8 Therapy and Pastoral Care for Severe Depression.

Depression does not have to be an unchangeable fate. The doctor and pastoral counsellor can offer hope even to the depressive person which sees no way out. What the depressed need, is the confident reassurance that there are passable routes out of depression, and that indeed, the road through darkness can even bless and help in one's personal growth.

In the previous chapter I have explained the factors contributing to the development of a depression. In the same way, there are many different routes and levels in therapy. We have established four important areas in the development of a depression:

- Thinking, or a person's belief system
- External stress (loss, rejection, disappointment, etc.)
- Physical reactions and disturbances
- The neurobiology of the brain

Correspondingly, the therapy of depression can be divided into four sections:

1. Counselling (Listening, Talking, Guiding)
2. Practical help and support
3. Treatment of physical symptoms and physical activation.
4. Pharmacotherapy (Medication).

These forms of therapy have a mutually intensifying effect on each other. No one approach should be taken without the others. It is possible to do without medication in mild depressions, but the doctor should always be consulted in more severe situations.

A depression is not only a crisis of emotion, but also a crisis of belief. For this reason, pastoral input is indispensable and helpful alongside the medical treatment, provided the pastoral counsellor knows the points to be careful and where his limitations lie.

Guidelines for Counselling the Depressed

Helping severely depressive individuals makes considerable demands on the patience and empathetic skills of both the doctor and the pastoral counsellor. These qualities are indispensable for counselling depressives. I have compiled a list of seven points to which attention should be given when counselling them. These are as follows:

1. Accept the depressive person in their illness and trouble, and show them your readiness to accompany them through this difficult time.
2. Talk over the patient's life history with him or her. Explore with them the experiences which triggered the depression. Give them the opportunity to empty their heart.
3. Emphasise the hopeful outcome of the condition. Most depressions improve after a certain time.
4. Explain treatment options and send the patient with a severe depression to their G.P.
5. Encourage the counsellee and speak about God's love, even at times when he or she feels little of it. There are many helpful passages to be found in the Psalms, as well as in many scripture promises.
6. Prepare the counsellee for occasional mood swings. I often tell my patients, »The road out of depression is lined with 'pot holes', but in the end it leads up to the light.«
7. Be patient! Set one goal for therapy at a time, so that the patient keeps having little successes. Don't expect too much at once. Remember, depressed people are often so hemmed in, that they are scarcely aware of pastoral conversations, and can take in only a little at a time.

Avoidable Mistakes

There are a number of concealed traps and pitfalls in conversation with depressive people which it is necessary to avoid. Most mistakes are related to the following points:

Demanding »Pull yourself together«: Depressed. people are already placing themselves under a massive burden of self imposed obligations, and suffering as a result of their supposed failure. It is of little help when the pastoral counsellor adds to this pressure, backing it up with verses from the Bible. You can't simply order someone to be happy!

Sending them on holiday or on leave: Even in their familiar surroundings, it is difficult for patients to make contact with people, enjoy beauty and fill their day on their own initiative. But that is exactly what will be required of them on a holiday. The person will feel trapped and overwhelmed.

Allowing them to take important decisions: Often during a depression a patient is not capable of properly evaluating his situation. He sees everything through »dark glasses«. His problems tower over him like a mountain, and he underestimates his abilities. Decisions taken during a depressive phase will often be recognised afterwards as wrong, and regretted.

Superficially asserting »Things are already better«: It is often difficult for the carer to understand that for a depressed person things are the same week after week. You will often find yourself trying to encourage them with cheap words, but the result is to leave them feeling they haven't been taken seriously. It is better to recognise that they are still going through the »valley of the shadows«, and to affirm the presence of God in the midst of their darkness.

Casting doubt on delusional ideas: Many people suffer from the delusions of guilt and failure. No argument can move them away from these delusions and each attempt to assert the opposite leads to new arguments to support the delusion. What is needed here is to be patient and convince the sufferer through the way they are personally valued by the pastoral counsellor and the grace of God. I often encourage my patients with the biblical promise from 1 John 3:19-20: »We can set our hearts at rest in

his presence, whenever our hearts condemn us. For God is greater than our hearts, and he knows everything.« Then I close the conversation without further discussion and give them a new appointment. The sick person needs time to digest what he has heard, even if he still carries a lot of »ifs« and »buts« about it.

Entering too deep into the depressive condition: The depressive person is often completely imprisoned by his cares and fears. There is great danger in allowing yourself to be drawn into this twilight world and completely forgetting to ask what he is still capable of and what gives him security. We find the right balance in the Psalms. Time and time again the divine *»nevertheless«* breaks into the personal trouble of the praying person and directs his gaze above.

Making too many spiritual demands: God's word should be like salt in a tasty meal. Without reference to God's promises, pastoral care is reduced to idle talk. But an abundance of words from scripture which lacks relationship to every day life and to the depressed person's suffering, is like a salty concentrate. Indeed it can add to the sick person's feelings to such an extent that he becomes unable to receive God's Word and feels condemned.

When studying the Bible intensively, a severe depressive will tend only to read the thoughts which are endorsed by his darkened perspective. The most beautiful promises will only awaken the thought »This no longer applies to a sinner like me!« and despair will grow.

For this reason, I deliberately advise depressed people not to immerse themselves very deeply in the Bible any more, but to read just one verse each day, preferably with an explanation in a devotional book. God's love does not depend on the number of chapters you read and how many hours you spend in prayer. God holds us in His hand, even when we lack the power to hold on to Him.

Practical help and encouragement

Counselling alone is not enough in many cases. The pastoral counsellor must be ready to climb down from lofty spiritual conversation into the »lower regions« of everyday life and give very practical help. It may be necessary to relieve an overburdened housewife of some of her responsibilities or a depressive husband will need to be encouraged to hand his committee responsibilities over to someone else until he is on his feet again.

It is often important to call in relatives and to discuss with them how the sick person can be relieved of some of their burdens. So for instance a young woman's mother may come in two days a week to do the washing and ironing while the husband helps a little more with the housework. In this way the burden is shared and rests on several shoulders.

On the road to health the depressed person will need to be slowly reactivated. Work out a daily schedule with him and encourage him to take part in small activities. Regular walks and some kind of sport stimulate the circulation and so have a positive effect on depression. In time the depressed person will begin to take up new responsibilities for himself once again. The more the numbness of depression is released, the freer he or she will be to be active and enjoy achieving things again.

Pharmacotherapy: Help through medication

About fifty years ago, the first drugs were discovered which had a pronounced influence on depression. We assume that they have a positive influence on neurotransmitters in the brain (especially serotonin and norepinephrine), restoring a balanced mood. However, many questions are still unresolved and need further research.

Not every depressive needs medication. You can do without medication in mild to moderate depressions, if the person receives regular help through counselling. Studies have shown that psychotherapy (especially interpersonal and cognitive-behavioral therapy) may be equally effective as antidepressant medication. Another possibility are herbal remedies based on St. John's wort.

In severe depressions, however, modern drugs are an enormous help, undergirding psychotherapy and counselling, enabling the person to stabilize to a degree that he or she is able to follow through with the goals they set in therapy.

With the prescription of antidepressant medication, the physician hopes to achieve the following goals:

- release from inward nervousness and tension
- reduction of crippling feelings of anxiety
- lightening of the melancholy mood
- reestablishment of adequate sleep

- improvement in the patient's ability to cope with tasks and social roles
- relapse prevention in recurrent unipolar and bipolar depression.

There is a broad range of antidepressants available to help in the achievement of these aims. Which drug the doctor chooses will depend on the characteristics which he observes in the patient. Is he suffering from restlessness, anxiety and insomnia? Or is she feeling weak and lethargic? Is she overwhelmed by feelings of sadness, or complaining that her feelings are totally numbed? In each case the doctor will prescribe a corresponding drug, either a more sedating or a more activating antidepressant.

It is important to instruct the patient that the drug will take five to ten days time to take effect. Nevertheless, the medication should be taken at regular intervals in order to facilitate the build-up of the therapeutic level in the brain which is needed for it to be effective.

I often explain this situation to my patients with the help of the following analogy: »Imagine a water reservoir, where the dam has been broken. The water has run out ... the reservoir is empty. In the same way, you are suffering from an exhaustion of your resources of physical and emotional strength. The antidepressants are now filling the hole in the dam, but it will take time for enough water to build up to drive the turbines again.«

However it often makes little sense to just wait a whole week for the drug to take affect. That is why the antidepressant is often supplemented with tranquillisers and sleeping tablets.. Patients are enormously thankful when at last they are able to sleep properly and their inner tension is relaxed.

The *side effects* of antidepressants vary according to the drug and the dosage (please check the Internet for details). Most patients take the prescribed drug without any problems Others quickly become accustomed to it and stop experiencing the side effects. A little constipation and dryness of the mouth is a small price to pay for a lightening of the depression. However, if the side effects continue to be very distressing, it will be necessary to change to a different remedy which may produce fewer undesired effects.

Lithium plays a particular part in the therapy of depressions. This simple mineral salt can prevent a relapse in cases of recurrent severe depression and manic-depressive psychosis. The reason may very possibly be that Lithium stabilises the ability of the nerves to conduct electricity. Many people who previously suffered from regularly recurring depressive

and manic phases are today, thanks to Lithium, free from trouble and able to live and work normally.

Personality Change Through Antidepressants?

I have been asked repeatedly by both lay people and theologians, whether antidepressants and tranquillisers alter a person's personality, and whether on these grounds they should be rejected from a Christian point of view. From my observation, I would say that exactly the opposite is true. It is depression, which alters the personality and leads to despondency, despair, nervousness and anxiety which the afflicted person would otherwise never have known. The medication helps the person to regain their capability to think and feel the way they did in their healthy time before the depressive episode.

Some patients complain that they experience a numbing of their feelings while taking antidepressants. But often it is not easy to discern whether the calming effect is due to the medication, or due to the depression itself.

Personally, I am convinced that modern psychopharmacotherapy can be a valuable help in conquering depression, even for Christians, if it is supplemented by regular counselling and practical help.

The problem of Suicide

This chapter about the treatment and care of depressive people would be incomplete were I not to refer to the recognition and treatment of suicidal tendencies.

Thoughts about death and suicide are part of the picture of a severe depression. They become a particular danger for depressed people who feel excessively hemmed in and isolated. To begin with, they may simply long to be able to sleep and not wake up again. But then they start to think more and more about how to end their life, and if the net of hopelessness is pulled closer together it often happens that the thoughts begin to actively control them, so strongly that they no longer know how to resist them.

For many Christians it is not easy to give expression to such thoughts. They are afraid of how their fellow Christians will react, expecting to be condemned »because a Christian doesn't have any thought of suicide«.

Some pastoral counsellors regard such thoughts as signs of a lack of devotion to God, or even as evidence indicating demonic influence in the afflicted person. But this is exactly the kind of attitude which can drive a person deeper into hopelessness. It is therefore important to recognise suicidal tendencies quickly, if effective counselling is to be given to the depressed person. The following questions can help in this:

SUICIDAL TENDENCY	Have you ever thought of taking your life?
PREPARATION	How would you do it? Have you already made preparations? (The more concrete the idea, the greater the risk).
COMPULSIVE THOUGHTS	Do you think about it of your own choice, or do the thoughts force themselves on you, even when you don't welcome them? (Thoughts which press in on someone passively are more dangerous).
WARNINGS	Have you already talked about your intentions, with someone else? (Always take warnings seriously!)
RESTRICTION	Have your interests, thoughts and social contacts become more reduced and restricted?
AGGRESSION	Do you have feelings of aggression against anyone, which you are forcibly suppressing? (such suppressed feelings can be directed against one's own person.)

There is a great deal of help to be gained from a book by Bill Blackburn, which deals with the subject from a Christian point of view. He enters in a very sympathetic way into the difficulties of those who are afflicted, and also the problems of their. relatives and those who care for them. I would only want to add a few pieces of advice from a medical point of view. Table 8.1 shows the risk factors for suicide in depressive patients

Helping People at Risk From Suicidal Tendencies

The inexperienced helper is often too inhibited to address suicidal thoughts when he or she is talking to a depressed person. But these impulses can become stronger, precisely because they are not talked about and covered with embarrassed silence (implicitly indicating: »Such a nice Christian like you could not possibly have such thoughts!«).

The first principle, for dealing with suicidal people is thus:

1. Give voice to thoughts about suicide. Talking naturally about the desire to die will make it easier for counsellees to express their innermost troubles and worries. The burden will be shared and preventive measures can be discussed.

2. Ask questions which probe beyond the hopelessness. Suicide is only an option for a person who can see no other escape. Reviewing the situation through the counsellor's eyes can raise the question: »Is my situation really

Table 8-1 Risk factors for suicide

A) EARLY INDICATIONS OF SUICIDE

1. Previous suicide attempts and indications of suicidal tendencies
2. History of suicide among family or other contacts
3. Direct or indirect suicide threats
4. Concrete plans or preparations for a suicide
5. »Uncanny calmness« after previous unrest and talk of suicide

B) SITUATIONS

1. Onset of a depressive episode (or towards the end of an episode)
2. Signs of anxiety or agitation
3. Prolonged disturbance of sleep
4. Biological crisis periods (puberty, childbirth, menopause)
5. Severe feelings of guilt or rejection
6. Prolonged or incurable illness
7. Hypochondria
8. Alcoholism or drug addiction.

C) ENVIRONMENTAL FACTORS

1. Broken family relationships in childhood
2. Absence or loss of human contact (loneliness, loss of ‚roots', disappointment in love.)
3. Redundancy, retirement, financial worries
4. Absence or loss of supportive religious relationships.

so hopeless?« The tiniest glimmer of hope can persuade the suicidal person to at least postpone taking their life for the time being.

3. A strong relationship between the pastoral counsellor and the patient is extremely important during a suicidal crisis. The feeling of being supported and taken seriously can weaken suicidal thoughts. You can work out a promise with the depressive person not to attempt suicide, at least until after the next counselling session. In addition you can offer the possibility of phoning every time thoughts of suicide start to come. In an emergency there are telephone counselling services which offer the opportunity to talk with a trained helper at any time, day or night. In Britain, the »Samaritans« provide this service and the number, which varies in each area, can be found in the local telephone directory. The equivalent service in some countries can be obtained by dialling a particular number nationwide.

Emergency calls like this are not always easy for the pastoral counsellor. I well remember an evening when the telephone rang about ten o'clock. A young woman was on the line whom I had already been helping for a long time through a severe depression. »Doctor, I can't go on any longer,« she said in a toneless voice. »The thought of killing myself is getting stronger and stronger. I can't resist any more. But I just wanted to ask you before I do it, can you help me?«

Don't think for a moment that I sat by the telephone and gave sound advice in a calm and professional way. I sweated and prayed inwardly for God to give me the wisdom to know how to help that woman. After a few minutes I noticed that the person I was talking to was calmer and in the end we managed to arrange for someone to call and see her that evening so she wouldn't be completely on her own. The telephone conversation, with God's help, had broken the spell of her suicidal thoughts.

Such telephone calls take a lot out of you, but the committed pastoral counsellor must be ready to share this burden as much as lies in him.

4. Consult with relatives and friends. A person who is strongly suicidal should never be left on their own. Admission to a psychiatric unit is not always necessary. In shorter crises their parents or partner can be asked – with the permission of the patient – to watch over the suicidal person and give him or her more attention. This constant supervision will become too much of a burden for the relatives if the risk of suicide is serious or prolonged. Then the courageous decision has to be taken to admit them for intensive supervision and treatment in hospital.

5. Give therapy at frequent intervals. Give the suicidal person an appointment to talk further at the earliest date possible. Encourage them to have medical treatment from a doctor including medication which will calm them and lead to reestablishment of normal sleep patterns.

6. Admission to hospital. When the measures described above are insufficient, a stay in a specialized hospital will be unavoidable.

In acute crises, a psychiatric unit has much to offer to every patient, the believer included: additional possibilities for therapy, increased attention and supervision, and a refuge from the fears and life situations which are felt to be unbearable. These measures can prevent the worst from happening in the majority of cases. Nevertheless, we always have to live with a residue of uncertainty. Unfortunately, a psychiatric unit cannot give the ultimate security. It comes as a shock to the pastoral counsellor and the psychiatric social worker alike when they experience their powerlessness to help as – in spite of all efforts – a patient succeeds in taking their own life. Often the pastoral counsellor will, as a result, carry wounds of his own which will take a long while to heal.

Help for the Pastoral Counsellor

A client's depression has an effect on the pastoral counsellor. It is his or her duty to help the depressed person, and he feels in part responsible for him. If as so often happens the pastoral counsellor becomes infected by the hopelessness and helplessness of the client, the counselling sessions become an increasing burden. For this reason I would like to conclude this chapter by giving some advice as to how this outcome can be avoided.

1. Keep the facts about depression in view! Don't allow yourself to be drawn along by the patient's temporary hopelessness.

2. Be on guard against untrue, depressive ideas in yourself, as well as in the patient. Are your thoughts always in tune with the Bible and with reality?

3. Learn to counter the client's suffering with a healthy objectivity. For instance, just accept tears as signs of inner distress. Consciously limit the length of each counselling session, otherwise it will be too taxing

for you as well as the sick person.

4. Don't accept responsibility for the thoughts, feelings and behaviour of your client. They have to carry this responsibility themselves. You can certainly give them a push here and there, but change in the patient has to come about through God's grace (and according to His timing).

5. Don't set too high goals for therapy. Keep reminding yourself that helping depressive people takes a lot of patience and always involves setbacks.

6. Have the courage to face your own helplessness and talk with another pastoral counsellor about your difficulties in caring for a depressive person (this is called »supervision«).

7. Take enough time for personal fellowship with God and with your family. Nurture contact with friends and enjoy time for hobbies, sport or music.

By far the greatest encouragement for any doctor or pastoral counsellor is to hear from former patients about how they survived their depression. The inward brokenness of a severe depression often leads to a deeper relationship with God, and the rebuilding of a faith which proved itself even in the time of trouble.

A woman with a prolonged depression recently said to me: »I wouldn't have wanted to miss this time. God broke my old, proud nature and directed my gaze back towards Him. I have nothing in this world that I can rely on. But He endures for ever. Sometimes I am afraid, at the beginning of a new depressive phase, that my clear, certain faith will be darkened again. Yet I know God comes with me, even when my path leads through another dark valley.«

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