

Representation of Mental Illness in Christian Self-Help Bestsellers

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Abstract

The present study examined messages about mental illness in 14 contemporary Christian self-help bestsellers. Content analysis revealed that most texts focused upon depression. Categories of textual units included *Underlying Assumptions Regarding Depression*, *Representations of Depression*, *Roots / Causes / Reasons for Depression*, and *Christian Responses to Depression*. Demonic influence was the most frequently cited reason for depression. Other reasons included negative cognitions, failure as a Christian, and negative emotions. Christian responses to depression included trusting God, religious activity, and individual willpower. Discussion of these results focused upon the problematic impact of these messages upon individuals with depression, and upon suggestions for reducing mental illness stigma in religious communities.

Key Words: Mental Illness, Depression, Self-Help, Media, Stigma, Demons, Religious Attitudes

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In a speech by the late Pope John Paul II (1996) on the *Image of God in People with Mental Illness*, the pontiff reflected on the inherent dignity, and the Divine image, within all persons, including those with mental illnesses. He further called for “sincere reflection on our behavior toward those persons who are suffering from mental illness” and noted that persons with mental illness frequently encounter “indifference and neglect” (Dodson, 1997, p. 14).

Perceptions of Stigma in the Christian Church

Despite the pope’s words, preliminary research evidence suggests that people with mental illnesses have encountered less accepting attitudes from some segments of the broader Christian community. Research in the United States (Fitchett **et al.**, 1997; Kroll & Sheehan, 1989) and in the United Kingdom (Neelman & Lewis, 1994) has demonstrated that the religious commitments, practices, and beliefs of psychiatric patients are similar or stronger than those of people without psychiatric disabilities. Even so, these individuals may describe a lack of emotional and social support from religious communities. Individuals with mental illnesses report that they feel estranged from the broader Christian community due to their perception of church members’ unspoken moral judgment and general lack of acceptance of mental disabilities (Bussema, 2000).

A recent online survey of Protestants and Catholics with mental illnesses assessed the quality of their experiences with the church (Stanford, 2007). A majority of the participants described positive, accepting interactions. However, approximately one-third of participants indicated that the “church [made them] feel like the mental illness was the result of personal sin” (p. 447); another third reported that the “church suggest[ed] that [they or their loved ones] did not really have a mental illness, even though a mental health professional said that [they] did” (p.

447). Participants were also offered the opportunity to respond to open-ended questions about their church interactions. Of those negative interactions described, 21% involved events in which mental illness had been associated with demonic influence, and another 19% involved events in which mental illness had been associated with the sin of the afflicted person.

Anecdotal evidence in the literature has further indicated that religious communities may hold specific biases regarding mental illness. Psychologist Kay Redfield Jamison described her encounter with stigma from religious persons following the publication of *An Unquiet Mind* (1995), her autobiographical account of her experiences with bipolar (or manic depressive) disorder.

I received thousands of letters from people. Most of them were supportive but many were exceedingly hostile. A striking number said that I deserved my illness because I was insufficiently Christian and that the devil had gotten hold of me. More prayer, not medication, was the only answer (Jamison, 2006, p. 534).

Research on Christian Attitudes towards Mental Illness

Although many Christian denominations officially support medical or psychological explanations for mental disorders, some authors have reported that lay Christians may still view mental illness as a reflection of one's alienation from God, or as a sign of demonic influence or possession (Dain, 1992; Hartog & Gow, 2005). Others have suggested that lay Christians may believe that religious persons should not be subject to these afflictions, based upon an assumption that genuine faith should prevent the onset of mental illness (Cinnerella & Loewenthal, 1999).

Unfortunately, there is little published, empirical research on the attitude of contemporary Christian groups towards mental illness. In a study examining the attitudes of evangelicals

toward mental illness, McLatchie and Draguns (1984) found that conservative religious persons in the United States were more likely to see emotional problems as spiritually based, and to advocate prayer for treatment. Demon possession was also seen as a viable etiology for mental disorders.

A second study conducted in the United Kingdom found that theological conservatives did not have more negative, or stigmatizing, views of mental illness than did the general population. Nor did this particular sample view mental illness as a moral failure. This study's church group was located in an area with a higher incidence of mental illness in its community; thus the author suggested that perhaps personal experience with individuals struggling with mental illness overrode stereotyped messages from other sources (Gray, 2001).

Finally, in a third, more recent study of an Australian Protestant sample, psychiatric interpretations of mental illness were the most frequently endorsed explanations for these disorders. Even so, more than one-third of all participants in this sample reported that mental illness in general, and depression and schizophrenia in particular, could result from either demonic influence or possession (Hartog & Gow, 2005).

Stigmatization of Mental Illness in the Media

Whatever its source, whether secular or religious, stigmatization is a powerful force in the experience of persons with severe and persistent mental illnesses. Researchers have described mental illness as "one of the most stigmatized conditions in our society" (Stout et al., 2004, p. 543). Multiple studies have confirmed that stigmatization impedes the process of mental health treatment, even when available to potential consumers. Individuals not wanting to be associated with the negative stigma of mental disorder may elect not to seek mental health services due to this social stigmatization (Corrigan, 2004). One estimate indicated that a quarter of the 50

million Americans afflicted with mental disorders every year choose not to pursue treatment for this reason (Stout **et al.**, 2004). In addition, stigmatized individuals may be denied equal access to housing, employment opportunities, and health services (Warner & Mandiberg, 2003). Stigma about mental illness may also impact insurance policies, health care legislation, and research funding decisions, potentially reducing both private and public financial support for the study and treatment of mental disorders (Jamison, 2006). For these reasons, the National Institute of Mental Health described stigma in 1986 as the greatest impediment experienced by persons with histories as mental health patients (Granello & Pauley, 2000).

According to multiple studies, one source of stigmatizing messages about mental illness is the media. While the media has the potential to educate and inform the public about mental illness, and thus to correct the distortion of stigma, research has suggested instead that the media “create and perpetuate mental health stigma and discrimination through repeated use of negative and inaccurate images of the mentally ill, mental health professionals and mental health treatments” (Stuart, 2006, p. 101). Research has documented the connection between stigmatizing media depictions of mental illness and negative public views, and the stability of these negative views over time once they have been developed (Angermeyer & Matschinger, 1996; Slopen **et al.**, 2007; Thorton & Wahl, 1996).

Religious Self-Help Literature

Thus, one potential way to study contemporary church attitudes regarding mental illness, and the potential for stigma in this community, may be to consider the messages about mental illness communicated through its various media outlets. In particular, we focused our research on a review of popular self-help literature published by the religious sector. Self-help literature is a

distinct genre in Western culture which may present attitudes and beliefs regarding mental illness.

Historically, much of the self-help literature has been published by religious figures, espousing religious themes. Spiritually-based self-help literature can be traced back to the late 1800s. During the earliest years of self-help, this literature assumed that problems arose from disharmony in a person's relationship with God (Woodstock, 2007). Psycho-religious self-help books became particularly popular following World War II, as demonstrated, for example, by the enormous success of *The Power of Positive Thinking* by Norman Vincent Peale.

Berger (1963, cited in Woodstock, 2007) noted that self-help books are capable of shaping one's identity, thoughts, and emotions. These self-help messages reach beyond the books themselves into popular discourse where they are translated into a shared language about the self. This influence is extremely impressive when one considers that the self-improvement market was estimated to be worth 5.7 billion dollars in the year 2001. According to Gallup poll estimates, one-third to one-half of all Americans have at some time purchased a self-help book (Wood, 1988; Woodstock, 2007). Thus, the potential of self-help literature to shape cultural perceptions about mental health issues may be profound.

Purpose of the Study

The purpose of this study was to utilize content analysis to describe how mental illnesses were presented in popular, contemporary Christian literature. This study reviewed bestselling self-help literature written by Christian authors.

Methods

Sample and Procedure

From the period between February 2006 and January 2007, bestseller lists were identified and reviewed through an internet search. Targeted websites included those with a religious affiliation or those with a religious bestseller list. No bestseller lists were excluded from the study due to the religious affiliation of the publishing organization, or the lack of any such affiliation.

Five different organizations published a bestseller list that met the study criteria. These included the American Booksellers Association, the Catholic Book Publishers Association, the Christian Booksellers Association, the Evangelical Christian Publishers Association, and Publishers Weekly.

Three of the five associations cited above were religious sources for bestseller lists. The Catholic Book Publishers Association and the Christian Booksellers Association published monthly bestseller lists. The Evangelical Christian Publishers Association reprinted its bestseller list from the Christian Booksellers Association list; therefore the Evangelical Christian Publishers Association's list was not utilized in the present study.

The remaining two associations cited above were non-denominational sources for bestseller lists. The American Booksellers Association is a non-religious, non-profit organization that represents nationwide independent booksellers. The American Booksellers Association published *The Book Sense Religion and Spirituality Bestseller List*, based on reporting from hundreds of independent bookstores nationwide for the 8-week period ending May 21, 2006. Other non-denominational bestseller lists were obtained from Publishers Weekly. During the time period of our study, this international company published the *Religion Hardcover*

Bestsellers List and the *Religion Softcover Bestsellers List* on nine occasions. These bestseller lists were published approximately once monthly, except for the months of July 2006, December 2006, and January 2007.

Each of the bestseller lists were reviewed for one full calendar year from February 2006 through January 2007. An electronic search of each book on the lists was conducted utilizing the search engine available on the website Amazon.com in order to determine if the book was applicable to the present study. In some cases, an electronic search of a particular text was not available through Amazon.com. If the electronic search of the text was not available, the researchers conducted a manual search of the book for applicable content.

Texts analyzed in this study were religious self-help books that met the search criteria. The search criteria included a chapter, text selection, or subtopic on any of the research key words or terms. Each section had to be a minimum length of one paragraph. The list of the key words or terms utilized during our text searches included: anxiety, bipolar disorder, depression, major depression, anxiety disorders, schizoaffective disorder, schizophrenia, mental illness, severe and persistent mental illness, and psychiatric disorder.

Of the 321 books posted on all religious bestseller lists from February 2006 through January 2007, 14 met the search criteria and were selected for content analysis. As demonstrated in Table 1, the final sample of 14 different books included Benkovic (1998), DeMoss (2001), Foster (1998), Graham (2006), Kelly (2004), Meyer (1995 & 2006), Moore (2000), Omartian (1995, 1997, 2001, & 2002), Osteen (2004), and Rolheiser (1999). Table 1 also presents additional information about each author's publication record and media production to provide a preliminary sense of the author's overall media influence in contemporary Christian culture.

Content Analysis Procedures

Following methods described by Krippendorff (1980), content analysis procedures were conducted on each selection of text material in order to determine data categories. The texts were read through three or more times, textual units were identified, and labels were applied to each unit. Labels were then sorted and developed as categories. Once the categories were identified, definitions were applied, and subcategories developed. The data were then recoded into these subcategories.

Reliability of the coding procedures was assured through the use of independent coders with 20% of the data set. This subset of the data was chosen randomly by assigning a number to each text selection and utilizing the online program *Research Randomizer* (accessed at <http://www.randomizer.org>) to select 20% of the sample randomly. The percent of agreement for the inter-rater reliability was set, and obtained, at .90.

Results

The sample initially consisted of 327 textual units from the 14 religious self-help books. Although our analysis included search terms such as bipolar disorder, schizophrenia, and schizoaffective disorder, none of the religious self-help books included text selections with these key words. This textual data focused predominantly on depression, with minimal focus upon anxiety.

From this larger sample, a subsample of texts ($n = 242$) was able to be coded into 4 preliminary overarching categories, entitled *Underlying Assumptions Regarding Depression*, *Representations of Depression*, *Roots / Causes / Reasons for Depression*, and *Christian Responses to Depression*. Once these categories were identified, definitions were further refined, and subcategories developed.

As is evident from our category titles, the categories and definitions developed from the data reflected a predominant focus upon depression, with only negligible attention to anxiety. Specifically, only 6% of textual units focused upon anxiety (n = 15). Even these textual units seemed at times to address the normal experience of fear, rather than the range of mental illnesses associated with anxiety. Thus we focused our analysis on those remaining textual units related to depression (n = 227).

Multiple subcategories were developed for each of the four overarching categories. The four categories and their subcategories are presented in Table 2 and are discussed below.

Underlying assumptions regarding depression. The first category, which we have entitled *Underlying Assumptions Regarding Depression*, consisted of those textual units in which authors described the belief that depression was not God's will or plan for the believer's life. Examples of these textual units included "So many of us live with depression.... But God doesn't want us to accept this as a way of life" (Omartian, 2002, p.182) and "[God] didn't intend for you to go through life miserable, depressed, lonely, sick, and defeated" (Osteen, 2004, p. 62). This category accounted for approximately 2% of the total 227 textual units.

Representations of depression. A second category emerging from the data, which we have entitled *Representation of Depression*, included 3 subcategories, and accounted for approximately 5% of the total data. Thus, the representation of depression was another minor focus of the texts. Depression in this category was described at times as feeling broken, weak, or oppressed in some manner. One author reported that depression "eclipse[s] a sense of well-being and hopefulness, strangling abundant life" (Moore, 2000, p. 250).

Depression was also described as being synonymous with darkness, as in one author's depiction of her experience with depression, "I descended into darkness," (Moore, 2000, p. 252) or another's comment that "Depression steals light and life" (Meyer, 1995, p. 164).

In contrast to the rest of the textual units in this category, one unit of analysis offered an alternative view. Depression was described as having a potentially positive impact on one's life, as it can make believers "humble," filling them with "compassion" toward others who suffer (Moore, 2000, pp. 252-3).

Roots/ causes/ reasons for depression. Our third category moves beyond assumptions and representations of depression. Entitled *Roots/ Causes/ Reasons for Depression*, textual units in this category described authors' conjectures regarding possible etiologies or sources of depression. This category included nine subcategories of potential roots, causes, or reasons why individuals become depressed and it comprised approximately 30% of all 227 textual units.

Demonic influence was depicted as the primary source of depression in a Christian's life. Of the nine potential sources described, demonic influence was discussed most often, in approximately 31% of the 68 textual units which fell within this category. Depression was portrayed in these textual units as a result of spiritual warfare, or attacks from the devil, the enemy, or Satan. A spiritual enemy was described as influencing the thoughts and the emotions of believers. Authors wrote, "Satan uses depression to drag millions into the pit of darkness and despair" (Meyer, 1995, p. 166) and "I believe it's one of his [the devil's] specialties because his fingerprints are all over it" (Moore, 2000, p. 250). One author suggested this prayer for the depressed believer, "The enemy has persecuted my soul; he has crushed my life to the ground; he has made me dwell in darkness," (Omartian, 2002, p. 185). When describing her own experience with depression, another author related, "...Satan took advantage of a time when I dove off a

cliff of closeness with God to coax me into a pit of despair, confusion, and depression” (Moore, p. 252). Finally, in her book written specifically for children, *Battlefield of the Mind for Kids*, one author warned, “Two of the biggest demons that your mind will ever battle are doubt and depression” (Meyer, 2006, p.102). She then offered children several steps to ward off “the depression demons at your back door” (Meyer, p.115).

The second most common reason offered for depression was that of negative cognitions. Authors stressed, “Your circumstances don’t have you down. Your thoughts about your circumstances have you down.” (Osteen, 2004, p. 103), and “God is certainly positive, and to flow with Him, you must also be positive” (Meyer, 1995, p. 51). As can be seen from the latter example, religious ideation was at times intertwined in the understanding of negative cognitions. This explanation for depression accounted for approximately 26% of all those offered in this category.

A third predominant source of depression in the textual data, cited in approximately 18% of the 68 textual units, was that depressed persons had in some way failed as Christians, that they were in fact ‘bad Christians.’ Individuals who sinned, who did not pray to God, or who were in rebellion against God were particularly susceptible to bouts of depression. Textual units which offered this explanation for depression included, “If you do not pray, you will either be habitually depressed or obsessed with your own ego...” (Rolheiser, 1999, p. 218), and “...sometimes depression is caused by our own sin” (DeMoss, 2001, p. 206). When describing her own depression, one author offered this prayer, “God, please help me to admit the part of my torment that has come from rebellion” (Moore, 2000, p. 259).

A fourth explanation for the roots, causes, or reasons for depression was that of negative emotions. Depression was described as resulting from such negative emotions as anger,

disappointment, ingratitude, or guilt. Authors described it this way, “Depression and suicidal thoughts can be rooted in anger against God’s choices” (DeMoss, 2001, p. 205), and “Intolerance, agitation, short temperedness mark our behavior. Clinical depression, a mental health problem largely caused by pent-up anger, becomes a real possibility” (Benkovic, 1998, p. 189). In another passage, one author wrote, “In many cases, the physiological symptoms connected with depression are the fruit of issues rooted in the realm of the soul and spirit, such as ingratitude, unresolved conflict, irresponsibility, guilt, bitterness, unforgiveness, unbelief, claiming of rights, anger, and self-centeredness” (DeMoss, pp. 204-5). As in the case of negative cognitions, negative emotions may at times be related to one’s spirituality. This explanation accounted for approximately 9% of those listed in this category.

Six percent of statements in this category suggested that there may be a physiological basis for depression. The following textual unit illustrated this explanation, “Many problems [including depression] are symptomatic of a hormone imbalance, chemical imbalance, or physical sickness” (Benkovic, 1998, p. 177). On occasion, this latter explanation for depression was combined with other explanations, as in the example from one author, “I do not think it is possible to be depressed without being negative – unless the cause is medical. Even in that case, being negative will only increase the problem and its symptoms” (Meyer, 1995, p. 163). Here, depression is rooted in both a medical disorder and negative cognitions.

According to a small portion of our textual data, approximately 4% within this category, depression could also result from negative self-images, a false sense of self, or lack of belief in one’s potential. One author explained, “The image God wants you to have of yourself has been distorted.... When you accept that warped image, you open yourself to depression, poverty, or worse” (Osteen, 2004, p. 62).

A lack of forgiveness was further cited as a cause of depression in rare textual units. One author suggested, for example, that, “Forgiveness is the key to being free from toxic bitterness...Don’t let the root of bitterness grow deeper and continue to contaminate your life. What does this toxic waste look like in our lives? For some people, it seeps out as anger. In other people it smells like depression” (Osteen, 2004, pp. 158-9). This explanation accounted for 3% of the textual units in this category.

Depression was also depicted as a result of living in a fallen world, in which the influences of society press upon the individual. “The pain we identify as emotional depression is simply one of the unavoidable consequence of living in a fallen world” (DeMoss, 2001, p. 204). Similarly, depression was described as a result of relationship stress. “Hannah was a godly woman who became depressed when she had to deal with unfulfilled longings and a strained relationship over a prolonged period of time” (DeMoss, p. 206). Each of these latter two reasons comprised approximately 1.5% of those 68 textual units offered to explain the etiology of depression among Christians.

Christian responses to depression. In the fourth and final category, we coded statements which described various Christian responses to depression. This was the largest category, with 142 textual units (or approximately 63%) of the total 227. Five subcategories were identified.

The first of these, accounting for 47% of the 142 textual units in this category, stressed the character of God as sufficient to help the depressed Christian and thus the need for Christians to address their problems with an attitude of trust in God. Within this category, Christ was portrayed as the Savior who frees the Christian from bondage, who provides wisdom for coping, and who restores the believer’s joy. God was also the Healer of depression, a conviction seen in the following textual units: “[God] is the Great Physician over every intricate detail of our hearts,

minds, souls, and bodies” (Moore, 2000, p. 249), and “All forms and origins of depression in a Christian fall under God’s category of expertise” (Moore, p. 250). One author offered this prayer to the depressed believer, “Where there is now any mental instability, impairment, or dysfunction, I speak healing in Jesus’ name” (Omartian, 1995, p. 145). Based upon this understanding of God, authors advised readers to “Lean on Him,” (Meyer, 1995, p. 49) because “With faith and hope in Him, the bad things can be turned around for good” (Meyer, p. 48). Trust in God may have been depicted in contrast to other forms of intervention, including psychotropic medications. One author cautioned,

...regardless of how we are feeling or what we are going through, our immediate response should be to turn to the Lord. More often than not, it seems our first response is to turn to someone or something other than the Lord...It is easier to drown out our feelings with the blare of the television than to humble ourselves and seek forgiveness from God and others for our anger. It is easier to pay for a refill of Prozac than to ask God to show us if we have an ungrateful, demanding, or bitter spirit. These means may provide a measure of relief, but they are likely to be inadequate and short-lived. Nothing less than the ‘God of all comfort’ can meet our deepest needs at such times (DeMoss, 2001, p. 209).

A second response involved practical religious engagement. Statements which stressed the importance of religious engagement comprised approximately 35% of the items in this category. In order to address depression, authors recommended that believers take actions such as assuming responsibility for their sins, praying, focusing their minds on God, and practicing religious rituals. Believers were advised, “Confess any sins that may be causing emotional weakness or sickness in your life” (DeMoss, 2001, p. 210), and were also assured, “It’s even

possible to live without negative emotions. God will take them off us like a thick blanket if we ask him to. But we have to pray” (Omartian, 2002, p. 179).

A third response to depression was to utilize one’s personal will or discipline to overcome these experiences. Believers may “refuse to be depressed” (Omartian, 2002, p. 182). They were encouraged to think positive thoughts in order to overcome negative emotions. Authors wrote, “We have to purposely choose right thinking” (Meyer, 1995, p. 34) and “If you are depressed you have to understand that nobody is *making* you depressed... You are choosing to remain in that condition...” (Osteen, 2004, p. 102; italics his). This response occurred in approximately 13% of the textual units in this category.

In approximately 3% of textual units, people were encouraged to engage in non-religious activities. For example, one author suggested, “Physical exercise can be tremendously beneficial in dealing with the physical symptoms related to depression” (DeMoss, 2001, p. 209). The same author also noted, “Medication may help a severely depressed person get stabilized enough to think clearly, providing a window of opportunity for the individual to begin dealing with the issue that created the problem” (DeMoss, p. 205).

Finally, a small sampling of textual units described different approaches toward health care providers. One author explained, “God’s desire for us when suffering from a mental illness or disorder is usually to be healed by Him through others (doctors, pastors, counselors, spiritual directors)” (Benkovic, 1998, p. 98). Others expressed doubt about a primary role of psychological or medical care for treatment. In a list of “Lies Women Believe,” one author included the statement: “The answer to depression must first be sought in medication and/or psychotherapy” (DeMoss, 2001, p. 204). This same author warned, “Our tendency to look to professionals and pills to solve what, in many cases, are problems of the soul and spirit has left

millions of women overmedicated, financially broke, disillusioned, and no better off than when they started” (DeMoss, p. 209). Statements which focused upon health care providers were not common, however, accounting for only 2% of all items in this category.

Discussion

The results of our content analysis have indicated that contemporary Christian bestsellers contain material that focuses upon a spiritually-based appraisal of clinical depression. While a smattering of textual units includes information about depression from professional mental health resources, the vast majority of the data stressed an exclusively spiritual interpretation of the basic assumptions, representations, causes, and treatments of depression. As demonstrated in previous research examining religious attitudes about mental illness (Dain, 1992; Hartog & Gow, 2005; McLatchie & Draguns, 1984), the messages within these bestselling texts included the beliefs that mental disorder, specifically depression, could be caused by personal sin or demonic influence.

Textual Focus upon Depression

Our review of these results should perhaps first consider why these texts focus upon depression and not upon other mental disorders. While various explanations may be offered for this emphasis, we wondered if perhaps the epidemiological data regarding the greater incidence and prevalence of depression might offer a clue. While the prevalence rates of bipolar disorder and schizophrenia are each approximately 1% of the population, some studies have suggested that the lifetime risk for an episode of major depressive disorder may be as high as 25% in women and 12% in men (American Psychiatric Association, 2000). In the United States, depression is the most common of all psychological disorders. Researchers have also observed that the rates of depression in Western society have steadily increased in recent decades (Yapko,

1997). Thus, the content of current self-help literature may accurately reflect a perceived mental health need among its readership.

While the textual units from these bestsellers may address current trends in mental health, they may not provide adequate or helpful information for mental health consumers. As health care professionals, we have multiple concerns about the content of the material reviewed for this research, involving both its assumptions and its implications for those afflicted with depression.

General Assumptions of the Texts

When the textual units are examined from a health care perspective, the bestselling authors presented some material which may be helpful for depressed persons. Pargament (2007) has extensively described the importance of positive religious coping (involving, for example, support from religious communities) when dealing with a variety of psychological stressors or traumatic life events. Multiple studies have demonstrated that spiritual coping following negative life events is correlated with better overall physical health and psychological well-being. In particular, research has demonstrated that individuals with mental illnesses may in fact utilize religious coping strategies, including prayer and Bible study, to deal with their disorders, and that these efforts can assist them in the management of their daily lives (Bussema, 2000; Fallot, 2001; Koenig, 1999; Reger & Rogers, 2002; Sageman, 2004).

Various models of psychopathology have also considered the role of cognition and of self-statements in depression (Beck *et al.*, 1979; Yapko, 1997). Other researchers have demonstrated the treatment potential of forgiveness (Berry & Worthington, 2001; Enright & Fitzgibbons, 2000; Freedman & Enright, 1996; Worthington, 1998), of hope (Bland & Darlington, 2002; Snyder, 2004), and of exercise (Byrne & Byrne, 1993).

Despite the inclusion of this material, several assumptions which are problematic from a health care perspective may be gleaned from the textual units. We will consider some of these assumptions below.

Failure to cite contributions of professional communities. It is notable that the textual units contain comparatively little, if any, awareness or appreciation of the contributions of professional communities regarding the psychological disorder of depression. For example, none of the authors discussed depression in terms of its formal diagnostic presentation in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR*; American Psychiatric Association, 2000). The authors did not discuss diagnostic criteria, symptom lists, differential diagnosis guidelines, epidemiological data about disorder prevalence or incidence, or features of the disorder specific to various cultures, age groups, or genders. The lack of inclusion of any of this material, or even a reference to the existence of this material, may suggest for some authors a cautionary, if not suspicious, approach to current mental health resources. While some textual units explicitly described this cautionary approach, those that did not make this explicit statement may still have communicated a lack of endorsement of mental health professions by a failure to refer to their existence.

Our concern about this lack of reference is not that the mental health professions have been slighted by these religious authors. We recognize the extensive history of conflict between religion and science, a division that began centuries before the publication of these bestsellers. Even so, the messages in these bestsellers serve both to reflect and to perpetuate this schism for contemporary Christians. Tragically, the person who suffers most from this division is not the bestselling author, nor the health professional, but the depressed individual. Depression is a serious disorder, with a potentially fatal outcome. We suggest then that all efficacious resources

be utilized for the understanding and the alleviation of this disorder, whether those resources are religious, community-based, psychotherapeutic, and/or psychopharmacological.

Homogeneity in the presentation of depression. The textual units also tended to assume a homogeneous, one-size-fits-all approach to the disorder. In general, the authors did not suggest that there may be individual differences in the presentation, course, and etiology of depression for various people. The reader did not learn, for example, that depression in a middle-aged Indian woman following cardiac arrest may differ from depression in an African- American female after the birth of her first child, or in a middle-class, Caucasian male recently laid off from his job. Each of these diverse experiences of depression may themselves differ significantly from depression which begins in childhood, and which is complicated by psychotic symptoms or by a substance use disorder.

Demonic influences in the etiology of depression. In addition, the etiology of clinical depression is described in a manner that markedly differs from those explanations offered by mental health professions, with a primary emphasis on the influence of demonic forces. There is currently a paucity of research in the psychology of religion related to the impact of cognitions regarding demons upon overall psychological health. Researchers know only that attributions to Satan as a causal agent for any event are very rare (Lupfer **et al.**, 1992; Lupfer **et al.**, 1994; Lupfer **et al.**, 1996; Weeks & Lupfer, 2000). It is striking, then, that these attributions comprise the largest set of explanations for depression in our media sample.

At present, one can only speculate about the effect that this approach to the etiology of mental illness has upon the person actually suffering with the disorder. Our assumption is that individuals suffering with severe depression – which may include both delusional and hallucinatory features – would not benefit from this approach in these texts. We cannot help but

wonder instead if the impact of this approach would be to increase the depressed person's potential anxiety, indecisiveness, guilt, lability, helplessness, sense of alienation from the church, and overall mental confusion.

Even in cases of mild or moderate depression, the heavy emphasis upon demonic influences in the etiology of depression presents problems. The use of demonic forces as causal agents in mental disorder introduces an external locus of control for depressed persons. Extensive psychological research over more than four decades has indicated that locus of control – that is, individuals' perceptions regarding their personal control over life events or, alternatively, the control of external forces over those events – significantly impacts their vulnerability to depression (for a review, see Benassi **et al.**, 1988). Multiple studies have demonstrated that individuals who attribute the power over their lives to forces outside of themselves (i.e., an external loci of control) are more prone to depression; this finding is particularly true when individuals believe that they cannot demonstrate anger toward those powerful, external others (Lester, 2001; Young, 1991).

One exception to this rule seems to involve the use of God as an external locus of control. Studies have not consistently supported the hypothesis that the conceptualization of God as an external force in one's life is associated with depression (see, for example, Bjork **et al.**, 1997, or Jackson & Coursey, 1988). Some researchers have suggested that while individuals may adhere to a view of God as an external power in their lives, they may also maintain some sense of personal control. For example, individuals may work constructively with God in the process of problem-solving when coping with life challenges (Pargament **et al.**, 1988.)

However, given the malevolent representation of demons in traditional religious narratives, it is not expected that individuals would perceive themselves to be engaged actively

and productively with demons in the constructive management of the ongoing events of their lives. This less favorable view of demons may be supported by research. On those infrequent occasions in which individuals do cite Satan as a causal agent in human events, the events described included human behaviors of which research participants disapproved (Lupfer *et al.*, 1994). In rare instances, Satan was also blamed for negative outcomes of events (Lupfer *et al.*, 1992).

Thus, we do not expect that the use of Satan as a locus of control would be associated with the same protective outcomes that research has demonstrated with the use of God as a locus of control. We wonder, instead, if Satan might represent a type of external locus of control which depressed persons might find particularly negative, powerful, and pervasive in their experiences, and therefore, less amenable to overcome. Thus, we tentatively suggest that with all forms of depression, whether mild, moderate, or severe, the use of demonic influence in the etiological model of the disorder may actually exacerbate individuals' symptoms.

As a final note, it seems important to consider references to demons in the bestselling book written specifically for children, *Battlefield of the Mind for Kids* (Meyer, 2006). In a number of textual units, the author described depression using the term "demon." It is possible that these references may have been intended by the author simply as metaphors, and not as descriptors of spiritual entities. Even so, we are concerned about the potential for the early education of children toward the association of mental illness with demonic activity. The use of this terminology in texts geared toward children may serve to foster mental illness stigma in the next generation of adult believers.

Personal responsibility in the etiology of depression. It is also notable that when demonic forces are not cited as the source of depression, much of the textual units were focused upon

depressed individuals' personal contributions to their disorders. If depressed individuals were not entertaining negative cognitions, or harboring negative emotions, then they were perhaps failing as Christians in some other way. These messages were also at times written in a distinctly moralistic tone. This heavy emphasis upon personal responsibility, and perhaps the implicit assumption of judgment, is particularly troubling, given that inappropriate guilt is a clearly defined symptom of clinical depression listed in the *DSM-IV-TR* (American Psychiatric Association, 2000). Depressed persons may experience inordinate degrees of guilt for relatively small offenses, and may also experience guilt for circumstances over which they have little or no practical control.

In general, the textual units did not offer a presentation of the complex biological, psychological, and social sources that can interact in one person's life to facilitate the onset of a depressive disorder. Comparatively little, if any, information was offered in these bestsellers about the multiple known predictors associated with depression, including (as a limited set of examples) family history of depression (Burcusa & Iacono, 2007; Waldinger **et al.**, 2007), traumatic life events (Schumm **et al.**, 2006; Trappler **et al.**, 2007), bereavement (Hensley, 2006), medical disease or impairment (Kristnan **et al.**, 2002; Steffens & Phillips, 2002), job loss and financial stress (Price **et al.**, 2002), relationship stress and divorce (Bruce & Kim, 1992; Hill & Hilton, 1999; Menaghan & Lieberman, 1986), parental stress (Merchant **et al.**, 1995; Thome, 2000), or the illness and caretaking of a family member (Lezak, 1978; Rosenthal **et al.**, 1993). Nor was depression described as a potentially typical or expected – albeit distressing – response to any one of these life challenges.

Lack of acceptance of the range of emotional experience. In a similar vein, the authors generally cast a disparaging light on any human affective experiences which might be considered

challenging or painful. Emotions such as anger, fear, or sorrow were often viewed as unacceptable, and to be avoided or refused by the faithful believer, regardless of the source of their occurrence. These experiences were not described as potentially necessary, if perhaps temporary, elements in the complex process of recovery from depression for any given individual.

Dismissal of temporal factors in recovery from depression. The lack of acceptance of a range of emotional experience in recovery may be due largely to an apparent assumption within the texts that recovery itself is not a process. Authors did not describe the alleviation of depression as a distinctly developmental event, requiring the passage of time. In contrast, clinicians have long understood that for all mental disorders, including depression, time may be a critical factor in the healing process. Even in the absence of professional treatment, research has suggested that some individuals can recover from an episode of depression simply as a function of time (Posternak, 2001). Textual units from this selection of Christian bestsellers did not suggest, however, that gradual – perhaps in some cases imperceptibly slow – intrapersonal development may be a necessary component for the healing of some forms of clinical depression; instead, an implicit assumption within the material was that depressed persons may recover in a quick, if not an immediate, manner.

Personal willpower in recovery from depression. This quick recovery may be possible in part because of another, major assumption underlying the textual data. As a whole, the data suggested that the individual has significant control not only over the onset and course of the disorder, but over its ultimate abatement. The authors placed a major responsibility for the outcome of the disorder on the willpower of the depressed individual. Evidence for this primary

role of personal control was seen even in the percentage of items (63%) which offered advice on how the individual needs to respond to depression, 142 of the total 227 textual units.

While clinicians in general might agree that individuals do indeed need to take responsibility for treatment of their disorders, and also that depressed persons must not imagine themselves to be victims of their circumstances, the heavy emphasis on personal willpower seems skewed in these texts. There was no similar emphasis, for example, on the importance of seeking assistance from the community, either through mental health professionals or through support groups. There were no occasions in which bestselling authors advised the development of church-sponsored ministries or faith-based support groups for those members afflicted with this disorder and for their families. Nor did these bestselling authors relate the importance of church and community advocacy for persons with mental illness at various regional and national levels. With few exceptions, dealing with depression was presented as a solitary, if not an exclusively mental, activity, in which depressed individuals confronted internal cognitive and emotional battles by themselves, with the help only of the bestselling author to guide them toward victory.

Dismissal of historical Christian experience. Finally, while a full Biblical and theological exposition of these issues is beyond the scope of this paper, it is worthwhile to note that only a minimum number of these bestselling texts included references to the experiences of Biblical figures who may have suffered with symptoms of mental disorders like depression. Nor did the textual units suggest that Christians of significant historical influence may have suffered with depressed affect during various episodes of their lives [e.g., Mother Theresa (Kolodiejchuk, 2007) or Abraham Lincoln (Shenk, 2005)]. Instead, the stress remained upon the victorious

Christian life as one marked by the absence of depression, not endurance in the midst of depression, or even triumph despite depression.

General Implications of the Texts

Our concerns center around not only the assumptions regarding the disorder of depression, but also around the potential impact of these materials upon persons suffering with depression and the family members who care for them. Individuals with mental illnesses do in fact incorporate religious coping strategies to assist them with daily challenges (Bussema, 2000; Koenig, 1999; Reger & Rogers, 2002; Sageman, 2004). While the authors of these bestselling self-help texts may offer positive encouragement toward engagement in spiritual disciplines, this encouragement is surrounded by other messages that are of questionable value for treatment, when they are not explicitly destructive. This juxtaposition of religious faith and mental illness stigma strikes us as especially tragic, given the potential support that individuals with depression may glean from the faith, both as committed believers themselves, and as members of a larger worshipping community.

Persons with mental illnesses are much more likely to find effective means of managing their disorders if they are welcomed back into an accepting community following the initial diagnoses of their disorders (Belsher & Costello, 1988; Corrigan & Phelan, 2004; Rogers **et al.**, 2004). Pargament has described the unique potential of religious congregations to serve as lifelong resources for interpersonal support for communities in general (2007). We wonder, however, if the emphasis within contemporary religious bestsellers on immediate, personal control in depression may unwittingly lead Christian communities to assume that depressed persons are not just responsible – but are also exclusively to blame – for the onset, course, and alleviation of their disorders.

What impact might a ‘blame the victim’ mentality in faith communities have upon depressed Christians? Would depressed persons exposed to these messages be less willing to admit to others their experiences of depression in a faith community, believing that they should be able to handle their disorders without assistance? Would these individuals be more likely to suffer in silence, and also to blame themselves when their personal efforts to control their cognitions and emotions do not result in the desired improvements in their symptoms? Would they question God’s love for them, and their sense of belonging in a Christian community, wondering if they have failed as believers? Would they then be more likely to seek professional treatment only as a last resort?

Delays in mental health treatment may come at a significant cost. While some individuals do recover from depression without professional treatment, research suggests that depression, and mental illnesses in general, are best treated if they are addressed earlier, rather than later (Kupfer *et al.*, 1989; Montano, 1994; Narushima & Robinson, 2003). Treatment delays may result in any number of unfortunate consequences, including for example increased relationship and vocational stress, as the depressed individual struggles unsuccessfully to cope with the disorder. With these increased stressors, some individuals may also acquire additional, more severe, symptoms which then require more aggressive treatment.

Addressing Stigma in the Church

Given the potential urgency of mental health care for members of the church community, and the challenge that stigma poses for the acquisition of that care, we would like to offer brief comments about how to address mental illness stigma in the church. Our recommendations fall into two broad strategic categories: (a) the provision of mental illness education and (b) the inclusion of persons with mental illnesses in the church community.

The first of these strategies, education, needs to occur at both the leadership and the lay levels of the church community. Our research examining Christian bestsellers suggests that it is perhaps, in some cases, the leadership of the church who are disseminating stigmatized messages in its self-help literature. Thus, it seems wise to consider education about the range of mental illnesses, and religious stigma about mental illnesses, in pastoral care programs in seminaries, where the development of Christian leadership is actively facilitated. In addition, some churches require the psychological assessment of their ministerial candidates prior to the rites of ordination. These churches might also provide education about religion and mental illness for these ministerial candidates in conjunction with their psychological evaluations.

Education might also include the lay membership of the church. Church leadership could actively work to secure Christian health professionals to teach Sunday school classes regarding various mental illnesses, Biblical approaches to mental illnesses, and stigma regarding mental illnesses. If the *DSM IV-TR* (APA, 2000) is correct in its estimates of the rates of various disorders, it is likely that there are presently many members of Christian churches who themselves are struggling – perhaps silently – with any number of psychological problems. Knowledgeable, sensitive, and religiously committed health professionals could offer a wealth of helpful information, all the while serving to dissipate mental illness stigma.

A second strategy, inclusion, involves the acknowledgment, acceptance, and even welcoming, of persons with mental illness within the church community. Pastoral care staff may establish ministries specifically for those members who struggle with mental illnesses. These might include fellowship and prayer groups for persons with a variety of disorders, or for family members coping with a loved one's disorder. These members might then be permitted on occasion to share their experiences with these ministries with the congregation as a whole

through essays in church newsletters or brief statements during services. Simply admitting that church members do deal with mental disorders, either in themselves or in their loved ones, and then permitting these disorders to be seen within the context of the church community, may accomplish significant reductions in religious stigma about mental illness.

It should not be assumed, however, that persons with mental illnesses may be only the recipients of ministerial care. Churches might also work with community mental health programs, offering individuals with mental illnesses opportunities to volunteer within the church community, perhaps in a supervised setting, in any number of ministry opportunities. The inclusion of persons with mental illnesses in ministry settings might not only offer these individuals opportunities for social interaction and a sense of personal accomplishment, but also this inclusion might help over time to ameliorate the stigma associated with mental illnesses in religious communities.

Concluding Comments

The current study examined messages about mental illness from a media outlet of the contemporary Christian church in Western society. The magnitude of the influence of these messages may be impossible to measure. It is important to recall, however, that the content of our research sample was extracted from bestselling religious self-help books, whose authors have written multiple books and who communicate to the broader Christian community via radio and television, video and DVD programs, and websites.

Further research is needed to consider not only the content of Christian media regarding mental illness, but also its impact on the believer. While the church has the potential to serve as an important ally in a member's recovery from mental illness, the presence of distinctly religious

stigma within segments of the Christian community may unfortunately thwart this important ministry opportunity.

References

- AMERICAN PSYCHIATRIC ASSOCIATION. (2000). **Diagnostic and statistical manual of mental disorders, (4th ed.), text revision.** Washington, D.C.: Author.
- ANGERMEYER, M.C., & MATSCHINGER, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. **Social Science & Medicine**, **43**(12), 1721-1729.
- BECK, A., RUSH, J., SHAW, B., & EMERY, G. (1979). **Cognitive therapy of depression.** New York: Guilford Press.
- BELSHER, G. & COSTELLO, C.G.(1988). Relapse after recovery from unipolar depression: A critical review. **Psychological Bulletin**, **104**(1), 84-96.
- BENASSI, V.A., SWEENEY, P.D., & DUFOUR, C.L. (1988). Is there a relationship between locus of control orientation and depression? **Journal of Abnormal Psychology**, **97**(3), 357-367.
- BENKOVIC, J.S. (1998). **Full of Grace: Women and the Abundant Life.** Ann Arbor, MI: Servant Publications.
- BERGER, P. (1963). **Invitation to sociology.** Garden City, NY: Doubleday.
- BERRY, J.W., & WORTHINGTON, E. L., JR. (2001). Forgiveness, relationship quality, stress while imagining relationship events, and physical and mental health. **Journal of Counseling Psychology**, **48**, 447-455.
- BJORK, J.P., LEE, Y.S., & COHEN, L.H. (1997). Control beliefs and faith as stress moderators for Korean American versus Caucasian American Protestants. **American Journal of Community Psychology**, **25**, 61-72.

- BLAND, R., & DARLINGTON, Y. (2002). The nature and sources of hope: Perspectives of family caregivers of people with serious mental illness. **Perspectives in Psychiatric Care**, **38**(2), 61-68.
- BRUCE, M.L., & KIM, K. M. (1992). Differences in the effects of divorce on major depression in men and women. **American Journal of Psychiatry**, **149**(7), 914-918.
- BURCUSA, S.L., & IACONO, W.G. (2007). Risk for recurrence in depression. **Clinical Psychology Review**, **27**(8), 959-985.
- BUSSEMA, K.E. (2000). Is there a balm in Gilead? The implications of faith in coping with a psychiatric disability. **Psychiatric Rehabilitation Journal**, **24**, 117-125.
- BYRNE, A.E., & BYRNE, D.G. (1993). The effect of exercise on depression, anxiety and other mood states: A review. **Journal of Psychosomatic Research**, **37**(6), 565-574.
- CINNERELLA, M. & LOEWENTHAL, K.M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. **British Journal of Medical Psychology**, **72**, 505-524.
- CORRIGAN, P. (2004). How stigma interferes with mental health care. **American Psychologist**, **59**, 614-625.
- CORRIGAN, P., & PHELAN, S.M. (2004). Social support and recovery in people with serious mental illnesses. **Community Mental Health Journal**, **40**(6), 513-523.
- DAIN, N. (1992). Madness and the stigma of sin in American Christianity. In P.J. FINK & A. TASMAN (Eds.), **Stigma and mental illness** (pp. 73-84). Washington, DC: American Psychiatric Press.
- DEMOSS, N.L. (2001). **Lies Women Believe and the Truth That Sets Them Free**. Chicago, IL: Moody Press.

DODSON, C. (1997). Finding God's image in the mentally ill. **America**, **177**(11), 12-16.

ENRIGHT, R.D., & FITZGIBBONS, R.P. (2000). **Helping clients forgive: An empirical guide for resolving anger and restoring hope**. Washington, D. C.: American Psychological Association.

FALLOT, R.D. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. **International Review of Psychiatry**, **13**, 110-116.

FITCHETT, G., BURTON, L.A., & SIVAN, A.B. (1997). The religious needs and resources of psychiatric inpatients. **The Journal of Nervous and Mental Disease**, **185**, 320-326.

FOSTER, R.J. (1998). **Celebration of Discipline: The Path to Spiritual Growth**. San Francisco, CA: HarperCollins Publishers.

FREEDMAN, S.R., & ENRIGHT, R.D. (1996). Forgiveness as an intervention goal with incest survivors. **Journal of Consulting and Clinical Psychology**, **64**(5), 983-992.

GRAHAM, B. (2006). **The journey: How to live by faith in an uncertain world**. Nashville, TN: Thomas Nelson.

GRANELLO, D.H., & PAULEY, P.S. (2000). Television viewing habits and their relationship to tolerance toward people with mental illness. **Journal of Mental Health Counseling**, **22**(2), 162-175.

GRAY, A.J. (2001). Attitudes of the public to mental health: A church congregation. **Mental Health, Religion & Culture**, **4**(1), 71-79.

HARTOG, K., & GOW, K.M.(2005). Religious attributions pertaining to the causes and cures of mental illness. **Mental Health, Religion & Culture**, **8**(4), 263-276.

- HILL, L.C., & HILTON, J.M. (1999). Changes in roles following divorce: Comparison of factors contributing to depression in custodial single mothers and custodial single fathers. **Journal of Divorce and Remarriage**, **31**(3/4), 91-115.
- HENSLEY, P.L. (2006). A review of bereavement-related depression and complicated grief. **Psychiatric Annals**, **36**(9), 619-626.
- JACKSON, L.E., & COURSEY, R.D. (1988). The relationship of God control and internal locus of control to intrinsic religious motivation, coping and purpose in life. **Journal for the Scientific Study of Religion**, **27**(3), 399-410.
- JAMISON, K.R. (1995). **An unquiet mind**. New York: Knopf.
- JAMISON, K.R. (2006). The many stigmas of mental illness. **The Lancet**, **367**, 533-34.
- KELLY, M. (2004). **The Rhythm of Life**. New York, NY: Fireside.
- KOLODIEJCHUK, B. (Ed.). (2007). **Mother Theresa: Come be my light: The private writings of the 'Saint of Calcutta.'** New York: Doubleday.
- KOENIG, H.G. (1999). How does religious faith contribute to recovery from depression? **Harvard Mental Health Letter**, **15**(8), 8.
- KRIPPENDORF, K. (1980). **Content analysis: An introduction to its methodology**. Beverly Hills: Sage Publications.
- KRISHNAN, K.R.R., DELONG, M., KRAEMER, H., CARNEY, R., SPIEGEL, D., GORDON, C., MCDONALD, W., DEW, M.A., ALEXOPOULOS, G., BUCKWALTER, K., COHEN, P.D., EVANS, D., KAUFMANN, P.G., OLIN, J., OTEY, E., & WAINSCOTT, C. (2002). Comorbidity of depression with other medical diseases in the elderly. **Biological Psychiatry**, **52**(6), 559-589.
- KROLL, J., & SHEEHAN, W. (1989). Religious beliefs and practices among 52 psychiatric

- inpatients in Minnesota. **American Journal of Psychiatry**, **146**, 67-72.
- KUPFER, D.J., FRANK, E., & PEREL, J. M. (1989). The advantage of early treatment intervention in recurrent depression. **Archives of General Psychiatry**, **46**(9), 771-775.
- LESTER, D. (2001). Relationship between locus of control and depression mediated by anger toward others. **The Journal of Social Psychology**, **129**(3), 413-414.
- LEZAK, M.D. (1978). Living with the characterologically altered brain injured patient. **The Journal of Clinical Psychiatry**, **39**(7), 592-8.
- LUPFER, M.B., BROCK, K.F., & DEPAOLA, S.J. (1992). The use of secular and religious attributions to explain everyday behavior. **Journal for the Scientific Study of Religion**, **31**(4), 486-503.
- LUPFER, M.B., DEPAOLA, S.J., BROCK, K.F., & CLEMENT, L. (1994). Making secular and religious attributions: The availability hypothesis revisited. **Journal for the Scientific Study of Religion**, **33**(2), 162-171.
- LUPFER, M.B., TOLLIVER, D., & JACKSON, M. (1996). Explaining life-altering occurrences: A test of the 'God-of-the-Gaps' hypothesis. **Journal for the Scientific Study of Religion**, **35**(4), 379-391.
- MERCHANT, D.C., AFFONSO, D.D., & MAYBERRY, L.J. (1995). Influence of marital relationship and child-care stress on maternal depression symptoms in the postpartum. **Journal of Psychosomatic Obstetrics and Gynaecology**, **16**(4), 193-200.
- MCLATCHIE, L.R., & DRAGUNS, J.G. (1984) Mental health concepts of evangelical protestants. **The Journal of Psychology**, **118**(2), 147-159.
- MENAGHAN, E.G., & LIEBERMAN, M.A. (1986). Changes in depression following divorce: A panel study. **Journal of Marriage & Family**, **48**(2), 319-329.

MEYER, J. (1995). **Battlefield of the Mind**. New York, NY: Warner Faith.

MEYER, J. (2006). **Battlefield of the Mind for Kids**. New York, NY: Warner Faith.

MONTANO, C.B. (1994). Recognition and treatment of depression in a primary care setting.

Journal of Clinical Psychiatry, **55**(12, Suppl), 18-34.

MOORE, B.(2000). **Praying God's Word**. Nashville, TN: Broadman and Holman Publishers.

NARUSHIMA, K., & ROBINSON, R.G. (2003). The effect of early versus late antidepressant treatment on physical impairment associated with poststroke depression: Is there a time-related therapeutic window? **Journal of Nervous and Mental Disease**, **19**(10), 645-652.

NEELMAN, J., & LEWIS, G. (1994). Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. **The International Journal of Social Psychiatry**, **40**, 124-134.

OMARTIAN, S. (1995). **The Power of a Praying Parent**. Eugene, OR: Harvest House Publishers.

OMARTIAN, S. (1997). **The Power of a Praying Wife**. Eugene, OR: Harvest House Publishers.

OMARTIAN, S. (2001). **The Power of a Praying Husband**. Eugene, OR: Harvest House Publishers.

OMARTIAN, S. (2002). **The Power of a Praying Woman**. Eugene, OR: Harvest House Publishers.

OSTEEN, J. (2004). **Your Best Life Now**. New York, NY: Warner Faith.

PARGAMENT, K.I. (2007). **Spiritually Integrated Psychotherapy**. New York, NY: Guilford.

- PARGAMENT, K.I., KENNEL, J., HATHAWAY, W., GREVENGOED, N., NEWMAN, J., & JONES, W. (1988). Religion and the problem-solving process: Three styles of coping. **Journal for the Scientific Study of Religion**, *27*(1): 90-104.
- POSTERNAK, M. I. (2001). Untreated short-term course of major depression: A meta-analysis of outcomes from studies using wait-list control groups. **Journal of Affective Disorders**, *66*(203), 139-46.
- PRICE, R.H., CHOI, J.N., VINKOUR, A.D. (2002). Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning, and poor health. **Journal of Occupational Health Psychology**, *7*(4), 302-312.
- REGER, G.M., & ROGERS, S.A. (2002). Diagnostic differences in religious coping among individuals with persistent mental illness. **Journal of Psychology and Christianity**, *21*(4), 341-348.
- ROGERS, E.S., ANTHONY, W., & LYASS, A. (2004). The nature and dimensions of social support among individuals with severe mental illnesses. **Community Mental Health Journal**, *40*(5), 437-450.
- ROLHEISER, R. (1999). **The Holy Longing**. New York, NY: Doubleday.
- ROSENTHAL, C.J., SULMAN, J., & MARSHALL, V.W. (1993). Depressive symptoms in family caregivers of long-stay patients. **Gerontologist**, *33*, 249-257.
- SAGEMAN, S. (2004). Breaking through the despair: Spiritually oriented group therapy as a means of healing women with severe mental illness. **Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry**, *32*(1), 125-141.

- SCHUMM, J.A., BRIGGS-PHILLIPS, M., & HOBFOLL, S.E. (2006). Cumulative interpersonal traumas and social support as risk and resiliency factors in predicting PTSD and depression among inner-city women. **Journal of Traumatic Stress, 19**(6), 825-836.
- SHENK, J.W. (2005). **Lincoln's melancholy: How depression challenged a president and fueled his greatness**. Boston: Houghton Mifflin Co.
- SNYDER, C.R. (2004). Hope and depression: A light in the darkness. **Journal of Social & Clinical Psychology, 23**(3), 347-351.
- SLOPEN, N.B., WATSON, A.C., GRACIA, G., & CORRIGAN, P.W. (2007). Age analysis of newspaper coverage of mental illness. **Journal of Health Communication, 12**, 3-15.
- STANFORD, M.S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. **Mental Health, Religion & Culture, 10**(5), 445-449.
- STEFFENS, D.C., & PHILLIPS, C. (2002). Head injury in early adulthood and the lifetime risk of depression. **Archives of General Psychiatry, 59**(1), 17-22.
- STOUT, P.A., VILLEGAS, J., & JENNINGS, N.A. (2004). Images of mental illness in the media: Identifying gaps in the research. **Schizophrenia Bulletin, 30**(3), 543-561.
- STUART, H. (2006). Media portrayal of mental illness and its treatments: What effect does it have on people with mental illness? **CNS Drugs, 20**(2) 99-106.
- THOME, M. (2000). Predictors of postpartum depressive symptoms in Icelandic women. **Archives of Women's Mental Health, 3**(1), 7-15.
- THORTON, J.A., & WAHL, O.F. (1996). Impact of a newspaper article on attitudes toward mental illness. **Journal of Community Psychology, 24**(1), 17-25.

- TRAPPLER, B., COHEN, C.I., & TULLOO, R. (2007). Impact of early lifetime trauma in later life: Depression among Holocaust survivors 60 years after the liberation of Auschwitz. **American Journal of Geriatric Psychiatry**, **15**(1), 79-83.
- URBANIAK, G.C., PLOUS, S., & LESTIK, M. (n.d.). Research randomizer. Retrieved from <http://www.randomizer.org>
- WALDINGER, R.J., VALLIANT, G.E., & ORAV, E.J. (2007). Childhood sibling relationships as a predictor of major depression in adulthood: A 30-year prospective study. **American Journal of Psychiatry**, **164**(6), 949-954.
- WARNER, R., & MANDIBER, J. (2003). Changing the environment of schizophrenia at the community level. **Australasian Psychiatry**, **11** (Suppl.), S59-S64.
- WEEKS, M., & LUPFER, M.B. (2000). Religious attributions and proximity of influence: An investigation of direct interventions and distal explanations. **Journal for the Scientific Study of Religion**, **39**(3), 348-362.
- WOOD, L. (1988, October 14). Self-help buying trends. **Publishers Weekly**, 33.
- WOODSTOCK, L. (2007). Think about it: The misbegotten promise of positive thinking discourse. **Journal of Communication Inquiry**, **31**, 166-189.
- WORTHINGTON, E. L. (1998). Empirical research in forgiveness: Looking backward, looking forward. In E. L. WORTHINGTON (Ed.), **Dimensions of forgiveness** (pp. 321-339). Philadelphia: Templeton Foundation Press.
- YAPKO, M.D. (1997). **Breaking the patterns of depression**. New York: Doubleday.
- YOUNG, T.J. (1991). Locus of control, depression, and anger among Native Americans. **The Journal of Social Psychology**, **131**(4), 583-584.

Table 1 *Study Sample*

Author	Book title	Number of books ¹	Author appears on television or radio?	Author appears as central figure in video(s) or DVD(s)?	Author constructed personal website?
Benkovic, Johnette S. (1998)	<i>Full of Grace: Women and the Abundant Life</i>	5	Yes	Yes	Yes
DeMoss, Nancy Leigh (2001)	<i>Lies Women Believe and the Truth That Sets Them Free</i>	>30	Yes	Yes	Yes
Foster, Richard J. (1998)	<i>Celebration of Discipline: The Path to Spiritual Growth</i>	24	No	No	Yes
Graham, Billy (2006)	<i>The Journey</i>	>25	Yes	Yes	Yes
Kelly, Matthew (2004)	<i>The Rhythm of Life</i>	8	No	Yes	Yes
Meyer, Joyce (1995)	<i>Battlefield of the Mind</i>	>75	Yes	Yes	Yes
Meyer, Joyce (2006)	<i>Battlefield of the Mind for Kids</i>	-----	-----	-----	-----
Moore, Beth (2000)	<i>Praying God's Word</i>	>30	Yes	Yes	Yes
Omartian, Stormie (1995)	<i>The Power of a Praying Parent</i>	>25	No	No	Yes
Omartian, Stormie (1997)	<i>The Power of a Praying Wife</i>	-----	-----	-----	-----
Omartian, Stormie (2001)	<i>The Power of a Praying Husband</i>	-----	-----	-----	-----
Omartian, Stormie (2002)	<i>The Power of a Praying Woman</i>	-----	-----	-----	-----
Osteen, Joel (2004)	<i>Your Best Life Now</i>	12	Yes	Yes	Yes
Rolheiser, Ronald (1999)	<i>The Holy Longing</i>	6	No	Yes	Yes

¹ This statistic was determined through a search on amazon.com and the authors' websites as of April 2007. It is accurate to the best of our knowledge.

Table 2 *Coding Categories and Subcategories*

	Approximate % of textual units (<i>N</i> = 227)	n
<i>I. Underlying Assumptions Regarding Depression</i>		
Depression is not a part of God's plan.	2%	5
<i>II. Representation of Depression</i>		
Depression as feeling broken, feeble, oppressed, tormented.	3%	6
Depression as darkness.	2%	5
Depression has a positive influence.	<1%	1
<i>III. Roots / Causes / Reasons for Depression</i>		
Depression as a result of demonic influence.	9%	21
Depression as a result of negative cognitions.	8%	18
Depression as a result of being a 'bad Christian.'	5%	12
Depression as a result of negative emotions.	3%	6
Depression has a physiological basis.	2%	4
Depression as a result of negative self-images.	1%	3
Depression as a result of lack of forgiveness.	1%	2
Depression as a result of the fallen world.	<1%	1
Depression as a result of strained relationships.	<1%	1
<i>IV. Christian Response to Depression</i>		
Respond to depression with trust in God or Christ.	30%	67
Respond to depression with religious engagement.	22%	49
Respond to depression with personal will or discipline.	8%	19
Respond to depression with nonreligious actions.	2%	4
Approaches toward health care providers.	1%	3