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Being Clinically Depressed: The Positive Effects of Gracious Christian Religion on Mental Health

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"So I breathe as deeply as possible, and I notice that sick is just a way to be Life didn't stop and no one fell off the earth rock 'cause sick happened to me."

Written by my sister Dora Dupree, musing about her recently diagnosed terminal illness, December, 2003 before her death on 8 January 2004.

Introduction

Once upon a time, I got sick. I began efforts to get well and simultaneously began efforts to discover the source of my dis-ease. Professionals determined that, even though I was experiencing physical symptoms, the source of my illness was clinical depression. As I experienced it, the depression was accompanied by anxiety

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(panic attacks), fatigue, and anorexia (loss of appetite) with accompanying weight loss. If I did not have to be at work or at church, I stayed in the bed. I avoided social situations, spending time only with my children, grandchildren or my best friend. I started taking the prescribed selective serotonin reuptake inhibitor antidepressant, and started therapy with a mental health professional. I also sought prayer support from fellow Christians. The support included what can only be called miserable comforting.

I was told that I needed to claim my healing. I was given scriptures and instructed to confess them as if I were taking a medication. One friend shared that she had a word from God for me, which was that God did not want me to take medication for depression. I was told to figure out how I had let the devil get in. I was told that my life was perfect, and that I had no reason to be depressed. Unfortunately, my experiences are not unique and are not an isolated incidence (see e.g., (Hilfiker 2002); (Fallot, New Directions for Mental Health Services 1998); (Stanford 2007). Stanford reported these and other responses to congregants with a mental illness. His study found that people were abandoned by the church, some were told by their church that they did not have a mental disorder or were told the mental disorder was a result of demonic activity, personal sin or a lack of faith. In this paper, I will discuss additional personal observations of interactions of Christian church members with fellow members who have a mental illness. I posit some explanations for common Christian responses to the mentally ill and suggest ways that mentally ill Christians, as well as others with mental illness, can be helped rather than harmed while living with a mental illness. This paper will not re-hash the well-documented problems of research (spirituality versus religiosity; religious/spiritual practice versus 'awareness'; psychometric measurement of an abstract phenomena). I use the terms mental illness and mental disorders as defined by the Department and Health and Human Services (DHHS):

> Mental illness is the term that refers collectively to all diagnosable mental disorders. ((DHHS) 1999)

Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination

thereof) associated with distress and/or impaired functioning (DHHS, 1999).

In thinking and writing about how Christians might respond mercifully to those with mental health care needs, I have situated myself as a member of that group, locating myself more as a teller or as a witness. However, I am also a member of the group 'Christians,' and consider myself as one who needs to give attention to others with a mental illness or disorder. Those of us with diagnoses of mental illness/disorder or those with a mental health care need to tell, to testify. Often, our words are not taken seriously. The language, "being a witness" or "testifying" is commonly used in a religious context. (Taylor 1998) wrote, "To testify is often as expressive act of resistance against larger social forces of oppression. It is a way to assert one's agency and to reclaim one's humanity." Indeed, that is a need of those with mental illness or disorder, who are oppressed by society's stigmatization and bias. My underlying assumption, arrived at though personal experience and my observations as a health care professional, is that there is a lack of value-free mental health care, including within the Christian church. My plea is for beneficence and mercy, not separative pity in relating to those with mental illness.

A. What Is Mental Illness?

Long before I was diagnosed with clinical depression, I took a quiz to determine my personality type, with the results showing me to have a melancholic personality. I took this quiz at church, and the results were just as acceptable as having a choleric, sanguine, or phlegmatic personality, which are the other three types that this quiz purportedly revealed. The purpose of assessing the personality types of church members was to assist us in getting to know ourselves and how we relate to others, with the end result being that we could be more appropriately placed in a ministry. A melancholy personality type is not seen as emanating from evil, but a diagnosis of depression is judged to have an evil source. Melancholy seems to be no longer acceptable (Watts 1997); (Yang 2007), as one who is melancholy is not demonstrating the 'joy of the Lord.' What was once a personality type is now a condition that should be medicated. Everyone has to be happy. Not only are personality types medicated, but normal life events result in medication. I have witnessed family members being medicated by their physicians with anti-depressants following the

death of a close family member. This is reported in the literature, and is called the medicalization of life (Aho 2010). As long as this medicalization occurs in the absence of a psychiatric diagnosis, it seems the church has no problem. In other words, there seems to be no negative response to the general use of medication. It is the medication for a diagnosed mental illness or disorder that causes discomfort.

Now, those with a melancholic personality type can get medication to help them feel 'normal.' Television advertisements instruct watchers to request prescriptions medications for sadness or discomfort in social situations. There is a lack of clarity regarding acceptable variation in expressions of personality, as well as confusion regarding what should or should not be considered a physical illness. Consider this: The brain is an organ. However, if there is a problem with the brain (not seizures or a tumor, for example), the label mental illness or mental disorder is applied, as opposed to brain illness or brain disorder. Unlike a disease of, for example, the liver, kidney or heart, one supposedly has control over the brain, such that no illness should occur. Hilfiker (2002) also described this, explaining that there is a belief that spirituality or the presence of God in one's life is a protection from a mental illness. This idea, even if subconscious, causes those with a mental illness to be judged as lacking in faith, or as having sin. The DHHS (1999) addressed this thusly:

> Mind and Body are Inseparable. Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that "mental health" or "mental illness" is unrelated to "physical health" or "physical illness." In fact, the two are inseparable (p. 5).

Brain failure has been differentiated from mind failure (Orr, Ethical Issues in Mind Failure, 2009) (Orr, Ethical issues in brain failure, 2009). Orr described brain failure in terms of conditions that can be assessed with physiologic measurement tools, and mind failure as a functional problem that has a non-physiologic cause. He acknowledged that in the future, this differentiation may cease, due to progress in determination of neurological causes of mental illness.

The problem of differentiation of mind and spirit is a source of confusion as well. Sometimes, a strong mind is thought to be

necessary to control the body, and a strong (well connected to God) spirit necessary to control the mind. So, the conclusion is that depression was the result of my inability to control my mind, which was obviously the result of a weak spirit. One can see how this cascade of blame assignment is not helpful to one who is already sick. In Christendom, we do not know what to do with the idea that sickness (especially mental illness) might happen because of fate, or because of genetics, or because of a greater Meaning that we cannot know. Fullerton (2007) actually defined mental illness as a crisis of meaning that requires mercy even more than does a physical or organic illness. We pray for and demand healing as a promise from God and a right assured us by scriptures. If healing happens, it is because of the goodness of God. If healing does not take place, the cause is a lack of faith.

Confusion in terminology is manifested by interchangeable use of the terms emotional and mental. For example, I have heard the terms emotionally needy, emotionally unstable, mentally unstable, or behaviorally inappropriate each used to describe the same observed actions of an individual. Mental illness is a temporary condition of one's existence, not an identity descriptor (Baskin 2007) . In our Christian church society, and in society as a whole, individuals with mental illness or disorder are defined by the illness. Once a person has been diagnosed with a mental illness, her behaviors and words are always suspect.

B. The Church's Role

Oddly enough, it may be church life itself that causes depression. Cohen wrote (Summer 1993):

> In my own research on the born-agains, I found out that behind their façade of euphoric calm, people marinated in the Bible and surrounded by the born-again church subculture tend to be depressed, and suffer from a sort of generalized emotional distress partaking of anxiety, worry, and fear. The way that Bible indoctrination brings about depression is complex. To put it in the smallest possible nutshell: For the prescribed prayer and devotions to achieve their intended altered state of mind, much effort must be expended to suppress thoughts and feelings considered inappropriate for a saved person. Pro-social or neutral interests and desires that conflict with the religious agenda come to arouse as much guilt as genuinely anti-social ones for the Bible-believer. By thwarting the normal process of valuing people and things—of making emotional investments in them—by laboring to constitute an imaginary and fictitious being as the primary recipient of his or her affections—the Bible-

> believer makes himself or herself depressed. Being constantly at war with one's natural and normal emotions wears a person out.

Additional self-doubt and depression comes from unanswered prayers. I said to myself, if I am a believer and I have prayed to be healed (or even just to *feel* better!), why am I still depressed? Being told by other believers to confess healing from depression until it manifested was actually counterproductive in my experience. I felt as if I were doing something wrong, because my physical sensations did not change. Additionally, at my sickest, I lacked the physical and mental energy necessary for the cognitive work of confessing. I never felt, however, that I had been abandoned by God.

People with a mental illness are especially in need of mercy because, according to the World Health Organization (Funk, et al. 2010) report, they experience "…stigma and discrimination; violence and abuse; restrictions in exercising civil and political rights; exclusion from participating fully in society; reduced access to health and social services; reduced access to emergency relief services; lack of educational opportunities; exclusion from income generation and employment opportunities and increased disability and premature death" (p. 8). Those with mental illness are stigmatized by society, evidenced by restrictions on public service or elected office, child custody, ability to rent residences, and restricted employment opportunities (Yangarber-Hicks 2004); (Overton and Medina 2008); (Bathje and Pryor 2011). This institutional bias leads to a cycle self-doubt, decreased self-esteem, self-stigmatization, and reluctance to seek treatment. I told my immediate supervisor (also a doctorally educated nurse) at my job of my new diagnosis of clinical depression, as I was fatigued, dealing with the side effects of medications, and panicky prior to going into the large lecture hall classes that were my teaching assignment. I was fearful that my behavior changes might be observable to others and might be misunderstood. Though she was compassionate, her first response was to ask me if I was suicidal, and if I was considering hurting myself (even though I was already on medication and in therapy). This reflects one of the stigmas and fears that people have regarding people with a mental illness or disorder. Knowing that I was viewed as someone that could possible commit suicide further decreased my self-esteem and added to the self-stigmatization about my behaviors.

This cycle becomes more complicated by the personal losses caused by mental illness and the accompanying stigma. People may lose self-identity, respect from others, cognitive abilities, relationships, and future opportunities (Fullerton 2007); (Baker, Procter and Gibbons 2009). Those in the Christian church may experience additional suffering from these losses. For example, a person previously respected as one who could 'hear from God' may now be judged as unreliable. Spiritual events that are accepted-or even expected as signs of spiritual growth-are dismissed if it is known that the person experiencing them has a mental disorder. For example, a prophetic word from one with a mental disorder might be dismissed as uninspired. A physical expression, such as dancing in the spirit or crying, may be judged as being emotional. Confusingly, a prophetic word or prayer given to one with a mental illness is expected to be understood. The rationale for this is understood as Spirit speaking to spirit. The spirit of the mentally ill person is expected to hear and understand. Also confusing is the assumption that persons with mental illness are particularly vulnerable to malevolent spirits. Thus, only a Christian therapist can be trusted, and rituals and symbols not common to the Judeo-Christian tradition are suspect. This limits the sources of help available to the ill person.

The fellowship with believers and church responsibilities that previously were a source of strength may be withheld. Admittedly, there is a need for balance, as some church work causes stress and has the potential to exacerbate extant coping difficulty. Disallowing participation is not the appropriate response. Isolation and alienation of the mentally ill person can cause an increase in the suffering that is already being experience, as well as an inability to make sense of or find meaning in the situation of being ill. (Aho 2010) described those with a psychiatric diagnosis as experiencing emotional suffering, and called for changes in treatment frameworks that will allow the mentally ill to make meaning of the suffering. Tellingly, Aho used the terms 'mental illness' and 'emotional suffering' interchangeably. Persons with mental illness may deepen their spirituality to assist them in coping with a mental illness or disorder and to help in recovery from such an illness (Hodge 2004); (Harris, Edlund and Larson 2006); (Fallot, Spirituality and religion in recovery: Some current issues 2007); (Lukoff 2007); (Stanford 2007); (Dein 2010).

C. Helpful Christian Responses

Christian mercy is based on the very foundation of Christianity-Love. I would posit that extending mercy to someone is the same as loving her. God sent His Son because of the love He had for humanity. That act was a merciful (read, "mercy-filled") deed. Christians become filled with that Love/Mercy upon accepting Jesus. Being a practicing, faith-filled Christian means to extend mercy/love out from oneself to others. A person acting from mercy basis will treat the 'other,' meaning here one who has been diagnosed with a brain disease, mental illness or mental disorder the same as anyone else would be treated. Appropriate mercy-filled responses to a person with a mental illness will not require that person's behavior to conform to fit the meta-narrative of the dominant Christian society, which expects constant happiness and (ill-defined) normative behaviors. The appropriate response will not disregard all of a mentally ill person's words, ideas, thoughts, requests, complaints or actions as invalid just because of a diagnosis applied by a psychiatrist or psychologist. In other words, we should not force a mentally ill person to become synonymous with her diagnosis, always expecting some manifestation of that part of her being. Just as a non-diagnosed person has many different facets to personality and behavior, the same is true of a diagnosed person. As my sister so brilliantly put it, "Sick is just another way to *be*" (Italics added).

A mercy-based response to a person with mental illness judges portions of one's own behavior as worthy of application of a label of mental disorder, at the very least in some cultures and at least some of the time. We say things like, "I am not myself today." That is a confession of something outside of normalcy. Generally, no one questions what that statement means. I never say it, because I don't know what it means. Similarly, something I do say might be questioned as well. That statement is, "I am out of sorts." Both of those statements could be indicative of a need for some mental health care, or could simply indicate a normal variation of a state of being.

A mercy-based response to one with mental illness is supportive of multifocal targets of healing, and doesn't demand healing without use of medications or therapy. Is also does not demand a sick person get saved or get exorcized. Mercy-based responses remember that, "…sick is just another way to be." There is no such thing as a

guaranteed constancy of stable thought, happiness, or health. There is inconstancy of health, being or any portions thereof. I previously described the awareness of the inconstancy of health shown by some while discussing end-of-life issues (Dupree 2000). Those discussants spoke of the potential of not being in one's right mind, and of not being 'at yourself.' Any of us, labeled Christian or not, can become 'mentally ill' at any moment.

Mercy based responses to the mentally ill could potentially alleviate some of the cautions expressed in discussions about religion and mental illness. There are warnings against over-involvement or excesses in ritual behaviors, dangers of becoming a cult-like follower, and of using religion as a strategy to avoid facing issues or to avoid treatment by health care professionals (Hodge 2004); (Fallot, Spirituality and religion in recovery: Some current issues 2007); (Dein 2010); (Stanford 2007) (Harris, Edlund and Larson 2006).

There is a common theme among people who have experienced a serious or life-threatening illness. This is a sense of a new-found sensitivity to what is really important, a clarity of awareness of surroundings, and/or a new sense of the spiritual nature of life. For those who have a serious mental illness or disorder, expressions such as these may lead health care professionals to make a diagnosis of hyper-religiosity, and fellow Christians may doubt the reality and validity of the meaning given to the illness. I believe that there is a self that one cannot know and will not know if one does not experience mental illness. That is, there are experiences that the mentally ill have that are unique in terms of reality perception. That does not mean that a mental disorder should be sought. It does mean that we should be respectful of and humbled by the reality accessible to those with a mental disorder but not to others. A mental illness, just like any other illness can be seen as an opportunity to 'build a testimony.' Christians can help in the construction of this testimony in some very simple, pragmatic but mercy-extending ways. We Christians should both tolerate and resist sickness and suffering. We can tolerate mental illness and disorders by acknowledging that we do not know what perfection is, or if it really exists. We cannot ever fully know the mind of God, and thus cannot know whether an illness has a meaning or a purpose. Psychology sometimes include God's omniscience and omnipresence as an essential theoretical component

(Helminiak 2010). This by no means implies that I think God inflicts illness for a learning experience. I do believe that if an illness comes, we should tolerate it as we seek healing, and as we stay aware of the purposes and divine appointments that are possible even in the processes of seeking healing. We should resist adding to the suffering of the mentally ill by blaming them for their illness, avoiding social contact with them, and questioning their status with God. We should tolerate mental illness by acknowledging that we may be the next one inflicted with a mental illness or disorder. We should tolerate mental illness by accepting that there is no biblical or sound theological support for demanding from a sovereign God that He does as we instruct.

There is much for us to learn and opportunities for us to grow in sharing in the suffering of another. Through my own experiences, I became aware of ways in which I was intolerant and lacking in mercy in realms other than illness care. I listen closely to not only the words but the heart of those who are pouring out complaints concerning their suffering. I carefully share in that suffering by patiently being with, caring for, caring about, and attending to the needs expressed. The most difficult task I have faced has been addressing my own suffering. As a prayer ministry team member, church elder, and single's pastor, I was accustomed to addressing the needs of others. I was the one who prayed, not the one who needed prayer. Coping with a diagnosis of clinical depression required that I humbly admit my need for help. When the church encounters a person with a mental illness or disorder requesting help, the response should not be over-spiritualization of the situation. If healing is expected, it should be expected no matter how long it takes. Until healing comes, the sick person is simply experiencing "… another way to be."

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