7 Depression – An Overview

I don't know what's wrong with me. 1 haven't had any energy for the last two months at least. Nothing gives me any pleasure nowadays.« The once confident businessman spoke in a low monotone voice, his eyes downcast. ‚I wake up as early as four o'clock in the morning ... filled with an agonising fear about the day to come. I'm no use for anything any more. I'm a complete failure. 1 can hardly summon up the courage to telephone a customer ... no one's giving me any orders nowadays.«

He took a deep breath. »But the worst thing is, God has deserted me. I used to get so much out of reading the Bible, but now it doesn't speak to me any longer. Every time I try to pray I feel condemned. I'm full of unbelief. God can't carry on listening to a person like me. I can't see any way out. Is there any help for me?«

A Desparate Search for Help

When his problems started, Mr. Brown tried to cope on his own. He swallowed vitamins and went out to jog every morning. But the pressure grew. His wife didn't know how to encourage him when he complained about his difficulties. He picked up a book on conquering depression from someone in his home Bible study group. He praised and thanked God, even for his difficulties. He tried to pray more, recognised his self pity, but the dark clouds didn't disperse. Even a prayer for deliverance from demonic oppression failed to bring the peace he longed for.

Mr. Brown was so aware of the sins in his life that he didn't expect to gain any help from the doctor. So he only told him that he was having pains around his heart, and said nothing about how he felt inside. The E.C.G. was normal, and the doctor didn't pursue the problem any further.

After a few conversations with him, the lay pastor of his church realised that he was dealing here with a severe depression, and referred him to me. Happy ending? No way! It took months of consultations and treatment with antidepressant medication. The road to healing was lined with pot holes. Days of hope were cancelled out by renewed darkness. But, in the end, the dark clouds did weigh less heavily on his mind. Increasingly, Mr. Brown opened what he once referred to as »windows of joy«. Today he is fully back in business again, and what is more important to him, he can read God's word with pleasure and take an active part in the life of his church. His odyssey from one therapy to the next is typical of many who suffer from depression.

Christians with depression often seem to find it difficult to understand their condition and to take the measures that are needed to deal with it. They suffer because even the faith in God which used to shape and motivate their life is unable to stop them walking into the valley of the shadow. They want to make sense of their trouble in the light of the Bible, but this isn't always easy for them. They do not fit the cliché of the victorious Christian. How can anyone understand someone not living in continuous joy, peace and hope, when these things are promised in the Bible? And how can anyone help a person who is suffering, not just from a passing mood, but from a severe depression?

Most Christian books deal with circumstances which in psychiatry would be labelled as mild to moderate depressions. The advice they contain is helpful, effective, and even biblical, in overcoming temporary oppression. But with two exceptions, I have found little help in them for Christians who suffer from severe »endogenous« depressions. My goal in the following two chapters is thus to show:

- the criteria by which a severe depression can be recognised;
- the connections which exist between biochemistry, environment, experiences of life, and behaviour;
- the course usually taken by a severe depression;
- the effect of a depression on a person's spiritual life;
- how to give pastoral help to someone with severe depression, and
- how to work together with the G.P. and the psychiatrist.

How to Recognise a Depression

Depression has many faces. A dark veil with a complicated woven pattern darkens the view. So before we talk about the forms, causes and treatments of depression, we first of all need to recognise the different »woven patterns« which eventually allow us to diagnose depression.

The diagnostic criteria of depression will be given in table 7.1. Notice in particular the duration: to justify the diagnosis of a typical (severe) depression at least four symptoms must be present for a period of at least two weeks. Milder depressions on the other hand last a shorter time and show fewer distinct symptoms. For instance, we would not talk about a severe depression if someone was in low spirits for a few days (but remained capable of work) and slept badly as a result of his worries. Nevertheless one should treat this complaint seriously since a mild disturbance of mood can develop into a severe depression in the course of time.

The accompanying physical symptoms are summarised in table 7.2. Both tables show how closely soul and body, »Psyche« and »Soma« are interwoven. The autonomic nervous system follows the swing of each upheaval of the soul. Breathing, pulse and digestion change their rhythm and each in their way give expression to the soul's distress.

Some *key questions* can quickly provide better contours to the disorder. Here are some questions, which the pastoral counsellor or the doctor should ask:

- Are you still able to enjoy yourself?
- Are you still interested in things you were interested in before?
- Are you less able to take initiatives than you were several weeks or several months ago?
- Do you feel exhausted during daytime?
- Do you feel nervous, tense or anxious inside?
- Do you find it difficult to make decisions?
- Have you been experiencing disturbances of sleep?
- Do you experience any pain? Do you notice a pressure on your chest?
- Do you notice any loss of appetite? Have you lost weight?
- Is there a decrease in your sexual desire?
- Have you had a tendency to be more thoughtful or worrying recently?
- Are you plagued by the thought that your life has become useless?

Table 7.1 Diagnostic Criteria for depression (adapted from DSM-IV)

At least four symptoms have to be present over at least two weeks:

- depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt nearly every day
- diminished ability to think or concentrate, or indecisiveness, nearly every day
- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

DSM-IV = American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, fourth edition. Washington, DC: American Psychiatric Association.

Table 7.2 Physical Symptoms Accompanying Depression

(somatic symptoms are frequent but not always present)

- Headaches, dizziness, dryness of mouth.
- Feeling of pressure or tightness in the neck or chest.
- Outbreaks of perspiration, pounding heart, palpitations, disturbances in the rhythm of the heart, pain in the region of the heart.
- Frequency of micturition, pain in the lower part of the body, disturbances in sexual function.
- General loss of energy and absence of freshness.

In addition, Christians will complain that they have »lost their joy in the Lord«, that the Bible doesn't speak to them any more and that they have difficulty with prayer. They will no longer be certain of their salvation and have the impression, because of their sense of guilt, that God might have rejected them. As well as being afraid of other people and the demands of everyday life, they will be afraid of a God who, in the distorted view of a depressive person, is angry and vengeful. Depression is often associated with social withdrawal and growing loneliness.

Everything which previously gave purpose to life disintegrates and no longer gives support. Often even a person's faith goes through a deep crisis. The dark veil of depression lies not only over everyday life, but also over the experience of God's presence.

All of these afflictions can occur in varying degrees of severity, in diverse gradations of grey tones, like the boards of a weathered wooden house. A valuable tool for measuring the severity of the depression is provided by the Beck Depression Inventory (BDI). If a client registers less than 11 points, they are not depressed in the strict sense of the definition. 12 to 19 points indicate a mild depression, 20 to 26 points represents a moderate depression, and more than 26 points indicate a severe depression, provided that the symptoms also last more than two weeks.

The Forms of Depression

Depression can occur in the most diverse forms (see Figure 7.1). These extend from illness which has a purely physical cause to depression occurring as a reaction to external circumstances (loss of a dear person or of other valued relations and things).

The diagram shows that in every depression there is an interplay between two components, namely the physical-biological (endogenous) component and the psychological-reactive (psychogenic) component.

The organic constituents of depression are most obvious. These occur as a result of brain damage, meningitis, interruptions of blood supply to the brain, etc. Severe depressions can also result from debilitating illness. A prolonged depressive condition can follow a severe bout of influenza or a long course of hepatitis. In these cases we talk about a symptomatic depression..

By »schizoaffective depression« psychiatrists understand those depressive conditions which occur within the context of a psychotic (for instance, schizophrenic) affliction (see chapter 9 to 11). This diagnosis can only be

Table 7.3: Some questions from the Beck Depression Inbventory

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

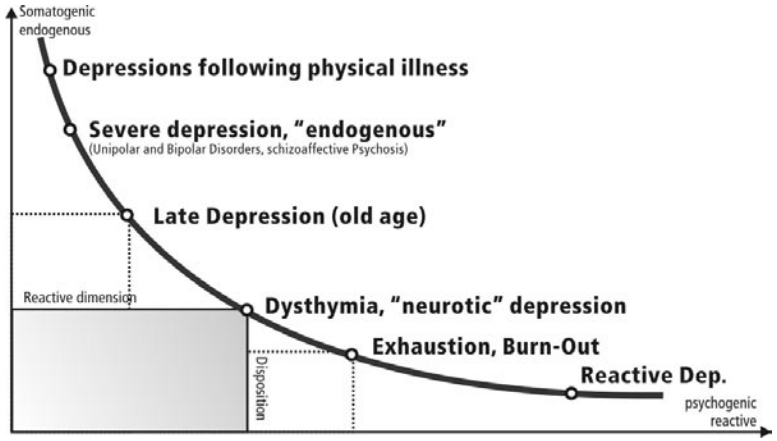
8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

The Beck Depression Inventory is a self-rating instrument and contains 21 items, which cover the following topics: Sadness, Hopelessness, Past failure, Anhedonia (=unhappiness), Guilt, Punishment, Self-dislike, Self-blame, Suicidal thoughts, Crying, Agitation, Loss of interest in activities, Indecisiveness, Worthlessness, Loss of energy, Insomnia, Irritability, Decreased appetitie, Diminished concentration, Fatigue, Lack of interest in sex. If a client registers less than 11 points, they are not depressed in the strict sense of the definition. 12 to 19 points indicate a mild depression, 20 to 26 points represents a moderate depression, and more than 26 points indicate a severe depressionThe full text can be found in the Internet (www.google.com) or in Aaron Beck's book, Cognitive Therapy of Depression, Guildford Press.

Figure 7.1: The forms of depression



made after a prolonged period of observation. In any case, the term covers severe forms of depression in which the patient's contact with reality is clearly disturbed.

I will deal with unipolar and bipolar depressions later. By a *»late-onset depression«* we understand a severe depression which occurs beyond the age of 60 years. It is more difficult to define the *»neurotic depression«*, also termed *»Dysthymia«* in newer textbooks. In these cases depression usually is not very severe, but takes a prolonged course (more than two years). These patients suffer particularly from the emotional wounds which they have experienced through other people. Traumatic experiences in childhood and youth are often put forward as the trigger for this kind of depression, but time will reveal that those who are affected generally find life more difficult and react with extreme sensitivity to both real and imagined letdowns. However, one does these patients an injustice. by portraying their depression as simply a false or sinful reaction.. The diagram shows that genetic factors also play a part making it more difficult for the person affected o cope with the normal disappointments of life.

How Does Depression Develop?

There are many theories about the causes of depression. I will restrict myself in this chapter to informing the reader what is known within the

current state of medical science, and what the pastoral counsellor can observe in dealing with depressive people.

In the outline above, the distinction between the individual forms of depression seems clear and unequivocal. However, inward and outward causes, soul and body, do not allow themselves to be separated as neatly and completely as we would like them to be. They have a mutual influence on one another. I have tried to present these connections in figure 7.2.

I have consciously placed the brain in the centre, because it is here that the processes which lead to depression are controlled. We have already looked at the miracle of the human brain (see chapter 3) and seen in the process the role played by biochemistry in the understanding of a psychological problem. Quite a lot of people have a moderate hereditary disorder in the metabolism of their brain (a so called *disposition*) which makes them vulnerable to external pressures, so that when they come under stress, they are likely to react with a depression.

The body is intricately tied with the mind. Even in young people depressions are often accompanied by physical complaints. On the other hand, physical disorders may trigger depression. In older people the condition of the blood vessels and the heart plays an important role. The human brain can only function when it is provided with a sufficient supply of blood (and hence with oxygen). But high blood pressure, arteriosclerosis and weakness of the heart all result in less oxygen reaching the nerve cells – depression can be the result. With appropriate treatment it can completely disappear.

There is also a close connection between thought and the biochemistry of the brain. On the one hand the disturbed biochemistry of the brain during a depression reduces the ability to experience joy and see the world from a positive viewpoint. On the other hand it is also influenced by the person's thoughts and belief system.

Mild and Moderate Depression

In mild and moderate depressions the reaction component is often predominant. How people work through bereavement or stress depends on the way they think, and on the value they put on particular experiences.

Physical reserves of strength also play an important role. Experiences such as the sudden death of a friend, or long periods of tension such as examination pressures or marriage problems can erode the »nerves« and lead

to an exhaustion of the supplies of biochemical substances in the brain.

As a result a dark veil falls over the person's whole emotional life and they begin to see everything – themselves, their environment, their future – in a dark perspective. Situations of depressive exhaustion do not happen by accident. Often a depression is also to be understood as an alarm: »Stop! You are overdoing it! You are expecting too much of yourself!« Or perhaps: »Why can't you get the better of this misfortune? What are you allowing to rule your thoughts? What is it that gives you a feeling of self worth?«

Even in milder depressions it can be observed that negative thoughts can strengthen the depression. But Christian faith changes thinking to the positive. It fosters hope, comforts, encourages, and directs the view on things above. So faith can be a very real help in overcoming a depression.

The troubles of a depression snatch a person out of the daily routine and make her think about the real meaning of her life. So the crisis can also provide the chance for a new beginning.

Severe Endogenous Depression

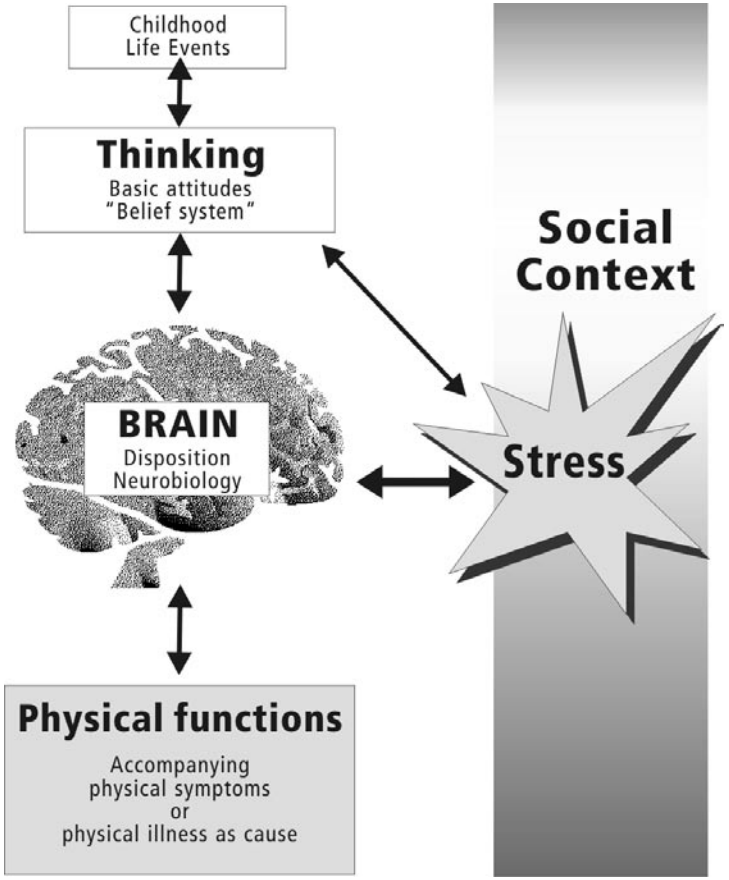
In my work as a psychiatrist I am seeing patients who become ill with the deepest depressions, far beyond the normal level, *without any external cause*. At any time about 1.3% of the population will be suffering from a severe depression. The risk of undergoing a severe depression at some time during the course of one's life lies at about 5 to 10%.

Those who are affected in this way have the impression that they have been suddenly, out of the blue, wrapped round with a gloomy fog of darkness of soul. »Look, I have everything I could wish,« a woman told me: »I have a dear husband and three bright children. Things are going well for us materially, and we have no cause for worry. We are both believers, and are active in our church. I can't understand why I have become so dejected, anxious and depressed.«

Another woman, who fell into a deep depression after the birth of her third child, complained: »I should be happy about our baby, but I can only see myself as a failure. I worry that I could harm this child. It would be best if we were all dead.«

Mostly there is nothing to be found in their life history to account for a severe depression of this kind. Of course, these people have not gone through life experiencing only sunshine and happiness. Indeed, hardly anyone has an ideal, burdenfree life behind them. But there is no relationship in these patients between the cause of the depression and their cir-

Figure 7.2: Factors in the development of depression



cumstances. Often there is an increased occurrence of depressive disorders or a history of suicide in the wider family.

The condition is not only characterized by a depressed mood, but also by sleep disturbances and somatic complaints as they are described in tables 7.1 and 7.2. In these cases, the physician will think of an endogenous, biochemical cause for the depression.

The Course of Severe Depression

There are four possible courses that an endogenous depression can take. There may be one or more episodes of severe depression which may last weeks or even months, with free intervals in which the person affected lives, thinks and feels as normal. In this case the psychiatrist will talk about a *unipolar depression*.

The other form of endogenous depression shows a wave pattern, not only below normality but also above it. The agonising depth is followed by a high which patients experience as a release from their unbearable situation. Here we talk of a *manic-depressive psychosis*, or of *»bipolar depression«*.

Finally, there are also *chronic* depressions. These last more than two years and respond only in an unsatisfactory way to medical and psychological treatment.

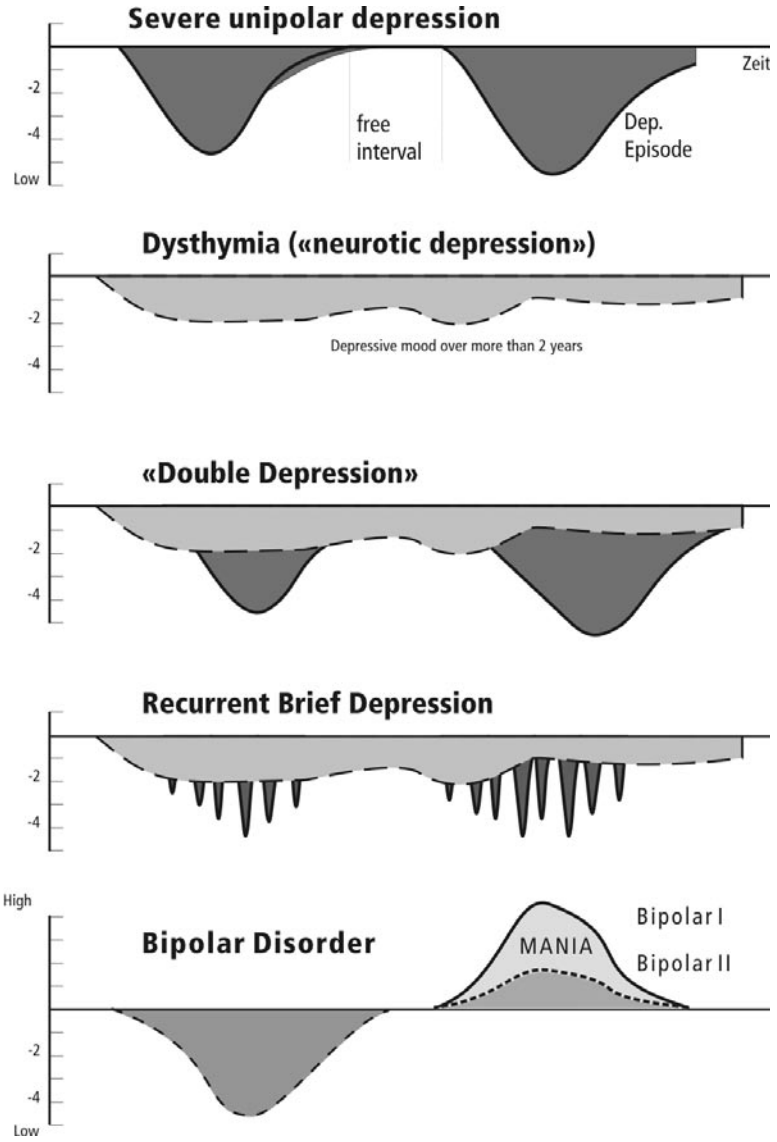
It has been estimated that 10 to 20 per cent of depression take a chronic course. These cases do not always consist. of the worst depressive states. Even a moderate feeling of depression can be enormously oppressive, when you see no light at the end of the tunnel. Chronically depressed people often meet with little understanding from those around them which drives them into the additional isolation.

Depressive delusions are a particularly alienating symptom in a severe depression. Rather than simply looking at everything through dark spectacles, the patient loses touch with reality completely.

I vividly remember an old man who stayed in the hospital for a period during a severe endogenous depression. He believed he had lost all his possessions. With a sad voice he complained to me: »I've nothing left. I'm in complete poverty. I can't provide for my family. My wife will have to go through the streets in rags. 1 don't even have any clothes to wear my-self.« Yet, his wardrobe was full of clothes. This condition is called »Delusion of Poverty«. Other typical delusions are:

- *Hypochondria.* The conviction that you are suffering from an incurable illness.
- *Self condemnation* beyond any real context. The sick person blames herself for having broken something, for which she must be punished. A man believes he has ruined the hospital because he didn't finish eat ing his meal, and so now he is going to be punished for it.
- *Ideas of failure.* The patient believes his or her life to be a complete failure. All their earlier achievements no longer count for anything. They have nothing to offer in comparison to everyone else. They have

Figure 7.3: Various courses of depression



failed with regard to their job, civic duties, etc., etc. A young woman complained »I don't even know how a radio works. My life isn't worth living any more!«

Delusions of Guilt and Sinfulness

Finally, there is yet another form of depressive delusion which afflicts Christians: Delusions of sinfulness. »My guilt stands like a wall between me and God,« complained one woman. »I'm a useless mother, I can't cook, I'm not cheerful enough, I'm afraid of people. I cry out to God, but he doesn't hear me. I try to cling on to a promise, but God can't accept a failure like me.«

Certainly, there are people who have every reason for remorse and fall into a depression (usually a mild, and reactive one) as a result of genuine guilt. But in this case it was different. There wasn't a single remaining sin, even a really tiny one, which this woman hadn't already confessed umpteen times. Yet her »sin« still towered before her like a gigantic mountain. When the milk boiled over she saw it as confirmation of her vileness. She lamented the terrible sin of not sending a card on time for her sister's birthday. This delusion has nothing to do with real conviction of sin. What we are faced with here is a pathological condition.

You may ask »What can be done for someone who suffers from a depressive delusion? How can a man with a delusion of poverty be helped?« I will go over the therapy of depression systematically in the next chapter, but let me anticipate this by saying that it takes patience, lots of patience. Every attempt to reassure the patient that the opposite of their delusion is true leads to a reinforcement of the ideas. However, usually, as the depression becomes less severe, the delusions also subside of their own accord.

In some cases such ideas may persist and may trouble the afflicted person into old age. These people will need a special degree of understanding and patient care by doctor and pastoral counsellor alike.

Mania: From joy to derailment

Emerging from the dark sea of melancholy is a powerful experience for any severe depressive. They will describe the change as »like being unchained«, indeed, »like a new life«. Yet for many people, depression is followed by a swing into mania. This is characterised by heightened mood, increa-

Table 7.3 Diagnostic Criteria for a manic episode (adapted from DSM-IV)

A) A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- inflated self-esteem or grandiosity
- decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
- more talkative than usual or pressure to keep talking
- flight of ideas or subjective experience that thoughts are racing
- distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

sed drive and accelerated thought processes.

A woman wrote the following words at the beginning of her manic phase: »I feel like nature itself at this moment. Progressing from its long winter sleep it sprouts from every tip and joint, sending out new buds. The birds trill and promise a new warm time to come ... a new year, a spring with blossom, soft, green meadows with bubbling rivers and streams ...«

Yet the joy soon turns into a nightmarish high altitude flight. The same woman paid an enormous amount of money for a new wardrobe of clothes with strident colours, because her »depressive clothes« no longer suited her new found joy. With her unbounded creative energy, she started getting up at four in the morning, and didn't go to bed until one.

She wasn't at all bothered that the loud music from her apartment bothered her neighbours. In her elation she lost all moral restraints and got herself involved with men who were complete strangers. The once withdrawn, decent and quiet lady spoke in a loud voice, and called her friends at all hours of the day and night to tell them how good things were going for her. In the end her behaviour became such a burden for people around her that she had to be admitted to a psychiatric unit.

The manic phase is thus the reverse side of the depression. Where before there was a lack of energy, the sick person now shows almost superhuman energy. Where before he was controlled by the worries and cares of life, he no longer sees any problems or dangers. Where before he withdrew into his shell, now he wants to embrace the whole world. Where before he struggled under his guilt and sinfulness, now he is incapable of experiencing guilt and sin, even though his behaviour frequently transgresses moral boundaries.

Relatives experience enormous suffering through their manic spouse or child. Parents often don't know any way to help, other than to ban their son from the house »until he comes to his senses«. Marriages are frequently shattered by the manic phase of a partner. The wife of a manic husband once wrote to me: »I find it such a torment, I don't know what to do. What I'd really like to do is to make a final break with him and leave him. But should I do that? All the time I keep praying and asking the Lord for a miracle, and for him to make things clear to me, but somehow I feel lost and alone.«

You have now read a lot about the forms, causes and the course of severe, endogenous depression. You may be asking yourself, what hope is there for severe depressives? Is there any hope for the hyperactive manic person? Is there hope for their suffering relatives? I would like to answer with a cautious »Yes«, and in the next chapter I shall look into the pastoral care of depressive conditions and the various possibilities for therapy.

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plus internet resources (www.google.com)