Ministering to the Depressed

Seventeen million people each year suffer from depression. Here's how you can minister to them.

by Enos D. Martin

Throughout all the ages depression has plagued mankind. Nebuchadnezzar's tortured nights of sleeplessness, Lincoln's suicidal ruminations, Churchill's "black dog" moods—the dark thread of depression is woven throughout history. It has beset rich and poor, strong and weak, believers and nonbelievers.

Depression undermines the lives of those closest to us: our neighbors, our friends, our families. The National Institute of Mental Health estimates that 7 to 15 million Americans suffer from serious depressive symptoms. Only 10 percent seek help from mental health professionals; the rest either don't know depression can be treated, or fear that it implies weakness or mental deficiency.

Church leaders are an extremely important resource for their depressed parishioners; people who need help with problems turn more often to the clergy than to any other professional.

An understanding of depression is formulated by the way a church perceives and responds to a depressed person.

Roots of Depression

Some churches espouse a spiritual explanation. To many, despair and depression are linked to unbelief and sin. Treatment for this sin is spiritual: One repents and renews his or her faith in God. But there are sincere Christians who, though they confess all known sins, remain depressed. Exhortation to return to God only adds to their depression.

Other pastors believe depression is primarily psychological. They feel it most often stems from internalized anger. They see self-expression as the remedy, and they tell people that to feel better they must "get the anger out." Although anger is a prominent part of depression and expressing it can be helpful, openly expressing anger can violate people's sense of self-control, sharpen their guilt, and deepen their depression.

A third group sees depression as primarily a medical condition—the product of a chemical imbalance that requires medication. It's true many people have loosened the stranglehold of deep depression with antidepressants, but medication can cause a drugged feeling and can drain the energy needed to deal productively with depression.

The church leader who blends all three of the above approaches into an overall perspective will be better prepared to respond to depressed people.

Common Traits of Depression

Different types of loss can trigger depression. Depression often begins with a real loss, such as a relationship severed through death or separation, a loss of health, or an end to an occupation or financial security. Paradoxically, a loss can also occur with a positive experience such as a job promotion or a religious conversion. When a person is promoted, the security of the old, familiar job can give way to a fear of being unable to fulfill new expectations. Similarly, although becoming a Christian leads many people to reorganize their lives and mature emotionally, others, when the benefits of conversion fail to continue as expected, fall into depression and feel even God has let them down. These people particularly need pastoral attention to prevent suicidal despair.

People often succumb to depression when they lose hope of fulfilling a goal. If a person finds self-worth in the pursuit of a goal, the loss of that possibility can cripple the person's self-image. For example, a man who thinks of himself as someday becoming an Olympic figure skater may sink into depression if he breaks a leg and thus loses his dream of becoming a champion.

A symbolic loss can be just as devastating. A middle-aged man became seriously depressed after he demolished his prized sports car, which symbolized the youth, vigor, and power that he felt slipping from his life.

Real losses frequently go hand-in-hand with symbolic or fantasized losses. A woman who continued to grieve two years after her husband's death was actually mourning the end of the fantasy that someday she would be able to have a good marriage and rectify the poor relationship she had with her husband.

Depression often affects personality: relationships with others and with God, thoughts, and especially mood. Depressed people complain of feeling sad, down-in-the-dumps, blue, low, irritable, helpless, and hopeless.

Feelings show in people's faces; they look down in the mouth even on a happy occasion. A rare smile in a moment of distraction quickly fades to sadness. Thinking changes; the focus is on loss and themes such as "I'm not worth anything" or "Things will never improve." Pleasures lose their appeal, and the depression seems never-ending. People sometimes become so engrossed with depressive thoughts, they can no longer concentrate on reality; things don't register with them, and they feel they're losing their memories.

Social relationships suffer. In trying to replace what they have lost, depressed people often cling to their families and friends. Then they grow angry and irritable when they awaken to the futility of this. If they feel guilty about their negative emotions, they eventually can withdraw from others completely.

Depressed people often feel estranged from God. They lash out in anger, wondering why God, who is able to do all things, has failed to answer their prayers. They wonder why God is distant and unloving, why he hasn't lifted them out of despair.

And depressed people experience physical changes. They nearly always battle insomnia. They have problems falling asleep or staying asleep or waking up too early. Sometimes they sleep too much as an escape from their depression. Other physical symptoms might surface as well: blunted appetites and weight loss are typical; others overeat to deal with depression; sexual interest may vanish; headaches and backaches occur.

Types of Depression

Depression can be classified into three basic types. The type that develops depends largely on certain predisposing factors in the person who experiences a loss.

Normal grief. The "normal grief reaction" is a healthy response to significant loss. Predisposing factors play a minimal role. There might be physical symptoms such as insomnia and loss of appetite, but they're usually transient and not debilitating.

Self-esteem remains intact. If bereaved people criticize themselves, it's for not having done more to prevent the loss. Although the social circle may narrow, close friends are a source of strength and support. People may question God, but they maintain their relationship with God and sometimes even strengthen it.

Grieving helps to reorganize bereaved people's lives. The pain of loss forces them to change attitudes and habits. The painful mood gradually paves the way for a new mode of living. Reorganization usually begins in less than three months, and the depression shows signs of lifting by that time.

Here's an illustration of the dynamics of a normal grief reaction.

Bob had worked as a machinist at a steel plant for 15 years and assumed he would be there until retirement. His company became too highly specialized and permanently laid off many employees, including Bob, who had seniority and good work records. For weeks following the layoff, Bob's friends noticed he didn't seem himself. He looked sad and was deeply concerned about how he would support his family. His wife often found him sitting in the darkened living room, sobbing into his hands. He had trouble falling asleep and lost his appetite.

Bob's pastor noticed his depressed appearance and preoccupied manner. He approached him after a Sunday morning service and said, "Bob, you look sad. Could we talk about it?" After a half-hour conversation in the pastor's study, Bob seemed a bit brighter in mood. The pastor commented, "Bob, you really seemed to be depressed over losing your job. I'd be glad to meet with you a few more times to talk about how you might want to reorganize your life." Bob readily agreed.

Neurotic depression. This type of depression develops in people who are psychologically predisposed to depression, usually because of a loss experienced during childhood, such as the death of a parent. Sensitized by this pain early in life, as an adult the individual has the tendency to react to loss like a frightened and abandoned child.

People susceptible to neurotic depression usually think poorly of themselves, but at the same time burden themselves with unreasonably high ideals. Parents often communicate these traits to their children, who build them into their self-concept. Throughout life, no matter how well they perform, they always feel they should have done better.

Early experiences like these frequently lead people to depend on others for fulfillment. A middle-aged woman, who lost her mother during childhood, felt that if she always agreed with her husband and pleased him, he would never leave her. Despite her efforts he did leave her, and she fell into a serious depression. She knew no role but her subservient one.

Neurotic depression differs from a normal grief reaction in several respects. Although usually precipitated by a loss, the fantasized or symbolic aspects of the loss predominate. The depression doesn't seem equal to its causes. A grief reaction usually resolves within three months; a neurotic depression can recur episodically over months and years. Further, the neurotic depression does not serve to effectively reorganize life. It actually prevents the person from recognizing and dealing with grief from the early childhood loss. The neurotically depressed person who tries to reorganize life often fails, which deepens the sense of loss.

Endogenous depression. Endogenous depression is related to a chemical imbalance in the body. Frequently, a family history of depression strongly suggests an underlying hereditary component. Although a loss might trigger endogenous depression, the cause of depression might not be immediately obvious, or the depression itself might seem grossly out of proportion to the degree of suffering.

Physical symptoms are usually severe and persistent. A poor appetite is typical: Weight loss can be up to 20 pounds over several weeks. There is a loss of interest in sex. Insomnia may be severe; the person may lie awake restlessly for hours or wake up fitfully during the night. Waking up too early typifies this kind of depression. Physically, endogenously depressed people often feel their worst in the morning but improve somewhat as the day progresses.

Thoughts of suicide are more common with endogenous depression than with any other type. Intense depression and unrelenting suffering prompt thoughts of suicide that become more and more persistent. Suicide seems to be the only solution.

This deep, unremitting depression can last up to six months if not treated. It sometimes alternates with periods of elation; the person becomes hyperactive and talkative. During these high periods, which can last for weeks, the depressed person uses extremely poor judgment, sometimes going on a shopping spree or behaving in ways that embarrass the family.

Medication can alleviate the chemical imbalance that causes endogenous depression. When the depression recedes, counseling can help the individual to reorganize living patterns and reduce vulnerability to future depressive episodes.

Matt, a middle-age college professor, became deeply depressed over a one-month period. He couldn't sleep or eat, and he lost ten pounds. He lost interest in his favorite pastime of golf, withdrew from his family and friends, and either sat motionless or paced the floor, wringing his hands in agitation over the doom that was going to befall him. He feared he was losing his mind and talked repeatedly about suicide.

His family searched for an explanation for the depression. Although they couldn't identify any precipitating incident, they knew his mother had had several nervous breakdowns with depression in mid-adult life. In a similar episode 15 years earlier, Matt had responded to a series of electro-convulsive therapy treatments.

Matt's pastor recognized the signs of serious depression and helped the family get in touch with a local psychiatrist. The psychiatrist immediately hospitalized Matt because of his intense agitation and suicidal intent.

Ministering to the Depressed

As a church leader, you can reach out to depressed people at a Sunday morning worship service, in a pastoral visit, or during conversation at a meeting. Be sensitive to the needs of parishioners who have suffered a loss.

Watch for signs of depression. Keep alert for nonverbal and verbal clues. Nonverbal clues take many forms: a downcast face, avoidance of eye contact, sighing or tearfulness, moving from an accustomed pew to a place near the door to leave quickly and avoid people. All of these may signal depression.

Although indirect verbal clues are more common, a person may come right out and say that he's depressed. Someone who asks how to help a friend with depression might be seeking help for himself. Or physical complaints may mask a plea for help. For example, a deeply troubled woman frequently asked her pastor to anoint her with oil for myriad physical problems and insomnia. However, when he counseled her about fears and anger and her sense of loss, her physical complaints diminished, along with her desire to be anointed frequently. If negative themes such as loss, helplessness, or hopelessness pervade a person's conversation, this should prompt the pastor to inquire gently whether the parishioner has been feeling depressed.

Of course, many pastors learn a parishioner is depressed through a relative or a friend. A casual inquiry such as "How's Bob? I haven't seen him for several weeks?" might be answered with, "Bob's not doing well; he's depressed. Could you visit him?"

Keep open communication with a depressed person. Effective communication is dependent on several factors.

- **Arrange an appropriate setting.** If you notice a depressed parishioner during a church service or group setting, decide whether there's enough privacy to approach the person afterward or if you should arrange for another time and place to talk. The church office can provide a setting for

confidentiality and freedom from distractions, and a visit in the home can help make the session non-threatening.

- **Communicate your observations.** Open a conversation by saying you've noticed some signs of depression. You need to be confident about discussing sensitive, personal subjects. If you're apologetic or indirect, the depressed person will have trouble dealing with his feelings openly and directly. You might say, "I've noticed over the past several weeks that you appear to be troubled; can we talk about it?" or "I know it must be difficult to go through what you've been experiencing; could we talk about it?" Statements such as these convey that a person hears, feels, and understands.
- **Allow the ventilation of feelings.** Now that you've stated your observations with understanding and confidence, invite the depressed person to share his own feelings. The parishioner should feel confident of your ability to handle his pain and confusion without becoming judgmental or overwhelmed.
- **Avoid premature reassurance.** Although advice and reassurance can do wonders for a depressed person, if they are offered too early they can stifle the expression of feelings. A person who is told to "snap out of it" or that "everything will be all right," or even "let's pray about it" might infer you don't want to listen anymore. Thus, the person will not only oblige by not saying any more, but probably also withdraw even further into depression.
- **Determine the type of depression** to clarify how you best can minister to a depressed person, keeping in mind the three types of depression: grief reaction, neurotic depression, and endogenous depression. You might have to ask about sleep habits, fatigue, appetite, weight loss, sex drive, previous periods of depression, and depression in family members. Carefully explore the type and extent of any loss suffered.
- **Most important, determine whether the person is suicidal.** Rather than being abrupt, ask a series of questions such as "How depressed do you get? Do you think you would yield to the impulse to take your own life? What means have you thought of using to end your life? How would ending your life affect your loved ones?" Some counselors fear that questions like these will introduce thoughts of suicide, but the opposite is true. Admitting suicidal thoughts can bring relief and even prevent an impulsive suicidal act.

Response to the Depressed

After you've gathered enough information and tentatively diagnosed the kind of depression, tailor your ministry accordingly. You might refer the person to a professional or decide to offer your own pastoral counseling; in all cases, provide effective pastoral support.

Be alert to the need for referral. A person who is endogenously depressed might need antidepressant medication and therefore require evaluation by a psychiatrist or knowledgeable family physician. If you've been counseling a parishioner who becomes worse or does not improve over several weeks, referral is necessary. Of course, prompt referral is essential when a person has suicidal thoughts.

You should tell the parishioner your impressions and recommendations, directly stating that you want to refer the depressed person to someone who can be of more help. Assure the person of your continued involvement through visits and phone contact, but emphasize that you will not participate in the treatment process. Ask the parishioner for reactions. A simple "How do you feel about my suggestions?" is adequate. Many people interpret the need for psychiatric help as weakness of character or a sign of mental disturbance. A parishioner who feels this way may resist referral. You can then point out that admitting a problem and seeking help for it is actually a sign of strength.

When the referral is accepted, contact the referral person to say you are having someone call. A good referral includes keeping accurate records of any interventions and recommendations along with the parishioner's responses to them. Then encourage the parishioner to make an appointment, keeping in touch to make sure he does. If the parishioner is suicidal, arrange for someone to stay with him until he is under the referral person's care.

For Pastors

Keep specific guidelines in mind when you counsel. A depressed person needs encouragement and definite limits in many areas.

1. **Define the ground rules.** The time, place, and length of the counseling sessions depend on your time limitations and the needs of the parishioner. An arrangement might include weekly, one-hour sessions for five weeks. If the parishioner has unrealistic expectations, such as requesting lengthy sessions several times a week and the liberty to make unlimited phone calls, you need to gently but firmly limit these demands.

2. **Inspire hope.** The adverse and destructive elements in a depressed person's life overwhelm him. Because he has no hope, you must convince him of his own hope. Your willingness to spend time boosts the depressed person's self-esteem, and your certainty that the depression will soon pass casts doubt on his depressive outlook. By listening patiently, you communicate that you see time as an ally of progress, not as an enemy that must be defeated by pushing for quick recovery.

Reminding the depressed person that he shares the struggles of many biblical figures who overcame their depressions—Elijah, David, Jonah, John the Baptist—helps him gradually develop the conviction that "If they can do it, so can I."

Giving emotional and spiritual support helps the depressed person define and take realistic steps toward practical, immediate goals. A depressed person loses hope that any actions can be fruitful; but since hope grows with evidence of progress, emphasize positive changes in his life. For example, you could close a session with "You were able to

talk about some very difficult things today. Although you're still pretty discouraged, you don't appear quite as depressed as you did at the beginning of the session." Confidence grows as the depression lifts, and he once again will begin to hope that his next steps will lead him closer to his goals.

3. **Help manage anger.** Depressed people often become angry toward their families, their friends, or even God. The parishioner sometimes blames the pastor for failing to magically replace a loss and resolve the depression. You should expect such anger and help the parishioner feel secure about expressing it. But anger should not be expressed prematurely. A person who doesn't have enough self-control to express anger appropriately might feel guilty and anxious and sink even deeper into depression.

4. **Alleviate guilt.** Guilt results from a sense of failure to live up to "what ought to be." If the depression began after a violation of the person's conscience, ask about discrepancies between the person's values and behavior. If a moral transgression actually caused the depression, accept the person's confession and help him find forgiveness and reconciliation with people he might have harmed. This usually relieves the depression and raises self-esteem.

Neurotic guilt, however, is immune to the forgiving process and seldom motivates constructive change. It reflects an inability to accept or forgive oneself. Rising in part from excessive blame and punishment during childhood, along with limited praise and love, neurotic guilt is the product of a distorted conscience that castigates the depressed person beyond reason.

The loving, accepting relationship developed with a pastoral counselor enables the person who is burdened with guilt to question his punitive self-assessment. As he learns to forgive and accept himself, his guilt dissolves and the depression begins to lift. The pastor's role is to help him develop a healthier, more functional conscience.

5. **Discourage social withdrawal.** Depressed people avoid social contact, either because they are convinced no one could replace their loss, or because they feel no one would want to bother with them in their depressed state. If unchecked, their withdrawal eventually seals them off from any source of social support, thus worsening the depression. Encourage depressed people to spend time with a few supportive friends, but be careful not to push them into potentially overwhelming social situations. Reinforce even the smallest effort at social interaction. The success of this approach is illustrated by a depressed businessman who withdrew from his work, community, and church-related social contacts, except for continued interest in teaching a Sunday school class. The pastor encouraged him to continue teaching, though on a reduced, biweekly basis. Later, after the depression lifted, this man gratefully recalled his teaching as "an island of hope and self-esteem in a sea of despair."

6. **Protect from self-destructive behavior.** Although suicide is the ultimate self-destructive behavior, there are other, more subtle forms. A medical student who drops out of school to become an orderly, or a businessman who turns down a promotion,

might both have self-destructive motivation. Try to deter people from endangering themselves or their future.

A man who thought his brother was taking advantage of him in their business partnership told his pastor, "What's the use of working so hard and having no say in what happens? I'm going to give my brother the business, and when my money is used up I'll go on welfare." Noting that the man's depression was mixed with anger, the pastor responded, "You're angry at your brother, but you're angry at yourself too. I think if you leave your business you might be hurt and suffer more than anyone else. Perhaps you can wait and decide a little later on what is in your best interest."

By suggesting what to do, the pastor avoided taking control of the person's life, yet protected him from a self-destructive decision.

7. **Clarify patterns that lead to depression.** The way people respond to life and its stresses can set them up for repeated depressions. Depressed people are often blind to their behavior patterns and fail to see how they lead to depression. A forty-year-old mother of four habitually looked to her husband for direction. She responded to his every whim. She was, in effect, saying, "I'll do whatever you ask, but then you must take care of me." When her husband started a new business and had less time for her and the children, she became deeply depressed and turned to her pastor. Counseling revealed that she felt her husband had failed to keep his part of the unspoken bargain. Her dependence and submission, along with neglect of her own thoughts and feelings, set the stage for her depression. As she realized this, she assumed more responsibility for her own life and learned to express her feelings to her husband and share in their decision-making.

Provide the support needed to work through depression. As Victor Frankl points out in his book *The Unconscious God*, "Despair is suffering without meaning." Even the most trying experience can be endured if the suffering has meaning. Help people view depression as an opportunity for spiritual growth rather than a sign of spiritual failure. Having descended into the dark depths of despair and survived, they can then face life with unprecedented vigor and the confidence that nothing, not even depression, can separate them from the love of Christ.

If a depressed person feels spiritually distant and alienated, use biblical passages to acknowledge the person's feelings of abandonment while fostering trust in God's continued presence. You can point out how Christ cried out in the midst of his suffering, "My God, my God, why hast thou forsaken me?" and yet in the end reaffirmed his faith: "Father, into thy hands I commend my spirit." Prayer strengthens the depressed person's spiritual contact when he feels estranged and angry at God for not lifting the depression. When you offer a prayer, mention those feelings of alienation from God. You might say, "Sometimes, God, you feel far away and don't seem to care; we feel angry and sometimes want to give up. Yet we know you're still there and that you care." By acknowledging negative feelings in the prayer, you imply that both the depressed person and God can hear about them without recoiling in horror.

The family of a depressed person needs guidance in understanding their depressed relative, as well as help in coping with the situation. They might resent the depressed person for overreacting to a loss they might have to deal with too. If the person suffers from a depression of the endogenous type, the family will need to understand how the depressed person's mood, thoughts, behavior, and physical symptoms are part of illness. If the person suffers from a neurotic depression, family members may be inadvertently contributing to the condition.

For example, a husband may discourage his depressed wife's attempts to express her feelings about their relationship. You can tactfully point out this kind of situation, sensitively exploring the family's thoughts and feelings about it. You should, however, be careful to avoid a blaming or accusing tone.

Friends often try to help at first, but then draw back in confusion when the depressed friend rejects their well-meant efforts. Explain the depressive symptoms to them, emphasizing the seriousness of social withdrawal. Encourage them to continue to meet singly or as a group with their depressed friend, and help them learn how to be supportive. Such involvement can strengthen personal relationships and can be an important factor in the resolution of depression.

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