



Sabbaths of **Hope**
Faith Communities
Responding to Depression

Depression & Hope
Workshop Module

The Mental Health Association of the Heartland

The Center for Practical Bioethics

• with funding from
The Health Care Foundation of Greater Kansas City



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Pictures of Depression

- *“I am lost in an immense underground cavern with tangles, unending passageways. What distant light I could once see soon shrank to a glimmer and now is gone. Earlier I tried mightily to get out, to find the light of day again, but it is no longer possible and I no longer care. I’m very, very tired.”*

Howard Stone, *Depression and Hope: New Insights for Pastoral Counseling*. Minneapolis: Fortress Press, 1998. P. 1.

Pictures of Depression

- *“The weather of depression is unmodulated, its light a brownout.”*
- *“... the gray drizzle of horror induced by depression takes on the quality of physical pain.”*



William Styron. *Darkness Visible: A Memoir of Madness*. New York: Random House. P. 19.

The writer, William Styron, was a world-famous author, in Paris to receive a \$25,000 award for his writing, when he experienced the depression he describes here. His circumstances (at the pinnacle of his career) offer no clue as to the source of his emotional distress.



Pictures of Depression

- *“...despair...comes to resemble the diabolical discomfort of being imprisoned in a fiercely over-heated room. And because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion.”*

William Styron.



God's Good Creation


- Human beings are mind/body/spirit
- And God said, "It is good."
 - The body is good.
 - The mind is good.
 - The spirit is good.
- We are always all three together.
- What happens to one, happens to the whole.
- When all aspects of our being work in harmony, life is good.

Depression challenges our understanding of who we are as human beings in relation to God.

Human beings are created as mind/body/spirit persons. And God pronounced creation "good" (Genesis). The body is good. The mind is good. The spirit is good.

Judaism and Christianity have historically been committed to understanding and valuing persons as mind/body/spirit, especially avoiding the spirit as more valuable. We are always all three together. What happens to one, happens to the whole. When all aspects of our being work in harmony, life is good.

In Christianity Jesus is portrayed as one who cared for the well-being of all aspects human life, the physical, the spiritual, and the mental.



Depression and God's Good Creation

- God created human beings in and for relationship
 - relationship to God
 - and relationship to one another.
- We are created for relationships of love.
- In the context of loving relationship,
persons (mind/body/spirit), communities
and the whole world can live abundantly.

God created human beings in and for relationship; relationship to God and relationship to one another.


We are not created to be persons by ourselves, separated from one another. We cannot survive alone.

What happens to one person, affects us all. Paul's image of one body with many parts is both an image of a person and of communities/worlds. We are deeply interconnected to one another.

We are created for relationships of love.

In the context of loving relationship,
persons (mind/body/spirit), communities
and the whole world can live abundantly.

We grow and thrive in a world of love and justice, in right-relationship with God and others.




Depression affects every aspect of
being:

Mind

Body

Spirit

Social



Is Depression a Sin?

- We are not God.
- Depression is a manifestation of human finitude.
- Depression is a distortion of God's hope for us as persons and as communities.

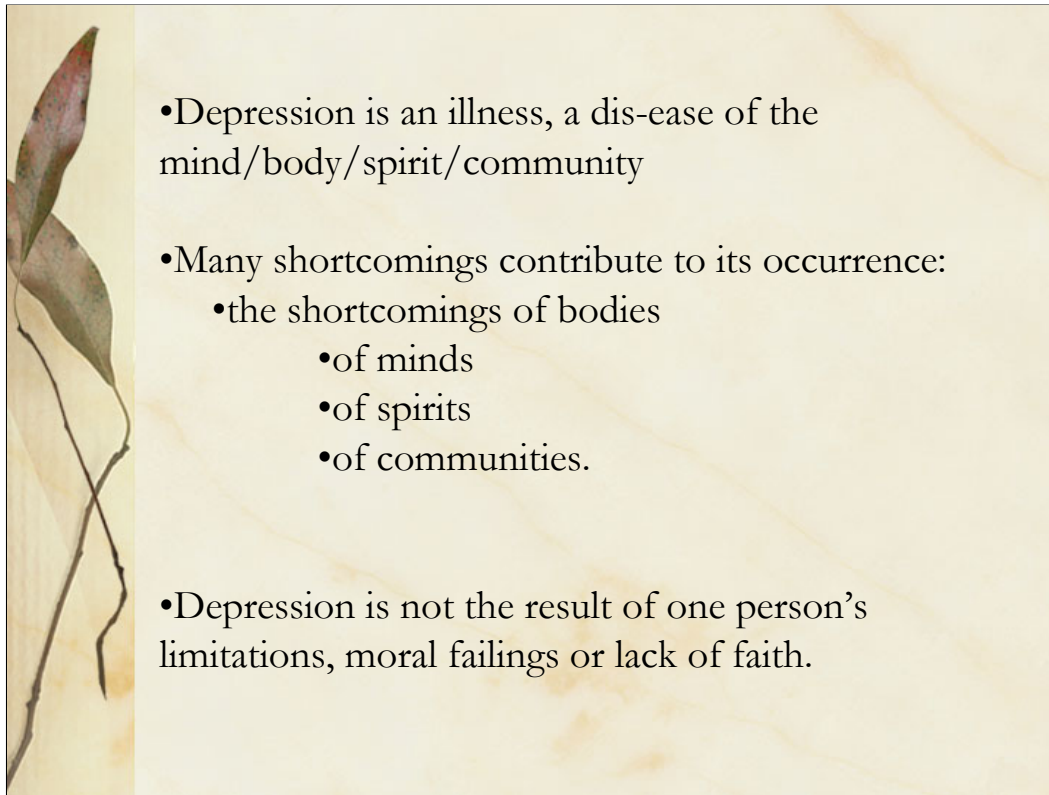
We are created in the image of God but we are not God. We are finite, limited, and prone to sin.

Depression is a manifestation of that human finitude.

Depression is a distortion of God's hope for us as persons and as communities.

Depression should be understood not as God's intent for us but rather a distortion of that intent. It is not something to be sought after or idealized but something to be "treated," something to respond to in hopes of alleviating its effects.

Depression is evidence of human beings not living in the full potential in which God has created us.



- Depression is an illness, a dis-ease of the mind/body/spirit/community
- Many shortcomings contribute to its occurrence:
 - the shortcomings of bodies
 - of minds
 - of spirits
 - of communities.
- Depression is not the result of one person's limitations, moral failings or lack of faith.

As we will see in this presentation, depression is caused by a multitude of factors, including genetics, emotional or physical stress, and societal oppression. Each of these is a sign of human finitude and failure to some degree but depression is not the sinful failing of an individual.

Depression is an illness, a dis-ease of the mind/body/spirit/community

Many shortcomings contribute to its occurrence:

- the shortcomings of bodies
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Depression is not the result of one person's limitations, moral failings or lack of faith.

In Western society we tend to see illness as something that must be proven to be biologically caused and beyond the capacity of the person to cure. Mental illnesses have historically been seen as not "real" illness, as something that can be "fixed" by stronger will or character or faith. Depression challenges our understanding of illness and refuses to set up these kind of dichotomies. It reinforces our theological convictions that, in fact, we are created as one interrelated whole, mind/body/spirit/relationship. Depression cannot be overcome by one person's willing it into submission. Certainly miracles of healing do happen, and they usually happen through the use of our God-given gifts and the faithful activity of God's people trying to live out God's call for a just and loving world.



Historical Figures in the Church

- **St. John of the Cross** (1542-1591) – Spanish poet and Roman Catholic mystic, wrote of the “Dark Night of the Soul,” that stage in the mystic path when “spiritual persons suffer great trials, by reason not so much of the aridities which they suffer, as of the fear which they have of being lost on the road, thinking that all spiritual blessing is over for them and that God has abandoned them since they find no hope or pleasure in good things.”



Historical Figures in the Church

- **Martin Luther** – winter of 1542, his daughter, Magdalena, had died and the plague swept through Wittenberg. The faithlessness of his fellow Germans discouraged him and he began to think of – and wish for – his own death.



Historical Figures in the Church

- **John Wesley** – described himself as helpless and hopeless, “Again, joy in the Holy Ghost I have not. I have now and then some starts of joy in God. But it is not that joy. For it is not abiding.” – written 7 months after his Aldersgate experience

John Wesley often wrote in his letters as one who had felt the hopelessness and helplessness of depression, or what he called “low-spiritedness.”




Historical Figures in the Church

- **Mother Theresa** – in the 1950s and 1960s wrote letters revealing depression: “I am told God lives in me – and yet the reality of darkness and coldness and emptiness is so great that nothing touches my soul.”
- *“In my soul, I can’t tell you how dark it is, how painful, how terrible – I feel like refusing God.”*

CNN article – Satinder Bindra, Sept. 7, 2001.

<http://archives.cnn.com/2001/WORLD/asiapcf/south/09/06/teresa.letters/index.html>

Catholic church officials have suggested that Mother Theresa's struggles with her own spirituality and calling show her humanity and strengthen the case for her sainthood. The balance of “both holy and human” make her more special, just as Jesus expressed feeling abandoned by God on the cross.



Biblical Characters Who Experienced Depression

- Jeremiah (Jeremiah 20:14-18)
- Job (Job 3:3a)
- Jonah (Jonah 1:3, 8-9)
- Elijah (1 Kings 19:4)
- David (Psalm 42:3)

Jeremiah curses the day he was born, and the man who brought his father news of his birth. He states that he was only born to see trouble and sorrow and to end his days in shame.

Job also cursed the day he was born -- literally, he asked that the day and night of his birth might perish.

Jonah asked God to take his life, saying "it would be better for me to die than to live."

Elijah, after his great victory over the priests of Baal, ran to Horeb, sat down under a broom tree and prayed to die.

David speaks here specifically about crying all night long, and having a "downcast soul." Often in the Psalms, especially the Psalms of Lament, we see David's vivid depiction of the pain of depression.



God's Response

- God listened – God let them speak (and even record it for us to read)
- God met their physical needs – shade and rest for Jonah, food and rest for Elijah
- God did NOT scold
- God DID challenge their thinking – reminded them of God's character, power, and presence
- Psalm 42:5b – David had a NEW vision and hope for the future
- How, then, should we (the Church) respond to each other?

God listened: God waited and listened to their pain, and led the writers of sacred text to record their words.

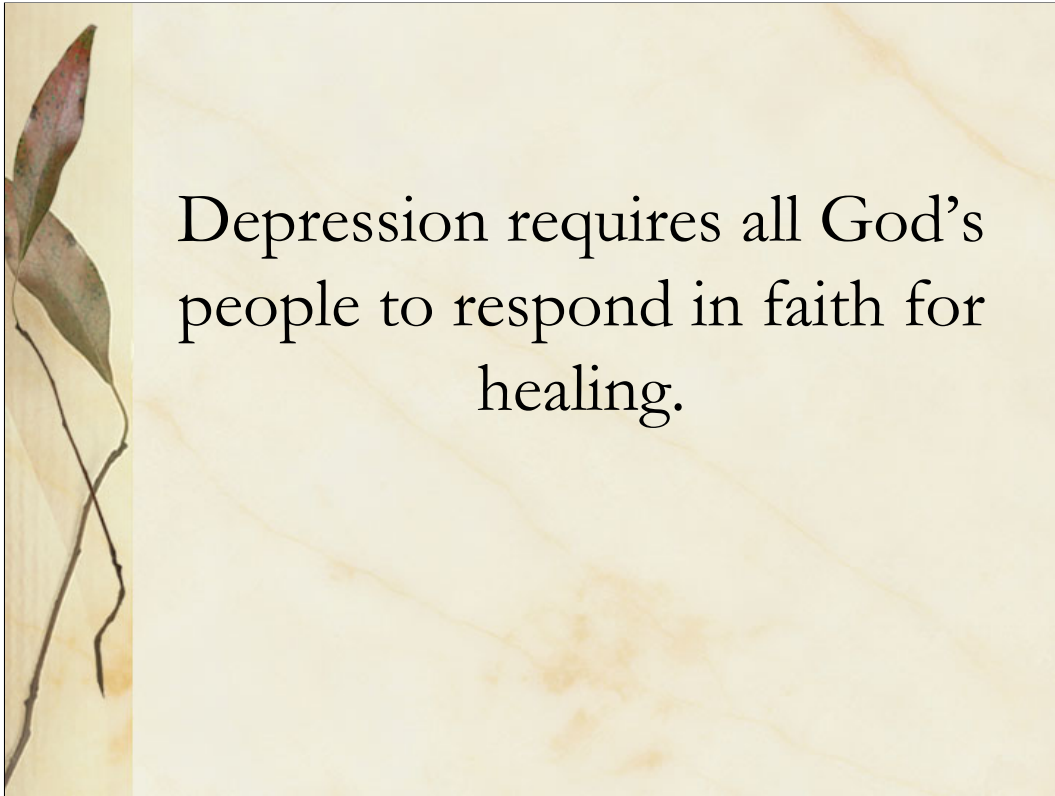
God met their physical needs

God did not scold them or shame them for their feelings.

God did challenge their thinking – reminding Job of God's power; reminding Elijah that he was not alone, not the only believer left on earth; reminding Jonah of God's great love for all people and desire that none should perish;

Psalm 42:5b – David reminded himself that he WOULD AGAIN praise God in the future – reminded himself of God's character and presence.

We as the Church, God's representatives on earth, should respond to those who are hurting in the same manner as God responds to them. We will look at some specific guidelines for this later in our presentation.



As people of faith we are called to work toward the healing of depression. The healing of one requires the actions of us all.



Identifying Depression

- Depression is a persistent mood disorder that affects the whole person – the emotional, physical, cognitive, social and spiritual aspects.
- There are different kinds and severities
 - Major depressive episode
 - Bipolar illness
 - Dysthymia

From what has already been said, it is clear that when we refer to depression, we are speaking about more than feeling down or “having the blues”. Depression is a persistent mood disorder that affects the whole person – the emotional, physical, cognitive, social and spiritual aspects of a person. There are different kinds and severities of depression. Some depression is part of a disease called bipolar illness, which includes both the extremely low moods of depression and the unusually high ones of mania. Dysthymia is a form of depression with less severe symptoms which persist for years. But to keep to the basics today, we are going to focus on major depression.

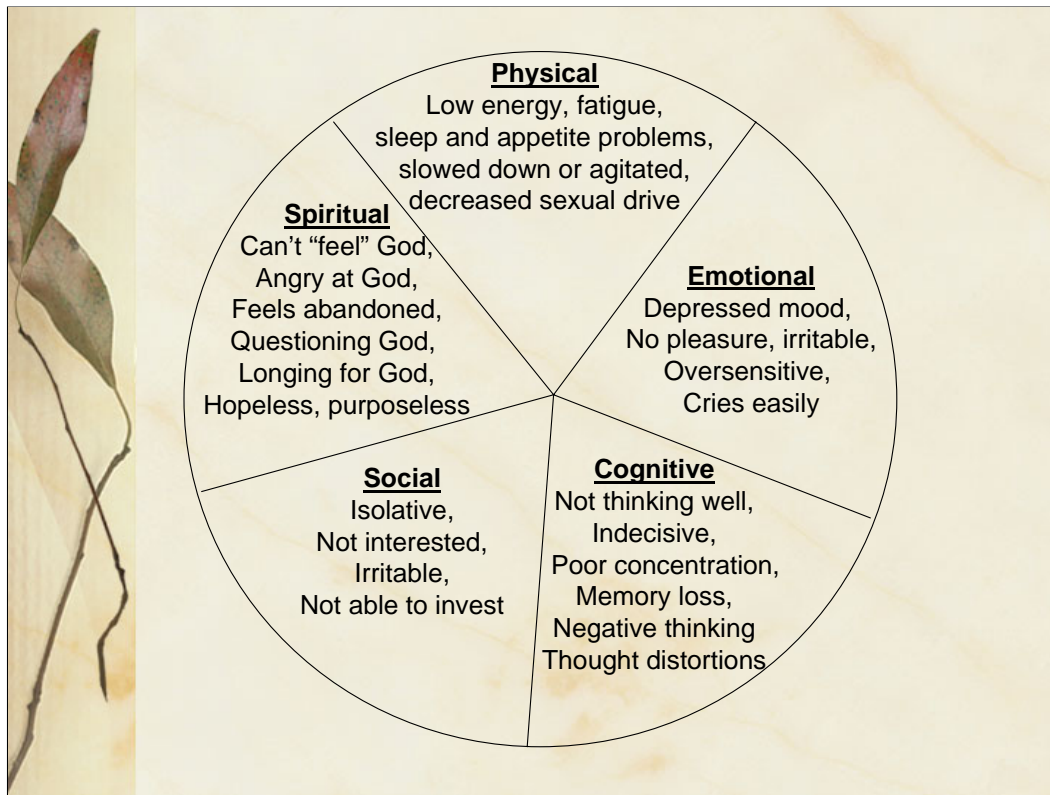


DSM-IV Criteria for Major Depressive Episode


- Depressed mood
- Loss of interest or pleasure
- Appetite/weight loss or gain
- Sleeping difficulties
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty thinking, concentrating, making decisions
- Recurrent thoughts of death or suicide

If a person were to go to a counselor or a psychiatrist to see if they were depressed, the standard criteria for determining that is found in the DSM-IV – or the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders. According to this manual, a person is having a major depressive episode if, for more than two weeks, that person has been experiencing many of the following symptoms most of the time:

- Depressed mood
- Loss of interest or pleasure in almost all activities
- Significant weight loss/gain or decreased/increased appetite
- Significant difficulty sleeping or sleeping too much
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Difficulty thinking, concentrating or making decisions
- Recurrent thoughts of death or suicide



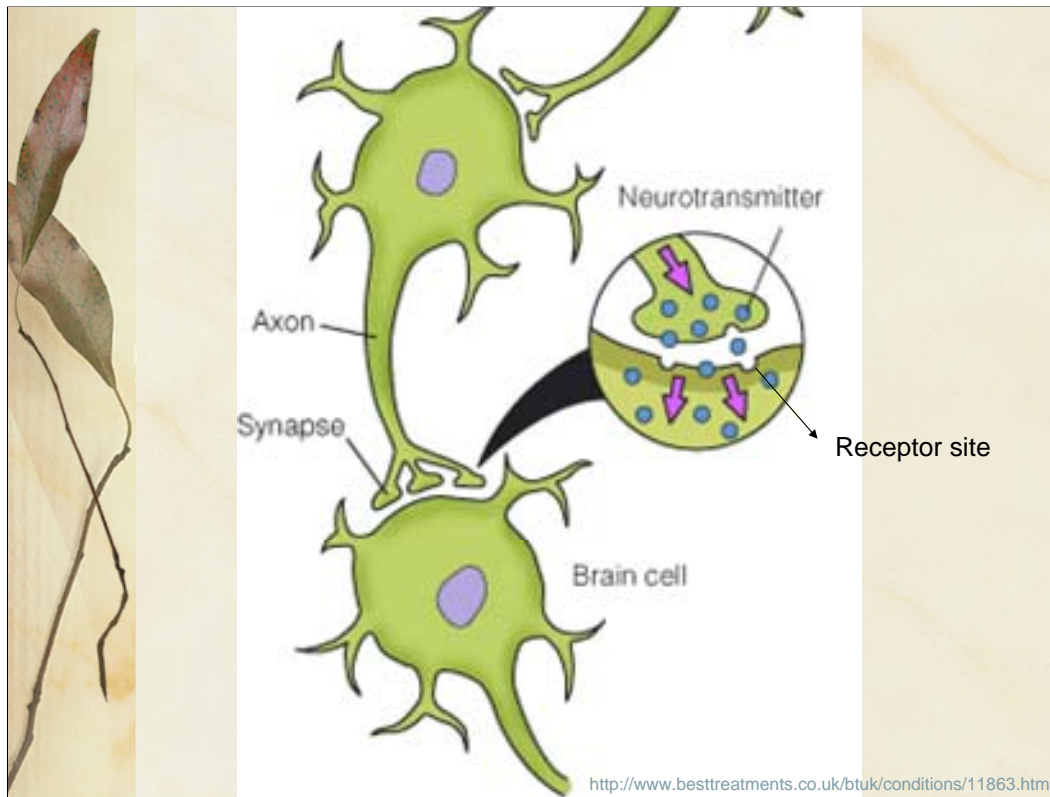
As you can see (from the diagram), depression is a disorder that affects the whole person. It involves the emotions, seen in a person feeling depressed, apathetic, uninterested, crying a lot, being irritable, or oversensitive. It affects the cognitive processes, making it difficult to think clearly, make decisions or concentrate. There are thought distortions, with the individual having an overly negative view of self, the world, and the future. Often there are thoughts of death or suicide. Sometimes there is thinking that is clearly out of touch with reality. Depression demonstrates itself significantly in the body. One experiences low energy, fatigue, feeling slowed down, difficulties in sleep or eating, decreased sexual drive, and various somatic problems like headaches. One's social life and interpersonal relationships are affected by depression because a person tends to isolate, be more irritable, and often not be interested or able to invest emotional energy in another person. There are also significant spiritual aspects with disturbances in the person's feeling or sensing God's presence. A depressed person may feel empty or abandoned by God, angry at God, and often hopeless or without meaning.



Depression as a Brain Disease

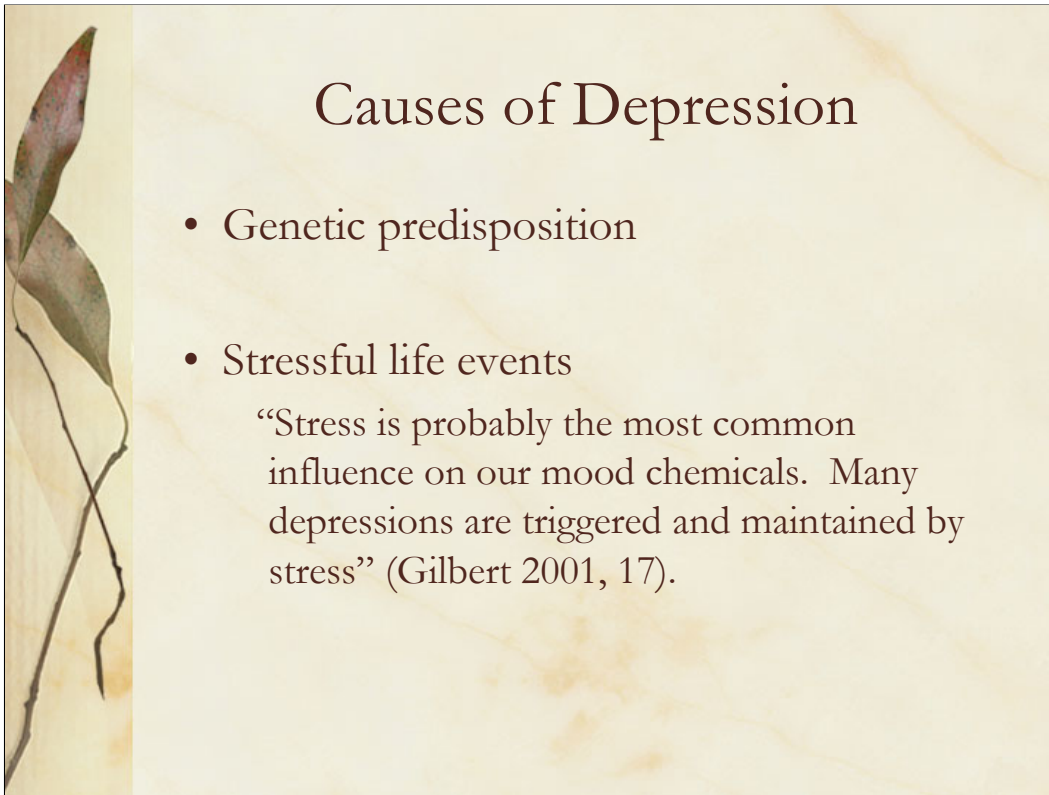
- Disturbance in the neurotransmitter system
- Neurotransmitters – chemicals that convey messages from one nerve cell to another
- Neurotransmitters especially involved in depression – serotonin, norepeniphrine, and dopamine

Many of these symptoms are a result of depression being a disturbance of the neurotransmitter system in the brain. Although much research has not identified exactly all aspects of this process, we know this is involved because when medications that affect the neurotransmitter system are given, improvements are noted. Neurotransmitters are chemicals that convey messages from one nerve cell to another. When someone is depressed, it appears that there are not enough of certain neurotransmitters, such as serotonin, norepeniphrine and dopamine, in the spaces between nerve cells to carry messages across adequately.



As you can see from this picture, the nerve cells, or neurons, in the brain are separated by a little gap called the synapse. In order to get a message from one neuron to another, these neurotransmitter chemicals are released from one cell, travel to the second cell, attach to specific receptor sites that matches to convey the message, and then are released back into that gap and reabsorbed into the first neuron, so they can do their work all over again.

What happens in depression is that there are not enough of these neurotransmitters remaining in the gaps of the transmission systems in those parts of the brain involving mood, motivation, sleep and appetite. When antidepressant medications are given that increase the amount of these chemicals – either by blocking an enzyme that breaks them down or by blocking the receptor sites that reabsorb them back into the nerve cell – the depression often improves.

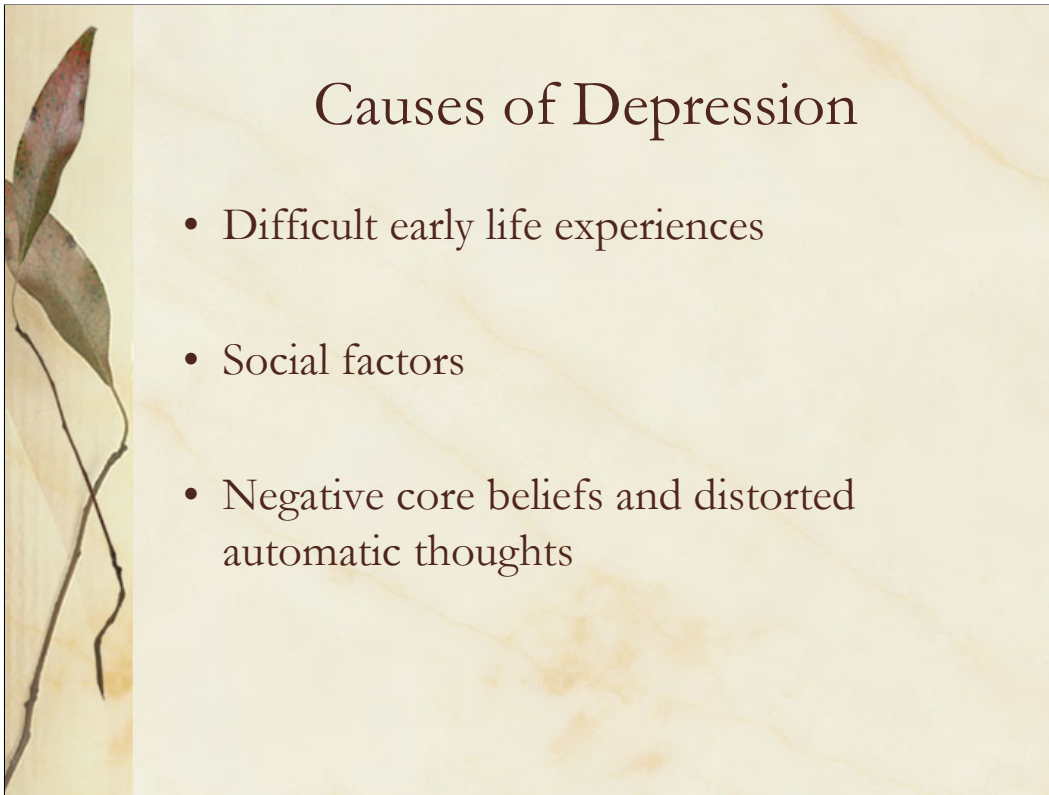


Causes of Depression - We may wonder what causes depression. What causes some people, and not others, to get depressed under similar circumstances? It appears that there are many factors that may contribute to the development of depression.

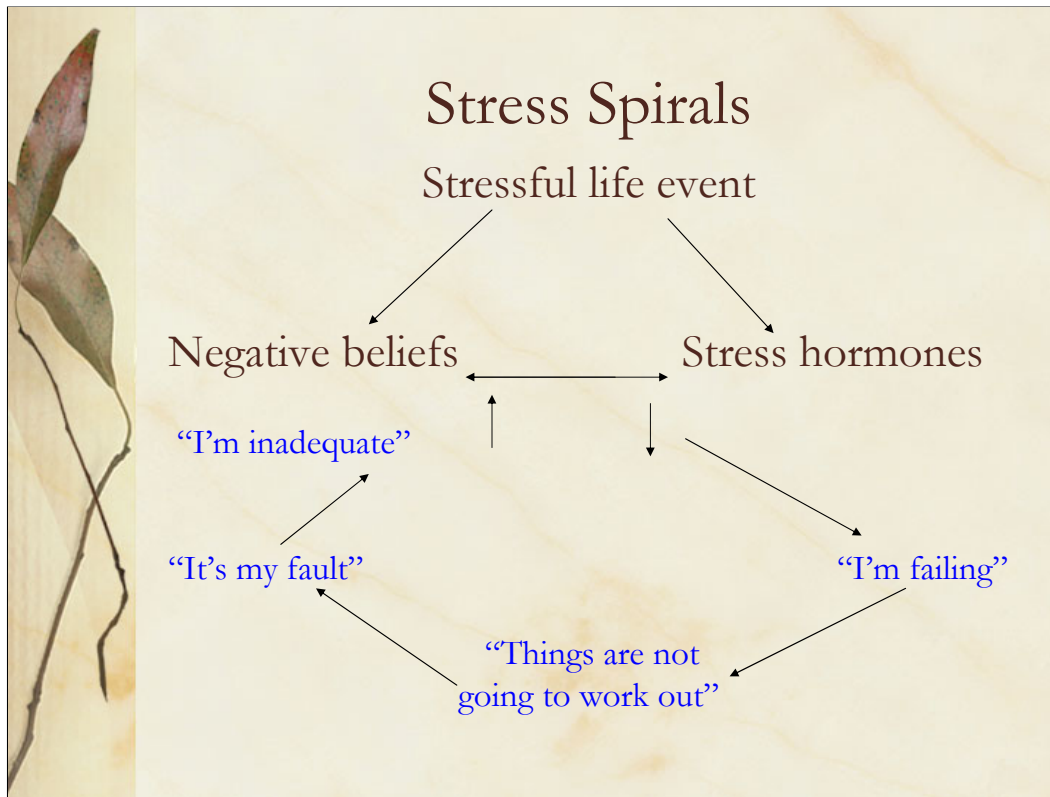
1. For at least some people, there appears to be a genetic predisposition towards developing depression. While researchers have not yet identified specific genes related to depression, it is quite certain that some people get depressed more easily because of their genetic make up. This is especially true for the depression related to bipolar illness. In one study done on twins, genetically identical twins were more than twice as likely to both have a depression than nonidentical twins (DePaulo, 2002, 90).

2. Stressful life events are another very significant contributor to the development of depression. Professor of Clinical Psychology Paul Gilbert (2001) writes, "stress is probably the most common influence on our mood chemicals. Many depressions are triggered and maintained by stress" (17). In fact, the connection between stress, how we handle it, and depression, is well documented. When a person is significantly stressed and thus confronted with some threat, the body automatically gears up to mobilize for action – the heart rate goes up, breathing gets more rapid, and energy is released in what we sometimes call the "fight or flight response." This mobilizing response to stress involves the release of a stress hormone called cortisol, which is good for a short-lived threat. But if the stress continues so that prolonged elevated levels of cortisol remain, neurotransmitters related to depression, such as serotonin, are affected. Research shows that many depressed people have a hyperactive hypothalamic-pituitary-adrenal system with elevated cortisol levels. Basically, this means their stress system is in overdrive and those neurotransmitters related to depression (serotonin, noradrenaline, and dopamine) are depleted.

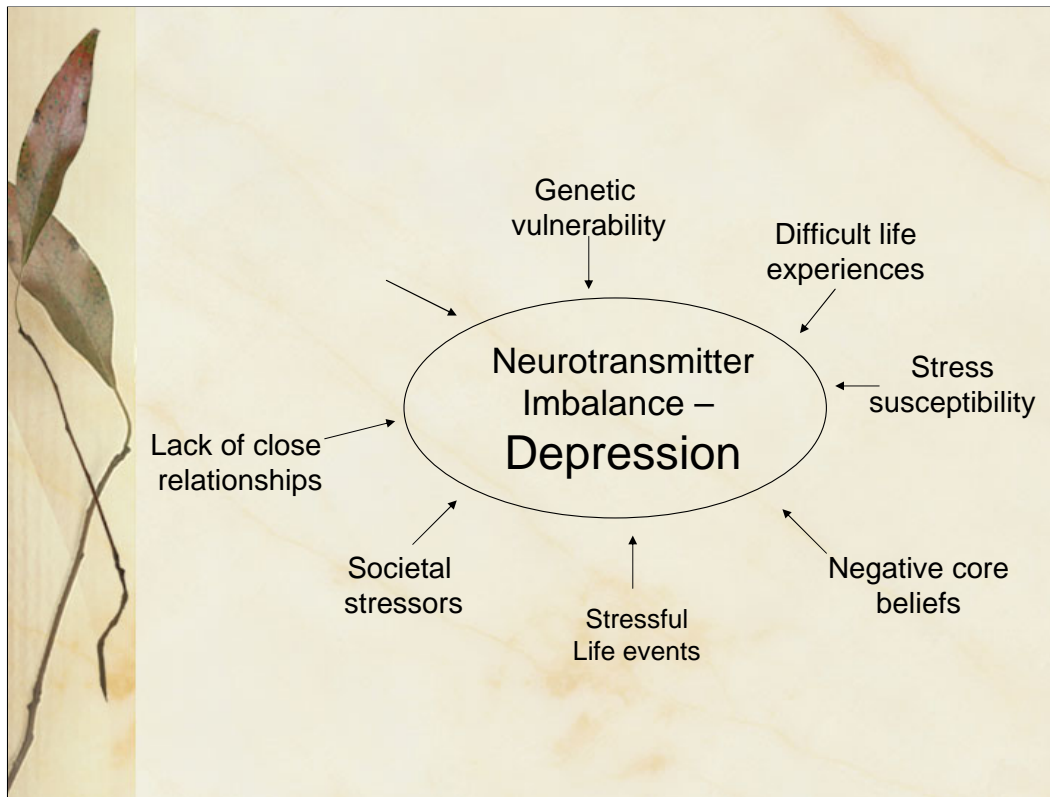
Studies have shown that this occurs especially when humans or animals are put under stresses they have no ability to control. Apparently, when we are stressed but feel we have some control because we can do something differently and have coping abilities that can have an impact, our brains respond differently than when we feel we cannot do anything about the stressful situation we are in. The more control we can take over the stresses in our lives, the less likely they will cause our stress systems to spiral out of control, which then results in important neurotransmitters taking a nosedive into depression.



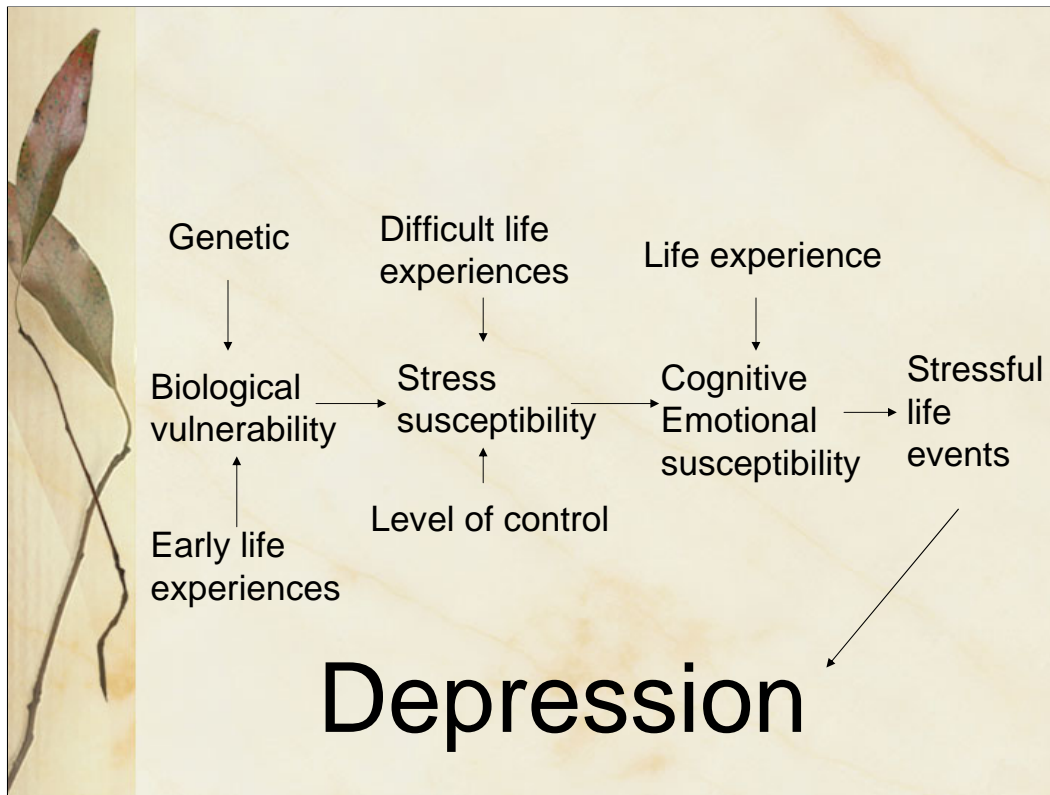
3. Difficult early life experiences also can be a significant factor in making one susceptible to depression, and there may be a couple of reasons this is so. For one, the human brain is quite immature at birth and develops a lot afterwards. The quality of our early relationship – whether they were loving or abusive – helps shape various types of connections that nerve cells make in the brain, and especially in those areas that are related to mood and emotions. There is increasing evidence that many people susceptible to chronic forms of depression have histories of being abused and stress systems that have an increased sensitivity. Other studies indicate increased depression among those who have lost a parent early in life.
4. There are also social factors that can be a part of developing depression. Larger societal forces, such as discrimination or overly stressful work environments can contribute. Also the quality of social relationships is important. There is more depression when there is marital conflict. In fact, those involved in a troubled marriage are 25 times more likely to get depressed than those in satisfying marriages (Weissman 1987, cited in Stone, 1998, 41). Vulnerability to depression is also related to having no close relationships with people we can confide in or feel supported by. Abusive relationships often result in depression.
5. Furthermore, our life experiences, especially our early ones, help us develop core beliefs about ourselves and our world that then function as a lens through which we interpret what happens to us. This interpretation of our experiences generates automatic thoughts that powerfully influence our emotions, stress levels, and hormones.



For example, if someone has a core belief about himself that he is stupid and incompetent and then makes a mistake on the job, he can quickly jump to the conclusion that his making a mistake means he is totally incompetent, he will never be successful, he will lose his job, and the future is bleak. The brain reads all these thoughts as actual threats and starts sending signals to the stress system to release stress hormones, which then causes him to focus more acutely on his negative thinking and sends him into a stress spiral that heads him towards depression (diagram).



To summarize, many factors contribute to the biochemical imbalance involved in depression – genetic vulnerability, difficult early life experiences, susceptibility to stress, negative core beliefs, stressful life events, societal stressors, and a lack of close, supportive relationships.



Genetic make up and early life experiences contribute to one's biological vulnerability. Difficult life experiences and one's level of control affect one's susceptibility to stress. Life experience, especially early ones, can result in cognitive/emotional susceptibility. And stressful life events themselves can eventuate in a depleted neurotransmitter system and depression.




Understanding Depression Reduces Shame and Blame

- Many factors contribute to depression, most unrelated to person's choices.
- Depression includes an illness process involving chemicals in the brain.
- Depression affects every part of a person's life and results in terrible suffering.
- Rather than being stigmatized, depressed people need help to find treatment.

What causes depression? There are even more factors than have been mentioned already, such as brain injuries or certain illnesses. Depression often appears to be caused by many things, and it is different for each person. Many of these factors are entirely unrelated to anything a person did, although some life stressors may result from a person's choices. But whatever the causes, the end result is that a person has an illness process involving the chemicals in the brain that affects every part of a person's life and results in terrible suffering.

This understanding can help us move beyond stereotypes that stigmatize or blame the individual for being depressed. Having depression is not a cause for shame. It is often a response to too much stress. Neurotransmitters are depleted or inadequate, similar to how a diabetic's insulin is inadequately produced by the pancreas. And as with a diabetic, there is much that can be done. Treatment is available that can be successful. But it often means seeking pastoral or professional help, and it takes some effort on the part of the depressed person and often, the loved ones. Besides understanding and therefore not stigmatizing a person who is depressed, we can know there are many things that can be done to alleviate depression. We can encourage depressed members of our congregations to seek professional help. And we can inspire their hope by our knowledge, something that is very helpful for those who are depressed. But obviously, in order to respond to depression, we need to recognize its presence. So our first response is to have a conversation that assesses for both depression and level of suicidal intent.




How do I know when someone is depressed?

Checking the signs:

- Depressed mood
- Loss of interest or pleasure
- Appetite/weight loss or gain
- Sleeping difficulties
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty thinking, concentrating, making decisions
- Recurrent thoughts of death or suicide

In order to discern whether or not a person is depressed, and not just sad, down, or blue, we return to the signs and symptoms of depression.



CASE STUDY


You are sitting with Jackie in the surgery waiting room while her husband, Thomas, is having surgery. This is one of many surgeries that Thomas has had in relation to his on-going heart problems. It is not a particularly dangerous surgery. You happen to have the waiting room to yourself and decide to try to open up some conversation with Jackie about how she is doing. You know that she carries a lot in her family since Thomas' illness was diagnosed about a year ago and he has been unable to work. They have two teenage children. Jackie works for Hallmark in a management position of some kind. You experience her as bright, capable and energetic but in the last six months you have not seen much of her or her family at church.

This Case Study will help us practice looking for those signs.



Jackie tells you that she feels exhausted and worn down by the stress of work and family. She notices herself being irritable with everyone and on edge. She says that she is not sleeping well and sometimes wake up in the middle of the night unable to go back to sleep. She is losing weight. She says that she knows she should eat better, get more exercise, and try to relax but there does not seem to be any time. She tells you that she has pretty much given up hope of having a fulfilling marriage again or ever getting back to normal. This heart illness has changed Thomas enormously. He has lost his sense of humor. Everyone is so focused on him that there is not much left for her and no one that takes care of her. She says that going to church seems like just one more thing she *has* to do and no one seems to complain about not going. Jackie's sister, who lives in another state, told her that she needs to see a counselor or something. She says she's worried about her. But Jackie is certain that she can get through it. She says, "This is just the way life is going to be and I just have to figure out a way to deal with it."

How many of the symptoms does Jackie display?



CASE STUDY

Ron is an elementary school teacher. He is the father of two children, a daughter in middle school and a son in high school. His wife left him and the children when the children were very young. He attends church regularly with his daughter.

After church on Sunday Ron asked if you would like to get together for coffee or something one afternoon. He says he feels like he needs someone to talk to. This is very unusual for Ron who likes to project the image that he “has it all together.”

You make arrangements to meet him the next day.

With this Case Study you will get to practice assessing someone for depression. (This is set in a Christian church but may be adapted for another setting.)



After some conversation about church, football, the weather, etc. you ask Ron what he wanted to talk about. He says that he is just feeling pretty overwhelmed these days, even though he has been divorced for a long time, it feels extremely demanding to work and be responsible for the kids and household. He worries a lot about money and college for the kids. Work is not as fulfilling as it once was and it seems the students are harder than ever to manage this year. Ron says, "I feel like I am just worrying all the time, sometimes I just want to scream."

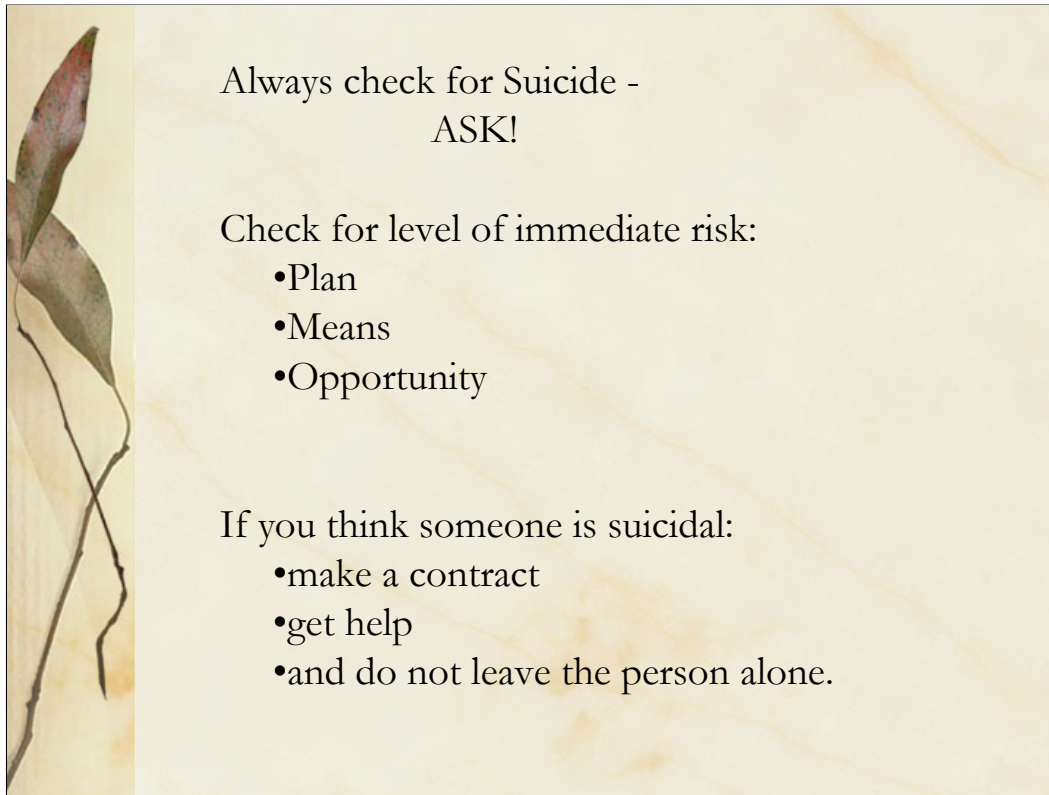
Ron has always had some problems with his son, Jordan, who is a senior in high school. It has reached the point where Ron just can't deal with Jordan's constant anger and argumentativeness. Ron says that he is just trying to make it until Jordan graduates. Jordan has a job and a car so is pretty much on his own now. The children's mother sees them fairly regularly but she lives in another city and with the kids' schedules, visits are getting harder to coordinate. They have never been close to their mother and she has not been very supportive. She remarried and has other children.

Ron had been dating someone for about a year but broke up last month. He doesn't want to get back together but misses having someone to do things with. He says, "I don't think I'll ever get married again or find someone to be really close to."

In small groups, assign someone the role of Ron and another the role of person who is talking with him (may be pastor, leader, lay person, or friend). Practice listening for the signs and symptoms of depression and asking questions that will help you decide whether or not Ron is depressed. Do you think Ron is depressed? Why or why not?

Refer back to the symptoms and signs of depression. Try to phrase a question or two that will tell you whether or not the person has that symptom. You may also ask about family or personal history. If a person has been depressed before they are more likely to experience a second episode.

Assessment may also include some education about what depression is.



If you suspect that someone is depressed, you should always check for the possibility that the person has ideas of committing suicide or otherwise harming themselves or others.


Asking people whether or not they have thought about harming or killing themselves does not make them more likely to do it. In fact not asking may increase the sense of hopelessness that a suicidal person feels.

Check for the level of immediate risk by asking whether or not the person has thought about or made a plan for carrying out a suicide. Ask, "Have you thought about how you would kill yourself?" Then check to see if the person has the means to carry out that plan and whether or not he or she has the opportunity. For instance, if the person said that she or he would shoot him/herself ask, "Do you have a gun?"

A "Suicide Contract" is a covenant or promise between the suicidal person and someone committed to helping them. It involves a verbal or written commitment on the part of the suicidal person to contact the other if they are thinking of hurting themselves and before they do. The other person commits to being available or making sure someone else is available for the person in danger of committing suicide. Suicide contracts help persons feel that someone cares for them and will hold them accountable.

Persons who are suicidal need professional help from doctors and/or psychotherapists. They may need to go to the hospital to assure their safety. You may need to call the police if someone is in imminent danger of committing suicide.

Depressed persons do not usually kill themselves when there is someone with them. Having someone with them at all times is a strong preventative factor.



Treatment of Depression

- Attention to all aspects of person best.
- Physical examination by medical doctor to rule out medical illness as factor.
- Medication
- Counseling

Treatment – Because depression is a disorder that affects the whole person, treatment at its best is multi-dimensional, with attention to all aspects of the depressed person. This may involve antidepressant medication, counseling, support measures, and spiritual care. In addition, because some types of depression are caused by another medical illness, such as hypothyroidism or hormonal imbalances, it is always wise for someone who is depressed to get a thorough physical with their medical doctor. Medication and counseling are two primary forms of treatment for depression.




Medications for Depression

- Antidepressants work to rectify neurotransmitter deficiency.
- Effective with 65-70% of depression.
- Only 50% of people continue taking medications as prescribed.
- Work slowly to relieve depression.
- Very important for treatment of severe depression.
- Sometimes electroconvulsive therapy (ECT) is recommended instead of medications.

Medication – Antidepressants are medications that directly act on the deficiency of various neurotransmitters in the synapses or gaps between the nerve cells. There are over thirty different antidepressants, with new ones being developed all the time. Each functions in a slightly different way but the net result of each is to increase the availability of these important neurotransmitters to the affected areas of the brain so it can function better. Somewhere between 65-70% of depressed people can be effectively treated with medications (DePaulo 2002, 209). Unfortunately, studies indicate that only about 50% of people continue to take their medications as prescribed, due to not liking the side effects or not seeing positive results quickly enough (Stone 1998, 101). Antidepressants can be frustrating to take, because they do not give immediate relief, but take a long time to start working. Often they need to be taken consistently for a couple weeks before any symptom relief is experienced, such as increased energy or better sleep. And frequently it takes up to two months to experience their full effectiveness. Many doctors recommend taking antidepressants at least nine months after feeling better to give the brain time to heal and avoid relapse.

I strongly encourage antidepressant medication when the physical symptoms are so severe that a person is hardly able to sleep, unable to function, does not have enough energy to do anything or cannot think clearly. If a person is very hopeless, is starting to become suicidal or have thoughts that are not reality based, I strongly urge their use. Such persons are caught in the disease process and need medications to correct the neurotransmitter disorder. Although for milder depressions, counseling may be just as effective as medications, for such a severe depression medication is needed and gives a jumpstart for the healing process. When depression is part of bipolar illness, mood stabilizing medications are also needed and usually need to be taken the rest of one's life to stabilize the mood swings.

Electroconvulsive therapy (ECT) is sometimes recommended, especially for those who are more severely depressed and those not helped by medications or who cannot tolerate them. It has the same effect as medication in addressing the neurotransmitter deficiency. ECT is actually more effective (80%) and lifts depression more quickly, but often requires some medication to maintain these effects (DePaulo 2002, 213).



Counseling

- Medications with counseling is best.
 - Supportive counseling
 - Counseling for life stressors
 - Marriage and family counseling
 - Cognitive-behavioral therapy

Counseling – Often medications with counseling is the best treatment approach. Medications alone are not as effective. In fact, there is a 50% relapse rate if medication is the exclusive form of treatment (Stone 1998, 103). There are a number of different approaches to counseling that can be helpful. Supportive counseling that provides a person the opportunity to express thoughts and feelings and helps them know they are not all alone in dealing with the depression is often helpful. Of significant assistance is counseling directed toward helping the individual deal with the significant life stressors contributing to the depression, such as divorce, unemployment, or death. Such counseling provides a place to talk about what is going on, to work through feelings, to rediscover hope, to make needed changes, and to develop new coping skills. Marriage and family counseling is often very helpful if the major stressor lies in this arena. Pastors are often able to provide the supportive counseling sufficient for milder forms of depression.

Cognitive-behavioral therapy, which looks at the thought distortions and core beliefs occurring in depression and helps the depressed person question their validity and find other ways of thinking, is very helpful. In fact, studies have shown that such a counseling approach is effective with moderate depression, as effective as some of the antidepressant medications. Pastors are sometimes able to utilize this approach helpfully. Otherwise, referral to counseling professionals for these other therapeutic approaches is wise, but referral must be done carefully, as a ministry of introduction, for it to be acceptable.



Cognitive Tools

Regardless of the original cause of depression, almost everyone who experiences depression becomes trapped in a trio of negative thinking about:

- The self
- The world
- The future

Negative thinking about:

The Self – we may say things to ourselves like, “I am no good” or “I can’t do that.”

The World – we may say things like “the world is going to hell in a handbasket” or “Things just go from bad to worse and this world is an awful place to be.”

The Future – we say all of the things above and add “and it will never get any better than it is now. So, why try?”



Cognitive Distortions

This negative thinking is reinforced by cognitive distortions (or “stinking thinking,” as some like to call it)

- All-or-nothing thinking – black and white; absolute; perfectionism
- Mental filter – either filtering out or disqualifying the positive
- Magnifying errors – “catastrophizing”
- Mind reading (of others)
- Accepting feelings as facts
- “Should” statements

All-or-nothing thinking – the tendency to see things as all good or all bad. “Either I do everything perfectly or I am a total failure”

Mental filter – saying “My job is awful because I don’t get paid enough” and overlooking the good work conditions and flexible hours; saying “I only got the job because I was lucky” and ignoring or denying my qualifications for the job

Magnifying errors – “I’m the worst mom in the whole world because I just yelled at the kids” or “it’s the worst possible thing that could happen; the end of the world”

Mind reading (of others) – “I know they don’t like me” “they think I’m stupid”

Accepting feelings as facts – “I feel ugly, so I must be ugly” or “I feel like a loser, therefore I am a loser”

“Should” statements – “I should be friendly to everyone I meet” – ‘shoulds’ are the most dangerous and most prevalent thinking error; we all seem to have long lists of ‘shoulds’ – “a good mother should _____” or “a good pastor should _____” often we learn our shoulds from society, or from our family, and we have accepted them as facts, but there is no rational basis to support them. We can challenge this kind of thinking error by asking ourselves “Who says so?” and we can decide whether to allow the expectation to control our lives in the future.

Burns, D.D. (1981).
Feeling Good: The New Mood Therapy. New American Library: New York.



Referrals – Who to Refer

- Those who can be helped more effectively by someone else.
- Those with problems for which effective specialized agencies are available in the community.
- Those who do not begin to use pastoral help in four or five sessions.
-



Who to Refer

- Those whose needs obviously surpass the minister's time and/or training.
- Those with severe chronic financial needs. Public welfare agencies with trained social workers are appropriate referrals.
- Those who need medical care and/or institutionalization.



Who to Refer

- Those who need intensive psychotherapy.
- Those about the nature of whose problem one is in doubt.
- Those who are severely depressed and/or suicidal.
- Those toward whom the minister has a strong negative reaction or an intense sexual attraction.

• From Howard Clinebell, Basic Types of Pastoral Care and Counseling




How to Make Referrals

- Create this expectation.
- Mention the possibility early, explaining why specialized help may be needed. (Be careful not to communicate that they are “too sick” for you to handle!)
- Start where persons are in their perceptions of the problems and help needed.

Create this expectation. – don’t promise them you will “fix it” for them or that they can see you forever. Let them know that referral is a very real possibility

Mention the possibility early, explaining why specialized help may be needed. (be careful not to communicate that they are “too sick” for you to handle!) – let them know the referral is for their own good, and that you want them to have the most qualified help possible.

Start where persons are in their perceptions of the problems and help needed – don’t try to convince them of your opinion about their issues.



How to Make Referrals

- Work to bring their perceptions of problem and possible solutions close enough to yours to make the referral “take.”
- Help person resolve emotional resistance to referral.
- Interpret the general nature of the help they may expect to receive.
- Establish strong enough rapport so your relationship serves as a bridge over which they may walk to another helping relationship.

Work to bring their perceptions of problem and possible solutions close enough to yours to make the referral “take.” – if you think they have problems that they don’t see, or that they are worse than they think, slowly challenge their perceptions, revealing your observations (“I’ve noticed that you seem very sad. Perhaps the situation at home bothers you more than you have realized.” or “I’ve noticed that you are biting your fingernails and I never noticed you doing that before. Are you feeling more anxious than usual?”)

Help person resolve emotional resistance to referral. – perhaps you will go with them to their first appointment, to ease their fears. Help them see the referral as for their benefit, not a rejection or judgment by you.

Interpret the general nature of the help they may expect to receive. – let them know what to expect in counseling. You can do this more honestly if you know the person or the agency to which you are referring them.

Establish strong enough rapport so your relationship serves as a bridge over which they may walk to another helping relationship. – they may lean on you, because they trust you. Honor this trust with a good referral and use your relationship to help them trust the new counselor.



How to Make Referrals


- Encourage them to try it, even if they are only mildly willing.
- Let them know your pastoral care and concern for them will continue
- Don't let the person drain energy from the problem by continuing to see you.

• From Howard Clinebell, Basic Types of Pastoral Care and Counseling.

Encourage them to try it, even if they are only mildly willing.

Let them know your pastoral care and concern for them will continue – the referral is not the end of your care. You are still the pastor; remain available for spiritual care and support.

Don't let the person drain energy from the problem by continuing to see you for counseling – you may need to say “that’s a good thing for you to mention to your counselor this week.” Don’t allow them to vent their emotional turmoil with you, so that they have nothing to talk to the counselor about.




Other Helpful Responses

- Reduce stigma through conveying an understanding of depression.
- Encourage physiological interventions:
 - Get more active and achieve small successes
 - Get regular exercise
 - Eat healthily
 - Get enough sleep

Other Responses

In addition to identifying depression, responding to suicidality, and making referrals for antidepressant medication and counseling, there is much that pastors, spiritual leaders and congregations can do to provide care for those who are depressed. Simply understanding what depression is and conveying that understanding to others in ways that help to reduce the stigma often attached to depression helps to alleviate some of the feelings of guilt and to make individuals willing to seek out help.

Since depression is a disorder that strongly affects the body, physiological interventions are often helpful, and pastors can help individuals understand their importance. Since people feel so exhausted from depression they often become increasingly inactive and isolated. Helping them simply get more active and do some activities successfully can be good. Regular exercise is immensely helpful, and in fact, can actually alleviate some mild to moderate depressions and enhance treatment of more severe ones. Physical activity releases chemicals called endorphins into the brain that create feelings of well-being, decrease pain, and improve action of the crucial neurotransmitters. By exercise, I mean 30 minutes of significant activity at least three times a week. People usually do not continue activities they do not like, so finding some form of exercise they normally enjoy is important. The body needs care in other ways as well. Good nutrition is important. To the extent possible, encourage them to get enough sleep.




Other Helpful Responses

- Help find ways to reduce stress.
- Provide spiritual support.
 - Allow expression of anger at God.
 - Help build connection to God.
 - Compassionately explore spiritual issues impacting depression.
- Remain supportive

Since stress is such a significant factor in triggering and maintaining depression, it can be important for pastors to help individuals find ways to reduce stress in their lives. People often feel caught in their circumstances and cannot see ways to do this on their own. Sometimes very hard decisions need to be made, particularly when the person is involved in abusive relationships.

Of course, the unique expertise of the pastor and faith community is in the spiritual arena, and this is important in caring for those with depression. Research studies (Koenig 2002) actually show that those with strong religious faith and spiritual practices often are able to deal with depression better than those without, so supporting an individual's faith and helping them deal with those things that are obstacles within it are important. Often people may be angry at God over some tragedy in life, but because anger at God is frequently viewed as unacceptable, it may be harbored and festering inside. Being able to talk about this to a pastor who understands and helps them build connection with God again can be helpful. Often there are distorted or negative thoughts about oneself, one's life, and the future. Healthier beliefs can be developed by drawing on the Scriptures for perspective. People who are depressed feel that life is hopeless and meaningless. These are significant spiritual issues, which when dealt with gently and compassionately, can make an impact on one's depression.



Other Helpful Responses

- Support family members.
 - Education about depression.
 - Encourage to take care of themselves.
 - Education about signs of suicide and preventive actions.
 - Possible need for family counseling

Families are often seriously impacted by one of its members being depressed, and so the whole family needs the pastor's care. Educating the family to understand depression so that negativity, irritability, or lack of interest are not taken too personally by family members is important. Family members need to be encouraged to take care of themselves and not take on too much responsibility for the depressed person. They need to be supported so they can continue in their supportive role. Furthermore, family members need to be educated to be attentive to indications of suicidal intent and know when and how to take preventive action. It is also important to remember that depression in one member of a family may be an indication of family issues that needs to be addressed in family counseling.

The Role of the Congregation

- Support
 - Social
 - Instrumental support (financial, physical needs, etc)
 - Spiritual – coping resources



Social support – listening, not pressuring, but accepting

Instrumental support – childcare, household help, financial needs met, etc

Givers of hope – the depressed individual may not be able to hope for themselves, but they may accept and lean on someone else's hope

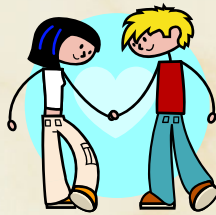
Advocates – help others understand depression. Fight for services if needed

Facilitators of Healing – help encourage counseling, make it easier to seek help.

Unconditional love and acceptance – just as they are. Proverbs 25:20 says “Like one who takes away a garment on a cold day, or like vinegar poured on soda, is one who sings songs to a heavy heart.” Don't deny their pain or try to ignore it.

The Role of the Congregation

- Givers of Hope
- Advocates
- Facilitators of Healing
- Unconditional love and acceptance





The Role of the Congregation

- Act for a more Just and Loving World
- Break down the social stigma
- Advocate for more equitable employment policies
- Advocate for more equitable, available and accessible physical and mental health care

Act for a more just and loving world.

Depression is often fostered by the world's ills. If we could end violence, war, abuse, discrimination, prejudice, poverty and environmental destruction we could make a lot of progress in preventing depression. Faith communities are called to involvement in bringing God's vision for our world into being.


In addition, there are many ways that congregations can be active in social realities that directly impact the possibility of healing for those with depression.

Social Stigma - Persons with depression are not moral or personal failures. Persons with depression have an illness that may limit their behavior at times but does not mean that they cannot work and love in ways that contribute to society and others. Persons who live with depression are not "crazy."

Employment policies – A person who lives with depression may be a productive, creative, and competent worker. They should not be discriminated against because of their illness or the treatment (ie medication) that they need in order to function.

Health Care – Persons who live with depression have a right to health care. Currently most health insurance policies limit care for mental illness, including psychotherapy, in ways that they do not limit treatment for other ("physical") illnesses.

It is the nature of the illness that a depressed person often does not have the ability to advocate social change for themselves. We must advocate on behalf of all those who are discriminated against or otherwise marginalized in our society.



Faith Communities as Communities of Hope and Healing

Qualities of Hope

- Hope is an action.
- Hope is specific.
- Hope means patience.
- Hope is rebellious.
- Hope is communal.

from Susan Dunlap, *Counseling Depressed Women*

Persons suffering from depression experience a strong sense of hopelessness. One of the roles of the faith community is to be able to help persons with depression identify the ways that hope is evident in their lives whether they feel it or not. Another role of the faith community is to hope on behalf of the depressed.

Susan Dunlap identifies some of the qualities of hope that are particularly pertinent for persons with depression.

“Hope is an action.”

“Hope is not confined to a feeling or attitude. It is also a way of acting or behaving.” (Dunlap, 122)
Sometimes actions precede the feelings and help bring the feelings into being. Hope is when a person struggling with depression asks for help.

“Hope is specific.”

Hope is both a “big” picture, like hope for the world, but hope also “dwells in the details” in the “mundane” activities of day-to-day life. Hope without the small acts day-to-day is only wishful thinking. Hope happens in one small step at a time. Hope for a depressed person is getting up in the morning, accepting a hug from a friend, or appreciating the sunshine (even if for just a moment). (Dunlap, 123)

“Hope means patience.”

Hope depends on working with perseverance through “confusion, uncertainty, insecurity.” “It depends on watching, waiting, and working.” (Dunlap, 124) Hope does not demand instant, quick and easy cures. Recovering from depression requires time, patience, and perseverance for both the depressed person and his or her family and friends. Hope can endure the experiences of doubt or frustration that are inevitable with depression.

“Hope is rebellious.”

Hope is also impatience, “a revolt against injustice, a revolt against pain and suffering, a revolt against all that would dehumanize another.” (Dunlap, 124) It is the “no” to death and yes to life. Every effort to heal from depression, every effort made by others to help a person who is depressed, or to change the world so that depressed persons have a more healing environment, is an act of hope. When persons and communities of faith refuse to simply accept depression and insist on acting to help persons heal, that is living out of hope.

Hope is communal.

We are called to hope as a church, as the body of Christ. “when we cannot find it within us to hope, others will hope on our behalf...Others will believe when we simply cannot. When we cannot pray, others will pray in our stead.” (Dunlap, 125) There are many times when individual persons cannot find their way through the darkness of depression to actively participate in the hope of their faith. At these times the community is called upon to act for them, to hope for them. And because we are of one body, created in and for loving relationship, when one of us hopes it is an act of hope for us all.

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