Depression

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A distraught woman approaches her pastor after church one day. "I don't know what to do, my husband just lies around all day. He has quit going to work and is up watching T.V. most of the night. He rarely eats. Lately, he has been so morose, claiming that he is not good for anything and life is not worth living. He won't go to church and claims to have lost his faith. Will you go talk to him?"

Understanding Depression

It is essential for caregivers to understand depression, not only because it is so common and potentially serious, but also because clergy and lay caregivers are likely to be the first people sought out by depressed parishioners or their families. Multiple studies have shown that even with serious mental disorders, Americans are far more likely to approach clergy than psychiatrists or psychologists (Milstein 2003; Weaver et al. 1996). Furthermore, since depression is the most common cause of suicide, it is only a matter of time before caregivers will be confronted by a suicidal person. We hope this chapter will help decrease the stress associated with such encounters.

Many may be shocked to learn that the World Health Organization (WHO) now reports depression is the leading cause of "burden

of disease" in the developed world and the third-leading cause worldwide. "Burden of disease" is defined as "the loss of the equivalent of one year of full health" (WHO 2004). For an illness to produce such a high burden it must be both very serious and very common. Indeed, major depression is associated with very high levels of mortality and extremely high morbidity, leading the WHO to refer to it as a silent epidemic.[1] It is the most common psychiatric condition that leads suffering individuals to seek help. Despite this reality, only 19 percent of those with depression seek treatment (Callahan and Barrios 2005).

One way to think of "health burden" is to consider how common an illness is. Put in mathematical terms, multiply the prevalence of an illness by its seriousness. Thus, "morbidity plus mortality" equals "health burden."

Morbidity, Mortality, and Prevalence

Although it seems cold hearted, morbidity is often measured in dollars. Very little cost has to do with treatment; by far the largest cost is caused by loss of productivity (Greenberg et al. 2003). The cost of depression in the United States in 2000 was estimated to be $52.9 billion (ibid.), second only to vascular diseases such as heart attacks and stroke. The true cost of human misery is immeasurable and depression is one the most destructive disorders when role functioning such as parenting or effectiveness at work is considered.

The true mortality rate of depression is not known. Coroners' reports can be inconclusive or wrong. The true cause of a fatal one-car accident or death that is secondary to poorly controlled diabetes may never be known. We do know that depression is the most common cause of suicide. The most widely quoted percentage is that 15 percent of those suffering depression complete suicide (Dunner 2008). If one considers the total body count, suicide overshadows homicide, a fact seldom discussed in the current gun-control debate. Although the rate of suicide is highest among older white males, the absolute number of suicides is higher among younger people. The Center for Disease Control (CDC) reports that suicide is the second leading cause of death among twenty-five to thirty-four year olds and third among fifteen to twenty-four year olds.[2]

The devastation caused by suicide cannot be overstated: parents divorce, families are destroyed, and emotional scars are never completely healed. Suicide, however, is far from the only cause of depression-related mortality. Individuals with depression are also more likely to have heart attacks, and depressed individuals with heart attacks are more likely to die. Similarly, depression can have lethal effects on patients with diabetes, transplant recipients, and exacerbate many other illnesses (DSM-IV). Because depression is associated with poor concentration and impaired judgment, individuals with depression are at high risk for accidents. Therefore, the Department of Transportation and the Federal Aviation Administration have regulations regarding individuals diagnosed with depression driving semis or flying airplanes.

Major depression occurs in at least 10 to 25 percent of women and 5 to 12 percent of men. Although major depressive episodes are twice as common among women, depression associated with physical illness, bipolar depression, substance-induced depression, and prepubertal depression is closer to having equal prevalence among males and females.

History

Unlike other disorders that have definitions which change over time, depression has been a constant, at least since the advent of written language. Depression was described in the oldest-known medical writing, the Ebers papyrus (Andreasen and Black 1995), an ancient Egyptian document written in about 1550 BCE (however, this material was gleaned from texts that are far older) (Lyons and Petrocelli 1978). Depression was well known to the ancient Greeks and appears in fourth-century writings by Hippocrates. The Bible has numerous references to depression, particularly the psalms of lament. King Saul, in 1 Samuel 18:10ff., appears to be one of the first well-described individuals with manic-depressive disease (bipolar disorder), making David one of our first music therapists. Unfortunately, Saul, who died by suicide, reminds us of the lethality of these disorders.

In modern times, symptoms that distinguished patients with depression from normal individuals were described in a classic 1957 work by W. L. Cassidy and his colleagues (Cassidy et al. 1957). These symptoms

were used to create a criterion-based diagnostic system by J. P. Feighner and others (Feighner et al. 1972; Dunner 2008), and eventually formed the basis of our current diagnostic system, the DSM-IV (see the introduction, above).

Symptomotology

According to DSM-IV, a depressive episode exists if a person experiences five of nine criterion symptoms over at least a two-week period. These symptoms must include depressed mood or loss of interest or pleasure in almost all things (anhedonia). The other symptoms include, in an abbreviated form: change in appetite or weight, change in sleep, change in psychomotor behavior (agitation or retardation), fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicide. Many pastoral counselors keep a copy of this list in their desk, a practice that is strongly encouraged, not for diagnostic purposes, but to remind the caregiver of the stated criteria. It is clear that depression makes people miserable, saps them of energy, ruins sleep, appetite, and even the ability to think clearly. It is an illness of intense misery.

Major depression is the most common subtype of mood or affective disorders. The depressive forms of these disorders include: major depression, as described above; dysthymia, a chronic but less pervasive depressive syndrome; and a variety of mood disorders caused by medical conditions and substances. Most are beyond the scope of this chapter, but can be easily researched in a DSM-IV manual.

Before focusing on manic or "bipolar" syndrome, it is important to discuss a very severe form of depression in which individuals truly lose touch with reality and become psychotic. These individuals may develop delusions of guilt, such as causing a war or perhaps somatic delusions that their "guts are rotting out." Furthermore, they may hear voices, possibly commanding them to kill themselves or telling them they are worthless. Occasionally, visual hallucinations may develop. Often these individuals may develop psychoses with religious content, thinking they are possessed by demons or controlled by the devil. All such patients

should be hospitalized for safety; happily, with treatment the psychotic symptoms generally resolve.

During a Bible study in the church basement, a parishioner jumps up and begins preaching in a loud voice. He reports that he alone has been given the power to understand the true meaning of Scripture. His speech is rapid and switches from topic to topic. No one is able to get a word in. He reports that since receiving his special gift he has felt elated, and he invites everyone to join him in his "special understanding," yet he is unable to articulate what that understanding is. His wife appears mortified and with the help of friends escorts him out of the church. Later she comes to you for help.

Mania

Mania represents a mood disorder that is nearly the mirror opposite of depression. It is less common than depression, and found in individuals who have had, or unfortunately likely will have, a depressive episode. Therefore, individuals with this disorder are referred to as bipolar, living with both "poles" of the mood-disorder spectrum. People with mania often feel "great" or "on top of the world," and are therefore unlikely to seek treatment.

Mania is defined in the DSM-IV as a "distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least one week." Manic episodes must contain three of the following criterion symptoms, again abbreviated: inflated self-esteem or grandiosity; decreased need for sleep; rapid, pressured speech; flight of ideas or racing thoughts; distractibility; an increase in goal-directed activities; and excessive involvement in pleasurable activities that have a high potential for painful consequences. Mania may also be associated with hallucinations or delusions. Often these delusions are grandiose, for example, with patients believing they are incredibly wealthy or presidents of companies. Hallucinations may be perceived as coming from a divine source. Religiosity is a frequent symptom of mania as in the above vignette and

can be a particular challenge to caregivers. Both depression and mania can be associated with mood-incongruent or paranoid psychotic features. These symptoms may be more difficult to treat but are less frequent.

People with mania can be extremely disruptive and a special challenge for families and co-workers. Frequently, they do not perceive that they have a problem. Prior to successful treatment modalities, mania was associated with death from exhaustion, and unfortunately continues to cause injury from accidents, excessive drinking, and other poorly considered behaviors. Mania usually responds well to treatment, typically with complete recovery. Unfortunately, it will usually recur, either as depression, mania, or both, that is, as bipolar disorder.

There are a variety of bipolar disorders, including bipolar I as described above; bipolar II, a "rapid cycling" bipolar disorder; and cyclothymia. *Cyclothymia* is an unusual form of affective disorder that is less pervasive, with lower amplitude in mood swings. Rapid cycling can occur at any time and may be exacerbated by certain psychiatric medications or physical illness. Bipolar II disorder can present in a variety of ways, but often is a syndrome that includes "hypomanic episodes" or manic episodes that cause little impairment. People with this disorder are often friendly, confident, gregarious, and quick witted. They may need little sleep and are able to pursue their ideas far into the night. These attributes can lead to tremendous creativity and accomplishment. Many of our greatest artists, writers, and composers benefited from this creativity and benefited the rest of us as well. Unfortunately, these individuals must inevitably pay with major depressive episodes.

We all should question the false myth that individuals with mental illness have little to contribute. Consider Martin Luther, who placed ninety-five theses on the Wittenberg church door—not three but ninety-five! He was able to translate and transcribe the entire Bible in less than two years. Modern scholars think he did a good job in a task that would typically take a lifetime. His biographers have documented periods of extremely high energy. Luther described in his writings very deep depressive episodes, yet his creativity in both phases of the illness has led to enduring insights. There are many other truly outstanding people who have suffered from mood disorders, often creating works in times of great elation such as Wolfgang Amadeus Mozart, Ernest

Hemingway, and Vincent van Gogh. Still others, like Abraham Lincoln, developed great empathy and generativity in times of depression.

There is one other mood disorder that deserves special attention: seasonal affective disorder (SAD). Seasonal effects can be seen in both bipolar and unipolar depression. Individuals with SAD seemingly act like bears getting ready to hibernate for the winter. As the hours of sun decrease they develop depression often associated with hypersomnia, carbohydrate craving, and weight gain, along with other criterion symptoms. SAD is more common in higher latitudes and can occasionally be treated with high-intensity full-spectrum lights (10,000 lux). Fortunately, people also can be treated with a prolonged vacation to a sunny destination (preferably with palm trees and sand beaches). SAD was once thought to be mythical, but now has been well described and researched by the National Institutes of Health (Rosenthal and Blehar 1989).

Etiology and Pathophysiology

No one knows what causes depression. We do know that it runs in families and has a strong genetic component, yet we also know it can be associated with external stress, such as bereavement, or as a result of internal stress related to a stroke or heart attack. Therefore, there is a strong interaction between genetics and the environment. We also understand that affective disorders are disorders of the brain, with recent imaging studies defining abnormalities in brain areas associated with emotion, memory, and reward. Exactly why brain areas develop abnormalities and exactly how these abnormalities interact remain a mystery, but researchers continue to progress in understanding brain function. Although depression is, at its core, a brain disease, its effects in the body are far reaching.

Our brains communicate with the rest of the body through direct nerve connections and through endocrine or hormonal communications. Both types of communication are likely disturbed in depression. For instance, the vagus nerve is a major line of communication between the brain and gut. It innervates our digestive tract, heart, and lungs. It is no wonder that patients with coronary bypass surgery, ulcerative colitis, and a variety of other gastrointestinal illnesses are likely to get depression.

More is known about hormonal abnormalities associated with depression. These can affect sexual and reproductive function, as well as the ability to metabolize glucose or respond to stress. The most well studied abnormality involves disturbed cortisol response, a stress hormone involved in a variety of functions, including the regulation of insulin and glucose. Individuals with diabetes may need to increase insulin during depressive episodes as a result of abnormal cortisol regulation. There are many other hormonal abnormalities that can interfere with multiple body functions including thyroid issues, immune response, pain perception, and others. Therefore, people with depression often feel sick as well as depressed. To make matters worse, lack of interest can mean lack of interest in faith, making depression a true mind, body, and spirit disorder.

Treatment

There are a variety of treatment modalities available for individuals with mood disorders, and the vast majority of these individuals do very well. Treatment starts with empathetic listening, taking people seriously, and not denying or minimizing symptoms. If people say they are suicidal, they generally are. Take them seriously. It is not helpful to attempt to argue people out of their symptoms and it is far from helpful to tell them that if they just had more faith they would not feel this way. Many, many "faithful" parishioners will suffer from mood disorders, just like many will suffer broken legs or tonsillitis. It is well documented that patients derive tremendous benefit from their religion, clergy, and faith communities. Compassion rather than blaming is the preferred dynamic of caregiving.

In this chapter's opening vignette, a person with major depression has become suicidal and is terrifying his wife. If there are guns in the house the concern becomes much greater. Obviously, the man needs help, and, if acutely suicidal, needs emergency help. In such situations the police need to be called and involved.

Once a patient is protected from harm, there are three general types of treatment: psychotherapy, medication, and, in life-threatening conditions, electro-convulsive therapy (ECT), often referred to as

"shock therapy." There are also experimental modalities such as transcranial magnetic stimulation, vagal nerve stimulation, or deep brain stimulation.

Psychotherapeutic techniques proven to be particularly helpful include cognitive behavioral therapy and interpersonal therapy. Although beyond the scope of this text, there is no reason why informed clergy and lay caregivers could not become familiar with cognitive behavioral techniques that could prove very helpful in alleviating the depression. Medications will be discussed in the chapter on psychopharmacology.

ECT is the most effective therapy currently available for severe, life-threatening depression. It is generally misunderstood and maligned in movies such as *One Flew Over The Cuckoo's Nest*. Like so many other therapies, no one knows exactly why ECT works, but it usually works well. Prior to ECT, and currently in third-world countries, people die from depression. As Lucy and William Hulme describe in their book *Wrestling With Depression*, in the most severe cases people simply lie down in a fetal position, don't eat, drink, or sleep, and just wait to die (Hulme and Hulme 1995). Obviously, these people require immediate help, as do people who attempt suicide. ECT is recommended in such cases. Other patients simply get tired of medications and request ECT, as it tends to work faster. Although we seldom think about it, nearly every major hospital in the developed world has patients who are currently receiving ECT. Many have had good success and request it during recurrence. Even before the use of anesthesia, when ECT was much more unpleasant, patients still requested ECT, as its side effects were felt to be more tolerable than depression.

Happily, with modern techniques, side effects have decreased significantly. Experimental treatments that have few side effects may someday make ECT obsolete, but for now it remains the safest and most effective treatment for people with the severest forms of depression.

Newer forms of therapy, such as transcranial magnetic stimulation, are becoming available and show great promise. New medicines are being discovered. Psychotherapies are improving. Even without any treatment most depressions will eventually resolve on their own. Therefore, given the natural history of the disorder and the vast array of useful treatments, future prospects for treatment are hopeful. There is

always genuine hope for depressed individuals and the vast majority will recover and resume fulfilling lives.

Spiritual Dimensions of Caregiving

This chapter's opening vignette is a scenario that frequently confronts lay caregivers or clergy in ministry in all religious traditions. Given the medical realities of this illness, the question before us is how to minister most effectively to those who are afflicted with or adversely affected by this illness that has been called "the common cold" of mental illnesses. The most judicious place to start is by articulating some basic generalizations to keep in mind about depression and all mental illnesses.

General Principles of Caregiving for Those Afflicted and Affected

Every experience and expression of depression is idiosyncratic. While comprehending the basic symptoms of the illness in its varying forms is important, it is imperative to remember that each case is unique and needs to be treated accordingly. The individuals afflicted and affected inhabit a social matrix that is always varied, so the impact of the illness varies according to the culture and social location.

*Caregivers are not trained as diagnostici*ans *and so should refrain from acting in a diagnostic capacity*. While there is power in knowledge, a "little knowledge" can also be a dangerous thing. Depression and mental illnesses in general are complex and making assumptions about the illness or persons with the illness are often predicated on erroneous myths that can do harm.

Distinguish between the illness and the person. The diagnosis of the person afflicted with any mental illness does not become her or his identity. People suffer from a variety of mental illnesses, but they are first and foremost people, created in the image of God. The humanity of the person must be preserved at all costs. Labeling people as "depressive," "bipolar," or "schizophrenic" is lamentable. This is a *person* who suffers from an illness and significant other *people* are affected by the illness.

Depression and other mental illnesses are stigmatized and therefore "unsanctioned illnesses" resulting in a sense of "disgrace shame" (Albers 1995).

The phenomenon of denial on the part of those afflicted and those affected is directly related to the nonacceptance on the part of society and religious communities who more often than not ascribe either psychological weakness or moral culpability as the cause of the illness. The hurdle of first dealing with the disgrace shame is monumental in the person afflicted as well as others who are adversely affected.

Depression is a wholistic illness and requires a wholistic approach to treatment. The historic internecine warfare between science and theology needs to be relegated to an unenlightened past! God has called all to a total ministry of the total person, which requires a cooperative effort on the part of all who are concerned about those suffering from depression and their loved ones. We have much to learn from one another in the various disciplines that we represent.

Depression should not be thought of as resulting from a lack of faith. The injunction to "have more faith," as an antidote to depression, irrespective of one's religious affiliation, is not a helpful caregiving tack. More likely is that persons first become depressed and then believe that they have lost faith, rather than that they lose faith, which then causes the onset of depression. Suggesting that an inadequate faith, improper prayer life, or questionable piety occasions depression only serves to exacerbate the sense of shame and increase the painful experience of depression.

Caregiving for all significant others affected by the depression is critical. In the vast majority of instances where a caregiver deals with depression, it comes to the caregiver's attention from a significant other, not the depressed person. Depression is a "household illness," an inclusive term signaling that all people in the social system are affected. It is *not* a communicable or contagious illness, but the depression creates an environment and ambiance that has an adverse impact on those who are close to the depressed person. Particular attention to that issue will be addressed later in this chapter.

Remember that caregivers also suffer from depression. As already noted (p. XX), there are many caregivers who have experienced depression in their lives. The narrative of Elijah in 1 Kings 19:1-18 might serve as both a paradigm and a reminder of that reality for those of us who are lay or clergy caregivers. Whether or not Elijah would be clinically diagnosed as being depressed is not the salient issue. Rather, it is the admission that

those who are lay caregivers, rabbis, priests, pastors, imams, or prophets are not immune from depression. What one reads in the Elijah narrative reveals his lack of energy, a negative outlook on life, preference for isolation, and his sense of being abandoned by God. All of these reactions are indicators of depression that may strike a respondent chord with religious caregivers who themselves are depressed.

Response of Those Adversely Affected

Both vignettes provided earlier in this chapter feature a significant other who is adversely affected by the illness. As with many unsanctioned illnesses, the dynamics that are often operative are predictable, though not necessarily universal.

Denial of the illness is commonplace as the affected also are resistant to the diagnosis that is made. One hears phrases like, "That can't be true, he has everything going for him." "There must be some mistake; she is just a little down and will get over it." The feeling of 'disgrace shame' is exacerbated for the afflicted and the affected when the illness is labeled with pejorative terms like "crazy," "nuts," or "loony," which usually results in everyone involved flatly denying the diagnosis: "We don't have depression in this family!" The sad reality is that sometimes people who require treatment do not receive it as a result of familial denial. If the diagnosis is accepted, significant others may respond by making this "the family secret" (Friedman 1985): "Don't tell anybody that Dad is depressed!" "What would people think if they knew that Mom who is a community leader is depressed?" The denial and secret keeping is understandable because of the social and vocational implications involving discrimination against those who have the diagnosis of depression in their medical history.

Fear is a common reaction on the part of significant others. Fear is often the result of being uninformed about the nature of depression. It behooves caregivers within communities of faith to become informed themselves and then to conduct classes or seminars in which accurate information concerning depression can be disseminated in the community, so as to break the conspiracy of silence. There is legitimate fear since suicidal ideation is a criterion factored into the diagnostic process.

Caregivers have themselves been fearful in simply "naming" the illness, by calling depression something other than what it is. Suggesting that it is really something other than depression is unconscionably dishonest and potentially dangerous! Being alert to actions or language that might suggest the person is thinking about suicide needs to be articulated. Many fear that asking the person directly about suicide might "put the thought into her or his head." If the person is not suicidal, you will be told. In many instances, the depressed person is waiting for someone to name what is going on, which gives you an opportunity to verify your concern. Three questions can be used to determine the intention of the person:

1. Are you thinking of hurting yourself? (Or: Are you thinking of taking your own life?) If there is an affirmative answer, then ask:
2. Do you have a plan by which to do this? If the answer is yes, then have the person detail the plan for you.
3. Do you have the means by which to carry out this plan? If the person responds positively, then the danger level is high and the suicide likely imminent.

Call 911 (or whatever emergency number is applicable), remain with the person until help arrives, or ensure that the person is *not* left alone until assistance is available. As already indicated, if lethal means are readily accessible, calling the police is certainly in order (p. XX). Fear needs to be supplanted by faith; that is, the trust that, with intervention, this is a treatable illness and appropriate action can be taken to address the depression properly.

Understanding and accepting anger. The person or persons affected may be angry with the person who is depressed. How can anyone be angry with a person who is ill? It is rather easy! As the symptoms of depression manifest themselves, significant others react to the mood, as well as to the concomitant behavior, language, and attitude that is occasioned by the depression.

"Fred" approached his caregiver and was visibly angry. He said, "My wife ("Laura") has become a real bitch! She gripes and

complains about everything, she gets nothing done, is yelling at the kids, missing work, and blaming me for everything that goes wrong in the family." The caregiver simply said, "I can see you are really upset!" Fred went on to explain how Laura had gotten into this foul mood several months ago and it was just getting worse. Their intimacy was now nonexistent; she never wanted to go the theater, which was an activity that they both used to enjoy. He said he had about had it and was thinking of filing for divorce because he just couldn't live this way.

It is evident that something had changed about Laura and the indicators are that she may be suffering from depression. The caregiver is not a diagnostician, but can plant the seed of suggestion that Laura would benefit from having an evaluation rather than Fred simply giving up and filing for divorce.

Understanding and accepting Fred's anger and frustration is a part of good caregiving. Mounting frustration, waning patience, and increased despair need to be accepted for what they are, as reactions to depression in the household. Fred would benefit from knowing something about depression and learning to respond in more understanding ways that would not exacerbate the problem. The situation might be ameliorated if his wife received treatment and both of them did some marriage counseling.

The Experience of Grief

A sometimes hidden dynamic for those adversely affected by depression is grief occasioned by the sense of loss that accompanies depression. As can be easily noted from the vignette about Fred and Laura, there is the loss of an intimate relationship, the loss of coveted companionship, and the loss of a stable and caring family environment. Opportunities are often sacrificed professionally and personally by those who are affected. The depressed person is often unalterably opposed to any kind of change, as the person feels her or his life is already spinning out of control.

The fate of children is often ignored or overlooked when there is mental illness in the household, as they suffer from neglect occasioned by the depression in one or both of the parents. A child interprets the lack of interest in their lives from a depressed parent as evidence of a lack of support, care, and love. The inability to name what they are feeling and why they are feeling as they do complicates an already complex situation.

Adult children often remember what it was like to grow up with a parent who was depressed. Some state that they felt "cheated out of their childhood," and mourn those losses. Because children do not have a parental role model to emulate, they oftentimes also have problems with close and intimate relationships.

Grief is often not named as the culprit, but it can be the underlying dynamic that subverts and even sabotages the whole household. Enabling those so affected to become more fully aware of their grief and to articulate it is critical. The person afflicted with the depression often has a long laundry list of losses. The fact is that time moves inexorably onward and, as a consequence, there are many missed opportunities, which becomes an occasion for "intra-psychic" grief (Mitchell and Anderson 1983).

Theological Principles in Caregiving

In the final vignette, Fred is articulating a sense of helplessness and hopelessness, which spells despair that his situation will ever get better or return to "normal." This sense of hopelessness that pervades the whole household often takes on a life of its own. When this collective mood persists for a protracted period of time, a general malaise of despondency descends on the whole system, coloring reality with a dark hue that engulfs and threatens everyone in that sphere of influence. The reality and power of despair provides a natural segue into considering the theological implications of caregiving.

Listen attentively to the lament of despair. It is imperative to put aside the proclivity to want to "fix" the person, "straighten the person out theologically," or "rescue" the person from despair. The despair is real and the caregiver needs to live with the uncomfortable nature of its

reality. The three most important aspects in the process of caregiving is to *listen*, *listen*, and *listen*! The most profound sentence uttered by my spiritual director, when I was in the midst of my depression, was, "I am not afraid of your despair!"[3] Susan Muto most poignantly articulates a theological description of despair as she writes about the "dark night of the soul" as experienced by St. John of the Cross.

> It will feel at times as if one has been abandoned by God. This is so because the intellect, once full of answers, is now left in darkness, confused and unsure of the next step. The will, once eager to give all to God, once rewarded by warm, confirming consolations, now languishes in aridity. The memory, once full of sweet residues of encounters with God, once able to recall occasions of nearness to the Divine and the certitude of God's presence, now feels utterly empty. On the affective level, it seems as if all is lost. Affliction replaces affection received and given by God. Bitterness seems to cancel the beauty of a sought after and received touch of love. Anguish seems to deprive one in a cruel way of the warmth and satisfaction once obtained from a seemingly endless storehouse of spiritual blessings. (Muto 1994)

It is uncomfortable for many caregivers to enter into the dark night of the soul with those who traverse the path of despair. Walk with the despairing person and listen, rather than attempting through words to coerce the person to walk a different path. Concisely stated, it is imperative to "legitimate the lament," both for the afflicted and the affected.

The sacred texts of the Judeo-Christian tradition known as *laments* legitimate such expressions, giving voice to the agony and anguish of spirits in distress. Feelings of despair, anger, and hopelessness are all articulately expressed in the lament psalms (Weiser 1962). One young person expressed it in this manner, "If God is not able to accept my anger, then he [sic] has no business being God."[4] People who are depressed are in spiritual distress, as are those who are affected by the depression. Listen! Listen! Listen! Listen with compassion, empathy, and patience, providing a ministry of a caring presence.

Distinguish clearly between "faith" and "feeling." The fundamental meaning of the word *faith* is "to trust." Faith is not intellectual assent to a given set of dogmatic propositions, be they creeds or confessions. Faith

is not obedience to an inviolate code of conduct. Faith is not equated with feelings of certitude, nor an ecstatic explosion of emotion. Faith is, rather, an implicit trust in the love of God, even when the abyss of despair looms large threatening one's very being. It becomes evident that "faith is a gift," not something that is earned, merited, or deserved. Rather, it is a dynamic experience of grace that embraces the totality of the person when that person surrenders all efforts to create, manufacture, or induce faith.

The person adversely affected might say, "I have lost all faith in God, in my loved one, and in myself. I never had any idea that depression could be so bad!" The night is too dark, the burden too heavy, the pain too excruciating. It is only when the person affected has opened herself or himself to "practicing the presence of God" in the midst of the seeming absence of God that the flicker of faith appears. This kind of faith that borders on absurdity is what Paul Tillich would term "naked faith" (Tillich 1957).

The caregiver does not attempt to instill faith; rather, the caregiver incarnates the presence of God in listening, empathizing, and agonizing with those suffering the effects of living with a depressed person. St. Chrysostom said that "Patience is the queen of the virtues," and for those who live in an "instantaneous society," expecting instantaneous gratification, patience is an attribute that is in short supply. Both the caregiver and the care receiver want the pain and the problem to be instantaneously resolved. Aid the person in distinguishing between faith as trust and feelings that are legitimate, but not as the ultimate foundation for assessing the value and worth of life.

Maintain a peaceful and prayerful presence. The gift of being a "nonanxious" presence when in the company of depressed people and their adversely affected loved ones is powerful (Friedman 1985). Actions do speak louder than words, and the most meaningful action is often the seeming "inaction" of simply showing up and being available. Caregiving at its fundamental level is being acutely aware and attentive. Many of us as caregivers have spent time with distraught people who pour out their anguished spirits, and we are the calming presence in a cauldron of bubbling pain. When they know that they have been heard, it is not unusual to hear them say, "You have been so helpful, thank you!" As the

caregiver, you haven't said a word! It is my conviction that people are not so much looking for answers as they are looking for understanding. It is often our anxiety as caregivers that gets in the way of our being "truly peacefully and prayerfully present."

The gift of presence is a powerful and potent experience. What is often missed in the narrative of Job is his friends' reaction to his incredible suffering of grief, which can eventuate in despair and depression. We focus on his friends' speeches (which come later), where they try to convince Job that his calamity is connected to some "sin" that he has committed. But we miss the gift of his friends who did not recognize him because of his condition, tore their robes, and symbolically threw dust in the air as an indication of their identification of suffering with him and then, "They sat with him on the ground seven days and seven nights, *and no one spoke a word to him*, for they saw that his suffering was great" (Job 2:13).

This kind of presence is prayer—that is, "practicing the presence of God"—with one another. Prayer in whatever mode or form it may be utilized in a given religious tradition is being present to others, being open to the Spirit of God, and commiserating empathetically with those who suffer. Of course, prayer may be utilized in its conventional form of uttering praises and petitions to the Holy One, but at its most profound level, it is relational. Prayer is a way of living in relationship to God, others as well as with ourselves. As such, it is an ensign of hope in the midst of hopelessness. It is more significant to have that hope incarnated in the silence of the caregiver, than to have it spoken in words (Welton 2006). Andrew Lester speaks of it as creating a new narrative or a new story for the person (Lester 1995).

The caregiving key is to "wait patiently for the Lord" (Ps. 37:7), as the timing is out of our hands as caregivers. Pushing another is always counterproductive and poor caregiving practice. The caregiver *is not responsible* for effecting healing; that is finally in the province of God. The caregiver ought not "get in the way of healing" by following a self-determined agenda thought to be "good for the person" who is depressed or the depressed person's family. Incarnating hope through a peaceful and prayerful presence is our role as we accompany those who suffer.

Assure the afflicted and affected of a supportive faith community. It is my conviction that "it takes a community to heal people," an inclusive community that features the best of biology, psychology, and theology. The focus at this point is specifically the community of faith that can surround those depressed and those affected by depression with their compassion, concern, care, acceptance, and gracious love. As already noted, faith communities of all religious persuasions need to be informed and educated about depression and its effects (p. XX). Accepting depression as a mental illness as opposed to a weak will or a moral failure is an important place to start. Attitudes about mental illness and all unsanctioned illnesses are deeply ingrained not only in individuals, but in the collective psyche of faith communities. Religious leaders need to work hard and tirelessly to change negative attitudes and to encourage community interest and support in ministry to the depressed and their significant others.

Those who have been afflicted or affected by depression may say, "I don't feel like going to worship." That feeling needs to be legitimated and honored. Others may say, "I can go to worship, but I don't feel like participating." That is a legitimate reaction as well and they can be assured that the community participates on their behalf. The critical issue is that they are welcomed and accepted whether they participate or not. They are always loved and accepted for where they are in their life's journey. The old hymn says it well, "Not in our temple made with hands, God the Almighty is dwelling."[5] The visible community needs to be open and accepting of their presence, but it is equally important to remember the invisible community of people whose absence for a time is legitimated by their illness and the concomitant behavior that accompanies the illness. A gracious, loving, welcoming, and accepting community can be a salutary refuge from the rigors and isolation accompanying depression. It is imperative that the community be educated, sensitive, and aware of the importance and impact of its ministry to those afflicted and affected by depression.

Advocacy for the marginalized. Faith communities, irrespective of their religious persuasions, are enjoined to advocate for the invisible, the voiceless, the suffering, and the forgotten as a way to fulfill the mandate

that the prophet Micah perhaps most succinctly articulated: "God has told you, O mortal, what is good; and what does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God?" (Mic. 6:8) "Doing justice" is an imperative that is a common theme in religious communities. The question of justice as equality of treatment, access to care, and compassionate acceptance for those afflicted with and affected by depression and all mental illnesses is a tall order. This kind of justice requires hard work, dedicated people, and advocacy at every level of society. Historically, it is evident that prophetic advocacy for justice is met with opposition, particularly when a society seems to value money more than people. It is too easy an answer to back away from the hard questions and decisions that are made in government and other halls of society by citing the "separation of church and state" as an excuse for inaction.

The Bible always pictures Yahweh as the champion of the oppressed. Jesus exemplified this in his life and ministry reaching out to the sick, (Mt. 4:24, 14:14, 35) the lepers, (Lk. 17:12) and the man thought of as possessed by a demon. (Mk. 5:1-13) The understanding of Allah in Islam as being merciful and concerned about the poor and the dispossessed is a foundational tenet. If systemic change is to occur on behalf of those who have no power, religious groups must be the voice for the voiceless and advocate for the ideal, "justice for all," and not just for the privileged.

This mandate from the very core of religious traditions needs implementation if those with unsanctioned illnesses are to experience the abundant life referenced in John 10:10. For those afflicted with and affected by depression in its various permutations, the advocacy of all religions must sound a cooperative clarion call of justice for all.

There is help and there is hope, there is heartache, but also healing. It is to that end that religious communities are called, as sisters and brothers say in Kiswahili, to stand "*bega kwa bega*" (shoulder to shoulder) in effecting positive change for hope and new life.

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