Depressed, Oppressed, or Possessed? Healing wounded minds

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1. Mental health is a delicate subject. I recently attended a mental health conference in Durham University, where a psychologist reported some preliminary research findings that appear to show that many clergy are prejudiced against people suffering from mental illnesses. Prejudice? – Or, were these clergy suffering from a lack of confidence in their own ability and understanding, and a fear of making things worse, and therefore tending to shy away from people suffering from mental health problems?

   - Story of priest stumped by a man who said he was a tree. In psychotic states of mind metaphors frequently assume concrete or literal meanings in our minds – but this needn't have prevented the priest from taking his cue from the patient. Maybe he could have wondered what kind of a tree he was; or, where he was planted; or, what season of the year he was in. None of these responses might have engaged the patient but, if they had, they would have enabled the priest to gain a better understanding of how the man was feeling, which would have created a measure of understanding and rapport between them.

   If today's meeting can help us to overcome our fears a little, and increase our confidence that we all have something precious to offer to each other, in the mental health field, then I will consider that this conference has been abundantly worthwhile.

2. I have been given a powerful, and possibly rather disturbing title: *Depressed, Oppressed, or Possessed? Healing wounded minds*. My brief is to address these subjects from the point of view of mental health. After coffee your Deliverance Ministry team will be making a presentation of their own.

   What do we mean by Depression, Oppression, and Possession?

   From a psychological point of view – and bear in mind, I'm coming at this from a mental health perspective - each word describes a different ego state: a different way of experiencing ourselves.
   - **If I feel depressed**, 'I' feel weighed down, boxed in, overwhelmed. I lose all sense of hope, colour, light and life. I wake early and become prone to nameless dreads and anxieties. I lose my appetites and sense of fun. I feel totally exhausted. If I am very depressed I may find myself wishing I could die – and maybe even begin to plan my death. A sure sign of depressive thinking is that I may begin to think that my death would be a blessing to my loved ones, because it would liberate them from the drag of having to put up with my listless, lifeless,

zestless presence in the home. When depression becomes this intense, it is almost a form of madness.

- **If I feel oppressed**, I may very well not feel depressed at all, but what I do feel is that something is impinging on me, trying to get at me, maybe trying to get inside me, or to get hold of me. I may or may not have a sense of what that 'something' is – perhaps inchoate feelings, or thoughts I can't get out of my mind, or temptations or inclinations which, perhaps, I despise, but which won't go away. But whatever it is that is impinging on me, it almost certainly appears to threaten my security and peace of mind.

  As we will see, the experience of oppression, either in ourselves or in others, may sometimes make us wonder about the activity of evil spirits – and there are certain Christian groups who major on demonic activity. In 99 cases out of 100, though, as I will hope to explain, feelings of oppression, and even of possession, can more helpfully be explained by easily recognisable forms of mental illness, or of neurological disorder, or of conflict between our ego and the contents of our own unconscious minds.

  I think it is important to stress this because, over the Christian centuries, terrible things have been done to men, women, and children by earnest, God-fearing, frightened, and over zealous Christian people. We cannot leap directly from the pages of the Bible into the 21st century, while ignoring 2,000 years of accumulated Christian wisdom and experience. Anyone interested in this area should know what happened in Loudun in the 1630's, or at Salem in 1692.

  If you take away nothing else from my talk, please remember always to be very, very wary before attributing any form of human distress solely and directly to the actions of evil spirits.

- **If I feel possessed**, on the other hand, it is as if whatever was oppressing me has got the upper hand and taken over my controls. Saint Paul gives a wonderful example of this in Romans 7, when he ponders why he doesn't do the good that he wants to do, but rather the sin that he doesn't want to do. Interestingly, he doesn't attribute this to 'possession' by evil spirits, but to what he calls 'Sin': a deviant tendency within himself, brought to life by his attempts to obey the Jewish Law: it was only when he learned that he shouldn't covet that the desire to covet came to life inside him. A very shrewd piece of psychological understanding.

3. **Depression.**

If you have ever suffered from depression you will know what a terrible experience it is: much worse than simply having an attack of the blues – though that can be bad enough. A depressed friend once sent me this little conversation that occurred in her church,

> Someone said to me, 'You look angry.'
> Me, 'I'm not angry. I have depression.'
> They responded, 'Don't you think everybody has depression sometimes.'
> Me, ' No. There is a difference between depression and feeling a bit low.'
> They responded, 'Is there?
> Please help me Lord.

If you haven't suffered from clinical depression, but want to have an inkling of what it might be like, I wonder if you can remember how you've felt at the end of a bad bout of flu? Depleted of all resources, totally incapable of facing the day, and with everything good and cheerful screened out of your perception: nothing but black hopelessness – despair that can make it difficult even to contemplate getting out of bed. For most of us, a cup of tea and an extra day in bed is all we need for hope and colour to return; but depression goes on day, after day, after day.

If we are depressed, we need help, but it can be very difficult to reach out for help because, when we are depressed, we are likely to feel that we are just being pathetically inadequate, that other people would despise us, that nothing can be done anyway, and so on and so on. These negative thoughts are, themselves, symptoms of depression.

What can be done to help? From the mental health point of view, there are a number of treatments available, and it is good we should be aware of them

1. CBT is the current NHS favourite. May be very useful,

a. In tackling the self-defeating and negative voices in our heads. E.g., "There's no point in my getting up and going out because nobody would want to see me anyway". CBT would say, "Nobody? Surely there's one person who would smile if they saw you."
b. Again, "My house is a tip, but I haven't got the energy to sort it, therefore it's useless to start." CBT would say, "Ignore 99% of the mess. Is there just *one* thing that you *could* contemplate doing today?"

CBT can be very effective in challenging the negative cycles of thought that generalise disaster, and in building confidence by concentrating on starting with tiny achievements.

2. Psychodynamic counselling or psychotherapy can also be very helpful with some forms of depression: e.g., after a bereavement, or during a long period of redundancy, or following the breakup of a key relationship, we may find ourselves sinking into a hopeless, tormented state of impotence and apathy. Depression may sound flat, but, actually, it can be supercharged with internal conflict: love and hate, hope and despair, and huge amounts of anger, often directed away from other people, and

boomeranging back upon ourselves. Within the protected and longer term space provided by psychodynamic counselling or psychotherapy all these feelings can gradually be expressed and worked through. It can be a protracted, painful business; but it can also be a real resurrection.

3. Mindfulness meditation is increasingly being used to help people suffering from chronic depression. An approach which doesn't attempt to challenge depressive thinking, or to understand it, but simply, as it were, to refocus our internal gaze and just look through it. We can all be helped by this approach: simply attending to what we are doing, as we do it. N.b. the Zen story: "Master, what does the unenlightened man do?" "He gets up, has breakfast, does his work, and goes to bed." "Master, what does the enlightened man do?" "He gets up, has breakfast, does his work, and goes to bed." In other words, the enlightened person does exactly what everyone else does but, instead of living in an endless stream of daydreams, he attends to what he is doing – which reminds me of Jesus' words (spoken as an antidote to anxiety, which is such a huge component in depression) "Consider the lilies of the field, they toil not, neither do they spin, and yet I say not even Solomon in all his glory was not arrayed like one of these."

4. Medication: Dr Sheila Cassidy, speaking last month in St Paul's Cathedral, acknowledged her debt to the 'chemical cure'.

Whenever we find a seriously depressed person confiding in us, we always need to be alert to the danger of suicide. If somebody is thinking about killing themselves, maybe beginning to plan how to do it, or even to be assembling the means, this information must be shared with appropriate people: family, GP, members of the Community `mental Health Team, whoever has direct responsibility for their medical care. Never go it alone. Never collude with the voice that says, "I'm going to tackle this by spiritual means alone." We wouldn't do it with a broken leg, so why should we do it with a mental illness?

Pastorally speaking, I'm tempted to say that what depressed people need most is not religion but relationship. I am being provocative, of course, but, time and again, at St Marylebone, we have defeated Christians coming to us who come simply festooned with Bible verses and words of knowledge. Friends and church members have prayed with them. One thinks he has 'heard' God saying that the depressed person must forgive; another feels she has been given the word that the Lord will restore the years that the locusts have devoured; another accuses the depressed person of calling God a liar because they said they didn't feel better after they had been prayed for; and yet a fourth person has told them that if they are still depressed they must be refusing to accept their healing. I'm not joking or exaggerating.

The irony is that all these good Christian helpers are ardent believers in the Bible, yet they haven't learned the first lesson of the Book of Job. Job's

comforters did so well, for seven days, while they shared Job's pain in silence. During those seven days, they were genuinely in relationship with him. But then, when they couldn't bear the pain of hearing Job curse the day of his birth – it's not what good people are meant to do, after all, is it? (had they never read the cursing passages in the psalms?) – they begin to try to argue with him, and to exhort him, and to persuade him, and then to accuse him – and the whole thing escalates into a horrid confrontation. Nothing changes!

When I say 'relationship, not religion', I don't mean we should abandon religious practice, in depression. Rather, we may well need help in making our religious practice more honest.

At the same time, we need always to remember that, wherever there is a seriously depressed person, there may well also be a deeply suffering family, who may also need our care and understanding. Sometimes, the best way to support the suffering person is to support those who are caring for them.

4. Let's move on to oppression and possession. Now, the message of this talk is that 99% of apparently supernatural events, in relation to experiences of oppression and possession, can best be understood in terms of psychiatric or psychological understanding, and need to receive medical or psychological help - as well, of course, as appropriate pastoral and spiritual support.

   I want to illustrate this by telling you a number of stories – almost all coming from my own experience of working in the field of deliverance ministry and mental health – where different forms of mental illness or distress presented as if they might be the work of evils spirits.

Requests for exorcism in cases where medical and psychological help is needed

i. I was approached by a woman who said that she was the victim of spiritual attack by satanists. The history was the she had formed an intense friendship with a woman living in another country. To begin with everything was wonderful, but then difficulties arose in the relationship and she began to fear that her friend was discussing her with other people. Soon afterwards she became physically ill, and 'knew' that this was because of the gossip and the spells which her former friend and her accomplices were directing at her. Since then she had discovered that they were part of a global conspiracy of satanists, of which she was the prime target.

ii. A man complained of being tormented by devils. Especially at night he could overhear them laughing and talking and mocking intimate details of his life. Sometimes they would curse him and claim that God hated

him and had abandoned him.

iii. A woman was in torment because she knew that she had committed the unforgivable sin (although she did not know what that sin was, or when she had committed it). Although she knew that prayer was useless and that nothing could save her from damnation, she still begged me to deliver her from her torment.

The common factor between these three people was that they were all suffering intensely, and all believed that the roots of their problems were spiritual or demonic, rather than psychological. In reality, though, the first was suffering from paranoid schizophrenia, the second from a schizophrenic type illness, and the third from psychotic depression. Each had profound spiritual needs, but their first need was for skilled psychiatric attention. This created particular problems for the first person who - as is frequently the case with paranoid conditions - believed she had a completely objective understanding of her situation, and clung to her belief that it had nothing to do with mental illness.

Ultimately, though, in each case, psychiatric attention coupled with medication reduced the intensity of the symptoms and enabled the sufferers to find comfort and reassurance in the ordinary practice of their faith. *Never underestimate the importance of the ordinary means of grace: prayer, communion, anointing and laying-on-of- hands.*

iv. A man came to me complaining of being haunted by faceless spiritual presences which constantly frightened and oppressed him. So much so that a great deal of his time was spent seeking sanctuary in churches and cathedrals.

v. Another man said that he was possessed by seven spirits, each with a name and a distinct personality.

On investigation, the first man was found to be suffering from a borderline personality disorder. In cases like this, the ego is too fragile to manage the stresses and strains of emotional life – the pain of having conflicting feelings and ideas – so it tends slightly to fragment and 'loses touch with' its more troublesome components. In this case, the man suffered most from the sense of being haunted and oppressed when, for good reason, he was feeling murderously angry although he could not experience his anger directly. Instead, his displaced anger created the terrifying sense of something awful and terribly dangerous hovering around him.

With the second man, it was found that his ego had been fragmented by repeated experiences of traumatic abuse, suffered during childhood. Subsequently, his ego had managed to reconstitute itself, but in the form, as it were, of a committee, rather than as a single centre of consciousness. Understandably, he found this very exhausting.

Both of these men found considerable relief through psychotherapeutic interventions, aimed at strengthening their egos, which enabled them to achieve a more coherent sense of themselves; coupled with the accompanying friendship and support of church members.

The danger, in these circumstances, of treating these difficult feelings as if they were 'evil spirits', and attempting to drive them out, is that we risk deepening the already dangerous dissociation between the suffering person and their problematic feelings.

vi. A woman approached me asking for her house to be blessed. Now, it had already been blessed by several Christian groups but, in each case, after a short period of time, she had been afflicted by returning feelings of anxiety and dread. Sometimes she found that furniture had been thrown around, or that crockery was broken. On several occasions she had also found traces of blood on her carpets and walls. To her, this was evidence of voodoo activity.

On investigation, she was found to be suffering from an epileptic condition that was poorly controlled by drugs. At one level she knew this, but what she did not appreciate was that, in the aftermath of a seizure, she would go into a zombie-like state in which she moved violently and erratically around – on one occasion even falling out of a window, an event which had convinced her that she was the victim of demonic assault.

vii. A man approached me, concerned that he might actually be Jesus. To begin with, I imagined he was suffering from a psychotic illness, but his lucidity and rationality gradually convinced me that this was not the case. Could he be a mystic? It seemed that, from time to time, he would be caught up into a visionary state in which he was unconscious of the passing of time, or of events around him. Most often, during these visionary episodes, he would 'become' Jesus, undergoing the events of his passion. Consultation with his GP revealed that he was suffering from Temporal Lobe Epilepsy, which sometimes manifests in the form of pseudo-mystical experiences or auras.

In situations such as these, where mental illness or psychological distress mimic spiritual possession or oppression, there is need for sensitive co-operation between pastors, therapists and medical practitioners.

Requests for exorcism in situations where psychological and spiritual factors predominate

viii. A young couple from a middle eastern country were referred by a parish priest because it appeared that the woman was being possessed by the devil. At times she would lapse into a coma in which she twitched and shook, and from which she could not be roused by calling or shaking. The only antidotes to these distressing

attacks were the prayers and the holy water supplied by the parish priest. When the woman recovered consciousness she would talk of being tormented by a demonic figure with terrible eyes who mocked her and told her she was now subject to his power.

The first time I saw them, their plight seemed profoundly mysterious and frightening. Communication was somewhat difficult because, although the woman understood more English than she spoke, her boyfriend had to interpret for her. At the end of that meeting I prayed with them, and made another appointment to see them in a few days time. By then the situation was worse: the seizures more frequent, and the demon's words even more terrible and triumphant.

The couple found it very difficult to confide what the demon was saying, but eventually it became clear that he was mocking and taunting her, telling her that she was damned eternally because of her wickedness in killing her baby. At this point the sad truth came out: some time before, finding herself alone in London, unmarried, and pregnant, the young woman had undergone an abortion. In the short term, this had solved her problem, but had left her with the unbearable thought that she had killed her parents' first grandson, and the knowledge that – should they ever find out – she would be disowned, or might even be in danger of her life. In her own eyes, she was beyond redemption.

In a case such as this a very sensitive psychological cum spiritual response is needed, which will address the issues of grief, guilt, and self-hatred in a culturally acceptable way.

ix. A woman was referred by a priest, who had attempted an exorcism following complaints of widespread psychic disturbances in her home. To begin with, I believed she was suffering from an incipient psychotic illness and sought to arrange a medical referral. But as I got to know her better – she was a visitor to this country and of another faith, with only an imperfect grasp of English – I sensed that she was undergoing a turbulent, violent (and potentially catastrophic) process of psychological and spiritual development – what is sometimes called a spiritual emergency.

In the country from which she came, women had no independent status, apart from their men-folk. In England she was glimpsing what it might mean for her to become her own person, which she found unthinkable, terrifying and exhilarating in equal measures. Religiously speaking, too, she had no confidence that God would, or even could, speak to a woman. But her dreams and fantasies were packed with visions and thoughts about God, so much so that they threatened to engulf her.

Again, since coming to England, she had had several positive contacts with individual Christians and Christian groups, and had visited Churches that had made a profound aesthetic and spiritual impact on her. Although her commitment to her religion was more social and cultural than spiritual, the idea of converting to Christianity was unthinkable to her. It would mean the end of her marriage, the loss of her family, and might lead to her death; and there was no one with whom she could share these overwhelmingly powerful thoughts and emotions.

In this spiritual emergency, the best way forward was to establish an ongoing relationship that provided sufficiently frequent opportunities for the woman to talk and think as her experience unfolded – something between psychotherapy and spiritual direction. The aim being to provide a secure enough container within which this accelerated process of development could work its way through, until she came to whatever adjustment to life and faith might prove beneficial for her.

x. There have been several tragic cases in which systematic child abuse, even murder, have been linked to belief in witchcraft and possession by evil spirits. Eleanor Stobart's government sponsored research report followed several high profile cases, most prominently the death of Victoria Climbié, on 25 February 2000 (Stobart 2006). Stobart writes,

> Research suggests that when a family experiencing problems has a child who exhibits a behaviour that the family views as problematic, difficult to understand or outside family norms; this, combined with a change in family dynamics may increase the risk of the family accusing the child of harbouring some 'evil' force such as 'witchcraft' or 'possession'. (Stobart 2006, p20).

In these situations, we need to understand that the carer may genuinely believe that the child has been taken over by the 'devil'. In the perpetrators' minds any violence, which may include beating, burning, cutting, semi-strangulation, starvation, or more general neglect and threats of abandonment (Stobart 2006, p16), is not going to affect the child, because the child is effectively not there any more. The violence is directed at the devil (Stobart 2006, p24). This course of action may be advised and supported by the perpetrators' spiritual advisors, who share the same religious and cultural understanding of the problem.

Such behaviour looks very different from a western perspective. In 2007, the Government issued an advisory document, *Safeguarding Children from Abuse Linked to a Belief in Spirit Possession*, which advises what should be done in cases of abuse or neglect linked to belief in spirit possession; or if there are concerns about the beliefs and practices of a place of worship. In every case, statutory services

must be informed, while the wider Church may have a role in attempting to intervene with the family's spiritual advisors.

From a psycho-spiritual perspective, we can see that the Victoria's initial distress, which caused her to behave in difficult and apparently inappropriate ways, was actually an expression of the distress being suffered by the whole family, as it tried to adjust to adverse circumstances. In these situations there is an understandable tendency to say, 'Something is wrong, therefore someone must be to blame.' Once a child is identified as the cause of the family's ills it may become the target for increasingly violent and desperate attempts to rectify the situation.

PASTORAL CARE

I have reviewed quite a wide variety of conditions which led deeply troubled people to look to the church for help. Many of them believed that their difficulties were caused by demonic interference, but their suffering would have been compounded had I, and others helping them, accepted this view. In each case the central problem was one of mental heath, and this needed to be recognised so that they could receive the most appropriate care.

If we are involved in the pastoral care of the mentally ill, we should always be working in a collaborative and interdisciplinary way; and never seeking to 'go it alone'.

This said, though, I do want to emphasise that faith communities can be an amazing resource for those going through troubled times in their lives. For example, they

1. Offer a story about the meaning of life within which we can locate our own experience.
2. Confer a sense of identity: e.g., child of God.
3. Hold us in time while opening a door on eternity.
4. Provide a moral compass, with an opportunity to acknowledge guilt and to receive the assurance of forgiveness.
5. Assure us of the ultimate justice of life.
6. Offer a pathway to healing, even if full healing is assumed to occur beyond the confines of this life.
7. Have rituals which cover the developmental crises of life: birth, puberty, marriage, death; as well as a perspective on what comes after death.
8. Draw people together in community; perhaps in special groups: at St Marylebone, the Mental Health Support Group, and our healing prayer group.
9. Negotiate the tension between our longing for an ideal and the necessity of having to cope with reality.
10. In prayer, meditation and worship provide an outlet for our frustrations, anxieties, and longings; as well as a container for conscious and unconscious processes and for transcendent experience.

11. Provide safe places of sanctuary were troubled people can take refuge, and simply *be*.

When it comes to praying with people suffering from mental health difficulties there are a number of simple safeguards to keep in mind,

- Would the person like us to pray with them? – never over rule their feelings.
- How would they like us to pray? What shall we pray for?
- Would they like to pray too?
- Keep prayers simple, and stay within the information we've been given.
- Don't go in for elaborate flights of fancy: rather, put the person and the way they are feeling in God's hands.
- Be aware of how the person is while we are praying, and adapt accordingly. N.b. man who nearly had a panic attack when his doctor closed his eyes and launched into an ecstatic prayer, 'as if he was possessed.'
- Never touch anyone without their understanding and consent: would you like to receive the laying on of hands?

Earlier, I stuck my neck out and said that what people experiencing mental health problems most need is not religion but relationship. I was being provocative, of course, but I want to end with a story which demonstrates the huge value of community support, within an atmosphere of faith.

> In a parish where I once worked, a member of the MU became – I will call her May - housebound, suffering from agoraphobia. Her husband was also suffering from the stress of trying to care for her. As soon as the members of the MU became aware of the situation – as so often happens, for some months the couple had been successful in hiding their plight – they organised themselves, so that a day never passed without May either being visited or phoned. At the same time, the men of the church rallied round her husband and ensured he had companionship and regular opportunities to get out of the house.
>
> Although, to begin with, May was pessimistic about ever getting out of her house again, the MU did not lose hope. Instead, they kept her in touch with everything that was going on. At the same time, May was receiving help from her local primary care team.
>
> After several months, May became able to make short accompanied trips to the local shops, which were only a few yards from her home; but progress seemed to stop there. The MU did not give up hope though and, without ever pressurising May, gently encouraged her to hope too. Eventually, after several more months, May began to say how much she would have liked to get to a special MU meeting that would be taking place in the local parish church in a few weeks time. As the day got closer,

she began to think she could make it, with a lot of support from her friends.

When the evening came the whole MU turned up at her door and, despite May's anxieties, formed up round her like a great swarm of bees, and swept her down the hill to the parish church – a distance of about three quarters of a mile. May was torn between panic and euphoria. After the meeting, they accompanied her home in the same way.

This was the beginning of the end of her phobia. Happily, when I visited the parish last year – over 30 years since these events took place – there were May and her husband, with her daughter and her children, in the thick of providing lunch for the parish gathering.

CONCLUSION

My brief was to say something about the experiences of depression, oppression, and possession from a mental health point of view. So this is what I've tried to do.

If you take nothing else away from this talk, I hope I will have given you a picture of the way in which a whole variety of mental illnesses, neurological disorder, and simple human distress can create symptoms which, taken simply at face value, might make the layman leap to conclusions about the presence of evil spirits.

But if the conditions I have mentioned require psychiatric, neurological, or psychotherapeutic intervention, this does not mean that pastoral and spiritual resources have no role to play in their alleviation. We should never underestimate the normal means of grace, provided within a secure and accepting environment, by people who are prepared to accompany the sufferer and their family, maybe over long periods of time; while also encouraging and supporting them to get the most appropriate professional care and help that can be found for them.

All Saints' Day, 2010