Though the darkness hide thee: a study of depression and Christian spirituality

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The study of depression and its effect on Christian spirituality is sparse at best. This study seeks to integrate the disciplines of psychology and theology in order to better understand the effect depression has upon spirituality. A survey of literature, both recent and historic, sheds light on the hypothesis that depression causes spiritual distress. Particular emphasis is given to the writings of the Puritans, who were prolific on the subject. Original qualitative research involving the interviews of depressed subjects is presented. Implications for clinical treatment and suggestions for further research are put forth.

"Holy, holy, holy, though the darkness hide thee!" These words, song #100 in The Trinity Hymnal; sung by thousands of Christians since its penning by Reginald Heber in 1826; tell a story of darkness, of separation from God, that is absent in most modern Christian literature. Why, then, is this hymn still so beloved? Why is it still sung in so many American churches? What about its story is so timeless that it continues to be loved even centuries after its writing?

The answers to these questions lie at the intersection of psychology and Christian spirituality. Although the scientific study of Christian spirituality has, to date, been somewhat sparse, the research that does exist is robust and for the most part cohesive. Theology, on the other hand, has done its best to completely avoid discussing psychology, and those few theologians who have ventured close enough to touch it often do so only to condemn the discipline. When studying Christian spirituality, one can study it from a psychological standpoint or a theological standpoint, but not both.

Archibald Alexander, in his 1844 work Thoughts on Religious Experience, calls for someone to pen "a volume...on the subject of religious melancholy [spiritual depression], and such a volume is much needed, but it would be difficult to find a person qualified for the undertaking. We have some books written by pious casuists, and the subject is handled in medical treatises on insanity, but to do it justice, psychological knowledge must be combined with an accurate acquaintance with the experience of that
of Christians" (p. 42). Since 1844, so few Christians and scientists have responded to this call that many aspects of Christian spirituality continue to be ignored in psychological research.

This work seeks to fill in one of those gaps by answering the question, "what effect does depression have on Christian spirituality?" I am endeavoring, through a survey of the literature of both Christians and psychologists, to paint a picture of what it means to be a Christian who suffers from an episode of Major Depression or Major Depressive Disorder.

Definitions and Presuppositions

My foundational assumption is that depression, though it is biologically based, can nevertheless have non-biological symptoms. My stance is profoundly anti-dualist: my perspective is that the human is a complete organism, both organic and spiritual, and both substances are so intertwined as to make one substance, not two connected substances. Thus disordered brain chemistry can cause spiritual distress. I assume that this link exists, and my research is seeking to find this link.

I am also a Christian, which of necessity carries with it the assumptions that God is real and his presence may be felt, or even should be felt, by Christians; I also approach this research with the presupposition that historic Biblical Christianity is the only path that leads to God. Nevertheless, I contend that although this research focuses only on Christians, because I have chosen to focus on spirituality and not religious beliefs some of the conclusions can be generalized to other populations who are suffering spiritual distress. Indeed, therapists working with individuals afflicted with Major Depressive Disorder would do well to probe the spiritual symptomology that may be present.

Unlike the majority of the Christian community, however, I contend that the presence of spiritual distress is not always the result of the individual's sin or wrongdoing, that it may simply be a symptom of an overarching disease. Although sin may indeed produce guilt and spiritual distress in an individual, guilt and distress are not necessarily a sign of sin and may be present when no sin has been committed. Spirituality, as defined by K. J. Edwards, refers to "personal religious experience...the experienced reality of an affective relationship with a personal, caring God." This is differentiated from "the cognitive dimension of belief in a religious system or in doctrinal statements. The construct includes a sense of being heard, cared for and forgiven by God, as well as a sense of God's presence and of being saved." Thus, when I speak of spirituality, I am intending "individual, subjective experience, not group norms or values" (1976, p. 218).

Depression is defined in the Diagnostic and Statistical Manual of the American Psychological Association as an episode lasting two weeks or more and including at least five of the following nine characteristics: depressed mood; markedly diminished interest or pleasure in all, or almost all, activities; significant weight loss or gain; insomnia or hypersomnia; either physical agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate; and finally, recurrent thoughts of death or suicide. Major Depressive Disorder is diagnosed when a patient has had two or more episodes of Major Depression. Major Depression is also a facet of Manic-Depressive Disorder, which alternates periods of Major Depression with Manic or Hypomanic episodes. Depression is often co-morbid with anxiety, and panic attacks are common. I will use the term "depression" to refer to depressed symptoms common to all of these possible diagnoses, since they all share the attributes of a Major Depressive episode.

A Survey of Depression

Depression is the most common of the psychological disorders, and is on the rise. A World Health Organization study predicts that depression will be the second largest cause of disability by 2020, accounting for a whopping
15% of the total disease burden (Baetz, Bowen, Jones & Koru-Sengul, 2006). It is certainly not a disorder from which Christians are exempt, either. In a survey of ministers in the southeastern United States, subjects estimated that the incidence of depression throughout their congregations was 80-85% (Kramer, et al., 2007). In fact, one minister even went so far as to say that this number may only be those who were on medication—the actual incidence rate may be far higher.

The multifaceted nature of depression makes it difficult to determine its etiology (France, Lysaker & Robinson, 2007). Although depression is most commonly associated with a lack of serotonin, chemical compound 5-HT, in the brain, either because of excessive reuptake or lower production of the chemical (McNeal & Cimbolic, 1986), the best explanation of depression etiology seems to be one that involves a biopsychosocial model, incorporating a holistic picture of a human being and the complex interactions between systems (Accortt, Freeman & Allen, 2008). Because Major Depressive Disorder, like other organically-based disorders such as Schizophrenia and Manic-Depressive Illness, tends to run in families, many psychologists hold to a diathesis-stress model of understanding depression: although psychosocial factors may lead to the emergence of depression, the underlying diathesis is the primary cause.

Regardless of its etiology, depression often manifests itself in profoundly relational ways. As a result of depressed mood or anhedonia, a patient with depression may withdraw from social situations that were originally a source of pleasure. Feelings of guilt or worthlessness also contribute to social withdrawal, as well as loss of energy and hypersomnia. The end result is that a subject with depression often withdraws almost completely from social relationships, sometimes even shutting out close friends and family. This can be both a cause for dysfunctionality and an end result of faulty cognition.

This is even greater when the patient is also suffering from anxiety, making social relationships a source of suffering rather than relief.

In light of the intensely relational nature of the disorder, it is only natural that depression should profoundly affect a patient’s relationship with God (White, et al., 2003). This is why I have chosen to study spirituality rather than religiosity; exploring the relational effects of depression rather just the cognitive belief aspect. I have found precious little current research dealing with this subject, since most studies focus on the cognitive aspect of religious belief rather than the experiential aspect of relational spirituality.

Historically, most literature dealing with depression at least acknowledged the effect it could have on a patient’s experience of spirituality. While the Puritans had the most substantial body of literature devoted to the study of what was then called “melancholy,” other more medically focused texts also acknowledged the role the disorder could play in spirituality. In the 1691 text The Anatomy of Melancholy, Richard Burton quotes an even earlier source as saying that “melancholy often works religious despair” (p. 358). 150 years later, Archibald Alexander wrote that depression was so often accompanied by religious symptoms that “a volume might be written on the subject” (1844, p. 42).

Melancholy and the Puritans

In order to begin a study of depression and Christian spirituality, a survey of the works of the Puritans is necessary. Not only have they written so much on the subject, but their writings continue to be some of the best literature on the subject to date.

The Puritans, a small group of devout Christians who lived and died during the years between the second wave of the Reformation and the Great Awakening, has received an inordinate amount of inaccurate scholarship and negative publicity in modern times. In fact, they have been the object of so much mud-slinging that
that Christian author and scholar C.S. Lewis advised his readers to “picture these Puritans as the very opposite of those who bear that name today” (1966, p. 121). In truth, there is no excuse for the gross inaccuracy of the contemporary view of Puritans, especially compared to the volume of self-disclosing literature they produced.

The word itself began as a slur. From the 1550s to the 1700s, roughly, various sectarian groups were given the title “Puritan,” usually from their enemies. In spite of the fact that many of these groups preferred the title “the faithful” or “the godly”, the name “Puritan” continues to delineate an historic group of people who demonstrated a “distinctive mindset, vibrant spirituality, and dynamic religious culture” (Kapic & Gleason, 2004, p. 18). Kapic and Gleason go on to say that Puritanism was primarily a movement of spirituality—not of new doctrines, but of individual experience of God. It is for this reason, among others, that their voice is relevant to our discussion.

In doctrine, the Puritan emphasis was, uniquely, both Scriptural and experiential.

“The Puritan intellectuals who formed the spiritual brotherhood were at once more sensitive to the Reformation ideals and more eloquent in giving expression to them than most of their contemporaries were. One they emphasized most forcefully was that individual men and women could achieve a personal relationship with God, and that this relationship could permeate all daily life with the light of eternity. To do this they used Scripture and their own experience to throw light on each other. Robert Harris said ‘that a Preacher had three Books to study. 1. The Bible. 2. Himself. 3. The People’....There is no evidence that a preacher habitually recounted his own travails in the pulpit, but ideally he ‘never taught any goodly point, but he first wrought it on his own heart’....This caused them to extend their range of self-awareness, as the doctrines which they learned became almost simultaneously embodied in personal experience and afterwards articulated through narrative and testimony. ‘Now to a poor soule’, said John Rogers, ‘all such things as are in the soule, are made know by experiences; experience, we say, proves principles.’ So, as their pastors, in plain and persuasive language week by week, explored the relation between doctrine and experience, men found they were being given a lens with which to bring their inward lives into focus....” (Watkins, 1972, pp. 15-16).

This resulted in a uniquely introspective and emotionally alert people. The Puritans were journal keepers, established the genre of spiritual autobiographies, and wrote and taught about the Holy Spirit more than any other historical Christian group. A Puritan sermon, though spoken in plain, simple language that the common people could understand, was never without emotion. To the contrary, their vernacular and message was considered melodramatic by many: the most famous Puritan sermon, Sinners in the Hands of an Angry God by Jonathan Edwards, is today considered a prime example of overwrought spiritual sentiments. Edwards’ sermon was certainly not the most sensationalist of its day. Some may use this as evidence to diagnose the Puritans as pathological, but such a diagnosis is pushing the definition of “pathological” and taking them out of their cultural context (Burton, 1691).

The emphasis on emotion and spiritual experience was not simply confined to religious contexts. J. I. Packer, noted Puritan scholar, has said of the Puritans that “as their Christianity was all-embracing, so their living was all of a piece” (Ryken, 1986, p. xi). These men and
women saw no distinction between their public and private lives, between their religious life and the rest of life. Compartmentalization was a foreign concept to them, they saw all of life as religious and religion as all of life.

Flowing from this focus on emotion and experience, the Puritans espoused a supreme compassion for their fellow man. "They spoke of themselves as 'physicians of the soul' who sought to apply the medicine of the Bible to the wounded consciences and broken hearts among their congregations" (Kapic & Gleason, 2004, p. 27). This meant that anthropology was an important part of a Puritan pastor's education, because in order to minister to the broken, he must understand their hearts. In Puritan thought, the heart of man was depraved, rebellious, and fragile; the heart of Christ, and therefore any minister seeking to represent him, was abundantly compassionate.

Timothy Rogers was one such minister. He wrote a book in 1691 entitled Trouble of Mind and the Disease of Melancholy detailing his own experience of depression and providing helpful advice for those who were currently suffering. The preface to his work, entitled "containing several advices to the relatives and friends of melancholy people," is considered one of the most compassionate and discriminating of any written before or since. His advice ranges from "be so kind to your friends...as to believe what they say" (p. xxxi) to "do not attribute the effects of mere disease to the devil" (p. xxxiii), sound advice that his readers would have done well to heed.

Far be it, though, for passionate emotions to overrule truth: the Puritans loved truth, and clung to the Bible even when their feelings belied it. In fact, their perceptive understanding of human nature was what caused them to do so: they knew their own hearts to be changeable at best. "Beloved, should Christians build their eternal comforts on their feeling and affections, their comforts would be up and down, ebbing and flowing. Their affections are feelings, their comforts would be up and down, ebbing and flowing. Their affections are feelings, sometimes hot as fires, and soon as cold as air....Now if you should build your comfort on the affections, you would never have stable comfort, but one that is still up and down" (Love, 1557, p. 109). The Puritans had no idyllic misconceptions about the human heart; they knew better than to trust it. Nevertheless, they gave it a prominent place in their theology and practice.

This unique psychological and theological makeup may be why the Puritans, as noted before, produced a substantial body of literature dealing with the subject of "religious melancholy." The descriptions of this state are colorful and varied, relating to the symptoms of depression with one significant addition: the presence of religious distress. "A man is not so affected with the things that he knows as in former days. Time was when the apprehensions of God's love worked mightily...but now the thoughts of divine love do not raise the heart so" (Symmonds, 1671, p. 43). "They generally apprehend themselves to be singled out as the marks of God's particular displeasure" (Rogers, 1691, p. 345). "As if the heart had none to fear and nothing to hope for, or none to judge it, it is dull, careless and heedless" (Symmonds, 1671, p. 44).

"The prevalence of melancholy in a man darkens the understanding and troubles the fancy. It disturbs the reason, saddens the soul, and clothes it in mourning weeds. And when these meet together, it must cast the man down and suspend the sense of God's favor from him....It is no more wonder, said Baxter, for a melancholy man to doubt, fear, and despair than it is to see a sick man groan. There is a natural distemper in the body that is the cause of melancholy, yet trouble of conscience, doubtings, and distress of spirit are the companions of it. You may silence a melancholy man when you cannot comfort him. If you abate his sadness by convincing arguments, yet
when he retires alone, through the prevalence of his humor, all is forgotten” (Love, 1557, pp. 70-71).

Those with religious melancholy suffered from depressed mood, anhedonia, disrupted sleep patterns, agitation or retardation, fatigue, suicidal ideation, inability to concentrate or make decisions, and profound feelings of worthlessness and guilt—in other words, a textbook example of Major Depression. Additionally, these patients felt that they had been abandoned by God, felt a diminished sense of God’s presence or loss of communion with God, feared that they were reprobate or condemned to Hell, and lamented that they were cursed or rejected by God because of their great sinfulness. These symptoms were not connected with any particular sin; in fact, they were often present in the absence of any objectively observable sinful behavior. This feeling was more an internal, stable and universal conception of being inherently sinful, a belief originating from the Reformational teaching of John Calvin but taken to a far extreme in these patients. For patients suffering from religious melancholy, there was no relief from these symptoms; no matter how many people reasoned with them and assured them their sins were forgiven, they continued to feel guilty and sinful. Although these subjects seemed to have latched on to some cognitive aspects of their faith, others, such as the forgiveness of sins or the abundance of grace, they were unable to internalize and no reasoning provided them with relief. The problem, then, seemed to be more experiential and affective than cognitive: regardless of what their pastor said or what beliefs they cognitively assented to, they continued to feel reprobate.

Although Puritan theology certainly may have contributed to this, with its emphasis on the sinfulness of human beings and God’s sovereignty in choosing on whom he would bestow mercy, Puritan pastors argued that the theology they preached should have the contrary effect of putting adherents to rest because their salvation did not rest in their good works. Indeed, in the majority of their congregations, it did; only those with religious melancholy seemed to have this problem.

Stanley Jebb, in a paper presented at the 2001 Westminster Conference, made this observation about Puritan pastor Richard Greenham, who founded a Puritan school of counseling: “this immediately tells us two things: first, that Richard Greenham was widely known for outstanding ability in this field, and, secondly, that there were many who were so troubled as to make the journey to seek him out” (p. 86). Indeed, much of the scholarship on the Puritans indicates that an inordinate amount of them suffered from the disease of melancholy (Sena, 1973).

There are several reasons for this. One is that the strong experiential emphasis of Puritan theology may have led its adherents to believe that the veracity of their faith rested in their ability to feel communion with God. If this were the only reason, then simply assuring the patient that they had misunderstood their faith should have removed the problem—but it did not (Hemming, 1956; Burton, 1691; Rogers, 1691; Love, 1557). “Melancholy persons are in perpetual darkness, all things seem black and dark unto them, their spirits, as it were, dyed black....Whatsoever is presented to a melancholy person, comes in a dark way to the soul....How fit are they then to judge of things removed from sense, as of their spiritual estate in Christ?” (Sibbes, 1973, p. 136). If it were simply a matter of insanity, however—that, as some psychologists speculate, the sexual repression and spiritualized guilt of the religious community are pathological and cause these disorders (Ellis, 1962)—than we would not expect Puritan pastors to see this as a problem, but to rather be blinded to it as much as their congregation. This was also not the case (Hemming, 1956; Crossley, 1994). Thus, the cause must be either a combination of the two—the twofold pressure of Puritan psychology and Puritan theology causing those vulnerable to for
to depression to crack and display religious symptoms—or another, third variable yet unnamed. Although I cannot rule out the possibility that, for some patients, the former hypothesis may be true, the Puritans themselves thought that a third variable was responsible for this phenomenon, and went through a careful process to make certain that the pastor was properly diagnosing and helping the patient (Hemming, 1956). As a result, the Puritan opinion on the subject, though not without bias, is fairly reliable. “There is evidence enough of some sound psychology in the Puritan approach to mental depressions, especially in their awareness of the distinction between mental and spiritual depression” (Lewis, 1977). In fact, Thomas Brooks himself wrote “the cure of melancholy belongs more to the physician than the divine,” (quoted in Lewis, 1977, p. 87) and Lewis goes on to observe that their advice was directed not to the condition, but to the Christian in the condition—they had no misconceptions that they could cure the disorder.

The Puritans’ understanding of the etiology of depression was also very sound—indeed, it was progressive for their age. They pointed to examples of Biblical figures who had gone through periods of darkness, and hypothesized that all Christians go through times when God seemed far away and “hid” himself from the believer—and that it was simply part of the rhythm of the Christian life, the primary cause being God’s sovereignty and to make the Christian long for Heaven (Love, 1557; Symmonds, 1671). Usually, the Christian had no responsibility for this happening; although the Puritans did not rule out the possibility that it could be caused by sin, they did not think that was the primary or usual cause. Augustus Toplady wrote, “I believe from scripture, from observation, and from experience, that all God’s people do, occasionally, pass under the cloud, and are baptized unto Christ in the cloud and in the sea of spiritual darkness and distress” (Toplady, 1901, p. 43).

For a Puritan whose theology was primarily experiential this withdrawal of communion could cause significant grief and distress. In response, Puritan pastors counseled their flock that this period of darkness was done for the Christian’s own good and growth, was temporary, and happened to all Christians. This attribution was actually incredibly healthy, relating to a therapeutic approach that focuses on depression being external, temporary and specific (White et al., 2003). This seems to debunk Ellis’ assertion that the religion itself was producing disordered cognition (1962, p. 304).

The second possibility, however, was that the period of darkness, although part of the normal ebb and flow of a Christian’s experience of God, was actually caused by an underlying medical condition. This is exactly in line with the current research on depression and its organic etiology. The Puritans, then, had a legitimate grasp on what was causing the depressive symptomology and in this aspect were very much ahead of their time. These two causes for religious melancholy—grief resulting from the withdrawal of communion and more organically-based depression—were so intertwined that a pastor had to exercise careful diagnostic practices, listening carefully to the presenting complaint and often probing the deeper problem to discover which was the case (Jebb, 2001). More often than not, a believer presenting with religious symptoms actually had an organic problem. Because the Puritans rejected the dualism of their day, it did not come as a surprise to them that disordered brain chemistry could cause a decrease in spirituality.

Treatment, then, was to be a combination of spiritual nurture and physical medicine (Baxter). The pastor was to encourage the afflicted to look to Christ, who had also suffered separation from God (Rogers, 1691), and to read scriptures written by Biblical figures who had also struggled with depression (Bridge, 1648). The role of the pastor was one of friend and encourager, not condemner. Counseling techniques also involved forms of Cognitive-
Behavioral Therapy; often prescribing activity with joyful persons, physical exercise, and meditating on more uplifting thoughts, the Puritan counselors emphasized hope (Baxter, n.d.; Love, 1557; Rogers, 1691). The combination of CBT with relational spiritual encouragement, as well whatever medical support was available, was very helpful for some Puritan men and women (Crossley, 1994; Jebb, 2001; Rogers, 1691).

**Spirituality and Depression Today**

Modern psychological literature has born out the Puritan hypothesis and has supported the validity of their treatment. The preponderance of research dealing with spirituality and depression has focused on establishing a relationship between religiosity and depression, demonstrating a strong inverse relationship (Maselko, Gilman, & Buka, 2009; Pearce, Little, & Perez, 2003). 77% of studies surveyed displayed this significant inverse relationship, 5% showed no relationship, and 18% a positive correlation (Murphy & Fitchett, 2009). Other studies have demonstrated that religious patients have 50% faster recovery rates than non-religious depressed patients and that depressed patients are “more likely to have no religious affiliation, be spiritual but not religious, and less likely to pray or read scripture” as well as being lower on intrinsic religiosity, a construct that basically fits our definition of spirituality (Koenig, 2009). Few studies, however, have gone further to investigate the nature of this relationship. Researchers have speculated that the social nature of religion may be the protecting factor, since social support has already been demonstrated to benefit depressed patients immensely. Koenig points out, however, that although there may indeed be a mediating factor for the benefits of religion on depressed patients, these benefits have been shown to work independently of social support (2007) and to be as significant as the influence of gender, a primary depression risk indicator (2009).

Koenig postulates that the relationship may be mediated through the action of the chemical serotonin. “R[eligion]-S[pirituality]-oriented people may be at increased risk for mood disorders based on [a particular] 5-HT receptor binding profile” (2009, p. 287). In other words, religious people may have a particular chemical makeup that puts them alternatively at risk for depression or other mood disorders and draws them toward religious beliefs. This also makes them particularly receptive to religiously-based therapy, which has been shown to be more effective than non-religious CBT (Armentrout, 2004).

Some of the variance in the literature can be accounted for the way each study measured religious commitment. Was it measured as a behavior, such as going to church or reading the Bible, or as an intrinsic motivation, such as feeling close to God and desiring to pray? The majority of studies focus on religiosity, the practice of being religious, rather than intrinsic spirituality. Since depression often causes a decline in functioning, it is possible that those who attend church before their illness and continue to do so during their illness simply have a less severe case of depression. It has also been hypothesized that the role of religion can be either helpful or harmful, depending on how the religious community reacts to the diagnosis and/or understands the etiology. “A key determining factor regarding whether social relationships in a Christian context are healing or harmful is related to the attributions made by significant others about the nature of the depressive symptoms and/or the depressed person” (White, et al., 2003, p. 51).

Can this relationship also work in an inverse direction? If religion is associated with a decrease in depressive symptoms, can a decrease in religious experience be caused by an increase in depressive symptoms? What does this research have to say about the Puritan hypothesis?

A smaller, but more focused body of research is involved in unraveling this confusing
relationship between depression and spirituality. Although prominent psychologists have postulated that religion causes mental illness and neuroticism (Ellis, 1962), a study conducted at the University of Basel found that “it is not primarily religion that causes illness, but it is illness that makes the practice of religion difficult. Thus, 71% of the religious patient group consented to the statement: ‘my psychological problems make it difficult for me to live my faith in the way I would like to’” (Pfeifer & Waelty, 1999, p. 43). As clinical psychologist William Kirwan has written, “There is...a virtually infinite number of different pathways through the brain. Physical disorders here can result in mental and emotional disturbance” (1984, p. 69). He goes on to conclude that the nature of depression, then, is not ultimately spiritual, but biological. Indeed, Koenig speculated that the relationship between religion and depression might be mediated by the intensity of the disorder itself—lesser depression may drive the patient deeper into the security of religion, but as the disorder progresses, causing patient fatigue, or becomes more intense, the patient experiences a decline in spirituality (2007). Pfeifer and Waelty agree with this, stating that “the primary factor in patients who display religious conflicts and anxieties seems not to be the degree of religious commitment itself but rather their underlying psychopathology” (1999, p. 44).

This observation is borne out in an overwhelming majority of related studies. In a study examining the response to treatment of a religious population, Murphy and Fitchett found that those with low Religious Belief Dimension scores responded less to treatment. The conventional interpretation is that the lack of religiosity makes the patient less able to cope and recover quickly. Murphy and Fitchett, however, postulate another interpretation: “another perspective on the results of our study is that low RBD scores might indicate a loss of belief or religious struggle in the face of symptoms which would add to a patient’s distress. If this is true, it is important for clinicians to assess for religious struggle in persons with depressive symptoms” (2009, p. 1006). Lower religious belief, then, is the result of the disorder and, in turn, contributes to slower recovery.

Studying Obsessive-Compulsive Disorder, Abramowitz, Deacon, Woods and Tolin found that religious patients often had religious presentations of symptoms, including “scrupulosity”, an intense attention to religious ritual and purification (2004). Historical cases include Martin Luther and John Bunyan, both textbook cases of OCD (Cole, 2000; Sneep & Zinck, 2005). Abramowitz et al. discovered that these patients, although they display religious symptoms, are actually suffering from an underlying disorder rather than a religious problem (2004). Quiles and Bybee, studying chronic and predispositional guilt, found that, although religious individuals do score higher on scales of guilt feelings, the fact that many religions, and especially Christianity, promise a release from guilt may indicate that these individuals are drawn to religion seeking relief rather than displaying religious pathology (1997).

It should not come as a surprise, then, that depression has such a strong effect on a patient’s spiritual experience. A study entitled “Christians and Depression” pointed out that the intense interpersonal nature of depression should naturally lead to the conclusion that depression affects one’s relationship with God, and that those with depression “may communicate... experiencing distance from God” (White et. al., 2003). In a study focused on female adolescent spirituality, the authors concluded that while “spirituality experienced in a personal way through a relationship to God may be uniquely protective against depression in girls and women,” yet “disruptions in relational spirituality may be associated with depression in adolescent girls” (Desrosiers & Miller, 2007, p. 1031). In another study focused on collegiate athletes, intrinsic religiosity was negatively correlated
with affective symptoms of depression—the emotional intensity of depression correlating with a downward spike in spirituality (Storch, Storch, Welsh & Okun, 2002). That depression results in spiritual distress, rather than the inverse, has been supported by other studies that have found that intrinsic religiosity does not increase the likelihood of depression (Richards, 1991), even though a self-claimed evangelical association has been associated with a greater frequency of depressive symptoms (Dalgalarrondo, Marín-León, Botega, Barros & De Oliveira, 2008). Religion may therefore be a refuge from depression, with depressed individuals turning to religion for relief, but it is not a cause for depression. Instead, the evidence seems to point more clearly to the claim that depression has a powerful effect on spirituality. Indeed, as one study observed, higher levels of depressed mood were correlated with a view of God as “distant” or subjects who found it difficult to trust God (Exline, Yali & Lobel, 1999).

Although many have hypothesized that regular church attendance can be a safeguard against severe depression, Yarhouse and Turcic’s survey of religious visual artists found that church association can actually hurt: a number of those surveyed reported experiencing guilt and a tendency toward denial of negative feelings as part of their involvement with a local church (2003). As mentioned earlier, White et al. found that attributions as to the cause of depression were the key moderating factor in this relationship (2003). Those with a lower education level tended to gravitate to a more Bible-focused “simple” explanation, often with no reference to current biological data, and this strongly influenced their behavior toward depressed persons, often resulting in greater distress for the person struggling with depression. These unhelpful attributions were usually internal, global and stable, something depressed persons are particularly susceptible to and exacerbate their symptoms. In a key study entitled “Disconnection, Depression and Spirituality,” Sorajjakool, Aja, Chilson, Ramirez-Johnson, and Earll at Loma Linda University Behavioral Medicine Center collected data on 15 patients suffering from extreme depression (2008). They indicated that they felt very disconnected from themselves, from God, and the community.

Most participants reported that depression made them feel disconnected from their spirituality. They indicated that they felt very disconnected from themselves, from God, and the community. “I have a hard time emotionally connecting to God during these five years,” reported one participant. “On my good days, the connection is great. But when depressed, the connection is much harder for me.” A female participant who struggled with depression since she was young stated, “It’s just a struggle. I would say that definitely....My heart is very protected and cold.” A female graduate student indicated that she “feels cold” in her heart and does not deserve God’s love. This sense of disconnection, for many, emerged from anger. They experienced anger because they felt as if God had abandoned them. “I feel very disconnected even though God was always showing me Himself. I feel very disconnected from God. I think I have to work through some of my anger before I can be connected again to God.” Another female participant who lived with depression since she was 12 stated, “Right now I am angry with God...I am angry because He is not attending to my need especially because I am vulnerable. He has not proved that He is there listening to me...He is not there.” She continued, “Sometimes in my life He was there, but most of the time I can’t see Him...because most of the time I was depressed and suicidal” (pp. 525-526).
This is not because of a rejection of faith—in fact, often it occurred when patients were most seeking God.

While the general mood of these participants during depression was that of disconnection from their spirituality, spirituality still played a role in helping many cope with their dark moods. All 15 participants acknowledged spirituality as one of their coping methods. When asked about coping with depression, the term “God” was present among all the participants. Of the 15, one felt that God had abandoned her but indicated at the same time that her spirituality prevented her from committing suicide....One participant indicated, “I seek because I believe. And I wish I could feel. I wish I could feel it because I do believe...my private prayers are to open my heart” (p. 526).

The southeastern pastors surveyed by Kramer et al. also observed this phenomena in their congregations. One subject said, “The folks who struggle with mental health issues—the people with depression—the phrase I hear over and over again spiritually is, ‘I can’t hear God and see God. I don’t know how to experience God’” (2007, p. 128).

To summarize, current psychological research seems to substantiate the Puritan hypothesis that many Christians experience depression and that it causes deep spiritual distress. Although the precise nature of that distress and the cause of it can vary from person to person, the main complaint seems to be feeling disconnected or far from God and/or rejection from the Christian community.

Current Christian Viewpoints

A major cause of this feeling of rejection from other Christians may stem from the sorry state of current Christian scholarship on the subject. Although the Puritans had a well-formed theology of depression, most current doctrinal camps do not. In spite of the overwhelming amount of data that supports a biological etiology of depression, a survey in Australia found that nearly 40% of the religious respondents believed that demon possession was a cause of depression (Hartzog & Gow, 2005) and many Christian counselors believe that “depression is etiologically spiritual” (Armentrout, 2004). Theologian Jay Adams has had no little hand in this: his book Competent to Counsel explicitly states that the cause of depression is sin (1986). Other Christian counselors coming from the Reformed tradition, especially those who are part of Adams’ Nouthetic school, echo these sentiments.

A lesser-known relative of the Nouthetic school is the Heart-Cry Method, which postulates that depression is simply “a normal, negative motivational state with a spiritual base, moving one toward corrective action” (Armentrout, 2004, p. 40). Armentrout draws his theory from a single Bible verse, 2 Corinthians 7:10, which reads, “godly sorrow brings repentance that leads to salvation and leaves no regret, but worldly sorrow brings death” (New International Version). Depression, then, is just a form of godly sorrow that should lead to repentance. Armentrout goes on to prescribe a method of treatment that involves confession of sin, warning that taking medication or seeking treatment outside Christian circles is part of “the world’s path” that leads to “death.” One can only imagine the kind of damage this opinion has done to those who are primarily suffering from a chemical abnormality in their brains.

Probably the most widely held opinion in Christendom is the one espoused by Piper in his recent book The Hidden Smile of God (2001). Examining the lives of John Bunyan, William Cowper and David Brainerd, famous Christians who are widely acknowledged to have suffered from severe depression, Piper concludes that the source of their problems lay in their reactions to and interpretations of life events and exhorts his readers to learn lessons from their lives in order to avoid their mistakes. The subtle inference is
is that, although these men may be pitied and perhaps even admired for suffering as long as they did, their illness was, ultimately, their own fault.

It is for this reason, then, that Alexander (1844) makes the recommendation he did, and why his exhortation to write a volume on this issue combining both a Christian and a clinical perspective is still very valid.

William Cowper: A Case Study

An excellent example, both of the spiritual distress caused by depression and the need for collaboration between clinicians and clergy, is the case of eighteenth-century Puritan poet and hymnist William Cowper.

William Cowper was born in 1731; a contemporary of John Wesley and George Whitfield. He was born a rector’s son in a small town near London, and upon his mother’s death, 6-year-old Cowper was sent to boarding school, where he remained until his graduation at age 17. From there he began an apprenticeship to a solicitor with the goal of practicing law. In 1752, however, at the age of 21, he suffered his first debilitating attack of depression that was to be his companion for the rest of his life. “Day and night I was upon the rack, lying down in horror and rising up in despair,” he later wrote. “I presently lost all relish for those studies, to which before I had been closely attached” (Thomas, 1935, p. 94).

In this suffering he found solace in the religious poems of George Herbert and his depression abated. It was back eleven years later, however, when he found himself faced with the prospect of a public examination in order to take a position as Clerk of Parliament. “What would have been a great career advancement to most men struck fear into William Cowper—so much so that he had a total mental breakdown, tried three different ways to commit suicide, and was put into an asylum” (Piper, 2001, p. 90). While in the asylum, under the spiritual care of Dr. Nathanael Cotton, Cowper became a Christian.

His declaration of faith was not the end of his suffering, however. After being released from the asylum, he moved to Ulney, where previous slave-trader John Newton was pastor. Newton, who found common ground with Cowper, befriended him and the two were lifelong friends, even after Newton moved from Ulney to London. Together the two composed the hymnal Olney Hymns, which contained, among other songs, Newton’s famous “Amazing Grace” and Cowper’s “There is a Fountain Filled with Blood”. Cowper grew spiritually under Newton’s leadership, becoming well grounded in the Bible and in Puritan writers like John Bunyan (Lake, 2005).

Cowper’s depression, rather than lessening through his contact with theology, close relationships, and spiritual encouragement, grew worse as he approached the end of his life. He often expressed the “melancholic” fear of being reprobate in his letters to Newton: “O brother, I am damned—damned. Think of eternity, and then think what it is to be damned” (Lake, 2005, p. 38). “Loaded as my life is with despair, I have no such comfort as would result from a supposed probability of better things to come, were it once ended” (Thomas, 1935, p. 281). Furthermore, “the last days of his life seemed to bring no relief in his sense of forsakenness. No happy ending. In March of 1800 he said to visiting Dr. Lubbock, ‘I feel utterable despair’” (Piper, 2001, p. 103).

Although no preaching from John Newton assuaged his despair and he often considered himself abandoned by God, his hymns are filled with hope and paint the picture of a man with great faith. For example, here are the words for “Sometimes a Light Surprises,” one of the Olney hymns. These do not seem like the typical writings of a person suffering from debilitating depression.

Sometimes a light surprises  
The Christian while he sings;  
It is the Lord, who rises  
With healing in his wings:
When comforts are declining,
He grants the soul again
A season of clear shining,
To cheer it after rain.

In holy contemplation
We sweetly then pursue
The theme of God’s salvation,
And find it ever new;
Set free from present sorrow,
We cheerfully can say,
Let the unknown tomorrow
Bring with it what it may.

It can bring with it nothing
But he will bear us through;
Who gives the lilies clothing
Will clothe his people too:
Beneath the spreading heavens
No creature but is fed;
And he who feeds the ravens
Will give his children bread.

Though vine nor fig tree neither
Their wonted fruit shall bear,
Though all the field should wither,
Nor flocks nor herds be there;
Yet God the same abiding,
His praise shall tune my voice,
For, while in him confiding,
I cannot but rejoice.

(Cowper, n.d.).

Qualitative Research at Covenant College

The final aspect of my research involved conducting 30-40 minute interviews of nine Christians, students at a Christian college, who had experienced or were experiencing depression. Three of the subjects were male, the rest female. The main goal of the research was simply to paint a picture of what it means to be a young Christian with depression—whether the Puritan hypothesis is correct and depression causes spiritual distress.

The subjects I interviewed were all undergraduate students, aged 18-22. All claimed to have experienced some form of depression, either as the depressed stage of Manic-Depressive Disorder, part of diagnosed Major Depressive Disorder or an anxiety disorder, or as an isolated incident. All of the respondents came from Christian families and had grown up with at least some church involvement and exposure to the Christian faith, all of them claiming to have personal relationships with God and to have experienced his presence on a semi-regular basis.

The interviews were all conducted by myself in a neutral setting, such as a study room, coffee shop, or, occasionally, the subject’s room. The interview was semi-structured; I began with a list of questions (see Appendix) but let the subject answer or tell their story as they wished, following a natural flow of conversation.

The average age of onset for the subjects was mid-teens, with about half the subjects recalling symptoms before the age of 13 and about half having their first episode during their freshman year of college, around age 18. The symptoms varied widely based on the intensity of the depression—about 30% had harmed themselves or attempted suicide at some point, even though all of them confessed to having suicidal thoughts during their depression. Some suffered from depression so severe that they were sent home from school; others found that
they could still function despite anhedonia and hypersomnia.

I asked the subjects about how they felt connected to God, if they remembered having any experiences of transcendence, if they experienced God more intellectually or emotionally, and if they ever struggled with guilt or doubt. The subjects expressed having mild doubts occasionally before becoming depressed, and were at various points along a continuum of intellectual or emotional worship styles, most falling closer to the intellectual side and attending churches that were very conservative in style and intellectual in focus. Most spoke of their experiences of transcendence before their depression and their inability to have those experiences during their depression.

Friends and family had various reactions to the diagnosis of depression in the subjects. Some refused to deal with the issue, some were understanding and supportive, and one subject said that her father told her depression was a sin, and then later apologized. Church members were helpful when they were aware of the problem, often going out of their way to find out if a subject “was okay,” and were understanding.

All but one of the subjects said they felt farther from God during depression, often stating outright that they felt abandoned or felt nothing at all. When asked if she was ever angry at God for “leaving” her, one subject replied, “Mostly, there was just a confusion factor. I couldn’t figure out why exactly God was doing it, and I felt very empty. It just didn’t make any sense to me because I hear all these stories about Christians who go through hard times and say ‘God was just with me, and he was so good’ ... and I was just like I go through stuff and I feel absolutely nothing right now.” Reading scripture offered no relief, except for the occasional sense of being understood; church attendance was, in the words of one subject, “not particularly helpful, but it doesn’t hurt either;” and although prayer at times offered comfort, often it felt like a futile attempt to connect with God.

One of the major themes that emerged during the course of the interviews was that of darkness, subjects describing their depression as an overwhelming dark period: “That whole period of my life was dark. Like, it just was dark...there’s never been a bright color after that.” One subject I interviewed put it like this: “It was like I couldn’t see anything. I couldn’t look at my Bible. It was like I couldn’t remember it. It was too dark to see anything.” There was also a sense of permanence to this darkness: “I didn’t think I was ever going to get out. I thought I was going to be stuck in that rut forever.”

Doubts and questions also emerged as a major theme, as the subjects wrestled with why God was allowing them to suffer. “I’ve never doubted him [God], but more what he is doing. I’ve had thoughts like, he’s not here for me, he’s not working...He’s allowing this bad to be in my life.” Another subject put it this way: “I say I don’t understand. I know he has the best plan in mind, but sometimes I have this sense of unfairness...like, if only he could explain it to me.”

In spite of having many questions, another clear theme was that these subjects continue to cling to their faith. Every single subject said that depression, while making it hard to experience their faith, had not made them lose faith. “I had to learn the difference between feeling close and being close,” one subject said. “I just long to be with [God] in heaven,” said another. Yet another subject said: “I’ve come to the conclusion that I don’t know anything—that’s why I need God.” Another told me how she is frustrated by people praying for her disorder to go away. “What if this is what God is calling me to...what if this is what God has given me to glorify him through pain?”

Implications for Treatment

As suggested earlier, the prevalence of depression and the close correlation with spiritual distress indicates that this is an issue of serious interest to clinicians. Many of the recent psychological studies on the link between
depression and spirituality conclude with the observation that this has great implications for the treatment of depression—at the very least, spirituality should be discussed with the patient and spiritual resources provided. The pastors surveyed by Kramer et al. (2007) complained that their ability to help their suffering parishioners was limited by a lack of training and by the disconnect between the mental health and religious communities. One stated, “once you enter into, you know, that mental health arena, then it’s been my experience most times, then, the pastor pretty much has been shut off.” Another indicated the lack of trust each profession had in the other: “I think there’s still some level of distrust on both sides...there might be some level of distrust of the church as a whole. I think on the church side there is some level of distrust of the mental health profession.” His suggestion was the opening of dialogue: “I think dialogue [between mental health and clergy] is the best information sharing there is and information sharing is the beginning of confidence sharing” (p. 131).

The subjects of my study also spoke of difficulties being diagnosed and treated within the Christian community. One subject said her experiences with Christian counselors involved them simply “listening” and “staring”, going so far as to ask, “do they tell you that? Like, ‘stare them down and maybe their problems will go away’?” Her Christian therapists did not engage in any behavior therapy or offer constructive advice, and overall evidenced unprofessionalism that broke down trust and destroyed the patient-therapist relationship. She tried three different counselors before finding one who was able to meet her needs. This kind of unprofessionalism and lack of useful therapeutic techniques is unnecessary and should not be difficult to correct, especially since many Christian counselors are licensed clinicians with a professional degree.

Another struggle the subjects of my study spoke about was trying to get Christian parents to submit them to a diagnosis and treatment. One subject said that her parents did not acknowledge her need for treatment, despite several suicide attempts, until she attempted to leap out of a van going 80mph down the highway. This, too, could be eliminated by a variety of church-sponsored resources, removing the stigma of mental health professionals within the Christian community by presenting them through a familiar and trusted source.

Clearly, there needs to be a healing of this rift, and even further, an active partnership between clinicians and pastors, especially since community support is such a powerful asset in therapy. The patient is a whole person, neither all body nor all soul, and thus both aspects of his or her suffering need to be addressed. Here, once again, we find the Puritans to have paved the way for us in this regard. Rogers writes, quoting Richard Greenham, the famous Puritan counselor, “there is a great deal of wisdom required to consider both the state of the body and the soul.’ He says that if a man who is troubled in conscience comes to a minister, he will likely look to the soul and not at all to the body; if that same man goes to a physician, he will likely consider the body and neglect the soul. For my part, I would never despise the physician’s counsel nor neglect the minister’s labor, because the soul and body [are] dwelling together” (1691, p. xxvi). His challenge to fellow pastors is to be gentle with their suffering flock: “but of all persons, ministers are especially to be blamed who, when they find poor sinners who are overwhelmed with a sense of guilt, with the terrors of the law, and who are slain by the law, still set the law more and more upon them. This...does not remove and heal their wounds” (pp. xxix-xxx). Both pastors and clinicians, then, are in need of more holistic training in order to properly serve those under their care; pastors need to not neglect the psychological aspect of their congregants, and psychologists need to not neglect the inherent spirituality of their patients. Treatment needs to incorporate the spiritual
needs of a patient as well as their biopsychosocial needs.

**Conclusion: Toward a Theology of Depression**

In conclusion, both pastors and clinicians need to be involved in developing an integrated “theology of depression” or “spiritual psychology” that treats the depressed person as an integrated being. Depression is one of the most distressing things that can happen to a Christian, and therefore its treatment should be a major priority for clergy and counselors alike. After all, William Bridge has written, “I do not know any thing, or any affliction, that is so afflictive to a gracious heart as this: for, take any other affliction, and though it be great, yet it is but a particular affliction, the loss of some particular good, and the putting out of some one candle, or the hiding of some one star; but if Christ hide his face, and God withdraw or hide himself, it is the darkening of the sun, which brings a universal darkness upon the soul” (1648, p. 173). If the loss of this sense of connectedness and communion with God is so distressing, then more attention needs to be paid to alleviating this distress, and the current mistrust between the psychological and religious communities needs to be overcome.

Particular attention should be paid to research that explores the nature of the spirituality-depression connections, especially empirical studies, for which most of the current qualitative work have laid the groundwork. Future studies would do well to focus on unearthing the prevalence of spiritual distress in the depressed population and what factors contribute to this distress.

Interestingly enough, although most Protestants consider themselves the heirs of the Puritan tradition, the place depression is most often mentioned in those circles is in the hymnals, in the poetry written by Christians like Cowper who have suffered from depression and have wrestled with how it relates to their spirituality. As a result, Christians with depression often find more solace in their songs than in the care of their pastors. Perhaps further research will heal this rift between faith and experience and bring greater comfort to those Christians who are suffering from depression.

As Archibald Alexander wrote in 1844, perhaps one day the research on the connection between spirituality and depression will be robust enough to write an entire book on the subject, one that can clearly integrate the theology and experience of Christians with empirical psychological research. May that day come soon. This work hopes to be a small step toward that goal.

**References**


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Appendix
List of Questions Used in Semi-Structured Interviews

Spiritual Experience

1. Talk a little about your background. Did you grow up as a Christian? What drew you to become a Christian? What is your family background like?
2. Did you ever attend a youth group or church camp? Tell me about a spiritual experience you had as a young person.
3. What kind of church did you attend? Describe a typical Sunday.
5. Have you ever had a spiritual “high”? Describe the circumstances and how it felt.
6. When you sing songs in church or in chapel, do you express yourself through clapping/raising hands or do you express yourself through singing/focusing on the words (or some mix of both)?
7. Have you ever felt like a sermon or passage of scripture was “speaking” to you? Describe what happened and how you knew it was for you.
8. Describe a time when you felt “close” to God. What does that feel like? How often do you feel that way?
9. What has your spiritual life been like lately?
10. Overall, how would you characterize yourself and your experiences? (Summing up)

Depression

1. Talk about when you first got diagnosed with depression. When did you first suspect something was wrong? Do you remember when you first began feeling poorly? Was there any defined cause for your depression (grief, illness, etc)?
2. People have individual differences in their expression of symptoms. Describe how it feels when you have depression. How does it exhibit itself? How often? How long do episodes last?
3. How would someone else (a friend or relative) describe you when you are having a depressed episode?
4. Have you ever harmed yourself while depressed?

Where they meet

1. When you feel depressed, how does going to church or participating in spiritual things feel? Does it help/hurt/do nothing, etc?
2. Think about the last time you felt depressed. How did it feel when you prayed?
3. Do you feel like your spiritual life is doing better (ie, more spiritual “highs”, better prayer and Bible reading) before, after or during depression? Do you remember having a spiritual “high” during a time of depression?
4. Once again, remember the last time you were depressed. How often did you believe the Bible was true, especially parts dealing with God’s love and forgiveness, hope for future? How often did you doubt these were true?
5. When you were depressed, were you tempted often to stop trying to be good or stop being a Christian? When you gave in to these feelings, how did it affect you? (No response, more discouraging, a relief, guilt, etc)
6. Describe a time when you sinned and felt guilty afterward. Contrast this with a memory from a time when you felt guilty during depression. Are they the same, one stronger, false or real, etc?

7. Did scripture memory or repetition of religious phrases (ie, “Jesus loves me”) alleviate the feelings of depression?

8. Tell me about the role fear played in your experience of God the last time you were depressed.

9. How did your church/other Christian friends respond when they found out you were depressed?

10. What do you wish churches/other Christians knew about your experience?