What Faith Communities Can Teach Psychiatrists about Depression

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Illustration by Andrew Zbihlyj

FOR CENTURIES, FAITH COMMUNITIES took care of the depressed. After Greek and Roman times, the depressed, if severely ill, were often housed in religious institutions such as priories or monasteries. As a result, depressive-like symptoms have long been of great interest to the Christian community. Though monasteries were cut off from Greek medicine, a knowledge of medicine was included in the general education of monastics, and many monasteries (such as Chartres) were centers of learning. Caregivers of the depressed in these institutions held the prevailing view of the humors, so they took a biological approach (such as baths for eliminating black bile). Even so, depression (melancholia) was closely associated with the moral strength of the individual, and the care was very crude.

According to Andrew Crislip, Evagrius of Pontus (ca. 345–399 CE) characterized depression (acedia) as "the most troublesome of all" of the eight genera of evil thoughts and equated it with "the noonday demon" (a term Andrew Solomon used for the title of his 2001 book describing his own depression). Crislip notes that Evagrius is in line with a "long tradition in Christian moral theology" that understood acedia as "the sin of sloth."[1] In describing religious melancholy (in his famous 1661 text *Anatomy of Melancholy*), Robert Burton suggested that one variety of melancholy was "that God himself is a cause for the punishment of sin, and satisfaction of his justice, many examples and testimonies of holy Scriptures make evident unto us" (citing King Saul as one such example). Melancholia was a malady that was visited on a person because he or she had wandered from the ways of God. Belief in God and the practice of religion were not the cause of melancholy, but melancholy could derive from religious excess or aberration. Despite Burton's interest in the humors that could cause melancholy, one cannot ignore the religious context.

> Searching for meaning is an important part of the experience of depression, and in a nonjudgmental faith community, such a search is encouraged and supported.

Today, a few within faith communities may still consider depression a sin, but this is not the prevailing view, and clergy are much more willing to refer the severely depressed to a psychiatrist. Thus, faith communities become the recipients of the expertise psychiatrists have to offer in helping the depressed among them. But psychiatrists are often blind to what faith communities can contribute toward soothing the emotional suffering of the depressed. Faith communities, in my view, have some important lessons to teach psychiatrists.

In this discussion, when I refer to faith communities, I am assuming they are true to their mission, and that this mission involves supporting mental health and human flourishing.[2] I speak from the perspective of a Christian faith community, because that is what I know best, but I believe that what faith communities can teach psychiatrists does not depend on the particular religious orientation, so long as that faith community functions well in support of its members.

Studies of religious groups, from Orthodox Jews to evangelical Christians,[3] reveal no evidence that the frequency of depression varies across religious groups. Therefore, the mere existence of a faith community has nothing to teach psychiatrists. However, I have seen firsthand that there are ways that faith communities can minister to the depressed, if they are committed to their mission of ministry.

To make my case, I will use the example of "Richard"—an example based on a real person, though I have disguised his identity enough that even he would not recognize himself. Richard is a physician who knew he was experiencing all the symptoms of a major depressive disorder. He ended up seeking not only professional help, but also help from his own faith community. Through this example, I will describe seven areas in which psychiatrists can learn something from faith communities. Each of these lessons may seem self-evident but, in the midst of a busy practice, they can, all too easily, be forgotten.

Depression is at once both biological and spiritual. We are embodied souls and, from the vantage point of the patient, there is no room for either Cartesian dualism or a totally materialistic approach (unless the patient is a philosopher, and, even then, I am not certain he would appreciate such an approach in the midst of illness). Describing his own depression, Andrew Solomon said that when he became depressed, he found a soul; he broadened his range of emotion and felt more connected to what was deep inside of him.

Likewise, even though Richard was a physician, had read the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and knew others who had experienced depression, about his own depression he said that he suffered from a "sick soul." He knew that there was an emptiness that had plagued him most of his life, and his major depression brought this emptiness to the fore. He did not totally regret the experience, even though it was very painful. For healing to occur, the road Richard had to travel to recovery passed through a spiritual, as well as a biological and a psychological, landscape. Faith communities consider spirituality to be a central property of personhood, so they are equipped to address this sense of having a "sick soul."

Psychiatrists count symptoms, but patients tell stories. These days, psychiatrists go through a checklist to determine whether a patient suffers from a disorder, as defined in DSM-5. There is nothing wrong with this process of diagnosis, but there is always a story behind the symptoms, and the patient wants his doctor (and his pastor, rabbi, or priest) to hear that story. There was a time, prior to the DSM-3, when a psychiatrist did not possess these checklists and had only the story as a basis for diagnosis: if the story was despairing, then melancholia; if bizarre, then perhaps schizophrenia. We are better off today (the diagnoses are certainly more reliable), and stories alone cannot direct modern therapies such as medication, or perhaps even cognitive behavioral therapy (CBT). Still, from the patient's perspective, there is a story, and it is important.

Richard had a story to tell, though he had difficulty telling it. His story was one of guilt over his failed marriage and estrangement from his two daughters, hard work in search of perfection, a sense of being stifled by never reaching his goals. His psychiatrist gave him meds, but his faith community listened patiently and tried to understand his story, especially the pain over his failed marriage. After all, faith communities are based on stories. Each faith community tells a larger story (a metanarrative), and the individual stories of its heroes (prophets, saints) fit into this larger story. For example, in Judaism, Passover is about remembering a metanarrative. Or, our stories of depression may lead us to identify with Job. In turn, each member of the community works to understand her or his story in relationship to the community's story. In Richard's case, the members of his church did not act in the way Job's friends did. Instead, the community listened to his pain but did not provide ready answers. Nor did they suggest that the pain was somehow not congruent with a strong faith or a proper understanding of God. Richard's story was one among many shared and equally valuable stories.

Faith communities help the depressed person search for meaning in the depression. Depression is an emotion in search of a meaning, yet that meaning may never be found while someone is in the midst of a severe depression. At times, the meaning is more or less apparent, but at other times, it is not apparent at all. Regardless, that searching for meaning is an important part of the experience of depression (it's not like such illnesses as a gallbladder attack). With the illness of depression, it is the search that counts, and a nonjudgmental faith community is an environment that encourages searching. Such communities tolerate uncertainty and futility in the search for meaning and adapt to their congregants.

Richard believed at first that his depression was caused by his failure as a husband and father, given the eighty to ninety hours a week he spent working. As he searched deeper, he realized that work was not the root cause of the failure of his marriage or of his depression. In fact, he found relief in his work, and his faith community affirmed his spiritual call to his secular work. He discovered how his story of being lost and eventually being redeemed fit into the Christian story of redemption. He had been only a nominal Christian until his illness; after his depression, he became much more active, studied more, and prayed more, which led to a gradual but definite improvement of his symptoms. He never did find an adequate answer to why his marriage failed, and he remained cut off from his two daughters. Stories do not have simple and neat endings, and supportive faith communities allow for this messiness.

Faith communities help us name our depression. We all search for a name for our infirmities. This has been

called the Rumpelstiltskin effect. In that story, the maiden captured by the terrible little creature was promised freedom if she could name him. When we seek help from doctors, we want a diagnosis. Yet, for emotional suffering, a diagnosis often falls far short of giving us control over our pain. Again, this is in contrast to a pain in the abdomen, which can be better tolerated, even cured, once we identify it as a gallbladder attack and remove the gallbladder. Faith communities can help by providing different names for what might seem like such a sterile term ("depression"): "the dark night of the soul," a pilgrim's progress, fellow strugglers (such as Job), or growth through pain toward something better. These names evoke a sense of community by suggesting that all people within the community are walking the same path and slogging through the same tough times.

Richard needed a communal name for his pain. The theme of his faith community was "the journey," and congregants referred to themselves as fellow travelers. The journey was not easy, and was more difficult for some than for others. Richard was a hiker, so the metaphor of traveling a long road through life, often a difficult road, provided a name for his emotional suffering that resonated with him. Although he did not initially notice it during his severe depression, he came to discover that others were traveling that road with him.

Some caveats are important here. Faith communities that buy wholly into positive psychology, discouraging any negative comments or anything but a smiling countenance, do not function as they should to help the depressed. Likewise with communities which isolate the depressed into small support groups, walled off from the rest of the faith community. Even supportive religious communities that emphasize growth need to be careful about suggesting that all suffering has an apparent reason, because this may get in the way of recovery from depression.

Faith communities teach us that there is a "social psychiatry." We have virtually lost our appreciation for the importance of the social environment in the causation and the healing of psychiatric disorders such as depression. But such factors as social support, social integration, a retreat to alternative social groups, and instrumental support (with the activities of daily living, like home repair) can be most important in the healing process of depression. Faith communities can be invaluable sources of such support; indeed, they are among the most natural places in our society to find it.

Richard found much tangible support within his faith community. Given his marital problems, he faced significant financial strain, which was alleviated through financial counseling offered in his faith community. He joined a small study group that met weekly, with equal time spent in study and in getting to know one another. Richard rarely missed a meeting, became friends with people in the group, and even led some of the sessions. Until this small group experience, he had been isolated (even before his depression) and might even have been labeled as borderline Asperger's or schizotypal. The support he felt helped him to defy these definitions and to become intentionally more social.[4]

Faith communities teach that hope and purpose are critical to healing depression. Depression often seals off those who are suffering from a sense of hope. They see no future, and our society does not always provide messages of hope to counter this perception. Faith communities almost invariably look to a future

that is better than the present, finding hope in that future. Faith communities also work well if they stress finding a purpose—not a purpose that comes from someone else, but an individual purpose, a sense of discovering one's own unique mission.

Richard found hope and a mission. Despite his busy work schedule, he started helping others in his faith community by sharing his unique skills as a handyman and computer expert. In his personal study, he focused increasingly on hope in the future. This opening up to hope eventually brought him a wife from within the community, which in turn acted as confirmation that hope would bear fruit.

Faith communities teach that helping those who are depressed is a "family affair." Depression occurs in context. It is not isolated. At some level this is obvious, but psychiatrists may overlook it, thinking they do not need to worry about the context. Depression doesn't work that way. To understand an individual's depression, a psychiatrist must understand the person, the family, the workplace, and the community (including the faith community) in which that person exists.

Richard's depression was very much related to his context, especially his workplace and his faith community. He worked exceedingly hard as a radiologist. He could not say "no" and had a very poor recognition of his limits (such that he might work to the point that he was not as accurate as he was when he was rested). Because of his severe depression, one of his colleagues stepped in and became an informal mentor to him, meeting two or three times a week to monitor his work and encourage him to set limits for himself. During Richard's deepest lows, he was suicidal, and it was the support from his faith community that saw him through those crises. He was single at that point and had few friends, but the pastors and members of his community were "on call" for him. He frequently reached out to them during a crisis and they talked him through it. And, as noted, Richard met a woman through his faith community. They were married after about a year, and Richard's mood improved remarkably after the marriage. (They have been married five years now, both considering it to be a "marriage made in heaven.")

In terms of his recovery from depression, Richard is a success story. Not all stories have such happy conclusions, but I hope his helps illuminate how and what faith communities might teach psychiatrists about emotional suffering and the road to healing. And, I hope his story encourages those of us in the profession to focus on holistic care for our patients, whether a faith community is involved or not.

Notes

1. Andrew Crislip, "The Sin of Sloth or the Illness of the Demons? The Demon of Acedia in Early Christian Monasticism," *Harvard Theological Review* 98, no. 2 (April 2005): 143–169. Crislip notes that these depictions of acedia, which covered "a variety of psychological states, behaviors, or existential conditions: primarily laziness, ennui, or boredom," were transmitted through Evagrius's contemporary, the Latin-speaking desert father John Cassian.
2. Of course, this is not always the case. Groups we would classify as cults, such as those led by Jim Jones or David Koresh, those with rigid fundamentalist tenants, militant religious groups at war, and some isolated sects, tend not to tolerate the depressed.

3. So far, these are the groups where virtually all empirical studies have been fielded.
4. Again, it is important to note that faith communities can also be among the most destructive social environments for people with psychiatric disorders, especially if these communities are controlling, isolating, or abusive.

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