

‘Physician, Heal Thyself’

7. Surviving Clergy Depression

BY A RETIRED MINISTER,

The week I commenced this article, I happened to pick up a book by Marilyn Hickey entitled *Angels All Around – The Present-day Ministry of Angels*. Opening it at random at a chapter headed, ‘Angels, Depression and You’, I read, ‘What’s the first step in overcoming depression? Repent! Depression is a sin; yes, a sin. When we’re depressed, what we’re really saying is that God is no longer in control of our lives or of the events that impact on our lives. Depression is the road to atheism. It’s saying in our hearts, “There is no God”.’¹ Reading that paragraph revived painful memories. For some forty years I have been subject to depression, at one point severe enough to make it necessary to stop work.

During that enforced break, two devout lay leaders called, apparently at the bidding of the Lord, to inform me in effect that a Christian minister with depression was a contradiction in terms. They said that if I had more faith and trusted more in Jesus, I would be healed – in other words, ‘Physician, heal yourself’. Meanwhile they promised to pray for my ‘baptism in the Spirit’. Unfortunately, their visit, although well-meant, had the opposite effect to that which was intended.

As I read on, another paragraph caught my eye: ‘The angel told Elijah to rise and eat. If you are depressed today, I believe that the Lord is saying the same thing to you: Arise and eat. He’s not telling you to eat ice cream or cookies; He is telling you to eat God’s Word. Can I be honest with you? You haven’t been eating enough of the Word or you wouldn’t be in unbelief and depression in the first place! If you will rise out of your feelings of depression long enough to eat God’s Word, the Lord will give you some revelation knowledge and some supernatural things will begin to happen in your life.’² That passage triggered the memory of a local cleric who called the week after my lay visitors. I had the impression that he thought I was malingering because such problems were ‘all in the mind’. He asked me somewhat brusquely to explain why I felt depressed and, like the author of *Angels All Around*, prescribed more Bible reading. I had not the energy to explain that I was unable to concentrate sufficiently to read even the newspaper headlines or do anything requiring much mental effort, least of all converse with insensitive, intrusive visitors. He, also, seemed to be saying, ‘Physician, heal yourself’.

As I held that book, I felt a growing concern for anyone who, in a depressed state of mind, might read it and be thrust deeper into the ‘dark valley’ of despair, possibly even into the ‘valley of the shadow of death’ itself. In the UK, 3% of the general population are diagnosed annually by GPs as suffering from depression; it is a reasonable assumption that an equal number of sufferers go unrecognized. On average, 70% of the 44,000 suicides a year in Britain are of those suffering from depression; approximately 15% of all depressives eventually kill themselves. I am not aware of any statistics for the incidence of *clergy* depression, but since (contrary to the belief of some church members!) we, too, are human, it would be surprising if clergy were exempt. It is more likely that their problems will go unacknowledged because of the social stigma attached to mental illness of any kind, particularly if the sufferer is a member of the clergy. Recently, a daily newspaper carried a centre-spread article asking the question, ‘What makes a man of God attempt to take his own life?’ It featured a 45-year old vicar, apparently enjoying his work, happily married and with no obvious anxieties, whose attempted suicide was almost successful. He was later diagnosed as suffering from unrecognized bipolar depression.

Having undergone surgery a number of times, including a major operation followed by several weeks of extreme pain, I have no hesitation in saying that, if given the choice, I would definitely opt for physical pain rather than that of a mental illness. Moreover, with physical sickness or injury one can usually count on the sympathy of other people and know that you will be expected to seek medical treatment. With an emotional disorder such as depression there are always those who, regarding it as a character defect, will exhort the sufferer to ‘cheer up and pull yourself together’. They may not go to the extreme of judging you to be ‘on the road to atheism’ but they are likely to suggest that you are seriously lacking in faith – a particularly hurtful accusation for us clergy. Furthermore, our distress is compounded by other people’s expectations of us and by our self-expectation. We are perceived as somehow ‘super-human’, above temptation, free from doubt and emotional weakness. Consciously or unconsciously, that may be how we regard ourselves. We are those who are called to lead, preach, teach, support and care. Our job is ‘to give and not to count the cost’, ‘to toil and not to seek for rest’. Consequently, we fail to recognize when we may be ill and in need of help ourselves. We struggle on with an increasing burden of self-reproach and our depression deepens as it feeds off our despair.

Depression is, of course, a normal experience and most people get over it. For this reason some find it difficult to empathize with those who are seriously depressed. If they, themselves, have been able to ‘snap out of it’, they may have little patience with those who seem to lack the same will-power. Usually there is a good reason for feeling

¹ Marilyn Hickey, *Angels All Around – The Present-day Ministry of Angels* (Marilyn Hickey Ministries), 92.

² *Ibid.*, 100ff.

depressed. It would be unnatural not to feel sadness at the death of a loved one, at the breakdown of a close relationship, or the loss of one's job. The varied circumstances of life account for much fluctuation of mood – even those of the most cheerful disposition cannot live indefinitely on a 'high'. The weather, the changing seasons and lack of daylight (causing seasonal affective disorder [SAD]), can all affect our moods. Our physical health also influences our emotional and spiritual well-being. So-called *Secondary Depression* may be related to other psychiatric or physical illness, for instance schizophrenia, alcoholism, viral infections, or anaemia. Giving birth is often followed by a period of post-natal depression.

At the risk of over-simplification, there are four main types of depression. When, for instance, the normal feelings associated with a loss of some kind are unusually prolonged or severe, this is indicative of *Reactive depression*, the commonest and most readily accepted by others because the reasons for *reacting* in this way are evident. Harder to understand and often going unrecognized is that which afflicts for no obvious reason. Because it 'comes from within' it is known as *Endogenous depression*. It is also referred to as *unipolar* as it is distinguishable from *bipolar* or *Manic depression* which is characterized by alternate states of *elation* (mania) and low mood. As with endogenous depression, the mood fluctuations are relatively autonomous, appearing to occur without a discernible cause; it is thought to have a biological, possibly hereditary origin. *Psychotic depression* is a serious condition which may be accompanied by delusions or hallucinations, or both, in addition to physical symptoms.

To distinguish 'normal' depressive moods from a medical condition, the term 'clinical' is currently used. Such depression is defined as, 'a pathological state of extreme dejection or melancholy, characterized by a mood of hopelessness and feelings of inadequacy, often with physical symptoms . . . a reduction in vitality, vigour, or spirits'.³ Samuel Taylor Coleridge describes this 'melancholia' more eloquently in his poem, 'Dejection':

A grief without a pang, void dark and drear,
A drowsy, stifled, unimpassioned grief,
Which finds no natural outlet or relief
In word, or sigh, or tear.

As Coleridge knew, a feature of major depression is the inability to find either 'outlet or relief'. You may wish desperately to share the misery, but feel that no one else could possibly understand; you may have a profound need to cry, but the tears will not come. Dr Anthony Clare, known for his radio programme 'In the Psychiatrist's Chair', writes, 'The depressed individual becomes increasingly negative in thoughts and attitudes. The past looks miserable and unsatisfactory. The present lacks point and purpose. The future looms as a futile,

empty and threatening vacuum. Guilt and self-reproach begin to develop together with the conviction that he would be better off dead, better off for his own sake and/or for the sake of relatives and friends, for whom he believes he has become an unmitigated burden. It is a conviction that in turn can lead to suicide.'⁴

I experienced depression fairly early in my ministry, but did not seek medical help for some years, and then only as the effort merely 'to keep going' absorbed so much mental energy that every aspect of life and work was adversely affected. My doctor prescribed an antidepressant with the caution that it could be several weeks before any improvement might be noticed. The drug's initial side-effects were hardly conducive to effective ministry! Drowsiness had me dozing at my desk and falling asleep when pastoral visiting, particularly when sitting in a hot, stuffy room while an elderly member related tales I had heard many times before! A dry mouth made preaching and speaking difficult and trembling hands were an embarrassment, especially when handed a cup of tea! However, gradually the depressive symptoms became less incapacitating and the side-effects more tolerable. It was a wonderful relief for which I was truly grateful.

After a couple of years we moved to a new appointment. With any illness there is the temptation to discontinue treatment too soon. Irrationally I continued to feel that somehow a 'physician should be able to heal himself' and that I ought to rely more on the grace of God and less on drugs; ironically I had often reassured others that it was not a case of either/or. Within a few weeks of coming off the antidepressant, all the symptoms returned. It seemed to me the root cause of my depression was being in the ministry and that the only solution was to resign from the ministry and seek some less stressful work. My new GP concurred and I began to think seriously about the practicalities. At the time, we had three teenage children at home, each at a crucial stage in their education. Our house and furnishings belonged to the church, and, without a job, there was no possibility of obtaining a mortgage for a house of our own. The practical difficulties seemed insurmountable. In addition there was the matter of the validity of my initial 'call' to the ministry, and the persistent 'chicken and egg' question: did I feel bad about my profession because I was depressed or was it the nature of the work which was causing the depression? In order to resolve the dilemma I requested referral for a psychiatric assessment. The NHS psychiatrist could not find sufficient in personality or past experience to account for the persistent lowering of mood and confirmed the original diagnosis of endogenous depression, prescribing an increased dosage of antidepressant.

A few years later we moved to a new and demanding situation where all my predecessors had been of particular

³ *The Concise Oxford Dictionary*, 9th edn.

⁴ Spike Milligan and Anthony Clare, *Depression and How to Survive It* (Arrow Books, 1994), 34.

ability and where much was expected of the incoming minister. This highlighted any inadequacies of mine, both real and imagined. It was a flourishing church with a large congregation. Although the members were mostly warm and encouraging, I began to feel threatened on one hand by a 'conservative' element and, on the other, by a small but vocal group of self-styled 'charismatics'. I was now in my late forties and the circumstances were such as to precipitate a period of more severe depression. Previously, by an effort of will, I had always managed to keep working, but, despite the antidepressants originally prescribed, the symptoms were now so debilitating that I came to a mental standstill.

In addition to the continuous 'melancholia' described earlier there are other symptoms typical of this type of depression, which I now experienced more severely than before. These included sleep disturbance, in particular waking in the early hours and being unable to return to sleep. Before dawn all the emotional symptoms are more pronounced, especially an anxious dread at the prospect of the day ahead. This was accompanied by a feeling of panic focused on the endless repetition of unspoken words, 'I can't go on, I must get out, but there is no way out'. There seemed not even a glimmer of 'light at the end of the tunnel' – only the sense of being trapped, as one imagines a pot-holer must feel when stuck fast in the darkness of a narrow passage with no outlet. This sensation, akin to a feeling of suffocation, persisted throughout the day. There were other physical symptoms, the most noticeable being a profound tiredness, when even the simplest everyday tasks requiring an immense effort. It was as if every ounce of energy went into the effort to keep going and the pretence that nothing was amiss. In Spike Milligan's words, 'It's like running the hundred yards with broken legs'.⁵ Making decisions, even as trivial as what shirt to wear, took on gigantic proportions. I lost my appetite and consequently lost weight; the latter was a bonus – some depressives experience increased appetite and its consequences. There was a noticeable loss of libido – exacerbated by the antidepressant. Any sudden surge of despondency produced a sinking sensation in the stomach similar to that which might be felt descending rapidly on a 'Big Dipper'.

Loss of concentration and an inability to think clearly became a major handicap. One morning I found myself sitting at my desk unable to read or write; it was as if the brain's functions had come to a halt. I telephoned my GP and admitted defeat. Before accepting his instruction to 'go sick', I forced myself to fulfil a speaking engagement and a couple of hospital visits. It was difficult to come off duty and in the following weeks I was obsessed with conflicting emotions of relief at not having to struggle on and yet anxiety to get back to work. There was also a feeling of extreme guilt about burdening other people, in

particular, my wife, who, apart from having to cope with me and our children, had to act as an unofficial *locum tenens*. Furthermore I was haunted by a sense of self-disgust that I, who had so much for which to be grateful, should be feeling sorry for myself when there were innumerable other people world-wide with much greater reason for despondency – the hungry, homeless, handicapped and those with 'real' illness. Additionally there was always the ignominy of the 'physician who cannot heal himself' – indeed, who should never have been a 'physician' in the first place.

It is often assumed that anyone who is depressed needs cheering up with lively company, television comedy, or light reading. None of these remedies had any attraction whatsoever, for apart from the prevailing feeling of sadness, all other feelings were numbed. Each day was an ordeal, relief came only with nightfall and the merciful oblivion of sleep. I am ashamed to admit that sometimes the possibility of sleeping without awaking presented a tempting way of escape. However, even if I had had the courage, there was no justification for leaving family, friends and church members to face the inevitable distress that follows suicide. It was a 'Catch-22' situation – no way out, no way on.

How, then, did recovery come about? I was fortunate in having help from three main sources: first, the unfailing patience, understanding and love of my wife and family; second, a wise, kind GP; third, the Medical Director of the psychiatric hospital where I was a part-time chaplain. He made time to see me regularly, treating me as a fellow professional-carer rather than as a patient, encouraging me to accept for *myself* that clinical depression is not a character weakness but as much an illness as diabetes or arthritis. He restored some of my lost self-esteem by pointing out the positive instead of the negative aspects of my personality on which I tended to dwell. By endorsing the diagnosis that the problem was primarily one of a chemical imbalance which could be treated, he gave me reassurance and hope – two essential elements in the management of depression. Wisely, he advised postponing any discussion about my future in the ministry until the depression had lifted significantly. We agreed that I would try some of the wider range of drugs that had become available. After several traumatic weeks sampling a number of the newer antidepressants, one emerged which seemed to be the most effective.

As the depression began to lift, and with further discussion, I was able to agree with the psychiatrist that my place was still in the ministry. Against advice, I made the mistake of recommencing before I was sufficiently recovered, and had to contend with the drowsiness and other side-effects of a fairly heavy dosage of antidepressant. I am unlikely to forget the Christmas morning service when I resumed work. Trembling hands made it well nigh impossible to relieve a dry throat without spilling the contents of the glass over myself and the floor! Nor was it easy to create the expected joyful

⁵ *Ibid.*, 115.

atmosphere and share in the excitement of the children in the congregation as they brought forward their gifts to be viewed. However, in the following weeks, with the gradual reduction of medication, the side-effects became more manageable. Since then I have had to accept the fact that, in my case, although not necessarily for others, medication is for life. Drug therapy is constantly improving, and I now take a maintenance dose of one of the newer generation of antidepressants, known as Selective Serotonin Reuptake Inhibitors (SSRIs), which have fewer side-effects and greater antidepressant effectiveness than the standard Tricyclic drugs.

It will be apparent that this, like the other articles in this series, is very much a subjective account and symptoms and treatment will vary with the type of depression and the individual. The debate continues regarding the relative merits of drug therapy and psychotherapy. The use of antidepressants *and* counselling is the ideal, but not always possible due to the scarcity of qualified therapists. Cognitive therapy, which can also take the form of Cognitive-behaviour and analytic therapy, aims at identifying and replacing negative thought and action patterns. There are self-help books describing this recently introduced treatment.⁶ *Electroconvulsive therapy* (ECT) is used mainly for severe depressions and those resistant to standard antidepressants.

Consideration of the treatment of depression raises the question, 'Who cares for the carers?' Perhaps, because it is so often taken for granted that 'the physician *is* able to heal himself or herself', churches have lagged behind other caring agencies in making adequate provision for support in this respect. For instance, my own 'pastor parvorum', although living nearby, did not visit or phone our home during the period I was off duty. As related earlier, some of my visitors from church, in spite of their good intentions, only succeeded in making me feel worse. Paradoxically, the psychiatrist who was instrumental in my return to health and in encouraging me to continue in the ministry was *alleged* to be unsympathetic to church and clergy. Pastoral care of clergy has improved but it was hard to find at the time when I most needed it. For this I may be partly to blame. Apart from a reluctance to admit to suffering depression, I have learned to mask my feelings and to 'carry on regardless'. In a caring role it is necessary to discipline oneself to listen to the problems of others and not to talk about one's own. Nor do care-givers find it easy to ask for help.

Furthermore, it is possible to put up barriers that make it difficult for other people to minister to us. If someone is not coping with their own difficulties they will not want to know that the person to whom they look for support cannot deal with theirs any better. Depression, like bereavement, is often a taboo subject, and people may

avoid a depressive because they do not know what to say or are fearful of any emotional reaction or a rebuff.

Nonetheless, although I was not always aware of it, there was much *indirect* support on the part of church members through their solicitude, affection and prayers. My wife and I appreciated those who called in person or by phone, particularly if they were succinct, unprescriptive and offered practical help. We were always grateful to those few who asked if they might pray (briefly) with us, and we knew that intercession was made at Sunday worship and the weekday meetings. One of our house fellowships invited me to join them for prayer with the laying-on-of-hands; I was moved by their concern but somewhat embarrassed by the experience. A minister, trained in Christian-orientated psychotherapy, kindly offered counselling, but I did not feel comfortable with him and made my excuses after the second session. There were other simple acts of kindness which meant a great deal. For example, on that nerve-racking Christmas morning, a card was left in the vestry with a message of encouragement for the service and an assurance of supportive prayer.

Are there any positive aspects to an experience of depression? Robert L. Randall states that depression can become 'a crucible for new life' and a 'transforming experience' from which we may 'wrestle a blessing' and find 'opportunities for spiritual growth'.⁷ This is not so for everyone. Spike Milligan, a self-confessed manic depressive, had to force himself to write the script and then take part in the weekly broadcast comedy, *The Goon Show*. He has since written, 'I see no value in my having been depressed . . . It is a dreadful scourge which has caused me terrible pain, caused my first wife much distress and my children much unhappiness'.⁸ Although I cannot claim that depression has been for me a 'transforming experience', nonetheless there is a sense in which my work as a minister has benefited. For instance, when confronted by someone in distress, we have no right to say, 'I know just how you feel'. However, understanding and ability to empathize will be much increased if we have undergone something similar ourselves; this is particularly true of depression. Rightly or wrongly, I have refrained from speaking in public about my experience. However, like so many others, I have found that those suffering from depression (or any other trauma), are likely to recognize intuitively anyone who knows at least something of what it is like. Jim Cotter says in verse: 'If others sense that we know in depth / the trials of suffering and dying, / they will beat a path to our door, / and will find for themselves some measure of healing'.⁹

Apart from the unspoken support of simply 'being there', which is often all that is appropriate, there are a

⁷ Robert L. Randall, *Walking through the Valley: Understanding and Emerging from Clergy Depression* (Abingdon Press, 1998), 15, 18.

⁸ Milligan and Clare, *op. cit.*, 203.

⁹ Jim Cotter, *Healing – More or Less* (Cairns Publishing, 1990).

⁶ E.g., Paul Gilbert, *Overcoming Depression: A Self-help Guide Using Cognitive Behavioral Techniques* (Robinson, 1997).

number of ways we can help someone with depression, for example: assist the sufferer to recognize and accept the reality of their depression as an illness that can be treated; encourage them to seek professional help; provide constant assurance that they will get well. If a doctor has prescribed an antidepressant, explain the possible delay in any noticeable improvement and discuss likely side-effects; emphasize the importance of continuing with medication while the doctor thinks it necessary and stress that, unlike tranquillizers, antidepressants are non-addictive. Unless the depression is very severe, suggest keeping to some daily routine and taking physical exercise whenever possible. Encourage the sufferer to talk with their family so that those closest know how best to help; look for an opportunity to offer support to that family in the exhausting task of caring for one who may seem disinterested, unresponsive and unloving. If the depressed individual is fond of alcohol, advise avoidance, explaining that alcohol is itself a depressant and could worsen the problem, possibly leading to alcohol dependency. The use of non-medical drugs is equally dangerous. It should always be kept in mind that anyone who thinks about suicide is at risk, though with depression it is most likely to be attempted as the sufferer starts to feel better and has sufficient energy to act. Try to persuade the person to seek professional help as soon as possible. If necessary take the initiative yourself. In our preaching, teaching and general attitude, we have the opportunity to help eradicate the stigma attached by the general public to mental illness, and at the same time reach out to anyone who might be suffering from unadmitted depression. We can give them reassurance that it is as much part of our humanity to be depressed as it is to be tempted or to have doubts, and that it is not an admission of weakness to seek assistance.

In what sense has it been possible, in Robert Randall's words, to 'wrest a blessing' and discover 'opportunities for spiritual growth' in this experience of depression? I would like to be able to say that even when the depression was worst there was still a sense of God's comforting presence. But 'walking in the valley of the shadow', I was more conscious of his absence than his presence and it is only in retrospect that it has been possible to acknowledge the validity of Christ's promise, 'I will be with you *always*' (Mt 28:20). This is one of several insights which, if appropriate, might be shared with a fellow sufferer; for faith is about clinging to the hope that the absent God will one day make his presence known: 'Faith gives substance to our hopes and convinces us of realities we do not see' (Heb 11:1). Also, it could be helpful to emphasize that depression, like any similar affliction, is not sent as a punishment or temptation. Moreover, the expression of utter despair is frequent in the Bible (e.g., Job 3:20, Pss. 22, 40, 42); Jesus himself echoed a sense of abandonment when he cried from the cross, 'My God, my God, why have you forsaken me?' (Mk 15:34). As the Psalmist

discovered, God is to be found not only on the heights but also in the depths: 'If I climb up to heaven, you are there; if I make my bed in Sheol, you are there' (Ps 139:8). When, for the time being, God is unreal and we cannot pray, read the Bible or find any inspiration in worship and sacrament, this does not signify that we are on 'the road to atheism' as Marilyn Hickey suggests.

If we accept that Jesus was truly divine and human, we may assume that there were times when he was depressed (e.g., in the Garden of Gethsemane), and therefore identifies with our anguish. As Edward Shillito says in his poem 'Jesus of the Scars': 'But to our wounds only God's wounds can speak'. Since he has suffered, we have confidence in his promise of aid: 'Because he himself has passed through the test of suffering, he is able to help those who are in the midst of their test' (Heb 2:18). Likewise, we are better equipped to minister because 'He helps us in all our troubles, so that we are able to help others who have all kinds of troubles, using the same help that we ourselves have received from God' (2 Cor 1:4 GNB).

This experience of depression may be seen also as an example of how God can use negative circumstances positively – 'in everything, as we know, he cooperates for good with those who love God' (Rom 8:28), although I would prefer to say, '*can* work for good for those who love God albeit *imperfectly*'. As the Psalmist discovered, 'As they pass through the waterless valley the Lord fills it with springs (Ps 84:5, 6).

I believe that I have survived and remained in the ministry because God's assurance, 'My grace is all you need' (2 Cor 12:9a), given to St Paul regarding his 'thorn in the flesh', is universally valid. It is grace which operates as much through human channels, aware or unaware, as directly through the Holy Spirit. Because 'the physician' *cannot* 'heal himself', he is forced to rely on the strength of the God whose 'power is most fully seen in weakness' (2 Cor 12:9b). As the novelist, Ernest Hemingway wrote, 'We are made strong at the broken places'. Likewise, Jean Vanier expresses it in verse: 'Our brokenness is the wound / Through which the full power of God / can penetrate our being / and transfigure us in him'.¹⁰

If, as ministers, we are called to take up the cross and follow Christ (Mt 10:38; Lk 9:23), we have to accept that carrying a cross will involve pain. I must confess I still feel that I could have been a much more effective minister without the burden of depression, but I do recognize the benefits to ministry of being, a 'wounded physician', and see the value of adopting the positive attitude expressed in verse by Jim Cotter: 'Listen to the language of your wounds. / Do not pine away in the pain of them, / but seek to live from the depths of them.'¹¹ Robert Randall is correct, 'There is life beyond depression'.¹²

¹⁰ Jean Vanier, *The Broken Body* (Darton, Longman & Todd, 1993)

¹¹ Cotter, *op. cit.*, 93.

¹² Randall, *op. cit.*, 125.

Addendum

There are some aspects of Christian theology which can intensify a depressive downward spiral; one is a particular interpretation of the doctrine of Christian Perfection. R. Gregor Smith states that 'Perfect' in the Bible has neither a legalistic background nor 'a pietistic authority as though perfection could be achieved by some kind of technique of "imitation of Jesus"'. The command of Jesus, 'Be perfect, therefore, as your heavenly Father is perfect' (Mt 5:48), 'falls within a religious situation, not simply a moral situation of improving our conduct by ever more strenuous efforts or the like'.¹³ However, our common use of the word 'perfect' is associated with the idea of the highest possible moral development. Too often the exposition of the doctrine has been ambiguous, inconsistent and potentially harmful – particularly to those of a neurotic disposition.

'Perfectionism', in the psychological sense of the word, is a characteristic of many depressives, and those who become increasingly perfectionist in their thinking become yet more depressed – the classic vicious circle. Self-orientated perfectionism – the obsessive striving to attain 'only the very best' – may be expressed in any aspect of life. In moral terms it is not simply a healthy pursuit of high ideals and good behaviour but an inner *compulsion* to achieve *impossibly* high standards and *faultless* conduct.

For a Christian this can take the form of strict adherence to the Ten Commandments, the relentless pursuit of 'sinless perfection' and the struggle to become 'like Christ in every way'. The hopeless nature of such a quest leads to a sense of failure, punitive self-criticism, guilt and frustrative anger. Whereas common-sense suggests that it is sufficient to 'do one's best', the perfectionist's self-judgment is by results not by effort; there is always more that could have been done or done better. This type of personality is dominated by what the clinical psychologist, Paul Gilbert, calls the 'internal bully', who persuades us that unless we reach our target all else is worthless – 'Do, do, do, and when you've done, do more'.¹⁴

We are not usually aware how much of our thinking is based on *comparison*. A theory advanced by Leonard Festinger and described by Oliver James suggests that 'social comparison' serves the basic purposes of self-evaluation, self-enhancement and self-improvement.¹⁵ Seeking self-improvement in a particular area, we might make an 'upward comparison' with someone superior to ourselves. Thus, if I aspire to be a top-class sprinter, I could select Linford Christie as my model. Thinking

positively, I will hope to improve my style by copying his. However, if I am thinking negatively I might feel so second-rate by comparison that I become discouraged and give up altogether. To avoid this feeling of inadequacy I need to see things in perspective, remembering that Linford is a full-time professional and is twelve inches taller than me, so I cannot expect to run as fast. This protective mental process is termed 'discounting'.

Depressed persons, with their negative thinking patterns, have an increased tendency to unfavourable self-comparison with others and, in consequence, suffer lowered self-esteem and miserable feelings of inferiority. They seem unable to exercise an effective 'discounting' process. For a Christian there is a sense in which the doctrine of 'Christian Perfection' invites 'upward comparison' in two directions, each with potentially harmful effects for a depressive. Firstly, there is a proneness to think, 'I'm not as righteous, devout, convinced or knowledgeable as other Christians'. Secondly, enjoined to strive after the 'imitation of Jesus', an 'upward comparison' will be made with Christ. Festinger's 'upward comparison' is reminiscent of St Paul writing to the Philippians: 'I press on toward the goal for the prize of the upward call of God in Christ Jesus' (3:14 RSV). Trapped in a web of negative thinking, the depressive is unlikely to employ the normal 'discounting' procedure and consequently is tormented by a feeling of abject failure as a Christian.

There is nothing unhealthy in having high ideals and seeking to fulfil one's true potential. The difficulty is in striking a balance between satisfaction with too low a standard and striving after one which is too high and beyond our capabilities. As a Christian I am faced with a paradox. On one hand, I am encouraged to accept myself 'just as I am'. If I am thinking positively, I will 'discount' by making allowances for my inherited genetic make-up and natural human limitations, believing that this is how God in Christ loves and accepts me. Then I need not fear failure because God is ready to forgive, and so I ought to forgive myself. I can take comfort in the belief that, 'All I could never be – this I was worth to God'. On the other hand, I am required to make an 'upward comparison' with Christ and labour to mould my life on his. I am challenged by St Paul's claim, 'I can do all things in him who strengthens me' (Phil 4:13 RSV), and by words in one of Charles Wesley's hymn's, 'If nothing is too hard for Thee / All things are possible for me'. I am then faced with the uncomfortable question: can I set limits on the attainment of sanctity without setting limits on the power of God?

Finding a balance between these two apparently conflicting injunctions is a problem for anyone who takes their beliefs seriously. For someone prone to depression the inability to find a solution may well add to the already heavy burden of self-despair.¹⁶

¹³ 'Perfection' in Alan Richardson, ed., *A Theological Wordbook* (SCM Press, 1956), 167.

¹⁴ Paul Gilbert, *Overcoming Depression* (BCA, 1998), 259.

¹⁵ Oliver James, *Britain on the Couch* (Arrow Books, 1998), 54ff.

¹⁶ Except where noted, Biblical quotations are from REB