WISCONSIN LUTHERAN SEMINARY

THE NARROW LUTHERAN MIDDLE: THE PROBLEM OF BEING A CLINICALLY-DEPRESSED CHRISTIAN

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ABSTRACT

Clinical depression can bring about a great deal of problems in a person's life. These include a depressed mood, negative self-image, harmful self-talk, a flawed perception of the truth, feelings of anger, sadness, worthlessness, or a lack of feeling, loss of energy, a tendency toward perfectionism, and an inability to self-motivate. As Christians face depression, this diagnosis becomes more complicated when treating the whole person: body and soul. The problems of depression bring significant spiritual implications into consideration.

The problem then for the Christian is to weigh the information before him: "Is this a spiritual problem, or is this a physical problem?" This question has been answered in many different ways in recent history, and this answer is exceedingly important because the answer effects how a person should seek treatment for his depression. In answering this, a Christian will have to be a good steward of the information psychology has provided in regard to clinical depression, while balancing that information with what God reveals in Scripture.

Satan works exceptionally hard on a person suffering from depression. Since depression often comes with a skewing of logic and perception of the truth, a depressed Christian can feel especially scared when thoughts of doubting God's promises creep into his mind. But God's Word brings comfort even as a Christian struggles with depression. In calming a Christian's mind from the fears of depression, a pastor will seek to find a qualified psychologist to assess the depression and continue to encourage the Christian with God's Word. Clinical depression cannot be considered a purely bodily or purely spiritual problem in a Christian; pastors will need to

minister to the whole Christian, allowing psychology to help in ways it is able, and applying God's Word appropriately in cases of clinical depression.

FOREWORD

"Can I really be a Christian if God's promises fail to give me joy in my daily life?" "Can I be a Christian if I feel separated from God by a cloud of sadness?" "How can I possibly find comfort in God's forgiveness when so often I've left God's house feeling as empty as when I walked in?" "Can I truly be called a Christian?"

These are just a few of the questions that daily run through a depressed Christian's mind. This paper is meant to address the big question behind all of those lurking thoughts: "Can I be depressed and still be a Christian?"

This problem is compounded by the varying opinions regarding depression in the Christian realm today. Most everyone will acknowledge the presence of mental illness in a case of Alzheimer's or schizophrenia, to name a few examples; but in the case of depression where the mental illness is sometimes more subtle and closely connected to a person's perception of truth, there remains great disagreement concerning proper care. Some claim depression is simply a mental illness, a sickness of the body; others claim depression is the result of a weak faith, a spiritual problem. But who am I to trust: the world which seeks to deny the reality of sin, or the spiritual leaders who use God's Word to condemn sadness and doubt, attributing these symptoms to a lack of faith?

People have addressed the problem of depression in many different ways. Even today psychologists do not fully agree on many aspects of depression. The church throughout its history has addressed depression with vastly different conclusions. The root problem of depression is more important to a Christian because of the close relationship between the mind

and the spirit. One's approach to depression has great spiritual implications. In this sense, depression strikes Christians harder than non-Christians; there's more at stake in the life of a Christian when eternal welfare is on the line. So what kind of comfort can a depressed Christian find in the face of all this uncertainty?

Depression has a way of making its home in the thoughts and emotions of an individual, even going as far as to hinder their cognitive and rational thinking. For this reason, I hope this paper can serve as a blessing to you as you struggle through your own battle with depression, or as you suffer through the opportunity to share comfort with a loved one. While I write this specifically for men suffering from mild to moderate major depression[1], depressed women and even those who aren't depressed may find benefit in the contents of this paper.

To the men who have suffered the great blows of depression, my hope as I write this paper is to give you comfort as you face the lies depression brings specifically to your faith. As a fellow sufferer from the pains of depression, these thoughts have haunted my own conscience and they aren't easily shooed away.[2] For this reason, I have decided to answer this basic question from many different angles: history, psychology, and Scripture itself.

Why not simply use Scripture? While all comfort is ultimately drawn from Scripture, God's Word never specifically addresses depression as a mental illness. For this reason, I find it imperative to define depression according to modern standards of psychology and to see how the church has historically dealt with the issue.

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[1] People suffering from other forms of depression may find helpful truths in this paper. Other forms of depression share many similar characteristics with major depression.

[2] As I address this topic, I will also bear in mind specific warnings from psychologists to pastors in this regard. Many psychologists during my research noted that pastors suffering from a milder form of depression are quick to judge other forms of depression. I have taken the time and effort to be as objective as possible in dealing with this issue, but the reader may find this warning helpful as he contemplates the subject.

As the reader evaluates this paper, I pray he takes caution. The goal of this thesis is not to diagnose mental illness or validate the reader's negative thought patterns; rather, I hope the reader finds a level of understanding about the nature of depression from both a physical and spiritual perspective. Since depression has a profound influence upon a person's perception of the truth, I pray the depressed reader will be able to find and hold on to these truths in order to combat the lies of his mind.

The trials of depression can bring a great deal of distress upon a Christian's soul. My prayer is that you may find the answers to deal with the lies of depression in your daily life. This disease carries extreme spiritual implications with it, but I hope you become convinced, as I am, that depression is not as spiritually condemning as you may be tempted to think.

INTRODUCTION

"Come to me, all you who are weary and burdened, and I will give you rest.
Take my yoke upon you and learn from me, for I am gentle and humble in heart,
and you will find rest for your souls" (Matthew 11:28,29 NIV).

Depression, more than any other mental illness, has come under more scrutiny from certain theologians since the rise of psychology as a science in the 1800s. Most other mental illnesses manifest themselves much more clearly to the outside observer, while depression "hides in silence."[3] Yet, at the same time, depression has become so prevalent in our world today that it has recently been referred to by many as the "common cold of mental illnesses." Studies estimate that upwards of five to seven percent of adults will suffer the effects of depression during any given year.

So why the scrutiny from these theologians? These theologians do not deny the pain depression causes or the seriousness of depression. The issue comes in understanding the nature of depression, and an overall hesitancy to accept the truths presented in psychology. This is for good reason: psychology, as a science, does not acknowledge the total depravity of mankind. That raises the question: "What parts of psychology present the truth, and what parts are making an attempt to excuse evil?" In questioning the validity of the truths found in psychology then, these theologians are simply trying to exercise a good, Christian approach to assessing truth. Since the Bible does not speak directly to depression as psychology has defined it today, we must use scriptural principles as we evaluate our use of psychology in treating depression.

[3] Philip L. Schupmann, "A General Introduction to the Subject of Depression," (1989), 1.

In studying this topic, I used a variety of sources from psychologists and theologians alike. In order to understand the psychology better, I used sources both from secular psychologists as well as Christian psychologists. There were few discrepancies between psychologists and for the most part, they all addressed depression in the same way—minus the understanding of sin and the need to hear God's grace from the Christian psychologists. Theologians varied greatly in their handling of depression in a few different areas: either in the nature of depression, psychology's value in treating depression, or simply their understanding of what psychology taught.

The books written by WELS, either Christian mental health professionals by themselves, or in collaboration with a pastor, seemed to be the most beneficial for calming the fears related to being a Christian with depression, and they were closest in their handling depression. However, the WELS sources did not present the common-ground between psychology and theology as well as other sources.

In looking at the history behind depression, there is not much that can be conclusively stated about depression throughout history; however, it did prove beneficial in the study due to early issues between theologians and psychologists. The history showed that the church has, in many different cases shown tender care in treating individuals suffering from depression-like symptoms, showing that the church of old acknowledged depression to be more than a spiritual problem. But when psychology emerged on the scene in the early 1900s, many church leaders reacted strongly to psychology's findings and stated that depression was a spiritual problem, not physical as psychology stated.

Upon studying this topic in its depth, I have come to the conclusion that depression must be handled on a case-by-case basis, but in general, depression affects the whole person—body

and soul. Clinical depression cannot be considered a purely bodily or purely spiritual problem in a Christian; pastors will need to minister to the whole Christian, allowing psychology to help in ways it is able, and applying God's Word appropriately in cases of clinical depression.

DEFINING DEPRESSION

"People feel sad and down all the time, what makes you any different?" This difference is understood best by the work psychology has accomplished in recording the characteristics of clinical depression. Since depression has been defined through the study of psychology, we must understand how psychologists have described it.

Depression indicates that a person is not mentally healthy. So first we must understand what mental health is, and what a mentally healthy person looks like.

> To be mentally healthy means that a person *feels* much the way he or she wants, is in control of his or her *actions*, and *thinks* both realistically and optimistically. Because one's ABCs are healthy, one is able to fulfill *obligations* to others and is able to make and keep important *relationships*… A mentally healthy person will perceive his faults for what they are (i.e., an inevitable aspect of being a sinful, imperfect human being) and accept them. A mentally healthy person realizes he is loveable despite being flawed, and he likewise loves other people even though they too have flaws. Being mentally healthy entails thinking realistically and not setting expectations excessively high for either yourself or others.[4]

Depression, as a mental health disorder, negatively effects the way a person feels, thinks, and acts, to the effect that realistic, logical thinking is hindered.

Depression is a mood disorder. It's important for our purposes to distinguish "mood" from "emotion." An emotion is a feeling one experiences in response to stimuli (anger, sadness, happiness, etc.). Mood is similar, but mood is not a feeling in response to certain stimuli; rather, mood is one's overall state of mind which colors the way a person responds to stimuli. In this

[4] Stephen M. Saunders, *A Christian Guide to Mental Illness. Recognizing Mental Illness in the Church and School*, (Milwaukee, WI: Northwestern Publishing House, 2016), 17-18.

way, "mood can be thought of as our baseline emotion, that is, the way we generally feel."[5] So while a person in a "good" mood may respond to a stimulus with laughter and happiness, a person in a "bad" mood may respond to that same stimulus with anger or sadness. Since depression is a mood disorder, individual instances of sadness or downheartedness for minutes, hours, or days may not be indicative of depression. In order to speak about depression then, it is important to distinguish depression from grief and sadness.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, or DSM V, gives the current requirements for a diagnosis of major depression. While this definition might seem overly thorough, this distinction will be important in understanding what we're dealing with. DSM V lists these criteria for a diagnosis of major depression:

> A. "Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
> **Note:** Do not include symptoms that are clearly attributable to another medical condition.
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> 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
> 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
> 4. Insomnia or hypersomnia nearly every day.
> 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
> 6. Fatigue or loss of energy nearly every day.
> 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
> 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
> 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

[5] Saunders, *A Christian Guide to Mental Illness. Recognizing Mental Illness in the Church and School*, 12.

> B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
> C. The episode is not attributable to the physiological effects of a substance or to another medical condition.
> **Note:** Criteria A-C represent a major depressive episode.
> **Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss. [footnote 1]
> D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
> E. There has never been a manic episode or a hypomanic episode
> **Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition."[6]

Admittedly, many of the above symptoms appear to be a response to traumatic episodes in a person's life (e.g. the loss of a loved one). DSM-V also notes the similarity of grieving to the diagnosis of major depression, and at the same time, DSM-V sees a clear distinction between grieving and the diagnosis of depression. In order to help psychologists with this diagnosis, DSM-V adds a footnote:

> In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or

[6] *Diagnostic and Statistical Manual of Mental Disorders : DSM-V*, (Arlington, VA: American Psychiatric Publishing), 2013, 160-161.

> pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.[7]

In other words, while grief is a normal reaction to occurrences in life, "Depression implies exceptional or disproportionate bad feelings. When feelings of loss are *disproportionate in intensity and duration*, it is appropriate to diagnose depression."[8] In this way, depression is not considered a normal response in every-day life. So while one might say he feels "depressed" by looking outside and seeing the gloomy reality of a rainy-day, this emotion we often refer to as "being or feeling depressed" is in no way synonymous with the diagnosis of Major Depressive Disorder. Depression is not normal. "Depression produces a total feeling of sadness that is not necessarily linked to any specific precipitating[9] event;" [10] Whereas, "Grief is a realistic reaction to an actual loss about which there is full awareness."[11] In all of these definitions, great effort is made to show what "normal" behavior looks like as opposed to the abnormality of depression. Curtis Lyon perhaps explains the difference the best: "While a grief reaction is a normal, predictable behavior that tends to resolve itself with time and spiritual care, the same is not true

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[7] *DSM-V*, 161.

[8] William D. Backus, *Telling the Truth to Troubled People*, (Minneapolis, MN, Bethany House, 1985), 141.

[9] In Telling the Truth to Troubled People, William Backus describes any events that might contribute to the development of depression as a "precipitant." So while no specific events can be pointed out to explain why a person has depression, the presence of precipitants helps psychologists in diagnosis. At the same time, even if specific precipitants do not present themselves, Backus is saying with this quote that depression may still be a valid diagnosis. 141.

[10] H. Curtis Lyon, and John Juern, *Pressed down but Not Forgotten: Depression*. (Milwaukee, WI, Northwestern Pub. House, 1993), 26.

[11] Schupmann, "A General Introduction to the Subject of Depression," 5.

for actual depression. A major depression affects every part of a person's existence. It does not necessarily go away with time. It is also quite true that the emotional pain of depression may be worse than the physical pain one experiences with a physical illness."[12]

DSM-V clarifies specifically the distinction between the normalcy of grief and the unnatural nature of depression, but what about other symptoms that are commonly linked to depression? Depression is often accompanied by anxiety, irritability, perfectionism, guilt, self-loathing, and an abundance of other symptoms. While we will not be able to address all of these in detail at this point, we will briefly look at the first accompanying symptom listed, anxiety, since anxiety, more than the other symptoms, may be more difficult to distinguish from the nature of depression itself.

While anxiety and depression often go hand-in-hand, they can be distinguished. Pastor Schupmann describes the difference:

> Depression goes beyond anxiety. The symptoms of anxiety are a pounding heart, troubled breathing, trembling, giddiness, nervousness, and hot and cold spells. The symptoms of depression include all of these plus fatigue, inability to eat, restlessness, boredom, an inability to concentrate on the daily tasks of life, a feeling of "going to pieces," and physical complaints such as a backache, muscle ache, or skin conditions. Crying spells are common in depression. Anxiety may be fleeting. Depression may persist for years. Anxiety is highly visible. Depression is obscure. Anxiety clamors for relief. Depression hides in silence.[13]

Visible signs of anxiety can lead to a diagnosis of the depression hidden under it. Though they have a tendency to manifest at the same time in an individual, they are by no means synonymous.

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[12] Lyon et al., *Pressed down but not forgotten*, 23.

[13] Schupmann, "A General Introduction to the Subject of Depression," 1.

As we continue to look at the challenges of depression, it will be important to keep this in mind: depression is not normal. That's why psychologists have gone to such lengths to determine what is normal and abnormal behavior. Dr. Saunders admits "It can be difficult to decide whether someone's feelings, thoughts, and behavior are an indication of something abnormal. But making the distinction between normal and abnormal is absolutely essential."[14] The truth of the matter is that many of these symptoms mentioned in DSM-V concerning depression are normal in and of themselves in reaction to certain stimuli. In fact,

> Many people have experienced some of the above symptoms. Just because a person experiences one or two of them, however, does not necessarily mean the person is depressed. We always need to look at the number of symptoms and the severity of the symptoms. Remember, everyone will have some of these feelings in daily life. Only when the symptoms are so severe that they begin to interfere with routine, daily living is a diagnosis of depression made.[15]

The skeptical reader will take note to see how the diagnosis of clinical depression is given great care. Mental health care professionals have strict guidelines for diagnosing clinical depression.

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[14] Saunders, *A Christian Guide to Mental Illness. Recognizing Mental Illness in the Church and School*, 5.

[15] Lyon et al., *Pressed down but not forgotten*, 29.

MODERN SCIENCE CONCERNING DEPRESSION

DSM-V is an invaluable tool to evaluate the presence of depression, but it doesn't by itself prove the idea that depression has physical roots. "Using the DSM, a person will be diagnosed as having a mental illness based on his or her *subjective* (i.e., phenomenological) experience of feelings, thoughts, and behaviors. A mental health professional would diagnose a person with a depressive disorder, for example, based on her subjective experience."[16] DSM-V evaluates depression based on the subjective report of an individual's perceived symptoms.

This also raises a difficult question: "How can I rely on my subjective experience for a diagnosis?" Depression is a mood disorder which affects a person's emotional responses. We defined mood as the baseline emotion or the way a person generally feels. Earlier we described an emotion as a response to a stimulus. Backus says there's more to it than that: experiencing an emotion is also based on a person's subjective experience. Backus says,

> The element in an emotional response which enables us to identify the emotion we are currently feeling, is a belief… Now perhaps we can identify what an emotion is. It appears to be a state of physiological arousal together with belief or interpretation of the situation eliciting the arousal. In other words, an emotion is a response to a stimulus. And what is critical for our purposes is this: the stimulus to which our bodies are responding is a belief in our heads![17]

We can understand then how people experience different emotions from the same stimulus. In the case of depression, we know there is something causing this false belief. The question is, "What causes this false belief?" And especially for Christians then, the question

[16] Saunders, *A Christian Guide to Mental Illness. Recognizing Mental Illness in the Church and School*, 24-25.

[17] Backus, *Telling the Truth to Troubled People*, 71-72.

remains, “Is depression a product of my sinful body, or a product of a ‘love that has grown cold?’[18]”

The most obvious solution then would be to simply ask a mental health professional about the physicality of depression. One problem with this approach at the writing of this thesis is the demand for mental health experts who are able to give this answer definitively.[19] The other problem is in psychology itself. Psychology, as a branch of science, functions under the assumptions that everything that happens occurs in response to a physical stimulus; that is, it does not acknowledge the human soul.[20]

So then, what about medication and its recent results in combatting depression? If many people suffering from depression find positive results in curing their depression with medication, doesn’t that prove depression is rooted in physical brain function? Dr. Sorenson claims in his article that over 55% of adults benefit from medication.[21] Yet this fact has recently come under scrutiny. In Johann Hari’s *Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions*, Johann Hari uncovers the unsatisfying truth behind drug companies’ drug testing procedure. The current problem in the drug industry right now is that drug companies are in charge of assessing their own drugs. In order to assess their own drugs, companies must pay an individual to test-drive their drugs. In his investigation, Johann Hari

[18] A reference to Matthew 24:12, in which Jesus describes the sinfulness of the end times.

[19] This is the current situation in Milwaukee, WI. A person can readily find a Psychologist or therapist, but if one wants to see a Psychiatrist, he can expect to wait months before seeing a qualified mental health professional.

[20] Some psychologists have claimed to have found evidences of the human soul. This is far from definitive science, but certain psychologists have a concept of the soul. The University of Virginia specifically has done extensive research on Near-Death Experiences, which have led some to question the reality of the human soul. Of course, this is not the same definition of soul that we know from the Bible.

[21] Stephen J. Sorenson, “Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity,” *Pastoral Psychology* 62, no. 3 (June 2013): 346.

found that many people who participate in these studies do not have the illness the drugs are meant to help them with and many of them simply tell the researchers what they want to hear. In other words, Johann Hari found that many of these volunteers lie in these tests; they must in order to qualify and get paid. While the testing process of drugs may be held under scrutiny, the results they have produced in the real world show the real results they can bring. Johann Hari combats this saying that many drugs simply numb the patient of their symptoms, and other positive results of drugs are due to the placebo effect. [22] Though Johann Hari's theory seems extreme compared to psychology's current state as a science, his scrutiny of the drug scene shows that the evidence of medication's positive effect on people suffering from depression cannot prove that depression has roots in physical brain function.[23] At the same time, this author cannot stress enough the value of medication for depression. Most mental health professionals encourage the use of anti-depressants and other medications for help with depression and would consider it foolish to abstain from using these medications.[24]

This author agrees with Dr. Sorenson's ideology: "explaining the causes and treatment of depression to a Christian requires common ground. Evidence that depression is a physical illness is the first step."[25] As we explore the physical aspects of depression, we will primarily use the research Dr. Sorenson has provided as an overview of these many studies as he proves that "clinical depression in the form of Major Depressive Disorder (MDD) is almost always a

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[22] Hari, Johann *Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions*.

[23] Note that while Johann Hari is convinced intensive counseling without the use of medication is the best treatment option, most psychologists (and this author) believe medication carries a significant positive effect to the persons suffering from depression.

[24] Many sources indicated that while depression is so common, the good news is that it is very treatable. A depressed individual will then want to see a mental health professional for a specialized treatment plan.

[25] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 344.

physical illness."[26] We will also make use of Dr. Daniel Amen's original research on depression using his own brain scans on patients.

First, Dr. Sorenson addresses the way scientists are able to measure brain structure and function.

> Traditionally, analysis of human brains has been done through magnetic resonance imaging (MRI) and computerized axial tomography (CAT). However, these scans are more helpful at showing physiological structure than function. These tools are designed to find physical abnormalities within the brain but are inappropriate for determining how well the brain—or a particular part of the brain—functions. Certain tools such as single photon emission computed tomography (SPECT) and the more recent functional MRI (fMRI) are better suited to determining how well a particular area of the brain is functioning. They show a time-lapse image of the brain that uses blood-oxygen levels to highlight areas that are overactive or underactive compared to a control population.[27]

These are the tools scientists use in their studies of human brains. By comparing healthy brains to those with depression then, scientists are able to understand interior aspects of the brain associated with depression. Dr. Sorenson continues to explain what these tools have been able to find so far:

> Diseases such as MDD [Major Depressive Disorder] and GAD [Generalized Anxiety Disorder] exist within the brain—a finding that recent science has been able to show objectively. According to Dr. Daniel G. Amen (a practitioner of SPECT scanning for psychiatric treatment), even the ability to feel closeness to God[28] may be controlled or limited by the mechanisms of particular functions of the brain (Amen 1998). Dr. Amen points to the deep limbic system of the brain as the emotional center, the area that houses the amygdala. Irregularities in this area along with the subgenual anterior cingulate cortex (subACC) are frequently linked to MDD (Gotlib and Hamilton 2008; Masten et al. 2011). Masten et al. (2011) point to the subACC in particular as an area very responsive to negative emotional inputs. Such findings help demonstrate that depression is a physical disorder.[29]

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[26] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 344.

[27] Sorenson, 344-345.

[28] Note he says, "*feel* close to God" not, "*be* close to God."

[29] Sorenson, 345.

Further studies tell us not only that there is a physical aspect to depression, but also how the brain is functioning incorrectly to cause depression.

> Brain imaging has been able to take us a step closer to understanding how symptoms manifest themselves in the human brain. A targeted study recently has shown that patients with MDD have heightened activity in their subACC region corresponding to lessened activity in the dorsolateral prefrontal cortex (DLPFC), which is commonly thought to be responsible for providing much of an individual's ability to override emotional responses to situational dilemmas with logical thought (Glenn et al.2009). Gotlib and Hamilton (2008) conclude that MDD patients tend to experience overactive subACCs and underactive DLPFCs. Another study (n0127) found that patients with MDD and the offspring of MDD patients showed smaller masses of white matter in both the subACC and the DLPCF (Amico et al.2011). Since white matter is mostly made of glial cells[30], this information could lead to the inference that depressed persons might have difficulty understanding emotions or overriding them with logic. Also, it might explain the difficulty MDD patients have in describing their emotions (Kahn and Garrison2009) and the inconsistent long-term results of basic anti-depressants.[31]

Dr. Sorenson's research presents a strong case that clinical depression—Major Depressive Disorder specifically—is physically present in the brain. Dr. Sorenson notes two points in conclusion to his work concerning the cognitive ability of those suffering from MDD: "First, the brain is a very complex organ that requires harmony among all regions in order to be "healthy." Second, research has revealed many ways that depression is linked to brain irregularities that cause many symptoms of depression."[32]

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[30] Sorenson explains the recent findings of these glial cells: "Recent science is only beginning to understand the mysterious glial cells, or astrocytes, that were previously thought of as purely passive material meant to hold the brain in place like glue. They compose the majority of the "white matter" within the brain. One recent finding of note shows that astrocytes have the ability to receive transmission and release gliotransmitters and calcium. The results of a study by Navarrete et al. (2012) show that astrocytes have some form of control over the ability in a neuron to increase or decrease the strength of a signal sent via neurotransmitters at the synapse (called synaptic plasticity). Essentially, astrocytes manage the strength and sensitivity of a message communicated from one point to another." Sorenson, 346.

[31] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 346.

[32] Sorenson, 347.

The average layperson may have difficulty understanding the significance of Dr. Sorenson's argument. Dr. Sorenson makes a strong point about how depression is rooted in the brain, but his arguments are inclined more towards an audience that is well-informed concerning current brain science. For this reason, Dr. Daniel Amen's work on noting differences in healthy and unhealthy brains may be of great value to the average layperson. Dr. Amen explains in a simple way how clinical depression manifests itself in the brain.

Dr. Sorenson had said earlier that Dr. Daniel Amen points to the deep limbic system as the emotional powerhouse of the brain. The deep limbic system is home to the amygdala, the part of the brain that is primarily responsible for emotions. Along with having a large impact on a person's emotions, the deep limbic system is also in charge of motivation, strong emotional memories, social relationships, sense of smell, and sex drive. So then when problems come in the deep limbic system it affects a person in many ways: moodiness, clinical depression, negative thinking and coloring, decreased motivation, appetite issues, sleep problems, social isolation, and a decreased interest in sex.[33] Problems in the deep limbic system come in a depressed person then due to a deficiency of certain neurotransmitters, namely, norepinephrine and serotonin. This inflammation causes many of the symptoms found in depression.[34]

While it might make sense that extra activity in the deep limbic system would make the problem go away, the opposite is true. "When the deep limbic system is less active, there is generally a positive, more hopeful state of mind. When it is heated up, or overactive, negativity can take over… It seems that when the deep limbic system is inflamed, painful emotional

[33] The reader may take note that these correspond in many ways to the symptoms listed in DSM-V.

[34] Daniel G. Amen, *Change Your Brain, Change Your Life: Revised and Expanded Edition*, (Piatkus Books), 2016, 183-232.

shading results."[35] To give visual representation to his argument, Dr. Amen in his book *Change Your Brain, Change Your Life* provides two SPECT scans: one of a healthy brain (Figure 1) and one of a brain affected by clinical depression (Figure 2).

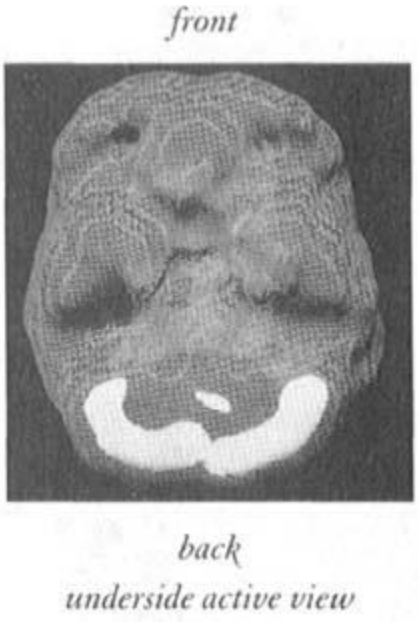

Figure 1

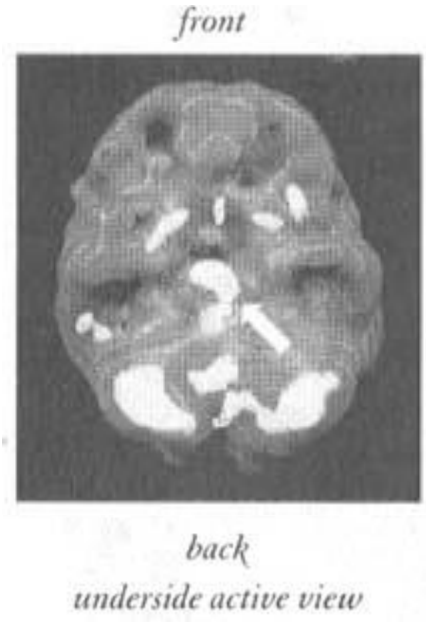

Figure 2[36]

Dr. Amen shows with his scans how differently these brains look. In Figure 1, the activity shown in the lighter color reveals the most active 15 percent of a healthy, functioning brain. In Figure 2, notice the activity happening in the deep limbic system.[37] These are just two examples of the thousands of SPECT scans Dr. Amen has conducted which all prove the same thing: depression has deep roots in the deep limbic system.

Looking at the evidence, it's hard to deny that depression is a physical illness. This evidence serves as a great comfort to a Christian because it lets him know there's a physical

[35] Amen, *Change Your Brain, Change Your Life: Revised and Expanded Edition*, 188-190.

[36] The arrow points to the deep limbic section of the brain.

[37] Amen, 118,252.

explanation; he need not feel guilty about his depression. In fact, understanding that depression is usually not rooted in the spirit is a great step toward understanding and healing.[38]

[38] Lyon et al., 39.

CHURCH HISTORY

Part of the difficulty in understanding depression is the tensions that exist between the study of psychology and Christianity. And for good reason too: in the 1900s psychology was still a budding science, it was new, and its ideology began to creep into church practice and understanding. Christianity in Wisconsin perhaps had even more reason to be concerned about psychology due to the dominance of behavioral psychology. This branch of psychology is especially dangerous according to Erstad because of its demeaning view of humans, which is contrary to God's design in creation. "As they [behavioral therapists] have a low view of humans, their therapy also aims low and often accomplishes little… The implication in this name [behavioral] is that if you attend to the behavior the organism demonstrates, you can pretty well forget about what is going on inside it."[39] Sievert relates another critique of psychology from a Christian perspective, "Someone has facetiously remarked that at one-time psychology included in its study the body, mind, and spirit, but it lost its soul when it became experimental, it lost its mind when the behaviorist took over. With only a body-a physical mechanism left for study, psychology would soon to have little more than a corpse to consider."[40] Overall, Christianity is concerned primarily about the soul, while psychology is concerned primarily about mental well-being. Psychologists also have valid concerns about church leaders. Put simply, psychologists clearly have more training in counseling than most, if not all Christian pastors. From

[39] Duane H. Erstad, "A Lutheran Perspective on Psychotherapy," (1994), 3.

[40] Erich H. Sievert, "Christian Psychology in Education," (1966), 4.

psychologists' perspective of experience comes their main complaint about Christian churches: "clergy are often judgmental, ignoring the specifics of the individual."[41]

In recent history, there has clearly been a significant difference in the philosophical approach to addressing problems between Christians and psychologists. At the same time, psychology has proven to be incredibly useful to Christianity as the church seeks to properly help its members. The question then that remains is: How do we as Christians make sure we are not relying too heavily on psychology to help us understand depression? One way Christians can take care in handling people with depression is by seeking how the church has understood depression in the past. One may ask himself: "How has the church historically dealt with the issue of depression?"

As we explore the history behind clinical depression in the church, we will take care to note some important limitations to our study. First, we need to recognize a difference in definition. Today, we diagnose depression according to DSM-V. Historically, definitions concerning depression have not been as precise as they are now. The best we can do then is to look back to find instances similar to our modern-day definition of depression.

Backus points out that the church has historically understood problems with emotional and mental health far before psychology came around.

> Long before there was a branch of medicine called psychiatry, and before the branch of philosophy called psychology ever began to deal with human soul pain, the Christian Church ministered to emotional and mental disturbances. For centuries, priests and monks in the confessional heard the difficulties of their brothers and sisters and applied the Word of God to help them. This counseling predates psychiatry by 15 centuries![42]

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[41] Erstad, "A Lutheran Perspective on Psychotherapy," 1.

[42] Backus, *Telling the Truth to Troubled People*, 59.

Backus is referring to an early phenomenon which occurred among monks in the monastery. The monks referred to this phenomenon as "acedia," and though it manifested itself in ways different from depression, many historians have suggested acedia is one of the earliest indications of depression we know of.

LaMothe contributed substantially to the understanding of acedia. Acedia was the name of a mental illness given to describe the abnormal emotional state of monks in the monastery, the primary emotion being depression. The problem with simply labeling acedia as depression is that many people used this term to describe a broader category of problems than simply depression. The word itself translated from the Greek means "lack of care." The monks in the monastery attributed acedia to the devil, even calling it "the demon of acedia." This "demon" was difficult for a monk to shake off on his own, but through prayer and meditation, monks would often return to a normal condition in a matter of weeks.[43,44]

Acedia was a term used primarily for monks and others in solitary, which later contributed to a diagnostic tool developed by John Cassian, "The Seven Deadly Sins."[45] The sixth deadly sin, *sloth*, is considered by many to have been derived from acedia. LaMothe sees the connection to be so close, he even equates acedia and sloth. Backus points out these are not sins in the way we normally think of the term "sin." Usually, sin refers to an action or behavior (e.g. murder, theft, slander, etc.).[46] "The Bible refers to another way to think about sin. At times,

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[43] Ryan Lamothe, "An Analysis of Acedia," *Pastoral Psychology* 56, no. 1 (2007): 16-28.

[44] LaMothe concluded contrarily to other historians that acedia didn't refer to depression; rather, he said it is much more broad referring to the lack of care that results in a lack of desire, need, and passion. At the same time, LaMothe did not deny that this could include depression.

[45] Historians differ greatly on how they view the Seven Deadly Sins, a diagnostic tool is just one of those viewpoints.

[46] Backus, *Telling the Truth to Troubled People*, 60.

the writers of Scripture discuss sinful traits in a way that sounds as though they were talking of something inside, under the skin."[47] The sin of sloth was characterized by a lack of motivation to do work and overall lethargy. Thomas Aquinas in the mid-1200s described the sin of sloth as having the result that "men plunge into evil without restraint and abandon their efforts to do good… [it] makes one spiritually sluggish because of weariness in flesh."[48] In LaMothe's evaluation of Aquinas' study of sloth, he points out three valuable distinctions of sloth:

> First of all, Aquinas, reminiscent of Cassian, acknowledged the emotional elements of being able to recognize, but not desire, the good. Second, Aquinas did not believe that acedia is mere laziness. A slothful person can be industrious. What links acedia as laziness and acedia manifested in busyness is that while one can recognize the good, one has no desire for the good and is thus not motivated to pursue it. Finally, for Aquinas, acedia meant that a person can recognize the good (assess positive value to an object) and attribute meaning to it, but she or he does not experience the good as meaningful—full of meaning.[49]

In this way, sloth isn't attributed to the sin of laziness; rather, it's connected to the emotions.

While sloth and acedia still cannot be completely equated with depression, four of the symptoms of depression could be present in sloth and acedia.[50] The presence of sloth and acedia could very well be an early example of clinical depression; however, in my research, no commentary was given on the severity or longevity of these symptoms. A trained psychologist would need all of this information to make an informed diagnosis, and to my knowledge, no psychologist has been able to prove it decisively.

These examples show that the ancient Christian church had already realized a component of depression separate from being a spiritual problem—even without the use of the science and

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[47] Backus, *Telling the Truth to Troubled People*, 61.

[48] LaMothe, "An Analysis of Acedia," 17.

[49] LaMothe, 17.

[50] Those symptoms being: depressed mood, diminished interest, Insomnia, and feelings of worthlessness

technology we have today. Even more recently, at the birth of the Lutheran church, we see a similar approach to the issue of depression in Luther's ministering to Spalatin. "Under Thesis VIII in The Proper Distinction Between Law and Gospel, C. F. W. Walther quotes Luther's words to Spalatin after Spalatin's conscience convicted him and he experienced strong negative feelings."[51] Many theologians have understood this to be depression. Luther could have come at Spalatin with the club of the law, but Luther recognized that wouldn't be helpful to his spiritual well-being. Spalatin's conscience was convicting him. The law would have simply led him to greater despair and self-loathing rather than to the forgiveness that is in Christ. Even without the use of psychology, Luther addressed Spalatin's need well with the gospel of Christ. Today we understand what Luther did was not only in line with Scripture, but this approach would also be considered good psychological practice.[52] Erstad even uses this historical point to prove "there is no unavoidable conflict between the gospel and psychotherapy, despite strong and continuing claims to the contrary."[53]

What is maybe even more striking about this interaction is what we learn about the great Father of Lutheranism himself, Martin Luther. In his reply, Luther writes, "I was a patient in the same hospital and suffering the same affliction as you."[54] Even this man, Martin Luther, considered to be one of the greatest Christians this world has seen—humanly speaking—suffered from the effects of depression. Luther did not consider this depression to be due to a lack of faith, he considered it to be a factor of living in a sinful world. Perhaps this depression even

[51] Erstad, "A Lutheran Perspective on Psychotherapy," 2.

[52] Erstad, 2.

[53] Erstad, 2.

[54] Erstad, 2.

contributed to one of Dr. Luther's greatest theological traits: Luther realized he could find no good in himself. In fact, when he looked inside, he found only an ugly sinner; but Luther knew he was still part of God's holy family due to the grace of God and the faith given him in Holy Baptism.

The problem then in understanding depression among Christians happened primarily once psychology became a factor in the early 1900s. Presumably, these problems happened as an over-reaction to the perceived threats of psychology on sound theological practice. When John Fritz published his book *Pastoral Theology* in 1932, the idea was that mental illness is a product of a spiritual problem, denying any physical components.[55] Jay Adams followed this same line of thought in the 1990s. "According to Adams, mental illness is a misnomer; all emotional problems can be attributed to personal sin."[56] Adams thought that a counselor's primary goal was to uncover a person's unrecognized sin in order to help a struggling Christian.

Another over-reaction to psychology consists in the denial of a psychologist's ability to cure people of their depression. In Schupmann's essay on depression written in 1989, he proposed that depression is the result of a medical or a mental problem. He proposed a medical problem could be uncovered by a routine physical.[57] The mental side of the issue then would have to be addressed by a pastor. He speaks about the cure to depression being found in restoring the concept of true purpose in a person's life: to live as blood-bought children of God hoping for the life to come. [58] It's perhaps at this point where Schupmann misspeaks. He comments on his

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[55] John H. C. Fritz, *Pastoral Theology*, (St. Louis, MO: CPH), 1932, 194.

[56] Rick Mars, *Christian Counseling* 31

[57] The problem of simply seeing a normal physician for a routine physical is that a normal family doctor is not qualified to the same degree in diagnosing mental illness. One who seeks to find the root problem of their depression ought to see a specialist. Erstad, 11-12.

[58] Schupmann, "A General Introduction to the Subject of Depression," 7.

idea of the cure saying, "It is indeed sad how many people will see secular counselors seeking to help them in their depression when only the Word of God will suffice. Here we see the need of mission work to solve man's most basic need with the Gospel of the forgiveness of sins."[59] If God's Word is the cure, then clinical depression is purely a spiritual problem to be forgiven through Jesus' blood like any other sin. But if depression is a physical problem, God's Word alone cannot—in its normal use of admonishing and forgiving sin— fully cure depression.

In his 2006 book, Pastor John Piper wrote that "one cause of depression might be sin" [60] and he was criticized by Dr. Sorenson. While Dr. Sorenson didn't disagree with the principle, he strongly discouraged speaking in this way due to the fact that this truth might not be helpful for the individual struggling with clinical depression.[61] Earlier we had noted that psychology has not yet identified any specific causes for clinical depression. Pastor Piper was playing with the question, "Might it be attributed to sin?" This disagreement between Pastor Piper and Dr. Sorenson is just another example of the uncertainty surrounding this topic in Christian circles. It's hard to even speak about the topic because Christians haven't come to a clear consensus as to how to address clinical depression. Though depression is a physical illness, does this mean it couldn't be caused by sin, or that sin is out of the picture? We will discuss this more fully under "Spiritual Implications".

Yet not everyone responded to the introduction of psychology negatively. C.S. Lewis used the knowledge gleaned from psychology and realized the principles of psychology did not necessarily contradict Biblical principles. In *Mere Christianity* C.S. Lewis said that "it is after

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[59] Schupmann, "A General Introduction to the Subject of Depression," 8.

[60] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 344.

[61] Sorenson, 344.

therapy has accomplished its goal that it is appropriate to emphasize moral responsibility as we do with people not experiencing severe mental difficulty" (as cited in Erstad, 6) Erstad expounds upon C.S. Lewis' statement: "His main point is that therapy is not a matter of morality; morality is in an important sense separate from and should become the main focus after therapy."[62]

Looking at the history behind depression and things that resemble depression in the past, we can see depression has never been an easy issue for the church to deal with. When psychology began to grow as a science, in theory, the issue should have become easier for the church, but due to the differences in ideology and the pseudo-rejection of psychology by certain churches, churches were tempted to combat the pulls of psychology instead of practicing good theology.

Though Christians have started to understand how depression can be positively viewed in the church, this brief look at the history of the church's practice toward depression shows why a clinically depressed person would not be sure of where to start to get help. It continues to add to the confusion a Christian may experience as he deals with one of the darkest points in his life. "The gaps in understanding resulting from the illness lead to inferences that attenuate the dissonance between belief and experience. Meanwhile, the person may remain clinically undiagnosed. The possibility is real and horrifying: clinical depression might remain undiagnosed for years because of the Christian context."[63]

This is what Christians dread to hear concerning their brothers and sisters: that what has been said and done in the past is hindering a fellow Christian from seeking the help he needs. This is where a mental health professional can and should be used by the church to help discover

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[62] Erstad, "A Lutheran Perspective on Psychotherapy," 6.

[63] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 348.

the proper treatment option. This is important for the Christian, because although before we said clinical depression had strong physical roots in brain function, it still brings along with it some spiritual implications. For this reason, it is best to begin to deal not only with the physical health of the individual but also to weaken the effects and temptations of depression on a person's spiritual health.

SPIRITUAL IMPLICATIONS

> A depressed Christian is a contradiction in terms, and he is a very poor recommendation for the gospel. Nothing is more important, therefore, than that we should be delivered from a condition which gives other people, looking at us, the impression that to be a Christian means to be unhappy, to be sad, to be morbid, and that the Christian is one who "scorns delights and lives laborious days." (Lloyd-Jones, 1965, as cited in Sorenson, 343).

Comments like these are the reason an understanding of depression is so important in treating a Christian dealing with it. To call a "depressed Christian" a "contradiction in terms," makes depression sound like the unforgivable sin. After all, it doesn't take a Christian too much time sitting in the pew listening to God's Word or reading God's Word at home to stumble across passages like these: "Rejoice in the Lord always. I will say it again: Rejoice!" (Php 4:4) and "Though you have not seen him, you love him; and even though you do not see him now, you believe in him and are filled with an inexpressible and glorious joy" (1 Pt 1:8). What's a depressed persons immediate reaction? "That's not me," he says to himself. "MDD patients are likely to compare their lack of joy with the joy written in passages such as this and derive their religious identity from such axioms repeated often in their church contexts. As a result, they may infer there is something wrong with them and their standing with God (i.e., they do not really love God or do not believe in God enough)."[64]

The problem is rooted in the same problem that all people face in this world: sin. In fact, "depression, in whatever form it takes, is a result of sin."[65] Note that he doesn't claim depression

[64] Sorenson, "Depression and God: The Effects of Major Depressive Disorder on Theology and Religious Identity," 349.

[65] Schupmann, "A General Introduction to the Subject of Depression," 3.

to be the result of any particular sin; depression is an illness caused as a product of sin, just like any other illness. In this way, depression described as a physical ailment is completely in line with what the Bible teaches. Christian psychologists understand the state of fallen mankind, despite the claims otherwise from their field of science.

> Christian psychology also pictures man in all of his sinful depravity as it is portrayed in the Bible. It shows how man, perfectly healthy in body and sane in mind, created in the image of God in true righteousness and holiness, without sin and knowing the will of God, nevertheless, used that freedom of the will which once was his to turn against his Creator and thus fell from his original state of perfection… His carnal mind is enmity against God. Now his understanding is darkened. He is spiritually dead, having a heart that is deceitful above all things and desperately wicked.[66]

Sin has made all of mankind enemies of God by nature. A Christian has been given a new man in Christ Jesus, a new man "created to be like God in true righteousness and holiness" (Eph 4:24). However, this does not mean a Christian will not fall into sinful temptations as they live in this world of sin; a Christian will always be burdened by temptation and will bear the consequences and pains of living in a sinful world. That's part of the cross a Christian bears. "If anyone wants to follow after me, let him deny himself, take up his cross, and follow me" (Mark 8:34).

As cross-bearers, a Christian's life won't be easy or free from problems. Erstad cites his personal experience dealing with mental illness to show that these problems are also prevalent among Christians. While he doesn't address depression specifically, the point is broad enough to include depression—and since it is the "common cold of mental illness," he no doubt also has it in mind.

> In my own experience, as well as in the experience of those to whom I have listened, it appears that what we roughly call mental difficulty is about as prevalent among believers as it is in the general population. This suggests that it tells us little about faith. Confining our attention to unpleasant feelings again, there are people who surely are believers by

[66] Sievert, "Christian Psychology in Education," 7.

> Scriptural standards who have real and unremitting mental difficulty. We have to recognize that there are also unbelievers who are remarkably free from mental difficulty. Why shouldn't they feel good? Many are successful in deadening their conscience to an extent which does not happen among believers. This information argues against using mental difficulty as a reliable and valid source of information about saving faith.[67]

Erstad raises a good point by citing examples of mental illness in unbelievers. One would expect if this truly were a spiritual problem, depression would be far more prevalent in unbelievers than believers. However, depression, along with the multiple symptoms that come along with it, certainly brings with it some spiritual implications and challenges.

The idea that depression has a profound impact on a person's faith is not a new idea by any means. Erstad notes this is a prevalent thought among Protestants, who go as far as to say that mental illness may even be linked to a lack of faith. Erstad notes this thinking doesn't even work doctrinally: "The position we take here is of profound importance. Unfortunately, this influence has now led more religious people to see mental difficulty as significantly related to faith, its absence, or weakness. I see more trouble—theological trouble—with this conclusion than with mental difficulty itself."[68] What theological problems does this present? Since we determined the connection between depression and the brain, connecting depression with a lack of faith would mean a malfunctioning brain would have the ability to destroy faith. This simply cannot be the case. "It is unbiblical to view the soul as just a manifestation and function of the physical body. The soul is a separate creation of God,[69] which during earthly life is intimately

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[67] Erstad, "A Lutheran Perspective on Psychotherapy," 7.

[68] Erstad, 7.

[69] Here Huhnerkoch takes a creationist view of the soul.

connected to the body. The body cannot exist without the soul, yet the soul can and does exist without the body as it awaits the glorious day of resurrection."[70]

This truth alone may bring a depressed Christian great comfort. Still, a depressed Christian must deal with the guilt of his sins and his prevailing negative thoughts. While these thoughts do not nullify the grace given through faith in Jesus, these thoughts are still very real for a depressed Christian and must be addressed.

> The Christian, in particular, may struggle with negative thinking. Christians are more inclined to be troubled about specific sins. Even though they have been assured that these sins have been forgiven, they do not "feel" forgiven. They may look at all the blessings God has given them and think, "How can I be depressed? Look what God has given to me." They feel guilty for being depressed. That only adds to the depression. They may have thoughts such as, "If I prayed more, I'd overcome this." "God must be punishing me for something I did." Although Christians often experience these thoughts, they are not true. They are ways the devil uses to attack our sinful flesh.[71]

Perhaps a closer look at this concept would be beneficial. Did you notice what Curtis Lyon said about all of those negative thoughts floating in your head? *They are not true*. I know to you these thoughts *feel* true, but they aren't. Your feelings about yourself don't make those thoughts true. The problem is that these thoughts are often so prevalent in a depressed Christian's mind it can be hard to silence them.

Backus mentions that one of the most challenging parts of depression is not just in the negative thoughts, but in a skewed sense of reality; a failure to perceive the truth. That's hard to deal with. A depressed person has become so used to their negative thoughts that "they do not know that they are rehearsing misbeliefs to themselves. They are literally unaware that they are making themselves feel bad and haven't the faintest idea how they are doing it."[72]

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[70] Herbert C. Huhnerkoch, "The Distinction Between Body, Soul, and Spirit," (1979), 9.

[71] Lyon et al., *Pressed down but not forgotten*, 29.

[72] Backus, *Telling the Truth to Troubled People*, 152.

So how do you address these lies of your mind? Some Christians might be fortunate to have "good times" where they can think through these problems logically—that will help them the next time the problem comes up as well. Others will have to rely on the people around them. This is one way friends, pastors, and counselors can be of priceless worth to a depressed Christian. If you can't remind yourself of the value you have in God's eyes as his child, bought by the blood of Christ, a listening ear from someone you trust can be of great help. They will be better suited to help you see that though you may not value yourself at the moment; nevertheless, you are valued by God.

Self-esteem has become a contentious word in the church. This author believes the tension comes from varied perceptions of what "self-esteem" really is. Certainly, there are understandings of self-esteem that we would have to reject as Christians. One of these perceptions is noted in Daniel Drew's "Panacea or Placebo? Psychology as Gospel."

> "Self-esteem" ought to be a red flag that what we are reading is psychology substituted for the Gospel of Jesus Christ. In the place of sin we have low self-esteem. Instead of guilt caused by sin we have low self-esteem attributable to poor (parents, teachers, etc; fill in the blank with your favorite scapegoat). Instead of Gospel comfort is self-pride. Instead of repentance wrought by the Holy Ghost through the means of grace is self-help. Instead of Gospel-motivated lives of thanks is self-centered, "I want to (get more active in church, get in shape. etc; fill in the blank with your favorite good work) to feel better about myself.[73]

If self-esteem is understood as an excuse for sin, or if it is understood as the feeling of self-fulfillment to take the place of Christ's all-atoning sacrifice for us, then we must reject it. But self-esteem can most certainly be understood in a Christian way.[74] People who are mentally healthy might understand self-esteem to be one tick away from vanity, but those who are

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[73] Daniel S. Drews, "Panacea or Placebo? Psychology as Gospel" (1993), 2.

[74] Pastors may want to be wary about preaching against "self-esteem" due to its many meanings. This author believes the term could probably be replaced by something more suitable among Christians.

depressed might very well understand self-esteem to be simply having a healthy self-image. Good self-esteem is that which is truthful.[75]

This deserves careful attention because those who are depressed often are completely unable to see how they could have any sort of value. This, like so many other things, can lead a person to seek answers in the wrong place. It's not uncommon for a depressed person to try to find value in something other than his value as a child of God. This is true for men and women with healthy minds as well:

> Apparently the female's sense of worth is tied very closely to her appearance and her relationship to her family members, whereas a man's sense of worth is more closely tied to his work and his physical prowess. We might question whether this should be true for the Christian especially. Should these identities mean so much to us that their loss can have devastating effect on our emotional well-being? The loss or removal of anything we overvalue in terms of our security can trigger depression. A pertinent question here is: Are these the areas of life in which the Christian is to place his security? I doubt it![76]

Not just depressed people, but *Christians* struggle with this identity problem more often than they may like to admit. But there is forgiveness even when Christians find themselves getting absorbed in seeking self-value. Paul said to the Colossians, "Once you were alienated and hostile in your minds expressed in your evil actions. But now he has reconciled you by his physical body through his death, to present you holy, faultless, and blameless before him" (Colossians 1:21,22).

God can in fact even use the tough times of depression to bless his children. "You might justifiably ask how something like depression can make a Christian's faith stronger. Simply put, when you feel the weakest, then God's strength means the most. When depression leaves you

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[75] William D. Backus, *Learning to Tell Myself the Truth*, (Minneapolis, MN, Bethany House Publishers, 1994), 161-162.

[76] Schupmann, "A General Introduction to the Subject of Depression," 6.

without any hope, God is your hope. Depression is a destructive disorder. Only God can make something so devastating accomplish a strengthening purpose."[77]

God gives encouragement as Christians suffer from depression. He lifts spirits that have been taxed and tried with one of Satan's favorite playgrounds: depression. God doesn't promise to take away depression in this world, but he does promise a heaven free from all worry and tears.

[77] Lyon et al., *Pressed down but not forgotten*, 54.

CONCLUSION

Depression is not a simple diagnosis, nor is it obvious how to care for the depressed spiritually. In recent years, the debate has grown about whether the problem is rooted in the mind or in the spirit of a Christian. However, we can say from psychology, the historical practice of the church, and theological study, that depression is much more than just a problem consisting merely in the brain or merely in the spirit. Clinical depression is primarily a physical illness which affects a person's perspective of the spiritual. While the illness does not nullify a Christian's faith, it can put up obstacles to hearing and understanding the love God has for his individual children.

Depressed Christians, therefore, need not worry about the quality or sincerity of their faith; rather, knowing what is at the core of the problem, they can focus on the forgiveness of Christ as they work to cope with, or hopefully be healed from their depression. For some depressed Christians, that healing may be delayed, or it may never come at all. As Christians living with the reality of depression, "We may need professional treatment and have to live with continued medication, but we bring God with us."[78] God remains your God no matter how dark your road may become. Jesus Christ sacrificed himself for your sins. You know your name is written in heaven, no matter what your mind tries to tell you. Take up your cross of depression and look to your Savior!

[78] Lyon et al., *Pressed down but not forgotten*, 53.

NOTE TO PASTORS

Pastors may have a hard time addressing the problem of depression. The outward manifestations of depression can come in many forms and depression may come upon a person you might think appears to be completely healthy in mind, despite their deep sense of guilt, shame, lethargy, etc. Pastors will be wise to seek the professional help of a Christian psychologist, or if one is not available, a psychologist who will respect the faith of your member. A pastor must leave this diagnosis up to a qualified individual; he certainly would not want to diagnose a depressed person with a spiritual problem simply because he cannot understand what is happening psychologically[79]—which is sadly what has happened in the past. You, as a pastor, are not qualified to diagnose depression, nor can you treat it (if it truly is clinical depression) with God's Word alone. This does not deny the gospel's power; rather, it recognizes there is something more at play here—this person's body is preventing him or her from showing outward fruits of faith.

A pastor may be tempted to address the sins presented by his depressed member—and that is not necessarily a bad thing. But a pastor will want to keep in mind that this is a person who is experiencing extreme guilt and suffering. Dr. Saunders gives some insight into the mind of a person who is clinically depressed when he talks about how Christians with any mental illness suffer from guilt.

> "It's not real," "It's not that common," and "It's not that bad." These beliefs are inspired by the commonly held *hope* that only bad or weak people will be stricken with mental illness. Christians sometimes adopt a particularly virulent and condemnatory notion that mental illness only happens to those of weak faith. I consolidate these notions into what I

[79] Archibald D. Hart, *Counseling the Depressed*, (Waco, TX: Word), 1987, 22.

> call the weakness-badness theory of mental illness. The effect of such notions, which are widely held, Is that persons suffering with mental illness feel incredibly ashamed.[80]

A pastor is then wise to take heed of Luther's words and Erstad's explanation of them:

> "In your tribulations you will become aware that the Gospel is a rare guest in men's consciences, while the Law is their daily and familiar companion." That is why we are more inclined to give ear to the Law than the Gospel. We must admit that we are far oftener troubled and worried than comforted. There is only one explanation, and that is because the Law is a constant guest in our hearts. Therefore, it is vital that we learn to look outside of ourselves, to the Gospel and listen to the soothing voice of the Gospel, which is greater than our heart and which says, "Be of good cheer, your sins are forgiven."[81]

A pastor has an excellent opportunity as the spiritual shepherd of one suffering depression to point a person back to the grace that they are having a hard time seeing due to the cloud of depression hanging over their heads. In this way, counseling a depressed person is like counseling any other person who comes into your office: let them know the good news of Jesus.

[80] Saunders, *A Christian Guide to Mental Illness. Recognizing Mental Illness in the Church and School*, 3-4.

[81] Erstad, "A Lutheran Perspective on Psychotherapy," 2-3.

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