

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, in 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 (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 scriptural passages 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.¹ Matthew Stanford reported these and other responses to congregants with a mental illness.² 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 essay, I will discuss additional personal observations of the 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. I also 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 on mental health issues (spirituality versus religiosity; religious/spiritual practice versus 'awareness'; psychometric measurement of an abstract phenomena). For our purposes, 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. 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."*³

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 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. Janette Taylor writes, "To testify is often an 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."⁴ 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 through observations as a healthcare professional and personal experience, is that there is a lack of value-free

churches to the general use of medication. Medication for a diagnosed mental illness or disorder, however, appears to cause some uneasiness.

Now, those with a melancholic personality type can get medication to help them feel 'normal.' Television advertisements instruct watchers to request prescription 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 versus a mental 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 describes this as a belief that spirituality or the presence of God in one's life is a protection from a mental illness.⁸ This idea, even if subconscious, causes those with a mental illness to be judged as lacking in faith, or as having sin. DHHS addressed this idea of dualism 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.⁹

Brain failure has been differentiated from mind failure. For instance, Robert Orr describes 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.¹⁰ He acknowledges that in the future, this differentiation may cease, due to progress in determination of neurological causes

of mental illness. Thagard also discusses neurological bases of mental illness, emphasizing that neurological causation should not negate the exploration of psychological and social origins and treatment modalities.¹¹ Differentiating physical from mental illness is confusing and does not provide useful guides for treatment or social expressions of concern.¹²

The problem of differentiation of mind and spirit is a source of confusion as well. Depending upon one's conception of the constitutive parts of our theological anthropology, a strong mind is thought by some to be necessary to control the body, and a strong (well connected to God) spirit necessary to control the mind. So, the implication of such reasoning is that depression is the result of an inability to control the mind, which was obviously the result of a weak spirit. One can see how this cascade of blame assignment is not helpful to someone who is already sick. For many Christians, 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 actually defines mental illness as a crisis of meaning that requires mercy even more so than does a physical or organic illness.¹³ It has been my experience that in our churches we pray for and demand healing as a promise from God and a right assured us by Scripture. If healing happens, it is because of the goodness of God. If healing does not take place, the cause is a lack of faith. While such realities can be true, this grossly oversimplifies the biblical and theological complexity surrounding these issues, and quite likely may incorrectly assess the relationship of prayer, faith, healing, sickness and disease, not to mention the implications of the Fall and living between the redemption initiated in Christ and the eschatological perfection of all things, for the situation at hand.

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.¹⁴ In our churches, and in society as a whole, individuals with mental illness or disorder are all too often defined by the observable manifestations of their illness. Once a person has been diagnosed with a mental illness, her behaviors and words are always suspect.

The Church's Role

Oddly enough, it may be church life itself that can contribute to depression. Focus on doing "Christian things," such as prayer and devotional life, in the 'right way,' can trigger anxiety, worry, and fear. Social pressures to appear calm and peaceful can cause believers to conceal any underlying dis-ease. Compounding the situation, 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 counter-productive 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 a World Health Organization 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."¹⁵ 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.¹⁶ This systemic bias leads to a cycle of self-doubt, decreased self-esteem, self-stigmatization, and reluctance to seek treatment.

I shared at the time my recent diagnosis with my immediate supervisor (also a doctorally educated nurse), 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

“not taking their medications”. A client can’t be persistent in getting his needs met without being written off as being “manipulative.” A productive day becomes hypomania. A tired day means signs of depression.¹⁷

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.¹⁸ 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 or suspected of being psychotic. 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

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 experienced, as well as an inability to make sense of or find meaning in the situation of being ill. Kevin Aho describes those with a psychiatric diagnosis as experiencing emotional suffering, and calls for changes in treatment frameworks that will allow the mentally ill to make meaning of the suffering.¹⁹ Tellingly, Aho uses 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.²⁰

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. Appropriate mercy-filled responses to a person with a mental illness will not require that person’s behavior to conform to fit a pseudo-narrative commonly espoused under the guise of the Christian life in contemporary America, one 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

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I was viewed as someone that could possibly commit suicide further decreased my self-esteem and added to the self-stigmatization about my behaviors. Edmund Walker described this:

When we speak as if someone has a diagnosis or has a “mental illness” we are unwittingly *creating* a reality—a reality in which human beings are transformed into the “mentally ill”. . . . We know not what we do. By seeing the medical and psychological vocabularies as truths (as opposed to perspectives) we cannot see the profoundly destructive consequences of them. . . . Without a recovery focus pathologizing runs rampant: A client can’t be angry without being accused of

be dismissed as uninspired. 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,

of a diagnosed person.²¹ As my sister so brilliantly put it, “Sick is just another way to *be*.”

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 do not know what it means.) Similarly,

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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 does not demand healing without use of medications or therapy. It also does not demand a sick person get saved or get exorcized. Use of prescribed medications in combination with psychological and social treatments such as psychotherapy and stress reduction should be supported. Mercy-based responses remember that there is no such thing as a guaranteed constancy of stable thought, happiness, or health. There is inconstancy of health, being, or any portion thereof. Elsewhere, I previously described the awareness of the inconstancy of health shown by some while discussing end-of-life issues.²² Those discussants spoke of the potential of not being in one’s right mind, and of not being “at yourself.” Any of us, 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 health. 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 healthcare professionals.²³

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.²⁴ For those

who have a serious mental illness or disorder, expressions such as these may lead healthcare 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. We cannot ever fully know the mind of God, and thus cannot know whether an illness has a meaning or a purpose. 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 must do as we instruct.

There is much for us to learn and opportunity 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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CLERGY GUIDE TO BEGINNING A CONVERSATION WITH A MENTALLY ILL CONGREGANT

- Tell me what you would like me to be concerned about right now.
- Are there people here that you feel comfortable talking with you and praying with/for you about specific things? Who are they? Is it o.k. if I ask them to contact you?
- What do you call/how do you describe your illness?
- What has changed about your relationship with God/with the church/with me since you have been sick?
- How are you keeping your faith? How are you staying positive?
- When/at what times/what activities allow you to forget that you are sick?

CLERGY GUIDE TO INTERACTING WITH A MENTALLY ILL CONGREGANT

- Use these questions and statements to determine the preferred language/terminology of the sick person.
- Be careful that no burden is put on the person to report to the church or the pastor about progress.
- Conduct visitation or pastoral calls as routinely done with sick members.
- If operation of spiritual gifts (such as speaking in tongues, prophetic utterances, etc.) were a part of normal behavior before the illness, accept the continuation of the behavior. If such activities cease, do not criticize or assume a spiritual laxity.
- If actions such as singing, dancing, raising/waving hands were common behaviors prior to the illness, understand that a lack of energy may prevent the ill person from continuing those activities. If the actions continue, judge them no differently than before the illness.