DEPRESSION: COGNITION AND SPIRITUALITY

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Depression is the third most prevalent mental disorder, with about 8% of the population suffering from this disorder (Robins & Regier, 1991). The effects of depression are varied with insidious consequences both to the suffering patient, his/her family and society. Depression was known to Job who tells us: "My eye has grown dim from *grief* [depression], it grows weak because of all my foes" (Job 17:7)(italics mine) . The prophet Jeremiah tells us: "My *grief* [depression] is beyond healing, my heart is sick within me"(Jer 8:18)(italics mine). The Apostles and Church Fathers equally knew the deleterious effects of depression. "…worldly grief produces death.", states St. Paul. This "death" is both of the social and occupational functioning, expected of us in this world and a "spiritual death" of the soul blocking out the light of God's love and leaving us in the darkness of despair. St John Cassian tells us: "But first we must struggle with the demon of dejection who casts the soul into despair. We must drive him from our heart. It was this demon that did not allow Cain to repent after he had killed his brother, or Judas after he had betrayed his Master."

Because we are made in God's image and likeness, we can use our intelligence to help understand and treat mental disorders such as depression. The best use of our "intelligence" today is scientific research. One of the fruits of this research is the Cognitive-Behavioral Model of Emotional Dysfunction (Beck, Rush, Shaw & Emery, 1979,; Ellis, 1962,; Morelli, 1987, 1988. 1996). According to this model, emotions such as depression are produced by distorted or irrational beliefs, attitudes and cognitions. Situations, (some event that has happened or something that someone has said or done) do not produce or cause emotional upset, rather we upset ourselves by our irrational "interpretations" of the situation. Recent research by Izard (1993) has revealed additional pathways of emotional activation which include sensorimotor and affective neural events. Morelli (1996) has pointed out however, that because of the reciprocal interaction of these events, cognitive behavioral treatment is usually effective with patients suffering from emotional disorders activated by any of the three (cognitive, sensorimotor, affective) pathways. Thus an understanding of the cognitive distortions that produce dysfunctional emotions, and more specifically depression, is important for effective clinical intervention.

There are eight cognitive distortions. *Selective Abstraction* is focusing on one event while excluding others. In one of my recent cases, "Jack" an engineer, selectively focused on a reprimand, he just received from his supervisor, while ignoring the praise he received the previous week from the Senior Project Manager. This irrational perception led to his depression. *Arbitrary Inference* is drawing a conclusion unwarranted by the facts in an ambiguous situation. The

same patient mentioned above, the engineer, concluded his next evaluation (given by his supervisor) would be unsatisfactory. This led to further depression. *Personalization* is attributing an event that occurs is being done to you "personally". Another patient "Linda" became depressed when during a business meeting (attended by her section comprising about 25 people), her supervisor made a said some in the section are not "team players". She immediately "personalized" the statement, of course with no evidence that the boss was directing it at her. *Polarization* is perceiving or interpreting events in all or nothing terms. "Cynthia", another patient of mine, became depressed after receiving a 'B' in a college course. She "polarized" events into two categories, good student-bad student. A 'B' fell into the bad-student pole. She failed to seen that all events can be graded on a continuum between two poles. On such a scale a 'B' is closer to an 'A' that to an 'F' for example. *Generalization* is the tendency to see things in always or never categories. Another patient, "Mary" became depressed during marital therapy, when she irrationally concluded that her husband will "never" change and will "always" be the same. Her dysphoria led to a self defeating pattern of behavior which further distanced her and her husband an set herself up for the very thing she did not want: a poorer marriage. *Demanding Expectations* are beliefs that there are laws or rules that have to be obeyed. "Kim" came into treatment because she was depressed over her son's talking back to her. She irrationally believed that there is a "law in the universe" that says that children should do what mothers ask and if not she has the right to get upset. God "asks" us to obey Him. He gave us free will. Christ Himself, respected the free will of the creatures he created as shown by the gentleness of His admonitions Like Christ, parents should prefer and constructively work toward reasonable obedience from their children. A program of rewards for appropriate behavior and punishment for inappropriate behavior administered without anger, anxiety or depression would be constructive. *Catastrophizing* is the perception that something is more than 100% bad, terrible or awful. "Kim" erroneously reacts to her son's talking back as the "end of the world". Finally, *Emotional Reasoning* is the judgment that one's feelings are facts. Sandy has a "feeling" that her new boss does not like her. When asked how she knows this she responds that her "feelings are always right". She fails to distinguish a feeling as real which it is versus a feeling 'proving something', which is impossible. For example, I tell patients: "No matter how strongly some people 'felt' during the time of Christopher Columbus the world was flat, it did not make it so".

Beck, (1976) points out that besides the cognitive distortions, depression involves the cognitive theme of "loss", and in addition, what he calls the cognitive triad: a negative view of self, world and future. In other words if a clinician were to analyze the "self-talk" of depressed patients, these themes as well as the cognitive distortions would be present. One example from above will illustrate this. "Jack" the engineer who received the reprimand from his boss, thinks of losing his bosses respect and esteem and further perceives he is less of a person, thinks others will see him as incompetent, and he may loose his job and

never find another one. This cognitive feedback loop of distortions, loss, and triad, produces a cascade of deepening depression.

Effective clinical intervention involves helping the patient to first recognize and label the cognitive distortions and themes. This is followed by helping the patient restructure the distortions. Three challenging question are helpful in restructuring: 1) Where is the evidence?, 2) Is there any other way of looking at it?, and, 3) Is it as bad as it seems? This can be illustrated with "Jack" the reprimanded engineer mentioned above. Answering these questions "Jack" might come up with an alternate more rational perception, "True my boss criticized my project, but in fact, he has praised other work I have done and even last week the Senior Project Manager was real pleased with something else I was working on". "Just because I was reprimanded for one error doesn't mean all my work is bad and unappreciated and surely doesn't mean I will loose my job and be out in the street." Following this cognitive restructuring process "Jack" begins to feel less depressed. The next step is to help "Jack" become more behaviorally 'pro-active' "Jack" was helped to "debrief" the error. That is to understand what brought the error about, and to develop a plan to change these circumstances for more effective current and future functioning. This behavior change process interacts with the ongoing cognitive restructuring to produce even less depression, that is, more mood elevation. This cognitive restructuring technique works with all the distortions listed above.

Special cognitive intervention procedures however, must be done with *Demanding Expectations, Catastrophizing* and *Emotional Reasoning.* As alluded to above, patients with *Demanding Expectations* frequently try to forcibly impose a personal set of rules on others or the world around them. Laws of Nature (e.g. gravity) are inviolate, because God made the universe to function by these laws. His commandments to us, societal and governmental rules and laws and family rules are of a different sort. God gave us "free will". We cannot violate the law of gravity, but we can disobey His commandments (as well as social, legal and family laws and rules). Of course to disobey these latter laws or rules has differing degrees of consequences, from eternal peril to minor significance. This is not to trivialize God's commandments, societies laws or parental values or family rules. God wants us to obey Him. So too, parents should want, that is prefer, (not demand) their children respect and obey them. Consequences (Patterson & Guillon, 1971) should shape behavior not emotional over-reactivity. In fact when our demands are not met we are not usually very effective at bringing about the result we want. Parents consumed by anger, anxiety and/or depression do poor parenting. They model inappropriate behavior and fail to use a behavioral management program that would bring about the desired appropriate behavior in their children. A motto for effective parenting might echo Theodore Roosevelt: "Speak softly [no dysfunctional emotions] and carry a big stick [not literally a stick, but lovingly and consistently applied consequences]. For example if a school aged child is having a problem doing homework, the rule might be first you do your homework then you go out to play. No exceptions!

Without, worry, anger and/or depression the parent merely let's the rewarding consequence (playtime) do the work of increasing homework.

A special cognitive technique has been shown to be effective with *Catastrophizing* (Burns 1980, Morelli, 1987). The "Mental Ruler Technique" involves evaluating a situation on a 0 to 100 scale, with 0 being the most pleasant thing you could picture happening to you. Patients infrequently have trouble imaging a very pleasant event (0). Sitting on a sun drenched tropical beach is a typical image. Patients frequently need help however, imaging a "graphic" worst event (100). Use of the example of the particularly horrifying death of a medical missionary in South East Asia several years ago has been helpful. After starvation failed to kill him quickly, his captors placed chopsticks in his ears and hammered them in a little each day, until they penetrated his brain with his resulting death. Patients or parishioners will frequently speak with me about the death of loved one especially a child as "the" most awful thing on earth. This is frequently said in a sanitized abstract way. While the clinician and/or parish priest surely must help the individual with the grieving process allowing for the expression of feelings, care should be taken not to endorse a "catastrophe" mental ruler appraisal. Thus for example, while the loss of a child is a bad thing and for which one has appropriate sorrow and grief, unless it reaches the dimensions of "100" it is surely less than the "most" terrible thing on earth. Catastrophic evaluations also frequently broadcast a lack of faith. Surely the faith of the Christian is of God Who freely gives life and calls us back to Him; does all for love and even though it is out of our understanding; and has a greater, higher, divine purpose for all that He wills or allows to happen. It behooves the Christian clinician to use spiritual as well as psychological means to aid to treat such depressed patients.

Emotional Reasoning also requires special cognitive intervention, because depressed patients tenaciously hold onto the irrational erroneous belief that their feelings are proofs of the truth or falsity of events. How many times has a parishioner or patient said something like: "I just *feel* I will never [get better…find a job…get over this…make friends …etc.]. As mentioned above, such individuals frequently mistake a feeling or emotion as real or felt (which it is) versus proving the truth or falsity of the event one has the feeling about. Giving the individual extensive practice with feeling and events that he/she may have had in the past but not now related to his/her specific problem is an effective starting point. For example, you might ask the patient to recall an event that he/she felt "really sure about", that turned out untrue. One of my patients recalled an instance in which they "felt certain" they had failed an exam. [Another common example is t someone does not like or approve of them.] In all cases help the patient explore what happened when they discovered they had felt incorrectly. What lesson is there in this discovery? For example, the individual above found out they had done well in the test, when they had previously "felt" they failed: What does this say about feelings as facts? Are there other ways of

interpreting or understanding feelings? After such cognitive exercises the patients current *emotional reasoning* distortion can be addressed.

Behavioral practice accompanies the cognitive restructuring procedures. This includes the filling out restructuring charts (see Burns, 1980) as well as to *invivo* exposure to challenging social and environmental events related to the depression. For example "Jack" our erstwhile patient, may be encouraged to go to his supervisor and ask for feedback regarding other projects he has worked on. Behavioral assignments decrease depression by providing realistic information that then may be processed through veridical cognitions. Increased behavioral activity itself has been shown to ameliorate depression (Beck, et. al. 1979). It may be hypothesized this dysthemic attenuation takes place due to the mediation of yet specified CNS neurotransmitors.

With the Orthodox Christian patient, spiritual intervention can also be initiated concomitant with the cognitive-behavioral treatment. Prayer, selected spiritual reading, and the sacraments provides spiritual healing for mind body and spirit. The clinician must take care that the patient does not misinterpret scriptural passages and spiritual reading and thereby increasing the depression. The patient may well make his/her own the words of Job: "For the arrows of the Almighty are in me; my spirit drinks their poison; the terrors of God are arrayed against me…. Can that which is tasteless be eaten without salt, … My appetite refuses to touch them; they are as food that is loathsome to me." (Job:6: 4-7). If reading were to stop here, surely the patient might consider God has abandoned him/herself as He Job thought initially that God abandoned him. Of course, Job is faithful to God despite his adversity and in the end God rewards him. Rather a prayer of hope can be made: "But thou, O LORD, be not far off! O thou my help, hasten to my aid! Deliver my soul from the sword, my life from the power of the dog. Save me from the mouth of the lion, my afflicted soul from the horns of the wild oxen! I will tell of thy name to my brethren; in the midst of the congregation I will praise thee:" (Ps. 21:19-22).

One factor that deserves special consideration in the treatment of depression is suicide. A high score on the Beck Depression Inventory (BDI) (Beck, et. al 1979), a score of 2 or 3 on item 9 (I would like to kill myself/I would kill myself if I had a chance) and thoughts and feelings of 'hoplessness' are special risk factors. [One good reason to give the BDI in initial and subsequent clinical sessions is that it has this suicide item which may be overlooked in a regular treatment session]. The Scale for Suicidal Ideation (SSI) (Beck, et. al. 1979) can also be helpful in diagnosis. Suicide should be immediately addressed by the clinician and patient. This is a clinical emergency and more than one concurrent session may be needed. One effective cognitive-behavioral clinical technique is to first explore with the patient all the favorable reasons to commit suicide. This helps the clinician understand the patients problem from the patients' viewpoint. Feeling understood the patient then may feel empowered to explore the reasons not to commit suicide. Of course the latter exploration

coupled with cognitive restructuring, and spiritual intervention is the therapeutic factor. Such patients may also require psychopharmalogical treatment. In no case should a suicidal patient be released without attenuation of suicidal ideation.

Depression is so insidious, not only because it takes away life's pleasures hopes and aspirations, but because it also robs us of the sight of God. In the depths of despair we do not pray to Whom we do not see. We see ourselves cut off from Him who is the source of all life. However using our intelligence, we may use scientific clinical approaches, which as outlined above, has been shown to be effective in the treatment of depression. Coupled with our faith, mind body and spirit may be healed and reunited to God.

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