary readers, however, differ.

For psychologists, the key message is that there was a time when renouncing the world and living in seclusion was seen by some writers as a cure for a state of depression; instead of indicative of a problem, it was deemed highly virtuous. This is in sharp contrast to behavioural activation, the first step of the Cognitive Behavioural Therapy protocol for depression. We would, of course, not recommend patients suffering from a

[57] Palladius (1918).

MDD in the modern Western world to spend their lives in seclusion or a state of excessive fasting. However, the examination of past case studies reveals the prevalent discourses at the time behind the construction of psychological categories. While in the context of the DSM-5, medical treatment could be recommended in order to cure the patient and to regulate behaviour, in the hagiographical examples, alienating conduct is interpreted as an integral part of holiness and is thus celebrated. Embracing Christianity and its central promise of future salvation and eternal life could change personal perspectives towards death and one's conduct in the present. Melania's experience of personal loss, for instance, increased her determination to become an ascetic, and her personal confrontation with death led her to reflect on her own salvation.

This comparison opens the possibility of reappraising emotional categories and might today introduce alternative perspectives for the categorisation of emotions and behaviour in modern Western psychiatry. A state of depression, for instance, might not always have been viewed as a medical condition in need of treatment. The current scientific paradigm in psychiatry is strongly focused on the brain as the seat of the mind (e.g., depression or autism as a disease of the brain). While there is little doubt that the brain is crucial to functions attributed to the mind (e.g., reasoning, memory, and the experience of desire and emotions), we should not forget that the brain interacts with the body and the outside world. The way the world is organised differs between cultures, and as the stories of Palladius illustrate, his world was very different to what it is now.

Among others, Dehue (2010) has pointed out that there is relatively little room for contemplation and introversion in modern Western societies and extraversion might be overvalued in our current cultural context. She calls this 'a ban on thoughtfulness' (Dehue, 2010). Similarly, in a recent book, Smit (2017) writes about the experience of being more inclined to introversion in a society that tends to value being outgoing, energetic, and enjoying the company of others. While acknowledging that this observation concerning current Western society is an oversimplification, there is some truth to this so-called 'ban on thoughtfulness' which may, in turn, have consequences for what is and is not viewed as a disorder (what comprises a psychiatric disorder is defined by what is assumed to be abnormal behaviour, and this differs from one cultural and historical context to another).

This might be a lesson for current clinicians: when we discuss our diagnostic findings with our patients, it may be preferable to give a disclaimer. Our patients need, at least to some extent, an understanding of the importance of context and of reification. ADHD, for instance, does not explain a lack of concentration, when lacking concentration is one of the classification criteria in the first place. The actual reasons for issues with concentration may vary from individual to individual, and having a less

focused (or being hyperfocused, as is sometimes the case in ADHD) but highly creative mind might be beneficial in certain contexts. Exploring these issues with our patients might provide a deeper level of understanding.

The difference, here, is between classifying and diagnosing. The writings of Horwitz and Wakefield (2007) on the subject of grief and 'the loss of sadness' imply that the criteria for MDD may again change: the pendulum might swing towards normalization of prolonged periods of a somewhat depressed, contemplative mood, although it is unlikely that fasting to the point of starvation, as practised by some ascetics, will be in the near future deemed an appropriate response. If these authors are correct, grief due to loss (not just bereavement), while currently seen as undesirable, might in the future be more widely interpreted as an opportunity for personal growth rather than a disease. DSM-5 does give some indication on how to differentiate MDD from grief, but contemporary clinicians are unlikely to recommend extensive periods of grief and are even less likely to recommend that grief be allowed to become a mode of living, as was arguably the case with Melania. A paradigm shift comparable to that concerning grief might also occur with introversion. If society shifts to favour introversion over extraversion, it would profoundly change psychiatric classification.

Historians and psychologists alike should be aware of the potential for shifting paradigms. Many historians will have heard of the DSM-5, which is influential in shaping our (conscious but also unconscious) thoughts about what is normal. It is our hope that this article will inspire reflection on how contemporary Western views about the expression of emotions and what is (ab)normal behaviour influence the way we view the past. This is probably the most important lesson we have learned through writing this paper: making sense of behaviour (and making sense of the way other people are making sense of other people's behaviour) is a very complex task. Influential texts (such as hagiographies or the current edition of the DSM) and the ideas and beliefs of the writers (as well as their cultural context) profoundly impact societal judgment of behaviour and the expression of emotions. Recognising the implications of this is a daunting task, but historians and psychologists can learn from and support one another along the way.

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The authors have no competing interests to declare.

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