Journal of Moral Theology, Vol. 14, No. 1 (2025): 89–107

How (Not) to Theologize Psychological Distress: Lessons from Thinking Across Conditions

Jessica Coblentz

Abstract: With appreciation for how Stephanie Edwards and Catherine Yanko apply insights from Coblentz's *Dust in the Blood: A Theology of Life with Depression* to theologies focused on other forms of psychological distress, Coblentz elucidates from their essays six insights or "lessons" to apply to the ongoing work of theologizing psychological distress. These lessons variously explore the relationship of different mental health conditions, mental health stigma, social dimensions of psychological distress, complexities of moral agency, epistemic injustice, and the place of Christ in the ongoing project of theologizing mental health.

LESSON 1: WE NEED TO SPEAK SPECIFICALLY, BUT NOT IN ISOLATION

When I started researching theologies of depression almost a decade ago, I was motivated by a curious lacuna in contemporary Christian theology. While there was much reflection on suffering and a small but growing discourse on trauma, I could hardly find a substantial treatment of depression. I knew depression was a reality far more common than what one might glean from academic theology, and so I began to wonder: Do we even need theological reflection on depression, in particular? Perhaps existing theologies of suffering, even these nascent theologies of trauma, suffice to address the theological issues presented by depressive experience. Would centering depression, specifically, shed any distinctive light on who God is and what God wills for our world?

I would not have written *Dust in the Blood* had I not perceived some need for a distinctively depressive account of our hope as Christians (1 Peter 3:15). This led me to pursue an articulation of Christianity that might be legible to those of us who inhabit, or have inhabited, the peculiar wilderness of depression. I strove to articulate Christianity in the native tongue of depression sufferers, one often seemingly untranslatable to non-natives and one sometimes rendered

mute by the sheer force of this psychic pain. And I continue to champion theologies that center depression, specifically: I think we need more of them!

Thanks to some thoughtful interlocutors of the book since its publication, I have also come to see the hazards of developing a theology that emphasizes depression's distinctiveness. Andrew Prevot, for instance, has wondered whether stressing the otherness of the world of depression could mislead us into thinking that it is wholly unrelatable to those who do not experience the condition. What about the possibility of shared worlds, he poses, experiences that resonate across the struggles of depressed and non-depressed persons?[1] Distancing depression from other ways of being in the world could inadvertently compound the isolation already experienced by depression sufferers, he suggests. And it could justify what Edwards rightly names as theologians' common "unwillingness to engage in the mental health of another," which already contributes to the social and theological marginalization of depression sufferers.[2]

How to advance a theology of depression that honors the particularities of this condition without obscuring its resonance with other experiences or its theological relevance beyond depression has thus emerged as another important issue for my theological reflection. One valued gift that Edwards and Yanko offer with this roundtable is intellectual companionship in actualizing this kind of thinking across conditions. With their essays, they lead the way: by bringing *Dust in the Blood* into dialogue with research on trauma and moral injury, Edwards and Yanko surface possibilities for theological reflection across psychological experiences without collapsing the differences among them. They show how reflection on depression can reveal or inspire truths of broader theological relevance. In the process, they demonstrate how theological insights born of trauma and moral injury redound to other realities as well.

Their thoughtful essays prove an important lesson I carry forth in my scholarship on depression: though the range and particularities of mental health struggles necessitate that we speak specifically so as to avoid generalities about psychological distress and any one condition in particular, we need not do this in isolation. Indeed, there are broadly applicable lessons to be culled from theologies that focus on discrete

---

[1] Andrew Prevot, "Shared Worlds," in "Symposium on Jessica Coblentz's *Dust in the Blood: A Theology of Life with Depression*," *Syndicate* (August 17, 2023), www.syndicate.network/symposia/theology/dust-in-the-blood/.

[2] Stephanie C. Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*: Moving Toward Enfleshed Counter-Memory," *Journal of Moral Theology* 14, no. 1 (2025): 82.

conditions, especially when we approach one another's work with the generous and collaborative spirit Edwards and Yanko exemplify.

I proceed by identifying several additional lessons Edwards and Yanko bring into focus or inspire with their essays, lessons that might guide the ongoing project of theologizing psychological distress. One might see these lessons as supplements to chapter 4 of *Dust in the Blood*, where I consider the moral and theological transgressions that result from imposing meaning onto another's depression and propose guidelines for theological reflection on this condition. That chapter bears the title, "How (Not) to Talk about Depression," and the title of this response is a nod to it.

LESSON 2: WE ARE RESPONSIBLE TO SPEAK, AND TO SPEAK RESPONSIBLY

Early in Edwards's consideration of how "insights about theology and depression hold wider implications for how Christian theology speaks (or does not speak) about mental health overall" is an incisive comparison of trauma and depression.[3] Her careful observations are vital for attending to all that is exceptional about the respective worlds of depression and trauma while recognizing what they also share—in her words, "time, dislocation, and healing practices."[4] With appreciation for the commonalities Edwards illuminates here, I found some of her points of contrast especially instructive for the ongoing project of theologizing psychological distress.

Edwards notes that "whereas depression holds a stigma . . . often setting the sufferer outside of the 'norm,' trauma is frequently applied to everyone."[5] Her subsequent discussion of trauma's relative ubiquity, both real and perceived, recalls recent news coverage of trigger-warning debates in our schools and viral trauma discourse on TikTok.[6] This coverage may seem a boon for sufferers and theologians of trauma, as anti-stigma campaigns often champion public awareness

[3] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 76.
[4] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 79.
[5] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 77.
[6] See, for example, Katherine Rosman, "Should College Come with Trigger Warnings? At Cornell, It's a 'Hard No,'" *New York Times* (April 12, 2023), www.nytimes.com/2023/04/12/nyregion/cornell-student-assembly-trigger-warnings.html; Olga Khazan, "The Real Problem with Trigger Warnings," *The Atlantic* (March 28, 2019), www.theatlantic.com/health/archive/2019/03/do-trigger-warnings-work/585871/; Jessica Bennett, "If Everything Is 'Trauma,' Is Anything?," *New York Times* (February 4, 2022), www.nytimes.com/2022/02/04/opinion/caleb-love-bombing-gaslighting-trauma.html; and Shannon Palus, "Why TikTok Is So Obsessed with Labeling Everything a Trauma Response," *Slate* (October 6, 2021), www.slate.com/technology/2021/10/tiktok-trauma-response-why.html.

and education as important priorities. Yet Edwards's observations about disjunctions between popular and medical understandings of trauma expose the potential pitfalls of the "normalization" or "universalization" of trauma—and other conditions.

Trauma's association with the kinds of emotional overwhelm experienced by the broadest swath of people sets up the public to overlook more severe, disabling, and persistent manifestations of trauma that affect a smaller number of us. And from this, ironically, more mental health stigma sometimes follows. The notion that, per Beste, "we are all traumatized" can function as an invalidating microaggression, one that minimizes the suffering of trauma survivors by suggesting that their suffering is really not so bad; to struggle to live with such trauma as well as everyone else allegedly does is therefore a personal failing, a sign of the survivor's immaturity or incompetence.[7] Meanwhile, reducing trauma to its most ordinary manifestations can obscure the public's perception of the *extra*ordinary work of healing some trauma requires, especially trauma at its most severe.[8]

Though trauma has exceptional standing in our public discourse, analogous normalizations play out in relation to other mental health conditions, making Edwards's cautionary analysis about the hazards of normalization relevant to theologians working on a range of psychological phenomena. I know firsthand that well-intentioned efforts to normalize depression can similarly play into stigma, for instance. A not-uncommon response to my own research is the assurance that "everyone gets depressed sometimes"—a line that always strikes me as a misunderstanding and belittling of the suffering I witness in depression research. The risks of normalizing mental health struggles take on even higher stakes when talking about suicidal ideation. Scholars of suicidality advocate for de-stigmatizing suicidality and suicide deaths *without* normalizing them, as normalization can deter experients and their companions from registering suicidality as an emergency and seeking out the life-saving mental-health interventions upon which people's lives depend.[9] As theologian

[7] For more on the role of invalidating microaggressions in mental health stigma, see Lauren Gonzales, Kristin C. Davidoff, Kevin L. Nadal, and Philip T. Yanos, "Microaggressions Experienced by Persons with Mental Illnesses: An Exploratory Study," *Psychiatric Rehabilitation Journal* 38, no. 3 (2015): 234–241, doi.org/10.1037/prj0000096.

[8] For a theological reflection on the demands of trauma healing, see Julia Feder, *Incarnating Grace: A Theology of Healing from Sexual Trauma* (New York: Fordham University Press, 2023).

[9] While not using the language of "normalization," suicidologist Thomas Joiner makes this point in another way in his advocacy for preserving fear of suicide: "For any stigma, the usual ingredients are fear and ignorance. If suicide is special in the degree to which it is stigmatized—and I and other believe it may be—then it is simply

Elizabeth Antus advises, we need to "de-stigmatize suicidal people without normalizing or romanticizing suicide."[10]

When it comes to mental health struggles, it is detrimental for depression and other conditions to be hidden away from the public eye and stigmatized as abnormal, but it is also not good that trauma or any other condition is so normalized as to be downplayed and misunderstood. Both shame-filled silence and careless conversation can do harm. This should humble theologians, especially those of us advocating for *more* theological reflection on psychological distress. While we have a responsibility to speak up about mental health challenges, we must speak responsibly when we do.

Edwards models for us how to speak to a broad range of experiences without flattening a condition, and for this, her direct acknowledgement of trauma's diversity and her descriptions of some of these variances are crucial. This requires us to speak from expertise and with specificity about each of the conditions we address—a task that builds on the first lesson of this essay. The cross-contextual exchange Edwards and Yanko model with this roundtable is yet another strategy for responsible theology, as it positions us to speak from our narrow expertise while leaning on and learning from one another's respective knowledge. Perhaps most obviously, we need to educate ourselves about the trappings of mental health stigma, which are more complex than what is typically conveyed in public discourse.[11]

LESSON 3: MENTAL HEALTH STRUGGLES ARE SOCIAL REALITIES IN NEED OF SOCIAL RESPONSES

Edwards offers another edifying contrast with her observation that "Trauma involves an 'other'—be they particular or universal—who is bound up in the experience. Depression as such often has no 'perpetrator' and is defined within one's individual mind and body."[12] I pick up and elaborate on these phenomenological and etiological

---

because the fear and ignorance are so great. Stigma about suicide should be reduced, of course, and it is a point of this book to do so, but I think it should be reduced via a decrease in ignorance, not in fear. I would prefer to leave the fear of death by suicide more or less intact. Fear can be quite healthy, and its absence can be deranged. Some of the most consistently fearless people are the most dangerous and disturbed" (Thomas Joiner, *Myths About Suicide* [Cambridge, MA: Harvard University Press, 2010], 4).

[10] Elizabeth Antus, "'The Silence of the Dead': Remembering Suicide Victims and Reimagining the Communion of Saints," *Theological Studies* 81, no. 2 (2020): 396.

[11] For more on this, I recommend Patrick W. Corrigan, *The Stigma Effect: Unintended Consequences of Mental Health Campaigns* (New York: Colombia University Press, 2018).

[12] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 79.

differences because they have far-reaching theological implications for these and other forms of psychological distress and can be misconstrued to distort our understandings of how depression and other conditions relate to the social worlds around them.

As Edwards notes, trauma has an identifiable originating cause or set of causes—what some call the "trauma event." This originating cause or set of causes continues to feature predominantly in the experience of trauma, as subsequent "triggers" or activators are often tied to the originating event. Following battlefield violence, for example, a traumatized veteran may be activated by loud noises reminiscent of weapons. The originating event is not just a past but also present component of ongoing trauma. Trauma's more-or-less discernable origin in something external to the person does not always spare sufferers of self-blame, to be sure, but it can make the interpersonal and structural realities of trauma more obvious. The trauma sufferer who survives sexual abuse by a Catholic priest needs personal psychological healing, but her situation also beckons responses that aim to restore her experience of interpersonal safety and structural interventions to prevent this kind of sexual and spiritual violence from happening again. In fact, these realms of healing often go hand in hand.[13] Thus while experiences of trauma are personal and subjective, the problem of trauma clearly originates from without; it is therefore more recognizable as a social problem in need of social address.

Because most depression does not have a clearly discernable, external cause or set of causes that continue to dominate one's experience of mental distress in obvious ways, the interpersonal and structural dimensions of depression remain much more elusive and therefore often go unnoticed.[14] Revisions to the American Psychiatric

---

[13] The scholarship of religious trauma brings into focus the entanglements of spiritual and other dimensions of trauma especially well. See, for example, Michelle Panchuk, "Distorting Concepts, Obscured Experiences: Hermeneutical Injustice in Religious Trauma and Spiritual Violence," *Hypatia* 35, no. 4 (2020): 607–625, doi.org/10.1017/hyp.2020.32 and Michelle Panchuk, "The Shattered Spiritual Self: A Philosophical Exploration of Religious Trauma," *Res Philosophica* 95, no. 3 (2018): 505–530, doi.org/10.11612/resphil.1684.

[14] One might assume that postpartum depression is an exception to this, as it is popularly presented as a direct byproduct of hormonal changes that accompany pregnancy and birth. Some research on postpartum depression complicates this etiological account, however, arguing that social constructions of motherhood contribute to this condition as much as, or even more than, biological causes. See, for example, Natasha S. Mauthner, "'Imprisoned in My Own Prison': A Relational Understanding of Sonya's Story of Postpartum Depression," and Paula Nicolson, "Postpartum Depression: Women's Accounts of Loss and Change," in *Situating Sadness: Women and Depression in Social Context*, ed. Janet M. Stoppard and Linda M. McMullen (New York: New York University Press, 2003), 88–112, 113–138.

Association's *Diagnostic and Statistical Manual of Mental Disorders*, the primary guide for diagnosing depression in the United States, have reenforced this by emphasizing that a presenting, external cause for one's depressive symptoms is diagnostically disqualifying: If the loss of a loved one results in what appears to be major depression, then it is, by definition, *not* depression.[15] This lends itself to individualistic characterizations of depression, especially under the influence of our Western biomedical milieu. Psychiatrist and theologian Warren Kinghorn observes how the biomedical model habituates clinicians and the wider public to conceive of depression as a problem *inside* the individual to be treated without concern for any external contextual factors.[16] Though this biomedical framework also prompts individualistic approaches to trauma, most clinicians carry out treatments aware that Post-Traumatic Stress Disorder (PTSD) has, by definition, external causes particular to the person's interpersonal and/or social context.[17]

In contrast to trauma—which, along with moral injury, is rather exceptional among mental health conditions for its definition *vis-à-vis* an external cause—depression is typically cast as a condition that originates and resides *within* the person, apart from anything in her wider social context. It is therefore much less evident that our understandings of and responses to depression should attend to social realities such as sexism, racism, poverty, transphobia, and homophobia. The same can be said for myriad other mental health conditions, from schizophrenia to anxiety to borderline personality disorder, also theorized as conditions that reside *within* the individual apart from her social world.

There is evidence, however, that social realities *do* contribute to, compound, and shape depressive experience and many of the other mental health conditions that tend to be thought of as maladies of the self-contained, individual "mind." My own interest in feminist psychology has introduced me to decades of empirical research connecting depression to poverty and patriarchy, for example.[18] But,

---

[15] See Coblentz, *Dust in the Blood*, 24–28.

[16] Warren Kinghorn, *Wayfaring: A Christian Response to Mental Health Care* (Grand Rapids, MI: Eerdmans, 2024), 83–86, 90–95.

[17] Kinghorn, *Wayfaring*, 48–49.

[18] See, for example, Dana Crowley Jack, *Silencing the Self: Women and Depression* (Cambridge, MA: Harvard University Press, 1993); Dana Crowley Jack and Alisha Ali, eds., *Silencing the Self Across Cultures: Depression and Gender in the Social World* (New York: Oxford University Press, 2010); Michelle N. Lafrance, *Women and Depression: Recovery and Resistance* (New York: Routledge, 2009); Janet M. Stoppard, *Understanding Depression: Feminist Social Constructionist Approaches* (New York: Routledge, 2000); Janet M. Stoppard and Linda M. McMullen, eds.,

as Kinghorn suggests, such theories and treatments have been overshadowed in the West by the modern, individualist biomedical milieu.[19] Reclaiming the social dimensions of depression and many other mental health conditions is thus a needed corrective.

To this end, I argue in *Dust in the Blood* that, especially among onlookers to depressive suffering, our willingness to suspend theodical questions about why God is causing or permitting depression can position us to investigate the interpersonal and social factors that cause or magnify the depressive suffering in our midst.[20] Letting go of theological justifications for the suffering of others can free us for another set of theological issues, such as matters of social sin. Edwards picks up on this with the proposed social ethic, which I welcome with enthusiasm.

Yet maintaining too stark an etiological contrast between trauma and conditions such as depression risks obscuring just how relevant Edwards's proposed social ethic can be for theologizing psychological distress beyond trauma alone. Though, unlike trauma and moral injury, depression is not diagnostically defined or phenomenologically centered on an external cause, there is growing awareness across depression studies of how interpersonal, cultural, and social-structural realities contribute to, magnify, and condition experiences of depression, as I noted above. In this research, depression is social as well as personal, albeit differently than trauma.

Edwards's exhortation to "enfleshed counter-memory" positions theologians to invest more attention in the oft-neglected social dimensions of depression and other conditions. It can, furthermore, renew appreciation for theologians who have already begun to break out of the prevailing individualistic frameworks to analyze mental health struggles as both social and personal realities. Edwards lifts up the contextual, embodied, and wholistic approach to health long modeled by womanist theological approaches; the centrality of Delores Williams in *Dust in the Blood* will make it no surprise that I see womanist scholarship as essential to the ongoing work of theologizing mental health.[21] Also reflecting the orientation of

Situating Sadness: Women and Depression in Social Context (New York: New York University Press, 2003).

[19] Kinghorn, *Wayfaring*, passim.

[20] Coblentz, *Dust in the Blood*, 203–217.

[21] Adding to the sources already cited by Edwards, see Christena Cleveland, *God Is a Black Woman* (San Francisco: Amistad, 2022); Monica Coleman, *Bipolar Faith: A Black Woman's Journey with Depression and Faith* (Minneapolis, MN: Fortress, 2016); Monica Coleman, *Not Alone: Reflections on Faith and Depression* (Culver City, CA: Inner Prizes, 2012); Phillis Isabella Sheppard, *Tilling Sacred Grounds: Interiority, Black Women, and Religious Experience* (Lanham, MD: Lexington, 2022); Phillis Isabella Sheppard, *Self, Culture, and Others in Womanist Practical*

"enfleshment" that "honors the bodily reality of mental health, placing our complex, literal flesh as a central connection to each other and to God," Tasia Scrutton critiques the biological reductionism too often facilitated by biomedical approaches to depression; analyzing the autobiographical comic strip of depression sufferer Marjane Satrapi, she demonstrates what we miss about depression when we fail to attend to the social and interpersonal realities of enfleshment in addition to the biological.[22] Exemplifying a willingness to embrace "counter"-cultural approaches to healing—to "accompany each other in a vision of transformation that is not limited by earthly systems"—John Swinton's study of voice hearing challenges readers to consider the positive theological significance of some voices and the potential losses accrued by experients when these voices are "cured" in accordance with prevailing conceptions of "mental health" in the West.[23] Elizabeth Antus's call to rightly remember the suicide dead for the sake of destigmatizing suicide and recognizing their inherent belovedness and dignity models ethical memorialization that "surges forward into praxis, 'not an account of what *has been done,* but of what *needs to be done*.'"[24] Edwards's social ethic gives us more reason to appreciate these and other socially attentive theologies of mental health and to bring them together in service of robust and accurate portraits of psychological distress and social responses to these conditions.

The juxtaposition of the essays from Edwards and Yanko is also instructive for considering how differences among psychological states may at times necessitate different social responses from theologians and our churches. As with Edwards's characterization of trauma, Yanko's portrait of moral injury shows it to be a personal experience with a social-political dimension. It is a "political wound" that results from situations of social constraint wherein a contradiction emerges between one's moral convictions, on the one hand, and one's chosen actions under the direction of an outside authority, on the other. This brings about kind of "moral fracturing"—a fracturing of one's moral self-identity. The sufferer is left struggling with guilt and shame about her own sense of moral complicity and a "loss of capacity for social trust." In another point of similarity with trauma, Yanko argues that recovery from moral injury—this political wound—must entail

---

Theology (New York: Palgrave Macmillan, 2011); and Chanequa Walker-Barnes, *Too Heavy a Yoke: Black Women and the Burden of Strength* (Eugene, OR: Cascade, 2014).

[22] Tasia Scrutton, *Christianity and Depression: Interpretation, Meaning, and the Shaping of Experience* (London: SCM, 2020), 89–113.

[23] John Swinton, *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges* (Grand Rapids, MI: Eerdmans, 2020), 119–161.

[24] Antus, "'The Silence of the Dead.'"

social remedies. And yet, whereas Edwards's paper emphasizes the work of justice as a necessary component of trauma recovery, treatment for moral injury often centers on group therapy.[25]

These divergent social responses to the respective social wounds of trauma and moral injury beckon reflection: To what extent do these social responses reflect differences in the social dimensions of these conditions? Might moral injury incite or even demand a social ethic of justice, too? Conversely, what is the relationship between the interpersonal healing that unfolds in group therapy and the justice work of enfleshed counter-memory in context of traumas? This last question is already alive in the wider field of trauma studies, as evinced by the latest book from renowned clinician and theorist Judith Herman.[26] As theologians continue to engage mental health challenges as social realities in need of social responses, we must continue to reflect on the kinds of social responses in order. While I exhort all theologians of mental health to take up this task, the concerns of moral theology and ethics may position scholars in these areas to lead this discernment.

LESSON 4: WE NEED TO CONTEND WITH THE SOCIAL, COGNITIVE, AND MORAL CONSTRAINTS THAT ACCOMPANY PSYCHOLOGICAL DISTRESS

Yanko's essay shows that mental health struggles are not the only human realities that have fallen prey to decontextualization in academic discourse. Her analysis of moral injury puts into relief the social dimensions of conscience, which have been lost in "self-serving" accounts of the conscience and their caricatures. Moral injury also exposes the dangers of legalism—a concern that contributed to the development of contemporary theologies of conscience, as Yanko recounts—for obedience to external authority is often a source of moral injury itself. These external realities result in the fragmentation of one's moral identity, "injuring" one's exercise of conscience.

While Yanko uses the experience of moral injury to intervene in debates about the law-conscience binary, it is notable that other mental health conditions entail analogous experiences of cognitive and social constraint that affect one's moral agency and discernment. Examples from other conditions evince the importance of Yanko's intervention

[25] Yanko's previous engagement with Jonathan Shay introduced me to this therapeutic difference. See Catherine Yanko, "Moral Injury and the Role of Community in Conscience Formation," paper presentation, College Theology Society annual convention, Denver, CO, June 1, 2024.

[26] Judith Herman, *Truth and Repair: How Trauma Survivors Envision Justice* (New York: Basic Books, 2023).

and the inadequacy of the anthropology underpinning these reductive views of conscience that "isolate human persons and their moral judgments from each other."[27]

Supporting Yanko's critique of overly individualistic portraits of conscience is Michael-Paul Cartledge II's discussion of the cognitive constraints that often accompany depression, for example. "Both cognitive psychological accounts of depression and first-hand narratives confirm that depression can often limit one's capacity to believe the clear presentation of 'truth,'" explains Cartledge.[28] "Realistic and rational thoughts become transient, and any attempt to modify the distorted beliefs, even with clear evidence, is met with resistance. At worst, depression leads a person to view herself as worthless and nothing more than a burden."[29] These observations lead Cartledge to interrogate right belief as the goal of Christian education, an aim that not only places depression sufferers at a troubling disadvantage but also advances what he deems to be a flawed view of sanctification that places undo onus on the individual for her transformation in Christ.[30] Applying insights from his analysis to the law-conscience binary bolsters Yanko's argument, for depression, like moral injury, can limit one's personal resources for exercising conscience: depression, like moral injury, can entail cognitive constraints that affect one's capacity for right belief, including those that contribute to moral discernment. Even if the constraints of depression are not so obviously "external" to the person, depression's cognitive constraints, like those of moral injury, are beyond the immediate control of the person.[31] Rather than blaming those experiencing cognitive constraint for their impaired consciences (Yanko) or heterodox beliefs (Cartledge), both scholars invite us to interrogate the anthropological assumptions that underpin our theologies and call for their revision.[32]

---

[27] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 72.

[28] Michael Paul Cartledge II, "Belief Through the Darkness: The Vicarious Humanity of Christ as a Theological Framework for Educational Ministry Amid Depression," *Journal of Disability & Religion* 28, no. 2 (2022): 101, doi.org/10.1080/23312521.2022.2097152.

[29] Cartledge, "Belief Through the Darkness," 100.

[30] Cartledge, "Belief Through the Darkness," 101–107.

[31] While acknowledging the distinctions between depression and moral injury, I also reiterate that social and cultural constructions inform our perception that depression is "inside" a person, whereas trauma and moral injury are conditions that originate "outside" a person. Insofar as we are relational creatures with inseparable biological, relational, social, and spiritual dimensions, what is "within" and "outside" us can be distinguished but not separated. See Kinghorn, *Wayfaring*, passim.

[32] For more on the cognitive constraints of depression, including a discussion of the importance of recognizing the agency that often emerges as a crucial dimension of

Meanwhile, aligning with the other pole of the law-conscience binary will not resolve the complexities that mental health challenges pose to our moral theologies. Research on suicidal ideation supports Yanko's resistance to this binary by troubling a singular reliance on the law as an alternative guide for moral discernment, especially in situations where conscience is hindered by cognitive constraint. Listening to the experiences of nine LGBTQ+ Christians who survived suicide attempts, Cody Sanders observes how church doctrines and more subtle, informal theological messaging contributed to their experiences of suicidality. As in instances of moral injury, Sanders's analysis shows how external authority—here, church "law" regarding gender and sexuality—can contribute to suicidal ideation and the cognitive constraints that constitute it—constraints that can impinge upon the suicidal person's moral discernment.[33] Put simply, the law can contribute to the cognitive constraints that hinder conscience. We can see, therefore, how fraught it can be to respond to the cognitive constraints of suicidality by encouraging the suicidal person to rely on church teachings to guide their moral discernment.[34]

Admittedly, our attention to experiences of moral constraint amid these conditions and their consequent effects on moral discernment and agency could backfire: The moral impairments of moral injury, depression, and suicidal ideation could be coopted as more reason to question the morality of people with these conditions, especially in a context of mental health stigma. Already, terms like "crazy" and "insane" are often used synonymously with charges of "immorality," as is evident in some public responses to the racist, misogynistic, and xenophobic rhetoric of Donald Trump's US presidential campaigns.[35] Framing moral injury as a "wound" to conscience or emphasizing the impairments to moral agency that accompany depression and suicidality could feed into the stigmatizing trope that mentally ill

---

survival (what I term "small agency"), see Coblentz, *Dust in the Blood*, 38–48, 189–192.

[33] Cody J. Sanders, *Christianity, LGBTQ Suicide, and the Souls of Queer Folk* (Lanham, MD: Lexington, 2020). For more on the "cognitive constriction" that characterizes suicidality, see Antus, "'The Silence of the Dead,'" 402–403; Joiner, *Myths About Suicide*, 45–47; and Edwin S. Schneidman, *The Suicidal Mind*, revised edition (New York: Oxford University Press, 1998), 51–66, 133–134.

[34] To be clear, neither Sanders nor I are suggesting that church teaching is an absolutely unhelpful moral reference for people in general or suicidal people in particular. The point is that some appeals to the "law" as moral guide overlook the damage that also sometimes results from some church teaching or its application.

[35] Patrick Kennedy, "Stop Calling Trump 'Crazy.' It Demeans People with Mental Illness," *Washington Post* (August 8, 2016), www.washingtonpost.com/posteverything/wp/2016/08/08/stop-calling-trump-crazy/; David M. Perry, "Stop Calling Trump Crazy," *CNN* (August 4, 2016), www.cnn.com/2016/08/04/opinions/stop-calling-trump-crazy-perry/index.html.

people are morally incompetent and thus *immoral* people—people incapable of responsible moral discernment and decision making. This, of course, need not be the case. But its possibility poses a challenge to theologians: how do we speak honestly about the complex constraints at play in moral injury and other mental health conditions while resisting this stigma?

Emphasizing a distinction between diminished moral agency, on the one hand, and immoral agency, on the other, could assist in this task. Such a distinction rejects the Western norm of the ever-agentive, autonomous self—the very same anthropology that bolsters individualistic views of mental illness as well as the self-contained conscience. Yanko calls to acknowledge constraints beyond the control of the individual herself—whether the "external" social constraints that produce moral injury and contribute to suicidality, or the cognitive constraints of depression (which are not disconnected from the social as well!). By moving us beyond this idol of the self for the sake of conscience, she also provides valuable tools for avoiding this trap of mental health stigma. Thus, to the benefit of all, we will heed her call to hold our moral theological reflection accountable to those who attest to the moral constraint that results from various kinds of cognitive and social factors.

LESSON 5: LISTENING TO EXPERIENCES OF PSYCHOLOGICAL DISTRESS REQUIRES RECKONING WITH EPISTEMIC INJUSTICE

Adding to the appeal of first-person narratives and phenomenology that informed my previous research on depression, Yanko's essay convinces me that the ongoing work of theologizing psychological distress must include first-person narrative and phenomenology in addition to—if not more than—the "thin" descriptions that dominate the psychological sciences and psychiatric medicine. Her thick description of moral injury concretely demonstrates the inadequacies of theologies built on thin accounts of human experience.[36] In doing so, she shows that thin descriptions leave us ill equipped not only to address psychological struggles such as moral injury but also to generate relevant theologies that pertain to a much wider range of human realities, including conscience.

Importantly, too, theology's incorporation of first-person narratives, or testimonies, has potential not only to enrich our

[36] Yanko, with other scholars, uses the language of "thick" description to refer to first-person narratives and phenomenologies of human experience. This is often contrasted with "thin" descriptions that, in the words of John Swinton, provide "the minimum amount of information necessary to describe a situation and context" (Swinton, *Finding Jesus in the Storm*, 14).

scholarship but also to support the experients who offer them. As Edwards notes regarding contexts of trauma, "One practice that can create as well as demonstrate resilience is testimony. Naming the suffering as it is felt by the person is shown to have lasting positive impacts. Rather than allowing systems, be they medical, juridical, or theological, to impose outside meaning on suffering, the sufferer should be encouraged to define their own story."[37]

Some challenges will accompany greater engagement with first-person narrative and phenomenologies in our theological work, however. John Swinton identifies one such challenge in his turn to phenomenology, noting that a great deal of listening time is required for generating thick descriptions of mental health. This is the case whether one is collecting first-person narratives by listening to experients in real time or gathering disparate narratives and phenomenologies from previously published sources. For a description of moral injury, trauma, or depression, relying on a dictionary definition or diagnostic manual is far more efficient.

Yet even with the will and the time, theologians face another challenge in actualizing Yanko's call to engage first-person narratives and phenomenologies, this one concerning the prejudices and conceptual resources that result in what philosophers call epistemic injustice. Philosopher Miranda Fricker first theorized epistemic injustice as a form of social injustice in which someone is harmed in their capacity as a knower.[38] Her original analysis focused on two central features of this injustice. First, testimonial injustice arises when "prejudice causes a hearer to deflate the credibility of a speaker's word."[39] This deflation of creditability results from social bias. A woman visibly upset as she recounts a transgression against her may be discredited by listeners who, consciously or unconsciously, filter her testimony through the stereotype that women are overly emotional and therefore less reasonable and reliable narrators. She may be unjustly discredited by her hearers as a result.

Often serving as an underlying context for testimonial injustice, hermeneutical injustice is the second dimension of epistemic injustice. Hermeneutical injustice occurs when "a gap in collective interpretative resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences."[40] Fricker famously uses the history of sexual harassment to illustrate this phenomenon.[41] The

---

[37] Edwards, "Christian Ethics, Trauma, and *Dust in the Blood*," 79.
[38] Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (New York: Oxford University Press, 2007), 20.
[39] Fricker, *Epistemic Injustice*, 1.
[40] Fricker, *Epistemic Injustice*, 1.
[41] Fricker, *Epistemic Injustice*, 149–152.

experience of what we today call "sexual harassment" occurred and often troubled victims, some of whom attempted to communicate about it long before the term "sexual harassment" was developed, widely known, or codified into US law. Yet because there was no collective concept of "sexual harassment"—due in part to the systemic marginalization of women in public life—these victims unjustly lacked the hermeneutical resources necessary to understand and effectively communicate about the experience. Returning to the aforementioned example, the woman visibly upset as she recounts a transgression against her may be unjustly harmed as a knower because of social stereotypes that call into question her knowledge and judgement (testimonial injustice) *and* also because she is speaking about a kind of transgression—say, sexual harassment—in a context where there was no such language or concept shared among herself and those to whom she is speaking (hermeneutical injustice).

These and other features of epistemic injustice reveal the social politics of knowing—of speaking and being understood. Dedicating our good will and time to hearing first-person narratives and phenomenological accounts of experience will not ensure that we escape testimonial and hermeneutical injustices, for these realities result primarily from collective ideologies and structures that shape our personal encounters with others' experiences, interpretations, and truth claims. While a wide range of social prejudices engender testimonial injustice and an array of experiences lack adequate recognition and theorization, resulting in hermeneutical injustice, this roundtable's focus on psychological distress compels me to emphasize the need to attend to the epistemic injustice often experienced by those with mental health challenges: if we are going to properly revere their credibility as knowers, then we need to heed and resist the epistemic injustice so often encountered by those of us who live with mental illness.[42]

Karen Newbigging and Julie Ridley warn that "people experiencing mental distress are particularly vulnerable to epistemic injustices as a consequence of deeply embedded social stigma resulting in *a priori* assumptions of irrationality and unreliability such

[42] Note that because people do not exist in a vacuum, the epistemic injustice faced by those experiencing psychological distress often intersects with other forms of epistemic injustice. For example, I discuss how gender, race, class, and mental-health biases coalesced to engender the epistemic injustice faced by Naomi Gaines in "'She Keeps Shouting After Us' (Mt. 15:23): Contextualizing Mental Illness, Restoring Epistemic Credibility, Expanding Care," in *Oxford Handbook on Theological Bioethics*, ed. Warren Kinghorn, John Berkman, and Robyn Elizabeth Boeré (New York: Oxford University Press), forthcoming.

that their knowledge is often discounted and downgraded."[43] Meanwhile, modern mental healthcare contexts often invest healthcare providers with epistemic privilege that disadvantages patients as knowers. "This privilege is accorded by virtue of their training, expertise, or third-person psychology, such that they occupy the epistemically privileged role of assessing which testimonies and interpretations to act upon, as well as deciding what sorts of testimonies to receive, from whom, what form they can take, and so on," explain philosophers Havi Carel and Ian James Kidd.[44] As such, when a person's first-person narration and interpretation of depression or trauma conflicts with the psychological establishment, social prejudice already disposes hearers to discredit the mentally ill person in favor of her clinician's take. This bias will incline our hearing regardless of the content of the sufferer's testimony.

Bringing first-person narratives and phenomenologies of psychological distress into our theologies will help to affirm the epistemic credibility of those with these conditions. It may also help the church develop hermeneutical resources for talking about psychological distress that our communities currently lack to the unjust disadvantage of experients. This is, in essence, what I attempted to do by centering first-person narratives and phenomenologies of depression in *Dust in the Blood*. Still relatively unfamiliar with the scholarship of epistemic injustice at the time, however, I did not theorize this methodological move with the tools of this philosophical discourse.[45] I am convinced that those of us who strive to center the voices of experients in our theologies henceforth will be better for thinking more with epistemic justice and the socio-political valence it brings to this methodological move, as some theologians of mental health have already begun to demonstrate.[46] We need, for instance, to anticipate and resist the social prejudices that we, as socially imbedded

---

[43] Karen Newbigging and Julie Ridley, "Epistemic Struggles: The Role of Advocacy in Promoting Epistemic Justice and Rights in Mental Health," *Social Science and Medicine* 219 (2018): 36.

[44] Havi Carel and Ian James Kidd, "Epistemic Injustice in Healthcare: A Philosophical Analysis," *Medicine, Health Care, and Philosophy* 17, no. 4 (April 17, 2014): 534–535.

[45] I am indebted to Erin Kidd, whose work on feminist theology and epistemic injustice inspired my interest in this area of feminist philosophy and demonstrates its importance for and beyond theologies of psychological distress. See Erin Kidd, "A Feminist Theology of Testimony," *Theological Studies* 83, no. 3 (2022): 424–442, doi.org/10.1177/00405639221117237.

[46] See Christopher Cook, *Hearing Spiritual Voices: Medieval Mystics, Meaning, and Psychiatry* (London: T&T Clark, 2023), 101–110; Swinton, *Finding Jesus in the Storm*, 145–147, 176, 180–181; Anastasia Philippa Scrutton, "Epistemic Injustice and Mental Illness," *The Routledge Handbook of Epistemic Injustice*, ed. Ian James Kidd, José Medina, Gaile Pohlhaus, Jr. (New York: Routledge, 2017), 347–355.

theologians, are already disposed to bring to the testimonies of the mentally ill. Those of us who live with these conditions are not exempt from these biases. Yanko's essay suggests that if we ignore the rich portraits of human experience advanced in first-person narratives in phenomenology—or, as I note here, if we incorporate these accounts of experience without adequately contending with epistemic injustice—our theologies will suffer for lack of the knowledge brought forth by those living with psychological distress.

LESSON 6: WE SHOULD CONSIDER THE PLACE OF CHRIST IN THEOLOGIZING PSYCHOLOGICAL DISTRESS

I opened this essay by recounting my motivating conviction about the need for theologies of depression such as the one I advance in *Dust in the Blood*. I conclude this essay by raising a related question, one apropos of this roundtable and one that continues to preoccupy and inspire my theological work: What can Christian theology bring to our understandings of and responses to psychological distress? Behind this question is the recognition that, with the expansion of mental health discourse, awareness, and resources in recent years, those in the church, academy, and wider world can turn to any number of sources *other than* Christian theology to address this dimension of human experience. Perhaps identifying the distinct potential of Christian theology will help theologians focus our efforts and articulate to various publics theology's potential for enriching our lives together. On the one hand, the aforementioned lessons from Edwards and Yanko already prove the generativity of theologies of psychological distress; there is much on offer in these two essays alone. On the other hand, there is much more theological work on psychological distress that remains to be done, as I have also tried to demonstrate here. Pondering what Christian theology, in particular, can bring to the diversity of mental health struggles in our midst may help us move forward intentionally and effectively.

The revelation of Jesus Christ is one place to begin an articulation of Christian theology's potential for a distinct contribution. Yet I am struck by the fact that in the essays from Yanko and Edwards as well as in my own book, *Dust in the Blood*, there is relatively little explicit engagement with the person of Christ. This presents an opportunity to build on and expand our theologies of psychological distress further. Hence, in the remainder of my response, I consider how Christ can enrich our shared theological endeavor.

Mindful that the absence of explicit discussions of Christ need not mean that Christ is wholly absent from this roundtable and other theological texts that focus on different figures and sources, we can already recognize in the essays from Edwards and Yanko an

incarnational sensibility that informs their affirmation of the body as sacred and that recognizes its struggles against sin and suffering to be of upmost concern to God and God's followers. On this, M. Shawn Copeland's contemporary classic *Enfleshing Freedom* reminds us that the life, death, and resurrection of Christ reveals that bodies matter—especially suffering, marginalized bodies. She shows that taking suffering bodies seriously—in their pain and their freedom—necessarily follows from the revelation of Christ, who enfleshed God's love and concern for bodies in his word and action and in so doing modeled it for all who follow him.[47] Copeland's work provides a Christological buttress for the centrality of the body in the ethic of "enfleshed counter-memory" that Edwards extends to theologies of psychological distress and for the methodological centrality of embodied experience that Yanko elucidates from *Dust in the Blood* and applies to debates about the law-conscience binary.

Considering the revelation of Jesus in the Scriptures is another means by which we can further elucidate the significance of Christ for mental health challenges. Several readers of *Dust in the Blood* have invited me to reflect more on how Jesus's wilderness experiences might enrich the interpretation of depression as a wilderness experience that I advance in the book, and so I pass on this invitation to Edwards, Yanko, and our roundtable readers: How might the Jesus of Scripture enrich our theological reflections on psychological distress?

For instance, Yanko's essay proposes a view of conscience that is neither hyper-individualistic nor uncritically submissive to the law. Jesus of Nazareth was a figure who both revered the law and at times challenged it—in obedience to his own conscience, we might assume. In view of how experiences of moral injury expose the limits of our more reductive treatments of conscience, might some of the biblical stories of Jesus—his picking of grain on the Sabbath (Mark 2:23–28, Matthew 12:1–8, Luke 6:1–5) or healing of the man with the withered hand (Mark 3:1–6, Matthew 12:9–14, Luke 6:6–11), for example—help us develop Yanko's corrective, constructive vision of conscience?[48]

Could stories of Jesus likewise enrich the sketch of "enfleshed counter-memory" advanced by Edwards? No scene seems a more fitting place to start than the Last Supper (Mark 14:12–25, Matthew 26:17–30, Luke 22:7–38), when Jesus and his disciples memorialized the Passover, a memory of past suffering and salvation that beckons God's continued call to participate in a praxis of liberation over and against worldly expectations and the status quo. "Like millions of

[47] M. Shawn Copeland, *Enfleshing Freedom: Body, Race, and Being* (Minneapolis, MN: Fortress, 2010).
[48] Thanks to Paul Schutz for suggesting these examples.

Jews before him and millions of Jews after him, in this ritual meal Jesus acknowledged, blessed, and praised God who, through mighty acts, chose, liberated, guided, protected, nourished, sustained, and ennobled a people," recounts Copeland.[49] Because this practice of counter-memory in Jesus's life emboldened him to continue to work for justice in the hours that followed, even to death, this Gospel scene should spur Christians to consider how our own commemorative enactment of this meal in the Eucharist—another ritual of "enfleshed counter-memory"?—likewise spurs us to justice, what Copeland terms "eucharistic solidarity."[50] Might reflection on Jesus's Last Supper and our ongoing practice of Eucharist enrich the understandings of enfleshed counter memory we bring to bear on theologies of psychological distress?

As we continue the work of theologizing psychological distress and articulating what theological reflection, in particular, can bring to understandings of and responses to the psychological distress in our lives and communities, I am grateful to be in this work together. That there are ideas from *Dust in the Blood* that ring true for the work of Yanko and Edwards and the communities of mental health sufferers with whom they think means that we sufferers and theologians of depression are not alone in pursuing God and struggling for the right words to communicate about the God who meets us in our experience—or does not. With gratitude for and inspiration from Yanko and Edwards, I conclude with hope for the theologies of psychological distress yet to come. Let us continue to do this work together.

Jessica Coblentz, PhD, is associate professor in the Department of Religious Studies and Theology and affiliate faculty in the Department of Gender and Women's Studies at Saint Mary's College in Notre Dame, Indiana. She is the author of *Dust in the Blood: A Theology of Life with Depression* (Liturgical Academic, 2022), and the co-editor of two volumes, *The Human in a Dehumanizing World: Reexamining Theological Anthropology and Its Implications* (Orbis, 2022) and *Women Responding to the Spirit: Selections from the Madeleva Lectures* (Paulist, 2025).

[49] Copeland, *Enfleshing Freedom*, 108.
[50] Copeland, *Enfleshing Freedom*, 124–128.